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# A Pilot Study of a Sex Education Program in a Sheltered Workshop Using a Cognitive-Behavioral Model Based on Rational Emotive Therapy

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This research is a product of the graduate program in [Clinical Psychology](#) at Eastern Illinois University. [Find out more](#) about the program.

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A PILOT STUDY OF A SEX EDUCATION PROGRAM IN A  
SHELTERED WORKSHOP USING A COGNITIVE-BEHAVIORAL  
MODEL BASED ON RATIONAL EMOTIVE THERAPY

(TITLE)

BY

Jacqueline A. Rieck and  
Thomas E. Frederick

**THESIS**

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF

Master of Arts in Clinical Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY  
CHARLESTON, ILLINOIS

1978

YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING  
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A PILOT STUDY OF A SEX EDUCATION  
PROGRAM IN A SHELTERED WORKSHOP  
USING A COGNITIVE - BEHAVIORAL  
MODEL BASED ON RATIONAL EMOTIVE THERAPY

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ABSTRACT OF A THESIS

Submitted in partial fulfillment of the requirements  
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of Eastern Illinois University

CHARLESTON, ILLINOIS  
1978

This pilot study was developed to teach people with mental retardation about their own sexuality, appropriate community behaviors, and to develop within them a basic sense of responsibility for their own actions. Problems in social/sexual behaviors have been consistently quoted as reasons for high recidivism rates, as well as difficulties in community living, vocational placement, and other generalized stereotypes about mental retardation. Often the public remains uninformed about, does not recognize, and/or feels that sexual rights for people with any mental differences should not exist. Additionally, when any form of sexuality was expressed by such people it resulted in shock and/or punishment. This in turn perpetuated the old custodial models, and the teaching of general effective living skills for eventual community re-integration remained inadequate.

Included within this pilot study were problem solving techniques based on Rational Emotive Therapy which were extended into sexuality and then generalized to other non-sexual areas. The basic philosophy behind the project was that people who attend a sheltered workshop are able to think and learn appropriate behavior, can accept responsibilities for themselves, and can learn how to solve their own personal problems with minimal support.

In the area of sexuality the paper concentrates on sexual knowledge and attitudes. A literature review shows that few researchers have asked the people themselves what they think or feel about sex. Several problems were revealed:

- 1.) Most of the literature covers philosophical positions or anecdotes.
- 2.) The few appropriate tests available have no published norms.
- 3.) Much of the material available remains inadequate and overpriced.

Other areas covered include problems in sex education programs; attitudes of institutions; parental reaction to sexuality and retardation; birth control, children, and marriage; and the legal aspects of sterilization.

A growing number of professionals have indicated that therapy can work if the counselor remains active, directive, structures meetings, is more verbal, uses repetition, accepts limitations, tolerates frustration, and works within narrow goals. While true insight is rare, a person can be taught several alternatives in solving his problems himself. The approach of Rational Emotive Therapy is explained and shows how it can be adapted.

Another section provides materials a counselor/educator could use to create a program for his own use. This includes philosophy, readings, format, games, slide presentations, comic books, posters, and curriculums. A chapter on research shows a short questionnaire format used to judge group needs and as a method for ongoing group evaluation. Results show the test to be reliable ( $r=.70$ ). More than 70% know the concepts involved in making a woman pregnant and defining terms. Some problems were seen in V.D. knowledge, homosexuality, who to have sex with, making decisions, and creating alternatives.

The end result is a cognitive-behavioral based sex education program which stresses acceptance of self responsibility, concept of self as adults, decision-making, and basic problem solving skills. The basic philosophy emphasizes that these are people with retardation not retarded people.

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## INTRODUCTION

Social and sexual problem behaviors among the mentally retarded have consistently been quoted as reasons for high recidivism rates, difficulties in community living, vocational placement, and stereotyping. Often the public remains uninformed about, does not recognize, and/or feels that sexual rights for people with any mental differences should not exist. Additionally, in the past, when any form of sexuality was expressed by such people, it often resulted in institutionalization, sterilization, and a general repression of their sexuality. This in turn perpetuated the old custodial models, and the teaching of general effective living skills for eventual community re-integration remained inadequate. This pilot study was developed to teach people with mental retardation about their own sexuality, appropriate community behaviors, and to develop within them a basic sense of responsibility for their own actions.

Included within this pilot study were problem solving techniques based on Rational Emotive Therapy which were extended into sexuality and then generalized to other non-sexual areas. The basic philosophy behind the project was that people who attend a sheltered workshop are able to think and learn appropriate behavior, can accept responsibilities for themselves, and can learn how to solve their own personal problems with minimal support.

## I. CHAPTER ONE - PURPOSE AND NEED

Within the last two decades, the Department of Mental Health has focused upon the transferring of people from the public institutions and the returning of these people to the community for community based treatment. In 1963, the Community Mental Health Centers Act was passed and since then there has been a proliferation of local mental health centers across the country (Test & Stein, 1976). The primary responsibility of these mental health centers is to provide therapy to the people within their own community, attempting to reduce the need for institutionalization and re-institutionalization, while providing "in vivo" treatment - treatment within the patient's natural environment (Roan, 1971; Test & Stein, 1976).

This community-based program has since been criticized. The number of people within the institutions themselves have decreased, but the number of re-admissions of previous patients has increased, this being labeled as the "revolving door syndrome" (Talbot, 1974; McNeese, 1977; Rosenblatt & Mayer, 1974). Much concern has also been expressed concerning the type of life many previously institutionalized people must live, feeling that they have been transferred from the back wards of the hospitals to the "back alleys" of their communities (Murphy, Pence, & Luchins, 1972). Partial responsibility for this situation seems to lie within the institutional system. It is felt that many of these patients while in the institutions developed the implicit license to behave in "sick" ways, with their coping skills having atrophied due to disuse (Murphy, et al., 1972; Test & Stein, 1976). Many institutions have

failed to develop adequate sets of standardized criteria to be met before determining who was ready to be released (Rosen, Kivitz, Clark, & Floor, 1969). Chances for success in the community was based primarily on the patient's "good" behavior and personality within the highly structured and controlled environment of the institution-forgetting that this "good" behavior exhibited in the institutional setting did not necessarily generalize to the completely different, unstructured lifestyle on the "outside" (Eagle, 1967). Institutions tend to provide little follow up as to care, and the discharged people commonly revert, almost completely, to the local agencies for aftercare (Perretti, 1974; Schafter, 1957). Without the development of programs to teach the people how to cope with the "outside" before release from the institutions, many had to return. Common reasons cited for these returns were an inability to get or maintain employment, an inability to interact with others, and the possession of poor self-concepts (Perretti, 1974).

Another major criticism of the current community mental health program deals directly with the treatment of the developmentally disabled, who make up a large section of the de-institutionalized population as well as the community population currently being served by mental health professionals. Community mental health centers do not seem prepared to contribute to the normalization process nor to the widespread community living of the retarded (Brown, 1972; Lippman, 1972). Many professionals have had minimal prior experience working with the retarded and it seems that in this area services remain lacking. This appears to hold true mainly with the adult mentally retarded population, who between 1960 and 1970 were attributed with a 53% recidivism rate. This high recidivism rate of mentally retarded individuals has been

attributed to the increasing complexity of society and their lack of necessary coping skills to adequately deal with this complexity, resulting in a return to the institutions (McCaver & Craig, 1973).

A review of literature by Eagle (1967) showed a recidivism rate of 39.6% for adult mentally disabled released between 1941-1967. These figures were compiled by reviewing 36 articles covering a total of 7,436 people released by various institutions. In compiling these statistics, Eagle did not count those as community failures who were reported on as partial successes, partial failures, and the "undefined", otherwise the percentage of failure would have been higher.

From this review of literature, a further delineation of the reasons for community failure were developed and grouped into the following headings: (A) antisocial actions—sex offenses, assault, theft, prison record, etc.; (B) undesirable personal conduct—unruly, destructive, untidy; (C) personality problems—jealous, insolent, moody; (D) unsatisfactory worker—unreliable, inefficient, lazy; (E) health problems—seizures, superimposed mental illness; (F) escape or voluntary return to institution; (G) adverse environmental factors—community objection, economic dependence, and the closing of placement homes (Eagle, 1967).

It seems evident that new or revised programs need to be implemented by mental health practitioners to meet the needs of previously institutionalized and community populations, for both developmentally disabled and mentally ill persons. Many of these people who are unable to function independently in the community are placed into community board and care facilities, rehabilitation centers, or halfway houses (Test & Stein, 1976). These supportive services are often then charged with the responsibility of providing programs to teach skills necessary to independent community functioning. Considering the recidivism rate (53%),

it seems that these supportive services are failing in adequately teaching these skills.

This pilot study was concerned with only one of these community systems, the vocational rehabilitation center. The primary goal of the vocational workshop is to teach the work skills necessary for community independence. Research was revealed that work programs do improve the rehabilitation and work attitudes of the people but generally do not improve their level of anxiety (Growick, 1976). It is felt that vocational workshops should also be teaching the clients how to cope with themselves, other people, and the world as well as how to work. This pilot study concerned itself with the development of a therapeutically based training program for clients within a vocational training center, focusing on their emotional and sexual development. The primary emphasis of this pilot study was specifically in the area of sexuality, using the teaching of coping skills as a way to deal with the problems presented by sexual feelings and actions, as well as the other problems of community living.

Rehabilitation has advanced considerably in the last 10 years. The manner in which those with mental retardation have been viewed has changed, slowly but surely. With this population being returned to the local communities, professionals are now finding it necessary to focus on the needs of this population, a group previously cared for only by the institutions. With this change has come a need for program development, and for the education of parents, communities, and professionals about the place of these people in society. One of the most controversial aspects of this re-integration is the sexuality of those with mental retardation.

People with handicaps have previously been viewed as individuals

without sex, as people who exist but no longer, never had, nor should not have had, any sexual feelings or thoughts. After being ignored for so long, a small group of professionals has finally started to push for the sexual rights and education of people with mental retardation.

Menolascino(1972) has listed several sexual myths about people with mental retardation such as:

- 1) They cannot make good choices for love partners, cannot express themselves physically, are not considerate of their partners wishes and cannot be faithful.
- 2) The more severely retarded a person is the less they are able to understand what is involved in marriage.
- 3) Retarded reproduce at a faster rate than normal.
- 4) Retarded are not able to function as parents.

Professionals are finally realizing that it is almost impossible to remove sex from the whole of a person's makeup-whether "retarded" or "normal". It is also impossible to expect those with mental retardation to re-orient themselves to community living while denying them knowledge of their own sexuality.

II. CHAPTER TWO - SEXUAL KNOWLEDGE AND ATTITUDES  
OF PEOPLE WITH MENTAL RETARDATION

For the most part research on sexuality and retardation has emphasized the study and reporting of behavior patterns, marriage, genetics, physical development, sex role adjustment, etc. The studies mainly talk about the subjects, but not what or how the subject thinks. Turner(1970) gives a fine example. He starts out promising by asking:

"...what of the deficient child? How does he react, what are his feelings and how can he reason out these sexual conflicts? It is so very difficult for a normal child to reason (this out)...then it must be even more difficult and more confusing for the deficient child..."

(p. 548-549)

The article then covers only the parents ideas, not the childs. Very few articles ask the subject what he thinks. This may be a result of a concensus that people with mental retardation cannot express themselves or cannot understand abstract questions. Logically if that was true why waste time on special education-or any sort of training for that matter. If they can show gains in moral conduct(Moore & Stephens, 1974), why not ask what they think and know about sex?

A problem within the studies concerns population. Of the studies located, only three papers deal with adults, all the rest concern adolescents or children. This may be a reflection of the growth of special education in the schools in the last ten years. The adult population as a whole should be just beyond school age and have had

minimal chance to be studied. The lack of social programs for adults, besides workshops and residential facilities, may also be a factor. The recent changes in funding patterns by state and federal agencies may change this eventually.

As most people realize human beings grow up, yet the knowledge and attitudes of adults in sheltered workshops, institutions, boarding homes, sheltered care homes, or half-way houses, seem to have been ignored. These are the people who are often suspected or picked up for sex crimes (Meyerowitz, 1971). They are also the ones who are of age to get married, have children, and whose self concept is partially based on knowledge of themselves as a male or female (Morgenstern, 1973; Rosen, 1975). Thoughts and ideas about sexuality increase as the human matures physically and enters adult life (Money & Ekhard, 1972). Many people need a place where they can receive help and answers for their questions, whether they have retardation or not. Family Planning Services, as described by David, Smith, & Friedman (1976), may be a possible answer. In any case, the need for correct sexual information extends beyond adolescence.

Just what is the sexual knowledge of these people. Since the studies are so few, each can be looked at individually.

Hall, Morris, and Barker (1973) gave 61 mentally retarded adolescents (I.Q. 41-65) a questionnaire covering various aspects of sexuality. Results indicated that they were able to answer slightly more than half of the questions correctly, but certain areas such as conception, contraception, and venereal disease showed a real lack of accurate information. Fischer and Krajicek (1974) interviewed 16 adolescents (I.Q. 33-57) at a large school for people with mental retardation. Through the use of a structured interview using pictures, it was found that they had

some concept of sex, identity of body parts, body functions, and emotional situations. There was some indecision on pregnancy and how a baby grows. They found that often the clients could not explain why or how people behave sexually. Males generally had more information than females. Edmonson and Wish(1975), in a semi-structured interview with 18 moderately retarded men (I.Q. 30-55) undergoing de-institutionization training, found they possessed acceptable information on masturbation, sexual intercourse, and identification of body parts. There was some idea of pregnancy in that babies came from the stomach. They had a difficult time identifying males versus females in slightly ambiguous situations.

Hall and Morris (1976) compared institutionalized vs. non-institutionalized adolescents using 171 people. They found that institutionalized subjects had less knowledge about sociosexual topics than non-institutionalized. The longer the person had been in the institution the less correct information the person knew. Co-ed living helped but not to the extent of those living with families. The institutionalized population had difficulty answering questions about family dynamics, peers, self concepts, and differences between people. Both groups had adequate knowledge about masturbation, menstruation, pregnancy, and sexual intercourse. Less than half could answer questions on family planning and birth control. Very few understood the idea of sterilization.

David, Smith, and Friedman(1976) attempted to develop "Family Planning Services for Persons Handicapped by Mental Retardation". They used open ended discussion with 35 individuals with mild to severe retardation with an age range of 14-37. All but three lived in institutions and were in programs of early transfer to the community.

Almost all agreed that dating could lead to intercourse and/or marriage and that through intercourse people could make babies. One third of the males knew of the "Pill" but only 1/6 knew it prevented pregnancy and very few knew about rubbers. The women had heard of the "Pill" but knew of few other methods. Many people of the group were sexually active and eventually planned on marrying. None had heard of fertility regulations. Interestingly, contraception was viewed as a status symbol because "normals" used it, so their own use of it made them feel more "normal".

Rostafinski(1973) studied tapes of discussions he had with 19 men and 19 women with an I.Q. range of 29-75 and aged 15-29. One-half came from state institutions and the other half from sheltered workshops. He found that they had no knowledge of family planning, birth control, sterilization or venereal disease.

In a study of imprisoned and institutionalized males, ages 11-40+, I.Q. 31-70, Gebhard(1973) found that compared to a controlled group of "normal" men there were no real differences in knowledge of coitus and pregnancy except more cases of extreme ignorance and belated learning among those with retardation. Knowledge of female anatomy came later than knowledge about pregnancy. Over 92% named peers as the main source of sexual information, not teachers, clinicians, or parents.

What do these show? First, that most people with retardation probably have a good idea about masturbation, intercourse, body parts, sex difference, and pregnancy. Where they generally are lacking is in areas requiring a little more thinking such as contraception, family planning, and venereal disease. Hall and Morris(1976) feel that the limited information generally possessed by people with mental retardation makes it easier to take advantage of them sexually and to abuse their

basic rights in the community.

In the area of sexual attitude, the research has been done by essentially the same people. Several trends were indicated, some contradictory. The first was that people with retardation, especially in institutions, have a tendency to develop puritan sex ethics (Edgerton, 1971, 1973; Edgerton & Dingman, 1964). At the same time Hall and Morris(1976), and Hall, Morris, and Barker(1973), while working with adolescents, indicated that actually the attitudes may be more liberalized than realized, when compared to their parents expectations. They also found a much less rigid interpretation of the rules by institutionalized adolescents in general(Hall, Morris, & Barker, 1973). These adolescents were more opinionated than previously thought, in addition to being more liberal in outlooks. There was a very low correlation between the amount of exposure to sexual material and the degree of liberalism. Fischer andKrajicek(1974) indicate that even though many of the verbalized concepts were meager and erroneous in content, many of the children they evaluated had some knowledge and attitudes about the importance of sexual ideas in their lives.

Edmonson and Wish(1975) found that while covering masturbation, the group was split roughly 50/50 on whether it was a good or bad behavior. Several related that they had been told by doctors that masturbation could cause trouble with the police and if the penis was pulled too hard they could rupture it. Another male in the group claimed masturbation could cause blisters.

David, Smith, and Friedman(1976) showed that most of the people they saw were aware that society generally disapproved of their sexual

activity. Inside the institution itself, Rostafinski(1973) showed some residents felt there were too many restrictions on sex. They wanted more ability to make their own choices.

Both the Edmonson and David studies make one important point when dealing with sex and retardation. The teacher must stay aware of the differences of confusion and error, fact and fantasy. They say that people with retardation can have problems in failing to categorize material properly, based on cues presented to them. They do not always distinguish inconsistent interpretations of unlikely events and will tend to focus on only one aspect. This remains important in understanding the person's motivations. The teachers must be able to tell mistakes from misinterpretation and explain the differences.

It seems incredible that so much has been written about these people yet so little is actually known of their ideas, thoughts, and opinions. This is hardly a way to develop successful programs, to educate the community, or accept them as real people.

III. CHAPTER THREE - STATE OF THE LITERATURE  
ON SEXUALITY AND MENTAL RETARDATION

Historically almost all cultures have viewed "the different ones" as being preventable; the Spartans let non-perfect babies die, and the Inquisitors burned witches. In the 1920's-1930's the Eugenics Movement flourished on the pretense that all mental retardation was inherited. The study of the Kallikak Family tried to show that prevention of marriage by "imbeciles" would prevent more from being born. Sterilization was viewed as the answer and often was a requirement to leave institutional life (Edgerton, 1967). Before the late 1960's, written material covered only "safe" topics such as marriage, parenthood and some social-sexual behaviors. Discussion of masturbation, homosexuality, or sexual intercourse and how these activities fit in the area of retardation were very rare (Kempton, 1975). Many of these ideas stem from thinking that people with mental retardation exist as impaired individuals who live without ability, insight, or sensitivity (Atwell & Clabby, 1971; Beier, Gorlow, & Stacey, 1951; Guthrie, Butler, Gorlow & White, 1964; Perron, 1962).

