EFFECTS OF ADLERIAN PARENT EDUCATION ON PARENTS'
STRESS AND PERCEPTION OF THEIR LEARNING
DISABLED CHILD'S BEHAVIOR

DISSERTATION

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

For the Degree of

DOCTOR OF PHILOSOPHY

by

Sherry R. Latson, M. Ed.
Denton, Texas
August, 1986

This study examined the effects of an Adlerian-based parent education program on parental stress and perception of Learning Disabled (LD) children's behavior. Forty parents, randomly assigned to treatment or waiting-list control groups, took the Parental Stress Index (PSI) and the Adlerian Parental Assessment of Child Behavior Rating Scale (APACBS) as pre and post tests. Parents in the treatment group attended a six-session Active Parenting program.

No significant differences were found on the analysis of covariance for perceived parental stress following the parent education program. Seventy percent of the parents in this study had total PSI scores in the range defined as high stress by the PSI author. All of the PSI Child Domain pretest z scores were elevated indicating that parents perceive their LD children to be demanding, moody, distractible, and unadaptable. LD children's behavior is perceived as unacceptable and does not positively reinforce parents. The elevated z scores on the PSI parent Domain pretest indicate that parents of LD children feel less competent as parents and experience less attachment to their children than do parents of normal children.

No significant differences were found on the APACBS following treatment, but 80 percent of the parents in the
treatment group did perceive some positive behavior change. A positive correlation was found between the PSI and the APACBS indicating that perceived parental stress and child behavior are related. Parents identified 67 perceived stressors of raising LD children on a questionnaire.

The results of this study indicate that parents of LD children perceive themselves to experience greater parenting stress than parents of normal children. This perceived parental stress was not reduced and perception of children's behavior was not improved after participation in the Active Parenting program. Therefore, parent education groups for parents of LD children may need to be smaller, provide more time to address the issues specific to raising an LD child, and include a stronger counseling emphasis in order to provide more emotional support for these highly stressed parents.
TABLE OF CONTENTS

LIST OF TABLES ....................................................... iv

Chapter

I. INTRODUCTION .................................................... 1

   Related Literature ............................................. 5
   References ..................................................... 37

II. PROCEDURES .................................................... 42

   Hypotheses ..................................................... 42
   Subjects ......................................................... 43
   Instruments ..................................................... 44
   Active Parenting Program ...................................... 49
   Data Collection ............................................... 51
   References ..................................................... 53

III. RESULTS AND DISCUSSION ................................... 54

   Analysis of Data ............................................... 54
   Related Findings .............................................. 67
   Discussion ..................................................... 73
   References ..................................................... 91

APPENDICES ........................................................... 94

BIBLIOGRAPHY ....................................................... 108
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Demographic Information</td>
<td>56</td>
</tr>
<tr>
<td>II. Means and Standard Deviations for the Total Score on the Parent Stress Index</td>
<td>57</td>
</tr>
<tr>
<td>III. Analysis of Covariance for the Total Score on the Parenting Stress Index</td>
<td>58</td>
</tr>
<tr>
<td>IV. Means and Standard Deviations for the Parent Domain of the Parenting Stress Index</td>
<td>59</td>
</tr>
<tr>
<td>V. Analysis of Covariance for the Parent Domain of the Parenting Stress Index</td>
<td>59</td>
</tr>
<tr>
<td>VI. Means and Standard Deviations for the Child Domain of the Parenting Stress Index</td>
<td>60</td>
</tr>
<tr>
<td>VII. Analysis of Covariance for the Child Domain of the Parenting Stress Index</td>
<td>61</td>
</tr>
<tr>
<td>VIII. Means and Standard Deviations for the Adlerian Parental Assessment of Child Behavior Rating Scale</td>
<td>62</td>
</tr>
<tr>
<td>IX. Analysis of Covariance for the Adlerian Assessment of Child Behavior Rating Scale</td>
<td>62</td>
</tr>
<tr>
<td>X. Parent Stressors Identified by Parents of LD Children</td>
<td>65</td>
</tr>
<tr>
<td>XI. Child Characteristic Stressors Identified by Parents of LD Children</td>
<td>66</td>
</tr>
<tr>
<td>XII. Means, Standard Deviations and z Scores for the Parenting Stress Index</td>
<td>68</td>
</tr>
<tr>
<td>XIII. Means, Standard Deviations, and Adjusted Post-test Scores for the Subscales of the PSI</td>
<td>70</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

All families experience many normative and transitional life events, such as birth, death, and moving, as well as catastrophic stressors such as war, economic depression or tornados. In addition, all parents are subject to the inherent chronic stressors of parenting. Parental psychological stressors are related to the worries that parents have about the physical safety and the growth and development of their children. Parents generally take pride in their children's accomplishments and are hurt by their children's failures. Parenting is particularly difficult and stressful when children do not "measure up" to family or community expectations (LeMasters, 1970). The potential for this failure related stress is especially high for parents of learning disabled children (Faerstein, 1981).

A child's learning disability (LD) often can lead to stress for both the parents and the child because, by the nature of the problem, LD children often face academic failure in the usual school setting. The consequences of such failure may be motivating or discouraging, depending on the child's perception of the failure. Likewise, the parents' perception of and reaction to the child's failure
may contribute to how they, the child, and the family manage the stress of failure (Schaffer & Schaffer, 1982).

Some families cope successfully with their child's problems because they perceive problems realistically and have developed strategies for coping with them. Other families do not have positive ways to deal with problems and therefore suffer from great stress. Counselors can be of assistance to these stressed families in various ways. Parent education classes, in particular, can provide parents the opportunity to learn to deal with child and family problems and also provide a setting in which parents support and help one another (Miller & Myer-Walls, 1983).

Although there are many different approaches to parent education, the Adlerian approach, based on the principles of Individual Psychology, has proven to be effective with many parent groups (American Guidance Service, 1985). Therefore, the Active Parenting program, based on Adlerian principles, was used in this study. This Adlerian approach to parent education is particularly relevant for parents who are experiencing psychological stress because Adlerian psychology and the phenomenologically based theories of stress emphasize the same principles.

