The Effectiveness of Group Therapy in Changing Family Role Patterns Towards Disabled Members.

Marvin E. Thames

Louisiana State University and Agricultural & Mechanical College

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The shop steward: An empirical study of work behavior and job satisfaction among black employees in a chemical mill.

La Louisiana state university and Agricultural and Mechanical college, Baton Rouge, 1976.

University Microfilms, Inc., Ann Arbor, Michigan
THE EFFECTIVENESS OF GROUP THERAPY IN CHANGING FAMILY ROLE PATTERNS TOWARDS DISABLED MEMBERS

A Dissertation

Submitted to the Graduate Faculty of the Louisiana State University and Agricultural and Mechanical College in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

The Department of Sociology

by

Marvin E. Thames
B. A., Louisiana State University, 1946
M. S., Louisiana State University, 1957
January, 1970
ACKNOWLEDGEMENTS

An expression of gratitude is extended to those who encouraged and influenced the author of this study. These include Professor Alvin L. Bertrand for his patience and encouragement in all aspects of this study, for his advice and criticism in guiding the research preparation, and for his direction of this dissertation; Professors Vernon Parenton and W. J. Jokinen to whom the writer owes his principle theoretical and analytical orientation; Professor Nelson A. Hauer to whom the author is indebted for his orientation in industrial and vocational education; to Professor Arthur G. Cosby for helpful suggestions; and to other Graduate Faculty of both Louisiana State University and Tulane University for the educational opportunities afforded.

Another note of thanks is due Dr. Harris Goldstein, Dr. Alvin Cohen, Dr. Ed Haslam, Dr. George Morlier, Henry Nebe and the Delgado Rehabilitation Center Staff, and the U. S. Office of Social and Rehabilitation Services for establishing a special project at Delgado College. Many others gave helpful suggestions, especially Mrs. Jeannie Dileo,
Mr. Bob Creel and Mr. Pat Galloway.

Grateful appreciation is also extended to my understanding wife and family for making conditions suitable during these many months to bring this work to a conclusion.
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ABSTRACT

This work represents an effort to determine the effectiveness of family group therapy as a device to improve role relationships within families having a handicapped member. The inspiration for the study came from the fact that many families tend to become disorganized when a member is disabled. On the one hand, family members are overprotective of the disabled individual; on the other, they tend to reject and be ashamed of him. The broad aim of the study was to improve such situations through induced change in role relations.

An experimental design was worked out, using families enrolling a handicapped member in a rehabilitation center as the source for an experimental sample population and a control sample population. These families were all administered a questionnaire designed to determine the closeness of their role relations. One-half of these families were placed in a control group and the other one-half were placed in an experimental group. The latter were administered group therapy relating to the care and adjustment of the handicapped. At the end of a sixteen week
period the families in the control group and experimental group were retested with the same questions asked them before.

Findings of the study indicate that group therapy can be used to change family role relationships. Those families in the experimental group improved their family relationship scores over time and over the control group as well. In addition, the handicapped members of experimental families made greater progress in performance and adjustment than the handicapped member of the control families. This finding serves to validate the usefulness of group therapy as a tool for improving family and individual adjustment in families with handicapped members.

The implication of the study is that rehabilitation centers can improve their effectiveness by adding family group therapy to their programs. It also appears that this approach would have application in other situations. The broader implications of this study was for social structure and organization along with some inter-disciplinary theoretical connotations for the fields of psychology, psychiatry, social welfare, vocational-industrial education, and sociology. The study has an implication for sociology in that very little attention has been paid thus far to the application of role theory to programs designed to bring about group change.
CHAPTER I

SCOPE AND DESIGN OF STUDY

Increasing public attention and funds have been devoted to programs for rehabilitating the disabled within recent years. This trend has been accompanied by investigations designed to shed light on the best ways and means whereby individuals with sensory handicaps, such as deafness or blindness, other physical handicaps, such as loss of limbs, or of mobility; and mental deficiencies could be prepared for some degree of participation in the social world about them. The research done has indicated that many sociological factors need to be considered in the planning for the rehabilitation of disabled persons. In this regard, the family (or relative) group is one within which most disabled persons must interact for prolonged periods. This interaction can and does have significance in terms of: (1) the disabled persons opportunity and potential for becoming better adjusted, and (2) the family's adjustment within the greater societal setting. The study undertaken and reported here finds its relevance in the fact that little empirical knowledge is available regarding these types of
adjustments and the problems they create.

The Study Setting

The setting for this study is a rehabilitation center located in the heart of a great metropolitan area, that of New Orleans, Louisiana. This center functions as one of the integral units of a comprehensive complex, including a Junior College and a trades and technical institute. It is a nationally supported pilot program for rehabilitating certain types of disabled persons, such as the deaf and the physically handicapped.

The rehabilitation services consist of three related programs: A Social and Rehabilitation Evaluation Center, an Orthotics and Prosthetics Technology Unit, and an Academic and Vocational Education Program for the Deaf. The operation of the division features a combination of vocational, psychological, social, and medical services. This program is complex and requires the joint skills of rehabilitation specialists such as physicians, psychologists, therapists, social workers, vocational evaluators, vocational instructors, and professional consultants. The major objective of the total unit is to assist the disabled by providing a social rehabilitation bridge between a period of hospitalization and/or inactivity, and vocational preparation for social and occupational adjustment.
Clients come to the Delgado Rehabilitation Unit as day students on referral of State Rehabilitation Agencies for vocational evaluation. Clients can be referred to the unit from any state in the nation for a sixteen-week evaluation period. In many cases this initial stay is lengthened by one or more additional periods of sixteen-weeks.

A client is accepted for evaluation at the Center by a decision made at a joint staff conference. If accepted, he or she is immediately assigned to one of the six vocational evaluation areas: Business, Graphic Arts, Personal Services, Crafts, Industrial Practices, and Building Trades. During this period of vocational evaluation, clients engage in work activities and are constantly under the close supervision and observation of a trained evaluator. This enables the handicapped individual to demonstrate his or her aptitudes, work habits, personality traits, and physical capacities in manual skills in a work setting and provides information needed for later placement.

The client may be evaluated in one area, a combination of areas, or in all six of the vocational areas. The evaluator maintains comprehensive vocational data on the client's performance, including weekly ratings on twelve items (which are called "criterion" variables): (1) Dress, (2) grooming, (3) posture, (4) application of instructions,
(5) learning retention, (6) work traits such as organization, initiative and perseverance, (7) work tolerance, (8) safety consciousness, (9) cooperativeness, (10) attitude toward vocational objectives, and (11) quality and (12) quantity of work produced. These ratings are suitably operationalized, in that tests have shown two independent raters of a client can agree within one scale point on 80 per cent to 90 per cent of all ratings.

Basic Assumptions and Objectives

The assumptions upon which the study was based can be outlined in two basic statements: first, that a disabled family member places tensions on himself and his family, and second, these basic tensions can be modified by group therapy.

In elaborating on the above assumptions, it may be pointed out that it is recognized that at least two basic "tension" patterns have been detected in families with a disabled member. In the first instance, there is a tone of resentment, of guilt, of blame and even of shame in family behavioral patterns. Family members resent the additional work and care the disabled person has to have, and may even feel stigmatized in the eyes of outsiders by his or her presence. In the second instance, the reaction of family
members can be described as overprotection, a behavior which has ramifications for the personality and adjustment of the disabled as well as other members, despite its seeming good intentions.

With regards to the above, it is obvious, of course, that some families can and do make relatively good adjustments in "handicap" situations. Jackson points out that it is an important fact that all families do not follow traditional role patterns.¹

With regards to the second assumption made, that stresses or tensions in role relationships in families with a disabled member can be modified through group therapy sessions conducted by a competent professionally trained person, the following can be said: first, therapy techniques have achieved a considerable degree of concensus. For one thing, there is general agreement that the family rather than the individual should be thought of as the "pathological" unit. Bowen² defends this position by arguing that because the family is theorized to be the "unit of illness,"


then the family must also be the "unit of treatment."

Satir\(^3\) found that a family will behave as a unit and insisted its members must be treated as such. Carroll, et al.,\(^4\) arrived at the conclusion that family therapy is particularly useful when discomfort exists in intimate relationships and there is reciprocal pathological interaction between family members. Finally, Ackerman\(^5\) makes it clear that the impairment of complementary role relations serves to undermind the stability of the family and to aggravate the intrapsychic stress between the patient and other members of the family. He feels that family therapy serves to remedy this situation.

The above listed assumptions are the basis for the specific objectives of the study. The latter were designed to apply to a sample group selected from clients of the Rehabilitation Center and include:

1. A determination of the socio-cultural characteristics and patterns of role relationships of families with a disabled member, which relate to this member.


2. A determination of whether a particular type of group therapy experience will serve to change the characteristic patterns identified in objective 1.

3. A determination of changes brought about by group therapy will serve to increase family solidarity and adjustment.

4. A determination of whether or not family therapy will improve the rehabilitation potential of disabled family members.

5. A contribution to sociological knowledge, through exploration in the realm of role theory and induced change.

6. A contribution to the field of rehabilitation studies, by providing evidence for using new therapeutic approaches in centers where study and training is carried on.

Conceptual Frame of Reference

At this point it is relevant to give a broad outline of the theoretical framework which was followed. Later chapters will be utilized to describe the conceptual and analytical approaches taken in much greater detail.

It was conceived that this study would fall within the framework of role theory, although it's broader implications would be for social structure and organization. It was also felt the study would have inter-disciplinary connotations for the fields of sociology, psychology, psychiatry, social welfare, and vocational education. However, the latter will not be made explicit in the brief statement which follows relative to the theoretical framework of the proposed research.
Role theory provides an efficient way to analyze the relationships which exist within a group structure. It also makes it possible to explain how one group or social system is linked with another to form more complex structures. Several authors have been very explicit in this regard. They point out that the norm or behavioral expectation is the smallest unit in the structure of a group. Subsets of norms which are closely related are seen as making up a role, and several roles, in turn, make up a status-position.

Role stresses were also conceived as vital to the analytical scheme in mind. In attempting to understand and describe the tensions which characterize families with disabled members, the literature which pertains to this aspect of role theory was utilized. In this regard the works of Coser⁶ and Dahrendorf⁷ are well known. More recent works, such as that of Bates and Nix⁸ which describes the source of

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role conflict and stress and of Bertrand which shows stress to be normal in social groups; was also utilized in a manner to be explained later.

Finally, in the analytical approach adopted, social change and especially induced change were of vital interest. Here works of authors like LaPiere, Barnett, Rogers, and Moore were used as general references. Specific aspects of group change were sought in the works of the role theorists mentioned above and others, who have dealt with small group situations.

Methodological Procedures

The research procedure followed for the study is classified under the general heading of an experimental technique. The steps involved were:


14For an appraisal of the use of the experimental
(a) To obtain participation in the study, relatives of all disabled persons referred to Delgado College Vocational Rehabilitation Center were interviewed personally and invited to take part in the planned experiment. (For unmarried clients, these interviews were with parents, and for married clients the interviews were with spouses.) The families with negativistic attitudes, those refusing to cooperate, were excluded from consideration because of their unsuitability for group therapy participation. It should therefore be understood that the same consists only of persons willing to participate in the study.

(b) Relatives who agreed to participate in the study were given a number which corresponded to a number given the disabled member of the family. Numbering was in chronological order of interview.

(c) Even numbered relatives and clients were designated "experimental" and odd numbered relatives and clients were designated "control," with one exception. Several experimental relatives were chosen consecutively at the beginning of the study, in order to facilitate the formation of a group. Following this, an equal number of

client relatives were assigned to the control group and thereafter relatives were assigned alternately to either the experimental or control group, with an attempt made to keep the groups equal in size.

A letter of acceptance was written to those chosen for group therapy and all experimental relatives were reminded of subsequent meetings by telephone and/or postcard. In order not to disrupt the group with frequent additions of new members, two or more relatives were added to therapy groups at the same time, in order to keep disturbances at infrequent intervals. Relatives were invited to remain in the group sessions until the client (the handicapped member of the family) was terminated from the Center.

(d) The family members in the experimental group were given weekly group therapy experience designed to improve understanding of disabled members. This experience lasted sixteen weeks. Therapy sessions were held under the direction of an experienced social worker, and included males and females in groups ranging in size from a minimum of four persons to a maximum of twelve persons. The family members in the control group did not receive the therapy experience. However, five experimental families were lost in the follow up because their questionnaires were not fully completed.
The experimental group ended with 28 families and the control group ended with 23 families.

(e) At the end of the initial interview explained in (a), all persons in cooperating families, experimental and control, were administered a carefully prepared questionnaire. This questionnaire was developed from a number of studies that were aimed at measuring role relationships, family solidarity, decision making patterns, communication patterns, and other kinds of family interaction. It was designed so that it could be completed without assistance by a husband and/or wife and independently of each other if desirable. Experience showed that on the average it required about thirty minutes for completion. The pattern of possible responses were on a continuum and permitted assignment of a numerical score to each item which will be explained subsequently.

The wording of items was deliberately planned so that for some items the response "almost always" and for other items the response "almost never" respectively represented maximum family solidarity and interdependent role relationships. This plan was adopted to reduce the likelihood of "halo effect" from item to item and any consequence invalidation of a response set because a respondent had tended to check the same categories for each item. General
information was also obtained -- that is data on age, sex, education, occupation, socio-economic level, etc., of family members.

(f) At the end of the therapy period, members of experimental and control family groups were readministered the questionnaire they had previously completed, described in (e) above. When a client classified as control or experimental was terminated, he was matched with a client of the opposite classification, who had approximately the same admission date. Some relatives found it difficult to return to the Center in person. These were mailed a questionnaire and return envelopes, addressed and stamped. Those who failed to return the questionnaire were reminded to do so by telephone or letter. When this procedure failed, visits were made to the home and the questionnaire was completed in an interview.

