

THE EFFECTS OF LECTURE-DISCUSSION AND GROUP-CENTERED  
COUNSELING ON PARENTS OF MODERATELY  
MENTALLY RETARDED CHILDREN

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The problem of this study was to determine if involvement in lecture-discussion classes of group-centered counseling would significantly alter anxiety level, aspects of self-concept, or knowledge of mental retardation in parents of moderately mentally retarded children. From the seventy-eight parents who wished to participate in parent discussion groups, twenty-four each were randomly assigned to a group-centered counseling group, a lecture-discussion class and a standard control group. Twenty-four of the thirty parents who declined the opportunity to participate were randomly assigned to the experimental control group. Lecture-discussion classes were held by the Directress of the school where the majority of the participating parents had children enrolled and the group counseling was held by a doctoral level counseling student.

The approach of the investigation involved administering a pre- and post-test of the IPAT Anxiety Scale,

the Index of Adjustment and Values, and the Knowledge of Mental Retardation Test to all experimental subjects.

Parents in the lecture-discussion classes met for fourteen one and a half-hour weekly sessions and were lectured on selected topics. The group-centered counseling groups met at the same period and for the same amount of time as did the lecture-discussion classes but their groups were unstructured and allowed for the exploration of feelings and attitudes. Control groups were pre- and post-tested only.

Hypotheses formulated for testing were as follows:

1. The group-centered counseling group will have a significantly lower post-test anxiety level than will the other groups.

2. The experimental control group will have a significantly greater pre- and post-test anxiety level than will the other groups.

3. The group-centered counseling group will have significantly greater post-test self-concept than will the other groups.

4. The group-centered counseling group will have significantly greater post-test self-acceptance than will the other groups.

5. The group-centered counseling group will have significantly greater post-test ideal-self than will

the other groups.

6. The group-centered counseling group will be significantly more congruent at the post-test administration than will the other groups.

7. The lecture-discussion group will have significantly greater post-test knowledge of mental retardation than will the other groups.

Results revealed that while some significant differences did occur between groups, these were not consistent and all of the null hypotheses were accepted. Data analysis indicated that the lecture-discussion group had positive gains on every measurement. The group-counseling groups had a lowered anxiety level, but were less congruent than they had been at pre-testing. The experimental control group was found to be no more anxious than the other groups and was more congruent.

The positive gains made by the lecture-discussion group and the failure of the group-counseling group to make such gains was seen as a function of the approaches used in this study. The lecture-discussion group was given more tangible and practical data which may have increased their self-confidence in regard to themselves and their retarded child while group-counseling group uncovered negative feelings and attitudes about themselves which were not resolved prior to termination.

It was concluded that neither approach was significantly different from the other in altering the variables under investigation although trends from mean scores indicated that the lecture-discussion approach produced more positive changes than did the group-centered counseling approach.

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COUNSELING ON PARENTS OF MODERATELY  
MENTALLY RETARDED CHILDREN

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## CHAPTER I

### INTRODUCTION

The growing field of mental retardation has progressed from a time when little professional attention was given to the anxiety experienced by parents of a retarded child to a time when parental counseling is an accepted practice. This interest in and concern for the parents of the mentally retarded child seems to be a result of the realization on the part of investigators in this field that the retarded child's adjustment to his environment and the parent's mental health are closely linked (21).

The bulk of the literature concerned with this topic has characterized the parents of mentally retarded children as being people who suffer some personal/psychological distress as a result of their having a mentally retarded child. Some typical comments regarding parental reactions to the retarded child are: "It may be stated categorically that all parents of mentally retarded children are likely to show some undesirable personality reactions to the fact that their child is retarded," (16, p. 292) and according to

Smart (25, p. 159) the production of a handicapped child "strikes at the vital emotional core of the parents." Thurston (29, p. 148) writes, "from the outset parents may become frightened and concerned, guilty and anxiety ridden" and Goodman and Rothman (12, p. 791) say, "certainly all parents of retarded children find their self-concepts shaken."

While many writers concerned with this subject tend to agree on the universality of some sort of a negative reaction by parents of mentally retarded children, others like Mahoney (18) and Beck (2) tend to view the parental response more individualistically. Mahoney (18, p. 81) believes that parents of mentally retarded children, "like all parents and all people, differ greatly with regard to the adequacy of their own personal adjustment to themselves and to others." He points out that the effects of the birth of the mentally retarded child to parents is relative to the prior integrations and adjustments those people have made in life.

It would seem that these parents could be as normal and as average, or as maladjusted and as neurotic as any selected group of parents--before the birth of a mentally retarded child (18). However, with this traumatic event, they suddenly become "parents of a mentally retarded

child" and many researchers have pointed out that the existence of a mentally retarded child in the family is sufficient reason to cause these parents to need counseling (7, 8, 13, 17, 20, 27, 29).

Authorities such as Begab (3), Egg (9), Farber (10), Hutt and Gibby (16), and Kanner (17) also share the view that the birth of a mentally retarded child is a very disrupting event which may upset otherwise stable, "normal" people. Much of the rationale forwarded to account for these common negative reactions concerns the nature of the birth process as well as the social importance of having a "complete" child (19, 24).

Parents of retarded children have been observed to employ various defenses in relation to themselves as parents of a defective child and in terms of "explaining" their child (19). It has, however, been pointed out by Michaels and Schuchman (19) that these otherwise neurotic defenses are, in some parents of mentally retarded children, actually very good adjustments which enable the parents and family to enjoy a more nearly "normal" life.

One defense which does not allow the retarded child's parents and family to enjoy a "normal" life is the "wall of silence" which can surround these families. Researchers (3, 9, 10, 16, 17) have observed this phenomenon and note that this "wall of silence" can grow

to effect the parent's and family's entire orientation toward life and the world in which they live.

These observations regarding the impact of the mentally retarded child on the parents and the family are often followed by the finding that these parents need and usually benefit from counseling. Generally, the type of counseling which seems to be most beneficial to these parents is the type which takes place in the group setting (1, 3, 4, 6, 8, 11, 12, 22).

Authors who have investigated the effects of the group process with parents of mentally retarded children have noted the increased ability of these parents to talk about their child (1, 5, 6). This breaking of the "wall of silence" must be regarded as a significant therapeutic gain and it would appear that it is a step in the parents' breaking the silence within themselves. In almost every reported situation of group work with these parents the progression has been from child-centered discussion to the recognition and more constructive handling of their own problems as well as a more realistic view of their child and his needs and problems.

Egg (9) observed that parents progress from the "I-stage" to the "child-centered stage" to the

"community-centered stage." In the "community-centered stage" the parents of the mentally retarded child have a realistic knowledge of their child, his assets and liabilities, and the ability to communicate with the outside world about their child and themselves. Parent groups would, hopefully, take a person who is either in the "I-stage" or in the "child-centered stage" and help him progress to the "community-centered stage."

Although counseling with parents of mentally retarded children in the group setting runs the gamut from "psychotherapy" to "teaching" (27), it does appear that the usual trend is toward aiding the parents to adjust some of their perceptions of mental retardation in relation to their own child so that they can better function in the world.

While the last twenty years have produced a substantial body of literature on the problems of parents with mentally retarded children, much of this literature has been comprised of professionals' opinions based on their experiences with these parents. Reviews of the literature on research with parents of mentally retarded children (24, 27, 30, 31) generally make comments about the poor design and subjectivity of these

studies. Ryckman and Henderson (24, p. 5) note that "few attempts have been made to conduct research experiments or to develop theoretical conceptualizations about these problems." With few notable exceptions (1, 4, 14, 28) studies relating the effects of parental counseling programs have been subjective in nature. While the few objective and controlled studies have tended to agree with the subjective observations of writers, this does not mean that those with an interest in this area can or should accept all the published findings before more supporting evidence is in.

Although there are design and procedural weaknesses in many of the reported studies, most of them attest to the progress and improvement in parents who are involved in group-oriented activities. What the various effects are that group-centered counseling and lecture-discussion approaches can have on parents of retarded children is a basic question yet to be systematically investigated. How do parents involved in a group compare on selected variables with non-involved parents? Are variables such as anxiety level, self-concept, and knowledge of mental retardation, which are characterized as being generally poor in parents of mentally retarded children, amenable to change due to participation in a parent group? Are parents who reject involvement in a group different in



some degree from parents who do choose to become involved? These are some of the critical questions which need to be researched if the use of group methods with parents of mentally retarded children are to have a valid theoretical base from which it can grow and progress.

#### Statement of the Problem

The problem with which this investigation was concerned was that of determining the relative effects of the lecture-discussion method and group-centered counseling on the self-concept, anxiety level, and knowledge of mental retardation of parents of moderately mentally retarded children.

#### Statement of the Purposes

The purpose of this study was to determine the effectiveness of the lecture-discussion method and group-centered counseling in modifying the self-concept, anxiety level, and knowledge of retardation of parents of moderately mentally retarded children. A further purpose of this study was to assess possible differences between parents of mentally retarded children who chose to participate in a group-oriented activity and those who had the opportunity to participate but did not.

### Hypotheses

The following hypotheses were tested:

1. The members of the group-centered counseling group will have significantly less mean change on the total anxiety score on the IPAT Anxiety Scale than either the lecture-discussion group, the standard control group, or the experimental control group.
2. The members of the experimental control group will have significantly higher pre- and post-test means for the total anxiety score on the IPAT Anxiety Scale than will either the lecture-discussion group, the group-centered counseling group, or the standard control group.
3. The members of the group-centered counseling group will have a significantly greater mean gain on the Self-Concept Scale of the Index of Adjustment and Values than will either the lecture-discussion group, the standard control group, or the experimental control group.
4. The members of the group-centered counseling group will have a significantly greater mean gain on the self-Acceptance Scale of the Index of Adjustment and Values than will either the lecture-discussion group, the standard control group, or the experimental control group.

5. The members of the group-centered counseling group will have a significantly greater mean gain on the Ideal-Self Scale of the Index of Adjustment and Values than will either the lecture-discussion group, the standard control group, or the experimental control group.

6. The members of the group-centered counseling group will have a significantly lower post-test mean score on the Discrepancy Scale (D) of the Index of Adjustment and Values than will either the lecture-discussion group, the standard control group, or the experimental control group.

7. The members of the lecture-discussion group will have a significantly greater mean gain in knowledge of mental retardation as measured by the Knowledge of Mental Retardation Test than will either members of the group-centered counseling group, the standard control group, or the experimental control group.

#### Background and Significance of the Study

Sternlicht (27, p. 331) writes, "it is generally acknowledged that the parents of a retarded individual need help in recognizing, accepting, and coping with the many problems inherent in their situation, and

that this help, when received, will reflect favorably on their child's development." This brief statement is one that essentially summarizes the rationale which underlies the use of group oriented activities with parents of retarded children. The statement emphasizes a feeling that most professionals in this area of research seem to share, that is, the need of parents of mentally retarded children for counseling due to the inevitable negative personal/psychological reaction they may suffer because of the existence of that child (16, 19, 20). Sternlicht's statement further points out that a therapeutic experience will result in a positive effect on the retarded child's development. This claim for the efficacy of group counseling with this particular population has not been subjected to any but the most minimal experimental procedures.

Probably the most provocative finding in this area of research is the almost unanimous endorsement given to the value of group oriented therapeutic procedures with parents of retarded children. One simply does not find negative comments regarding these procedures. There seems to be widespread, if sometimes unfounded, support for the value of group activities with these parents but there is still controversy over what can be considered the "best" type of therapy for these parents.

Sternlicht (27, p. 332) says, "the difficulties that arise appear to be primarily semantic ones, stemming from a lack of clarification of terms. For nowhere is there a clear definition of what is meant by therapy in working with parents of mentally retarded children." Wolfensberger (31) echoes this criticism, as well as others, and lists the many names under which group counseling with these parents is done.

Blatt (5) proposed the use of different groups with different parents. Those who were seen as possessing sufficient "ego-strength" could become involved in "therapy" while other parents participated in "discussion groups." To avoid confusion in definition Blatt proposed three groups:

I. Educational group counseling: to include those parents whose defenses are fragile and brittle. This group would study the techniques of child rearing and development.

II. Group counseling: to include those parents whose ego-strength is sufficiently strong to explore their attitudes and feelings as related to the child.

III. Group psychotherapy: to include those parents who indicate a desire to delve into their own emotions and feelings. This would only be incidentally related to the child.

Although these divisions and definitions have been theoretically supported by both Sternlicht (27), and Wolfensberger (31), to date no studies which have meaningfully compared these "types" or "levels" of

counseling have been made. In relation to the present study, educational group counseling appears to be analogous to the lecture-discussion groups and the group-centered counseling group could be defined as either Group Counseling or Group Psychotherapy, depending on the depth of the participant's psychic and emotional involvement in the group situation.

The need for different levels of group involvement has support from Sternlicht and Alston (28) who found that when therapy became "more intensive," several parents dropped out. These authors feel that, ideally, there would be at least two groups available to parents. Parents, whether or not psychologically capable of engaging in therapy, should be able to choose a less intensive situation such as might be afforded by the lecture-discussion type groups. As yet there is no objective data on the best therapy process for this particular population.

The most comprehensive reviews of the literature all seem to reach the same conclusions and have the same criticisms. In terms of the use of group procedures, Sternlicht's "review of the research on therapy with parents of retarded children indicates general agreement on the value of such a program," (27, p. 334). Ramsey (21, p. 86) claims that the studies, "testify

to the general value of such procedures and also support more extensive use of them in the future." The generally positive feelings that researchers in this field have toward this counseling approach was also described by Wolfensberger (31).