Phenomenology is an individual's subjective reality, including impressions, views, perceptions and conclusions (Manaster & Corsini, 1982). Phenomenological theories of stress emphasize that the individual's perception of the
stressor or the event is a major component of distress. Likewise, in families, the perception of the stressor by the family members is the critical factor in determining the amount of strain the stressor will create within the family (McCubbins & Figley, 1983). Abidin's (1983) research on parenting stress also indicated that parents' perceptions of their child's behavioral characteristics is a major factor in the parents' total stress. Thus, if the parents' stress level is to decrease, parents must learn to deal effectively with their own perception of stressors, as well as with the child's behavior.

Adlerian parent education focuses on both the stressor and the perceived stress. In Adlerian parent education groups, parents learn how to change their own phenomenological attitudes as they learn to cope with the stress of their children's behavior by teaching their children responsible behavior through the use of encouragement, natural and logical consequences, and consistency (Yura, 1981). The emotional and social support needed for stress reduction (Miller & Myers-Walls, 1983) can be provided by Adlerian parent education groups because major components of the program are encouragement by the group and the recognition of commonality of problems.

Because of the principles common to Adlerian parent education and theories of family stress, Adlerian parent groups would seem to be an appropriate approach for helping
parents learn to deal with parental stress. However, no research was found that specifically addressed parental stress and parent education. Adlerian parent education groups have been found to be effective in changing parental attitudes (Frazier & Matthes, 1975; Freeman, 1975; Hammett, Omizo, & Loffredo, 1981; Schultz, Nystul, & Law, 1980; Williams, Omizo, & Abrams, 1984), improving child rearing practices (Berrett, 1975; Croake & Burness, 1976; Frazier & Matthes, 1975; Freeman, 1975), and furthering family cohesiveness and changing family environment (Campbell & Sutton, 1983). While none of these studies actually measured parental coping skills or stress levels, all of these findings are tangentially related to coping strategies needed by parents.

Because parenting stress has been found to be related to parents' perceptions of their children's behavior (Abidin, 1983), parent education groups should focus on change in the perception of children's behavior. The results of studies on perceived change in children's behavior through participation in Adlerian parent groups have been mixed. Some studies have demonstrated significant change in perceptions (Berrett, 1975; Fears, 1976; Freeman, 1975; Hinckle, Arnold, & Croake, 1980; Palmo & Kuzniar, 1972), while others have shown little or no change (Croake & Burness, 1976; Frazier & Matthes, 1975).
Although many studies have examined the effectiveness of Adlerian parenting groups for parents of normal children, few studies have focused on Adlerian parenting groups for parents of learning disabled children. Practitioners have hypothesized that learning disabilities create stress for parents (Briard, 1976; Faerstein, 1981; Schaffer & Schaffer, 1982), but only one research project (Heibert, Wong, & Hunter, 1982) was found that examined parental stress of parents of LD children. No study was found that examined the effect of parenting groups upon this stress, or the relationship of parenting stress and perception of LD children's behavior.

Because parents' perceived behavior of their children has been shown to be a component of parental stress (Abidin, 1983), because the research on the effectiveness of Adlerian parent groups on children's behavior change is inconclusive, and because studies of parenting stress and the use of Adlerian parent groups for parents of LD children were not found in the literature, further study of these topics seemed warranted. This study examined the effect of an Adlerian parent education group on parents' stress and perception of their LD child's behavior.

Related Literature

Few studies were found that specifically examined the stress of parents of learning disabled (LD) children or the effects of education groups on parental stress; therefore,
this discussion focuses on studies related to (1) parenting LD children; and (2) Adlerian parent education. Since the empirical studies of parental stress and parent education for parents of LD children is limited, theories and observations of practitioners who work with parents of exceptional children are summarized first.

**Parenting Learning Disabled Children**

Parents of children with any handicap face difficult child-rearing tasks, but parents of learning disabled children seem to face some unique problems. The LD child's handicap is invisible. Often, as an infant and preschooler, the child is irritable, active, and gives little positive feedback to the parent, but is not identified as having a learning disability until school age. The family may have reacted adversely to the child before it was apparent that the child had impairments (Faerstein, 1981). When the child's problems are diagnosed, the family may have to adjust their aspiration level for the child. The family homeostasis is threatened (Silver, 1974), and the child may become a scapegoat and be viewed as the source and cause of family and marital problems (Kaslow & Cooper, 1978).

A learning disability may predispose children and parents to stress. Whether a child and parent will experience stress is a function of the individual's perception of the event and the interaction of the environment (Schaffer & Schaffer, 1982). A learning disabled child's ability to
cope with problems is a function of the severity of the handicap, the supportiveness of the environment, the child's self-concept, and previous experience with confronting failure. LD children sometimes develop self-defeating patterns of behavior because they lack appropriate alternative coping strategies (McNamee & McNamee, 1981). They need significant adults to help them learn more effective strategies. Parents are a logical choice because of their emotional involvement and the amount of time spent with the child (Murray, 1973). Parents can significantly modify their LD child's self-concept (Hammett, Omizo, & Loffredo, 1981).

These concepts of family interdependence, personal perception, and the importance of parents in the development of children are all basic to Individual Psychology (Manaster & Corsini, 1982). The Adlerian view of disabilities is that each individual formulates a personal response to a handicap. Each individual's lifestyle is developed early in childhood according to the individual's interpretation of experiences and difficulties. What each person chooses to do with life experiences determines the lifestyle (Dreikurs, 1946).

Three common behavior patterns of exceptional children were identified by Dreikurs, the foremost proponent of Individual Psychology in America, as pamperedness, discouragement, and overcompensation (Zuckerman & Zuckerman, 1982). Pamperedness can be manifested by LD children in different ways. Some pampered children believe that they receive
attention only for their lack of performance, other pampered
children demand the service of others because so much is done
for them, and some pampered children become helpless because
others will care for them when they are frustrated. Discour-
agement is another common behavioral pattern in exceptional
children because the potential for failure is high and these
children are not taught a successful way to deal with it.
Discouraged children may react to their mistaken beliefs about
their worth and ability by avoiding stressful events, seeking
negative attention or acting-out. The third behavioral pat-
tern found in exceptional children, overcompensation, is dis-
played by LD children who avoid areas in which they experience
difficulty and put all their energy into an area of strength.