(g) The final step was the coding, and processing of the data obtained in the questionnaires. Conventional statistical procedures were used to test for differences between the means and distributions of the data from the experimental and control groups. These procedures and the findings derived from them are described in the chapters which follow.
CHAPTER II

ROLE THEORY, THE SICK ROLE, AND THE ROLE OF THE HANDICAPPED

Attempts to systematize sociological thought and explorations in human behavior have taken many facets. On the one hand there have been total societal approaches, such as Sorokin's notion of fluctuations in "cultural supersystems."¹ On the other hand, there have been the micro level approaches exemplified by the concepts and postulates of role theory.² The present study was conceptualized in terms of the latter, because of the adaptability of induced social change processes and behavioral problems to this theoretical framework. Role theory concepts relevant to the study made are presented and defined in this chapter and the roles of the handicapped are described.


The Perspective of Role Theory

The growth of role theory has proved to be a prominent feature in the development of sociology within recent years. Its advance has been favored because it is an orientation which both sociologists and social psychologists may share. It is an attempt to provide a conceptual framework suitable for the discussion of personal interaction in organizations and in institutionalized relationships, such as familial, professional and class-room relationships.

The approach of role theorists is based on two major assumptions: first, there is an assumption that roles are learned in the process of social interaction; secondly, there is an assumption that when people interact with others they see themselves and their alter actors as occupants of particular statuses, and their action is guided by what they know, or have learned, are the behavioral expectations associated with these statuses. There are several role theory schools, but two traditions stand out: the structural tradition which came to the fore with the work of Ralph Linton, and the

\[ ^3 \text{Ralph Linton, "Status and Role," from Readings on Sociology, Schuler, et al., eds. (New York: Thomas Y. Crowell Co., 1960).} \]
social-psychological tradition which is an outgrowth of the work of George Herbert Mead.\(^4\)

The approach of this study combines certain aspects of both the structural and social-psychological schools. It is assumed that roles are structural parts of status-positions and serve to link two positions through reciprocal behavior. The structural relations of roles are seen as determining how resources in any social system are to be employed to perform systemic functions.

The perspective taken may be explained as follows: In examining the social structure of, for example, a family, several characteristics of roles can be seen. There is a web of normative behavioral requirements for maintaining the family, including the informal rules that arise out of the activities of those involved in the system. Often, however, a discrepancy between the normative structure and actual behavior can be detected. This non-conformity depends on many factors: clarity of roles, how difficult they are to

\(^4\)George Herbert Mead, *Mind, Self and Society* (Chicago, Illinois: University of Chicago Press, 1934). In addition there is a psychiatric version associated with Harry Stack Sullivan (1953) and the psychological varieties of Theodore Newcomb (1950) and others. One of the fundamental postulates of role theory, as expounded by Newcomb and Parsons and other role theorists, is that a person's attitudes will be influenced by the role that he occupies in a social system.
perform, and the sanction system, among other things. The sanction system includes rewards and punishments for behavior. Conformity is related to the effectiveness of sanctions in bringing about desired behavior. The nature and severity of the sanction depends on the type of norm violated; i.e., the importance which is attached to it. Social pressures, thus, underlie both approved and disapproved behavior.

The Basic Concepts of Role Theory

There are several basic concepts from role theory which are significant to this study. Each of these is defined and described in detail to provide a conceptual framework for the analysis which follows:

**Norm**

A Norm is viewed as the smallest unit of analysis in the study of social structure and is defined as brought out in Chapter I, as "a patterned or commonly held behavioral expectation, a learned response held in by members of a group."\(^5\) From a social-psychological point of view, Newcomb

makes the following observation:

The important thing about a group's norms, you will remember, is that they make possible communication among its members. People can interact without any common body of norms, but they cannot communicate in the sense of sharing meaning through their interaction.\(^6\)

From the above, it can be seen that norms are social rules that govern conduct in social situations. A norm, in this sense, can be called a cultural specification that guides behavior and promotes cultural values. Norms can be subdivided into many types of classes and categories. The following classification is one of the most common:

1. Folkways are norms that are not supported by written laws, but are followed due to traditional practice. An individual acts to conform because it is customary to do so. Examples here are manners, dress, and eating habits. Affective overtones attached to folkways are not strong and non-conformity to norms is seldom followed by strict social sanctioning.

2. Mores are norms which are involved with moral conduct. They are integral elements in social functioning. Violation of a more threatens a value which society considers of great importance. This results in reactions which are often regarded as both legal (official) and social. Social associations, employment and other affiliations may be cut off for a bigamous man and even stronger punishment can come to the individual who engages in murder or rape.

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(3) Laws are socially enacted norms which appear in societies having some type of political organization. Laws are institutionalized, but are in keeping with prevailing social values. They usually have a base in public feeling. Attention should be given to the fact that, due to the institutionalized nature of laws, there is more resistance to change from legal expectations than other norms.

Thus, norms make social life predictable. In some situations that emerge, an actor does not have to think rationally, make a choice, decide a matter, etc., because the appropriate responses and behavioral patterns are already known to him. In addition, norms tend to support what may be called cultural "ethos," a basic life pattern emphasized by the society; therefore, an individual actor can observe a common thread running through most examples of "norm behavior."

Role

A role is viewed as the second smallest conceptual unit of social analysis. Roles are seen as "a part of a social position consisting of a more or less integrated or related subset of social norms which is distinguishable from other sets of norms forming the same position." Linton, in

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7Frederick L. Bates, "Position, Role and Status, op. cit., p. 314.
8Ibid.
what has become one of the most quoted references on role, states: "A role represents the dynamic aspect of a status."⁹

Role relationships are reciprocal in nature. This means that actors play roles toward other actors and a role, thus, implies and requires the carrying out of another role by a second actor.¹⁰ Said another way, there are well-defined obligations and duties, as well as certain rights, which are associated with roles.

Role Consensus: The concept of role is incomplete without the concept of consensus which refers to the degree of identicalness in role perception among a specified group of role definers.¹¹ Consensus indicates some kind of mutual understanding, but not absolute and rigid in the form of agreement. With consensus, actors are able to play roles and understand roles played by others. In Parsons' words,¹²

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actors are presumed to share and be aware of each others' behavior applicable to given situations. When the role incumbent or actor puts these expectations into effect, then he is said to be playing his role according to a general consensus.\textsuperscript{13} In this regard, complete consensus on a given role is seldom found. When consensus is lacking, stresses in role relationships occur. These stresses are listed below because they are of importance to this investigation.

\textbf{Role Frustration:} An actor may find that, for some reason, he cannot perform his role satisfactorily; although, he knows what to do. These situations occur because of inadequate facilities or other limitations. A handicapped person or a "sick person" might become frustrated in trying to play roles because of his condition. He is just not able to do what he knows should be done. Role frustration can, obviously, lead to difficulties in a group, such as tensions.

\textbf{Role Inadequacy:} Sometimes actors are placed in status-positions for which they are inadequately prepared; that is, they cannot perform well, because they do not know what to do. Their inadequacy may be due to personality traits,  

such as lack of experience or mental ability. A handicapped person, very often, has not had the experiences a normal person receives. For this reason he may be placed in a position of responsibility without proper evaluation of his capacity to perform. Such a situation, again, can cause stresses in interpersonal relations.

**Role Incongruity:** Role incongruity is a third type of stress which may affect the handicapped. This occurs when the formal attributes of a status-position are not consistent with the informal attributes associated with this status-position. For example, if an actor with a disability is paid less than others in similar work positions, then he is likely to fall a victim of role incongruity. Such a consequence has implications for both adjustment and morale.\(^\text{14}\)

**Role Conflict:** A fourth type of role stress is role conflict. This is, perhaps, the most common type. Role conflict occurs when inconsistencies arise between two roles which the actor has to play. To illustrate, the newly handicapped father experiences role conflict when he cannot provide for his family, yet he does not want to accept charity.

In this instance, conflict comes with whichever role is played. If the handicapped is too independent, his family group will suffer; if he accepts help, he may develop a "shame, guilt-type complex."

**Role Superfluity:** When an actor finds himself occupying a status-position requiring role performance beyond that which he or any one like him can fulfill, this is an example of role superfluity. Role superfluity emerges from misinformation or the part of role alters. The latter somehow expect more from an actor than anyone in his class can deliver. The limitations of the handicapped quite often place them in roles which go beyond the capacity of persons like them. This seems especially true in family situations and makes role superfluity an important source of stress.

**Status-Position**

Status-position is the third analytical unit of relevance to role theory. It is the structural place where actors can be located in groups. Status-positions are ascribed, that is, unalterably assigned to actors; or, achieved, that is, earned by the actor. Status-positions are made up of roles and the latter prescribe the behavior for the actor holding a given position.

All social units, such as groups, organizations and communities are divided into positions. A family, for
instance, can consist of the positions of father, mother, son and daughter; a school may be divided into administrators, teachers, students, clerical personnel, and maintenance workers. Each position has rights and obligations and is occupied by a person who has the requisite qualifications for these particular rights.

Status-positions all have a degree of power, prestige, and exclusiveness. So, it is quite likely that the handicapped person will suffer stress, because of "loss of status." This notion is important to this study and will be elaborated in the discussions which follow.

The Sick Role

The person who is ill is, of course, not expected to behave in the same manner as a well person; for example, the freedom of the disabled or sick person from regular activities creates a dependency upon others for his well being. To this extent, it is possible to identify a sick role and to see such a role as a bona fide part of social structure. In the discussion which follows, an attempt will be made to describe the characteristics of the "sick role." It will be understood that being disabled or handicapped will be treated separately and in relationship to the disabled.
Characteristics of the "sick role."

Parsons, perhaps more explicitly than any other writer has described the characteristics of a sick role. He lists four features of this role as follows: 15

1. The sick person is exempt from social responsibility.

   This exemption requires legitimation by and to the various actors involved and the physician often serves as a court of appeal as well as a direct legitimatizing agent. It is noteworthy that like all institutionalized patterns the legitimation of being sick enough to avoid obligations can not only be a right of the sick person but an obligation upon him. People are often resistant to admitting they are sick and it is not uncommon for others to tell them that they ought to stay in bed. The word generally has a moral connotation.

2. The sick person cannot be expected to take care of himself.

   ... the sick person cannot be expected by 'pulling himself together' to get well by an act of decision or will. In this sense he is exempted from responsibility - he is in a condition that must be taken care of. Of course the process of recovery may be spontaneous but while the illness lasts he can't 'help it.' This element in the definition of the state of illness is obviously crucial as a bridge to the acceptance of 'help.'

3. The sick person should want to get well.

The third element is the definition of the state of being ill as itself undesirable with its obligations to want to 'get well.' The first two elements of legitimation of the sick role thus are conditional in a highly important sense. It is a relative legitimation so long as he is in this unfortunate state which both he and actor hope he can get out of as expeditiously as possible.

4. The sick person should seek medical help.

Finally, the fourth closely related element is the obligation - in proportion to the severity of the condition, of course - to seek technically competent help, namely, in the most usual case, that of a physician and to cooperate with him in the process of trying to get well. It is here, of course, that the role of the sick person as the patient becomes articulated with that of the physician in a complementary role structure.

Parsons states that because of the severity of stress-strain and anxiety brought on by an illness, the sick role may not be accepted and other reactions could take place such as to reject and deny illness or adoption of helplessness with excessive care demands. He states:

Perhaps the most definite point is that the 'normal' person, illness, the more so the greater its severity, constitutes a frustration of expectancies of his normal life pattern. He is cut off from his normal spheres of activity, and many of his normal enjoyments. He is often humiliated by his incapacity to function normally. His social relationships are disrupted to a greater or less degree. He may have to bear discomfort or pain which is hard to bear, and he may have to face serious alterations of his prospects for the future, in the extreme but by no means uncommon case the termination of his life. . . . Therefore, even the necessary degree of emotional acceptance of the reality is
difficult. One very possible reaction is to attempt to deny illness or various aspects of it, to refuse to 'give in' to it. Another may be exaggerated self-pity and whining, a complaining demand for more help than is necessary or feasible, especially for incessant personal attention.

It is made clear in the above that the sick role is one which generally occurs in a group situation and in values of others besides the sick person. In recognition of this point, Freidson observes that it appears that the sick role relationships can best be conceptualized by a model relating the family, the patient, and the doctor.¹⁶

**Validation Criteria for the "Sick" Role**

There has been very little research aimed at validating the sick role. Yet, it is known that sickness is not only a medical matter, but a social phenomenon as a social phenomenon as well. An actor is sick in a social sense only when he is identified and treated as sick by other actors.

Of the men who have worked on validation criteria for being sick, the works of Apple and Mechanic are perhaps best known. They did studies which provided them with a basis for establishing four factors to validate when a person

was "sick." These factors are:

1. Legitimization by a physician.

   This legitimization occurs when an occupant or actor has been placed under a doctor's care and authoritative recognition has been given of the need for medical care.

2. Symptoms.

   The discriminators in this validation criteria are described in terms of pains, discomforts, or other manifestations that suggest a changed condition in the persons health.

3. Functional incapacity.

   The recognition that a person is functionally incapacitated, that is, he definitely is unable to perform normal work-life activities.

4. Prognosis.

   The fourth set of validating factors relate to prognosis, that is, an expectation of future well-being, even though the actor is still functionally incapacitated.

Gordon attacked the problem of validation differently. He provides some twelve descriptions as relevant for the validation of the sick role; these descriptions would be

expressed toward an actor as follows:\textsuperscript{18}

1. He has a severe case of pneumonia.

2. He had something a year ago and as a result lost the use of his legs.

3. He is recovering but not yet back to work.

4. He had something five years ago and since then cannot do strenuous work.

5. He has persistent pains in the stomach but can still work.

6. He has had arthritis for the past several years.

7. He is under a doctor's care but can work.

8. He has increasingly bad attacks of rheumatism.

9. He has an illness which keeps him in bed on and off. It has gotten worse, there appears little hope that it will improve.