There are, however, some pertinent criticisms which are frequently heard. Of the criticisms leveled at studies of group counseling with parents of mentally retarded children, the most common charges concern the poor experimental designs, lack of controls, and inadequate objective measurements. Some of the failures of the studies in this field are noted by Ramsey (21) when he writes, "the greatest research need is to introduce more objective measures so that more quantitative types of data can be secured." He found that the few studies that used somewhat objective measurements used them only after group formation and only then were the data incidentally related to the therapy processes. Many investigators have also failed to utilize control groups or before and after measurements of selected variables on both experimental and control groups (21). According to Sternlicht (27, p. 335), "although objective measurement of the changes reported in the literature would seem to be essential, the fact is that few studies

report their use." He found only four studies that report any objective measurement of their findings. These are the same studies that Ramsey (21) refers to as the ones which met the criteria of objective measurement.

Although Sternlicht's criticism must be modified somewhat due to the recent appearance of some controlled, objectively measured studies (4, 14, 29), the general criticisms about poor design, control, and measurement which he shares with other reviewers of the literature are still largely valid. One of the conclusions that can be drawn from the quality of the studies in this area is that, "all the subjective professional reports of parental change in group counseling are suspect. Uncontrolled and unquantified group studies can no longer be considered adequate or acceptable research" (31, p. 369).

This statement emphasizes the need for controlled studies which are subject to some objective measurement. There is currently a definite need to attempt to find out what may be the "best" approach to counseling with parents of mentally retarded children. It is imperative that researchers in the area begin studies which attempt to compare different counseling approaches. It appears that most researchers and practitioners in the



field are using either the lecture-discussion approach or group-centered counseling and studies comparing these two methods are needed.

#### Definition of Terms

1. Anxiety is defined by Coleman (7, p. 657) as "a state of emotional tension characterized by apprehension and fearfulness." Rogers (23) says that when inner or outer experiences, such as information that is incongruent with the self-structure are denied admission to the realm of consciousness, conscious control becomes more difficult. If the individual senses the discrepancy in himself he becomes anxious and unsure of his direction and feels he is not united or integrated.

2. Group-centered counseling is counseling which involves more than five people in which "the goal is to maintain . . . a dependable atmosphere of acceptance and understanding" (15, p. 308). There is, basic to this definition of group-centered counseling, the belief that each person has the capacity to regulate his own self-awareness and growth. In this situation of unconditional acceptance the participants are free to guide and accept themselves, accept and support others, reveal themselves, test reality within the confines of the group, have mutual trust, and have the opportunity

for problem solving. In establishing this unique atmosphere, the group, and the counselor, assure that, "no person is forced into a group mold and leeway is provided for individual differences in manners of self expression" (15, p. 302).

Given the potential of each individual for constructive self-growth and the atmosphere in which that growth will occur, the counselor will facilitate the process by his acceptance, reflection, and clarification. He will not select material to be discussed nor will he dictate that the group take any particular direction. The group itself will dictate and is responsible for the direction it takes and the material it deals with.

3. Lecture-discussion classes: these are classes concerned with a pre-determined topic. The leader acts as a teacher in this didactic approach and actively directs the group. Discussions are restricted to the topic that is on the given agenda. The sessions are conducted by the teacher with a lecture on the scheduled topic, usually thirty to forty minutes in length, specific questions on the topic, which are directed to the leader, and a short discussion period lasting until time for the meetings to close. The general design of the lecture-discussion sessions for this study was taken from Bitter (4).

4. Moderately mentally retarded are defined as individuals whose measured Intelligence Quotient is in the 35-50 range. These individuals are also termed "trainable" or "semi-dependent." Moderately mentally retarded children are slow in learning to walk, have poor motor skills, minimal speech, and few communication skills. Though traditional academic skills are generally beyond their capacity, many have sufficient manual abilities to perform useful tasks around the home and contribute to their partial self-support through sheltered employment.

5. Self-concept is basically one's unique perceptions about his self. The self-concept is comprised of a constellation of attitudes and ideas that an individual holds about his own being. The self-concept includes "all perceptions the individual has differentiated of the self he calls I or Me" (26, p. 124).

#### Limitations of the Study

The subjects included in this study were ninety-six parents who had moderately retarded children who were not institutionalized but were attending either Angels Inc., Loving Care School, or the Mesquite Developmental Center at the time of the study. The study was further

limited by accepting only those people as members of an experimental or control group who had responded to a request that they join a parent group.

#### Assumptions of the Study

The following assumptions were made in this study:

1. The instruments used were sufficiently valid and were suitable for measuring the variables investigated in this study.
2. The randomization procedure was adequate for the statistical procedures used.
3. The group facilitator and the lecture-discussion leader performed with equal proficiency in their roles in this study.

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## CHAPTER II

### REVIEW OF THE LITERATURE

#### Introduction

The field of counseling with parents of the retarded is one that has shown tremendous growth over the past two decades and it is of no small significance that only a few studies have been of an experimental nature (45, 49). Ryckman and Henderson (41) emphasize that much of the literature in this area has been comprised of professionals' opinions and that few attempts have been made to conduct research experiments or to develop theoretical conceptualizations about these problems. Wolfensberger, in support of this observation, says that while hundreds of publications have dealt with the problem, the vast majority of these only report personal experience, opinion, or speculation and that, "despite the many testable hypotheses that have been advanced or that can be derived from these publications, only a small number of experimental studies have been conducted" (49, p. 329).

There also seems to be much confusion and contradiction in terms of the definitions about group methods



with parents of mentally retarded children. One study, for example, listed some eight different terms under which parental group counseling was conducted (17). Pointedly absent, though, were definitions of the group process in the studies of counseling with parents of mentally retarded children. "Few in the field of group counseling agree on definitions, rationalizations or structures of the groups" (49, p. 365). One definition is contained in Beck's pamphlet, The Closed, Short-term Group (5). She says that the "treatment group is developed for the relief of a problem situation" and that "treatment goals need to be clearly defined and should be understood by the group members" (5, p. 1). In reviewing some general considerations, Beck points out that "the specific value of group treatment lies in the particular changes that occur in relationships among group members and between group members. There is opportunity for mutual support and mutual stimulation" (5, p. 1).

Cummings and Stark (14) do, however, offer the rationalization that the use of group techniques "is likely to grow, stimulated by the greater acceptance of the total-family approach to problems of handicapped children, by the appropriateness of a group

approach for parents whose problems derive from a common source, as well as from the greater availability of trained group therapists" (14, p. 739).

Wolfensberger (49) has noted that while group counseling advocates originally saw the value of this approach in terms of economy, they now agree that due to the relationships which can exist within the group, a unique contribution is being made. Many writers propose that parent's attitudes toward retardation are, partially, the result of community and, thus, group pressure. The World Health Organization reports (50, p. 31) that since these negative attitudes are socially determined, "association with other parents may be of more benefit than individual guidance or psychotherapy from professionals." An additional value of group-oriented activities with parents of mentally retarded children seen by Goodman (21) is that involvement with others tends to counteract these parents' tendency to cut themselves off from conventional life.

#### Parental Attitudes

Reports in the literature have substantially indicated that there is widespread acceptance of the fact that parents of a mentally retarded child suffer some sort of negative emotional reaction to the birth and

existence of that child.

Wolfensberger (49, p. 330) lists some forty-five different reactions to the mentally retarded children described in the literature. Among them are anger, anxiety, depression, grief, and pain. Although many parents exhibit some of these characteristics it is beginning to be recognized that a diversity of reactions may be present in the parental situations. Parents may, at the same time, be "depressed about their disappointment, guilty about their responsibility and ambivalence, angry about the narcissistic injury done to them, and anxious about the child's future" (15, p. 525).

There are a number of studies which define and delineate some of these parental reactions. The most common finding in studies concerned with this topic is that parents of mentally retarded children feel guilty (15, 42, 49). It seems that, whatever the reason for the retardation, a parent will often identify with some occurrence or attitude related to the child and feel guilty for that. This seems to be, basically, an attempt at self-blame and the puzzlement parents experience when confronted by a retarded offspring only adds to the difficulties. Guilt is sometimes based on reality, such as when retardation is a result of an avoidable accident, or an abortion attempt, or drug taking (51).

This common feeling of guilt is based on largely unrealistic ideas such as retardation being God's punishment (29) or because of pre- or extra-marital sex episodes (8). Guilt is probably the most common reaction of parents of mentally retarded children. There are, however, a few writers who feel that this widespread finding of guilt may be somewhat artificial. Roith (39, p. 51) says that no matter what a parent does, some professional is apt to attribute it to guilt and McDonald (31) explains that, at the history-taking, questioning may lead to a feeling of parental guilt which would be a situational guilt that might be mistaken for a more basic type.

In studying parents of mentally retarded children in an educational clinic and using the frustration-aggression model, Grebler (24) concluded that there are three types of parents, each exhibiting a different mode of acceptance: the extra-punitive parent who rejects the child, the impunitive one who accepts the child, and the intro-punitive ones who are ambivalent. Peck and Stephens (35), in a later study, found frustration as well as disappointment to be two primary reactions. Zuk (53) also noted three primary parental reactions: disappointment, anger, and guilt. He hypothesized that one of the causes of guilt is denial

and inward turning of anger and that the parental search for the cause of the retardation is an attempt to shift anger and guilt.

Currently, there is growing interest in the theory that grief and mourning are typical psychological reactions to the birth and existence of the mentally retarded child. Roos (40) postulated that the presence of these feelings of depression are so typical that their absence may be pathological. Olshansky (33) advances a version of the idea of grief as a reaction when he says most parents of mentally retarded children suffer from a psychological reaction which is sorrow. He writes, "all the parental reactions reported in the literature, such as guilt, shame, and anger may well be intertwined with chronic sorrow" (33, p. 193).

One of the most widely accepted ideas about types of parental reactions is that of Kanner (27). He states that the parent may either accept, deny, or reject the child's mental retardation. The accepting parent has a reaction that is constructive and aids both child and parents in forming healthy attitudes. Such a parent eventually comes to accept the child and love him as he is. This parent harbors no illusions about the child's abilities or lack of abilities. In achieving acceptance

of the child, this parent must be aware of the nature of his own emotional relationship with the child. The rejecting parent disguises the situation. Not only does he attempt to hide or disguise the condition from other people, but more important, he hides it from himself. Such parents often realize that something is wrong but they attribute the condition to such things as "bad tonsils," "laziness," or "poor teachers."

A severe emotional reaction to the stress situation resulting from the mental retardation of the child is shown by the type of parent who feels the need to deny, both to others and to himself, the reality of the child's disabilities. In effect this parent says, "What I refuse to see does not exist." Some of the characteristic personality reactions of the maladjusted parents are given by Kanner (27). They may have distorted perceptions of the child and judge him on an unrealistic basis. These parents may reject the child in an emotional sense. While the rejecting parent may verbalize love and concern he may in reality not have these feelings. These reactions may often be guilt responses as the parents often feel that the retardation is in some way their fault.

Some objective evidence which supports the claims made for negative parental reactions comes from Graliker,

Parmalee, and Koch (23). They interviewed sixty-seven families who had come to a mental retardation center and found that 48 percent of the parents showed guilt, shame, embarrassment, and frank rejection as a result of the diagnosis. A full 30 percent worried about the reactions of friends, relatives, and other children. Additionally, a recent, well controlled study by Harris and Schechtman (25) gives further objective support to the hypothesis that virtually all parents of mentally retarded children suffer from some sort of personal/psychological response due to the existence of the handicapped child. They found that parents of retardates at a day care center had a very high number of atypical deviant MMPI profiles. Of 111 parents, only 5 percent deviated by at least two or more standard deviations on at least one scale.

An understanding of parental dynamics offers some interesting contributions to the understanding of parents of handicapped children. Although most of the studies are based on experience or impression, there have been a sufficient number of objective experiments conducted which support clinical observations and lend some strength to the tentative finding that, "parental attitudes may vary to some degree with type of handicap, but that some handicap groups may share certain

dynamics" (49, p. 342).

Coughlin (13), in an early study, implied that parental feelings toward handicapped children are like those feelings held for other children except that the condition elicits feelings that otherwise might be more repressed. Cohen (9), in a more recent study has supported this finding. Klebanoff (28) used the P.A.R.I. (Parent Attitude Research Instrument) with mothers of schizophrenic, normal, and brain-injured or retarded children. He found that mothers of brain-injured or schizophrenic children were most possessive but, surprisingly, mothers of brain-injured or retarded children showed more pathological attitudes than did the other groups. Cook (12) used the P.A.R.I. with mothers of blind, deaf, mongoloid, and cerebral palsied or "organic" children and he found mothers of mongoloids and cerebral palsied children tend to be punitive, those of the deaf overindulgent, and those of the blind overprotective. Mothers of mongoloid, cerebral palsied and blind children were authoritarian in their child-rearing attitudes. Fredrick (19) administered attitude scales to socio-economically matched groups of mothers of orthopedically handicapped, retarded, and normal children. She found no difference between mothers of orthopedic and normal children, but mothers of the retarded were significantly



high on scales which indicate a repressive and domineering element in their attitudes toward the child.

A number of experimental studies have been published which used the Thurston Sentence Completion Form (T.S.C.F.) (46) to measure and assess the attitudes and emotional reactions of parents of mentally retarded children. This instrument was used by Thurston (46) in a study of six hundred parents of mentally retarded children involved in group counseling. He found that, "In general, the parents were highly sensitive, suspicious, anxious, and unhappy individuals" (46, p. 353). He also concluded that virtually all the parents experienced emotional upset and anxiety which stemmed from the existence of the handicapped child and that the resulting attitude was not a constructive one.