Parents of learning disabled children often become dis-
couraged themselves. Adlerian practitioners, through clinical
observations, have noted the ways in which this parental dis-
couragement contributes to difficulties in the parenting of
exceptional children. Parents of exceptional children find
that techniques that worked with their other children may not
be as effective with their learning disabled child. They get
caught in the confusion of sorting out the behaviors that are
clearly misbehaviors and the behaviors that are associated
with the disability (Zuckerman & Zuckerman, 1980). The
parents' own mistaken ideas about parental responsibility
and their personal reactions to the child's difficulty in-
fluence their parenting behaviors and attitudes.
Practitioners have reported that parents of exceptional children may overprotect or reject the child, deny problems, or become martyrs (Yura, 1983). If any of these behaviors occur, the child will be even more demanding of the parents and will create further strain in the parent-child relationship since this relationship is affected by the child's characteristics, external stressors, and the parent's level of psychological stress (Abidin, 1983). A circular, interactive dynamic is set up between parents and child and stress escalates.

Some studies have attempted to validate the reported observations and theories of the practitioners in regard to parenting LD children. Studies of parental attitudes and perception of children's behavior have been done using self-report instruments, interviews, and by observing parent-child interaction and parent and child behavior.

The only study found that empirically measured parenting stress was done by Hiebert, Wong and Hunter (1982) using a self-report measure, the State-Trait Anxiety Inventory, with parents of LD adolescents. They found that parents of LD adolescents did not obtain significantly higher stress scores than parents in the control group.

Although no other study was located that specifically measured parental stress, many studies have examined parental attitudes and behaviors of parents of LD children. Wetter (1972) used self-report measures to investigate several
hypotheses: (1) mothers of LD children would show greater overprotection, overindulgence, and rejection towards the child than mothers of non-LD children; (2) fathers would perceive the child as being better adjusted than the mothers; (3) parents with an LD child would show greater disagreement in assessing adjustment than parents of non-LD children. Seventy sets of parents registered in a pediatrician's out-patient clinic completed the Child Behavior Rating Scale and the Mother-Child Relationship Evaluation, and the results showed that parents of LD children did have significantly higher scores on measures of overindulgence and rejection than did parents of non-LD children. Wetter concluded that there were no differences between paternal and maternal attitudes of perception on their LD child's adjustment, but the degree of agreement between parents of LD children was less than the degree of agreement between parents without an LD child.

Maternal attitudes as measured by The Parental Attitude Research Instrument were studied by Humphries and Bauman (1980). This self-report instrument was given to 35 mothers of normal achievers and 35 mothers of learning disabled children. Univariate analyses of variance using unweighted factor scores revealed that mothers of LD children were significantly more authoritarian and controlling in child-rearing, had significantly lower democratic attitudes, and were significantly less hostile and rejecting. The authors suggested that the
mothers of LD children had adopted an authoritarian and restrictive child-rearing philosophy because of their perception of the child's need for structure due to the typical LD characteristics of disorganization, motor awkwardness, frustration, poor attention, and school failure.

These typical LD characteristics were defined as a "syndrome" by Strag (1972) after his research on parental perception of LD children's behavior. Strag compared the scores on behavior rating scales filled out by 56 parents of normal children, 23 parents of retarded children, and 30 parents of learning disabled children. The Behavior Rating Scale developed by Strag consisted of a total of 30 items, some indicating possible neurological dysfunction, behavioral or emotional disturbance, and some items which had little or no diagnostic function. Parents were asked to rate frequency of each behavior on a scale of one to five. Means, standard deviations, and F-tests were used to compare the responses of the three groups. Parents of LD children rated their children more negatively than did parents of normal children on their perception of their children's consideration of others, ability to receive affection, clingingness, tendencies to be rigid, general negativism, physical coordination, and fatigability. Four variables were found to be significantly different when responses of parents of retarded children were compared to parents of LD children. Jealousy and clingingness were lower for mentally retarded (MR) children,
and stubbornness and ability to receive affection were higher for MR children. Strag concluded that certain behaviors reported by parents of LD children were characteristic of the LD population and differed from observations reported by both parents of normal children and mentally retarded children.

The constellation of behaviors associated with learning disabilities appears to influence parents' attitudes towards their children. Boersma and Chapman (1979) studied 81 children with learning disabilities and 81 normally achieving students and their mothers. The children completed the Intellectual Achievement Responsibility Questionnaire to measure locus of control and the mothers completed the Parent Reaction Questionnaire and the Projected Academic Performance Scale. The mothers of LD children reported significantly more negative interactions with their children and significantly less positive reactions to their children's school behavior, and expected their children to perform less well on future academic tasks than did mothers of normally achieving children. The authors expressed concern that parents of LD children may give up on their children's academic achievement, thus setting up a self-fulfilling prophecy of failure with the children. They suggested that parents should be helped to understand how their expectations and the parent-child interactions affect learning, and should be given assistance in setting appropriate goals and expectations.
Another study of parental expectations used interviews to explore parental perceptions of strengths and weaknesses (Bryan, Pearl, Zimmerman, & Matthews, 1982). Fifty-six mothers of elementary school students were interviewed about their child's strengths and weaknesses, the causes of their child's strengths and weaknesses, predictions for future performance, and comparison of their child to classmates on six dimensions. In comparison to mothers of nondisabled children, mothers of learning disabled children described their children as having fewer academic, social, and behavioral strengths, were more pessimistic about the child's future performance, and tended to express feelings of less self-efficacy.

A combination of self-report and observation was used to focus on material expectations and birth order in families with normal and LD children in a study by Epstein, Berg-Cross, and Berg-Cross (1980). Ten families were included in each of these four groups: (1) LD-B1 in which the LD child was first-born; (2) LD-B2 in which the LD child was second-born; (3) N-B1 in which the normal control child was first-born; (4) N-B2 in which the normal control child was second-born. Only boys between the ages of eight and ten were included in the study. Mothers predicted their child's performance on the tasks of Block Design from the Weschler Intelligence Scale for Children-Revised (WISC-R); the Spelling subtest from the Wide Range Achievement Test, and a beanbag catch. Mothers were also asked to complete five subscales from the
Personality Research Form and the Mother-Child Relationship Evaluation. Each child in the study performed the three tasks after the mother predicted the child's performance. The results showed that mothers who had first-born LD children tended to have significantly higher expectations on the WISC-R for the normal sibling, and significantly lower expectations for the LD child. When the LD child was second-born, the mothers tended to underestimate both children. In the control group, the maternal expectations were generally consistent for each child. Mothers of first-born LD children showed significantly greater overprotection and a significantly lower need for social approval. The authors concluded that mothers with first-born LD children were more affected because they did not have previous satisfactory child-raising experiences to draw upon.