10. He has been told that if he does not take it easy, he will have a severe attack.

11. He has had something which has left him deaf.

12. He is recovering but still in bed.

Each of the above descriptions was assigned a validating factor, such as "symptoms exist, functional incapacity, uncertain prognosis, etc.," by Gordon. He found that the

anticipated prognosis or outcome of an illness plays a key role in the social identification of someone as sick. Other findings of Gordon were: (1) The poorer defined or more uncertain the anticipated consequence, the greater the tendency to define someone as sick; (2) Persons physically impaired by a past illness (handicapped) are least often identified as being sick; (3) Persons who are confined to bed are more likely to be defined as sick than persons who cannot work because of an illness; and (4) If a person can continue to work, there is a greater tendency to identify him as sick on the basis of persistent pain than on the basis of his being under medical care. Of the factors studied (functional incapacity, medical attention, prognosis and symptomatology) the most important single factor for all socio-economic groups in the validation of the sick role was **prognosis**.

**Behavioral Expectations Relevant to Illness**

There are several common role expectations regarding one who has been validated as ill. Gordon has listed these as follows:  

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19Gordon, **op. cit.**, pp. 72-73.
1. Medical Care: (a) See to it that he sees a doctor, (b) Encourage him to see a doctor, (c) Discourage him from running to a doctor with small aches and pains, (d) See to it that he doesn't run to a doctor with small aches and pains.

2. Physical Comfort: (a) Give him a great deal of extra care, (b) See to it that he is comfortable, (c) Encourage him to do things for himself, (d) Treat him like everybody else.

3. Social Responsibility: (a) Make major decisions for him, (b) Keep responsibilities and worries from him, (c) Encourage him to do some sort of work, (d) Urge him to carry his daily responsibilities.

4. Information: (a) Make sure that he tells you about any changes in his condition no matter how unimportant they seem, (b) Discourage him from bothering you about every little ache and pain, (c) Encourage him to tell you about any changes in his condition no matter how unimportant they seem, (d) Steer him from bothering you about every little ache and pain.

Gordon found that there is an inverse relationship between socio-economic status and the importance of functional or physical incapacity as a factor in identifying someone as sick. His findings further revealed that respondents defined someone as sick by the same factors that they treated the ill person as dependent or in Parsons' terms as "sick."  

Gordon found two distinct statuses with complementary role expectations associated with sickness: The "sick role" occurring when the prognosis is considered to be uncertain or serious, and "impaired role" emanating from known and non-serious prognosis. Role pressures apparently tend to insulate and protect the ill person in a "sick role," while they seem to aid and maintain normal activities or involvements for the ill person in an "impaired role."\(^{21}\)

The Disability and/or Handicapped Role

Disability has been defined as the inability to perform usual role activities as a result of a physical or mental impairment of long-term duration. Thus, the incapacity for normal role performance, or being handicapped, can be identified and defined as the crux of disability.

In order to discuss the attributes of disability and/or handicapped appropriately, one must not only define disability but describe the elements that comprise this role as well:

These elements have been identified as:

1. Residual Impairment: as may be noted in the example of partial blindness.

2. Disease Process or Injury: for instance, the crippling effects of polio.

3. Duration of Impairment: as may be experienced while awaiting orthotics and prosthetics appliance for final fittings and usage.

4. Functional Limitations: for example, such as speech functions, subject to speech therapy.

5. Inability to perform required role activities: for instance, a stroke or cardiac case, subject to treatment.

The concept of handicap and/or disability also include the following elements:

1. Recognition of a change in behavior characterized by failure in normative role performance.

2. Assessing of responsibility for handicap condition as an impairment beyond the individual's control.

3. Legitimation of role failure by an appropriate person in the social control matrix who holds some status as a validation agent.

The nature of disability and/or handicap sometimes leads to the development of forms of trauma or pathological conditions. The latter have implications for role playing since they can lead to a mental or physical abnormality.

The sick role and other formulations of illness behavior suggest that acceptable patterns of response for disability and/or handicapped behavior are similar to illness behavior. It has been noted that "illness is one of the few
widely recognized and acceptable reasons for failing to meet social responsibilities and obligations."\textsuperscript{22}

The above discussions demonstrate that the concept of role is central to the analysis of the disabled and/or the handicapped. For it has been shown that the actor conforms to the obligations of specific roles by behaving just as close to the behavioral expectations of his group as he possibly can.\textsuperscript{23}

Thus, those who play sick roles have exemption from normal role expectations, which is considered temporary, that is, relative to the duration of illness. Although there are some inconsistencies, the handicapped and/or disability role also carries the notion of relief from usual behavioral expectations under certain circumstances.\textsuperscript{24}

The foregoing discussion outlines the conceptual framework for the study made; it also provides a basis for understanding the structural components of the role of the handicapped.

\textsuperscript{22}Parsons, \textit{op. cit.}, p. 443.

\textsuperscript{23}Ibid., p. 452.

\textsuperscript{24}Andrew C. Twaddle, "Health Decisions and Sick Role Variations," \textit{Journal of Health and Social Behavior}, Vol. X (June, 1969), 105-115; also, Freidson, \textit{op. cit.}
CHAPTER III

GROUP THERAPY AS A PROCESS OF INDUCED SOCIAL CHANGE

There are many ways in which change can be brought about in individuals and groups. However, educational processes almost always play a large part in this process. In this regard, there is always the question of adapting the techniques and instruments of change to the specific problem at hand. This is especially critical when the change sought calls for departure from normative patterns, such as modifying the roles played by members of a family with a handicapped or disabled member. Of all the techniques which have been used for bringing about change of this type, group therapy appears most effective. That is why this approach was selected for changing the role behavior of family members toward the handicapped. Selection of group therapy as an induced social change process suggests that a family can be strengthened and made more effective in the changing role patterns towards handicapped or disabled members.
Since the approaches and practices of group therapy are not generally known, they are outlined in this chapter.

Definition of Group Therapy and Role of Therapist

Therapeutics is that part of medical science which deals with treatment of disease and healing. Therapeutic agents are usually construed to be such things as surgical operations, diet, heat, massage, and medicines.

Social interaction can also be defined as therapeutic, if it is designed to restore health. The practitioners who use this approach have generally been trained in the fields of psychiatry or psychiatric social work. They are usually known as psychotherapists.

The work of psychotherapists is more or less well known. For example, most persons know that occupational therapists aid in the recovery of the injured or the physically or mentally ill by providing their patients with mental and physical activities in occupations, activities, or different kinds of hobbies which are of interest to them. It is also widely known that a soldier who is blinded may be taught a skill and thus given a new look on life, or an industrial worker may be aided in his adjustment to an artificial leg by being taught to dance.
The approach of the psychotherapist is thus seen as in rather sharp contrast to the work of other therapists who work with the handicapped. To elaborate, a professional physical therapist under the prescription and direction of a physician would make use of physical aids, such as infrared and ultraviolet rays, massage, exercise, water, heat, cold, electricity, and mechanical devices for diagnosis and treatment, rather than "interaction" sessions. Physical therapy is primarily concerned with strengthening muscles and improving the range of motion of joints through exercises, as well as teaching clients to use orthopedic appliances.

There are several specific areas within which psychotherapists work, in addition to the occupational and physical therapy areas. The most common are probably speech therapy, art therapy and music therapy. Speech therapy includes instruction and supervision of clients in exercises designed to help them overcome deficiencies in hearing and the results thereof, including the prescription of protheses lip reading, auditory training, and speech correction and development. Art therapy aids clients in recovery through instructional techniques with mental and physical (skill) concentration of expression through art. This interest may be a leisure-time or hobby activity leading to improved social relationships, a better feeling of worth and a contribution to the field of
Music therapy is the use of music to help clients achieve a better social relationship in both the working situation and the community. The music activity also helps the client learn new skills or improve existing ones. Often, the music activity permits the client to get a better image of himself—his capabilities, potentialities, and self-worth. A logical area of consideration is that one's ability to maintain a job is largely dependent upon his acceptable social relationships. Music therapy plays a vital supportive role in the vocational training experience which can help strengthen the vocational future of the individual.

There are two approaches in psychotherapy -- with individuals and with groups. The latter is of major concern here. Group therapy makes use of the group dynamics approach. Normally, the aim of the therapist is to help members of the group to become aware of the effect the behavior of others has on them and vice-versa. This technique is designed to increase the empathy of the participants. Empathy consists of the ability of an actor to become aware of the feelings and attitudes of other actors in the group and depends on the sensitivity that one actor has developed towards others.

Group therapy differs from individual therapy primarily in the area of stimulating "social reality." Here, "the group situation with its social give-and-take is much more
like real life. . . . In the hands of a skilled therapist, this process eventuates in increased insight and clarification of the self-picture, the resolution of disabling conflicts, greater self-acceptance, and general personality growth toward maturity and independence."¹

Coleman has outlined the major functions of the group therapist as follows:²

1. The provision of a therapeutic atmosphere, including structuring the group in terms of the aims and limits of the group and maintaining and accepting permissive atmosphere.

2. Promoting unity, so that the group becomes a focal and stabilizing point in the therapy situation, and so that each patient may identify with the group.

3. Encouraging and to some extent directing group interaction in order to maintain it along therapeutic channels.

4. Recording and evaluating procedures and results. This includes the maintenance of systematic records of the group sessions which can be used for purposes of clinical evaluation.

This section can be appropriately concluded with a characterization of the role of the professional therapist.


²Ibid., p. 560.
Fortunately, Parsons, in reviewing therapeutic processes, considered the social role of the therapist. Indicating that this role represented a major functional area in modern society, he outlined four main conditions necessary for the successful practice of this role:

1. "support," the acceptance of the therapist as a member of a social group;

2. "permissiveness," to express wishes and fantasies as within the family and other normal social relationships;

3. "restrictions," the reactions of the therapist not to reciprocate to the expectations which are expressed in the patient's deviant wishes and fantasies;

4. "conditional manipulation of sanctions," by the therapist; to give and withhold approval is of critical importance to the patient.

Parsons notes that the above four conditions are all to some degree "built into" the role which the therapist typically assumes, and likens this role to the "physician" role.

With the notions of group therapy and of the role of the therapist in mind, it is possible to show how group therapy approaches can be used to induce change in role behavior. This is done in the discussion which follows.

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3Talcott Parsons, "Illness and the Role of the Physician: A Sociological Perspective," op. cit.
Group Therapy as An Approach to
Induced Change

The use of group therapy in a deliberate effort to induce change has been reported by several persons. One example will suffice for our purpose of illustration. In this example, reported by Elliot Jaques, the idea was to produce change in a factory by means of group processes, so that needed improvements could be made with a minimum of stress and conflict. The therapists thus served as the change agents but induced the groups with whom they worked to discover the underlying causes of their resistance to change. In Jaques words:

The method used was to draw attention to the nature of the resistance on the basis of the facts known to those concerned. Opportunities were taken to illuminate in the specific situation the meaning of the feelings (whether of fear, guilt, or suspicion) that constituted the unpalatable background to anxieties that were present about undergoing changes that were necessary. When successful, interpretations of this kind allowed group members to express feelings which they had been suppressing sometimes, for years, and then to develop an altered attitude to the problem under consideration.\(^4\)

The researchers in the above project suggested three desirable factors, two as necessary, for successfully

inducing change through group therapy:

1. The existence of a felt difficulty. (A severe and painful problem must be recognized by the group).

2. The existence of a feeling of cohesiveness or group solidarity. (Actors in a group must have a commitment to its objectives).

3. The prevalence of a state of frustration. (Normal devices of avoidance and denial used by groups members to avoid facing up to their problems, must be partially or completely ineffective).

In summary, when a close knit group acknowledges a problem and accepts the fact that there is no relief in running away from the problem, then the members are in a state of readiness for change. Such groups are generally susceptible to group therapy approaches designed to help them make the transition from old behavior patterns to new ones.

The Rationale for Family Group Therapy

The basic question faced in this study was whether or not the stresses and tensions in role relationships which exist in families with a handicapped member could be modified through group therapy techniques. In an attempt to gain insight on this question the findings of several studies done

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Ibid.
with family groups were reviewed. The conclusions which provided the rationale for the approach used are presented below.

The first observation which is pertinent is the consensus of writers that family groups are good therapeutic units. This fact was brought out in Chapter 1, but may be elaborated here. In all the sources consulted, the family was seen as a dynamically interacting whole which made it a natural "pathological unit." In this regard Satir found that a family will behave as a unit and insisted that its members be treated as such. Bowen argues that because the family is theorized to be the "unit of illness" in cases such as those where there are disabled members, its members should be treated as such. Carroll and his associates support this view with their conclusions that family therapy is particularly useful when discomfort exists in intimate relationships and when there is reciprocal pathological interaction between family members.

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The rationale for family therapy can be summarized without over-burdening the point, by referring to work done by Nathan Ackerman, a specialist in the psychodynamics of family life. After a long period of study, Ackerman concluded that the impairment of complementary role relations serves to undermine the stability of the family and to aggravate the intrapsychic stress between the patient and other members of the family unit. He is convinced that family therapy serves to remedy this situation.9

The Approach of Family Therapy

The major purpose of family group therapy is to reduce stresses in family relationships. There are some procedures which seem to work better than others in striving for such goals. These procedures are designed to remove the dis-sociating elements in family role relationships and thereby reestablish unity.

In the above light, Basamania considers the purpose of family therapy is to get at the inner emotional life of the family as a unit. He cautioned therapists not to become

too active and to allow but not interfere with family interaction. We further instructed the therapist to distinguish fact and feeling, and to not have one to one relationships, but relate to the family as a whole.\textsuperscript{10}

Gabler and Otto emphasized another approach to family therapy. They stressed a focus and emphasis on the recognition, identification, and utilization of the healthy elements of family functioning as an integral part of the treatment process. Some of the clues to "family strengths" which they identified were:\textsuperscript{11}

1. Strength within itself.
3. As parents.
4. Do things together.
5. Satisfactory social and economic status.
6. Recognizing need for and accepting help.
8. Religious beliefs.
10. Community affairs.
11. Education.
12. Capacity to change.
13. Attitudes to sex.