In recent years the process of de-institutionalization has placed many of these people back into the community. It has been estimated that over 95% of people with retardation live in the community and of these, 85% fall into the educable range (Kempton, 1975). These people exist in this society, learn its rules, see its movies, watch its television programs, and use other available mass media.

This exposure creates a situation where some sort of education often

becomes required to help appropriate and acceptable behaviors. Bass (1972) and Kempton(1975) show some of the needs for sex education based on real problems:

- 1) Low reading levels limit access to accurate information.
- 2) Through limited social outlets, few opportunities exist to learn socially approved behavior, so social skills do not develop beyond elementary levels.
- 3) Difficulty in reasoning, judgment, inner control and distinguishing reality from fantasy.
- 4) Easily exploited and respond to affection quickly.
- 5) More confused about identities, self image and sex role.
- 6) Low self esteem leading to acute feelings of being "stupid".
- 7) With fewer interests and outlets they tend to be more troubled by impulses and ideas not easily understood.
- 8) Feelings of guilt about common sexual feelings and fantasies.
- 9) Poor at appraising their own abilities and limitations due to others trying to shelter them from their handicaps.
- 10) Often need help to establish realistic goals based on their abilities and values.
- 11) Difficulty predicting consequences of action.

Based on these problems and the fact that so many people are returning to the community, some sort of program becomes required. Perhaps even more important than teaching appropriate behavior is establishing the research groundwork to educate the public to be able to show them that people with handicaps are not the troublesome creatures they have been presented to be. Research is needed to help correct the misconceptions people hold which create the negative environment in

which most "handicapped" live.

In the past ten years there has been an explosion of materials dealing with sexuality and the handicapped. Heslinga(1974), Jacobson(1974); Singh & Magner(1975); Talbot(1971); Teal and Athelstan(1975), movies such as "Like Other People"(British Spastics Society,1973), and the materials produced by the Human Sexuality Program and the Department of Physical Medicine and Rehabilitation of the University of Minnesota Medical School have been doing an outstanding job in the area of physical handicaps and trauma. In the area of mental retardation there are easily over 200 articles, books, and curriculums to help spread information. The problem here continues to be a lack of research. Most of what can be found is basically philosophical presentations of what should be taught, how to go about it, what to look for, and not interpretation of data (Vockell & Mattick, 1972). Very little is known about the sexual knowledge and attitudes of people with mental retardation. Comparing the sheer number of articles produced in studies on "normals", the materials in this area are extremely minimal. This is not to say that the material that has been produced is insufficient and weak. Quite the contrary, this material concentrates more on behavioral aspects and peoples reactions to the behavior. People like Gordon, Kempton, Bass, Hall, de la Gruz, LaVeck, Goodman, Johnson, and others have pushed the way to recognizing as aspect of life for another group of people who are generally ignored or pushed aside. The theoretical groundwork has been laid and now the research must follow if the whole approach is to be taken seriously.

Several factors have influenced this problem. The first consists

of the absence of adequate procedures to evaluate a program of sex education for people with mental retardation. While several such procedures exist for the population with no retardation, none have been validated on the population with retardation. Recently Zelman and Tyser(1976) have released the "Elementary Adult Sex Education for the Mentally Retarded"(EASE), which supposedly has been empirically tested and aimed as an education and research tool. Hall et. al (1973, 1976) have been developing a questionnaire used in research with adolescents in institutional verses non-institutional settings, but has not been yet released. Fischer, Krajicek, and Borthick(1973) have developed a structured interview booklet using illustrations. It describes typical responses and tells the interviewer how to give information at the same time. Neither EASE nor Fischer's booklet contain norms with which to make comparisons. Several other questionnaires have been developed but for the most part they were either washed down versions of more complex tests or simply questionnaires made up by researchers to provide numbers. Until tools such as EASE contain norms and become more common, these latter methods may have to do.

A second problem has been the general inaccessibility of sex education materials. If theoretical papers have been fairly easy to find, actual materials were equally difficult. Zelman (unpublished paper) credits this problem to:

"an effort by sex educators to keep a low profile. They have disguised sex education curricula with titles such as, Health and Safety, Level 2; Family Life; Biological Sciences-Curriculum Study; and Health and Family Life Education." (p. 6)

Meyon and Retish(1971) follow up this same theory with the idea that due to actual learning problems, much of the material used in "regular" classes becomes almost worthless. With these learning problems limited reading skills (if any) and an inability to easily comprehend much of the biological facts makes the task of teaching extremely difficult without materials. Unfortunately (or fortunately), this usually forces the teachers to create materials or purchase them. As Zelman further notes each has its own difficulties.

"Obtaining useful sex education materials is extremely difficult, because a complete curriculum must include instructional objectives, programming or sequencing of material presentation, a comprehensive instructional content whose scope is determined by the needs of the retarded individual, visual and other instructional aids and an evaluation tool.

Consequently, the search for sex education materials goes on. Unfortunately, teachers have little opportunity to review sex education materials because of fees charged by publishers and film producers for the rental or review of their material. As a result, materials which are referenced and/or suggested in position papers or resource guides are purchased, sight unseen, at an exorbitant cost. Perhaps even more frustrating is the realization, once the materials have been purchased, that they are incomplete, inaccurate, inconsistent and/or irrelevant." (p. 6)

Needless to say the cost of these materials can easily become prohibitive to programs or agencies running on small or limited budgets. Unfortunately what works fine for the funded research grant project, may not work so well in the community based program which does not have similar resources.

The literature remains influenced by more than just a lack of materials as just discussed. The problem includes the everyday pressures that sex education and family planning services face. Without programs

and people even the finest materials are fairly worthless, but (in a chicken or egg type syndrome) people are needed to help develop the materials. An understanding of what has occurred can be seen in the various factors involved.

Robert Perske(1972) has been an advocate for the idea of the "Dignity of Risk". To him people with retardation often end up in situations where they become so overprotected that they never get a chance to experience the normal instances of risk needed for growth and development. This comes about by:

"...limiting their spheres of behavior and interactions in the community, jobs, recreation, relationships with the opposite sex, etc. Even buildings are designed to help the residents avoid risk". (p. 24)

He views this risk as commensurate upon the skills of each person. He uses Denmark and Sweden as examples where people with retardation have been expected to encounter some degrees of risk and face a world where life does not always stay safe, secure, and predictable. This same idea reverts to the traditional institution or sheltered care home where these supposedly, "safe" environments exist. In such total environments much of a persons life has been structured or patterned to provide little choice(Goffman, 1961). Gordon(1972) has indicated it has not been unusual for all instances of sexuality to be disapproved of by cutting down bushes, installing bright lights, constant staff patrol, and segregating sexes. Rules and guidelines often appear vague and contradictory to behaviors. Mulhern(1975) surveyed the attitudes of 82 administrators of residential facilities

for people with mental retardation and looked for information concerning tolerated sexual behavior of residents. He found:

- 1) 70% endorsed delineated guidelines to handle sexual behavior, yet only 23% had them.
- 2) The only forms of sexual behavior to receive majority endorsement were private masturbation and brief public kissing.
- 3) A greater tolerance for private activities compared to public.

The problems of administration often become complicated by aspects not easily controlled such as state and federal funding regulations, various state and federal agency guidelines, community stereotypes, legal problems, parental pressures, accreditation requirements, staff feelings, locations, age and type of residents, and the size of the facility. Administrators can still get around these problems. They hire the staff they do. They can help educate the community and parents. They can enforce their rules and philosophy.

There are several specific factors involved in the problems within sex education programs.

- 1) People with mental retardation being seen as sexual deviants as discussed so far. (Zelman, unpublished paper)
- 2) Parent-teacher conflicts and fear of pressure groups(David, Smith, Friedman, 1976; Zelman, unpublished paper). While many groups feel sex education is appropriate, various anti-sex education attacks by groups such as the John Birch Society and some religious groups can quickly cause problems for programs which must keep good public relations. Solutions may lie in involving more parents (if available) and/or following recommendations

given by Bass(1972), Gordon(1976), Kempton(1975), Rolett(1976), and others on developing community acceptance.

3) Lack of available staff time, trained staff, and organized resources(David, Smith & Friedman, 1976). There are very few courses where training in this field has been provided. Most people learn by trial and error, reading literature, and being forced into it by program circumstances. The socio-sexual problem faced by many people with mental retardation must often be dealt with everyday and does not receive the emphasis it should in training programs. As time goes on this area may receive more attention in special education, psychology, and counseling department in universities(Floor, Rosen, Baxter, Horowitz, & Weber, 1971).

4) The question of what morality to teach(Zelman, unpublished paper).

This divides into four identifiable approaches.

a) ban all sex education with the idea that no discussion brings on no behavior.

b) teach the "Old Sex Morality" with emphasis on purity and sentiment while ignoring biological facts.

c) teach the facts of life focusing on scientific-biological information leaving out psychological, social and ethical aspects.

d) teach the "New Sex Morality" based on situational ethics (Fletcher, 1965), while focusing on the individuals responsibility both morally and socially.

The day to day problems many programs and agencies face do not always permit more than crisis-band-aid help. The goals for research

faces many obstacles, those mentioned here being some of the main ones. Maybe more research will develop as a more serious position becomes taken. Most likely it will have to be on the grant, university, or occasional institutional level but these have been slow in coming about.

#### IV. CHAPTER FOUR - DEVELOPMENT OF SEXUAL VALUES AND ATTITUDES

If, as many psychotherapy systems maintain, early events in life can have a profound effect on later patterns and thoughts, then an understanding of the attitudes of possible "parental" role models of those diagnosed as mentally retarded becomes important to an effective program.

The idea of parents attitudes about the sexuality of their retarded offspring remains a touchy one. How it is handled depends on the parents and how severely retarded their child is. Hall(1975) indicates that:

"If the parents I.Q. average is close to that of their retarded adolescent (as might be expected in cultural familial retardation) sexual expression in the retarded person predicably would be accepted by the parents and seen as similar to their own sexuality. Sexual expression in these cases is less devastating and less anxiety provoking to the parents than it would ve to those parents whose IQ's may be significantly discrepant from their adolescent. In this latter case all the adolescents social situations are extremely threatening to the parents. As a result willful ignorance of the emergence of sexuality and even repression of sexual expression may follow" (p. 3)

Facing the aspect of sexual education is something a parent cannot ignore. The issue forces itself as all children grow up no matter how retarded. Eventually, the parent will be forced to face the facts of puberty through the female menarche and the male secondary body growth. At this time questions of pregnancy will arise and how this is handled depends on the adjustment of the parents. On one hand are parents who feel their child has the right to a natural sex life, to desire love and closeness, and to marriage if the person finds a partner who returns love

with all the support that would be needed. Children would require serious planning(Goodman 1973). On the other hand, due to guilt, aggression, overprotection, and incomplete acceptance of the problem, there are several ways less well adjusted parents may feel(Heslinga, 1974), These parents tend to fall into these patterns:

- 1) Denial of Sexuality: The person is viewed as a child without any form of sexual desire or thoughts. "Talk about sex only causes trouble"(Goodman, 1973).
- 2) Pseudo Enlightenment: Sex is defined so narrowly that the person has no opportunity to learn how to develop socio-sexual behavior. "He has a right to sex but..."(Goodman, 1973). In fact, some are so isolated socially they do not even have the chance to learn the usual misinformation(David, Smith, & Friedman, 1976; Morgenstern, 1975).
- 3) Vicarious Sexuality: The parent unknowingly encourages his/her own fantasies and later holds the child responsible(Johnson & Szurek, 1952).
- 4) Oversexualized Response: Sex is seen everywhere with excessive concern about any possible problem and always finding faults(Goodman, 1973).
- 5) Sex is Sinful: Sex is acceptable only in marriage and then only for procreation, but people with retardation are seen as not being able to handle marriage, so that any expression of sex means trouble. This usually comes from severe religious, moralistic or stereotyped personal beliefs and are very hard to work with(Goodman, 1973).
- 6) Sex is too Risky: Overprotection is deemed as important because the person is viewed as not being able to handle his/her own feelings or actions. This attitude cuts down on the risks needed for growth

and development(Perske, 1972).

Fortunately, the most common response is, "I don't know what to do. I want to do the right thing, but I just don't know", (Goodman, 1973). Parents usually do want to be involved but because of their childrens learning problems the usual teaching techniques do not work. The literature indicates that most parents prefer that someone else teach about sex. Typically parents usually cover only birth(Fischer & Krajicek, 1974; Goodman, Budner & Lesh, 1971; Hall, Morris, & Barker, 1972; Hammar, Wright, & Jensen, 1967; Turchin, 1974; Turner, 1970). Fischer and Krajicek(1974), point out that parents are interested but they prefer to let sexual topics go until crisis develops. Those authors credit this to several trends:

1. The general societal reluctance to discuss sex openly.
2. A real concern about their child's ability to handle the information adequately.
3. Trouble of knowing just what the child understands and learns.

Throughout all the studies there was a recurrent reference to the idea that parents felt it would be dangerous to tell their retarded children about sex because it might create ideas, and cause problems. They seemed to follow the idea that silence equals a lack of interest(Hammar, Wright & Jensen, 1967). Hall, Morris and Barker(1973) have shown that most parents do not know what their child's attitude was. In a test of correlation of the child's attitude and knowledge, what parents tended to overestimate was knowledge and self-concept of their children when the child had a low I.Q. or MA. At the same time, the parents underestimated knowledge and self concept scores of high I.Q. or MA children. The parents had trouble predicting what their children would say. Two other observations came out of this. First, as the adolescent self concept rose, the difference between the parents prediction and adolescents

score got bigger. Secondly, the adolescents were less rigid and more liberal than the parents thought. The apparently had some ideas about sex and themselves even if it had not been discussed with them.

Just what is discussed at home? Hammar, Wright and Jensen(1967) indicate that parents put off as much as possible. The advent of the female adolescents menarche made some talk about sexuality mandatory for 88% of the females. Males would be put off longer with the hope that the schools would handle the problem. While mother-daughter relationships were fairly close, few fathers helped their sons. Any father-son talks were usually limited to basics of birth and pregnancy. Only 32% of the males had heard anything about sex at all. As little as possible was discussed, apparently in the hope that ignorance was bliss and the fear that information would cause problems. At the same time the parents were willing to take part in a sex education program for themselves and their children(Goodman, Budner, & Lesh, 1971). As much as parents might be looking elsewhere for a source of information, it must not be the schools since only seven percent of the children had any form of sex education in school(Turner, 1970). Apparently the children are on their own outside of some simple discussions of birth and contraception.

This leads to a major problem. In almost all the studies parents have their greatest concerns about sexual misbehavior such as homosexuality and rape. Yet this was discussed with few children(Hammar, Wright & Jensen, 1967). Fischer and Krajicek(1974) found that 60% of the mothers questioned felt their children could eventually date when the young men learned to control aggressive behavior, and young women were taught to refuse sex explicitly from strangers. Over half the parents

they interviewed felt that their child could become involved with a romantic love affair but only 1/5 thought they could marry. Hammar, Wright and Jensen(1967) indicate that parents felt the older, more socially accepted the child, the better the chances for marriage. Young and severely limited were not seen as well suited as borderline or moderately retarded could be.

Turchin(1970) shows several advantages of marriages: (1) prevention of loneliness, (2) broadened personal relationships, (3) an extended family, and (4) a sexual partner. These apply to any person retarded or not. Hammar, et al, tried to show that parental anxiety was based on an anticipation of problems to come. Puberty and sexual maturation were seen as being early problems which could cause extreme stress. The question of marriage brings one other aspect quickly into view - children.

In this society the acceptable tradition indicates a person grows up, falls in love, gets married, and has children. Just as many retarded people learn the societal norms, they also learn marital expectations. Exposure to television, movies, newspapers, books, magazines, and social relations teaches all children what to expect from life and proper goals to set. While many parents may feel marriage could be a good goal for their children, the aspect of grandchildren is a whole new area. Research shows that with two genetically retarded parents 39.5% of the children are retarded, with one retarded parent 11.2% are retarded, when both are normal .05% are retarded(Bars, 1972; Begab, 1970).

"Those parents who questioned the retardates ability to be a parent not only challenged the child's capacity to make appropriate judgments and to plan purposefully, but also were concerned with whether or not any offspring would be retarded. If they were normal the subjects wondered how

they would feel about having parents of limited mentality and what the emotional impact would be (Goodman, Budner, & Lesh, 1972, p. 44).

How do parents plan for their childrens sexual maturation and what do they do? As reported earlier, some do not know how to handle it. The very emotionalism makes it a difficult problem to deal with. Parental attitudes quickly become influenced by several factors as their child grows older(David, Smith, & Friedman, 1970). The first of these is fear of pregnancy for women and of the males being accused of fathering children out of wedlock. The sons problems tend to be intensified by the community interpreting erotically suggestive behavior as intent to commit rape or sex violence. The parents fear was that their sons would be the first accused of rape or molestation even without evidence. This extends to the expectation parents have of their children living unsupervised in the community and attitudes toward possible marriage and parenthood.

Hammar et al, (1967) found parents tend to use four methods to help control the problems: (1) close supervision, (2) medical control through birth control, (3) institutionalization to prevent marriage and reproduction, and (4) sterilization. Experience with retarded individuals show that these have not always been the most useful. Sexual ideas or desires do not die in institutions, as many places have known for years. This supervision works fine but places great demands on parents time and life. Birth control can be successful as long as it is appropriate to the intellectual level of the person involved.

Sterilization is a complex issue currently going through a stage of re-evaluation as to the legal, social and emotional implication for the

mentally retarded. There are several good reviews of the literature on the effects of it by Whitcraft and Jones(1974) and Bass(1967). Whenever discussions of marriage and children enter the idea of mental retardation, sterilization is sure to follow. From the time of the Eugenics Movement of the 1920's to 1930's the thoughts on it have varied widely. Some professionals feel the retarded are incapable of providing for children, and children themselves would be such a burden as to hurt the chances for success for the couple. Others feel that some retarded can care for children and do a good job, thinking that a child can help stabilize the marriage. Goodman, Budner, and Lesh(1971) found a surprising readiness by parents of daughters with retardation to view sterilization as a way to allow their child to develop to her fullest with the least restrictions in marriage and a good sex life. Whitcraft and Jones(1974) in a study of parents and professionals showed that the overwhelming majority of their sample approved or strongly approved of sterilization for any retarded person on a voluntary basis with 84% of the samples feeling it was morally right.