Family dynamics were studied by Amerikaner and Omizo (1984) with 180 predominantly white, middle-class families that had children ranging in age from five to fourteen. Both parents of 30 LD children, 30 emotionally disturbed (ED) children, and 30 normal children took the Family Adaptability and Cohesion Evaluation Scales (FACES). FACES is designed so that scores fall into one of four ordered categories on two scales. For the scale of Adaptability, the categories are designated as rigid, structured, flexible, and chaotic, and in the scale of Cohesion, the categories are entitled disengaged, separated, connected, and enmeshed. Disengaged
and enmeshed are considered problem categories for the Cohesion scale; rigid and chaotic are the problem categories for the Adaptability scale. A series of chi-square analyses indicated that LD family interaction is significantly different from non-problem families and similar to the interaction in families with emotionally disturbed children. The exception was that mothers of LD children, when compared to mothers of ED children, less frequently perceived their families in the disengaged direction, and more frequently in the connected direction on the Cohesion scale. Parents of normal children perceived their families as enmeshed, which was operationally defined as a problem category. Parents of LD children and parents of ED children both perceived their families as chaotic on the Adaptability scale.

To investigate parental attitudes, and coping functions and defense mechanisms, Faerstein (1986) interviewed 24 mothers of LD children who attended the Pediatric Neurology Clinic of a large metropolitan medical center. Although practitioners have reported in the literature that parents commonly react with shock, grief, and denial when their child's learning disabilities are diagnosed, Faerstein found that parents in her sample had suspected for some time that there was something wrong with their child, although they could not identify the problem. These mothers described feelings of relief on confirmation of their suspicions. Only four mothers stated they were angry or depressed, and
only one mother denied the problem. Fifty-eight percent of
the mothers felt responsible in some way for the child's
disability and seven mothers said they did not think about
what could have caused the learning disability. Faerstein
reported that coping functions did break down and that, when
parents were in direct confrontation with the child, projec-
tion, denial of the problem, and displacement of anger onto
the child were evidenced. One-half of the parents did not
explain the diagnosed learning disability to the child in an
effort to protect the child from upset. Faerstein did not
quote actual numbers, but she reported that some mothers de-
scribed feelings of frustration and anger which led to physi-
cally aggressive acts towards the children or ridicule of
them. Mothers were very aware of how they thought others
saw them. Often the mother attributed to others the belief
that she was a bad mother, rather than recognizing the belief
as her own.

Actual behavioral observations provide valuable infor-
mation that self-report or interview measures cannot provide.
Doley, Cartelli, and Doster (1976) used both observation
and self-report in their study of mother-child interaction
of nonclinic children, noncompliant children and LD children.
Mother-child interaction was observed through one-way glass
in a 20-minute play session. For the first 10 minutes, the
child could choose what to play with and how to interact
(Child's Game). For the second 10 minutes, the mother
determined and directed the activities (Mother's Game).
The frequency of the maternal behaviors of Rewards, Commands, Questions, and Criticisms were coded during the Child's Game, and the child's compliance was recorded during the Parent's Game. Maternal attitudes and perception of their children's behavior was assessed by the Parent Attitude Test. An analysis of variance showed that the mothers in the LD group gave significantly more rewards than nonclinic mothers and asked significantly more questions than both clinic and non-clinic mothers. The nonclinic mothers elicited a higher percentage of compliance from their children than either the clinic or LD mothers. A multiple comparison test showed that the compliance scores of the mothers in the LD group were significantly higher than the nonclinic group but significantly lower than the clinic group. The authors noted that parents of LD children reported problem behavior in nonacademic, as well as academic, areas. The LD children demonstrated a comparatively low percentage of compliance behavior in response to parental commands and the parents described their LD children as having inappropriate verbal behavior, poor peer relations and poor self-help skills. Even though similar behaviors were observed and reported for both the clinic group and the LD group, parents of LD children perceived their children as better adjusted than the clinic population because misbehavior by LD children was seen as a function of the learning disability rather
than a behavior disorder. The authors noticed that, although mothers of LD children had higher rates of rewarding behavior, the rewards often followed the child's inappropriate behavior. The authors believed that the high rate of questioning and the low rate of compliance behavior recorded in the play observation indicated a need for parent counseling and training for management of children's behavior.

In summary, the research indicates that parents of LD children perceive their children as having behavioral characteristics that make their parenting role more difficult. As a result, these parents may have attitudes and behaviors that contribute to their children's negative self-perceptions and misbehaviors. Almost every study of LD children and their parents discussed the need for counseling and/or parent education. Therefore, professionals need to establish effective ways to help these parents deal with their own personal stress as they, at the same time, work to help their LD children. Individual counseling is one way to work with these parents, but research has shown that parents are more likely to take suggestions from other parents in a group than from a counselor in an individual session (Chapin, 1949) and that parents, by sharing experiences, learn to perceive their exceptional children differently and to deal with problems more effectively and realistically (Apell, Williams, & Fishell, 1964).
Adlerian Parenting Groups

Parents of Normal Children. Much research has been done to determine whether Adlerian parenting groups are effective. Studies conducted prior to the late 1970's primarily reported using *Children: The Challenge* (Dreikurs & Soltz, 1964) as the curriculum base for parent education, while studies from the late 1970's primarily reported the use of the *Systematic Training for Effective Parenting* (STEP) program (Dinkmeyer & McKay, 1976). Most of the research has focused on parental attitudes with or without concomitant parental perception of behavior change in their children. Most of the studies relied heavily on self-report measures. The research findings regarding the effectiveness of parent education for attitude and perception of behavioral change have been mixed, and this review includes a discussion of the researchers' explanations for these inconsistencies.

To measure change in parental attitudes, child-rearing practices and perception of children's behavior across time, Croake and Burness (1976) used the *Attitudes Towards Freedom in Children, Child Rearing Practices Scale*, and the *Children's Behavior Checklist* with 109 subjects divided into five groups. Two of the groups participated in a parent education program using *Children: The Challenge*, and three groups served as controls. One control group was tested every week, one experimental and one control group was tested after four weeks, and the other two groups were tested after six weeks. Scores
on the behavior checklist did not improve as a result of participation in the parent education group. Positive changes in parent attitudes of participants in the experimental groups were evident at the fourth week, but not at the sixth. The authors stated that they believed the subjects experienced testing fatigue because they filled out four questionnaires weekly, thus making the results of the sixth week testing inaccurate. They also believed that the democratic attitude change in the parents will occur before behavior change in the children is noted.