Condell (11) used the T.S.C.F. with sixty-seven parents of mentally retarded children in a rural setting and found that attitudes were not uniform. The study, which also assessed parents' attitudes toward the local program for their retarded children, revealed that while parental attitudes were sometimes poor in relation to the child the parental reactions toward programs for the retarded were even poorer. Appel, Williams, and Fishell (2) used the T.S.C.F. to assess attitudes in twenty-one mothers of retarded children who were involved in group meetings at a day care center. Prior

to counseling these mothers were confused about the diagnosis of mental retardation, did not feel free to talk about mental retardation, saw other people as pitying, and were somewhat pessimistic. On the basis of these studies there does seem to be some controlled evidence that parents of mentally retarded children have somewhat negative attitudes toward themselves, the world, and their handicapped children.

In reviewing the literature one is not only impressed with the seeming agreement among findings related to parental attitudes, but it is clear that the great majority of the studies are based on a population of mothers only. The few studies that have included fathers have noted specific sex differences in attitudes. Anderson (1) decided that fathers accept the diagnosis of retardation more readily and take more initiative in describing details of the child's behavior than do mothers. Similarly, Hersh (26) described fathers as more remote and objective, and less involved and expressive. Fathers were characterized as less accepting of the diagnosis of mental retardation, but Yates and Lederer (52) found them to be more intellectualized and less personal than mothers. After a review of the studies, Wolfensberger concluded that "The evidence on

differences between fathers' and mothers' attitudes is inconclusive. The more complex studies seem to indicate that parental sex differences, if demonstrated, would be rather meaningless" (49, p. 342).

This portion of the review of the literature which has dealt with the attitudes and feelings of the parents of mentally retarded children has established the fact that the populations with whom the present experiment dealt are, indeed, involved in a situation where psychological help might be needed and beneficial. A result of approaches such as those proposed have previously been reported to have engendered change in a positive direction.

#### Lecture-Discussion Groups

From a review of the literature on various forms of group work with parents of mentally retarded children, it appears that the structure of a group often varies with its function. The type of group organized ranges from those in which the primary interest is in feelings (14) to those in which lesson plans and a schedule of topics are drawn up and facts rather than feelings are emphasized (6). Gollar (20, p. 8) warns that even when the parent group is designed primarily for the sharing of facts, "the nature and purpose of the group

inevitably leads, though, to emotional involvement." About half the studies reviewed, however, attempted to combine both formal presentation and informal discussion in their structure.

The purpose of the more formal and organized type of program was to give parents facts about the child's care and training, sources of help, causes of retardation, educational procedures etc. The primary role of the parents in these lecture-discussion groups was to listen and be informed. This group orientation is the type defined by Blatt as "educational group counseling" which is, "to include those parents whose defenses are fragile and bitter. This group would have as its core matter the techniques of child-rearing and development" (7, p. 136). The lecture-discussion group "is primarily educational and didactic" (49, p. 364). Parents are taught about such subjects as mental retardation, research, home management, and discipline. While the discussion of parents' personal feelings and attitudes are sometimes brought into the discussion, they are sometimes considered unnecessary, and often undesirable.

Perhaps the basic psychological rationale underlying the use of lecture-discussion type groups is

the idea that because so much confusion and ignorance abounds where retarded children and their needs are concerned, knowledge and facts can help parents adjust to the particular difficulties they face. It is probable that most investigators who have used the lecture-discussion approach would admit that group interaction must play some part in shaping the results of these experiments, but this approach does minimize interaction. This rationale is supported by the results from a number of studies (6, 10, 25).

The findings from investigations using the lecture-discussion approach also reveal that parents tend to have different perceptions of the benefits of counseling than the workers do. The authors found that while the professionals prefer to "give" them therapy, the parent's desire is more in terms of child management and facts about retardation. "Adhering rigidly to a feeling-oriented therapy is absurd when a parent is overwhelmed by . . . situational demands" (49, p. 365).

Bitter (6) formulated a lecture-discussion format in his experiment which was designed to alter parents' attitudes. The study was undertaken to determine the effectiveness of parent group discussion sessions in terms of their attitudes toward their retarded children

and related family problems. Bitter hypothesized that positive attitude change would result due to involvement in the discussions and that parents attending most meetings would have greater positive changes in attitude than parents not attending meetings. Four instruments were used to assess possible changes. These were the Parent Attitude Research Instrument, a semantic differential, the Child Character Trait Questionnaire, and a true-false knowledge of mental retardation test. Seven, two hour sessions were held once a month and were conducted by classroom teachers. The classes were on special education, speech and language development, vocational potential, and home and family relationships. The author concluded that the sessions were effective in changing the parental attitudes to more positive ones toward the child and toward the family problems occasioned by the retardation.

Reviewers (49) of Bitter's research noted, however, that there were some procedural errors which rendered the results obtained inconclusive. On the true-false test, parents made more errors after counseling than before, and the Child Trait Questionnaire was, for some reason, unscorable. On the P.A.R.I., democratic attitudes were found to be significantly more positive after group attendance. A primary value of this study,

other than being one of the few attempts to construct a qualified experiment, was that the lesson plans and areas of concern Bitter emphasized in the experiment were the model for the lecture-discussion class used in the present study.

Longer term lecture-discussion groups were formed by Sternlicht (44) in order to better acquaint parents with their children's special adjustment problems. Attendance was voluntary at these semi-monthly, two-hour parent group meetings and techniques which parents could use in helping their children were stressed. Although Sternlicht's model of the lecture-discussion approach did not use any formal, objective measures of what effect involvement in the group had on the parents, a questionnaire to assess parent's satisfaction with the process indicated that "The majority (59 percent) of the parents who completed the questionnaire were completely satisfied with the sessions as they were held" (44).

According to Coleman (10) the need for the group therapy movement with parents grew out of (1) need for better home and school coordination, (2) demand of parents for counseling, and (3) common problems of the parents. In Coleman's study, no attempt was made to select particular participants and the only acceptance

criteria were (1) to have a retarded child and (2) a positive response to a postcard which told about the sessions. No control groups were used. About thirty (of a possible ninety) parents attended, and the attendance figure varied between twenty and thirty-five throughout the study. Meetings were held twice each month for six months. Each meeting lasted approximately one and one-fourth hours. Chairs were arranged in a semi-circle around the speaker's lectern.

In the meetings, emphasis was placed on the coordination of home and school activities. Each meeting was initiated by a thirty-minute talk by a local authority or parents were shown a relevant film. The question-and-answer and discussion period which followed the presentation was presided over by the group leader.

The major problems brought out by parents were (1) acceptance of themselves as parents without feeling guilty or devaluated, (2) acceptance of their mentally deficient child, (3) adjusting parental level of aspiration, (4) avoiding pampering the child, (5) problems with normal siblings, (6) sexual problems of the moderately retarded child, (7) concern over institutionalization, (8) providing for the child's future, (9) home training, and (10) things parents can do to help the school.



Coleman noted that the process in these groups was strikingly similar to the processes that occur in regular group therapy. He also commented on the lack of objectivity and control in the study. Coleman's study has been used as a model for many research projects in the area of parental counseling groups. This is especially true of the organizational factors, and the problems outlined by Coleman are those that have been commonly reported by other authors.

Another early and important experiment was Shapiro's (43) which was designed to measure the effects of a series of group discussion meetings upon the child-rearing attitudes of the twenty-five parents who participated. While the people who participated in this study were not parents of mentally retarded children, this experiment served to establish lecture-discussion methodology and an approach to objective measurement.

Sternlicht (45, p. 374) reported on an experiment designed to measure the effects of a series of group discussion meetings upon child-rearing attitudes of twenty-five parents of mentally retarded children. Prior to group selection, participants were given a 115 item questionnaire which explored their attitudes toward children, their child handling practices, and their reaction to varying situations.

The findings of the experiment showed that the participants in the experimental groups modified their child-rearing attitudes in the predicted direction to a statistically significant degree. Those attending at least four meetings showed the greatest change, leading to the conclusion that the time interval is a determinant in effecting change. The results led the author to conclude that exposure to a group discussion technique will modify parental child-rearing attitudes in a predetermined direction and that this modification is positively related to the amount of exposure to the group discussion.

Lecture-discussion groups have, additionally, been conducted by Babitz (3), Daniels (16), Popp, Ingram, and Jordan (36), and Wolfensberger (49). One of the most consistent findings from the literature on the lecture-discussion group is that this orientation seems to be able to modify parents' attitudes and increase their factual knowledge about retardation. Harris and Schechtman (25) report that their lecture group reported gains in the area of facts and that the participating parents were very satisfied with this approach. Reviews of this field of inquiry (37, 45, 49) tend to support the finding that the primary value

in lecture-discussion groups is the indication "that the sessions were effective in changing the parental attitudes to more positive ones toward the child and toward the family problems occasioned by the retardation" (6, p. 8).

In summary, it appears that authors and reviewers dealing with experiments using the lecture-discussion approach are united in their finding that this approach does modify some parental attitudes. In addition, parents seem to gain in factual knowledge and child-rearing practices.

#### Group-Centered Group Counseling

The informal and feeling-centered group represents an orientation opposite to that used by lecture-discussion groups, but, like the lecture-discussion research, most group-centered counseling with parents of mentally retarded children has been characterized by poor methodology and a lack of objective measurement (37, 45, 49).

A description of the group-centered counseling group is given by Cummings and Stock who state, ". . . the group sessions would consist of open, unstructured discussions intended to provide opportunities for exploration and increased understanding of each

member's feelings about herself and her child, her relatives and neighbors" (14, p. 740). Among the studies of unstructured groups involving counseling and psychotherapy, the subjective report given by Blatt is representative. His findings, based on his group therapy experiences with parents of severely retarded children, were that "through catharsis, facing each other, identification of feelings of other group members, support from group members and from the therapist, they are able to derive maximum benefits" (7, p. 138). Working with parents of mentally retarded children in a group counseling setting led Weingold and Hormuth to conclude that "our work with parents of the mentally retarded has definitely established the value of the group guidance for parents of the mentally retarded children as one of the most effective tools to bring about more adequate adjustment of the family to such a child, as well as reintegrating the family into the community" (47, p. 123).

In addition to the Cummings and Stock and Blatt studies, the studies of Appell, Williams and Fishell (2), Rankin (38), and Yates and Lederer (52) also fall into the group-centered counseling category. In their study, Appell, Williams and Fishell (2) made one of the most significant contributions in terms of objective

measurement. Their investigation included twenty-one mothers of retarded children who were enrolled in a day care center. The mothers were divided into two groups, each of which met for approximately sixty sessions over a period of two years. A modified form of the Thurston Sentence Completion Form (T.S.C.F.) was administered before the sessions began and again at their conclusion. The results showed that the T.S.C.F., as a reliable and valid measure of parents' attitudes, reflected the cathartic value of the sessions and revealed that parents were better able to accept the diagnosis of mental retardation after counseling. Additionally, the authors found that their data supported the hypotheses that parents would see the world as more sympathetic after counseling, and that the sessions would help parents shift from short to long range goals and to be more optimistic about their child's future.

A study which provided one of the most complete descriptions of the methodology of group-centered counseling was that of Yates and Lederer (52). In their report a series of three evening sessions was planned with each of three groups, meeting at monthly intervals, so that both parents could attend. In the course of a year ten meetings were held. A total of sixteen

parents participated, all of whom had had their children evaluated in the clinic and had received interpretation. The children represented ranged in age from one year to four years.

The evaluation procedures used in this case were subjective and findings were couched in terms of group dynamics and reports of parents' feelings. The authors concluded that "Small short-term, undirected group sessions, spread over a three-month period, with both parents attending were quite helpful and useful. This approach would seem to work best with persons who have some ability to put their feelings into words" (52; p. 471).

Rankin (38) had a therapy program consisting of weekly hour-and-a-half sessions which extended for a total of twenty-one sessions over a six month period. Of the eleven mothers who attended the first session, five dropped out after the first two meetings. During the ninth session, five new members joined the group which raised the group membership to its original number of eleven mothers. As in the Yates and Lederer article (52), group dynamics was the focus of Rankin's study and he described the group changes from session to session. The unique value of this report was that it described the dynamics in psychoanalytic terms. Rankin

structured the sessions and indicated to the participants that the group was meeting for mutual exploration of feelings of people faced with the common problem of having a mentally retarded child. Although group resistance to investigation was observed in every session, the author stated that the results from the group-therapy experience justify including this service as a regular part of programs offered to parents of mentally retarded children.

In a project of short-term groups of approximately eleven sessions, groups of five to seven mothers were used to assess the effects of group therapy on certain relevant attitudes (14). The authors, Cummings and Stock, used a battery of self-administered tests which contained three objective and two projective tests. They used "a child-rearing attitudes scale, a modification by Drews and Teahean of the Shoben Inventory, a general personality inventory, the Edwards Personal Preference Schedule, a 'Family Drawing' task, and a sentence completion test constructed and designed to tap specific attitudes about the retarded child" (14, p. 475). The authors concluded that "experiences thus far have led us to a more realistic awareness of what can be achieved by short-term group therapy in alleviating the psychological stress load of mothers of retarded

children" (14, p. 747). The objective data gathered from this study indicated that group involvement provided ventilation for participants, allowed the sharing of practical advice, and let members give reassurance to one another. The involvement in the group also enabled members of the groups to have a more appropriate recognition of reality. It appears that, like proponents of the lecture-discussion approach, experimenters who support the group-centered counseling approach have substantiated claims for the positive effects of this orientation.

#### Didactic and Therapy Group Approach

There is a third type of group organization which is a combination of the unstructured and informal and the structured and formal. In these groups, the goals are both the presentation of facts by experts and some controlled participation by parents. The latter aspect is attained by providing the parents with a question-and-answer period following a lecture or film, or allowing them some limited expression of attitudes through directed group discussions. White states, "Our groups are a compromise between the predominantly affective experience of group therapy and the intellectual experience of educational lectures" (48, p. 713).