Whitcraft and Jones came to these conclusions:

1. "Any possible humane method of prevention of mental retardation must be utilized. Voluntary sterilization could reduce the incidence of genetic retardation by 50% in one generation(Reed & Reed, 1965, p. 77).
2. Obligation and responsibilities of parenthood appear beyond the capabilities of mentally retarded persons and may negate potentially successful adjustment to independent community living.
3. The normal expression of sexuality of retardation could be viewed with equanimity by parents, counselors and others of the complication inherent in possibilities of procreation are not involved". (p.33)

Bass(1967) questioned 132 parents on their attitudes toward voluntary sterilization. Her findings tend to follow Whitcraft and Jones-60% of the total sample approved of sterilization. Several other findings

of Bass are worthy of note.

1. Approval of sterilization is positively correlated to knowledge.
2. Intensity of attitudes is positively related to approval.
3. Many parents are not aware of the legal issues.
4. Many parents though sterilization equals castration.
5. Even if they thought it immoral, many parents felt their child should be sterilized.
6. Parents need counseling on the scientific, legal and moral aspects of sterilization.

Tarjan, in accepting an award from the Joseph P. Kennedy, Jr. Foundation for Human Rights, Retardation, and Research, talked about who can authorize sterilization. He felt that parents, because of their concern and fears, should not be allowed to use their judgment alone no matter how worthwhile. He concludes:

"...It would not be possible for anyone to rationally decide what is right and just for a retarded person on the basis of sexual acting out that may occur in adolescence but that often disappears in adulthood...(also) mildly retarded people are capable of making many significant decisions about their lives and if the question of sterilization arises after they are of age, they should be allowed to decide for themselves." (Tarjan, in Clayton 1972, p. 31)

He backs this up with letters he has received from doctors who have told him that whatever the original reason was for sterilizing some of their retarded patients. These reasons have ceased to exist for some. The physicians could find little difference between these people and their other patients. Some have shown themselves to be adequate mothers to their husband's children.

The legal implications in sterilization are many and have varied.

While many people may assume individuals with mental retardation are inadequate as parents, such generalizations do not convince a court(Linn, 1977).

"Sterilization is a drastic procedure...most competent geneticists now reject social Darwinism and doubt the premise implicit in Justice Holmes incantation that...'three generations of imbeciles are enough'...the nature of retardation, its causes and effects are not susceptible to facile generalization"

North Carolina Association for Retarded Children v. North Carolina(1976).

Sterilization, involuntary or voluntary, is rapidly being placed under more drastic court supervision and while typically seen only as the last option available(Cochran, 1974; Paul, 1974), at least 22 states have laws for forced sterilization for people the court defines as "mentally defective"(Marine, 1974). Several court decisions have noted that more than parental consent is required for sterilization surgery(A.L. v. G.R.H., 1975; Buck v. Bell, in Varnar, 1975; North Carolina Association for Retarded Children v. North Carolina, 1976; Wade v. Bethesda Hospital, 1971; Wyatt v. Aderholt, 1973). What has evolved is a situation where without a finding of genuine desire and a finding where the procedure is in the person's best interest as defined by the courts, no sterilization may take place(Relf v. Weinberger, 1971; Varnar, 1975). Parents and guardians are being allowed less and less voice in the decision. However, the law varies from state to state and is rarely very legally clear in any state(Krishef, 1972).

In general, what is the attitude of parents? One of confusion seems to be the best answer. They are not quite sure exactly how to handle the problems that come up but they still must plan for the future. Many parents want to help their children for when they grow up, but

sexual behavior, marriage, and pregnancy call for some deep consideration. Realistically, parents know they will not live forever. While a normal child will eventually be independent, this is not always as certain with a person with mental retardation. The concerns of the parents are many with no easy answers. Fischer and Krajicak(1974), have some suggestions to help in decision making process.

1. Know what the person's terms are. Communication of any kind of idea is difficult if not all the words are mutually understandable.
2. Read some of the recent literature that is available. This often means the parent must educate themselves out of necessity.
3. See a professional working in the field. With recent legislation and affirmative action programs more money is being spent in states to help people with handicaps. There are many workshops, agencies, or mental health facilities that provide some sort of service. Depending on the area of the country a person can just about shop around for the best deal. A professional working in the field of retardation should be aware of recent developments and be able to help the parents plan for the future. More professional education is needed in this area especially in the legal aspects.
4. Development of specific equipment and audio visual material - Special education is a developing field with many changing ideas. Equipment changes and new materials make it easier for the parent to teach their own child or adult how to grow up and live in society. Good comprehensive materials would be an excellent method of attempting to look at all the variables involved. Parents can find help even if the known facts are not as complete as they could be.

V. CHAPTER FIVE - RETARDATION AND PSYCHOTHERAPY  
AND RATIONAL EMOTIVE THERAPY

Many professionals feel that the mentally retarded do not benefit from therapy and that they do not experience the full range and depth of human feelings and emotions(Lazarus, 1976). They feel that they are inferior, not possessing the ability to learn as others do(Slivkn & Bernstein, 1970). As stated by Guzburg(1975) many studies, which reflect the above attitude, fail to take the following factors into account:

- 1) the emotional disturbance in a mentally retarded person has usually been longstanding.
- 2) the person has little innate ability to assist the therapist in his work.
- 3) much experience is needed with the "subnormal personality" to get at his "wavelength" and have adequate rapport.
- 4) the subnormal is a "slow-learner" and much more time must be spent with him.
- 5) the available assessment instruments to register any changes which might occur within the mentally retarded are generally not sensitive enough and usually quite irrelevant to the users.
- 6) any success which might be achieved in short personal contacts will be neutralized by adverse experiences in non-supportive environments.

It is true that the traditional methods of therapy seldom work with this population and must either be adapted to their particular problems or new techniques developed, but therapy and learning is possible with

this population. Only 11% of mentally retarded individuals are labeled as severely retarded with the other 89% falling into the mild and moderate range of retardation. These 89% are capable of learning, although usually at a slower rate than the "normal" population (Hersch & Brown, 1977; Lazarus, 1976; Menolascino, 1970). It is crucial that professionals working with people with disability adopt an attitude that reflects the opinion that clients do have the ability to learn, respond, and benefit from counseling services, that subnormality is not simply a problem of a cognitive deficit, but the problems of a whole person (Clarke & Clarke, 1976). In a study of 34 mentally retarded children, Jolles (1947), concluded that mental retardation which has been diagnosed as familial or undifferentiated is, many times, a symptom of a personality disorder and does not necessarily represent a failure of the intellect to develop normally. He feels that many diagnosed as mentally retarded can be treated successfully by psychotherapeutic techniques. Additional support to the benefits of psychotherapy with the mentally retarded is provided by Ackerman & Menninger (1936), Hackbusch & Klopfer (1946), and Sloan (1947). It seems that to deny a person psychotherapy on the grounds of I.Q. may be depriving the individual of the very help he needs to utilize whatever potential he may have. As discussed by Masland, Sarason, and Gladwin (1958), it is difficult to state whether the condition of subnormality predisposes a person to increased neurotic symptoms, or if these neurotic conflicts aid in the emergence of the condition of subnormality in an individual. They state that for any person whose functioning is considered subnormal, there probably also exists longstanding neurotic conflicts, which could only have added insult to injury to whatever handicaps he may originally have had.

In initially considering therapy with the mentally retarded, several problem areas need to be considered. This population will often resist change and attempt to cling to old habits and patterns of functioning. These clients are usually referred by others and rarely seek therapy or counseling on their own, with self-developed goals for therapy being minimal or absent(Sellan, 1976).

Mental retardation is a social term, not a purely medical condition, and it is a condition which is not totally irreversible(Hersch & Brown, 1977). Jakeb(1970) has suggested five generalized goals of therapy specifically for those who are retarded. These are: 1) the alleviation of painful symptoms; 2) the realization of intellectual potential; 3) improvement or irradiation of socially unacceptable behavior; 4) development of emotional maturity; and 5) teaching or reinforcement of coping mechanisms.

Most research indicates that a therapist working with the mentally retarded be extremely active and directive in approach, able to structure most of the sessions and to make-up for the limitations or deficits in the mentally retarded client(Hersch & Brown, 1977; Lazarus, 1976; Sellan, 1976; Sternlicht, 1974). It is felt that success with non-directive methods is based largely on the client's ability to perceive subtle cues from the therapist. Those with mental retardation are usually unable to accomplish this and seem to view silences as a form of hostility or not-caring, and can often lose the point of the conversation(Sellan, 1976). Group therapy is favored in working with the retarded, with both a male and female therapist capable of interacting in such a way as to model appropriate behavior. The therapists must be able to verbalize more than other therapists, to create simple tasks

within the therapy sessions which ensure success, and be patient enough to use much more repetition and instruction than is necessary with other type clients(Guzburg, 1975; Lazarus, 1976; Menolascino, 1970; Sellan, 1976). By conducting therapy in groups, more people are reached and the group process aides in the development of stronger inter-personal relationships. Other positive aspects of using group therapy with the mentally retarded are to make each client aware that he is not the only one with problems, to help break down feelings of isolation and withdrawal, to reorient clients to their immediate environment, and to make them aware of others and their feelings(Guzburg, 1975). In depth insight is rare with most people with mental retardation and counseling usually concerns itself with problems as they arise, usually in a very direct manner. Solving these problems through the group can provide for them some form of insight into their own and others behavior(Guzburg, 1975). The group discussions should be on a very realistic plane with emphasis on clarifying and understanding problems in relation to community expectations.

Group selection should be as homogeneous as possible in relation to intelligence, social functioning, and personality type, with the groups being small enough to provide for individual attention(Guzburg, 1975, Lazarus, 1976). The sessions should last anywhere from ten to forty-five minutes, depending upon the attention span of the clients. Each session should end with a repetition of the main discussion points. It is good to remember that people with mental retardation respond well to structure and routine. If there is a change in routine, whatever skills acquired in therapy may have to be patiently repeated. Skills learned and applied in one situation may not generalize to another (Sellan, 1976), which can be a very frustrating experience for the therapist.

Therapists who choose to work with those diagnosed as mentally retarded must be able to tolerate much more frustration than those who deal with other types of clients. They must be able to accept small success arrived at through much effort, be able to make decisions without regret, and to accept responsibility for failure. They must be able to deal with their own feelings and the limitations which often accompany working with the narrow goals of people with mental retardation. Therapists can easily become frustrated by clients who are verbal and initially show rapid progress. They often set up goals which are too high for the client to reach. Working with people with mental retardation almost demands that a therapist be patient, diplomatic, and possess a sense of humor. It must be remembered that in working with the mentally retarded, the therapist plays a far more important role in the life of his client whose social contacts are limited, than he would to a non-mentally retarded client who often has unlimited choice and variety of social exposure (Sellan, 1976).

It is therefore evident that therapy with the mentally retarded is a difficult task requiring specialized techniques. The purpose of this pilot program was to develop a workable therapeutic approach for this population which could be utilized specifically within a vocational rehabilitation center. The therapeutic orientation for this program is Rational Emotive Therapy, modified for use with this population. This therapeutic modality was chosen due to many of its basic precepts which are: (1) an active and directive in approach, 2) a simple ABC analysis which can fit most problems, 3) a requirement of much repetition in use, 4) that deep insight is not a necessity for improvement, and 5) it is easily used within a group process. The following section will deal with an explanation of the therapy itself.

Rational Emotive Therapy is a cognitive behavioral approach with the therapist taking a very active and directive role (Beck, 1970; Diguiseppe & Kassinove, 1970; Ellis & Harper, 1975). It is based on the assumption that peoples feelings are not caused by events or actions (A), but by the individual's evaluative thoughts, (B), about the action or event which results in (C) a feeling. This, Ellis refers to as the "A-B-C Theory of Personality and Emotional Disturbance" (Church, 1975). Maultsby (1975) further defines the anatomy of an emotion in the following manner: "There are three parts to an emotion, not merely the affective part: (1) is the perception; before one can feel anything, one must first have an awareness of perception of or about something; (2) is the evaluative belief about the perception, which directs the selection of; (3) the affective response." The second major assumption in Rational Emotive Therapy concerns the B section (Belief or evaluative thoughts) which, Ellis contends, leads to our emotions. This B section of the ABC's can consist of either rational beliefs or irrational beliefs. Irrational beliefs which people continue to perpetuate are what cause useless negative emotions. What people say to themselves (thoughts or beliefs) or, as Ellis (1975) calls them, "internalized statements" determine the rest of the things people do or feel and exert a strong influence on a person's state of well-being (Beck, 1970; Farber, 1963; Meichenbaum & Cameron, 1974; Fimm & Litvak, 1969). Basically, whenever man behaves irrationally one of the following variables is usually involved: "1) man's biologically self-centeredness and his tendency to be grandiose; 2) Man's biopsychosocial tendency, and to some degree, his reality-oriented (especially as a child), tendency to externalize security, worth and happiness; 3) Man's tendency

to think magically, and 4) Man's tendency to continue childish thinking processes into adulthood"(Ellis, 1974). Ellis has developed a list of twelve basic irrational beliefs which seem to cause people problems most often(Ellis, 1975). These irrational beliefs fall usually into three categories: 1) awfulizing statements which exaggerate negative consequences; 2) shoulds, oughts, or musts, which reflect unrealistic demands; and 3) statements of blame(Diguisepe & Kassinove, 1977).

Research has begun to support irrational beliefs and specific psychological disorders, some of these being in relation to neuroses, strong desires for social approval, depression, test anxiety, and public speaking anxiety(Argabut & Nidorf, 1968; Beck, 1963; Goldfried & Sobocinski, 1975; Karst and Trexler, 1970; and Laughbridge and Stanley, 1975).

Rational thoughts and behavior, as defined by Ellis(1975), are those behaviors of an individual which produce for him maximum pleasure and minimum pain. This definition has been further defined by Maxie Maultsby through the development of the five rules for rational thinking which are: 1) It will be based on objective reality, or the known relevant facts of the situation; 2) It will enable you to protect your life; 3) It will enable you to achieve your goals most quickly; 4) It will enable you to keep out of significant trouble with other people; 5) It will enable you to prevent or quickly eliminate significant personal emotional conflict. Rational physical and emotional behavior will meet three of these five criteria(Maultsby, 1975). The most important word in the criteria is "significant", this meaning the amount of conflict to a manageable level, meaning a person; 1) will not get as upset, 2) will not get upset as often, and 3) will not get upset as long(Maultsby, 1975).

Within the therapy session itself, the therapist assumes a very active and directive part, attempting to get the client aware of his irrational self-statements. Emphasis is placed on the fact that outside people or events do not cause feelings. Responsibility for feelings is placed on the client and his perception of events, which in turn, causes the emotional upset. It is emphasized that people do have emotional choices, that they have the ability to change their irrational beliefs, thereby developing a different emotional consequence. Ellis' ABC paradigm is then expanded to section D and E. Within the D section the therapist teaches the client to question and dispute his irrational beliefs with questions such as, "Why is it awful? Where is my proof? Why should it be?" By the process of discovering, disputing and replacing the old irrational beliefs with new rational thinking, the client can often alter his emotional reaction. With this type of rational re-structuring, a person can learn to use his anxiety as a signal to work on the reason for his upset and modify his cognitive set with which he views upsetting situations (Goldfried, DeCenteces & Weinberg, 1974). Many people feel that their emotional reactions are often automatic, involuntary reactions, but in actuality these reactions are learned emotional habits (Beck, 1970; Maultsby, 1975a). Beck (1970a) states that people need to be trained to distinguish thought from external reality, between hypotheses and fact. Rational Emotive Therapy offers a method for accomplishing this rational restructuring. Although the format appears simple, it must be remembered that old habits are difficult to break, and that this applies also to old emotional habits. The success of the therapy depends on the client's desire to change and the amount of effort he is willing to put forth to effect that change,

both in and out of the therapy session. Once a client has learned the Rational Emotive Therapy system, he is then introduced to the use of the ABC's of written Rational Self Analysis(Maultsby, 1974). This is a homework form which aides the client in discovering and disputing his irrational beliefs outside of the therapy sessions. These are often assigned to clients along with the assignment of specific Rational Emotive Therapy reading materials during the course of therapy, and aides in promoting positive personality changes(Gustav, 1968; Hartman, 1968, Maultsby, 1971).

Other research supporting the effectiveness of the principles of Rational Emotive Therapy include increasing rational thinking and the diminishing of anxieties in older persons over sixty(Keller, Croake, & Brookings, 1975); reduction of speech anxiety through group insight treatment(Meichenbaum, Gilmore, & Fedoravicious, 1971); reduction of test anxiety(Karst & Trexler, 1970; Meichenbaum, 1972); and the reduction of irrational fears through graduated prolonged exposure combined with rational restructuring(D'Zurrill, Wilson, & Nelson, 1973). Several analogue studies have also been sited as supportive of the principles of the therapy(Burkhead, 1970; Karst & Trexler, 1970; & Ellis, 1971).

An efficient and effective way to change an individual's perception of his own anxiety state is to attack his perceptions directly with rational techniques(Beck, 1970a). As Farber(1963) states: "The one thing psychologists can count on is that their Ss will talk, if only to themselves; and not infrequently, whether relevent or irrelevant, the things people say to themselves determines the rest of the things they do."

From this foundation of Rational Emotive Therapy, William Knaus(1974), developed a program of preventive psychotherapy (Rational Emotive Education)

to be used within the school systems. The program which he developed is divided into three sections: 1) Rational Emotive Education background for the instructor; 2) lessons and concepts; and 3) special activities aimed at reducing specific classroom behaviors(Knaus, 1974). Knaus has published a manual for elementary school teachers which outlines lesson plans in detail. As Knaus(1974) states: "The series of lessons and related activities will help children minimize their reactions to disappointment and frustrations, to cope more effectively with problems stimulated by outside events, and to more fully accept themselves by learning a systematic approach that will allow them to challenge their irrational assumptions".

The format for Rational Emotive Education is very flexible and can be used inside of outside of the classroom, for small or large groups. An important component of this program, once the basic rational concepts have been taught, is the use of experiential methods such as role-playing, group problem solving, skits, etc. which reinforce the concepts taught. The instructor should be aware of everyday situations which occur and use these to also reinforce the principles of Rational Emotive Education. Several studies have been done in successfully utilizing this type of approach with children, including reducing impulsivity in children(Meichenbaum & Goodman, 1971); increasing children's tolerance of frustration(Brody, 1974); reducing anxiety(Knaus & Boker, 1975; Albert, 1971); improving the self-concept of children(DeVogue, 1974; Knaus & McKeever, 1977); and the lowering of trait anxiety and neuroticism scores(Digueseppe & Kassinove, 1976).

Since this program format is flexible and approaches the therapy from an educational model, many of its basic techniques were used within

the pilot study, primarily for initial organization. The people who were involved were divided into groups with scheduled meeting times, the basic theory itself was taught within an educational framework, many special activities were incorporated into each planned meeting, and many discussions were centered around current life situations.