Satir identified still another problem of treatment. She notes that the patient's symptoms serve a family function as well as an individual function, and when the identified patient has symptoms, all family members are feeling his pain in some way. With the family behaving as a unit, a balance in relationships can be achieved.\(^{12}\)

It can be seen from the above that family therapy rests on a unified diagnostic formulation for dynamic processes of family life within which is included adaptation of individual personality to respective family roles. Family therapists therefore must be concerned with:

1. The psychosocial evaluation of a family.

2. An appropriate level of social support for the family.

3. Educational guidance for the family.

4. A therapeutic approach to a multiplicity of conflicting family relationships.

In summary, the basic rationale for working with the family group is the fact that the family and not the individual, is the problem in dealing with certain problems of the handicapped. The goal of family group therapy is the change of members' role which are played toward a handicapped member. This change may be considered beneficial if it leads to

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\(^{12}\) Satir, *Conjoint Family Therapy*, op. cit.
the recovery of a normative (pre-handicap) pattern of behavior. It will be unsuccessful if the handicapped individual moves into greater dependency on public or family resources than his capacities require.\(^{13}\)

The behavioral alternatives of the disabled or handicapped family member were used in the evaluation of the experiment done, as will be seen. Successful adaptation to a handicapped condition or disability was conceptualized as occurring through the process of normalization and conformity to a new set of roles.

In this regard, it has been pointed out that the "problem is less the handicap than it is people" for recovery of the handicapped person. In other words, the system which structures the relationships among people also imposes limits on behavioral choices. In final essence, the hope was that the therapy given would serve to bring the handicapped person and his family group back into a "healthy" behavioral relationship. What this relationship might be is difficult to arbitrarily assess. However, it would be as close as possible

as one might get to what the eminent psychiatrist, Thomas
Rennie, considers to be the criteria of a healthy American
adult:

Independence of action, thought, and stan-
dards . . . freedom from crippling inferiority and
guilt feelings, from excessive egotism, and from
competitiveness and unbridled hostility . . . con-
cern for others . . . an appreciation of one's own
liabilities and assets . . . the assumption of
adult responsibilities (including) the obligation
to find and sustain a satisfying job, to recognize
the need for play and rest, and to find satisfac-
tion in one's role as an individual in relation to
family, social, and civic life . . . .14

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14 As quoted in Leo Strole, et al., Mental Health in
the Metropolis: The Midtown Manhattan Study, Vol. I (New
CHAPTER IV

CHARACTERISTICS OF HANDICAPPED CLIENTS AND OF THE
MEMBERS OF THEIR FAMILIES INTERVIEWED

The characteristics of the handicapped clients studied and of their relatives interviewed provide a basis for determining the validity of the comparative aspect of the study. Such data also places the variables that bear upon client rehabilitation and family solidarity into a meaningful frame of reference.

In this chapter the characteristics of clients and their families in the experimental group are contrasted to the characteristics of clients and their families in the control group.

The first four tables in this chapter were derived from the Client's Intake Form administered by therapists at the beginning of each client's stay at the Center. The instrument used is shown in Appendix A. These forms were administered to a responsible family member, usually the mother or spouse of the client. Table 5 was derived from vocational evaluation report forms. See Appendix B. Tables 6-13 were
derived from records obtained at the time a family agreed to become a part of the study.

The Age of Handicapped Clients

The age characteristics of clients is given in Table I. The numbers and frequencies of individuals in the age categories listed are shown for the sake of easy comparison of those in the experimental group with those in the control group.

<table>
<thead>
<tr>
<th>Age</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
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<tr>
<td>16-17</td>
<td>16</td>
<td>57</td>
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<td>41-50</td>
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<td>0</td>
</tr>
<tr>
<td>51 and over</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>99.0</td>
</tr>
</tbody>
</table>

In both the experimental and control groups, 16 clients were between the ages of 16 to 17 years. This number represented 57 per cent of the experimental group and 67 per cent of the control group total. It may be noted in Table I
that 85 per cent of the clients in the experimental group are below age twenty-two, while 79 per cent of the clients in the control group are below this age. Another slight difference between the two groups also occurs in that the remainder of the control group clients were slightly older than the remainder of the experimental group clients. However, the experimental and control groups were deemed sufficiently matched for purposes of this study.

The fact that handicapped clients are predominantly in the younger ages but over 16 is explained as follows: First, no client is admitted to the Center earlier than 16 years of age, because of the fact that individuals cannot be employed in skilled and hazardous occupations until they are 18 years or over. Second, the Center operates as a day program only and thus eliminates individuals in older ages, who are employed during the day.

The Sex of Handicapped Clients

Table II shows the sex of clients who participated in the study. It can be seen that the experimental group was composed of 25 males and 3 females while the control group had 20 males and 3 females. Since both groups were heavily weighted towards males, it was felt that representation was adequate for purposes of the study. The explanation for the high sex ratio is primarily accounted for because of
the types of training skills taught. The latter are more appropriate for men. Also, dormitory space for girls is limited at the Center.

TABLE II
SEX OF HANDICAPPED CLIENTS

<table>
<thead>
<tr>
<th>Sex</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>89</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Religious Affiliation of Handicapped Clients

Table III was prepared to show the religious affiliation of clients.

There were no Jewish persons in either the control or experimental groups, as can be seen. However, there were 16 Catholics (57 per cent) in the experimental group, and 12 Catholics (53 per cent) in the control group. The fact that no information was obtained on the religion of 5 clients in the control group was unfortunate. However, there appear to be sufficient Protestant clients in the control group to test for variability.
The high percentage of Catholics among clients is explainable in that most of them came from the metropolitan areas of New Orleans. This part of Louisiana has a high proportion of Catholics, which traces back to the strong French and Spanish heritage.

TABLE III

RELIGION OF HANDICAPPED CLIENTS

<table>
<thead>
<tr>
<th>Religion</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Catholic</td>
<td>16</td>
<td>57</td>
</tr>
<tr>
<td>Protestant</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>Jewish</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>None Given</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The Handicaps of Clients

The disability of clients, as determined by a physician, is shown in Table IV. Some clients had more than one type of disability, and this accounts for the number of handicaps being greater than the actual number of clients.

The following types of disability appear to be fairly well matched between the experimental and control groups:
TABLE IV

CLIENTS' HANDICAP (DISABILITY AS STATED BY PHYSICIAN)

<table>
<thead>
<tr>
<th>Type of Disability *</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Psychosis</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Neurosis</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Mental or Academic Retardation</td>
<td>15</td>
<td>34</td>
</tr>
<tr>
<td>Brain Damage</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Orthopedic **</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>General Debility ***</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Communications Difficulty</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Visual Difficulty</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44*</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*The number of disabilities is more than the number of clients because some clients had more than one disability.

**Orthopedic includes cerebral palsy and skeletal-reuromuscular disabilities.

***General debility includes cardiac, T.B., anemia, diabetes, epilepsy.
1. Retardation
2. Brain damage
3. General debility
4. Psychosis

Although the other disabilities of the clients listed in Table IV are not as well matched between the experimental and control groups, it may be noted that all clients were selected so that they were similar in their motivational level and eligibility for rehabilitation services.

The range of handicaps shown in Table IV also indicates those conditions considered most likely to respond to therapy of the type available at the Center.

Evaluation of Handicapped Clients' Performance

The performance characteristics of clients as they progressed from one type of training to another is shown in Table V. Each client moved from one type of training to another at a slightly advanced level of difficulty until he had completed eight areas of training. He was evaluated in each area by independent vocational evaluators. The data for the table was taken from the Weekly Evaluation Report forms completed by these evaluators. (See Appendix B). The clients were rated on each of the variables (listed in
TABLE V
EVALUATION RATINGS OF HANDICAPPED CLIENTS' PERFORMANCE AT END OF THEIR THIRD WEEK OF TRAINING

<table>
<thead>
<tr>
<th>Rating Item</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>Difference:*</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.</td>
<td>Mean</td>
<td>St. Dev.</td>
<td>N.</td>
</tr>
<tr>
<td>Dress</td>
<td>24</td>
<td>5.29</td>
<td>2.29</td>
</tr>
<tr>
<td>Grooming</td>
<td>21</td>
<td>4.67</td>
<td>1.43</td>
</tr>
<tr>
<td>Posture</td>
<td>20</td>
<td>3.90</td>
<td>1.17</td>
</tr>
<tr>
<td>Application of</td>
<td>21</td>
<td>3.71</td>
<td>.64</td>
</tr>
<tr>
<td>Instructions</td>
<td>Learning &amp;</td>
<td>19</td>
<td>3.21</td>
</tr>
<tr>
<td>Work Traits</td>
<td>19</td>
<td>2.89</td>
<td>1.15</td>
</tr>
<tr>
<td>Work Tolerance</td>
<td>19</td>
<td>3.32</td>
<td>2.19</td>
</tr>
<tr>
<td>Safety Consciousness</td>
<td>21</td>
<td>3.67</td>
<td>1.28</td>
</tr>
<tr>
<td>Adjustment</td>
<td>19</td>
<td>4.0</td>
<td>1.11</td>
</tr>
<tr>
<td>Vocational Objective</td>
<td>20</td>
<td>3.85</td>
<td>1.31</td>
</tr>
<tr>
<td>Quality</td>
<td>11</td>
<td>3.36</td>
<td>.81</td>
</tr>
<tr>
<td>Quantity</td>
<td>2</td>
<td>2.50</td>
<td>.71</td>
</tr>
</tbody>
</table>

*None of these values are large enough to represent a significant difference between the experimental and control group. (The critical t value for 50 degrees of freedom at the .05 level of significance is 1.68 for a one tailed test, direction predicted.)
Table V) on a scale ranging from 0 to 8. The scores assigned to clients in each group by their evaluators were averaged and are shown. Means are used here because of the obvious problem of attempting to analyze individual scores. In this regard, the standard deviations computed make it possible to determine the extent of deviation of clients in the experimental group from the mean score of this group on each of the ratings shown. The N column in Table V indicates the number of clients evaluated on the particular rating. Totals in this column vary due to class period absences or inapplicability of rating scale for clients in that particular work area. Applicability was determined by the evaluators, and when an item was judged inapplicable it was left blank.

Although 8 vocational evaluators were involved in assigning the raw scores from which the data in Table V were taken, each evaluated all clients participating in his area of performance. Quality and Quantity of Performance were not on the original forms and thus were often overlooked in evaluations. Since the clients were well distributed between the various evaluators, at various times, the possibility of a "halo effect" in score assignment was minimized.
Characteristics of Clients

Column seven of Table V shows the differences between mean scores for each of the 12 performance reference items rated for the control and experimental groups. Column eight shows the differences between the standard deviations for each rating for both experimental and control groups.

The smallest difference between the means of performance reference items for the experimental and control groups was +.01 -- for Posture, while the largest was -1.0 -- for Quantity of Performance. The smallest difference between the standard deviations of performance items for the experimental and control groups was "0" for Quantity of Performance. The greatest difference was +1.19 for Dress. None of these values is significant at the .95 level of confidence, when a "t" test is applied. It can, therefore, be deduced that there was no significant difference between the two sample populations insofar as performance characteristics were concerned. This finding strengthens the position that the client groups were representative of the total population.

Characteristics of Members of Clients' Families Interviewed

Information was obtained from one key member of each clients' family group. It will be recalled that the mothers
of unmarried clients were considered the most appropriate relative to interview, while the spouse of married clients were considered most appropriate for them. In each case the purpose was to obtain a family record from the person deemed most knowledgeable. Information was also obtained from a second relative of the unmarried group. This was generally the father. No second relatives were interviewed for married clients.

Data was compiled including relationship to client, age, religion, education, employment, occupation, and the distance from the Center to their home. Relatives were also judged by the therapist on their motivation for therapy.

The evidence presented in Table VI shows that the experimental and control groups were well matched in that mothers were primary respondents to the Family Questionnaire. In the one instance where a mother or spouse did not serve as respondent, the client was orphaned and lived with his aunt. The latter was interviewed in lieu of his mother.

The reason for the high percentage of mothers in the respondent group has already been explained. This selectivity was practiced to interview the person most likely to be knowledgeable about family matters and to keep the methodological procedure consistent.
TABLE VI

RELATIONSHIP TO CLIENT OF RELATIVE
RESPONDING TO THE QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Family Relationship</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No info.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mother</td>
<td>23</td>
<td>82</td>
</tr>
<tr>
<td>Spouse</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The age level of the persons responding to the family questionnaires is fairly consistent as can be seen in Table VII. The fact that most of these persons fall in age groups from 34 to 53 indicate they are middle-aged individuals. This has significance for their participation in and understanding of group therapy. The younger respondents were the spouses of married clients. Age information was obtained on 19 fathers of clients in the experimental group and 15 fathers in the control group. These distributions paralleled those for mothers shown in Table VII.
### TABLE VII

**AGE OF RELATIVE RESPONDING TO QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Age</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No. info.</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Under 30</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>30-33</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>34-37</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>38-41</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>42-45</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>46-49</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>50-53</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>54-60</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Over 60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>
TABLE VIII

RELIGION OF RELATIVE RESPONDING
TO FAMILY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Religion</th>
<th>Experimental Group</th>
<th></th>
<th>Control Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No info.</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Catholic</td>
<td>17</td>
<td>61</td>
<td>13</td>
<td>56</td>
</tr>
<tr>
<td>Protestant</td>
<td>10</td>
<td>35</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Jewish</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>23</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Interestingly, the majority of families of clients appear to be Catholic. It can be seen in Table VIII that 61 per cent of the relative respondents in the experimental group were of this denomination and 57 per cent of those in the control group were also Catholic. Only 35 per cent of the relatives responding to the questionnaire in the experimental group and 26 per cent of them in the control group were Protestant. There were no Jewish or other faiths represented in either the control or the experimental groups. Again, this distribution is accounted for by the religious culture predominant in South Louisiana. There was no startling divergence in educational level between the relative responding to the family questionnaire in the two study groups. The data in Table IX shows that these individuals tended to
have some secondary school education and did not vary greatly in pattern of educational attainment. Only four individuals in the experimental group and two in the control group had college level experience. By contrast one-fourth of those in the experimental group and one-eighth of those in the control group had eighth grade education or less. The data on fathers followed similar patterns in both groups.