Based on the finding that parents responded better and with less resistance to group work, Goodman and Rothman (21) developed a didactic and therapy-oriented group counseling program for mothers of mentally retarded children in a clinic setting. They worked with two groups of mothers, one of which despaired of ever being good mothers and had no idea of what to give the child and what to receive from it. The other group could not intellectually understand the concept and meaning of retardation. As a result of their experience, the authors stated "that the group counseling method can be constructively utilized at almost any time in the life experience of parents of mentally retarded children" (21, p. 789).

A further possibility inherent in group processes is that a number of people may profit by jointly learning more about their problems. Popp, Ingram, and Jordan (36) devised a curriculum for parent education with the following specific subjects: (1) the causes and effects of mental retardation, (2) how the child feels, (3) family and neighborhood relations, (4) a trip to a state school, (5) parent's commitment, and (6) community's commitment to child's needs. "A series of classes such as this communicates facts. It also does something more, it brings people with common problems together in

such a fashion that a sense of mutual sympathy and support is engendered, while people are ostensibly pursuing the problems at an emotionally neutral level" (36, p. 534).

White (48) held weekly time-limited, content-structured sessions with groups limited to ten parents. Pre-selected topics were used and the basic group goal was to help essentially normal people gain added understanding about being parents of retarded children. Additionally, Nadal used methodology similar to that of White and reported that ". . . on the basis of clinical and rater's judgment, it can be said that genuine improvement was made in such areas as attitudes toward the child, child-rearing practices, ability to handle the child, and the general level of the mother's communication of her concern and problems" (32, p. 82).

#### Group Variables

There are a number of important variables related to all the types of group orientations to counseling with parents of mentally retarded children. Among these variables are group size, number of meetings, recruitment, and counselor qualifications. While this list of variables is certainly not all-inclusive, each of these was particularly relevant to the present project being undertaken.

Various reviews of reported studies with parents of mentally retarded children have revealed that group size and orientation were usually linked. The number of members in groups ranged from a low of three to thirty-six, with one as high as sixty, the median being ten (2, 37, 49). Groups having over ten participants were generally those which were formal and organized, the lecture-discussion types. These larger groups were primarily designed as education information meetings in which the parents' role was primarily that of a listener. On the other hand, smaller groups (with less than ten) were largely informal and unstructured and were primarily counseling and therapeutic type sessions in which parent participation and discussion was encouraged (37).

The number of meetings also varied with the nature of the group, although not to as great an extent as number of participants. The median number of sessions was ten. The groups meeting for a longer period of time were seen as more therapeutic (37). While there are exceptions (52), the group tends to meet over long periods, even years, but sometimes only once or twice a month (6). The rationale for the limited short-term concept was forwarded by Beck (5) and was followed by

almost every other writer who had groups that met for a similar number of times. Using this limited short-term concept, groups were reported to meet approximately six to twelve times (49).

In terms of recruitment the selection criteria were extremely vague. Ramsey (37, p. 858) reports, "Generally, the groups were composed of mothers or parents of: a mentally retarded child, a trainable retarded child, a child on the clinic waiting list, a child diagnosed as mongoloid, and so on." Rarely were the terms defined.

Parents were recruited in several ways. Parents were often referred by a physician or clinic staff who was treating the retardate. In one project, parents were required to attend as one of the conditions set for admission of their handicapped child to the treatment program. Another group was easily organized by writing letters of invitation asking parents to join (10, 37).

Additionally, parents who were eligible to participate in any of the projects but who chose not to were briefly mentioned in only one study (14). It is possible that parents who are eligible to participate in counseling or parent groups and who reject the opportunity are different in some significant ways than parents who want to participate and who are used as controls.

It seems particularly important that the leader in any of the types of groups used with parents of mentally retarded children be not only qualified to deal with groups but be knowledgeable about mental retardation and the unique problems involved in being a parent of such a handicapped child. Wolfensberger states that "a professional must be very conscious of the fact that his intervention may have the profoundest effect, perhaps for their lifetime, not only on clients but also their entire family group" (49, p. 354).

Ramsey (37) points out that most groups used one person as a leader and that the leaders were from a number of professions. Psychologists were most often leaders, followed by social workers, physicians, psychiatric nurses and, once, a special-education teacher. The more therapeutic type groups usually utilized psychologists while lecture-discussion type groups more often used other types of professionals. However, Ramsey found that "most of the studies gave little or no information regarding the special qualifications, if any, of the leader's training, experience and skill in directing such a group" (37, p. 859).

While training and knowledge of mental retardation may be important, Wolfensberger suggests "that a counselor's professional affiliation is irrelevant.

Possession of a medical or any other degree neither qualifies nor disqualifies a person from counseling and managing parents" (49, p. 355). Instead, he cites criteria such as experience in group work, possession of positive attitudes toward retardation, and patience as examples of those which an effective counselor should have when dealing with parents of mentally retarded children.

This brief overview of some of the variables involved in group work with the parents of retarded children has indicated that in very few instances have these variables been held constant from one experiment to another so that meaningful comparison can be made.

Although there have been many articles dealing with counseling parents of mentally retarded children, both Wolfensberger (49) and Sternlicht (45) agreed that there were only a minimum number of studies done which could be considered experimentally adequate. Wolfensberger claims that he "could only find four studies that subjected the group counseling process to satisfactorily quantified experimentations; two of these were uncontrolled and another statistically inadequate" (49, p. 367). These studies were those of Harris and Schechtman (25), Fleigler and Hebel (18), Bitter (6), and Wolfensberger for the Institute for Retarded

Children of the Shield of David (49). Sternlicht's four acceptable studies inducted those of "Appell et al., Bitter, Sternlicht and Alston, and Thurston" (2, 6, 44, 46). Both the Appell and Bitter studies have been dealt with earlier in this review, and the Sternlicht and Alston, Thurston, and Wolfensberger studies are concerned with pre- to post-test data on one type of group orientation only. Two of the experiments which seem especially pertinent to this review are those of Harris and Schechtman and Fliegeler and Heveler which used instruments and methodology similar to the present experiment.

Harris and Schechtman (25) assigned parents of children in a day care center randomly to three treatment groups: a didactic lecture series, a group discussion with a group worker, and informal interaction with a day care director. The treatments were administered in ten "doses" over twenty weeks. A group of parents on the waiting list served as controls, and the three treatments were replicated at a second day care center. The following measures were obtained at the beginning and the end of the experiment: (1) a mental retardation knowledge and information test, (2) a number of attitude tests toward children and child-rearing, (3) an interview in five attitude areas, and (4) observation

of mother-child interaction in an experimental situation. No gains were noted in any group on any measure, nor any differences between any groups. Further, all groups expressed satisfaction with the treatments they received. The parents in the lecture group were very satisfied, those in the informal contact group were somewhat less satisfied, and those in the discussion group were the least satisfied. The most satisfied of all, however, were the controls. Also, the parents in the lecture group reported that their greatest gain was in the area of facts, while those in the discussion group reported largest gains in the realm of feelings and attitudes.

The authors offered a number of explanations as to why the experiments' results were so confusing and some of these were: poor attendance, quality of presentations made, the skill of the personnel making the presentations, and the psychological disturbance of participants. In this case the results did not lead to any viable conclusions but an experimental design and procedure were used which proved to be pertinent in comparing various group-oriented approaches.

In a study reviewed by Wolfensberger (49), Fliegeler and Hebler (18) investigated four types of group counseling structures upon the attitudes and adjustments of parents of mentally retarded children.



In their experimental design, one group of parents received all their counseling in one massive dose over a weekend, in another group it was spread over six months. Two other groups received intermediate-type treatment while controls received no counseling but were pre- and post-tested on the same instruments as were experimental groups. Wolfensberger says of this study, "Unfortunately, the results of this rather massive experimental study are virtually uninterpretable" (49, p. 368). He felt that this was so for reasons such as using the incorrect statistical analysis and poor subject selection. The actual design had a great deal of merit and some of the results which were found were rather provocative.

Fliegeler and Hebelier felt that the most noteworthy conclusion they found was that parents of normal children evidenced more positive attitudes toward retarded children than did the parents of the retarded children. This implies, to these authors, that these parents may be in so much conflict over their retarded children that they are often incapable of a stable set of attitudes and facts toward retardation (18).

These experiments demonstrate that, despite good experimental design, often such factors as population selection, instruments, and statistical choice disrupt the outcomes. However, both the Harris and Schechtman (25)

and the Fliegeler and Hebelers (18) studies were constructed well enough so that their provocative findings raised legitimate questions which the present experiment hopes to partially answer.

#### Summary

Reviews of research on group oriented counseling with parents of mentally retarded children have repeatedly pointed out that the research conducted has been generally deficient in experimental design and measurement. The basic weaknesses of poor criterion measures, lack of comparability of groups, and lack of controls are only recently beginning to be changed. One of the most pervasive problems is the continuing publication of, and interest in, subjective reports which lack controls and an objective basis for evaluation (37, 49). The lack of information on the variables of parent attitudes, therapist's training, type of group approach used, subject matter covered, and the size of the group add to the inability of researchers to extract the essentials from the data obtained.

There has not been a commonly agreed upon definition of any of the various group oriented procedures used with these parents (49). However, a large number of the research studies in this area reported "success"

with group procedures in terms of altering the attitudes of parents toward their retarded children and toward retardation itself (45). Perhaps the best and most clearly defined potential value of parent's involvement in groups of some sort is advanced by Sternlicht (45). He contends that, since retardates are dependent upon others, parents most often, it would be most beneficial to their physical and emotional growth if those caring for the retarded child possessed positive attitudes toward the child and his handicap in addition to holding similarly positive attitudes toward themselves.

Essentially, there have been three types of group methods used in the research with parents of retarded children. One of these types is the formal and organized type of program which focuses on "training" the parents. These lecture-discussion classes typically meet in a classroom setting with a designated leader teaching parents certain preselected topics. Another type, representing the opposite orientation, is the informal and unstructured type of program which is designed to deal with the parents' emotions and feelings about themselves and their retarded children. Many authors see this as group psychotherapy. A third type combines the group-centered counseling and lecture-discussion

orientations in an approach which has controlled participation by parents as well as the didactic presentation of material by designated leaders.

The question of whether or not any of these approaches can or do modify parental attitudes, adjustment, or knowledge is one that can not yet be positively answered in objective terms. There does, however, seem to be ample evidence that parents of retarded children possess negative attitudes about themselves and their children which indicate that they are in need of some assistance in modifying these attitudes.

There is a wealth of material both objective and subjective which describes the attitudes of the parents of mentally retarded children and almost without exception these parents are characterized as possessing rather negative attitudes toward themselves, their retarded child, and the world in which they live. It has further been shown, with some substantiation, that these parents are similar in attitude to people without retarded children--prior to the birth of the handicapped child and the existence of that child is sufficient to cause negative feelings in these parents. It is felt by researchers that these attitudes are typically of such magnitude as to cause these parents to need counseling.

Many writers in this field not only agree on the universality of parents' negative reactions to their situation but they feel that group-oriented counseling procedures are most beneficial in assisting these people. Wolfensberger (49) points out that formerly one of the primary considerations for the use of group procedures was one of economy but that the unique benefits from group interactions and sharing make the group contribution a unique one.

There is, however, little objective, controlled research on which proponents of the value of group oriented activities base their claims. Ramsey (37) reviewed fifteen studies and of these only five begin to meet the criteria for a well designed experimental study. Even these few were found, however, to have equivocal results, and the studies "cannot be satisfactorily repeated by others because of inadequate research design or description in certain parts of each study. Therefore, most of the findings reported cannot be checked by independent investigators" (37, p. 863). Reviewers generally agree that the development of objective instruments which are both reliable and valid for use with parents involved in group activities is a pressing need. Additionally, the failure of many researchers to utilize control groups renders many of

their otherwise positive results uninterpretable.

There are currently many questions left unanswered in this area of interest, and there are no commonly agreed on principles or foundations as yet in dealing with the parents of mentally retarded children. Recently, however, there does seem to be a growing agreement that different levels or types of counseling for different "types" of parents may be a fruitful avenue of explorations. This definition, advanced by Blatt (7), has been supported by both Sternlicht (45) and Wolfensberger (49). Discovering what changes can be attributed to any of the various group approaches and defining more clearly what is needed in the groups to engender these changes is the challenge that rigorous experimentation must answer to insure that group oriented approaches with parents of mentally retarded children become an integral part of programs concerned with the welfare of mentally retarded children.

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## CHAPTER III

### METHODS AND PROCEDURES

The purpose of this chapter is to describe the type of schools the participant's children attended, the children themselves, the parent's socio-economic level, the school's counselors, the design of the study and the instruments selected for use in this study. The procedures used in collecting and treating the data will also be discussed.

#### . The Schools

The three schools participating in the study were Angels Inc., Loving Care School, and the Mesquite Developmental Center. All three schools are for the training and education of mentally retarded children. At the time of the study fifty-eight moderately mentally retarded children were enrolled in Angels Inc. which is supported by the Dallas County United Fund and the Dallas County Mental Health/Mental Retardation funds. Loving Care School had twenty-seven students registered at the time of the study, and was being supported by tuition and donations while the study was in progress.

The Mesquite Developmental Center, a Dallas County Mental Health/Mental Retardation Office direct service for the training and education of mentally retarded children, had eighteen moderately mentally retarded children enrolled at the time of the study.

These three particular schools were chosen because they are geographically close together, all being, located in the eastern sector of Dallas County. All three schools had, in a sense, somewhat the same leadership in that the Directress of Angels Inc. was also a founder and on the Board of Directors of Loving Care School. Additionally, the Directress of Angels Inc. assisted the County in setting up the Mesquite Developmental Center program and the staff of Angels Inc. worked closely with the other two schools on problems and programs common to them all.