In reviewing the literature, there was no actual research found in utilizing this therapy specifically with those diagnosed as mentally retarded. In Reason and Emotion, Ellis(1962), talks briefly about Rational Emotive Therapy's use with "mentally limited" people. Because of how simple and clear it can be stated he felt it would work better than most other therapies for "less intelligent, poorly educated, economically deprived patients", (Ellis, 1962, p. 372). Knaus(1975) also stated that he felt the therapy successful with those he termed as "slow-learners".

The most similar work being done seems to be that of Howard S. Young, who practices Rational Emotive Therapy with people within the lower class. By using the instrument developed by Hollingshead and Redlick(1958). Young(1977) subdivided his lower class clients into two groups, the working class and the poor. He then further defined each group. His description of the "poor" in relation to occupation, education, and family structure seemed to be very similar to those of many clients involved in this pilot study:

"The poor are usually involved in those non-unionized, semi-skilled, and unskilled occupations in which irregular employment is common. Education beyond the eighth grade is rare, and family life is marked by frequent separation and divorce. Examples would be individuals who are farm workers, housekeepers, ghetto dwellers, and those supported exclusively by welfare or other marginal subsidy programs.

In addition to research findings, actual contacts with

the lower classes have revealed other endemic characteristics. The most frequently observed include a tendency on the part of the lower-class individual to adhere to strict or extremist religious views; to use alcohol (especially among males) as an exclusive leisure or recreational activity; to express anger and rage spontaneously; to resort to physical punishment or combat to resolve conflicts; and to follow rigid sex-role stereotypes in interpersonal relationships". (p. 3)

Young(1977) also operates his program from an educational framework, allowing for flexibility and diversity, while maintaining a well directed plan of action. This framework includes: 1) developing a relationship, 2) defining a problem, 3) solving the problem, and 4) encouraging change. His recommendation for length of sessions was thirty minutes. Young's work is carried out primarily through individual sessions, but many of his ideas are amenable to a group process and have also been modified and incorporated into this pilot study.

## VI. CHAPTER SIX - PHILOSOPHY AND FORMAT

This chapter covers a basic overview of the ideas behind the groups used in this pilot study and as a guide to their development and planning. The leaders involved need to be personally comfortable about sexual issues, view sex as a natural part of life, and have basic knowledge about sexuality. The relevancy of the groups can be enhanced by viewing each member as a person with a diagnosis, not as a retarded, a schizophrenic, an epileptic, a psychotic, etc. They are people first. A diagnosis merely describes a behavior pattern and/or a learning disability which a person may have, but does not describe the person as a whole, only one aspect (Ellis, 1974; Szasz, 1970; Brolin & Lesnik, 1977).

Throughout this pilot study the idea that these people are adults with adult plans and behaviors—not children in adult bodies—was constantly repeated. This was important in planning the teaching of responsibility on an adult level. This concept allowed the leaders to use material not usually associated with this population. In conducting the groups, higher level materials were utilized by translating complex information into understandable terms. For example, college slide series on embryology was used with adaptations made to a first grade language level, leaving out complex terminology. Borrow other peoples ideas and methods but gear them to the level of the groups. With practice, using first to third grade language to express complex ideas becomes easier. With this type of thinking, the cognitive-behavioral techniques and ideas developed in the last several years by people like Beck (1976) and Meichenbaum (1977), can be adapted and used within the group. The

leaders followed several general rules.

1. Go as slow as needed
2. Break ideas down to easy concepts
3. Translate higher level material to simple explanation
4. Do not be afraid to improvise
5. Keep it pertinent to the groups experiences
6. Remember that good ideas can flop with different groups
7. Laugh - DO NOT LECTURE

#### PART A -SEX EDUCATION MATERIAL

The sex education material presented was divided into four basic areas: 1) physiology 2) sexual behavior 3) birth control and venereal disease, and 4) social and interpersonal relationships.

Physiology covered the basic male/female body parts, with emphasis on the similarities and differences between the sexes. External and internal organs were explained as to what they looked like and what they were for. Peoples bodies were discussed in relation to the growth which occurred from birth to adulthood, with emphasis on puberty and its resulting emotional and physical changes. The groups discussed the differences in body characteristics, that no two people looked exactly the same, but body functions remained similar.

The second section, sexual behavior, was concerned with sexual intercourse and non-coital sexual behavior. Some specific topics covered were masturbation, pregnancy, homosexuality, emotional/sexual feelings, kissing, and caressing of other's bodies. In this section the leaders began with the factual information relating to the specific topics. With each topic covered, the discussions were extended to people's attitudes toward sexuality, why do people have sex, and what

are the responsibilities in having sexual relations. The decision to have sex was approached as a very serious matter which needed much thought by each individual as to whether it was right for him/her. All viewpoints expressed by the group members were accepted. Many expressed very liberal ideas; others were very conservative, believing sex before marriage was wrong. At this point, the five rules for sex were developed and emphasized in all classes. These were:

- 1) have privacy, behind closed doors,
- 2) make sure your partner is over 18 and also want to have sex,
- 3) use birth control-pills, rubbers, etc.
- 4) make sure no one gets hurt physically, and
- 5) see a doctor regularly for venereal disease and other infections.

Additional discussions focused upon sexually-related crimes, community laws, and community attitudes, all placed in the perspective of the clients and the effects of these topics on their personal lives.

Birth control and venereal disease followed. The leaders began with birth control, stressing the need to prevent pregnancy and why some people should not have babies. All forms of birth control were discussed, with special emphasis on the birth control pills and rubbers. Each type was explained as to how it prevented pregnancy, how to use it, where to purchase, and who to ask for advice concerning the type best for each person. The pros and cons were discussed, as well as why some methods fail to work. Genetics were also introduced to the group in this section in relation to the possibility of their passing on their physical problems to their children.

With discussion of venereal disease, each type was introduced separately but emphasis was placed on three points: 1) symptoms-burning, discharge, sores, 2) see a doctor regularly if you engage in sexual relations, and 3) transmission is usually by sexual activity. The

specific topics covered were syphilis, gonorrhea, herpes, and crabs. Discussions entered into how serious these diseases are - how long they last, what they do to your body, and how are they cured.

The fourth section, social and interpersonal relationships, was very lengthy. Incorporated into this were problems and discussions of dating, friendship, marriage, children and parenting, genetics, alcohol and drug abuse, and male/female role stereotypes. Within these areas the previous three sections were reviewed and related to all the above situations. Attitudes, pros and cons of situations, decisions making, personal responsibilities, and problem-solving skills were incorporated in this section.

#### PART B - RATIONAL EMOTIVE PRINCIPLES AND PROBLEM SOLVING

The second major educational area taught to the clients was Rational Emotive Therapy principles and problem solving. The language used in the groups was very simple and easily understood. The examples used were problems presented by the clients. Group progression in this area can be divided into: 1) thinking and feeling, 2) basic identification of ABC's and how this system can work, 3) the introduction of Maultsby's five rules for rational/irrational statements, and 4) discussion of increasing choices or options which are available to each person concerning emotional reactions.

The groups began in this area by discussing and identifying feelings in themselves and others, where the group felt feelings came from, and what they felt caused feelings. A feeling was defined to the group as a combination of their thoughts and what their insides felt like. Words of actions (such as "cry"), were associated with feeling words such as sad, depressed. Initially many clients did not seem to be able

to identify or understand feelings, responding to the question, "How did you feel?" with "I hit him". The group also discussed learned behavior in relation to having learned to feel and react in a certain way. Examples of past learned behavior used to emphasize this concept were learning to tie a shoe or learning to dress independently. This was expanded by a very slow process to the idea of having learned a long time ago how to feel and react in certain situations, such as when someone calls you a dirty name. At this time, the process of thinking was discussed. Again the group began with very basic material and with questions such as, "Does everybody think? Do you think?" Some claimed they could not think. Proof was given that all people do think. This, initially, was as simple as asking questions like, "Who decided that you get a bottle of pop at noon? Who decided what you wear to work?" etc. Additional discussions centered around where is the brain, what parts of the body help a person to think (senses), what are thoughts and ideas, and what is thinking? The clients then again discussed learned behavior, stressing that sometimes they do not always realize they are thinking. The examples of tying a shoe was again used. The clients were asked to pretend that this was a task they had just learned and to again do it step by step, saying out loud what they were doing. They were asked if this was necessary now, to think about each step. The concept of remembering was then introduced and discussed, using many more examples.

The next step in the groups was the A-B-C's, which were presented as - Action-something happens, Belief-your thoughts about it, and Common feelings-how you feel about it. At first this was strictly educational, beginning with associating the first letter with the appropriate word,

defining the word, and then giving examples of the word. The leaders used only these sections of Ellis's paradigm, not expanding to the D & E sections. Ellis' idea of disputing and changing emotional consequences was accomplished by repeating the A-B-C's, retaining the same action but altering the belief and feelings. The concept was introduced here that actions do not cause feelings, that first a person tells himself ideas about the action, then gets the feelings, then decides to act. This was repeated continuously with many examples, all taken from the current life events of the clients. Within this structure, the clients became more aware of what they were telling themselves which got them into trouble or made them unhappy. This also reinforced the idea that they all were capable of thinking.

The following section began with the leader's version of Maultsby's five criteria for rational thinking. Rational thinking was presented as a way to help decrease problems and a way to be less upset. This was called sane thinking. Irrational thinking was called crazy thinking, defining this as words and thoughts which would probably get a person into trouble or upset. The rules for sane thinking, based on Maultsby's five criteria, were: 1) based on true facts you can prove, 2) help protect your life, 3) help you feel like you want to, 4) keep you from feeling the way you do not want to, and 5) keep you out of trouble you do not want. All of this was discussed and explained, supported by examples. This was then applied to the belief section of the ABC's, with the focus placed on people choosing how to think and being in control of their thinking and actions. The group continuously practiced examples of the ABC's picking out the crazy/sane statements in the B section.

The last section of the Rational Emotive Education focused upon the concept of choice. Emphasis was placed on the idea that all people have choices, they can choose how to think, they can choose to change some of the ways they are now thinking. The ABC's were again utilized, with the clients separating the crazy/sane statements in the B section and also were given the responsibility of presenting some new beliefs they could use in this section. All previous information presented was reviewed and utilized in conducting these sessions. This often resulted in the clients changing the C, or feeling section, of the ABC's. The idea was stressed that this would not make all their bad feelings magically disappear, but would allow them a way to keep themselves from getting very upset and doing something which would get them into trouble. One of the most often used examples was becoming angry because the boss at work yelled at you. One choice they had was to say to themselves, "I hate her. She has no right to yell at me," with the person becoming very angry, and yelling back, this usually resulting in suspension from work. The other choice could be to say, "I don't like to be yelled at. It is her job to yell if I'm goofing off. Guess I'll just keep quiet", this resulting in the person remaining a little calmer and being able to keep the job.

#### PART C - SEX EDUCATION AND RATIONAL EMOTIVE THERAPY

These two areas, sex education and Rational Emotive Therapy were often combined in the course of teaching both subjects. Once past the factual information for sexuality and the ABC's, the concept of choosing actions, making appropriate decisions, responsibility for actions, and the solving of problems were all applied to the issues of sexual behavior and social/interpersonal relationships. Sexuality itself

seemed to be one of the most motivating factors in stimulating discussions and participation within the groups. Most all clients have, or have had, problems in this area, such as losing a boyfriend or girlfriend, wanting to have sex with someone, or dating. Other areas of interest included and used within examples were: work, family relations, friendships, community problems, and isolated crises type situations. With all group discussions, topics were applied to the most common and interesting client problem areas. Following will be many of the most often used techniques utilized by the leaders in conducting the group sessions.

PART D - TECHNIQUES USED WITHIN GROUP SESSIONS

1. Two leaders-male and female: Having two leaders for the group can be helpful in many ways. When working with the group on sexuality, discussions can center on male/female viewpoints concerning sexuality. This can include arguments and ideas for and against the stereotypic male/female sex roles, a male/female reaction to having sexual intercourse, and the answering of questions by a member of the opposite sex. Discussions for this includes such topics as how to and who asks for a date, who pays, which sex is "smarter", who initiates sex and how, who's responsible for birth control, and who's head of the house, etc.

Two leaders also aides in dual-leadership of the group. One leader is usually at the front of the group, writing on the blackboard. The other can be asking questions of the clients, can provide additional feedback if the other leader is having difficulty getting an idea across, and can provide leadership in a game situation in which the group is

divided in half. Two leaders can also insure the continuity of the group meetings. If one leader is unable to attend, the other can conduct the meeting. This dual group leadership also provides additional ideas for conducting the group, ways of improving the group, and more input for problem-solving.

2. Use of humor: The client's seemed to respond very well to jokes and light bantering between the leaders, especially at the beginning of group sessions. This seemed to instill more energy into them, with them responding and verbalizing to what was said or done by the leaders. They began laughing, talking, and directing their attention to the leaders actions and comments. This was as simple as one leader making faces at the other behind his back. The client reaction to this was usually to get the other person to become aware of what was going on and to make other comments. This then led into a verbal exchange in which the person with his back turned could make statements such as "I don't care what he/she is doing. Words and faces can't hurt me!" This type of interchange stressing that words and actions (unless physically abusive) cannot hurt served as an example of behavior, led into a group presentation, or was used as an attention-getter leading to participation.

It needs to be remembered that most of the clients have been with the leaders a long time. They recognize, by tone of voice, facial expression, and knowledge of how the counselors usually interact that this was a form of teasing. There was little tension and the clients feel free to interact.

3. Role Playing: This was done both by the leaders and by the clients.

A. Leaders-the leaders role played appropriate behaviors for

any given situation. This was applied to social-sexual situations, work situations, or any generalized social interaction. This was done in either a serious or a humorous manner. The role playing was also conducted in relation to the Rational Emotive Therapy concept of words being unable to hurt. Example: One counselor calls another counselor a name beginning an exchange. One counselor was irrational in statements, the other rational. The clients would often join in and take sides, with the argument continuing until the clients all came around to the rational side of the argument. The counselors often initiated the clients joining in by directing a question to a client such as, "Patty, what do you think about what Tom is saying?"

B. Clients-role playing with the clients usually centered around a personal problem, a work situation, or a practice situation. Personal problems included fights with boyfriend, family, etc.; work situations usually concerned problems with supervisors, getting a job, etc.; and practice situations usually concerned such things as asking a girl for a date, conversations with girls/boys, etc.

4. Use of exaggeration: Within the group, symptoms, feelings, body posture, verbalizations and consequences were all exaggerated to show that often many things were blown out of proportion and were made more difficult to handle. Emotions commonly exaggerated included extreme sadness, anger, or lack of knowledge as to what to do. This was often used in role playing and interactions between the group leaders. Example: One leader made a statement, beginning an interchange, such as, "Boy, are you stupid." This leader then continued to reinforce this statement with similar comments. The reaction of the other leader was with such statements as: "I guess I really am stupid. I can't do anything right,

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She said I was stupid so it must be true. I'll just give up." The body posture of the leader was droopy, head hanging down, expression very dejected, and the leader appeared to cry. The group would usually support the dejected leader with consoling statements. This then led into a group session on what was wrong with what the counselor was saying to himself, how he could correct his own negative feelings, and realization that the situation was not so awful that he could not do anything about it.

5. Games: These have been developed by the group leaders as aides in learning concepts associated primarily with Rational Emotive Therapy. The games required speaking in front of the group and often standing in front of the group. The clients enjoyed the games and seemed able to speak out more easily in the group situation. The games could be played individually or as a team effort. The team games provided pressure to the people on each team to answer questions correctly, with most of the members of the team providing positive encouragement to the person who was to answer. The games will only be listed here. Full explanations for each will be detailed in appendix A.

A. Speaking in front of the group--this game had as its goal the desensitization of the individual to speaking in front of a group. The game consisted of nonsense actions to be performed by each member. This game was then followed by a discussion of how each person felt while in front of the group and what belief systems were operating.

B. Feeling identification game--this game dealt with feelings and how to identify them. Once the feelings were identified, the client's were questioned as to possible belief systems behind these feelings, as

well as possible actions which could be responsible for the belief systems.

C. Fact finding game--the purpose of this was to develop skills in finding out information.

This next series of games were played after the appropriate lesson plan had been presented. They were used to further teach and clarify the appropriate concepts taught primarily in Rational Emotive Therapy and could be expanded to sexuality. These games followed the same format: 1) statements pertaining to the lesson were written down on individual pieces of paper, 2) each client took two, 3) turns were taken to read statements or read to clients who cannot read), 4) a decision was made on the statement for whatever lesson was being applied and give reasons, 5) the group provided feedback, 6) correction was made immediately if incorrect decisions were made, 7) cards were placed on tape which was on the blackboard with the appropriate title at the top. The role of the leader was to ask questions to aid the client in arriving at his decision.

D. True and false facts: This game concerned learning to differentiate between something that was true and could be proven true and what was false and could be proven to be false. Emphasis was placed on what could be done to find evidence to support whether a statement was true or false, and parts of the body that could be used to find this evidence.

E. Facts verses opinions game: This was based on the concept that facts were things which were true and could be proven and opinions were ideas about things. Opinions were often mistaken for and accepted as true facts. The goal was to teach the clients to be capable of

making this discrimination and later learn to apply this to their own lives and their personal belief system.

F. Rational verses Irrational statements: For this concept we have changed these words to sane (rational) and crazy (irrational) statements. With this game the clients seemed to have had the most difficulty in understanding the concept. For the crazy statements, the ideas of absolutism and perfectionism were used the most. Emphasis was placed on ways to think to help you feel better. The goal was to learn to discriminate between crazy and sane statements.

G. Demand verses desire: This game was designed to teach the differences between demanding something to be a certain way and desiring something to be a certain way. A demand was defined as something which absolutely had to be a certain way and a desire as something more changeable. Cue words were taught for demands such as have to, must, always, etc. Desire cue words were would like, want, it would be nice if, etc. This game again dealt with absolutism and was expanded to the lesson on choices, with emphasis placed on demands limiting ability to choose what to believe, how to feel, and possible courses of action.

6. Visual Aides: This section consisted of visual aides which were made or purchased by the counselors to benefit the group.

A. Props--almost anything can be used to help get an idea across to the client, especially if money for supplies is limited. Some of the improvisations used and the lesson associated with it will be briefly explained.

1) piece of wood, steel pipe, chair, etc.-this was used in a demonstration of the idea that words by themselves cannot hurt you. They do not magically fly through the air and cause pain. The pain is caused by

what you tell yourself about the word. The only things which cause pain are things which can cause you physical harm.

2) coke bottle with about 1" of water--this was used to demonstrate how a rubber works or does not work.

3) samples of rubbers, douches, contraceptive foam and applicator, tampax, hygiene sprays, birth control pills, K-Y jelly, pictures of IUD and diaphragm were all obtained by a visit to a local pharmacy.