TABLE IX

FORMAL EDUCATION LEVEL OF RELATIVE RESPONDING TO FAMILY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Education Attained</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No info.</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>1-8th</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>9-12th</td>
<td>13</td>
<td>47</td>
</tr>
<tr>
<td>College</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Graduate Work</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It can be seen in Table X that 39 per cent of the relatives responding to the family questionnaire in the experimental group and 48 per cent of those in the control group were unemployed. This high percentage is explained because most were housewives. It may be more important that
over half of the experimental and 30 per cent of the control group were working, since these persons were predominantly women. All but two of the 20 fathers of handicapped clients in the experimental group interviewed were employed, and all but one of 17 fathers in the control group were employed.

TABLE X

EMPLOYMENT STATUS OF RELATIVE RESPONDING TO FAMILY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No info.</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Employed</td>
<td>16</td>
<td>57</td>
</tr>
<tr>
<td>Unemployed</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table XI shows the occupational classification of relatives responding to the questionnaire. It can be seen that 39 per cent of the experimental group and 52 per cent of the control group were housewives. The second largest number, 21 per cent of the experimental group and 18 per cent of the control group were employed in clerical or sales positions. In general, the two groups were fairly well matched insofar as occupation was concerned.

Information was obtained on 20 of the fathers of clients in the experimental group and 16 of the fathers of clients in
the control group. The majority in both instances were occupied in semi-skilled or clerical and sales occupations.

TABLE XI

OCCUPATIONAL CLASSIFICATION OF RELATIVE RESPONDING TO QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Occupational Classification</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>No info.</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Unskilled</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Cler. Sales</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Managerial</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Professional</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Housewife</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Each relative interviewed was evaluated by the interviewers on the degree of interest expressed in family group therapy designed to help improve family relationships. Interestingly, almost three-fourths in the experimental group and over three-fourths in the control group of those on which information was available, as shown in Table XII, were judged as interested and motivated for such an experience. These percentages may have been greater, had such information been
obtained on all interviewers. Very few individuals (two) expressed negative reactions and both of these were in the experimental group. Four of the relatives in the experimental group and a like number in the control group were neutral or non-committal on the matter of family therapy sessions.

**TABLE XII**

**MOTIVATION OF RELATIVE RESPONDING TO QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Degree of Motivation</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Well Motivated</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Motivated</td>
<td>15</td>
<td>54</td>
</tr>
<tr>
<td>Neutral</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Not Motivated</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Extremely Unmotivated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Conclusion

The study made of the characteristics of handicapped individuals in the experimental and control groups indicates that there was no important difference between the two. Nor was there a great deal of difference in the characteristics of their relatives interviewed. These findings set the stage for the experimental procedure planned by providing a validation check on the representativeness and comparability of the sample populations selected.

1. A large proportion of both experimental and control families had sound relations at the start (scores of 150 or above).

2. With such families this does not appear needed or useful.

3. Many families had too little exposure. We have learned this is probably to be dealt with.

4. To get the maximum group we had to go down as far as the 7th session.

5. Thus the difference between experimental groups and the control group that show despite the fact that some experimental groups had only 7 sessions is supportive of the belief that with more exposure those families who **needed** this would benefit.
CHAPTER V

FAMILY BEHAVIORAL PATTERNS BEFORE THERAPY EXPERIENCE

How Family Role Patterns were Determined

The experimental nature of the study planned necessitated a measurement of family behavioral patterns before and after therapy experience. After a thorough review of pertinent studies, it was decided to utilize a questionnaire in the determination of what might be called general patterns of family role relations. Four broad areas of such relationships were delineated for special consideration: family solidarity, family decision making, family communication patterns and other types of family interaction.

These four "role areas" were operationalized in terms of questions asked persons participating in the study. The questions in each role area related to family behaviors in connection with child rearing, household tasks, recreational activities, economic activities, expressed values, and other unspecified activities. Role areas and their related questions are shown according to family behavior patterns in Table XIII. The questionnaire was developed from a number of
TABLE XIII

QUESTIONS RELATING TO ROLE RELATIONSHIPS*

<table>
<thead>
<tr>
<th>Behavioral Area</th>
<th>Family Solidarity</th>
<th>Decision Making</th>
<th>Communication Patterns</th>
<th>Other Role Patterns</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Rearing</td>
<td>2, 40</td>
<td>14, 44</td>
<td>43, 47</td>
<td>35</td>
<td>7 items</td>
</tr>
<tr>
<td>Household</td>
<td>28, 41</td>
<td>6, 12</td>
<td></td>
<td></td>
<td>10 items</td>
</tr>
<tr>
<td>Tasks</td>
<td>45, 49</td>
<td>37</td>
<td>20, 39</td>
<td>33</td>
<td>10 items</td>
</tr>
<tr>
<td>Recreational Activities</td>
<td>1, 22, 25</td>
<td>3, 7, 17</td>
<td>30</td>
<td></td>
<td>8 items</td>
</tr>
<tr>
<td>Expressed Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9, 13</td>
</tr>
<tr>
<td>Economic Activities</td>
<td>15, 50</td>
<td>8, 21</td>
<td>5</td>
<td>38, 46</td>
<td>9 items</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16 items</td>
<td>14 items</td>
<td>11 items</td>
<td>9 items</td>
<td>50 items</td>
</tr>
</tbody>
</table>

*See Appendix B for questions referred to by number.
studies that were aimed at measuring role relationships.\textsuperscript{1} It was designed so that it could be completed without assistance by a husband and/or wife independently of each other, if desir-able. Experience demonstrated, that, on the average, it required thirty (30) minutes for completion.

The pattern of possible responses to each item on the questionnaire were: almost always, often, once in a while, and almost never. The wording of items was deliberately planned so that for some items the response "almost always" and for other items the response "almost never", respectively, represented maximum family solidarity and interdependent role relationships in decision making, and communication patterns. This plan was adapted to reduce the likelihood of a "halo effect" from item to item with consequent invalidation of a response-set because a respondent tended to check the same categories for each item.

On items where "almost always" represented close role relationships the scoring was done as follows: "almost always" = 4; "often" = 3; "once in a while" = 2; "almost never" = 1. A zero was assigned to items which were left blank or which were checked with more than one response. The twenty-one items of this type included question numbers 1, 4, 5, 8, 9, 12, 15, 16, 22, 23, 27, 28, 29, 30, 37, 38, 40, 41, 45, 46, and 48. (See Appendix C).

Items in which "almost never" represented close ties were scored as follows: "almost never" = 4; "once in a while" = 3; "often" = 2; "almost always" = 1. A zero was again assigned to items left blank or where the respondent checked two or more categories. The 29 items of this type included questions 2, 3, 6, 7, 10, 11, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 31, 32, 33, 34, 35, 36, 39, 42, 43, 44, 47, 49, and 50. (See Appendix C).

The above scoring system assumes an interval scale between each of the four scale points, an assumption which appears justified in view of the usual differences that have been found characteristic of these adjectives on scales measuring their discrimination power.

The overall scoring for each family was translated into a generalized concept by summing the scores on all items. A subscore for each of the areas of role relationships was obtained - that is, for family solidarity, decision making, communication, and other interaction.

Altogether, a total of 50 statements were developed to test family relationships. The content validity was determined by a panel of four expert judges. In two instances (Items 25 and 31) questions were deliberately designed to repeat the content of items appearing elsewhere on the questionnaire. This was done as one method of testing for internal consistency.

Internal consistency was also tested through the use of split-half correlation scores on odd and even numbered items. The questionnaire was pretested by being administered to forty relatives of clients before the beginning of the experimental study. The questionnaire items were found to have a reliability of .80.

The instrument devised was administered to the relatives of clients (described in Chapter IV) who were participating in the study, at the beginning of the therapy sessions and again at the end of the therapy period, when the client was leaving the rehabilitation center.
Participant selection for the study was described in Chapter I. There it was pointed out that each family group indicating a willingness to participate in the project was invited to participate.

The questionnaire was administered to the proper member of the family by qualified counselors or therapists in the employ of the Center, including the writer.

After the initial completion of the questionnaire, the information obtained was coded and computer processed. The findings with regards to family behavioral patterns before therapy are described in the remainder of this chapter.

Family Solidarity Characteristics

It can be seen in Table XIII that 16 items were used to test for solidarity in family relationships. These questions were designed to cover five behavioral areas, as mentioned, including child rearing, household tasks, recreational activities, expressed values, economic activities, and other activities. The specific questions used were:

1. Teaching the children how to behave, like teaching them table manners or what to do or say with the opposite sex, is left up to either the father or the mother and the same person takes care of this.
2. When there are things to be done about the children like taking them to school or helping them to get dressed or answering their questions about something, it is about as likely for any one person to take care of this as for someone to be assigned to it.

3. In carrying out domestic duties about the house like making beds, washing dishes, washing and ironing, putting out the garbage, keeping up the lawn the family tends to help each other and does not concern itself whether a particular job belongs to one person or another.

4. In our family each tries to do more than his share of things that have to be done around the home like cleaning up, mowing the lawn, washing the car, etc.

5. For some of the jobs around the house like doing the evening dishes or cleaning the car, where everyone could help, we often take turns.

6. In doing such things like cleaning the house, washing the dishes, doing the laundry, mowing the lawn, keeping up the car and so forth, each family member has his own job and other family members do not take over somebody else's job.
7. The question what television program we should watch is usually decided by the children rather than by a family conference.

8. In our spare time activities inside the home our family tends to do things together whether it is playing cards, watching TV, talking to each other, reading and so forth.

9. In recreational activities that take place outside the home our family members have different interests and will be found doing different things.

10. In recreational activity outside the home our family have quite different interests. Each family member tends to follow his or her own kind of recreation.

11. All members of the family attend the same church.

12. There are differences of opinion in the family regarding whether financial success, good health, getting along with each other, having friends or something else is the most important thing in life.

13. If someone in the family needs to find a job, everyone tries to help as much as they can since we think this kind of thing affects the whole family.

14. Keeping the household records and paying the bills is done by either the mother or by the father and they do not exchange this task with each other.
15. The family funds are divided up so that each person has an allowance and no person lends or gives some of his to another.

16. Our family takes part in community affairs like PTA meetings, church fairs or suppers, political campaign speeches and so on by going to it as a family and one person does not go without the others.

The answers given to the above battery of questions were scored, summed and means, medians, and standard deviations calculated as shown in Table XIV. This table shows the family solidarity scores as determined by the role relationships studied, for both the experimental and the control groups. The highest raw score possible for a family was 64 (16 x 4). Differences in means and medians are also shown in Table XIV. Both these measures of central tendency were calculated in order to see if differences in tests of significance would result.

The highest individual family scores for both the experimental and control groups was 55 each. However, the lowest score by an experimental family was 31 as contrasted to 33 for a control family. The application of a t test shows no significant differences between the two groups.

Although it is an arbitrary decision, it appears that the families of clients were characterized by a relatively
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<td>Other role Patterns</td>
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(Negative sign indicates experimental group score is higher than control group score.)
high degree of solidarity. The mean scores of 44 for the experimental group and 43 for the control group out of a possible 64, suggest this fact. Such a finding has relevance for the experiment conducted, since there is not too much room for improvement.

Decision Making Characteristics

In Table XIV, it is shown that 14 items were used to test for decision making in family relationships. As previously noted, these questions were developed with applicability to the family behavioral areas of child rearing, household tasks, recreational activities, expressed values, economic activities and other activities not otherwise specified. The questions included were:

1. The question of what are standards for good manners for the children or how often they should go to church is settled by whomever the children ask or left up to them.

2. Decisions about what friends our children should have are made by each of the children independently of parents.

3. The assignments of jobs in our family, like house- cleaning or keeping up the car, are decided by the father.
4. To make decisions in our family about who must do little jobs about the house that come up, we have a family meeting and then assign the job.

5. The tasks in the home that our children are responsible for are decided on in a family conference.

6. The question of what our family does with its spare time as a family does not have to be answered, - each person decides what he wants to do and does it without bothering with the others.

7. The father in our family is the one who suggests family recreational activities and the rest of the family accepts them.

8. Decisions when persons will be invited to visit our home and who will be invited are made by each member independently and each invites whom he wants when he wants without consulting with others.

9. In making decisions, our family is more likely to think about whether a decision is right or wrong than what will happen if it is made.

10. The decision regarding what is important for our family is made by the father.
11. Decisions about important economic matters such as whether the wife should take a job or whether a major piece of household equipment should be bought or a new car purchased are made by the man of the house and there is little discussion among family members.

12. When we have to pay more bills than we have money for, the husband and wife together in our family discuss this to decide what to do instead of one making the decision.

13. When the family is faced with the need to have more income coming into the home this is something the father decides how to get, as it is considered his responsibility and not the rest of the family.

14. In making decisions our family tends to be influenced more by what friends and relatives think than by members of the immediate family.

Again, as can be seen in Table XIV, family cohesiveness in decision making was measured to be reasonably high in both groups. The mean score of the experimental group for the 14 items relating to decision making was 35 out of a possible 56. In contrast, the mean score for the control group was 37 out of 56. This difference is not significant at the .05 level, according to the t test. The highest raw score for the experimental group was 47 as compared to 51 for the control
group. The lowest scores in both groups was 16.

Communication Patterns

Table XIII shows that 11 items were used to test roles related to family communication patterns. The specific questions used were:

1. When the family has to make decisions about one of the children like whether he should be allowed to go to dances or participate in a school activity, the decision is made by whichever person first hears about it and there is no consideration of a discussion among family members.

2. Some kinds of the children's questions are more likely to be asked of the father while others would more likely be asked of the mother. The mother and father don't exchange places about answering these questions.

3. Discussions of who should do various household tasks like keeping the house straight or the grounds looking nice are likely to result in an argument.

4. The question of who must do unpleasant jobs in the home like taking out the garbage, washing dishes, etc. can be a source of argument because there is no special agreement who does them.
5. When there are things to be done about the children like taking them to school or helping them to get dressed or answering their questions about something, it is about as likely for any one person to take care of this as for someone to be assigned to it.

6. It is permissible for the children to say what they feel is important for the family. They can disagree with adults about what is important if they wish.

7. Questions about family finances are never discussed in our family because this kind of thing isn't encouraged.

8. Problems that happen on the job of working members of our family are shared with other members of the family who do not work.