To further investigate change in parental attitudes and perception of behavior over time, Croake, along with Hinckle, Keller & Arnold (1980), administered the Attitude Towards Child Rearing Scale, the Child Rearing Practices Scale and the Children's Behavior Checklist to 100 parents 4 times during a 9-week period and the Self-Esteem Inventory to 60 of the parents' children during the first and last week. One-half of the parents were designated as the experimental group and participated in an Adlerian parent education program during this same period. The parents in the experimental group had significantly improved scores on all measures following treatment. However, perceived misbehavior increased as measured by the Child Behavior Rating Scale for the experimental group at week five, then dropped off. The authors stated that two things could account for this pattern. The parents could have become more sensitive and aware of their
children's behavior during the course of the class, thus increasing their scores on the checklist; and the children's behavior could have become worse temporarily as a means of testing parental changes.

Croake and Hinckle (1983) did a third study of 39 married and 34 unmarried participants in an open-ended family education program which used families from the audience for counseling/education demonstration. The participants took the *Minnesota Multiphasic Personality Inventory* and the *Child Rearing Practices Scale* during the first session and then again when they discontinued participation in the program. Twenty-four sessions were held, but the median number of sessions attended was eight. T-tests revealed significant differences from pretest to post-test. The married participants with children significantly improved their test scores in a favorable direction on the Manifest Anxiety, Social Desirability, and Dependence scales of the *Minnesota Multiphasic Personality Inventory* and the total score on the *Child Rearing Practices Scale*.

Several studies reported in 1975 used similar instruments and procedures to measure effectiveness of Adlerian parent education (Berrett, 1975; Frazier & Matthes, 1975; Freeman, 1975). Child-rearing attitudes and practices were measured with the *Attitude Towards Freedom of Children Scale* and the *Child Rearing Practices Scale*. Berrett and Freeman both used the *Child Behavior Checklist*, and Frazier and Matthes
used the Freeman Behavior Checklist to assess parental perception of behavior change. Frazier and Matthes divided their 49 participants into a control group, an Adlerian group using Children: The Challenge, and a Behavior Modification group. They found that the Adlerian group scored significantly higher on the Attitudes Towards Freedom of Children Scale than the other two groups, and on 9 of the 27 items in the Child Rearing Practices report. However, since none of the groups differed significantly on the Freeman Behavior Checklist, the authors questioned the use of a parents' group to impact change on children's behavior.

Freeman, in a similar study, divided 66 parents into two Adlerian parent education groups, two unstructured mothers' discussion groups and one control group. The Adlerian groups, using Children: The Challenge, reported significantly less use of spanking, withdrawal of privileges, confinement, and bribes on the Child Rearing Practices Scale than the other groups, significantly less bothersome behaviors from their children on the Child Behavior Checklist than the control group, and significantly more democratic child-rearing attitudes on the Attitudes Towards Freedom of Children than the control group following treatment. The parents in the unstructured discussion groups reported significantly more allowance for child participation in family decision making and more parent-child play on the Child Rearing Practices Scale than the parents in the Adlerian
parent education groups following treatment. The authors concluded that Adlerian parent groups were more effective than no treatment in changing mothers' child-rearing attitudes, some child-rearing practices, and children's misbehavior, but were not significantly more effective than mothers' unstructured discussion groups.

Berrett (1975) used the same instruments and parent education program in his study, but included one group of parents who had hearing impaired children. He also wanted to determine if pretesting influenced the post-test scores, so two of the groups (one with 11 parents of normal children, and one with 5 parents of deaf children) took the pretest, while the third experimental group of 11 parents of normal children did not. The results showed that the pretest-treatment interaction was not significant for any of the instruments. Both experimental groups had significantly lower scores on the Attitudes Towards Freedom of Children Scale and the Child Rearing Practices Scale following treatment and indicated more democratic attitudes and child-rearing practices, but only the parents of the deaf perceived improved behavior change of their children on the Child Behavior Checklist. While the authors did not mention the difference in the size of the groups, one possible explanation for the significant difference in perception of children's behavior for parents of deaf children
might be that the parents in the smaller group received more attention regarding their specific child-rearing concerns.

To compare Parent Effectiveness Training, Adlerian (using *Children: The Challenge*) parent groups, Behavior Modification, Placebo, and Control groups, Schultz, Nystul, & Law (1980) used the *Attitudes Towards Freedom of Children Scale*, parental ratings of improvement in behavior, and the *Parental Attitude Research Instrument*. Three different leaders were assigned to each of the 4 treatment conditions resulting in 12 groups. One hundred and twenty parents attended enough sessions to be counted in the study. A follow-up was completed on 28 mothers 12 months after their groups ended. The results showed that a significant short-term attitude change occurred for all three parent education groups when compared to the control and placebo groups, but the PET group had significantly more democratic attitudes towards child-rearing practices. All three models also produced significantly more democratic attitudes than the control groups at the follow-up. The three treatment groups all significantly rated their families as happier as a result of the course. Leader variables, such as age and marital status, did not influence outcome when leader expertise and experience were controlled.

The *Parent Attitude Scale* was used by Summerlin and Ward (1981) in their study of the attitudes of parents of 50 children in kindergarten through second grade. Twenty-five
of the parents participated in the STEP program and twenty-five served as controls. MANOVA and a discriminant function analysis showed that parents who completed the STEP program were more accepting of their children's feelings and behavior and they trusted their children more as individuals.

Family structure and children's behavior were examined by McDonough (1976) by using questionnaires and behavioral records entitled Behavioral Records and Day at Home. Thirty parents who attended various Family Education Centers, a "quasi-control" group (n = 25) selected from a suburban population, and a comparison group (n = 14) of parents who had already completed the parent education program completed the instruments. No statistical data is reported in the article, but McDonough stated that parents in the experimental and comparison group had more democratic patterns of interaction and less tension in regard to their children's actions. The misbehavior of the children did decrease, but a significant decrease was not maintained over time.