Each was presented to the clients to look at and touch, with explanations given for use. This was repeated many times.

4) pictures from magazines of fetus within embryonic sac, diagrams of male and female reproductive systems (some from Planned Parenthood), magazine pictures of people in different emotional states were identified by the group, all were used and explained accordingly.

5) five dollar bill was used to get across the idea of learning to put a meaning of value to something. The basis was that money is only paper. We have learned that with this piece of paper, it is possible to purchase something that is wanted. This has become an automatic reaction. You no longer have to think about what money means.

B. Posters--the following posters were made and placed on the walls of the group room. Each was developed in accordance with a prepared lesson, and often served as aides to the clients in the daily group sessions. Most were combined with cartoons out of magazines. Rationale being due to learning problems many people do better if they can read the information.

1) The first poster dealt with the rational irrational statements and was made up of cue words to recognize these statements. The words "sane" and "crazy" have been substituted for rational and irrational.

Crazy Statements

must                   it makes me  
should                 I'm no good  
have to                always  
got to                 can't  
awful                 don't care  
terrible  
cannot stand it  
can never

Some To Watch

I am  
he is  
she is  
they are  
you are  
it is  
he was  
they were

Sane Statements

acts like  
I don't like  
I prefer  
I wish  
I hope  
I want

This poster was used specifically with the analysis of the belief system within the A-B-C analysis. Emphasis was placed on being able to recognize crazy statements you tell yourself which often led to negative feelings. The clients were taught to use the sane statements to reduce negative feelings. Emphasis was placed on the ideas that: 1) Crazy Statements often lead to irrational ideas, 2) Some To Watch phrases was connected to equating people with actions. Example: "He is stupid"- This sentence connotes that the person is stupid in everything he does. This became, "He did a stupid act." 3) Sane Statements lead to rational ideas and feelings.

2) A-B-C analysis poster-this poster served as a simplified example of the ABC system. This poster was placed directly above the blackboard which was used to work out the ABC's for personal problems as well as teaching the concept with examples. During the group, this poster served as a reference for the clients in being able to work out the specifics of the A-B-C system.

PosterAction-something happens

someone calls you a name you do not like.

"you are an asshole"

Beliefs - your thoughts  
(some sane ideas)

- 1) I don't like to be called an asshole
- 2) I wish it did not happen
- 3) I can stand to be called an asshole
- 4) I am not an asshole, you just don't like how I acted

Common Feelings

Follow these sane ideas and you would feel: calm maybe a little upset.

---

(some crazy ideas)

- 1) I must not be called an asshole.
- 2) I should not be called an asshole.
- 3) It is awful to be called an asshole.
- 4) It is true I am an asshole.
- 5) Words can hurt me.

Follow these crazy ideas and you would feel: angry pissed off depressed

You make yourself mad by what you tell yourself or think in your head.

REMEMBER

Sticks and stones may break my bones, but names or words cannot hurt me unless I let them.

3) Rational thinking poster-this poster consists of a simplified edition of Maultsby's five criteria for rational thinking. According to Maultsby, three of the following five criteria must be met in order for beliefs to be rational. Again, the word sane has been substituted for rational.

SANE IDEAS:

- 1.) are based on true facts you can prove
- 2.) help protect your life
- 3.) help you feel like you want to
- 4.) keep you from feeling the way you don't want to
- 5.) keep you out of trouble you do not want

4) This was a poster dealing with the idea that people do not equal their actions. People are not good or bad people, just people who perform certain actions which can be termed good or bad.

Good People and Bad People

DO NOT EXIST

No one acts good all the time

No one acts bad all the time

A person is usually made up of:

2 arms	a mouth	a liver	2 hands	lots of muscle
2 legs	a heart	a butt	2 feet	lots of bones
2 eyes	a stomach	a brain	to think with	

Actions do not make a person!

A person can do things which other people think are good or bad.

Some bad things

stealing, fighting  
lying, name-calling  
cheating

Some good things

sharing, working hard  
helping, telling the truth

REMEMBER: You cannot be good or bad. You can only be a person who does a good or bad act. If you get in trouble for doing bad acts, that's your own doing. You can and do decide to act good or bad. No one makes you do anything.

5) Rules for sex poster. Some ideas to think about before engaging in sex.

So you want to have sex, huh? Well remember this--What you do is your business, but make sure to do these too.

1. Have privacy--behind closed doors
2. Use birth control--pills or rubber
3. Make sure your partner is over 18 and also wants to have sex with you
4. Make sure no one gets hurt.
5. See a doctor regularly to check for venereal disease.

Remember this too:

1. When you date someone you do not have to have sex with that person.
2. You can decide when and where you want to have sex or not.

Don't listen to everything you are told about sex. Many people are stupid about the facts. That only gets you in trouble.

Find out the facts about sex by listening to someone who knows what they are talking about.

c) Blackboard: The blackboard was used almost daily within the group to work out the examples of ABC's, to list ideas, and as an aid in the games. It gave the client's something to focus their attention on and serves as a good way to review the day's lesson. At a later time, the clients have also used the blackboard and lead the groups, especially in working out the ABC's themselves.

d) Comic books: The comic books used initially dealt with sex education. They were written by Sol Gordon and published by Ed-U Press, 760 Ostrom Avenue, Syracuse, New York, 13210, 1975. Copies are in Appendix B. Enough copies were purchased for the groups. Those who could not read were helped by others. These comics contained many pictures which also helped to get ideas across. Those used were:

- 1) Ten Heavy Facts About Sex,
- 2) Protect Yourself from Becoming an Unwanted Parent, and
- 3) Venereal Disease Claptrap.

The second set of comic books were actually short synopses of the major principles of Rational Emotive Therapy. These were written by the group leaders with the language used in the group sessions. The purpose of these was to give the people something to be able to see and read on their own pertaining to problem solving. Many examples were

used to get ideas across. Initially, the leaders wanted to put these into comic book form, such as those of Sol Gordon or Howard S. Young's Rational Emotive Therapy Primer(1974). This has not yet been accomplished. These comics are: 1) Your Thoughts-How They Affect You, 2) ABC's and Sane Ideas, and 3) ABC's and Decision Making.

7. Films: Films seemed to be very popular within all the groups, especially those dealing with sex and/or retardation. The films were usually short and were followed by a discussion period concerning what was seen. Film presentation was limited to free films usually from the local library.

8. Slide Presentation: Two sets of slide presentations have been used throughout the group. Both sets of slides were purchased approximately a year after this pilot program was begun.

a) Understanding and Overcoming Emotional Upset - This slide presentation was purchased from the Institute for Rational Living, 45 East 65th Street, New York, New York. The slide presents the most basic concepts of Rational Emotive Therapy in very simple terms, using cartoon characters. A tape was provided with the slide presentation, which could be used at the discretion of the group leaders. The presentation was written by Howard S. Young, M.S.W., A.C.S.W., and Michelle Young, M.S.W., A.C.S.W.

b) Sexuality and the Mentally Handicapped - This slide presentation was written by Winifred Kempton, M.S.W. and Gail Hanson, and is distributed by Stanfield House. The slide presentation is accompanied with scripts to be used as a guide for a dialogue between leaders and clients. The script can be modified by the leader for the particular clients viewing the film. Eight sections are in the slide presentation and these are:

1) parts of the body, 2) male puberty, 3) female puberty, 4) social behavior, 5) human reproduction, 6) fertility regulation and venereal disease, 7) marriage, and 8) parenting.

9. Expert opinion: The technique dealt primarily with the attitude of the clients toward the leaders. The majority of the clients have been surrounded by counselors or social workers for most of their lives. The position they seem to view counselors from is one of a person in authority, one who helps you solve problems, or helps you to get what you want. By utilizing this position, positive change can be effected with the client feeling that the counselor is expert and knows what is best. Care must be taken if this technique is employed. The counselor needs to be forceful and directive, but not demanding and dictatorial (Young, 1977). Emphasis must still be placed on the fact that the client make his own decision, but, if he feels that the counselor knows what is best, he will be more likely to listen and follow advice. This position can be reinforced in group by often speaking in a loud voice and by using commanding gestures, such as pointing a finger, pounding on a desk, etc. This can give the counselor a strong position of leadership, while remaining empathetic and responsive to the client's needs.

10. Individual problem discussion: During each group session the clients were allowed to bring up individual problems which they would like to discuss in group. This decision was usually left to the client's themselves. At times, if the counselor was aware of an ongoing problem, the counselor brought the problem up in the group. If this was done, permission was asked of the clients involved. At other times, generalized problems which affect many, such as low paychecks, or generalized anger toward a staff member, were brought up and discussed, either by the counselors or the clients.

11. Counselors personal feedback: In conducting the group, the counselors have also found that many personal questions were directed toward them. These usually concerned living in an apartment, how money was spent, family matters, and sex questions. Most were appropriate and the counselors attempted to answer them openly and honestly.

12. Increasing group responsibility: After the basic concepts had been taught for both sexuality and Rational Emotive Therapy, the group leaders began making the groups more responsible for daily discussion ideas. Each group was assigned the task of developing a list of ideas for their group. These were then made into a poster and placed on the wall of the group room. Then, on days when ideas were few for discussion, topics were picked from each groups own list. The purpose of this was twofold: 1) increased responsibility for group members, and 2) decreased pressure on the leaders to provide stimulating topics.

13. Group members as leaders: This technique was incorporated again after basic concepts were taught. Those group members who exhibited learned knowledge of what was being taught were assigned as leaders for the day, either in pairs or singly. The counselors provided support and some aide in the progression of the group.

14. Newspapers: Discussions of current events has been the most recent technique incorporated into the group. Newspapers were purchased from Lauback Literacy International, Box 131, Syracuse, New York 13210, and are written on a third grade level. Articles from the paper are picked which could relate to the client's own personal lives.

## VII. CHAPTER SEVEN - GROUP DEVELOPMENT AND RESEARCH

### PART A - PROGRAM DEVELOPMENT AND RESEARCH METHODOLOGY

The research methodologies used here were basically descriptive and correlational. They were used in the development of a brief questionnaire/interview format capable of being used in a daily program to survey the knowledge and attitudes workshop clients held in sexual and emotional areas, with a minimal amount of time. This was not an extensive review of all knowledge factors but a tool to rapidly check the basic pattern in a group of people. The results could then be used as an ongoing guide in program-subject emphasis. Second, as a correlational research tool, using the questionnaire/interviewer techniques to determine the interaction of sexuality and emotions. Third, use of the test to determine the interaction of place of residence of the people and the workshop program in relation to knowledge and attitudes concerning sex and emotions. Basic research areas included:

1. The questionnaire/interview format will be able to indicate a common method of response and therefore be practical in identifying specific areas for program development.
2. There should be a significant interaction between workshop program and place of residence where those people living outside of sheltered care situations know more about sexual and emotional facts.
3. Subgroupings within the test should be able to accurately predict outcomes on other parts of the test above a  $r = .60$  level.
4. Correlation between the test subgroups should all be high at least an  $r = .65$  level.

PART B - TEST CONSTRUCTION - RATIONALE

The rationale for development of the questionnaire/interview used in the pilot study was based on four ideas. First, the main purpose was to create a test which could be given easily and quickly in an agency situation while not taking up a great deal of time (10-15 minutes at maximum). Second, the test needed to be written with second-third grade language, using adult ideas which could easily be adapted to each persons learning skill. Third, it should be able to give some indication of knowledge and attitudes on sexual and emotional education for those taking the test with some statistical backing. Last, the test itself would be used for the evaluation of the ongoing groups to see what changes should be made in emphasis. There are several tests mentioned in the literature but they were difficult to get or had no statistical support. Zelman and Tyser(1976) have put out a researched 92 item test to be used in their EASE curriculum, but the length plus the number of people in the workshop groups would be too difficult to handle. Time schedules and production demands did not allow much time beyond the group meetings. The decision was to create an instrument based on the program needs.

The resulting test included three sections; eight questions based on Rational Emotive Therapy (RET) theory, eight definitions and eleven questions on sexuality, and a four point section on how a woman gets pregnant. The first section (RET) contains many basic concepts of the therapy with emphasis on the ideas that, "sticks and stones may break my bones..." and that a person does think. The sexuality areas stressed both knowledge and various details necessary for responsible decisions

concerning sexual activity. Again, the questions reflected that each person goes through a decision process and is responsible for themselves. The last part follows up specifically on physiology, emphasizing what needs to occur in order for a baby to be made.

On some previous testing situations the experimenters found that multiple choice questions had poor reliability as the last choice was regularly picked by many subject. The use of true and false answers helped reduce this confusion. Directions were self explanatory and allowed any sort of words to be used in written responses. (For a copy of the blank test, the totals of correct answers, and an explanation of each question, see Appendix C).

All testing was done in the workshop setting during the normal group meeting times. The purpose of it was explained to the groups and any questions answered. During the test those who could read and write filled out their own sheet. Help was supplied to all who needed it. All tests were reviewed with each person to make sure all questions were answered and understood. Occasionally some items had to be explained in different words and answers were accepted as they were stated. In the pregnancy section more information was asked for with statements such as, "Can you tell me more? Is that all?" On other sections of the test where people found it difficult to speak of sexual body areas, they were asked to point to that specific body area.

#### PART C - EXPERIMENTER/LEADERS

The experimenter/leaders of the groups were two master candidates in clinical psychology. They have worked in the workshop for 4½ years as counselors and evaluators. They were well known by the clients and rapport was well established. Since one leader was male and the other

female, this provided for both sex role models and appropriate interaction.

#### PART D - SUBJECTS

Fifty-five Ss were solicited from the workshop, 33 males and 22 females, all of whom were capable of working a 6½ hour day. Of the 55 clients, 34 have been previously institutionalized anywhere from 2 to 30 years, 26 are living in a shelter care facility, 8 in room and board situations, 7 in apartments, and 14 are living with family. Only 5 have completed special education programs in the community. Diagnoses included mental retardation and various emotional disorders. I.Q. range for these clients was from 40 to 130 with an age range of 17 to 64 years. Referrals to the vocational workshop program came primarily from local shelter care homes, families, school systems, the local mental health center, and the local probation office. The clients entered the group on a volunteer basis or as recommended by the evaluation period.

Five groups were organized and divided into two low functioning, two high functioning and one mixed, based on mental and verbal skills. This was determined by direct dealings with the clients by the group leaders and consultations with the special education teacher at the shop. The division allowed each group to cover the same material but gave the leaders the freedom to adjust vocabulary, examples, and approaches to each group. The groups have been forced to re-organize several times due to the following reasons: 1) entrance of new clients. As new people come in, group sizes changed, requiring some alteration so that one group did not become huge. 2) Changes in production patterns in the workshop. The workshop operates partly on contract work procured in

the community. Often groups must be rearranged as people move from one area of the shop to another. Groups often came from people working in a common work area which could then be shut down. When production demands were high, meetings were occasionally cancelled, and 3) changes in the clients themselves. As a person goes through the groups it quickly became apparent who did not understand the material and who was bored with concepts below their level. Adjustments were made to place each person in a level they could learn in.

Altering the groups provided more homogeneity as to interest, common work areas, levels of understanding and progression of the groups. The actual influence these changes had on the outcome were not part of this program, and were generally not studied.

The groups met twice a week for 45-60 minutes. The one exception was the mixed group which met on Fridays for 1½ hours. This group worked in the powershop area where the criterion for working was based on work speed and the ability to work around power tools and equipment, not intellectual skills. The production demands are very similar to those found in the typical factory environment. This mixture could not be changed which created a situation of high functioning and low functioning people in the same group.

#### PART E - DATA ANALYSIS - RESULTS

For the purposes of analysis the tests were split up according to place of residence and program placement. Due to the mixture of groups no other division was attempted. The data could then be placed in a matrix of:

##### I. Residence consisting of:

- 1) Sheltered Care Home residents
- 2) Those who live with parents or guardians
- 3) Boarding home or community apartment

II. Program placement consisting of:

- 1) Work Activities - those people still in the workshop after one year, but unable to work above 25% of the industrial minimum wage.
- 2) Extended Employees - those people in the workshop after one year who can work above 25% of the industrial minimum and who are hired by the workshop as employees.
- 3) Work Adjustment Training/Evaluation - those people in training for less than one year or those people starting the evaluation period.

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Table A shows a summary of the test results in the 3 x 3 matrix form.

Table B shows a summary of an analysis of variance of program and residence.

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The summaries indicate slight support for residence alone or program alone but not enough to rule out chance. The interaction of residence x program was not meaningful. Due to the imbalance of the cell population the data may not be perfectly correct.

The results show that while there was no relationship between residence and program, those people who live more independently in the community (boarding/apartment), and those who have been in the program the shortest (Evaluation/Work Adjustment Training) tend to score a little better. This could be accounted for by the fact that these people were the newest in the workshop. They tended to be younger, had spent very little time in institutions, were more community oriented, had taken part in more programs such as special education or other rehabilitation services, and generally had benefitted from legislation emphasizing program development. The other groups remain in a somewhat sheltered or restricted environment while having been through the institutional movements of the past and thus generally had not had the chance to develop much social skill or awareness.