#### The Student Population

There were 103 eligible mentally retarded children registered in the three schools at the beginning of the project in the spring term of 1970 and all were classified as moderately mentally retarded. Thirty of these children exhibited Down's Syndrome, thirty-seven were primarily brain-injured, twenty-two were cerebral-palsied, with associated mental retardation, and the remaining

fourteen were either undiagnosed or had an indefinite diagnosis. The chronological ages of the children ranged from a low of twenty-three months to the upper limit of sixteen years allowed in the schools.

#### The Parent Population

During the period in which initial contact was made with the parents of the mentally retarded children there was a total population of 190 people who were potential participants in the study. Of this number, 108 responded to the original invitation (Appendix A) for formation of parent groups. These were seventy-eight positive responses and thirty negative responses. The group of 108 parents was composed of forty-nine couples and ten parents without partners.

There was only one Negro couple which could have been involved in the project. However, they did not respond to the request to join a group, and all participants in the project were, therefore, Caucasian. Generally, the socio-economic level from which these parents came could be described as middle to lower-middle. None of the families could have been considered "marginal" or poverty families and, as far as could be determined from financial statements available from the school, none would be considered wealthy. These

parents all came from an essentially urban environment although most did come from one of the less densely populated areas of the county.

### The Counseling Program

None of the schools involved in this study had a formal counseling program. At all the schools, however, an evaluation was required for each child as an admission criterion so that at least one parent had contact with a psychologist prior to the child's admission to the school. At Angels Inc., where the majority of the participants came from, yearly re-evaluations of each child were made and at that time the parents were called in for a consultation regarding their child. These sessions were usually of a practical, problem-solving nature and were focused on the child and his needs. Educational goals and the progress of the child were often discussed. In almost all cases only the mother attended these sessions because the father worked during the day when these evaluations were held. It was this previous exclusion of the father in situations regarding the mentally retarded child that was one of the prime considerations in holding night counseling meetings for this study.

### The Counselors

The facilitator for the group-centered counseling groups was a doctoral student in Counseling at North Texas State University and the Staff Psychologist at Angels Inc. during the time of the study. Previous to this he had taken courses in group methods which involved conducting groups as well as classroom work. At the time of the study he had completed all work toward the doctorate with the exception of the doctoral dissertation and had had supervised internship experiences which involved individual as well as group-counseling experiences.

The leader of the lecture-discussion groups was the Directress of Angels Inc. Additionally, she had completed the course work toward the M. A. Degree in Special Education. Anticipating that the lecture-discussion leader's position of authority and control within the school might bias the results of the approach, a series of structured lesson plans (Appendix B) was used to guide the lecture-discussion leader. By having the subject matter and specific topics outlined for the leader, it was hoped that this would minimize the variables of this leader's job position.

### Description of Instruments

In reviewing the literature relating to group-oriented



activities with parents of retarded children, authors such as Ramsey (10), Sternlicht (14), Tretakoff (18), and Wolfensberger (19) all emphasize the lack of objective measurement as one of the greatest drawbacks to the validity of many of the studies conducted to date. All these reviewers felt that comparative studies need to be undertaken which can help define which therapeutic approaches produce what types of results.

Index of Adjustment and Values.--The self-concept of parents of mentally retarded children has been described by previous investigators as being generally lowered (17) or at least "shaken" (6). The Index of Adjustment and Values was used to assess the possible changes that might occur in the self-concept of parents of mentally retarded children through a therapeutic experience such as they might receive in group-centered group counseling.

The Index of Adjustment and Values (Appendix C) was designed to test certain theoretical formulations, to serve as a research tool, and to assess changes in adjustment during psychotherapy (1). Measures are obtained on four variables consisting of self-concept, acceptance of self, ideal-self, and the discrepancy

between self-concept and the ideal-self.

An odd-even corrected reliability of .91 is reported for the acceptance of self scores, and a similarly corrected reliability of .88 is given for the discrepancy (D) scores of a sample of 237 students. A test-retest reliability coefficient for 175 of these students after a period of six weeks was .83 for the acceptance of self scores and .87 for the D scores. For a group of 100 college students, an odd-even, corrected reliability of .53 was found for the perceived self and a reliability coefficient of .77 for the ideal-self. A test-retest reliability coefficient (six-weeks interval) on another group of 160 students was .90 for the perceived self and 192 for the ideal-self. The Rorschach was used to validate at least partially the acceptance of self scores as a measure of adjustment and to validate the mean acceptance of self scores as an important dividing point between certain personality groups (16). ✓

The data which have been collected from several sources indicate that the Index is a reliable and valid measure of adjustment and values (13, 16). Renzaglia (12) concluded that reliable and valid samples of the self-concept, self-satisfaction, and the ideal-self can be elicited from this instrument.

IPAT Anxiety Scale.--A "characteristic" of parents of mentally retarded children which is frequently observed is their anxiety level (7, 9, 19). To measure the changes in general anxiety which might take place as a result of participation in any of the groups, the IPAT Anxiety Scale was used.

The IPAT Anxiety Scale (IPAT Self Analysis Form) was written by R. B. Cattell and I. H. Schier (4) and is an inventory to assess "general anxiety." It is based on a second order factor analysis of the seventy-five most representative items from the 16 PF Questionnaire (3). The authors write that "It is a brief, nonstressful clinically valid questionnaire for measuring anxiety, applicable to all but the lowest educational levels and appropriate . . . throughout the adult range" (4, p. 5). Additionally, they write that this forty item questionnaire is "probably the most effective available brief questionnaire instrument for supplementary clinical purposes" (4, p. 5). Buros (3) comments that there is much background research to support that statement.

Although the Scale reports six separate scores it appears that the total anxiety score measures best Cattell's anxiety syndrome which is comprised of the qualities of tension, irritability, lack of self-confidence, unwillingness to take risks and tremor (3).

The reliability of the total score is reported to be .84 for a sample of 240 normal adults and .91 for a mixed group of normals and hospitalized neurotics. These reliability estimates compare favorably with those for other available instruments, some containing more items and hence being more time consuming (3).

Validity is extensively defended on the basis of external diagnosis of anxiety and the Scale's ability to differentiate more accurately than independent raters. Cattell points out that the obtained correlation between clinical consensus and the IPAT Anxiety Scale of .30 to .40 are actually quite substantial considering the much lower values generally achieved between raters (3). This estimate of Construct or Concept Validity for the total scale is taken three separate ways, and in the manual the authors state that "The three methods of estimating construct validity converge on a value of, conservatively, .85 to .90" (4, p. 7).

Knowledge of Mental Retardation Test.--In some of the more recent experiments conducted with parents of mentally retarded children the most provocative findings are those related to the parent's knowledge of mental retardation. As noted in the Related Literature chapter of this paper, there have been conflicting and confounding findings regarding this topic (2, 7, 8, 14, 19).

In an attempt to help resolve this issue, an instrument measuring knowledge of mental retardation was developed by the present writer for this experiment. The Knowledge of Mental Retardation Test (Appendix D) was designed to get an estimate of an individual's general knowledge of mental retardation.

The original questions were developed by giving each teacher, the Executive Directress, and the Assistant Directress of Angels Inc. the following instructions on a blank sheet of paper: "Twenty to twenty-five most commonly asked questions about mental retardation are: (Phrase these so that they may be answered yes or no)." Additionally, selected questions from Kanner's questionnaire on mental retardation were used (8).

The fifty most frequently asked questions were put in a "Yes-No-?" format and administered to thirty-three students enrolled in an introductory course in psychology at North Texas State University during the Spring semester of 1970. The purpose for this administration of the questionnaire was for item analysis. From this analysis the forty most discriminating questions were chosen to comprise the current instrument. Scoring was done on the basis of each question being worth one point. Scores can range from 0 (low knowledge of mental

retardation) to 40 (high knowledge of mental retardation).

Validity is of content type and the choice of questions and format are supported by a study of Kanner's (8) in which he gathered questions which were frequently asked about mental retardation. Additionally, this type of instrument has been previously used in research with parents of mentally retarded children (3, 7, 8). Reliability data on the Knowledge of Mental Retardation Test was obtained by administering the instrument to twenty-two students enrolled in the Nature of Man course at Southern Methodist University during the Spring semester of 1970. The test was administered on March 4, 1970, and again on May 6, 1970, which was an interval of nine weeks. A test-retest reliability coefficient of .51 was obtained. The reliability findings are summarized in Table I.

TABLE I  
RELIABILITY OF THE K-MRT

Value	Type of Coefficient	Sample
.51	Test-retest (nine week interval)	Twenty-two freshmen students at Southern Methodist University

### Selection of Subjects

There was, initially, a total parent population of 190. This number represented all the parents of the moderately mentally retarded children who were enrolled in Angels Inc., Loving Care School, and the Mesquite Developmental Center six weeks prior to the first scheduled meetings.

The first step in the selection of the subjects was to notify all possible participants about the parent meetings. This was achieved by sending, six weeks prior to the first scheduled group meetings, a letter to all potential participants explaining that parent groups would be forming. Included with the letter of explanation was a return form which allowed the parents to check whether they wished to attend on Monday night, Tuesday night, or not to attend at all. A stamped return envelope was enclosed to facilitate returns. Parents were allowed three weeks to respond to the call for group formation. Ninety-six of the 108 parents who had responded by the end of three weeks were divided into four major groups with twelve people in each of the four experimental sub-groups and twenty-four in each of the two control groups. The group division is illustrated in Table II.

TABLE II  
GROUP DIVISION

Lecture-Discussion Group		Group-Centered Group Counseling		Standard Control Group	Experimental Control Group
Mon.	Tues.	Mon.	Tues.		
12	12	12	12	24	24

Assignment to one of the four experimental sections was made as follows: All positive responses from the subjects who elected to meet on Monday night and all positive responses from those who wanted to meet on Tuesday night which were received within three weeks after being sent out were placed in separate boxes. Twenty-four names were randomly drawn from each box. Out of each of the two pools of twenty-four names, twelve names were randomly drawn. The twelve names drawn from the Monday night pool were designated as lecture-discussion section one. The twelve names remaining comprised group-counseling section one. The first twelve names drawn from the Tuesday night pool were designated group-counseling section two and the twelve remaining names comprised lecture-discussion section two.



This sampling procedure, then, created two major experimental groups, the lecture-discussion group and the group-centered group counseling group.

The third major group, the standard control group, consisted of twenty-four randomly selected parents who had chosen to participate in the project. Twelve names were chosen from those remaining in the Monday night pool and twelve were similarly chosen from the Tuesday night pool. This randomized selection procedure produced a balanced control group which was chosen in a manner identical to that which was used to choose the lecture-discussion and the group-centered counseling experimental groups.

The fourth major group, the "experimental" control group, consisted of twenty-four randomly selected parents from the thirty who responded negatively to participation in the project. The subjects were chosen by placing all the names of those parents who checked the "no" response on the request form in a box and randomly drawing the first twenty-four names.

As noted in the Related Literature section of this paper, there is some evidence (9, 15) which indicates that some differences may exist between people who do not care to participate in projects such as this and

those who are willing to do so. To investigate this assumption and the resulting hypotheses it was necessary to construct an "experimental" control group as well as one of the usual type which consists of people willing to participate but, because they are assigned to a control group, cannot.

This selection procedure produced four groups which were randomly selected but were somewhat unbalanced in terms of married couples and parents without partners. By shifting one couple to the standard control group and two single parents to the experimental control group a sex and marital status balance was achieved. The final pre-test group alignment resulted in six married couples in the Monday night lecture-discussion section, the Monday night group-centered counseling section, and in the Tuesday night lecture-discussion section. The Tuesday night lecture-discussion section had five married couples and two single parents, both female. Both experimental sections had eleven married couples and two single female parents in them. All of the single parents in all of the schools were female. No male parents indicated that they would come without their wives nor did a lone male parent attend any of the group meetings.

One hundred and eight people responded to the original call for participants so there were twelve people not used in any group. These twelve represented four couples and four single female parents. Of those not chosen, three of the couples and one of the single parents responded positively while the rest rejected the opportunity for group involvement. While the overall selection procedures used for all the experimental groups were not completely randomized ones in that the subjects were not randomly picked and randomly assigned to groups to form one large population pool, it was felt that the concession to parent's preference in regard to meeting times was very important as subject participation, interest, and enthusiasm is of primary importance in a project such as this. It did not seem wise to jeopardize positive feelings about the meetings and to take the chance of people dropping out of the program due to scheduling difficulties.

#### Procedure

After final group assignments were made, all participants in the experimental sections were contacted by telephone and told exactly when the sessions would begin, how long each one would last, and were reminded that free baby-sitting service was available. There

were sixteen scheduled group meetings of which the first and last sessions were devoted to testing so that there were fourteen actual meetings.

All experimental sections held regularly scheduled weekly group meetings which began at 7:30 P.M. each Monday and Tuesday and lasted one and one-half hours. The control group subjects were involved in the pre- and post-testing only. The place where the meetings were held, Angels Inc., is located in a converted residence. The two spacious rooms which were used for the meetings have a common door but each room can be reached without having to go through the other.

In the lecture-discussion sections, seats remained in a classroom type arrangement throughout the meetings. The procedure during the actual lecture-discussion phase of these meetings was for the leader to assume a position in front of the class, as a teacher would, and deliver a lecture on the subject which was to be discussed for that evening. After the lecture, which lasted forty-five minutes to one hour, a five-minute coffee break was taken after which the discussion phase began. In this period questions and comments were directed to the leader and she controlled the discussion period. At all times an effort was made to keep the discussion

focused on the evening's topic.

In the group-centered counseling sections, seats were arranged in a circle for all meetings except for pre- and post-testing sessions. The leader attempted to become a part of the group and, as defined earlier in this paper, he did not dictate the directions the group would take. In the group-centered counseling sections there was no actual coffee break taken; instead, participants were free to excuse themselves from the group and get refreshments at any time.