Changes in family environments as a result of participation in a STEP program were studied by Campbell and Sutton (1981). One hundred and forty parents were divided into thirteen parent education groups. A comparison group was composed of parents enrolled in continuing education courses. Parents completed the Family Environment Scale, the Child Behavior Scale, and the Attitudes Towards Freedom of Children Scale as a pretest and post-test. The experimental group
also completed a delayed post-test. Analysis of covariance revealed statistically significant liberal adjusted scores on the *Attitudes Towards Freedom of Children* for the experimental group. The Cohesion, Independence, and Control sub-scales of the *Family Environment Scale* changed significantly in a positive direction. The *Child Behavior Scale* showed a curvilinear pattern of behavior change for the children similar to that reported by previous research (Croake & Burness, 1976; Hinckle, Croake, Keller, & Arnold, 1980) which indicated, in the authors' opinion, intensification of the problem behavior is the first step in changing it.

Some studies have focused only on perceived behavioral change in the children of parents who attended Adlerian parent groups. Hillman and McKay (1979) used the *Adlerian Assessment of Child Behavior Rating Scale* to assess parental perception of behavior change of 20 parents divided into a STEP program group and a control group. The analysis of covariance showed that the experimental group had significantly higher scores on the *Adlerian Assessment of Child Behavior Rating Scale* following treatment than the control group, indicating that the parents in the experimental group perceived their children's behavior as positively changed.

Fears (1976) developed an instrument to measure parental perception of children's behavior change. Seventy-five parents who completed the eight-hour Adlerian parenting course took the questionnaire as a pretest and post-test.
Twenty-three of the forty behaviors included on the questionnaire were rated by the parents as significantly more positive after they had completed the course. The parents also reported less agreement about child-rearing with their spouses who did not attend the course. Fears cautioned counselors to be aware of this finding and to encourage both parents to participate in parent education.

Most of the studies that have been reported here have relied on self-report, but Moore and Dean-Zubritsky (1979) used behavioral observations in addition to the Attitudes Towards Freedom of Children and the Parental Attitude Research Instrument to measure effectiveness of parent education. They studied eight control families, and eight families who attended eight sessions of an Adlerian parenting group using Children: The Challenge as the text. Each family was videotaped for seven minutes before and after the parent education experience. A modified version of the Merrill Mother-Child Interaction Scale was used to code behaviors. The results showed that parents in the experimental group had significantly higher democratic post-test scores on the Attitudes Towards Freedom of Children and on six scales of the Parental Attitude Research Instrument. After treatment, the experimental parents were observed on the videotaped behavior samples to show more contact with their children and more encouragement, but they also became more directive.
Some studies have looked at changes in children's attitudes in addition to parental attitudes and perception of behavior change. Meredith and Benniga (1979) used the **Attitudes Towards Freedom of Children Scale** and the **F-Scale** to measure parent attitudes, and the **I Feel...Me Feel** instrument to measure children's self-concept. The **STEP program** was used with 14 parents of children in kindergarten through second grade who scored below the mean on the self-concept scale. The parent control group consisted of parents in a graduate education program. The children's control group (n = 28) consisted of children who also scored below the mean on the self-concept scale, but whose parents did not attend the parent education program. The analysis of variance with repeated measures showed no significant difference between the pretest and post-test means for the experimental and control groups on **Attitudes Towards Freedom of Children** or the children's self-concept score. The **F-Scale** showed significantly lower authoritarian scores for the experimental group following treatment.

Another study of change in children's self-concept as a result of parent education was done by Esters & Levant (1983). They compared the **STEP program** to a **Self-Esteem Method (SEM)** group with rural, lower socioeconomic parents. The 33 parents of low achieving third through fifth graders were divided into a **STEP group**, a **SEM group**, and a wait-list control group. The **Piers-Harris Children's Self-Concept Scale**, the
Coopersmith Behavior Rating Form for Teachers, and grade point average were used for pretests, post-tests, and follow-up assessment. The results showed that both parent groups had a positive impact on academic achievement which was maintained at the follow-up. At post-test, the Self-Esteem Method group reported higher self-esteem scores on the Piers-Harris Children's Self-Concept Scale than the STEP or control group. On the Behavior Rating Form for Teachers, teachers reported significantly higher scores for both experimental groups. By follow-up, however, only the Self-Esteem Method group showed a significant difference on both measures of self-esteem. The authors stated that the emphasis on the feeling dimension of the Self-Esteem Method group probably accounted for the higher scores on the Piers-Harris Children's Self-Concept Scale for this group. However, Esters and Levant noted that both groups were effective in changing children's behavior.

Another group of studies examining effectiveness of Adlerian parent groups are those which included the children in the counseling process. In order to compare effectiveness of direct intervention with indirect intervention in changing children's behavior, Taylor and Hoedt (1974) compared group counseling of elementary school children with Adlerian group counseling of significant adults. Three hundred and seventy-two children with behavior problems were randomly assigned to one of four treatment groups. The first group consisted
of parents who used *Children: The Challenge* as the basis for their group. The second group consisted of teachers who used *Encouraging Children to Learn* (Dinkmeyer & Dreikurs, 1963). The third group consisted of children who participated in eclectic group counseling, and the fourth group served as the control. Analysis of variance following a 10-week treatment period indicated that counseling with significant adults was significantly more effective in reducing behavior problems as measured by the *Devereux Elementary School Behavior Rating Scale* than direct counseling with the children. Results indicated that a significantly greater percentage of children improved who had either parents or teachers who participated in the Adlerian education group.

The effectiveness of using an Adlerian children's group which was conducted during the same period as an Adlerian parent's group was studied by Wantz and Recor (1984). The *Adlerian Assessment of Child Behavior Rating Scale* was used to measure perceived behavior change in the children of the eleven families who participated. The average age of the children was 4.06 years. The children were divided into three age groups, but all of the children's groups used the *Developing Understanding of Self and Others* kit as a basis for their group experience. The mean score on the *Adlerian Assessment of Child Behavior Rating Scale* significantly increased from the pretest to the post-test. Improvement was noted on 75 percent of the 32 items from pretest to post-test.
In summary, Adlerian parent education with parents of normal children has been effective in changing parental attitudes and child rearing practices towards a more democratic style of parenting. However, findings related to changes in parents' perception of children's behavior have been less consistent. Some researchers have indicated that change in children's behavior will occur after changes in parent attitudes and behavior have had a chance to take effect. The curvilinear pattern of perception of change in children's behavior noted by some research seems to be related to increased parental sensitivity to their children's behavior, as well as the children's tendency to increase misbehavior as a means of testing parental consistency.