9. Our family feels free to express their feelings to each other. We believe in "letting off steam" whenever we want.

10. Our child or children seem to be more willing to talk about his or their problems with each other and with friends than with their parents.

11. In our family we act like it is more important for each member to try to solve his own problems than to discuss it or bring it to other members of the family.
The answers given to the above battery of questions were processed in the same manner as described previously. The highest raw score possible for a family was 44. The highest individual family score for the experimental group was 37. This number is in contrast to the highest family score for the control group of 41. The lowest score made by an experimental family was 26, while no control family scored lower than 29. The application of a T test shows no significant difference between the two groups. (at the .01 level of significance)

Other Interactional Factors

Nine items were used to test for closeness in role relationships in other interactional patterns characteristic of families. The specific questions used were:

1. When it comes to supervising the children's homework, nobody in the family does this but each child is allowed to work on his own and seek help from whomever he wishes or do without help.

2. If anything needs repair or fixing at our house like drapes or slipcovers, or sticking windows or squeaking doors we call in someone else rather than fixing it ourselves.

3. Each member of our family feels almost the same about civil rights and civil rights legislation.
4. There is a difference of opinion in the family about "what we want for our children."

5. In elections the voting members of this family are likely to vote for the same candidate or for the same laws.

6. The kind of things that we want for our family like a modern home and furniture are like what other families want.

7. There is no real plan for deciding how to budget our income. We buy food first, pay bills and then what is left sometimes goes for one thing and sometimes for another.

8. There is little understanding of the feelings of one family member by other family members in our family.

9. Having a person with a disability in our family has tended to make the family feel closer together.

The highest a family could score on this scale was 36. The highest individual family score before therapy for the experimental group was 33. The highest score in the control group was near perfect, 35. The lowest score made by an experimental family was 15, as compared with 21 for a control family. Mean and Median scores (See Table XIV) once more shows a high degree of role strength. The application of a T test shows no significant differences between the two groups.
Summary

This study of family behavioral patterns before therapy experience in the experimental and control groups indicates: (1) that there were no important differences between the two groups; (2) that the families studied had relatively "good" patterns of relationships. The former finding serves as an additional validation check on the comparability of the samples selected. The latter finding indicates that relatively healthy role patterns had already been developed by the families in the study, and that it would be somewhat difficult to improve on already existing interactional patterns.
CHAPTER VI

FAMILY BEHAVIORAL PATTERNS AFTER THERAPY EXPERIENCE

The procedure used in matching experimental and control families of handicapped clients was explained in Chapter I. These same sample groups were again tested after the experimental group families had been given a group therapy experience. The idea was to determine whether or not the therapy had served as a stimulus to changed role relationships. The data collected at the end of the therapy period are analyzed in this chapter.

Procedure Followed in Therapy Sessions

The families selected for the experimental group were given a schedule for appearance at the Center for therapy. The number of families invited to any one therapy session ranged from four to eight. Two therapists conducted the therapy sessions and recorded the results. Sessions were held once a week, in the evening. The latter time was most convenient for the family groups. Experience gained in the initial phase of group therapy showed that group members were
motivated to attend if they were given a report on their handicapped members' activities at the Center. The need for this practice lessened as each family group became more at ease and as members of various families became more able to react to one another, and to relate their behavior to the problems of their handicapped member.

Therapists followed the Parsonian model described in Chapter III in their treatment sessions. Previously outlined discussions were not used. Persons participating in the therapy sessions were encouraged to react to spontaneous statements of other group members during each session. The therapist did not participate except to provide guidance and control.

As group leader, the therapist used various techniques to improve group interaction. These included the provisions of a topic problem to begin the discussion, and the encouragement of total group discussion. These approaches facilitated the aims of the project. The latter were to get the therapy groups to gain an awareness of the relation and affect of anxiety, frustrations, shame, and other feelings to the rehabilitation efforts. It was also purposed to have family groups practice introspection so that they would see how their previous behavior could be altered to provide a more healthy home environment for their handicapped member.
All therapy sessions lasted for approximately one hour, and the time therapy was given extended over a period of sixteen weeks. The number of therapy sessions participated in by families in the experimental group ranged from five sessions to sixteen sessions. Ten families participated in seven or more therapy sessions. This group was designated a maximum exposure sub-group and is analyzed separately in the discussions which follow. Of the remaining 18 families, five did not adequately complete the follow-up questionnaire and were thus eliminated from the total. The total number of experimental families were thus reduced to 23. The latter are compared with the 23 families in the control groups in the analyses which follow.

Changes in Experimental Group

It was pointed out in Chapter V that the families used in the research done scored rather high on the test given. This indicated that the group being dealt with was a rather sophisticated one to begin with. It also suggested that such a group would not stand to benefit as much from therapy experience as a group characterized by a smaller degree of adjustment in family role relationships.

In light of the above observations, it was interesting to discover that 18 of the 23 experimental families tested
registered higher scores on their role relationships after some degree of therapy experience. Those families registering the smallest degree of positive change or showing a drop in total score generally had high initial scores. The latter indicated that they were relatively well adjusted before being exposed to therapy. The highest change recorded was 59 points and five families improved their scores by at least 20 points. The changes recorded for each client family are shown in Table XV.

The evidence presented above indicated rather clearly that group therapy had had some type of impact. The question of how significant that impact was remained however. Two tests were applied in an effort to answer this question. The first was designed to determine if the differences in scores made by the total experimental group before and after therapy were statistically significant. The results of this test are shown in Table XVI. Scrutiny of this table shows that the changes which occurred were indeed significant. When a difference in means value is used to compute a "t" score for all role relationships the change recorded is significant at the .01 level. When a difference in mediums is used the significance level jumps to .0005.

It can be seen in Table XVI that the changes which occurred in roles relating to family solidarity were the only
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<td>30</td>
<td>27</td>
<td>131</td>
<td>38</td>
<td>34</td>
<td>30</td>
<td>29</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>23</td>
<td>125</td>
<td>41</td>
<td>32</td>
<td>26</td>
<td>26</td>
<td>137</td>
<td>45</td>
<td>36</td>
<td>29</td>
<td>27</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

1. All Role Relationships.
2. Roles Related to Family Solidarity.
3. Roles Related to Decision Making.
4. Roles Related to Communication Patterns.
5. Roles Related to Other Role Patterns.
TABLE XVI

COMPARISON OF BEHAVIORAL CHARACTERISTICS OF TWENTY-THREE EXPERIMENTAL FAMILIES, BEFORE THERAPY AND AFTER THERAPY

Differences in Test Scores Before and After Therapy (t-value)

<table>
<thead>
<tr>
<th>Relationship-Concepts</th>
<th>Between Mean</th>
<th>Between Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Role Relationships</td>
<td>-2.437**</td>
<td>-3.625****</td>
</tr>
<tr>
<td>Roles Relating to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Solidarity</td>
<td>0.589</td>
<td>0.445</td>
</tr>
<tr>
<td>Decision Making</td>
<td>-2.308*</td>
<td>-0.420</td>
</tr>
<tr>
<td>Communication Patterns</td>
<td>-2.098*</td>
<td>2.978***</td>
</tr>
<tr>
<td>Other Role Patterns</td>
<td>-2.303*</td>
<td>-2.433**</td>
</tr>
</tbody>
</table>

*Significant at .025, using t-Test
**Significant at .01, using t-Test
***Significant at .005, using t-Test
****Significant at .0005, using t-Test
ones which did not test significantly. The explanation for this fact is not clear. It may be that the therapy given tended to stress other types of role relations more, and that clients became more aware of these roles.

The second test carried out was designed to see if the number of therapy sessions were related to improvement in role relations. This test was carried out by selecting out the families which had had at least seven therapy sessions for special study. The latter were termed the maximum exposure group. The results of this test are shown in Table XVII. There it can be seen that the changes which occurred in all role relationships are significant, but at a somewhat lower level than for the total group. In fact, only one of the special areas of role relationships tested significantly. There appears to be only one explanation for this lack of correlation between therapy and change. This is that the clients in the maximum therapy exposure group who were the most highly motivated, were also the ones who needed therapy least. In other words, they were rather sophisticated in understanding how to behave toward a handicapped member before undergoing their experiences.

An interesting development is apparent in Table XVIII. This is the fact that the control group also changed significantly during the study period. The explanation appears to
TABLE XVII

CHANGE IN BEHAVIORAL CHARACTERISTICS OF FAMILIES EXPOSED TO MAXIMUM THERAPY EXPERIENCES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Between Means</th>
<th>Between Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Role Relationships</td>
<td>-0.956</td>
<td>-1.425*</td>
</tr>
<tr>
<td>Roles Related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Solidarity</td>
<td>0.947</td>
<td>0.295</td>
</tr>
<tr>
<td>Decision Making</td>
<td>-1.475*</td>
<td>-0.810</td>
</tr>
<tr>
<td>Communication Patterns</td>
<td>0.047</td>
<td>0.399</td>
</tr>
<tr>
<td>Other Role Patterns</td>
<td>-1.504</td>
<td>-1.632*</td>
</tr>
</tbody>
</table>

*Significant at .10 level, using t-Test
TABLE XVIII

TESTS OF SIGNIFICANT DIFFERENCES BETWEEN
THE MEANS OF THE CONTROL GROUP
BEFORE THERAPY AND THE
CONTROL GROUP AFTER THERAPY

<table>
<thead>
<tr>
<th>Variable</th>
<th>&quot;t&quot; Value</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Role Relationships</td>
<td>-1.598</td>
<td>S</td>
</tr>
<tr>
<td>Role Relating to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Solidarity</td>
<td>-0.337</td>
<td>NS</td>
</tr>
<tr>
<td>Decision Making</td>
<td>-1.404</td>
<td>S</td>
</tr>
<tr>
<td>Communication Patterns</td>
<td>-0.898</td>
<td>NS</td>
</tr>
<tr>
<td>Other Role Patterns</td>
<td>-2.026</td>
<td>S</td>
</tr>
</tbody>
</table>

(Degrees of Freedom = 44)
be the well known "Hawthorne" effect. The mere fact that they were selected for study probably inspired this group of families to perform at a higher level. There were no formal mechanisms for keeping families from discussing their experiences and no doubt some "contamination" occurred. It may be possible in future studies to correct this problem. This could be done by selecting control families whose handicapped member was not enrolled at the same Center as experimental families.

Tables XIX and XX were prepared to show if there were greater differences between the Experimental and Control families after the former had received a therapy experience. A study of these tables indicates clearly that there was more difference at the latter period although less than expected. This finding serves to validate the impact of therapy. Again, it can be suggested that the Hawthorne effect and the relative sophistication of the study group explains too small a margin of difference.

Changes in Handicapped Clients

One final check was planned to help determine if therapy could be associated with changes in role behavior. This was a follow-up evaluation of the performance of the handicapped clients represented in the study. It was hypothesized that
TABLE XIX

COMPARISON OF BEHAVIORAL CHARACTERISTICS
OF TWENTY-THREE EXPERIMENTAL AND
CONTROL FAMILIES, BEFORE
THERAPY

<table>
<thead>
<tr>
<th>Relationship-Concepts</th>
<th>Between Means</th>
<th>Between Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Role Relationships</td>
<td>1.256</td>
<td>0.741</td>
</tr>
<tr>
<td>Roles Related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Solidarity</td>
<td>-0.444</td>
<td>0.417</td>
</tr>
<tr>
<td>Decision Making</td>
<td>0.912</td>
<td>1.612</td>
</tr>
<tr>
<td>Communication Patterns</td>
<td>2.230*</td>
<td>0</td>
</tr>
<tr>
<td>Other Interactional Patterns</td>
<td>2.042</td>
<td>1.297</td>
</tr>
</tbody>
</table>

*Significant at .025, using t-Test.
TABLE XX

COMPARISON OF BEHAVIORAL CHARACTERISTICS OF
OF TWENTY-THREE EXPERIMENTAL AND
CONTROL FAMILIES, AFTER
THERAPY

Differences in Experimental and Control Test
Scores After Therapy
(t-value)

<table>
<thead>
<tr>
<th>Relationship-Concepts</th>
<th>Between Means</th>
<th>Between Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Role Relationships</td>
<td>-0.789</td>
<td>-2.194*</td>
</tr>
<tr>
<td>Roles Related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Solidarity</td>
<td>-6.747**</td>
<td>-5.729**</td>
</tr>
<tr>
<td>Decision Making</td>
<td>-1.098</td>
<td>-1.030</td>
</tr>
<tr>
<td>Communication Patterns</td>
<td>-0.072</td>
<td>-0.732</td>
</tr>
<tr>
<td>Other Interactional Patterns</td>
<td>-0.529</td>
<td>-1.234</td>
</tr>
</tbody>
</table>

*Significant at .025, using t-Test.
**Significant at .0005, using t-Test.
if the families of clients in the experimental group were in fact motivated to improve their role relationships, then the client's performance would improve at a faster rate.

The procedure for evaluating clients was explained in Chapter IV. This procedure was repeated after their sixteenth week at the Rehabilitation Center. Table XXI was prepared to show the difference between the mean scores awarded clients in the experimental group and clients in the control group. In this regard, it will be recalled that no significant differences appeared in the performance of these separate groups, when they were evaluated at the end of the third week.

Study of Table XXI shows the interesting fact that the handicapped clients in the experimental group out-scored clients in the control group on all of the twelve (12) items on which they were rated. These differences in ratings were statistically significant for five of the rating items, including the important matters of work traits, safety consciousness, vocational objective, and quantity of work.