#### Collection of Data

Data were collected in the experimental groups by devoting the first session to pre-testing and the last session to post-testing. In all experimental groups, the leader of the group greeted the sections at the beginning of the first session, made an attendance check, and after some introductory remarks to put the participants at ease, administered the instruments which were used in the experiment. The order of administration was, the Knowledge of Mental Retardation Test first, followed by the IPAT Anxiety Scale and then the Index of Adjustment and Values. Instructions regarding each test were given immediately prior to the administration of the test. Questions which related to how

to answer the questions were answered but participants were asked not to ask for help with the actual answers. The same procedure was used in these groups to gather post-test data. During meetings after the pre-test session none of the specific tests was discussed in any way. During the course of the lecture-discussion classes, the information presented to the participants was certainly relevant to the Knowledge of Mental Retardation Test but this was not given in terms of being specifically applicable to the test.

Data were collected from the participants in the control groups by having the leader of the group-centered counseling group contact the people in those groups and then either taking the instruments to their homes for administration or having the participants come to Angels Inc. to take the tests. In the control groups there were twenty-two couples and four parents without partners. At the pre-test administration all four single parents and eight of the couples came to the school for testing. The remaining fourteen couples were tested in their own homes during the latter part of the week in which the experimental groups met. At the post-test administration three of the single parents and ten of the couples came to the school for testing, which

left one single parent and twelve couples to be tested in the home. As in the pre-testing, all post-testing was completed in the same week for all participants in all groups. All home contacts took place at a time when both husband and wife were present, which was usually after 6:00 P.M., and the latest any contact was made was 10:30 P.M. Each testing session took approximately thirty minutes, and the order of administration of the instruments was the same for the control groups as it was for the experimental groups.

There were eleven participants who dropped out of the experiment. Of these, six were originally in the lecture-discussion group and five were in the group-centered counseling group. The lecture-discussion group lost two couples from the Monday night section and one couple from the Tuesday night section, while the group-centered counseling section which met on Monday night lost one couple and the Tuesday night section had one couple and one single parent quit. Of those who dropped out, all except one couple did so after the first meeting. One couple, in the lecture-discussion Monday night section, attended intermittently until the sixth week and then failed to show up again. Data collected from parents who withdrew from the study were

not used in the final analysis of the data. Therefore, the number of participants in the lecture-discussion pre- and post-test data analysis was eighteen and the number in the group-centered counseling group was nineteen. There were twenty-four participants in both the experimental control group and the standard control group for the final analysis of the data.

#### Treatment of Data

The research hypotheses were converted to null hypotheses for statistical treatment.

Data obtained from the pre-tests and post-tests on all measures were treated statistically at the Computer Center, University of Texas at Arlington, on an XDS Sigma 7 computer.

Hypotheses 2 and 6 were treated statistically for significance of difference between means of small samples using Fisher's  $t$ , while hypotheses 1, 3, 4, 5, and 7 were treated statistically for significance of difference between mean gain of small samples using Fisher's  $t$ .

The appropriate Fisher's  $t$  was used to compare all groups on the basis of the scores yielded by the various instruments used.

A significance level of .05 was required for rejection of the null hypothesis for all computations.



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## CHAPTER IV

### STATISTICAL ANALYSIS OF RESULTS AND DISCUSSION

The purpose of this chapter is to present and describe the results obtained from instruments used in this experiment. Data analyzed were selected pre- and post-mean difference scores and selected post-test mean gain difference scores on the instruments used. The statistical technique used was Fisher's  $t$ . The research hypotheses were converted to null hypotheses for statistical treatment. A significance level of .05 was required for rejection of the null hypothesis for all computations.

#### Hypothesis I

Null Hypothesis I was: The group-centered counseling group will not differ significantly from either the lecture-discussion group, the standard control group, or the experimental control group with respect to mean change on the IPAT Anxiety Scale.

The pre- and post-test means and standard deviations for the total IPAT Anxiety Scale scores are shown in

TABLE III  
PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS  
OF TOTAL IPAT ANXIETY SCALE SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	37.53	31.95	12.90	12.74
Lecture-discussion	25.11	19.83	15.28	11.61
Experimental control	35.62	35.04	9.52	12.54
Standard control	32.46	29.04	13.35	12.14

Table III. The lecture-discussion group and the group-centered counseling group each experienced a mean loss of slightly more than five points. The standard control group's mean loss was .58. Although the lecture-discussion group exhibited somewhat less anxiety at the pre-test administration than the other groups did, a reduction in anxiety level of similar proportions took place in both the group-centered counseling group and the lecture-discussion group.

Fisher's t technique was utilized for further statistical analysis and the resulting data are shown in Table IV.

TABLE IV

t VALUE COMPARISONS OF PRE- TO POST-TEST MEAN LOSS DIFFERENCES ON THE IPAT ANXIETY SCALE

Group	Mean Loss	Fisher's <u>t</u>
Group-centered counseling and lecture-discussion	-5.58 -5.28	- .058
Group-centered counseling and standard control	-5.58 -3.42	- .445
Group-centered counseling and experimental control	-5.58 - .58	-1.027

In the comparison of pre- to post-test mean loss differences for the group-centered counseling group and the lecture-discussion group, a t value of 2.030 was required for significance at the .05 level using 35 degrees of freedom. The t value obtained, -.058, fell below the level of significance.

For the group-centered counseling group and the standard control group, using 41 degrees of freedom, a t value of 2.021 was required for significance. The obtained t value of - .445 was not significant.

For the group-centered counseling group and the experimental control group comparison, the t value required for significance, using 41 degrees of freedom,

was 2.021. The obtained  $t$  value of -1.027 fell below the level required for significance.

Although there was some reduction of the participants' anxiety level when they were involved in one of the experimental groups, the decrease was not great enough to be statistically significant; therefore, the null hypothesis was accepted.

#### Hypothesis II

Null Hypothesis II was: The experimental control group will not differ significantly from either the lecture-discussion group, the group-centered counseling group, or the standard control group with respect to pre- and post-test means for the total anxiety score or the IPAT Anxiety Scale.

The results of the statistical treatment computed to test this hypothesis are shown in Table V and Table VI.

TABLE V

$t$  VALUES OBTAINED FROM PRE-TEST MEAN TOTAL ANXIETY SCORES ON THE IPAT ANXIETY SCALE

Group	Mean	Fisher's $t$
Experimental control and lecture-discussion	35.62 25.11	2.646*
Experimental control and group-centered counseling	35.62 37.53	- .486
Experimental control and standard control	35.62 32.46	.861

\*Significant at .05 level.

A  $t$  value of 2.021, using 40 degrees of freedom, was required for significance at the .05 level in the comparison of the experimental control group and the lecture-discussion group. The obtained  $t$  value of 2.646 was, therefore, significant at the .05 level.

Using 41 degrees of freedom, the  $t$  value required for significance of difference was 2.021 in the comparison of the experimental control group and the group-centered counseling group. The obtained  $t$  value of -.486 for these two groups was not significant.

The  $t$  value required for significance in the comparison of the experimental control group and the standard control group was 2.014 using 46 degrees of freedom. The obtained  $t$  value of .861 fell below the level required for significance.

The results related to the portion of Null Hypothesis II dealing with the post-test scores are shown in Table VI.

Using 40 degrees of freedom, the  $t$  value required for significance at the .05 level in the comparison of the experimental control group and the lecture-discussion group was 2.021. The  $t$  value obtained was 3.976 which was significant at the .01 level.

The  $t$  value required for significance in the

TABLE VI

t VALUES OBTAINED FROM POST-TEST MEAN TOTAL  
ANXIETY SCORES ON THE IPAT ANXIETY SCALE

Group	Mean	Fisher's <u>t</u>
Experimental control and lecture-discussion	35.04 19.83	3.976*
Experimental control and group-centered counseling	35.04 31.95	- .821
Experimental control and standard control	35.04 29.04	1.694

\*Significant at .01 level.

comparison of mean scores for the experimental control group and the group-centered control group was 2.021, using 41 degrees of freedom. The t value obtained, - .821, does not indicate significant difference between these two groups on this measure.

Using 46 degrees of freedom, the t value required for significance between the experimental control group and the standard control group was 2.014. The obtained t value of 1.694 does not indicate significant difference between the groups.

As shown by the data in Tables V and VI, research hypothesis two was partially supported by the data. The experimental control group had a significantly



greater mean score on the IPAT Anxiety Scale than did the lecture-discussion group at both the pre- and post-test administration. There were no significant differences between any of the other groups, and the null hypothesis was accepted.

### Hypothesis III

Null Hypothesis III was: The group-centered counseling group will not differ significantly from either the lecture-discussion group, the standard control group, or the experimental control group with respect to mean change in Self-Concept Scale scores of the Index of Adjustment and Values.

The results of the statistical treatment computed to test this hypothesis are shown in Table VII and VIII.

TABLE VII

PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS  
OF THE INDEX OF ADJUSTMENT AND VALUES  
SELF-CONCEPT SCALE SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	176.32	178.26	17.01	10.26
Lecture-discussion	188.06	194.67	18.16	17.95
Experimental control	194.75	198.58	17.01	20.38
Standard control	181.96	186.00	13.51	10.63

The mean gains on the IAV Self-Concept Scores were 1.94 for the group-centered counseling group, 6.61 for the lecture-discussion group, 3.83 for the experimental control group, and 4.04 for the standard control group. All groups showed a slightly more positive self-concept, as measured by the IAV, at the post-test administration than they had at the pre-test administration. The results of the analysis of the data to determine the statistical significance of these changes are shown in Table VIII.

TABLE VIII

t VALUE COMPARISONS OF PRE- TO POST-TEST MEAN CHANGES ON THE INDEX OF ADJUSTMENT AND VALUES SELF-CONCEPT SCALE

Group	Mean Changes	Fisher's <u>t</u>
Group-centered counseling and lecture-discussion	1.94 6.61	-.767
Group-centered counseling and standard control	1.94 4.04	-.369
Group-centered counseling and experimental control	1.94 3.83	-.332

Using 35 degrees of freedom, the t value required for significance of difference between the group-centered counseling group and the lecture-discussion

group was 2.030. The obtained  $t$  value of  $-.767$  fell below the level of significance.

The  $t$  value required for significance of difference between the group-centered counseling group and the standard control group, using 41 degrees of freedom was 2.021. The obtained  $t$  value of  $-.369$  did not reach the required level.

In the comparison between the group-centered counseling group and the experimental control group a  $t$  value of 2.021 is required for significance at the .05 level using 41 degrees of freedom. The obtained  $t$  value of  $-.332$  was not significant.

There were no significant differences between any of the groups; therefore, the null hypothesis was accepted.

#### Hypothesis IV

Null Hypothesis IV was: The group-centered counseling group will not differ significantly from either the lecture-discussion group, the standard control group, or the experimental control group with respect to mean change in Self-Acceptance Scale scores of the Index of Adjustment and Values.

The results of the statistical treatment computed to test this hypothesis are shown in Table IX and X.

TABLE IX

PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS  
OF THE INDEX OF ADJUSTMENT AND VALUES  
SELF-ACCEPTANCE SCALE SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	173.26	180.26	10.80	8.75
Lecture-discussion	182.28	193.33	13.09	14.78
Experimental control	188.87	186.50	13.86	10.70
Standard control	173.92	176.54	14.85	14.12

Analysis of the pre- and post-test scores shows that the experimental control group's self-acceptance score was the highest of all the groups in the experiment at pre-testing and remained so during the period between testing.

The lecture-discussion group had the second highest pre-test mean self-acceptance score and the mean score rise of eleven points at the post-test level reveals that the participants in the lecture-discussion group had a substantial gain in self-acceptance from the pre- to the post-test administration of the IAV.

The standard control group, which had the third

highest pre-test mean score, showed a rise of three mean points at the post-test administration, which indicated a rather stable self-acceptance. The group with the lowest pre-test mean, the group-centered counseling group, showed a gain of seven points on the Self-Acceptance Scale at the post-test level. This indicates a more positive self-acceptance at the conclusion of the experiment. The trends established seemed to indicate that the two experimental groups' participants moved in the direction of more positive self-acceptance and that the self-acceptance of the two control groups remained relatively stable during the period of the experiment.

The Fisher's  $t$  technique was used to determine the statistical significance of these changes, and the resulting data are shown in Table X.

TABLE X

$t$  VALUE COMPARISONS OF PRE-TEST TO POST-TEST MEAN CHANGES ON THE INDEX OF ADJUSTMENT AND VALUES SELF-ACCEPTANCE SCALE

Group	Mean Changes	Fisher's $t$
Group-centered counseling and lecture-discussion	7.00 11.06	.753
Group-centered counseling and standard control	7.00 2.62	.870
Group-centered counseling and experimental control	7.00 -2.37	1.863

A  $t$  value of 2.030, using 35 degrees of freedom, was required for significance at the .05 level in the comparison between the group-centered counseling group and the lecture-discussion group. The obtained  $t$  value of .753 was not significant.

Using 41 degrees of freedom, the  $t$  value required for significance of difference between the group-centered counseling group and the standard control group was 2.021. The  $t$  value obtained of .870 indicates no significant difference between these groups.

For the comparison between the group-centered counseling group and the experimental control group, a  $t$  value of 2.021 was required for significance at the .05 level using 41 degrees of freedom. The  $t$  value obtained, 1.863, was not significant at the .05 level.

There were no significant differences between any of the groups; therefore, the null hypothesis was accepted.

#### Hypothesis V

Null Hypothesis V was: The group-centered counseling group will not differ significantly from either the lecture-discussion group, the standard control group, or the experimental control group with respect to mean change in Ideal-Self Scale scores of the

Index of Adjustment and Values.