TABLE A

## SUMMARY OF QUESTIONNAIRE/INTERVIEW DATA

## WORKSHOP PROGRAM X RESIDENCE

	Sheltered Care	Home	Boarding Home/ Apartment	Total
Evaluation-	N = 3	N = 6	N = 6	N = 15
Work Adjustment Training	$\bar{x}_t = 25.7$ $\bar{x}_r = 6$ $\bar{x}_s = 16.33$ $\bar{x}_p = 3.67$	$\bar{x}_t = 21.8$ $\bar{x}_r = 5.17$ $\bar{x}_s = 13.50$ $\bar{x}_p = 3.17$	$\bar{x}_t = 24.167$ $\bar{x}_r = 6.0$ $\bar{x}_s = 15.33$ $\bar{x}_p = 3$	$\bar{x}_t = 23.5$ $\bar{x}_r = 5.72$ $\bar{x}_s = 15.02$ $\bar{x}_p = 3.28$  sd = 3.563
	N = 9	N = 5	N = 6	N = 20
Extended Employment	$\bar{x}_t = 20$ $\bar{x}_r = 4.89$ $\bar{x}_s = 12.89$ $\bar{x}_p = 2.22$	$\bar{x}_t = 19.4$ $\bar{x}_r = 4.4$ $\bar{x}_s = 12.20$ $\bar{x}_p = 2.80$	$\bar{x}_t = 23.0$ $\bar{x}_r = 5.67$ $\bar{x}_s = 14.17$ $\bar{x}_p = 3.33$	$\bar{x}_t = 20.75$ $\bar{x}_r = 4.99$ $\bar{x}_s = 13.09$ $\bar{x}_p = 2.78$  sd = 5.911
	N = 12	N = 5	N = 3	N = 20
Work Activities	$\bar{x}_t = 20.5$ $\bar{x}_r = 4.33$ $\bar{x}_s = 13.42$ $\bar{x}_p = 2.83$	$\bar{x}_t = 20$ $\bar{x}_r = 5.20$ $\bar{x}_s = 12.60$ $\bar{x}_p = 2.20$	$\bar{x}_t = 24.677$ $\bar{x}_r = 7.0$ $\bar{x}_s = 17.0$ $\bar{x}_p = 4.0$	$\bar{x}_t = 21.0$ $\bar{x}_r = 5.51$ $\bar{x}_s = 14.34$ $\bar{x}_p = 3.01$  sd = 4.117
	N = 24	N = 16	N = 15	N = 55
Total	$\bar{x}_t = 21.0$ $\bar{x}_r = 5.07$ $\bar{x}_s = 14.21$ $\bar{x}_p = 2.91$  sd = 4.438	$\bar{x}_t = 20.5$ $\bar{x}_r = 4.92$ $\bar{x}_s = 12.77$ $\bar{x}_p = 2.72$  sd = 4.427	$\bar{x}_t = 23.8$ $\bar{x}_r = 6.22$ $\bar{x}_s = 15.50$ $\bar{x}_p = 3.44$  sd = 5.294	$\bar{x}_t = 21.6$ $\bar{x}_r = 5.16$ $\bar{x}_s = 13.80$ $\bar{x}_p = 2.89$  sd = 4.794

## Best Possible Scores

$\bar{x}_t$ = mean of whole test score	31
$\bar{x}_r$ = mean of RET section	8
$\bar{x}_s$ = mean of sexuality section	19
$\bar{x}_p$ = mean of pregnancy section	4

TABLE BANALYSIS OF VARIANCE SUMMARY TABLEINTERACTION OF PROGRAM X RESIDENCE


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 Random effects design

Source	df	ms	F	P
Main Effect				
Residence	2	47.9268	4.04	.109
Program				
Interaction	2	28.4583	3.25	.145
Residence X				
Program	4	11.8511	.53	.717
Within Cells	<u>46</u>	22.5478		
	54			

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An important aspect of the questionnaire/interview format was to see if it yielded reliable information. This would have to be necessary regardless of program or residential placement. For this reason a Kuder-Richardson formula 20 reliability was run to test for interitem consistency. The premise being if the test scores were not reliable further study would be useless. The section on pregnancy was not included in this section as it was scored on a four-point scale. The results show a reliability coefficient of  $r = .70$ . This indicates the test was accurately measuring some characteristics of the people who took it. Individually the items were producing similar response patterns in different individuals. The  $r$  value here shows the items were homogeneous and therefore measured what they were intended for. The format was valid.

A smaller Kuder-Richardson design was run on the emotional/R.E.T. theory and the knowledge attitudes on sexuality sections to see if they, by themselves, showed similar patterns. The emotional/R.E.T. section analysis showed  $r = .54$ . The sexuality section yielded  $r = .66$ . This indicated that while the  $r$  value was not as high as the overall test, the sexuality section tends to be homogeneous and measures as intended. The emotional/R.E.T. value, not being as high as the test, has more variation in it. The scores here would indicate a slight pattern of scoring but with other variables having some effect. All three  $r$  values indicated an acceptable degree of reliability. Based on the relatively small  $N$  value in this sample, further testing would be required to see if this pattern holds up. So far the format appears valid and fairly reliable for use as a rapid screening tool.

A third area of interest concerned the correlations of the three sections with each other - emotion based on Rational Emotive Therapy theory, knowledge and attitudes on sexuality, and the knowledge of how a

woman gets pregnant. The sections were arranged to give a measure of factual information (pregnancy), a combination of factual and abstract thinking (sexuality), and general abstract thinking (R.E.T.). Abstract thinking refers to concepts such as attitudes, responsibility, and decision making applied to problem solving skills and absolutistic statements. As the Kuder-Richardson indicated the format appeared valid and reliable, a Pearson Product Moment Correlation was run between the sections. This would indicate how the sections related to each other. The results (Table C) showed that while all results were significant, the correlation between sex and pregnancy was high but when R.E.T. concepts

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Table C - Pearson Product Moment Correlations of each section to the others.

	<u>r</u>	<u>z</u>
1. R.E.T. - Sex	.32	2.13*
2. R.E.T. - Pregnancy	.29	2.37*
3. Sex - Pregnancy	.69	5.04*

\*  $p < .05$

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were involved, results fell dramatically. The sex-pregnancy results would be expected as these are very related topics. The lower scores with the R.E.T. concepts show this section measured some facet more independent of sexual knowledge and attitudes in general. This further supported by a series of multiple correlation regressions on the three variables (Table D) where the R.E.T. concepts showed independence when used as a predictor of either of the other two sections. An independent predictor should raise criterion correlation. This is exactly what occurred.

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Table D Multiple Correlations of the three test variables

1 = pregnancy	r 1.23 = .70
2 = R.E.T.	r 2.13 = .34
3 = Sex	r 3.21 = .88

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These results would indicate a desirability to teach abstract concepts such as decision making, problem solving, and responsibility in conjunction with basic sex education, as related to other life situations (e.g. How to handle the emotional problems of ones boy-friend/girlfriend breaking off a relationship; how to handle jealousy, deciding on children or birth control, decisions to engage in sexual activity before or after marriage, or coping with sexual desires). This lends support to the program format of expanding sex education beyond factual information and into other life problems which commonly occur. The questionnaire/format developed here showed itself as being useful as a quick survey tool for group planning in both factual and abstract areas. While it does not cover all possible areas it can quickly indicate where a group could concentrate its activity that would be of interest to all members.

Part F - Methodological assumptions, limitations, and future areas of research.

As this was a pilot study, many variables were ignored or could not be controlled. The day-to-day activity of the workshop and production demands were discussed earlier. Several other problems must be noted and could be areas of future investigation.

1. It was assumed the clients of the workshop were representative of the typical sheltered workshop participant in a large rural area. No attempt was made to include people from a larger urban center. Due to limited social outlets in rural areas there may be a difference in the knowledge and attitude levels of the two groups.
2. No attempt was made at semantic research to see exactly how much of the format vocabulary was really understood or what was not memory. It

was just assumed that by working with the special education teacher in the workshop, vocabulary could be at the most common denominator level.

3. There was no real degree of random selection or matching. The difficulty of keeping the groups distinctly different, due to production changes in the workshop and a change in client personnel as people leave or enter the workshop, could not be totally compensated for. The emphasis was more on keeping the groups as homogeneous as possible so group members could follow the level of presentation.

4. As this is a pilot study no "non-workshop" individuals have taken the test to see if the results are unique to this group of people. Future work in this area could include other workshops, students in training, other professionals, and the general public in comparing their responses to the questionnaire/interview format and their knowledge compared to the clients.

5. There has been a change in incoming clients within the last year. Those people in long term programs (Work Activities and Extended Employment) tend to have spent a great deal of time in sheltered environments (institutions or care homes) and average around 35 years old. The short term people (Work Adjustment Training/Evaluation) tend to come from Special Education programs, have spent more time at home and average 22 years of age. The difference could be important to explore the benefits of special education enrollment.

6. The possibility of experimenter's bias could not be overlooked. The leader/experimenters have been with the workshop for four years, running the groups since they started 2½ years ago. Interactions with clients, testing, recording data, etc., have all been done knowing of this possibility. The experimenters have tried to be as neutral as possible.

PART G - INTEGRATION OF FINDINGS AND FUTURE GROUP PLANNING

Since the test was used as a screening device for group planning the results will be discussed here in that manner. Planning will go section by section in accordance with specific answers to questions. A pass-fail mark of 70% has been assigned as a criteria for emphasis, since this is the level commonly used in schools for grading. Items below this level will be emphasized in future groups.

1. Emotional/Rational Emotional Therapy

This section as a whole falls below the pass-fail mark with a percentage average of 64.88. The last three items show a general feeling that words by themselves cannot hurt you, that retarded can think for themselves, and that what you tell yourself in your head causes your problems. This is in contrast to the first question where more people think only "crazies talk to themselves," and that words do have some power to cause feelings. In fact, almost half think their feelings come from outside of themselves, with a relationship seeming to exist between how others treat them and how they feel(item 4).

Due to the lower scores in this area, much more time needs to be spent on what emotions are and how a person can control them. Some of the higher scores may simply be role memory feedback from the groups.

Future planning:

- 1) More explanation to be given as to how feelings are formed, and the developing and perpetuating his own feelings.
- 2) Emphasize more on the idea that what someone says to you does not have as much of an effect as what you tell yourself about what was said.
- 3) Emphasis to be placed on the idea that words of and by themselves are not powerful and cannot cause feelings; people give them power only by attaching their own meaning to the words.

- 4) Continual education and practice for the group in developing different options for themselves in relation to their emotional choices in situations they may not like.
- 5) Continue to emphasize the idea that all people have brains and they can think. Also insist that people, even if called retarded, can make decisions for themselves and be responsible for their own actions. This will include work on how to make a decision, deciding what choices they have as to what to do or feel.

## 2. Definition of

This section fell right on the cutoff point (70%). Almost everyone knew what the words penis, vagina, and pregnant meant. Those who could not think of a common word, such as dick, cunt, prick or pussy, or man/womans thing, were able to point to the appropriate body location. Many people had trouble with masturbation and homosexual. This was expected as these words are not common and fairly difficult to remember. Once explained as beating off or two men/two women having sex together, most people understood. Periods, birth-control, and venereal disease all scored at about the 70% level. An understanding of these concepts is important in teaching about intercourse. Knowledge of venereal disease and techniques of good birth control help increase the chances of responsible relationships. Venereal disease itself remains an ever increasing health problem among all segments of the population.

## Future Planning

- 1) More time will be spent on the ideas of masturbation, homosexuality, venereal disease, and periods. Emphasis remains on how knowledge helps in responsible decision making and concerning sexual actions.
- 2) Continued emphasis on the idea that sexuality is more than just fun and games.

### 3. Questions on sexual attitudes and knowledge.

This section scored a little above the cutoff point (71%). The problem areas here include birth control, being only a womans problem (item 6), homosexuals being sick people(item 7), ease of getting venereal disease(item 2), and the idea you must have sex with someone if you like them(item 12). Strong areas include having sex in privacy (item 11), what sexual intercourse is(item 3), what to do if your genitals hurt(item 5), and not forcing someone to have sex(item 1), a slight improvement in the understanding of periods(item 4), and a need to stress the importance of age in a sexual relationship(item 8).

#### Future Planning

1. Continued emphasis on the five rules of sex.
  - a. Privacy - behind closed doors
  - b. Using birth control
  - c. Both people want to have sex together and are over 18
  - d. Make sure no one is hurt
  - e. See a doctor if your penis or vagina hurts or you stop having periods
2. Spending more time on deciding if, how, when, where, and with whom to have sex.
3. More time on sex role models and each person being responsible in a relationship.
4. Stress that sex is not a necessity for every relationship.
5. Continued explaining that a woman could become pregnant everytime she has intercourse.
6. Stress heavily that whether or not to have sex with someone is your own decision. No one can talk you into it and no one can force you to have sex when you do not want to.

7. The type of sexual activity is not anyone's business, as long as the five rules are followed.

4. How a Woman Gets Pregnant.

This section was based on a four point answer. A perfect score had four ideas. 1) a man and a woman together, 2) a penis in a vagina, 3) sperm in the vagina, and 4) sperm and egg meeting. The X score here was 2.89 for a percentage of 72%. Most people knew a man and woman are needed but some insisted that the man played no role. They felt a baby just started to grow in a woman for no reason other than she is supposed to have babies. The concept of a penis in a vagina was rather easy for most people. Problems developed in the concept of sperm. More than 80% knew it came from a man but only half knew what it did. An egg in a woman was easy for almost everyone, although two people claimed it hatched.

Future Planning

1. The level of understanding determines the degree of repetition. The groups will consistently go over the process of conception in simple terms. Without this, an understanding of birth control is limited. Concentration is again placed on being responsible for your actions. As adults they have a right to a basic understanding of how their body functions.
2. General discussion of other aspects of the body and health issues.
3. Explaining the visits to the doctor and development of a fetus up to birth.
4. Effects of genetics and why some people would be better off not having children.
5. Responsibilities, financial and emotional, of having children and how long it lasts.

6. Importance of such issues as abortion, sterilization, adoption, and birth control.

For a random selection of responses to the definitions and pregnancy sections see Appendix D.

APPENDIX A

Card Games

Purpose:

- a) to reinforce a variety of lessons over a given time
- b) to teach Maultsby's five criteria for rational thinking on simplistic level
- c) to provide active verbal and physical involvement of the clients
- d) to add variety and to stimulate interest by changing the routine

Materials: box, tape, blackboard, cards pertaining to each game

Methodology:

- 1) make up set of cards pertaining to each subject to be covered--true/false facts; facts/opinions; sane/crazy statements;
- 2) prior to each game spend time discussing with the group the appropriate subject material
- 3) on a wall or blackboard, hand strips of tape, sticky side out, to which cards can be attached. Leave space in the middle.
- 4) label each section with the appropriate title
- 5) Have each client pick two cards at random out of a hat, read, and place under appropriate heading. Reasons for choice must be given. Ask for comments from the group as to agree or disagree.

Sample games: all items can be changed to accommodate the population within the groups as to cognitive skills. All games generally follow a lesson teaching each concept.

Facts

The sun is yellow  
This place is called CCAR  
My car gets 25 mpg  
I have gained ten pounds  
Fire can burn you  
 $5 + 3 = 8$   
I can read  
Jimmy Carter is the President  
The sky is blue  
Words cannot hurt you  
 $2 + 2 = 4$   
V.D. can hurt you  
I have no money  
Water is wet  
Corn grows from seeds  
Beef comes from cows  
Peanut butter is made from peanuts

Opinions

It is good not to fight  
McDonalds has the best hamburgers  
Beer is bad for you  
Television is boring  
This is a bad place to work  
Fords are the worst cars  
Arithmetic is easy to learn  
Everyone should work hard  
Brown hair is the best color  
Country and Western is the best music  
Rock and roll is the best music  
Jimmy Carter is a good president  
You should spit on people you do not like  
Work is hard  
I am horny and must have sex  
Everyone should take a bath  
I like to spend money

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Sane

- 1) some people don't like me
- 2) I don't like my job, but I can do it
- 3) sometimes I do not like what my supervisor does
- 4) I don't always get what I want
- 5) I can help myself
- 6) I make myself mad
- 7) I make myself happy
- 8) I cause my own problems
- 9) I can be good at alot of things, but not everything
- 10) I wish people would treat me better
- 11) It would be nice to have a girl/boyfriend
- 12) I can stand to take orders even if I don't like it
- 13) Some people like me
- 14) I can change myself
- 15) People hurt their own feelings
- 16) Words cannot hurt me unless I let them
- 17) I hurt my own feelings
- 18) Sometimes mistakes are my fault
- 19) Sometimes I cannot have sex
- 20) I don't always get what I want

Crazy

- 1) people have to like me
- 2) I can't stand to work
- 3) I hate my supervisor
- 4) I must get what I want
- 5) I cannot help myself
- 6) People make me mad
- 7) People make me happy
- 8) My mother causes all my problems
- 9) I should be the best at everything
- 10) People must treat me better
- 11) I have to have a girl/boyfriend
- 12) I cannot stand to take orders
- 13) Everybody hates me
- 14) I cannot change myself
- 15) I hurt other peoples feelings
- 16) Words can hurt me
- 17) Other people hurt my feelings
- 18) Trouble is never my fault
- 19) I must always have sex
- 20) I always get what I want

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This game can then be expanded.

TRUE FACTS

- 1) soda costs 15¢
- 2) grass is green
- 3) you have to wear a hard hat in back area
- 4) cement is hard
- 5) cars have tires
- 6) people sit on chairs
- 7) you have a birthday every year
- 8) peoples' eyes are different colors
- 9) Saturday comes after Friday
- 10) people need to drink water
- 11)  $4 + 4 = 8$
- 12) you play basketball with a basketball
- 13) most people have five fingers
- 14) people wear shoes to work
- 15) it is cold in winter
- 16) your hair on your head grows
- 17) you call someone on the telephone
- 18) you walk through a door to go outside
- 19) watches keep track of time
- 20) most cars run on gas

FALSE FACTS

- 1) the blackboard is blue
- 2) the sky is falling
- 3)  $3 + 8 = 10$
- 4) people make me mad
- 5) sex makes you crazy
- 6) blue pens write in red ink
- 7) screwing does not make babies
- 8) tab makes you fat
- 9) all paper is white
- 10) potato chips help you lose weight
- 11) soda is good for your teeth
- 12) we get paid every Saturday
- 13) people never make mistakes
- 14) exercise is not good for you
- 15) men can get pregnant
- 16) car tires are square
- 17) all flowers are red
- 18) frogs eat people
- 19) a cow is the same as a pig
- 20) fish can fly

Today is Monday  
Yesterday was Tuesday  
Today is Wednesday  
Tomorrow is Thursday  
Today is Friday

TALK TO THE GROUPPurpose:

- a) to desensitize clients to talking in front of the group concerning feelings
- b) to make clients aware of their belief systems while talking in front of the group; what they were telling themselves to make them feel scared, silly, etc.

Materials: box, slips of paper with nonsense actions written on them, video unit if possible, blackboard

Methodology:

- 1) Make up nonsense actions for each group member to perform in front of the group. Examples are: bark like a dog, walk like a duc, make a funny face, etc.
- 2) Write each one on a slip of paper and have each client draw one out of a box.
- 3) Have each client read their slip of paper to the group (leaders read if client illiterate) and perform the action.
- 4) Ask all clients how they felt while in front of the group--scared, silly, etc.
- 5) Do an A-B-C analysis, with the clients providing their different beliefs which brought about their different feelings
- 6) Tape procedure if possible and play back to group.

<u>Action</u>	<u>Belief</u>	<u>Common Feeling</u>
crazy action in front of group	I'll look dumb this is stupid people will laugh	scared silly dumb

THE PIPE

Purpose:

- a) show clients they can think; that
- b) they can change their thinking when the situation changes; and
- c) can support this with logical reasoning

Materials: lead pipe (or similar instrument), piece of wood, blackboard

Methodology:

Follow the Leader: At the start of the group have people stand and do several movements (touch nose, stand on foot, put finger in air, jump up and down, etc.) After about six to seven movements pick up pipe and ask everyone to smack themselves in the head until they bleed.