The above findings are so unidirectional as to suggest a strong relationship to therapy. It can be deduced that therapy had a direct influence on clients in the sense that improved relationships with members of his family raised his morale and as a consequence his performance in a training situation. This finding has implications which will be explained in the final chapter which follows.
TABLE XXI

DIFFERENCES IN EVALUATORS' RATINGS IN EXPERIMENTAL AND CONTROL GROUPS OF HANDICAPPED CLIENTS AT SIXTEENTH WEEK

<table>
<thead>
<tr>
<th>Rating</th>
<th>Difference Means</th>
<th>Control Mean</th>
<th>Experimental Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dress</td>
<td>-.75</td>
<td>5.08</td>
<td>5.73</td>
</tr>
<tr>
<td>Grooming</td>
<td>-.53</td>
<td>4.40</td>
<td>4.65</td>
</tr>
<tr>
<td>Posture</td>
<td>-1.33*</td>
<td>3.67</td>
<td>4.20</td>
</tr>
<tr>
<td>Application of Instructions</td>
<td>-.88</td>
<td>3.64</td>
<td>4.0</td>
</tr>
<tr>
<td>Learning and retention</td>
<td>-1.21</td>
<td>3.20</td>
<td>3.68</td>
</tr>
<tr>
<td>Work Traits</td>
<td>-1.60*</td>
<td>2.67</td>
<td>3.32</td>
</tr>
<tr>
<td>Work Tolerance</td>
<td>-.34</td>
<td>3.62</td>
<td>3.80</td>
</tr>
<tr>
<td>Safety Consciousness</td>
<td>-1.40*</td>
<td>3.60</td>
<td>4.05</td>
</tr>
<tr>
<td>Adjustment</td>
<td>-.90</td>
<td>3.73</td>
<td>3.95</td>
</tr>
<tr>
<td>Vocational Objective</td>
<td>-2.03**</td>
<td>3.71</td>
<td>4.45</td>
</tr>
<tr>
<td>Quality</td>
<td>-1.22</td>
<td>3.0</td>
<td>3.65</td>
</tr>
<tr>
<td>Quantity</td>
<td>-1.51*</td>
<td>3.30</td>
<td>4.0</td>
</tr>
</tbody>
</table>

(A negative "t" value indicates that the experimental group's score is higher than the control group's score.)

*Significant at .10 level, using t-Test
**Significant at .05 level, using t-Test
CHAPTER VII

SUMMARY, CONCLUSIONS AND IMPLICATIONS

Study Setting and Approach

The subject of this dissertation has been an experimental study designed to test the effects of group therapy on the role behavior of handicapped persons and their families. Inspiration for the study came from two sources: (1) the obvious advantages in minimizing the tensions which disabled persons tend to place on themselves and their families, with consequent implications for their social adjustment; (2) the fact that the sociological factors are of importance in the adjustment of handicapped persons and their families, and these factors had not been subject to a great deal of research attention.

A rehabilitation center, erected in New Orleans, Louisiana, provided the setting for the study, which was set up as follows: During a period of several months, the families applying for admittance of a handicapped member at the Center were invited to participate in the study. Some sixty (60) families accepted. These were randomly divided into an

100
experimental and a control group. Members of both groups, the mother or wife, were administered a questionnaire designed to test the closeness of family relationships at the time they were enrolled in the study. The experimental group families were then exposed to a varying number of group therapy sessions, lasting over a period of six weeks. Both groups were retested after this period to determine if the experimental group had changed in a manner significantly different from the control group. The purpose was to check on the effectiveness of group therapy as an additional approach to the rehabilitation of handicapped persons.

A second check was also planned as a supplement to the procedure outlined above. This was a measurement of the progress of the handicapped clients of the study themselves. Each such person admitted to the Center was periodically evaluated on his performance relative to twelve (12) rating items. The study clients were evaluated at the end of their third week and again at the end of their sixteenth (16) week, and the scores of the individuals in the experimental group compared with the scores of the persons in the control group.

The basic assumption of the study was that the "adjustment" of handicapped persons could be speeded by providing members of their families with an opportunity to learn more
about how such persons should be tested. Some six basic objectives were outlined: (1) a determination of the sociodemographic characteristics and patterns of role relationships of families with a handicapped member; (2) a determination if group therapy would serve to change family behavior patterns; (3) a determination of whether or not the adjustment of the family to its handicapped member would be improved by group therapy; (4) a determination of whether or not the adjustment of the handicapped person would be improved by such a technique; (5) a contribution to sociological knowledge; and a contribution to knowledge in the field of rehabilitation of handicapped persons.

The study was conceived as falling within the framework of role theory, and especially the area of the sick role. In this regard, the perspective was taken that there is a web of normative behavioral requirements which are characteristic of families in a given cultural setting. These requirements are understood in terms of norms, roles and status-positions and the consensus which develops around these "action units." However, the sick or handicapped person serves to disrupt or change role continuities because he is unable to play roles as expected. To this extent there is disorganization in the family group, which is manifest in stresses and tensions.
The overall hypothesis of the study was that family stresses and strains caused by having a handicapped member could be reduced by family group therapy under the direction of a professional therapist. This inference was drawn from studies which had shown that group therapy could be used to induce social change. The findings and implications of the study are summarized below.

Limitations of the Study

One can always profit by hind sight, and this study is no exception. There are several procedures which could have been conducted more rigorously, had problems which arose been anticipated before the study. An identification of these problems may help those wishing to follow with a similar type of investigation.

First, it became quite clear to the investigator that the members of his control group should have been recruited outside the Rehabilitation Center, and within the community at large. It was impossible to prevent "contamination" in the sense that the clients and family members in the control group were aware of the therapy sessions and their intent. They were thus able to profit from a certain amount of feedback, which affected the results of the study.

Another problem was the inability to provide the same number of therapy experience for all experimental
families. Control was lost here because attendance was on a voluntary basis. The study could have been more rigorous had some mechanism been worked out to promote uninterrupted attendance.

A third limitation of the study is perhaps more basic. This is the fact that the sample populations were quite small. This limitation was a function of limited resources and time. It would have been possible to generalize with a greater sense of validity had a larger number of cases been studied. For this reason, the present study can claim to be no more than explorative or pilot in nature.

Findings of Study

The socio-demographic characteristics of handicapped clients can be outlined as follows. They were predominantly male (because of type of school and type of dormitory space available), they were primarily between the ages of sixteen (16) and twenty-two (22). They were rather evenly divided between Catholics and Protestants; their handicaps tended to be retardation, brain damage, general debility and psychosis. The individuals in the control and experimental group did not score significantly different on performance, at the end of three weeks. Also, there was little difference in the two groups on the other characteristics described.
The members of the clients family interviewed, their mothers or spouses, were also matched sufficiently for purposes of the study - mothers tended to be middle aged, while wives or husbands were somewhat younger, religious affiliation was not too widespread between Catholics and Protestants, education tended to be of a high school level, and the occupations of family breadwinners were concentrated in unskilled, semi-skilled and clerical-sales type of work.

As mentioned, each family was tested for the closeness of its role relationships. Their relationships were studied according to four types: those relating to family solidarity, those relating to family decision making, those relating to family communication patterns, and those relating to other family interactional patterns. It was found that all families, control and experimental, rated rather high at the beginning of the study period. This was accounted for by the fact that all the families had voluntarily applied to the Center, and could thus be assumed to be somewhat knowledgeable about the problems of the handicapped. It was reassuring, however, that not too much difference appeared between the experimental and control group. In fact, the latter tested significantly higher than the former in two role areas (communication and other roles), although not in terms of total role relationships.
The last procedure was to retest all families after the experimental group had received therapy experience. Findings from the tests made indicate that the therapy experience did indeed make a difference. Not only did the experimental group improve in the pattern of its role relationships over time, but it definitely improved more than the control group. It is interesting that the latter did change somewhat in a positive direction. The explanation appears to be the "Hawthorne" effect, that is, the fact of being part of a study made them more conscious of their roles.

It was also discovered that group therapy had a carry-over effect to the handicapped member of the family. An evaluation of performance check performed at the end of the sixteenth (16) week showed clients in the experimental group out-performed clients in the control group on every item.

The implications of the above described findings are explored in the remainder of this chapter.

Conclusions and Implications

The conclusions and implications of the study can be related to the objectives which prompted its undertaking. In the first place, it can be observed that families with handicapped members are not too different from other families of
the same general socio-economic level. The group attracted to the Center which was the focus of this study were primarily in the lower middle and working classes. In this regard it is of importance that as much sophistication about the handicapped and his problems were displayed initially. This is a commentary on the effectiveness of mass media and educational programs in the enlightenment of the populace at large.

The more important conclusion, of course, is that there is a "pay-off" in the use of group therapy to bring about a change in the direction of more healthy family relationships. Despite some procedural weaknesses, the investigation made definitely indicates that therapy can and does change family role patterns. The latter has ramifications far beyond the study made, although it's immediate implications are for new approaches in the operation of Rehabilitation Centers. With regards to the latter, the findings of the study suggest that it would be worth while to plan family therapy as an integral part of "rehabilitation centers." Of course, further testing should be done to determine if some families would profit more than others. It may be that families with higher socio-economic and educational levels would not profit as much as those in lower economic and social levels.
The fact that handicapped persons showed greater progress in their performance at vocational and other tasks, if members of their families experienced group therapy, is also worthy of further study. One can hypothesize that the total program of rehabilitation centers might be speeded up if family therapy were normally provided.

A more profound implication of the study is the significance it has for all types of programs where changes in role relationships are desired. The effectiveness of group therapy in induced change seems apparent in the findings of this investigation, although it is hardly sufficient to make broad generalizations. One can conceive of implications for problems of morale in such organizations as business establishments, hospitals and even homes for the aged. Beyond this, many problems of education, such as those involving new instructional approaches on curriculums, might be lessened by some kind of "therapy" sessions with parents. Obviously, parents with exceptional or problem children would be potential benefactors from such experience.

Finally, the findings of this study has implications for the well being and adjustment of individuals who are handicapped on the one hand, or who are in close and responsible association with the handicapped on the second hand. It seems appropriate to illustrate the impact of group therapy
with two or three case developments at this time.

One young man, classified as retarded because he had dropped out at the ninth (9) grade, had experienced great trauma because of his "academic failure." His family was highly upset and as a consequence he became highly disturbed. During their therapy experience, the member of his family gained an insight into their son's problems and their own. They changed their attitudes and role behavior toward their son. He responded so well to this new environment that he was able to complete the requirements for the High School Diploma (G.E.D. Tests). He now has secured a good job.

A second case involved another young man, with a similar disability. However, in this instance, when their son was classified as a slow learner, the parents became overprotective. When their son entered the Center, he was almost completely dependent upon his parents. After therapy sessions, his parents changed their pattern of behavior. As a consequence, the son became more independent, and eventually joined the Army.

A third young man, treated as "dumb," also had a complete lack of self confidence. His parents were ashamed of him and "wished he could be kept away from the perils of society." He had never succeeded in any field, and was determined to have low self-esteem, shame, guilt, to be shy and to
be a "failure" at everything. During therapy, his parents began to reverse their feelings and to reflect their change in their relationships with their son. He reacted immediately by showing enthusiasm for cooking and baking. This new interest and commitment has resulted in his enrollment for further training in the Culinary Arts. He is now a very happy college student and his family feels they profited greatly from the therapy sessions.

Perhaps clients with visual difficulty have the greatest problem of adjustment. One such individual in the experimental group had failed to make an adjustment and had a completely disrupted home atmosphere. The fact that one of his parents was also blind complicated matters, since he did not trust the Center and was skeptical of therapy. However, after only three sessions, a remarkable change occurred in family relationships. As a consequence, this client developed an interest in music and music therapy. He is now a successful student in Loyola University's College of Music Program, operated under contract at Delgado College.

Another blind client, member of a large family with blind parents, had failed in a regular college program and was becoming increasingly maladjusted. His parents, after therapy experience, changed their patterns of behavior toward him and are now most pleased with his renewed interest in his
training. He developed an interest in Graphic Arts, and especially liked to work in the dark room. It is a commentary on the adjustment this young man has made, that the whole world is no longer his "dark room."

In final conclusion, it appears that sociologists have a challenge to explore group therapy as a technique of behavioral change. There are at least two approaches which this study indicates would be worthy of further investigation. On the one hand very little has been done in the study of groups as units of manipulation and change as a whole. On the other, the importance of role changes in and of themselves as an instrument of therapy or change has been left relatively un-researched. It is hoped that this study may serve as an indication of the importance of these approaches.
SELECTED

BIBLIOGRAPHY
BIBLIOGRAPHY

BOOKS


JOURNALS AND PERIODICALS


_________. The Sociology of Confrontation: An Interactional Theory of Conflict and Cooperation, a paper prepared for Congresso Nacional de Sociologia, Republica Mexicana.


Klein, Josephine. "The Family as a Small Group Association, Sociological Inquiry, XXXIV (Spring, 1964) (Journal)


Taves, Marvin J., Ronald Corwin, and J. Eugene Haas. Role Conception and Vocational Success and Satisfaction (Columbus, Ohio: Bureau of Business Research, Ohio State University, 1963).


APPENDIX A

INTAKE FORM 1

DELGADO VOCATIONAL REHABILITATION CENTER

Admission Staffing Work Sheet
(MEDICAL)

Client's Name ____________________________ Age _________

Medical History

Surgical Procedures

Present Treatment

Diagnosis

Precautions, restrictions, and medical limitations

Additional information needed

Medical Director's Recommendations
APPENDIX A

INTAKE FORM 2

Information or client

1. Client's name ________________________________
2. " age ___________________
3. " sex ___________________
4. " religion ___________________
5. " disability as diagnosed by Dr. Haslam ___________________

Information on relatives

1. Relative's name ________________________________
2. " age ___________________
3. " address ________________________________
4. " religion ___________________
5. " relationship to client ___________________
6. " educational level ___________________
7. " occupation ___________________

8. Statement about the relative's degree of motivation for group therapy.

________________________________________________________________________

________________________________________________________________________
9. (Indicate on the scale below the degree of motivation for group therapy circle the appropriate number.)

<table>
<thead>
<tr>
<th>+2</th>
<th>+1</th>
<th>0</th>
<th>-1</th>
<th>-2</th>
</tr>
</thead>
</table>

We motivated   motivated   neutral   not motivated   extremely un-motivated

**Neutral** - the relative makes statements that indicate they have no feelings one way or the other about attending meetings.