The results of the statistical treatment computed to test this hypothesis are shown in Table XI and XII.

TABLE XI

PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS  
OF THE INDEX OF ADJUSTMENT AND VALUES  
IDEAL-SELF SCALE SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	222.68	212.42	9.47	10.27
Lecture-discussion	212.83	230.17	54.37	14.18
Experimental control	209.25	218.37	16.98	11.13
Standard control	223.46	220.67	10.35	13.57

The pre- and post-test means and standard deviations for the IAV Ideal-Self scores are shown in Table XI. The group-centered counseling group experienced an Ideal-Self Scale score loss of approximately ten points and the standard control group also registered a loss on this scale, although this group's loss was approximately two points. The lecture-discussion group and the experimental control group

scores showed a rise of seventeen and nine points respectively on the Ideal-Self Scale.

Fisher's  $t$  test was utilized to determine the statistical significance of these mean changes, and the resulting data are shown in Table XII.

TABLE XII

$t$  VALUE COMPARISONS OF PRE-TEST TO POST-TEST MEAN CHANGES ON THE INDEX OF ADJUSTMENT AND VALUES IDEAL-SELF SCALE

Group	Mean Change	Fisher's $t$
Group-centered counseling and lecture-discussion	-10.26 17.33	-2.861**
Group-centered counseling and standard control	-10.26 - 2.79	.830
Group-centered counseling and experimental control	-10.26 9.12	-2.153*

\*Significant at .01 level.

\*\*Significant at .05 level.

In the comparison of pre- to post-test mean gain differences for the group-centered counseling group and the lecture-discussion group, a  $t$  value of 2.030 was required for significance using 35 degrees of freedom. The  $t$  value obtained, -2.861, was significant to the .01 level.



For the group-centered counseling group and standard control group, a  $t$  value of 2.021 was required for significance using 41 degrees of freedom. The  $t$  value of .830 was not significant.

For the group-centered counseling group and the standard control group comparison, using 41 degrees of freedom, a  $t$  value of 2.021 was required for significance. The  $t$  value found, -2.153, was significant at the .05 level.

Statistically significant differences were found to exist between the group-centered counseling group and both the lecture-discussion group and the experimental control group, but since a significant difference was not found between the group-centered counseling group and the standard control group, the null hypothesis was accepted.

#### Hypothesis VI

Null Hypothesis VI was: The group-centered counseling group will not differ significantly from either the lecture-discussion group, the standard control group, or the experimental control group with respect to post-test mean scores on the Discrepancy Scale (D) of the Index of Adjustment and Values.

The results of the statistical treatment computed

to test this hypothesis are shown in Tables XIII and XIV.

TABLE XIII  
PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS  
OF THE INDEX OF ADJUSTMENT AND VALUES  
D SCALE SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	52.28	37.32	14.14	15.87
Lecture-discussion	35.56	37.56	14.16	11.71
Experimental control	27.46	28.33	13.53	11.83
Standard control	50.17	47.50	13.59	9.97

Post-test data reveal that only the group-centered counseling group showed substantial pre- to post-test mean score change. The 14.96 point decrease indicates that this group showed much less discrepancy between ideal-self and self-concept at the post-test administration of the IAV than it did at the pre-test administration.

Fisher's t technique was utilized for further statistical analysis and the resulting data are shown in Table XIV.

TABLE XIV

t VALUES OBTAINED FROM THE POST-TEST D SCALE  
ON THE INDEX OF ADJUSTMENT AND VALUES

Group	Mean	Fisher's <u>t</u>
Group-centered counseling and lecture-discussion	37.32 37.56	.059
Group-centered counseling and standard control	37.32 47.50	-2.683*
Group-centered counseling and experimental control	37.32 28.33	2.367*

\*Significant at .05 level.

A t value of 2.030, using 35 degrees of freedom, was required for significance at the .05 level in the comparison of the group-centered counseling group and the lecture-discussion group. The obtained t value of .059 was not significant.

Using 41 degrees of freedom, the t value required for significance of difference was 2.021 in the comparison of the group-centered counseling group and the standard control group. The t value of -2.683 was significant at the .05 level.

The t value required for significance in the comparison of the group-centered counseling group and the experimental control group was 2.021, using 41

degrees of freedom. The  $t$  value found, 2.367, was significant at the .05 level.

The significant differences which were found to exist between the group-centered counseling group and both the control groups tend to support the contention that the group-centered counseling group would become more congruent during the course of the experiment. However, since no significant difference was found to exist between the group-centered counseling group and the lecture-discussion group, the null hypothesis was accepted.

#### Hypothesis VII

Null Hypothesis VII was: The lecture-discussion group will not differ significantly from either the group-centered counseling group, the standard control group, or the experimental control group with respect to mean change in knowledge of mental retardation scores as measured by the Knowledge of Mental Retardation Test.

The results of the statistical treatment utilized to test this hypothesis are shown in Tables XV and XVI.

TABLE XV

PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS OF  
 THE KNOWLEDGE OF MENTAL RETARDATION TEST SCORES

Group	Mean		S.D.	
	Pre-test	Post-test	Pre-test	Post-test
Group-centered counseling	20.68	22.32	5.93	5.20
Lecture-discussion	18.56	23.44	4.76	4.79
Experimental control	15.00	14.75	4.60	4.48
Standard control	15.37	16.62	6.15	5.95

The lecture-discussion group showed a pre- to post-test mean gain of approximately five points while the group-centered counseling group gain was about two points. The standard control group had a gain of 1.25 points and the experimental control group showed a loss of 1.25. These data indicate that all but the experimental control group participants gained more knowledge of mental retardation, as measured by the K-MRT, during the course of the experiment. The Fisher's t technique was utilized to determine the statistical significance of these changes and the resulting data are shown in Table XVI.

TABLE XVI

t VALUE COMPARISONS OF PRE- TO POST TEST  
MEAN CHANGES ON THE KNOWLEDGE  
OF MENTAL RETARDATION TEST

Group	Mean Change	Fisher's <u>t</u>
Lecture-discussion and group-centered counseling	4.89 1.63	1.294
Lecture-discussion and experimental control	4.89 - .25	2.153*
Lecture-discussion and standard control	4.89 1.25	1.524

\*Significant at .05 level.

Using 35 degrees of freedom, the t value required for significance of difference between the lecture-discussion group and the group-centered counseling group was 2.030. The obtained t value of 1.294 did not indicate significant difference between these two groups.

The t value required for significance of difference between the lecture-discussion group and the experimental control group, using 40 degrees of freedom, was 2.021. The obtained t value of 2.153 was significant at the .05 level.

In the comparison between the lecture-discussion group and the standard control group, a t value of

2.021 was required for significance at the .05 level using 40 degrees of freedom. The obtained  $t$  value of 1.524 did not indicate significant difference between the groups.

As shown by the data in Table XVI, research hypothesis VII was partially supported by the data. The lecture-discussion group had a significantly greater mean gain on the K-MRT than did the experimental control group, and since no other significant differences existed between any of the other groups, the null hypothesis was accepted.

#### Summary

The purpose of this chapter was to present and to describe the data obtained from the instruments used in the experimental study. The hypotheses were stated in the null form and the .05 level of significance was required for rejection.

Examination of pre- to post-test means indicated that the changes which occurred, although not statistically significant in all cases, were generally in keeping with what was predicted by the research hypotheses. While some statistically significant changes were found to exist between some of the groups, these changes were not found to hold up to any consistent degree. Therefore, all of the null hypotheses were accepted.

## CHAPTER V

### SUMMARY, RESULTS, INTERPRETATIONS, AND RECOMMENDATIONS

This study was designed to measure the effects of lecture-discussion classes and group-centered counseling on parents of moderately mentally retarded children. The variables investigated were anxiety level, knowledge of mental retardation, and aspects of self-concept. There were two control groups with which the experimental groups were compared; one consisted of parents who wanted to be involved in parental discussion groups but who were assigned to a standard control group, and the other was made up of parents who did not want to take part in the discussion groups.

#### The Method

The subjects were eighty-five parents who had moderately mentally retarded children enrolled in one of three Dallas County schools for the education and training of mentally retarded children at the time of the study. A population of 190 potential participants were sent a letter explaining that parent groups were



forming and that their school was requesting that they join. Parents were given a choice of meeting on one of two nights. Two name pools were created from the responses and these were comprised of parents who responded positively to the invitation to join the discussion group. A third name pool was comprised of parents who declined the opportunity to participate. From these pools, random drawings were held to determine which people would comprise the groups in the experiment. From the pool of names responding positively to the invitation, twenty-four subjects were selected for the group-centered counseling group, twenty-four subjects for the lecture-discussion experience, and twenty-four for the standard control group. From the name pool of those who declined to participate, twenty-four subjects were selected for the experimental control group in order to determine if there were any differences, as a control group, between those who declined and those who accepted. As a result of member attrition, in the final data analysis there were nineteen group-centered counseling group participants, eighteen lecture-discussion group participants, and twenty-four participants in each of the control groups.

Subjects assigned to the lecture-discussion groups received lectures on pre-assigned topics delivered at their meetings. The lectures were followed by a

discussion period in which the leader kept the discussion at a content-academic level. Subjects assigned to the group-centered counseling group set their own direction and point of focus in counseling sessions. The facilitator attempted, as much as was possible, to be a part of the group rather than one who directed the group. The control groups were pre- and post-tested only and had no other contacts concerning the study during the period between test administrations.

All eighty-five subjects were pre- and post-tested with the Knowledge of Mental Retardation Test (K-MRT), IPAT Anxiety Scale (IPAT), and the Index of Adjustment and Values (IAV). The lecture-discussion and the group-centered counseling groups met for fourteen weekly one-and-one-half-hour sessions.

#### Results and Interpretations, and Conclusions

The hypothesis that members of the group-centered counseling group would have significantly greater mean change in anxiety level than would the other groups in the experiment was not accepted. Pre- to post-test changes were in the direction indicating a lower level of anxiety by the experimental groups but the differences between the groups were not statistically significant.

The finding that both experimental group situations resulted in decreased anxiety level suggests that involvement in a group activity, whether group-centered or directive, has the effect of helping participants feel slightly less anxious about themselves and their difficulties.

The hypothesis that members of the experimental control group would have higher pre- and post-test anxiety levels than would other groups was not accepted. The lecture-discussion group did have significantly less anxiety than the experimental control group. However, there were no significant differences in anxiety level between the experimental control group and the standard control group or the group-centered counseling group.

In interpreting the data obtained from the IPAT Anxiety Scale, the general indications were that some minor changes did occur among the participants in the experimental groups. Although the null hypotheses concerning the Scale were not accepted, discussion of the trends which were found was indicated by the possible differences in the norms of the experimental groups used in this study and the norms of the groups upon which the Scale was standardized. These differences would tend to obscure possible significant findings and relationships between experimental groups. The comparison between the experimental control group and the

lecture-discussion group was significant at both the pre- and post-test comparisons. The lecture-discussion group did exhibit a decrease in post-test anxiety level and the experimental control group's anxiety level remained stable during the period of the experiment.

This finding indicates that participation in the lecture-discussion series contributed to lowering those parents' anxiety level and that parents who rejected participation in the study did so for reasons other than a prohibitively high anxiety level, as was originally hypothesized.

The hypothesis that members of the group-centered counseling group would have a significantly greater mean gain in self-concept than would the other groups in the experiment was not accepted. Analysis of the data indicated that all of the groups demonstrated some positive change in self-concept and that the lecture-discussion group showed the greatest amount of gain, while the group-centered counseling group showed the least amount of change. However, none of the changes exhibited by any of the groups were of such magnitude as to be statistically significant.

The hypothesis that members of the group-centered

counseling group would have a significantly greater mean gain in self-acceptance than would the other groups in the experiment was not accepted. Pre- to post-test changes for both the lecture-discussion group and the group-centered counseling group were in the direction indicating more positive self-acceptance. The control groups showed only slight changes during the course of the study. None of the differences between the groups were statistically significant.

The hypothesis that members of the group-centered counseling group would have a significantly greater mean gain in ideal-self than would the other groups in the experiment was not accepted. On a statistical basis the group-centered counseling group was found to have a significantly lower post-test mean ideal-self scale score than both the lecture-discussion group and the experimental control group.

The group-centered counseling group had the least positive concept of ideal-self, as measured by the Index of Adjustment and Values, while the lecture-discussion group registered the greatest positive change on this scale. The experimental control group also demonstrated a rather large positive change on the Ideal-Self Scale, while the standard control group had a very slight change in the negative direction. In

terms of the research hypothesis, the results were diametrically opposite to those which were predicted.

The decrease by the group-centered counseling group in ideal-self may be accounted for by the fact that the participants discussed personal problems. Group members may have begun to feel that many of their attitudes and ways of dealing with problems were not as adaptive as they had felt they were prior to the beginning of the sessions. At the time of post-testing, then, participants in the group-centered counseling group may have been more aware of their problems and their difficulties in handling them than they had been at the beginning of the experiment. This awareness was perhaps reflected in the lowered Ideal-Self concept of these people.

In general, the data obtained on the Ideal-Self Scale indicated that members of the lecture-discussion group viewed themselves in more positive terms as a result of their experience. The nature of the lecture-discussion group's classes gave parents information and advice on how to deal with their children as well as helping them gain a less overwhelming view of their problem. The result of this may have given these parents an increased feeling of control over their situation and this more positive feeling was reflected in the increased Ideal-Self Scale score.

The hypothesis that members of the group-centered counseling group would have a lower mean score on the Discrepancy Scale of the Index of Adjustment and Values than would the other groups was not accepted. The group-centered counseling group was significantly more congruent than the standard control group and was significantly less congruent than the experimental control group. There was no significant difference in congruence between the group-centered counseling group and the lecture-discussion group. The actual statistical change in the Discrepancy Scale, which is derived by subtracting Ideal-Self Scale scores from Self-Concept Scale scores, can be accounted for by the Ideal-Self Scale changes. The possible reasons for the changes were discussed previously.