Most everyone will refuse (make sure all do). Ask why they refused and write answers on board. Point out at first they went along with it. When the pipe became part of it, they changed self talk to, "I'll get hurt, You're nuts, I might get killed or go to the hospital," etc. It helps if beforehand you have shown what the pipe can do--break board with it. The memory of this will last long enough.

RUBBERS AND THE BOTTLE

Purpose:

- a) instruction in function and proper use of a prophylactic
- b) initial discussion of venereal disease and pregnancy

Material: rubber, water, coke bottle

Methodology:

- a) This lesson began with an initial discussion as to how a woman gets pregnant, how to prevent pregnancy, and how venereal disease can be contracted.
- b) Discussion centered upon what rubbers are for, where to purchase them and what they cost.
- c) It then progressed to correct use of rubbers.

This is to show how rubbers work without films. Get a coke bottle, demonstrate how intercourse works. Make a circle with thumb and forefinger, call it a vagina. Call bottle an erect penis (hard-on) and put the neck of the bottle in the finger circle moving back and forth as in intercourse. Put a little water in bottle and pretend it is sperm. Explain how sperm comes out. Ask them if they know. Talk about sperm. Get out a rubber and let all of them feel it. Explain its use. Place it on top of the bottle, roll it down the bottle neck. Go through intercourse motions again. Let some water in rubber from bottle. Take off rubber. Explain need for care where sperm is present. Show rubber with water in it. Swing it around to show water cannot come out. This is graphic and should be remembered a long time. Explain that since water cannot go through, neither can sperm. For same reasons venereal disease germs cannot pass through.

WORDS AND SELF-TALKPurpose:

- a) demonstrating that self-talk changes the reaction of a person to the same word
- b) emphasis placed on fact that words themselves do not change, only the belief system changes.

Materials: blackboard, chalk, eraser

Methodology:

Counselors set up actions involving someone being called a bad name, first by enemy then by a friend. Client's responsibility is to supply belief systems and feelings using the A-B-C analysis. Begin with the situation involving a friend, completing this for A-B-C before going on to the next situation. Do same procedure with second example.

If words have power they must always have the same effect. For example, if the word "fucker" makes you mad you should get mad everytime you hear it. But think about it. You usually do not. It depends on its use and how you define it and the situation of things.

Action	Belief	Common Feeling
A friend calls you a "damn fucker" in a joke	1) He's a friend-I don't like it but he's joking around	neutral
	2) It's not meant personally	happy
	3) That's nothing	
	4) I like having him around	
An enemy calls you a damn fucker, mad	1) He's not a friend-I don't think it's a joke	mad
	2) I don't like it	angry
	3) He shouldn't call me that	upset
	4) I must not be called that	
	5) He has no right to call me that	
A girlfriend calls you a good fucker-as in sex	1) That's great, I like sex and pleasing her	good
	2) Maybe we'll screw some more	pleased
	3) Might meet more people	happy
	4) Sex feels good	jolly
	5) We use good birth control	
A girlfriend calls you a good fucker-as in sex	1) Sex feels good but it's wrong before marriage	guilty
	2) I should have more self control	worried
	3) How could I do that	depressed
	4) It was wrong	
	5) I wish it did not happen	

NEEDS AND WANTSPurpose:

a) differentiate between needs, meaning something required for existence, and desires, meaning something which will make existence easier or more pleasant.

Materials: blackboard, chalk, erasers

Methodology:

I. Write a statement on one side of the board:

"I need to have a friend:. Ask if that is true. Record answers.

II. Make a list of needs clients came up with on the other side:

food	transportation	Add them on until you feel there are enough. Go back and decide the ones your body must have to stay alive and that help make life easier. Circle needs. Check off those things that would make life easier and show difference of how adults can live without them.
water	hobbies	
health	cold weather	
clothes	recreations	
work	heat-furnace	
air	air conditioning	
money	t.v., radio, records	
gas stations	tapes	
shows	doctor, dentists	
home-place to live	school	
	church	

A few examples:

Food, water, and air are all requirements of your body for staying alive. Having a doctor, your health, heat, school might help you do better in life, but they are not required to function and you can live without them, maybe not in the most pleasant way, but you can live without them. Continue discussion until it is clear. Ex.: "I need heat", implies without heat you would die. This could be so depending on where you live. Heat helps make tolerating the cold easier. You can always move to a warmer climate. What you really mean is, "It gets cold where I live. To stay comfortable heat would be better. I want to be comfortable, so I get heat". Make a point of showing that if something is a need all people

in all parts of the world must have it to exist. Heat could be defined as a requirement in cold areas but not necessary in warmer climates. Make this clear. It would be true that you could freeze to death without heat (assume the earth will be current climate. Some people will really take issue with this idea). There will be some questionnaire topics but make sure all needs are actual requirements of the human body to continue to stay alive and not just desires.

III. Go back to statement, "I need to have a friend", and decide if it is really a need or a desire. Most likely they will say it is a need, but then point out how, while friends are nice to have (point out benefits) humans can live without anybody (condition of life does not matter just physical life). Go over the point until it is clear. Change sentences around to make it easier to understand. "I need to have a friend" turned to, "I like to have a friend."

COMIC #1 - DECISIONSAPPENDIX B

Do you know where people's feelings come from? Most people think that feelings are made by what other people say or do to them. They think things like:

He made me mad!

You made me feel bad!

People often blame others for their feelings. They think that something happens (A) which makes them feel something (C)

A(action)

My boss yelled at me

this makes me

C(common feeling)

mad and angry

But this is not true. People make their own feelings. Your feelings come from the ideas you tell yourself in your head. They do not come from what other people say or do to you. Let's look at how it happens. This time we will put in some ideas that we tell ourselves.

First, something happens

A(action)

My boss yelled  
at me

then

then we talk to ourselves

B(belief)

I can't stand it  
I hate my boss  
I hate my work

then

then we get feelings

C(common feelings)

mad angry

People forget that they talk to themselves about everything. They tell themselves if they like something, don't like something, or want something. They decide what they want what they do, and also how they feel. People do this by what they tell themselves in their own heads.

People use their brains to think and make decisions. Sometimes they get in the habit of thinking one way. They tell themselves the same thing over and over. They still think, but they don't have to think as much. Do you remember when you were a child and learned how to tie your shoes. First you tied a knot, then picked up the strings and made a loop, then you picked up the other string and wrapped it around the loop. You finally pulled it under and made a bow. Do you still have to think about each step? No. You have learned the habit of tying your shoes so well that you do not have to think about it at all. You have learned how to do it.

You can learn to think in the same way. Some people learn to get mad whenever they get yelled at. They may have learned how to do this when they were a child, just like they learned how to tie their shoes. It does not seem that they think about getting mad anymore, but they do! And they still get mad!

People are always thinking. They talk to themselves about everything. They decide what to do. They decide what clothes to put on, when to take a bath, what to eat, and what they want to drink. People also decide what to think. They can also change the way they think. They have a choice. They can decide to think in a way that will help them get what they want or feel how they want to.

Many decisions are pretty easy to make. Most people can decide when to take a bath or what kind of pop to buy. But sometimes you have to make a big decision. This can be like trying to decide to leave your boyfriend or girlfriend. It can also be trying to decide if you want to run away, or quit work, or to buy a car. Remember: no matter what, you always have a choice. You choose what to think. You choose what to do.

How do we make a big decision? Usually we first think of something we want. Something like, "I want to quit my job." But remember, everything you want may not always help you. Sometimes people want things that can hurt them.

Let us look at an easy example.

Let's pretend that you see a big chocolate cake in the store. You want the cake really bad. You can see yourself eating the whole thing. You also weigh 200 pounds and are trying to lose weight. But you still want that cake! What do you do?

Well, people start to talking to themselves. You begin to tell yourself ideas why you want the cake. You may also tell yourself ideas why you do not want the cake...It may go like this:

#### Buy the cake reasons

- |   |  |
|---|--|
| 1. That cake would really taste good          | 1. It costs \$3.00 for one cake                            |
| 2. I wouldn't eat supper if I ate the cake    | 2. It has enough sugar in it to make me gain weight anyway |
| 3. I'll only buy it this once                 | 3. If I buy it, I'll still want more                       |
| 4. If I do gain weight I'll lose it next week | 4. I don't want to go on a diet all next week              |

What you are doing is talking to yourself. You are thinking about what to do. You are talking to yourself about how the cake could help you. You are also telling yourself how the cake can hurt you. In other words, you are trying to make a decision. "Yes, I'll buy the cake", or, "No, I won't buy the cake."

Sometimes you can ask otherpeople what they think. They may tell you what they would do. But, you are the person that decides for you. You are the one who buys the cake or does not buy the cake. If you do what someone else says, then you let other people think for you. You don't decide for yourself. Remember: What is okay for other people may not be okay for you. Suppose you are still thinking about the cake. You ask your best friend about it. She says "Sure, but it. I would!" But, your best friend only weighs 100 pounds. She does not want to lose weight. She does not care if you lose weight. Would you do what she says? No! Your friend is not thinking about losing weight. It won't hurt her to eat the cake. It won't hurt her if you eat the cake. Remember, if you buy it and you eat it, you are the one who will get fatter. Not your friend!

Everybody has to make decisions. You decide for yourself. You decide what's best for you. Here are some ideas to think about when you want to make a decision. The ideas are:

1. Is it what is best for me?

Is it better for me to get fatter if I weigh 200 pounds - OR -

Is it better to stay on my diet and get thinner?

2. How much is it worth to me?

Would I want to eat the cake and eat very little all the next week - OR -

Stay on my diet and eat more food the next week

3. What's most important to me?

Is it more important to me to stay fat and eat what I want - OR -

Would I be happier if I was thinner and gave up some of the things I like to eat.

Everybody makes their own decisions. They decide what is best for themselves. Some people may want to stay fat. Others may want to be thinner. It is up to you. You decide what you want. It is your life, nobody else's.

Let's take another example. This time we have to make a big decision. Lets say your boss has yelled at you everyday this week. You start to think. "I sure do want to quit work." "But if I quit work, I won't have much money. What should I do?" Here again, remember-what you want may not help you. Some things you want may hurt you.

Okay, now lets go on. You have started to think about quitting work. What are some of the things you tell yourself? Lets look at some of these things.

#### Quit Work

1. I hate to be yelled at.
2. I can get along without my paycheck
3. If I quit, I could do what I want all day.
4. I hate to be yelled at.
5. If I quit work I might be able to find another job on my own.

#### Stay at Work

1. If I quit, I lose my paycheck. Maybe if I did my work better, no one would yell at me.
2. My paycheck gives me \$100 a month extra to spend. All my other money pays my bills
3. My friends will all be at work. I'd be alone. My friends would have more money than me. I would'nt have any extra
4. If I did my work better, no one would yell at me.
5. If I stay at work and work harder I might get a better job where I am at.

What would you decide to do? (circle one).

Would you stay at work?            Yes    No

No matter what your answer is, yes or no, you are still thinking. You still make a decision. You may decide to ask someone else what they would do. But, what is best for someone else may not be best for you. You decide for yourself. Remember these things:

1. Is it best for me?

Do I want extra spending money to pay for things I like -OR-

Do I want all my money to pay for my bills?

2. How much is it worth to me?

Can I work harder to keep people from yelling at me-OR-  
Is it better to just quit work and lose my extra money

3. What is most important to me?

Do I want my paycheck. Do I want to do a better job-OR-  
Do I want to quit and live off of other people.

You always have to decide for yourself. You are the one who lives with  
what you decide. No one else!

How do you get upset? Do you think the things that happen to you make you mad? Do you think that if someone yells at you that is why you feel bad? Well if you do, you are thinking CRAZY IDEAS. Many people make the mistake of thinking things can do something to them.

Many people think like this.

Something happens <u>Action</u>	and they think that makes	them have feelings <u>Common Feelings</u>
The boss yells at you because of your work		mad anger

Alot of people think this way. It is called the "Things make me upset" idea. This is not what really happens. They forget that they do think. They don't know that it is the way they think that causes their problems.

If you went back and asked the person who was yelled at why he got mad, he'd probably say, "Because I got yelled at and I don't like to be yelled at." If you then said "so what. Words cannot hurt you unless you let them, so why worry. You can only be hurt if someone hits you". He would then say something like, "Well, I wish it didn't happen but I should not be yelled at like that. It makes me upset. I just cannot stand it. He must not do it. This is awful".

Do you see what is happening here? This person is telling you why he got mad. He got himself mad by what he told himself in his head. It is the exact same thing he said earlier. This is called your thoughts or Beliefs. Now we can fill out the ABC chart.

<u>Action</u>	<u>Beliefs</u>	<u>Common Feeling</u>
Something happened	What you think	How you feel
The boss yelled at you about your work	I wish it didn't happen I don't like to be yelled at I shouldn't be yelled at like that It makes me upset I cannot stand it. He must not do that This is awful	mad anger

Your beliefs cause your feelings. What you do is think about what happened to you. You decide if you like it, dislike it, or could care less.

Remember this. It is important. Things or actions do not make you upset. You do that by what you tell yourself in your head. You always have feelings or desires. The way you talk to yourself helps you make those feelings sane or crazy.

People tell themselves two kinds of ideas. Sane ideas and crazy ideas. Let us get one thing straight right away. You talk to yourself about everything that happens to you, what you see, what you hear, what you touch, what you taste and smell. Everything.

Not only do you talk to yourself, you do it in different kinds of ideas. That is the Sane and Crazy ideas.

Sane ideas are your thoughts about things. They do not cause any problems. They are simple ideas about what you like or not. What is right or wrong. You learn to think these things.

Sane ideas are based on five (5) Rules.

1. Sane ideas help keep you alive.
2. Sane ideas are based on fact.
3. Sane ideas keep you out of trouble with other people.
4. Sane ideas keep you out of trouble with yourself.
5. Sane ideas give you a choice of how to feel or act.

Here are some examples of sane ideas.

1. I'm not going to do that. I might get hurt.
2. I make some mistakes and do some things right.
3. I do not like to work but it gets me money for what I want.
4. If I hit that guy I might get put in jail.
5. I'm not stupid. I just made some mistakes.
6. If I can't do this, I'll just try something else.

Crazy ideas are things that cause all kinds of trouble. These are the ideas you use to get yourself in trouble. This can be called "Have To" thinking. Everyone has a choice to do something or not do it. No matter what, you always have a choice. You may not like your choices but who said you have to? You choose to go to work or stay home. You choose to hit someone or ignore them. You choose to run away or stay. You choose to take a bath or stay dirty. Sometimes the choices are hard to make, but you have them!

The only time you might not have a choice is when you tell yourself crazy ideas. By telling yourself crazy ideas you do not let yourself have a choice. You say things like, "I cannot stand being yelled at so, I have to get mad." "I can never be happy so I have to be sad."

Crazy ideas usually have these words in them.

must	cannot
should	It makes me
got to	cannot stand it
have to	awful
can never	terrible
always	I need

If you see or use these words watch out for them. Only you can let words have a bad effect on you. By telling yourself crazy thoughts with crazy words you start to do crazy thing.

People have learned how to think and act. You learned everything you know from friends, parents, television, movies, books, magazines, your teacher, your counselor, and whatever you have done in your life. You learned how

to talk to yourself into being upset-able, so you can teach yourself to be less upset in situations you do not like.

The ABC chart is an easy way to help you learn how to think clearer. Let's go over it again and show the crazy and sane ideas used in our example. Remember you make yourself upset by what you tell yourself!

The ABC's stand for three things.

Action: something happens

Beliefs: what you tell yourself (thoughts)

Common Feeling: how you feel

Here is our example:

<u>Action</u>	<u>Belief</u>	<u>Common Feeling</u>
Something happens	What you tell yourself	How you feel
The boss yelled at you because of your work.	<ol style="list-style-type: none"> <li>1. I don't like to be yelled at</li> <li>2. I wish it didn't happen</li> <li>3. I shouldn't be yelled at like that</li> <li>4. It makes me upset to be yelled at</li> <li>5. I can't stand being yelled at</li> <li>6. He must not yell at me</li> <li>7. It is awful to be yelled at</li> </ol>	<p>mad anger</p>

Lets look at the first two ideas.

1. I don't like to be yelled at
2. I wish it didn't happen

These are sane ideas. They are statements about what you simply like or dislike. You won't get hurt by them! You will not get in any trouble with them! You still won't like what happened but, who said you had to like everything that happens to you. You are left with a choice to stay calm or get a little upset.

Now let's look at the next five (5) ideas.

3. I shouldn't be yelled at like that.
4. It makes me upset to be yelled at.
5. I can't stand being yelled at.
6. He must not yell at me.
7. It is awful to be yelled at.

These are all crazy ideas. Look at the words with a line under them. They all come from the crazy list. Everyone of them. By using these words you start to tell yourself crazy ideas over and over until you think they are true.

If you tell yourself crazy ideas you give yourself no choice but to get mad or upset. Why is that? Because you let things bother you. You think they are true because you do not stop and think about what you tell yourself. You are so used to thinking these crazy ideas that you think they are the only way to think. In fact you are so used to thinking crazy

ideas, you don't even know you are doing it most of the time.

Look at each one of these crazy ideas and see how crazy they are.

3. I should not be yelled at like that.

Why not--are you perfect? Don't you make mistakes? Maybe your boss was wrong when he yelled at you, but words cannot hurt you unless you let them. Besides doesn't he have a right to yell if he thinks you made a mistake. He is paying you with his money. Just because he yells doesn't make his idea correct. So the boss yelled, try to do better next time.

4. It make me upset to be yelled at.

Only you can make yourself upset by what you tell yourself. You control how you feel. No one or no thing makes you do anything. You decide to get upset. You make the choice of getting along with people when you do not like what they do.

5. I cannot stand to be yelled at.

What garbage this is. If you could not stand something wouldn't it kill you? If you have not been killed then you can stand it. Remember you do not have to like things but you can stand them. You have done it all your life. You are still alive. You have faced all sorts of really bad things you thought you could not stand. How do you explain that?

6. He must not yell at me like that.

He can do anything he wants. You do not control him. He can say anything he wants. Just because you don't like it does not mean he cannot say it or has to stop. You will get along. You will live. Who said the world must go only your way.

7. This is awful to be yelled at.

What does awful mean? Most people think it is something so bad they cannot stand it or it will make them mad. We have already seen that you can stand almost anything (unless it kills you) and only you can make yourself mad. Nothing is awful. It may be really bad or scary, but awful? Nope!

Let's look at the chart with all the stuff filled in and the sane and crazy ideas separated.

Something Happens  
Action

The boss yells  
at you about  
your work

Your Thoughts  
Beliefs

Sane Ideas  
I don't like to be yelled at  
I wish it did not happen

---

Crazy Ideas  
I should not be yelled at  
like that  
It makes me upset to be yelled  
at like that  
He must not yell at me  
This is awful to be yelled at

Your Feelings  
Common Feelings

Use these sane ideas and  
you will feel a little  
mad. Who likes to get  
yelled at. You decide  
you can stand it.