Parents of Learning Disabled Children. One of the problems in determining the effectiveness of Adlerian parent education has been the use of several different kinds of Adlerian programs. The programs vary in length, curriculum, group size, format and materials used. Croake and Glover (1977) have suggested that this lack of standardization makes research difficult to replicate and compare. The use of structured programs can eliminate this problem to some extent. The use of the STEP program in research of Adlerian parenting groups became popular in the late 1970's at about the same time that interest in parent groups for parents of LD children grew. Therefore, reported research using the Adlerian approach to parent education with parents of LD
children was usually done using The Systematic Training for Effective Parenting (STEP) (Dinkmeyer & McKay, 1976) program. Since the format, number of sessions, curriculum and materials are consistent in this program, the results of these studies are more comparable than the results of some of the studies already reported.

The effectiveness of the STEP program for changing parental attitudes, and in changing LD children's self-concept, was studied by Hammett, Omizo, and Loffredo (1981). Child-rearing attitudes as measured by the Parent Attitude Survey and the self-concepts of their learning disabled children as measured by the Primary Self-Concept Inventory were the focus of this study. The subjects were 50 mothers and their 5- to 8-year-old LD children who were randomly assigned to experimental or control groups. On the post-test measures, multivariate analysis of variance demonstrated that the parents in the experimental group scored significantly higher than the parents in the control group on the Parent Attitude Survey subscales of Acceptance and Trust, and their children scored higher on the Primary Self-Concept Inventory subscales of Social Self and Personal Self. The authors noted that the Academic Self scale did not change. They believed that LD children have had so much academic failure that more than a short-term group is needed to change LD children's perception of academic self-esteem.
A similar study found that STEP was effective in changing 9- to 12-year-old LD children's locus of control and parent attitudes (Williams, Omizo, & Abrams, 1984). Thirty-eight parent-child dyads were divided into treatment and control groups. After attending nine STEP sessions, the experimental group parents' scores were significantly higher than the scores of the control group parents on the subscales of Acceptance, Trust and Causation of the Parent Attitude Survey. The children in the experimental group had a more internal locus of control on the Success Social Domain, Success Physical Domain, Failure Intellectual Domain and Failure Physical Domain of the Locus of Control Inventory for Three Achievement Domains, indicating that parents, through parent education, can learn to teach their children to take more responsibility for their success and failure.

The STEP program and Parent Attitude Survey were also used in Kreig's (1984) study of parents of elementary school-aged learning disabled children. Kreig added the Adlerian Parental Assessment of Child Behavior Scale to compare perceptions of parents of learning disabled children and parents of children with no learning disabilities, and to measure change in parents' perception of children's behavior following the STEP program. There were 5 groups of 15 parents included in the study. Group 1 was an experimental group of parents of learning disabled children who completed a six-week STEP course. Group 2 was a control group of parents who had
LD children. Group 3 was made up of parents who had non-LD children and who had completed nine weeks of the STEP program. Group 4 was made up of parents who did not have LD children and who simply read the STEP handbook. Group 5 was a control group of parents who had no LD children.

Kreig first compared parents of LD children with parents of non-LD children and found that, on post-test measures, parents of LD children did not differ significantly from other parents in their perception of child behavior on the Adlerian Assessment of Child Behavior Rating Scale and attitudes reflecting understanding of child behavior on the Parental Attitudes Survey, but did have significantly lower confidence in their roles as parents as indicated by their scores on the Parent Attitude Survey. Kreig then examined the effectiveness of the STEP program and found that it did not have a statistically significant effect on any of the measures used. Since a 9-week group of parents with LD children was not included, the nonsignificant change in behavior cannot be directly compared to the other studies using the entire STEP program.

A comparison of the effectiveness of behavioral parent education, a commonly used approach for parents of exceptional children, with Adlerian parent education for parents of elementary school-aged, learning disabled children was done by Lifur-Bennett (1982). She randomly divided 82 parents into 3 groups, entitled wait-list control group, a
STEP group, and a Confident Parenting (behavioral approach) group. The Parent Acceptance-Rejection Questionnaire, the Piers-Harris Self-Concept Scale, the Missouri Children's Behavior Checklist, and the Parent Retrospective Relationship Questionnaire were administered as pretests, post-tests and follow-ups. She found both approaches were equally effective in improving the LD child's self-concept and classroom behavior and improving the parent-child relationship.

In summary, practitioners believe that parents are a significant influence on their children, and that parents' attitudes toward themselves and their children are affected by the identification of a learning disability. Practitioners also believe that parents can develop parenting skills which will help them help their child to cope effectively with the consequences of their learning problem. Parent groups are considered to be helpful in reducing parental stress because parents can learn from one another, form a support system, and realize that their problems are not unique. Studies have indicated that Adlerian parent education programs using the STEP program are effective in changing parent attitudes, LD children's self-concept and locus of control, and the parent-child relationship. One study showed that teachers perceived improvement in children's behavior as a result of the STEP program. The one study that examined changes on the APACBS with LD children used a shortened version of the STEP program, and found no significant difference.
All of the studies of parent groups for parents of LD children reviewed here used the STEP program (Dinkmeyer & McKay, 1976) for Adlerian parenting education. However, Active Parenting (Popkins, 1983), a program with content and objectives similar to the STEP program, was used in this study. The program is structured and has weekly outlines of activities, objectives, and materials, which is in keeping with Croake and Glover's (1977) recommendation that a standard format for research of parent education groups be used. The Active Parenting Program is video-based and more recently developed and published than the STEP program. This study was the first to use Active Parenting in experimental research (communication with the author, see Appendix A), and the first to investigate the effectiveness of Adlerian parent education on parental stress levels and perception of LD children's behavior.
References


CHAPTER II

PROCEDURES

This chapter presents the hypotheses and describes the subjects, instruments, parent education program, and procedures for the collection of data used in this study.

Hypotheses

1. Parents in the treatment group will have significantly lower adjusted Total post-test scores on the Parenting Stress Index following intervention than parents in the control group.

2. Parents in the treatment group will have significantly lower adjusted Parent Domain post-test scores on the Parenting Stress Index following treatment than parents in the control group.