It appears that group involvement of the types utilized in this experiment was not a factor in consistently promoting statistically significant changes in self-concept, self-acceptance, or ideal-self as measured by the Index of Adjustment and Values. There were, however, trends suggested by the changes which did occur from pre- to post-test. Although all the null hypotheses relating to the Index of Adjustment and Values were not accepted, discussion of the results was

indicated, as the statistical technique employed may not have been appropriate, and significant relationships may have existed which were not apparent. In terms of the Index of Adjustment and Values, it was found that the lecture-discussion group showed positive mean change in self-concept, self-acceptance, and ideal-self.

The hypotheses that members of the lecture-discussion group would have a significantly greater mean gain in knowledge of mental retardation than would the other groups in the experiment was not accepted. The lecture-discussion group demonstrated a mean gain on the K-MRT which was significantly greater than the gain made by the experimental control group. Other comparisons revealed that mean gain differences tended to be in the predicted directions, although none of them reached an acceptable level of significance. Even though trends were found to exist in relation to this instrument, the findings may be suspect, due to the rather low .51 reliability coefficient.

The significant increase in knowledge of mental retardation demonstrated by the lecture-discussion group may be attributed to the content of the classes, which enabled participants in the lecture-discussion group to learn more about mental retardation than did members of the other experimental groups.



The lecture-discussion classes, which had as their focus the dissemination of information about mental retardation, appeared to be somewhat successful, as the lecture-discussion group did show a greater mean gain on this variable than did the other groups. However, these changes only proved to be statistically significant when the lecture-discussion group was compared to the experimental control group.

Results of the study indicate that the lecture-discussion group and the group-centered counseling group decreased about the same in anxiety level from the pre- to the post-test administration of the anxiety scale. The lecture-discussion group's anxiety level was the lowest of all the groups. It was also found that the lecture-discussion group was significantly less anxious than the experimental control group at both the pre- and post-test administration.

The results of the Index of Adjustment and Values test indicated that the lecture-discussion group, while showing positive change on every variable, was only significantly different from one other group, the group-centered counseling group, on the Ideal-Self Scale.

Although not always statistically significant in comparison to other groups, the lecture-discussion group demonstrated change in a positive direction on every

measure. A factor which may have played a part in the lecture-discussion group's positive changes was the effects of the lecture-discussion leader. This leader, as noted earlier, was the Directress of the school where the majority of the participants had children, and it may have been that their responsiveness and motivation was due to her influence and presence as well as the lecture-discussion classes themselves.

It was hypothesized that participants in the group-centered counseling groups would benefit from the experience by demonstrating a lowered anxiety level and increased aspects of self-awareness. It was found, however, that group-centered counseling group participants' anxiety level decreased no more than that of the lecture-discussion group, and was not significantly less than any of the groups.

In terms of increasing aspects of self-awareness, the group-centered counseling group had less positive change in the self-concept scale than did any of the other groups. The group did show non-significant gains in self-acceptance, while having a large drop in Ideal-Self Scale scores. The group-centered counseling group and the lecture-discussion group were about the same in congruence between ideal self and self-concept, and the data suggested that this congruence came at the expense

of a greatly lowered ideal-self, which may have been due to the participants' experience in the group-centered counseling sessions.

It appears that group centered counseling was only slightly helpful in relieving anxiety and positively increasing aspects of self-concept and self-awareness. It seemed, also, that this experience had some negative effects on the participants; and this may have been due, in part, to the feelings of inadequacy uncovered by group members during the sessions.

It was originally hypothesized that parents who would reject the opportunity to become involved in a counseling program would do so, to some degree, because of a prohibitively high anxiety level. The findings indicate that the parents who chose not to participate had an anxiety level which was not significantly higher than that of parents in the other groups, and that their anxiety level remained stable from the pre- to the post-test administration of the anxiety scale.

The experimental control group had a slight gain on the Index of Adjustment and Values in self-concept, and had the largest gain of any of the groups in Ideal-Self. The data from the Index of Adjustment and Values

further indicated that parents in this group had better congruence between ideal-self and self-concept at the pre- and post-testing than did parents in the other groups.

These findings suggest that these parents, rather than being immobilized by their anxiety level, appear to have dealt with their reactions to their mentally retarded child in rather positive ways; and, while they are no less anxious than other groups, they did demonstrate a greater acceptance of themselves than did parents in the other groups in the experiment.

The standard control group demonstrated relatively few changes on any of the instruments during the course of the study. These parents did, however, have the greatest incongruence between self-concept and ideal-self of any of the groups, and this incongruence remained stable during the period of the experiment. The parents in this group and those in the group-centered counseling group gained about the same in terms of Knowledge of Mental Retardation Test mean scores.

The data collected and analyzed for this study suggest that while some positive and some negative changes occurred in the groups, few of the changes were found to be statistically significant and none were found to hold up consistently.

The findings did indicate that the lecture-discussion group participants demonstrated positive change on every measure. However, these changes were, for the most part, trends only, suggested by mean score gains from the pre- to the post-test administration.

The results obtained in this study further suggested that the group-centered counseling group tended to have some positive, although statistically non-significant, gains in self-concept, knowledge of mental retardation, self-acceptance, and anxiety level. The experimental control group had gains in self-concept and was the most congruent of all groups, while the standard control group was the least congruent of all the groups.

It may be concluded, then, that participants' responses to the variables measured in this experiment were not generally altered from the pre- to post-test administration to any consistently statistically significant degree.

#### Recommendations and Interpretations

On the basis of the findings of this study, it is recommended

1. That, in planning a counseling program for parents of moderately mentally retarded children, the specific effects of each approach used in this study be

considered. It appears, for example, that the lecture-discussion approach is relatively more effective than the group-centered counseling approach in enhancing certain aspects of self-concept, while both affected anxiety to about the same extent. This study suggests that various counseling approaches may be used to realize specific goals, and is consistent with the research findings of Goodman and Rothman (3), and Popp, Ingram, and Jordan (4).

2. That, when disseminating information about mental retardation to parents of mentally retarded children, a lecture-discussion approach be considered. This study found the lecture-discussion approach to be relatively more effective than group-centered counseling in improving participants' knowledge of mental retardation. This supports the previous findings of Babitz (1), Daniels (2), and Wolfensberger (5).

3. That, when utilizing a group-centered counseling approach with parents of mentally retarded children, sessions take place over a longer period of time so that negative feelings which may be uncovered can be dealt with and worked through to more positive feelings prior to termination.

4. That parents be allowed to select for themselves whether or not they wish to participate in counseling sessions. This study suggested that those

parents who chose not to participate were somewhat more congruent and self-aware, and no more anxious than those who did want to participate.

5. That, in using this or similar experimental designs, pre-testing take place prior to group assignment. Groups could then be equalized so that they would not be significantly different from each other during the course of the study.

6. That an additional variable not included in this study, that of the leader's effect on the group, be considered in other experiments utilizing the basic design of this study. A design control would be to have the group leaders switch sections during the period of the experiment so that their effect would be minimized.

7. That, in order to increase the reliability of the Knowledge of Mental Retardation Test, the length of this instrument be increased.

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APPENDIX A

Dear Parents:

In response to the many requests that we have received at Angels Inc. we are starting discussion groups for parents.

These groups will be concerned with you, your child, and his school. The meetings will be informative as well as giving you a chance to ask questions and to discuss concerns that you might have.

These meetings, which are free, are going to be held in the evening so that all fathers will be able to come. All meetings will start at 7:30 and will last an hour and a half. Meetings will be once a week on the night you choose. Baby-sitting will also be available at the school.

Please mark your first and second choices below:

	Mon.	Tues.
First choice		
Second choice		
Cannot attend any night		

Make your plans now so that we can have 100% participation in this school project.

The meetings should start in about one month and you will be notified about a week before the first meeting.

Mark your choices and send this letter back to the school as soon as possible so that we can get ready for this exciting program.

Carolyn Quattlebaum  
Exec. Dir., Angels Inc.

APPENDIX B

LESSON PLANS

- Session 1. Introduction  
a) brief welcoming remarks  
b) testing  
c) orientation  
d) questions and discussion
- Session 2. Mental Retardation I  
a) causes of retardation  
b) discussion of specific types  
Mongoloid  
c) questions and discussion
- Session 3. Mental Retardation II  
a) continuation of discussion of specific types  
cerebral palsied  
brain injured  
b) questions and discussion
- Session 4. Mental Retardation III  
a) the moderately retarded child  
definition of  
development of the child - physical  
scholastic potential  
hopes for the future  
b) questions and discussion
- Session 5. Diagnosis  
a) psychological testing  
intelligence tests  
social maturity scales  
b) limitations of the instruments  
c) questions and discussion
- Session 6. Education I  
a) special education at private schools such as  
Angels Inc.  
b) purposes, goals, curriculum outlines and  
school setup  
c) questions and discussion

- Session 7. Education II  
 a) learning abilities of the mentally retarded  
 b) questions and discussion
- Session 8. Education III  
 a) state laws concerning the mentally retarded's education  
 b) Dallas Indep. School District provisions for the mentally retarded  
 c) questions and discussion
- Session 9. Adjustment Techniques  
 a) behavior therapy  
 b) psychotherapy  
 c) questions and discussion
- Session 10. Emotions and health care  
 a) emotional characteristics of the mentally retarded child  
 b) health care and its value to the mentally retarded child
- Session 11. Speech and Language \*  
 a) speech problems  
 b) speech therapy  
 c) questions and discussion
- \* Guest speaker at this session to be Sharon Knowles, teacher, MH/MR unit of Angels Inc., and speech therapist at Callier Speech and Hearing Center, Dallas.
- Session 12. Recreation  
 a) value of exercise and recreation for the mentally retarded child  
 b) activities for the parents to do with the child at home  
 c) questions and discussion
- Session 13. Home Training \*  
 a) activities that can be done at home in the area of academic training  
 b) activities that can be done at home in the area of social training  
 c) questions and discussion

\* Guest speaker at this session to be Muriel Brahinsky, head teacher at Angels Inc..

Session 14. The Theme

- a) institutional placement vs. retention at home  
Centerwall and Centerwall study  
Baumeister's criteria
- b) questions and discussion

Session 15. The Family

- a) effect on siblings
- b) responsibilities of the mentally retarded child  
within the family and as part of the family unit

Session 16. Conclusion

- a) questions
- b) testing

APPENDIX C  
BILL'S INDEX OF ADJUSTMENT AND VALUES

This scale lists a number of traits which most of us share. We usually can see ourselves as having more or less of a characteristic and sometimes we like that and sometimes we do not.

To complete this scale, the first step is to read the word on the left.

Next in Column I, indicate how much of the time you are like that. The ratings to be used are:

- 1 = rarely
- 2 = occasionally
- 3 = about half the time
- 4 = a good deal of the time
- 5 = most of the time

The sentence, "I am a (an) \_\_\_\_\_ person." may help you decide how to rate yourself if you put the word you are thinking about in the blank space and think about the whole sentence. For example, the first word is acceptable. After thinking about "I am an acceptable person," you rate yourself and put the number in Column opposite the word acceptable. In Column II you are to indicate how you feel about yourself as described in Column I. The ratings to be used in Column II are:

- 1 = I very much dislike being as I am in this respect.
- 2 = I dislike being as I am in this respect.
- 3 = I neither dislike or like being as I am in this respect.
- 4 = I like being as I am in this respect.
- 5 = I very much like being as I am in this respect.

If, for example, you rated yourself 5 on acceptable in Column I and you liked that about yourself, you could respond with a 4 in Column II. In Column III, use each of the words to complete the sentence, "I would like to be a (an) \_\_\_\_\_ person." as you did for Column I. Here you are to indicate how much of the time you would like the trait to be characteristic of yourself. The ratings here are the same as in Column I.

	I	II	III		I	II	III
1. acceptable	_____	_____	_____	26. merry	_____	_____	_____
2. accurate	_____	_____	_____	27. mature	_____	_____	_____
3. alert	_____	_____	_____	28. nervous	_____	_____	_____
4. ambitious	_____	_____	_____	29. normal	_____	_____	_____
5. annoying	_____	_____	_____	30. optimistic	_____	_____	_____
6. busy	_____	_____	_____	31. poised	_____	_____	_____
7. calm	_____	_____	_____	32. purposeful	_____	_____	_____
8. charming	_____	_____	_____	33. reasonable	_____	_____	_____
9. clever	_____	_____	_____	34. reckless	_____	_____	_____
10. competent	_____	_____	_____	35. responsible	_____	_____	_____
11. confident	_____	_____	_____	36. sarcastic	_____	_____	_____
12. considerate	_____	_____	_____	37. sincere	_____	_____	_____
13. cruel	_____	_____	_____	38. stable	_____	_____	_____
14. democratic	_____	_____	_____	39. studious	_____	_____	_____
15. dependable	_____	_____	_____	40. successful	_____	_____	_____
16. economical	_____	_____	_____	41. stubborn	_____	_____	_____
17. efficient	_____	_____	_____	42. tactful	_____	_____	_____
18. fearful	_____	_____	_____	43. teachable	_____	_____	_____
19. friendly	_____	_____	_____	44. useful	_____	_____	_____
20. fashionable	_____	_____	_____	45. worthy	_____	_____	_____
21. helpful	_____	_____	_____	46. broad-minded	_____	_____	_____
22. intellectual	_____	_____	_____	47. businesslike	_____	_____	_____
23. kind	_____	_____	_____	48. competitive	_____	_____	_____
24. logical	_____	_____	_____	49. fault-finding	_____	_____	_____
25. meddlesome	_____	_____	_____				







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