---

Add these crazy ideas  
to your sane ideas  
and you will be sure  
to make yourself  
crazy and mad. Real  
mad.

The way people get themselves upset is by saying sane ideas to themselves then adding on a whole bunch of crazy ideas. People who get upset alot only listen to the crazy things they tell themselves. They listen for so long and so hard, they do not let themselves think any other way. There are so many people who think these crazy ideas that they all think the ideas must be true. They forget they have a choice to stay calm, maybe a little mad or to get REAL MAD LIKE THEY ALWAYS HAVE.

How do you stop being upset? It takes practice, practice, and then some more practice. You took a long time to teach yourself crazy ideas and it will take w ahile to learn a new way to think. Like a bad habit, crazy ideas are hard to stop.

It is so easy to get mad then blame someone else for making you mad. If you want to keep telling yourself crazy ideas, go ahead. It is your life. You will just keep getting upset and acting crazy. If you want to change yourself, work at recognizing crazy ideas and try to get rid of them. It takes hard work like anything else.

#### REMEMBER

1. You control yourself
2. You decide how to act
3. You talk to yourself all the time
4. You learned how to act like you do
5. You can learn how to act differently
6. You break old habits by not doing them and practicing new ones over and over.

Two of the most important things to do are the homework form regularly. This will help teach you what to look for and show you how you think. Second talk to your counselor and read these comics regularly. It is all up to you. Only you can do it. No one else.

Many people think that other people or things can make them mad or feel bad. They think that because someone calls them a name they have no choice but to get mad. Maybe they did not get what they wanted so they think that made them upset. Or they have to fight because someone does not agree with them.

Is any of this stuff true?

Not a single bit of it is!

People make themselves mad by what they tell themselves in their own head.

No one can make you upset except yourself.

Remember that saying when you were a kid.

"Sticks and stones may break my bones but names or words can never hurt me, unless I let them".

That is true.

Why is that?

Well if you get hit by sticks and stones it is going to hurt and few people like to be hurt.

Can words hurt your body like a bat or a rock can? Think about that. Did you ever get cut or bruised because someone called you a name? Has any word you have heard ever killed you?

Words have no magic. Only you can let words get to you by putting a meaning to them. Lets look at an example. Say someone called you a "stupid jerk". A lot of people would get mad about that. Some people would want to fight. Other people might just yell back. These people think words can hurt them.

What if you were called \_\_\_\_\_, would you still get mad? Unless you know \_\_\_\_\_, I doubt you would. You have to know what a word means before you can let it bother you. You put meaning to words.

Words by themselves are just sounds. People like your parents, teachers and friends have taught you what certain sounds stand for. You make the sounds mean something by remembering what you learned. This way you can talk to people and yourself because you know what some sounds mean.

What do cows mean when they go "mooo?" What do cats mean when they go "meow". You don't know because they are sounds that you have no meaning for. If you are called a "stupid jerk" in English you know what it means because you learned what those sounds stand for. You did this with your brain by talking to yourself.

Can anyone's action hurt you? Well, as long as no one touches you there is nothing that anyone can do to make you feel mad, make you feel happy, or any other feeling. If people just yell at you, or something you have worked on breaks or stuff just does not go your way, it is impossible for it to hurt you. You may not like it but who said you have to like everything that happens to you.

What does all this mean?

Exactly this: Things or people do not make you upset. You do that by what you tell yourself in your head.

Here are two examples:

This is an easy one. Watch closely for the facts. See if you can pick them out. Two friends go to the fair. They decide to buy tickets for the biggest, fastest rollercoaster they can find. They find it and they both ride the same car. When they get off together one of the friends acts really scared and says "I'm not getting on that again, it scared me to death." The other friend is really excited and says, "That was great, I want to ride this all day."

So, what are the facts?

1. Two friends go to the fair.
2. They both buy tickets to the rollercoaster.
3. They both ride it.
4. They had different ideas about the same facts.

What made one person afraid and the other one excited. They both did the same thing. It was their thoughts about the rollercoaster ride that made them feel different. Their thoughts in their head, not the rollercoaster.

This one is harder.

You are in a crowded room. It is so crowded you cannot turn around. You start feeling someone behind you poking you with something. You start getting real mad. When you find some space you turn to yell at the person. Then you see the person is blind and had hit you with his cane. You decide not to get angry because the person cannot see what is in front of him. You decide to just forget it.

What are the facts here?

1. You are in a crowded room and someone is poking you from behind and you are getting real mad about it.
2. You finally turn around to yell then see that the person is blind and had touched you with his cane.
3. You stop being angry and decide to forget it.

What happened to your anger? Did it just go away or did you start to think different thoughts. Can you see that when you changed your thoughts your feelings changed. By deciding that the blind person had hit you by accident you told yourself in your own head, "It is not worth getting upset about. It was just a mistake."

So you see by changing your thoughts that you tell yourself in your head you change how you feel. You control your thoughts, no one else does. You learned how to think and act like you do. You can learn how to think and act differently.

REMEMBER THESE FACTS BECAUSE THEY ARE TRUE.

1. All human beings (that's you, too) think with their brain.
2. With your brain you can learn to figure things out.
3. People use their brain to talk to themselves all the time.
4. Sometimes you think so fast you do not even know you are doing it.

Everybody talks to themselves all the time. You talk to yourself about the clothes you wear, when to wash up, when to change your underwear, when to go to sleep, what television show to watch, what food to eat, who you like or dislike, everything. You tell yourself how to act, what to think and how to feel.

You control yourself. As a human being you think all the time about everything that happens to you. Some things you decide to like, some things you decide to not like, and some things you decide not to care about. Sometimes you can control what happens to you and sometimes you cannot. The point is - you think about everything. By thinking you control how you will feel.

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## APPENDIX C

ANSWER THESE SENTENCES AS TRUE OR FALSE BY CIRCLING THE LETTER.

			<u>NUMBER RIGHT</u>	<u>PERCENTAGE</u>
1. Only crazy people talk to themselves.	T	F	33	60
2. You must get mad if you get yelled at.	T	F	35	63
3. If at first you don't succeed you might as well quit.	T	F	14	24
4. Your feelings come from how people treat you.	T	F	25	45
5. There is nothing you can do but be upset if someone calls you an "asshole".	T	F	32	58
6. Words can not hurt you unless you let them.	T	F	32	67
7. You make yourself feel good or bad by what you tell yourself in your head.	T	F	42	67
8. People who have been called "retarded" cannot think for themselves.	T	F	42	76

WHAT DO THESE WORDS MEAN? YOU CAN WRITE THE ANSWERS HERE OR ON THE BACK OF THE PAGE. USE ANY WORDS YOU WANT.

1. Masturbation -			21	38
2. Venereal Disease (V.D.) -			36	65
3. Penis -			51	92
4. Vagina -			49	89
5. Period -			37	67
6. Pregnant -			52	94
7. Birth Control -			41	74
8. Homosexual -			26	47

ANSWER THESE QUESTIONS TRUE OR FALSE.

1. Masturbation will make you crazy.	T	F	40	72
2. You can get venereal disease easier if you have sex with many people.	T	F	34	61
3. When you put a penis into a vagina it is called sexual intercourse.	T	F	49	89
4. If a girl misses two periods it is a good sign she might be pregnant.	T	F	43	78
5. If your vagina or penis hurts you should see a doctor.	T	F	53	96

6. Birth control is a woman's problem not a man's.	T	F	18	32
7. All homosexuals are sick.	T	F	32	58
8. It is alright to force someone to have sex with you.	T	F	44	80
9. You should not have sex with anyone under the age of 18.	T	F	42	76
10. It is best to have sex where other people can see you.	T	F	50	90
11. If you like someone you must have sex with them.	T	F	35	63

EXPLAIN, IN DETAIL, HOW A WOMAN GETS PREGNANT. YOU CAN USE OTHER SIDE OF PAPER IF YOU WISH.

#### Explanation of the Answers to the Test

1. Only crazy people talk to themselves. T (F)

This is a common misconception. Every human talks to himself in some form. Thinking, evaluation, fantasy, decision-making, or any form of cognitive process all involve some form of self-talk. The main emphasis here is that this self-talk is how you create most of your emotional feelings.

2. You must get mad if you get yelled at. T (F)

If this were true you would have to become angry every time someone raises their voice to you. The truth leans more towards the choices you allow yourself. A friend may yell at you and you'll forget it because you are willing to. An enemy may say the exact same phrase and you blow up because you evaluate the situation differently.

3. If at first you don't succeed you might as well quit. T (F)

One of Ellis's major irrational ideas is basically the idea "I must be perfect in everything." It's pretty obvious that people usually improve as they practice and that they regularly make errors. If everyone quit at the first error the world would be a real mess. Practice won't make

perfect but it may help you do things easier and quicker.

4. Your feelings come from how people treat you.

T (F)

Initially, this seems true to many people. No one likes to be treated badly and it is easy to blame your emotional problems on someone else's pressure or harassment. However, why don't people become upset every time something they don't like happens? Often they shrug off problems or decide to ignore what has occurred or make changes in their life to lessen the problem possibilities. Surely a person may feel tired of fighting continual pressure, but since different people react differently in the same situation something besides how they are treated causes feelings.

5. There is nothing you can do but be upset if someone calls you an "asshole".

T (F)

This follows the same logic as #2. There is a lot you can do if called names you don't like. The first steps people generally follow include evaluation: who said it; whether they themselves care at the moment; and the situation they are in. A friend at a party could say almost anything but the same phrase in another situation may result in another evaluation and another feeling. Again, a person makes a choice of how to cope.

6. Words cannot hurt you unless you let them.

(T) F

Find out what words someone is really bothered by and translate them into a foreign language not understood by the person. Will that individual have the same emotional response if he hears the foreign phrase? Probably not. Words are merely sounds with meanings attached to them. A phrase in English, German, Chinese, or Swahili still means the same. Words assume a pseudo-power only after some semantic education. You control words, words don't control you.

7. You make yourself feel good or bad by what you tell yourself in your head.

(T) F

Situations do not really have power over your feelings (#4 & #6). You cause your own feelings. By evaluating what you experience by the rules you have learned in the past, you decide how you will feel. This is done in the head through self-talk. A person fits or twists new situations to fit into past experiences. A person would feel "good" when their desires, wants, or other goals become fulfilled. The degree of good feeling would come from how important or valuable that goal was to them.

8. People who have been called "retarded" cannot think for themselves.

T (F)

This is one of the bigger myths that many people believe. More accurately, people with a learning or behavioral pattern called mental retardation may indeed be slower in understanding or remembering things, but they can think for themselves. Their emotional feelings come from evaluating the same circumstances as anyone else. In a special education class it is the student who completes the tests alone. Who decides to put on clean underwear? Who decides they want to eat Oreos? Who decides they don't like certain television shows? Who decides they like the Chicago White Sox? The degree of thinking or level of complexity may not be equal for all people, but all people, with or without retardation, evaluate what happens around them and can learn coping mechanisms to lessen emotional problems.

### Questions on Sexuality

1. Masturbation will make you crazy.

T (F)

Along with other myths like hair on the palms, pimples, senility, etc. this is false. Masturbation may hurt if done too hard or too

often. In that case stop for a while. Since it is a sexual activity, privacy is of prime concern. Problems only come from guilt, worry, or if other people do not approve.

2. You can get V.D. easier if you have sex with many people.

(T) F

This is obvious as more facts about V.D. are learned.

Various surveys show that V.D. is a severe problem in the United States. Because of learning problems and the symptomology of V.D. this population needs the facts stressed often especially to the sexually active people. This includes where to go for help.

3. When you put a penis in a vagina it is called sexual intercourse.

(T) F

This is pretty obvious.

4. If a girl misses two periods it is a good sign she might be pregnant.

(T) F

This question assumes some sexual activity is already occurring or a person has knowledge of periods. Usually after missing two regularly scheduled periods, a woman could probably consider seeing her doctor to find out what is going on.

5. If your vagina or penis hurts you should see a doctor.

(T) F

While there may be a simple cause (too much masturbation) persistent problems should be looked into. This question is geared toward V.D. but can be generalized to bladder and yeast infections or any other genital problem.

6. Birth control is a woman's problem, not a man's.

T (F)

A sexual relationship assumes a mutual decision on the part of the people involved. This idea simply carries over to responsibilities in all areas. Unless both people want a baby, both people should practice good birth control techniques together. Responsibility is on both people.

7. All homosexuals are sick.

T (F)

This may be an emotional or moral problem for many people. The approach taken here is that nothing is sick, unnatural, perverted, or immoral as long as the five rules of sex are followed. This program deals with adults who can make their own decisions. A person's sexual activity is ones own business unless it begins to be a problem he or she cannot handle or if it effects the community. All judgements about someone's sexual life are merely that - judgements. Each person's own choice for themselves is acceptable as long as it is not forced on others.

8. It is alright to force someone to have sex with you.

T (F)

It is never alright to force someone into anything, especially sexually. Mutual consent is one thing, one sided demands another. Laws in each state deal with rape and other violent situations. This is important to stress.

9. You should not have sex with anyone under the age of 18.

(T) F

Again this follows the laws of each state and may vary. The age of 18 is legal adulthood in Illinois. It must be stressed heavily that adults over 18 should not have sex with those under 18, due to statutory rape laws and social norms.

10. It is best to have sex where other people can see you.

T (F)

Privacy is of utmost importance in sexual activity, especially with the various values people hold about it. Sex in public will surely get someone in trouble with morality and vice laws or someone else who feels such behavior is totally wrong. Again, responsibility is each persons problem and must be accepted.

11. If you like someone you must have sex with them.

T (F)

Each person can decide when and how they wish to engage in sexual activity after they have thought through all of their choices. You do not have to have sex with everyone. While it may be fun and feel good, it is not a necessity to every relationship. In fact it may cause more problems than it is worth. Each person can make a judgement in this area based on thier own moral values.

APPENDIX D

1. A woman gets pregnant when she has sex with a guy and they shoot their load and pop your cherry. It is a sperm that makes you pregnant.
2. Take a shower together, stick it in her, he leaves sperm, makes love to her.
3. Some man lays on top of her and makes her pregnant. Has sex with her. No clothes on.
4. By getting in bed with her and also playing with her! Looks at her. Loving her.
5. Put the penis in the vagina and make sure all the stuff gets in her real good.
6. When you fuck a girl when the girl is on her period.
7. Easy. No idea, Don't go to Fox Ridge or here the man gets on top of the woman. No clothes on.
8. Man asks you to lay on bed. He puts penis in you. He's on top of you. He goes up and down. If you feel wetness from juice of man-comes in you.
9. Fuck her in the pussy, get a baby. Man leaves blood in her.
10. Woman gets pregnant by getting fucked by other men and some boys, too.
11. Has a baby. I don't know how its done.
12. You go to bed with a woman and if she wants to have sex with you let her have it if she wants you to stick your penis in her and start screwing and then you have a girl pregnant, then you have a baby with sex on the side.
13. It takes nine months to have a baby. The man goes with you. Laying in bed with a man. He kisses you by his thing and white stuff-gook comes out.
14. Screwing-getting a baby, get your thing in her cunt real good.
15. Going to bed you have sex. On top either male or female. Going to bed for love and increases and eat. Go to the movies.
16. Have a baby in the stomach by a boy talking to you. Fuck a boy and girl pussy and peter-puts it in womb. Fucking poisons you then bleed-this gets rid of the poison-take to hospital and get shot then you do not bleed anymore.
17. When she has sex with a man-man puts peter in her (points to genitals).
18. A woman gets pregnant when a man has sexual intercourse together with a woman. And then she gets pregnant. Sperm gets together and develops the

woman's eggs.

19. By having intercourse with a man when the guy puts his penis in the girls vagina. When the guy lets go of the sperm while his penis is in the vagina.

20. When a woman has sexual intercourse with a man, the man has his penis in his vagina, the man has to do something in there. It's the stuff that has to come out of the penis.

21. Someone does it to her.-F \_\_ \_king his filth comes-come.

22. A man and a woman decide it is okay to go to bed through marriage or illegally before marriage. The male produces sperm in the nuts and sends them through his penis into the vagina. The sperm travels through the vagina to the uterus. Either in the uterus or the fallopian tubes the sperm joins with the eggs. The egg then fertilized moves into the uterus and connects to the wall of the uterus. The uterus does not shed its lining and the girl finds she is pregnant.

23. By putting a man's penis inside her and a sperm appears inside and during several months she is pregnant and has a baby.

24. When you put the penis in the vagina.

25. Let a boy do it to her, gets on top of you, pulls pants down, fucks you, puts on his pants.

TERMS:

1. Masturbation: sexual relief, play with self, guy or girl playing with themselves, inner sex-thinking about having sex, nervous or mad, jack off,

2. Venereal Disease: disease from screwing, disease you get from some other person, getting along with people, disease for both sex organs, pill, disease from sex, stick it in you might quit, disease-don't know this kind, has back syphilis

3. Birth control: being able to control babies-prevent, pill for woman to keep from getting pregnant, a way not to make babies, pills to keep you from getting pregnant, IUD, to keep from getting pregnant, pill to help you not have babies, play with yourself, a pill to stop kids, disease or sickness

4. Penis: a prick, on a man, man's private, man's peter, man's dick, man's thing, like Bob has

5. Vagina: What a man screws on a woman, on a lady, woman's private, pussy, big giant Jolly Green, puss

6. Period: no fertile egg, bleeding at the vagina, woman's time of the month, red stuff coming down out of her, doesn't happen too often, girls bleed, getting ready for a baby.

7. Pregnant: having a baby, girl having a baby

8. Homosexual: queer, fag, boys who suck peters, Someone who can't stand sex at all or someone who gets all they can, two guys together, a guy who plays with a guy or a lesbian, man that gets you pregnant, queer= a man, men likes guys, man goes with a woman, someone who wants sex all the time, a man and a woman, different things about sex, sex person, does sex in the home

APPENDIX ERECOMMENDED READING

Here are several books found to be helpful in development, philosophy, and general good ideas. (There are more)

A New Guide to Rational Living	Albert Ellis & Robert Harper(1975)
Creative Approach to Sex Education and Counseling	Patricia Schiller(1973)
Not Made Of Stone	K. Heslinga(1974)
A Teachers Guide to Sex Education for Persons with Learning Disabilities	Winifred Kempton(1975)
Guidelines for Planning a Training Course on Human Sexuality and the Retarded	Winifred Kempton(1973)
Handbook of Rational Self Counseling	Maxie Maultsby
Rational Emotive Education	William Knaus(1974)
Cognitive Therapy and Emotional Disorders	Aaron Beck(1976)
Cognitive-Behavior Modification An Integrative Approach	Donald Meichenbaum(1977)

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