**Not motivated** - the relative shows disinterest, but will attend group meetings, although they don't want to.

**Extremely un-motivated** - the relative indicates he will not attend group meetings under any circumstances.

**Motivated** - the relative is interested in becoming involved in group therapy and indicates they will attend.

**Well motivated** - the relative is eager to become involved in group therapy and will attend; high degree of interest.

10. (Give a brief statement quoting the relative's response to the possibility participation in group therapy. The statement should include comments the therapist feels indicate the relative's feelings about group therapy.)
### APPENDIX B

**DELGADO COLLEGE**
**VOCATIONAL REHABILITATION CENTER**
New Orleans, Louisiana

**VOCATIONAL EVALUATION REPORT**

<table>
<thead>
<tr>
<th>Client:</th>
<th>Age:</th>
<th>Sex:</th>
<th>Counselor:</th>
</tr>
</thead>
</table>

#### VOCATIONAL PERSONALITY

<table>
<thead>
<tr>
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<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dress</td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
</tr>
<tr>
<td>Posture</td>
<td></td>
</tr>
<tr>
<td>Application of Instructions</td>
<td></td>
</tr>
<tr>
<td>Learning &amp; Retention</td>
<td></td>
</tr>
<tr>
<td>Work Traits</td>
<td></td>
</tr>
<tr>
<td>Work Tolerance</td>
<td></td>
</tr>
<tr>
<td>Safety Consciousness</td>
<td></td>
</tr>
<tr>
<td>Adjustment</td>
<td></td>
</tr>
<tr>
<td>Vocational Objective</td>
<td></td>
</tr>
</tbody>
</table>

#### VOCATIONAL PERFORMANCE

<table>
<thead>
<tr>
<th>Category</th>
<th>Activity:</th>
<th>Quality</th>
<th>Quantity</th>
</tr>
</thead>
</table>

#### RATING SCALE

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Superior</td>
</tr>
<tr>
<td>6</td>
<td>Above Average</td>
</tr>
<tr>
<td>4</td>
<td>Average</td>
</tr>
<tr>
<td>2</td>
<td>Below Average</td>
</tr>
<tr>
<td>0</td>
<td>Poor</td>
</tr>
</tbody>
</table>
### WEEKLY EVALUATION REPORT

<table>
<thead>
<tr>
<th>Area</th>
<th>Client's name ____________________________</th>
<th>Week of ________________</th>
</tr>
</thead>
</table>

#### 1. Dress

<table>
<thead>
<tr>
<th>Subarea</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Clothes and shoes - appropriate for work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- neat and clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- fit and tidy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- good state of repair</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Grooming

<table>
<thead>
<tr>
<th>Subarea</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Hair</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Hands and fingernails</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Face and teeth</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Breath and body odors</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### 3. Posture

<table>
<thead>
<tr>
<th>Subarea</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Standing posture</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Sitting posture</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Walking posture</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>On-the-job posture</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
4. Application of Instructions
   a. Application of demonstrated instructions
   b. Application of oral instructions
   c. Application of written instructions
   d. Generalization from one application to another

Total

5. Learning and Retention
   a. Rate of learning - abstract material
   b. Rate of learning - concrete material
   c. Retention of abstract material
   d. Retention of concrete material

Total

6. Work Trait Components
   a. Organization of work
   b. Initiative
   c. Perseverance
   d. Method of completing job

Total

7. Work Tolerance
   a. Physical functioning - full time
   b. Emotional functioning - full time
   c. Physical functioning - part time
   d. Emotional functioning - part time

Total
8. Safety Consciousness
   a. Seriousness toward work safety
   b. Following safety rules
   c. Use of equipment for intended purpose
   d. Alertness for hazards

   Total

9. Adjustment
   a. Cooperation with co-workers, one-to-one
   b. Cooperation with co-workers, group
   c. Cooperation with area policies
   d. Cooperation with supervisor

   Total

10. Vocational Objective
    a. Willingness to discuss vocational objective
    b. Degree of realism
    c. Possibility of modification
    d. Seriousness of intent

    Total

11. Quality
    a. Coordination
    b. Interest
    c. Use of tools
    d. Accuracy - Neatness

    Total
12. Quantity
   a. Coordination ...........................................
   b. Interest ............................................
   c. Use of tools ........................................
   d. Time ................................................

   Total ______

COMMENTS:

Recommendations: (Include Reasons)
FAMILY RELATIONSHIP QUESTIONNAIRE

Each of the sentences below could be true about your family almost always, often, once in a while or almost never.

Tell how it applies to your family by putting a "/" in the blank before the word or words that best describes how the sentence fits your family. The example below shows how one family replied to a question about TV use to show what happened "often" in their family -

Example: The question what television program we should watch is usually decided by the children rather than by a family conference.

_____almost always, ____often____ once in a while _almost never.

(If the questions below mention children and you have only one child, read it as though it was about your one child. If there is no father or mother read the sentence to mean the person who acts as father or mother.)

1. For recreation we tend to stay at home and do things together like watch TV, play cards, talking or reading rather than go out and do things separately like one bowling and others going to the movies, visiting with friends and so forth.

__almost always, __often, ___once in a while, __almost never.

2. Teaching the children how to behave, like teaching them table manners or what to do or say with the opposite sex, is left up to either the father or the mother and the same person takes care of this.

__almost always, __often, ___once in a while, __almost never.
3. The question of what our family does with its spare time as a family does not have to be answered, - each person decides what he wants to do and does it without bothering with the others.

__almost always, __often, __once in a while, __almost never.

4. If someone in the family needs to find a job, everyone tries to help as much as they can since we think this kind of thing affects the whole family.

__almost always, __often, __once in a while, __almost never.

5. It is permissible for the children to say what they feel is important for the family. They can disagree with adults about what is important if they wish.

__almost always, __often, __once in a while, __almost never.

6. The assignments of jobs in our family, like housecleaning or keeping up the car, are decided by the father.

__almost always, __often, __once in a while, __almost never.

7. The father in our family is the one who suggests family recreational activities and the rest of the family accepts them.

__almost always, __often, __once in a while, __almost never.

8. In making decisions, our family is more likely to think about whether a decision is right or wrong than what will happen if it's made.

__almost always, __often, __once in a while, __almost never.

9. Each member of our family feels almost the same about civil rights and civil rights legislation.

__almost always, __often, __once in a while, __almost never.

10. Keeping the household records and paying the bills is done by either the mother or by the father and they do not exchange this task with each other.

__almost always, __often, __once in a while, __almost never.
11. There is no real plan for deciding how to budget our income. We buy food first, pay bills and then what is left sometimes goes for one thing and sometimes for another.

almost always, __often, __once in a while, __almost never.

12. To make decisions in our family about who must do little jobs about the house that come up, we have a family meeting and then assign the job.

almost always, __often, __once in a while, __almost never.

13. There is a difference of opinion in the family about "what we want for our children."

almost always, __often, __once in a while, __almost never.

14. The question of what are standards for good manners for the children or how often they should go to church is settled by whomever the children ask or left up to them.

almost always, __often, __once in a while, __almost never.

15. All members of the family attend the same church.

almost always, __often, __once in a while, __almost never.

16. Our family feels free to express their feelings to each other. We believe in "letting off steam" whenever we want.

almost always, __often, __once in a while, __almost never.

17. Decisions when persons will be invited to visit our home and who will be invited are made by each member independently and each invites whom he wants when he wants without consulting with others.

almost always, __often, __once in a while, __almost never.

18. In making decisions our family tends to be influenced more by what friends and relatives think than by members of the immediate family.

almost always, __often, __once in a while, __almost never.
19. Decisions about important economic matters such as whether the wife should take a job or whether a major piece of household equipment should be bought or a new car purchased are made by the man of the house and there is little discussion among family members.

__almost always, __often, __ once in a while, __almost never.

20. Discussions of who should do various household tasks like keeping the house straight or the grounds looking nice are likely to result in an argument.

__almost always, __often, __ once in a while, __almost never.

21. The decision regarding what is important for our family is made by the father.

__almost always, __often, __ once in a while, __almost never.

22. In our spare time activities inside the home our family tends to do things together whether it is playing cards, watching TV, talking to each other, reading and so forth.

__almost always, __often, __ once in a while, __almost never.

23. When we have to pay more bills than we have money for, the husband and wife together in our family discuss this to decide what to do instead of one making the decision.

__almost always, __often, __ once in a while, __almost never.

24. Our child or children seem to be more willing to talk about his or their problems with each other and with friends than with their parents.

__almost always, __often, __ once in a while, __almost never.

25. In recreational activities that take place outside the home our family members have different interests and will be found doing different things.

__almost always, __often, __ once in a while, __almost never.
26. Questions about family finances are never discussed in our family because this kind of thing isn't encouraged.

almost always, often, once in a while, almost never.

27. Problems that happen on the job of working members of our family are shared with other members of the family who do not work.

almost always, often, once in a while, almost never.

28. In carrying out domestic duties about the house like making beds, washing dishes, washing and ironing, putting out the garbage, keeping up the lawn the family tends to help each other and does not concern itself whether a particular job belongs to one person or another.

almost always, often, once in a while, almost never.

29. Our family takes part in community affairs like PTA meetings, church fairs or suppers, political campaign speeches and so on by going to it as a family and one person does not go without the others.

almost always, often, once in a while, almost never.

30. The children tend to talk to the mother or father about as much as they talk to each other about what they do with their spare time.

almost always, often, once in a while, almost never.

31. In recreational activity outside the home our family have quite different interests. Each family member tends to follow his or her own kind of recreation.

almost always, often, once in a while, almost never.

32. In our family we act like it is more important for each member to try to solve his own problems than to discuss it or bring it to other members of the family.

almost always, often, once in a while, almost never.
33. If anything needs repair or fixing at our house like drapes or slipcovers, or sticking windows or squeaking doors we call in someone else rather than fixing it ourselves.

almost always, often, once in a while, almost never.

34. The family funds are divided up so that each person has an allowance and no person lends or gives some of his to another.

almost always, often, once in a while, almost never.

35. When it comes to supervising the children's homework, nobody in the family really does this but each child is allowed to work on his own and seek help from whomever he wishes or do without help.

almost always, often, once in a while, almost never.

36. When the family is faced with the need to have more income coming into the home this is something the father decides how to get, as it is considered his responsibility and not the rest of the family.

almost always, often, once in a while, almost never.

37. The tasks in the home that our children are responsible for are decided on in a family conference.

almost always, often, once in a while, almost never.

38. In elections the voting members of this family are likely to vote for the same candidate or for the same laws.

almost always, often, once in a while, almost never.

39. The question of who must do unpleasant jobs in the home like taking out the garbage, washing dishes, etc. can be a source of argument because there is no special agreement who does them.

almost always, often, once in a while, almost never.
40. When there are things to be done about the children like
taking them to school or helping them to get dressed or answer­
ing their questions about something, it is about as likely for
any one person to take care of this as for someone to be as­
signed to it.

__almost always, __often, __once in a while, __almost never.

41. In our family each tries to do more than his share of
things that have to be done around the home like cleaning up,
mowing the lawn, washing the car, etc.

__almost always, __often, __once in a while, __almost never.

42. There is little understanding of the feelings of one
family member by other family members in our family.

__almost always, __often, __once in a while, __almost never.

43. When the family has to make decisions about one of the
children like whether he should be allowed to go to dances
or participate in a school activity, the decision is made by
whichever person first hears about it and there is no con­
sideration of a discussion among family members.

__almost always, __often, __once in a while, __almost never.

44. Decisions about what friends our children should have
are made by each of the children independently of parents.

__almost always, __often, __once in a while, __almost never.

45. For some of the jobs around the house like doing the
evening dishes or cleaning the car, where everyone could help,
we often take turns.

__almost always, __often, __once in a while, __almost never.

46. The kind of things that we want for our family like a
modern home and furniture are like what other families want.

__almost always, __often, __once in a while, __almost never.
47. Some kinds of the children's questions are more likely to be asked of the father while others would more likely be asked of the mother. The mother and father don't exchange places about answering these questions.

almost always, often, once in a while, almost never.

48. Having a person with a disability in our family has tended to make the family feel closer together.

almost always, often, once in a while, almost never.

49. In doing such things like cleaning the house, washing the dishes, doing the laundry, mowing the lawn, keeping up the car and so forth, each family member has his own job and other family members do not take over somebody else's job.

almost always, often, once in a while, almost never.

50. There are differences of opinion in the family regarding whether financial success, good health, getting along with each other, having friends or something else is the most important thing in life.

almost always, often, once in a while, almost never.
VITA

The author was born on July 21, 1917 in Dry Prong (Grant Parish), Louisiana. He attended public schools in Grant Parish and graduated from Dry Prong High School in May, 1935. He attended (off and on) Louisiana State University, University of Southwestern and Southern Methodist University from 1935 to 1946 when he received the Bachelor of Arts Degree from Louisiana State University. He entered (part-time) Tulane University and Louisiana State University Graduate Schools and earned the Master of Science Degree in 1957. The author continued the graduate studies at Louisiana State University and Tulane University and is presently a candidate for the Ph.D in Sociology and Education.

The writer's experience includes professional teaching at Tulane (part-time); counseling and managerial work with State and Federal Employment Security Agencies, State and Regional Chief of Manpower Utilization and Training, and Area Director for War Manpower Commission; State Employment Security Administrator and Deputy State Labor Commissioner for Louisiana; Administrative Officer for the
Institute of Inter-American Affairs, the International Labor Office and United States Department of Labor in Washington, and Foreign Diplomat for United States Department of State and International Cooperation Administration with over-seas assignment; Teacher, Professor, Director, Executive Dean and President of Delgado College in New Orleans (formerly Delgado Trades and Technical Institute.) The author has served as college President since 1961-62, which is his present assignment.

The author is an active member of many civic, fraternal and religious organizations. He has served on numerous Boards, Commissions, and Study Groups affecting education for youth, adults, minorities and community improvement missions.

The writer is married to the former Sybil Elizabeth Watson and they have three sons: Marvin, Jr., Charles Watson, and Philip David.
EXAMINATION AND THESIS REPORT

Candidate: Marvin E. Thames

Major Field: Sociology

Title of Thesis: The Effectiveness of Group Therapy in Changing Family Role Patterns Toward Disabled Members

Approved:

[Signature]
Major Professor and Chairman

[Signature]
Dean of the Graduate School

EXAMINING COMMITTEE

[Signatures]

Date of Examination: December 19, 1969