3. Parents in the treatment group will have significantly lower adjusted Child Domain post-test scores on the Parenting Stress Index following treatment than parents in the control group.

4. Parents in the treatment group will have significantly lower adjusted post-test scores on the Adlerian Parental Assessment of Child Behavior Scale than parents in the control group.
5. There will be a significant positive relationship between parent stress as measured by the post-test Parenting Stress Index and children's behavior as measured by the post-test Adlerian Parental Assessment of Child Behavior Scale.

In addition to the five hypotheses, one research question was explored: What are the parenting stressors identified by parents of LD children?

Subjects

The subjects for this study were 40 parents of learning disabled children drawn from volunteers who responded to publicity about an Adlerian parenting group for parents of LD children. Invitations and announcements were made through North Texas metroplex organizations for children with learning disabilities, private schools for children with learning disabilities, and community newspapers (see Appendix B).

The definition of learning disabilities adopted by the National Joint Committee for Learning Disabilities (1981) was used to define the population of LD children. Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g., cultural differences, insufficient or inappropriate instruction, psychogenic factors), it is not the direct result of these conditions or influences. (p. 1)
A student was diagnosed as "learning disabled" in his or her educational records in order for the parents to participate in this study. Parents who responded with a completed application form by the deadline date, and who qualified by having a child identified as LD according to the criteria, were randomly placed into either the treatment or control group using a table of random numbers. A total of 24 parents was placed in the experimental group and 20 parents were placed in the control group. Four parents in the experimental group dropped out of the program so 20 parents in each group, a total of 40 subjects, completed all of the pretest and post-test instruments.

Instruments

The Parenting Stress Index (PSI) (Abidin, 1983) was developed to be a screening and diagnostic tool for identification of the magnitude of stress in the parent-child system (Abidin, 1983). This instrument contains 101 items divided into two domains, Child Domain and Parent Domain. The Child Domain contains 47 items and measures qualities associated with children which make it difficult for parents to fulfill their parenting role. The subscales of the Child Domain are Child Adaptability, Acceptability of Child to Parent, Child Demandingness, Child Mood, Child Distractability, and Child Reinforces Parent. The Parent Domain is comprised of 54 items related to dimensions of parent functioning.
The subscales of the Parent Domain are Parent Depression, Parent Attachment, Restrictions Imposed by Parental Role, Parents' Sense of Competence, Social Isolation, Relationship with Spouse, and Parental Health. The scores are normed for use with parents who have children who are less than one year of age, children between the ages of one and two years, and children older than two years of age.

The items are arranged in a multiple choice format. The raw scores for each subscale and domain can be plotted on a profile sheet so that percentiles for each can be compared. High stress scores are those which fall above the seventy-fifth percentile in any subscale or domain for the child's age group. A guide for interpretation of high scores for each subscale is given in the test manual.

The original 151 test items for the PSI were developed from a literature review and clinical judgment based on practice. After a pilot test for readability, format, and administration, a panel of six professionals rated each item for relevance of content and adequacy of construction. After additional field testing, the instrument was used with several populations of parents for norming purposes. The final instrument contains 101 items with 95 percent of those items directly related to research (Loyd, 1983).

Since 1979, 19 research projects relating to the validity of the PSI have been completed. The PSI's validity is continuing to be studied at 23 universities and medical
centers in the United States and Canada (Abidin, 1983). The PSI's validity has been examined with measures of the same construct. Lafiosca (cited in Abidin, 1983) compared parents of normal children with parents of children brought to a child development clinic. Significant correlations were found between the Child Domain of the PSI and the Child Behavior Problem Checklist. The Parent Domain of the PSI had a correlation of .68 with the State-Trait Anxiety Scale. Zakreski (cited in Abidin, 1983) reported that the Bayley Infant Development Scales were significantly correlated with the PSI scores for the Child Domain, Parent Domain, and Total score with a population of mothers with full term infants and mothers of premature infants. Casey (cited in Loyd, 1983) found a correlation of .56 with the Achenbach Child Behavior Checklist and the Child Domain and Parent Domain with parents of children with and without otitis media.

Discriminant validity was demonstrated by showing that the test scores were more highly correlated with certain criteria than with others. The PSI has been found to discriminate between groups with different characteristics by significantly different patterns of scores on the PSI. Loyd (1983) reported 17 studies that found the PSI discriminated between populations. Twenty parents of cerebral palsied children had significantly higher scores on 10 of 13 PSI subscales than a matched control group of 30 normal children, with most of the differences in the Child Domain. The only Parent
Domain scores which were different were those directly related to the child's problem, e.g., Social Isolation (Zimmerman, cited in Loyd, 1983). Lafiosca (cited in Loyd, 1983) found that the PSI was able to correctly identify 100 percent of the parents of the normal children (n = 70) in her study and 60 percent of the parents of the children (n = 70) who attended a child development clinic when the 90th percentile of the PSI Total Score was used as a cut-off. She found significant mean differences for the total score, for the three domain scores and for 11 of the 15 subscales. Upshur (cited in Loyd, 1983) also found that a cut-off score at the 90th percentile was useful for screening infants with developmental problems. He was able to identify eighty-nine percent of the 26 children evidencing developmental delay using that cut-off score. Casey (cited in Loyd, 1983) examined the PSI scores of parents of normal children (n = 30) and parents of children with serious otitis media (n = 30) and found significant differences between the two groups on the subscales of Adaptability and Acceptability.

Factorial validity was investigated by three factor analyses of the scores of a sample of 534 mothers of both clinic-referred and normal children who ranged in age from one month to 19 years. The results showed that each subscale was measuring a moderately distinct source of stress. The factor loadings supported the hypothesis that
the Child and Parent Domains are two distinct traits and that each subscale is measuring a moderately distinct source of stress (Loyd, 1983).

Alpha reliability coefficients were also computed for each subscale, for each domain, and for the total score on the same sample of 534 parents. The alpha reliability coefficients ranged from .62 to .70 for the subscales of the Child Domain, and .55 to .80 for the subscales of the Parent Domain. The reliability coefficients for the two domains were .89 and .93, and the reliability coefficient for the Total Stress Score was .95. Test-Retest was .817 for the Child Domain and .706 for the Child Domain after three weeks, and .55 for the Child Domain, .65 for the Parent Domain and .65 for the total after one year (Loyd, 1983).

Two studies have used the PSI to measure pretest-posttest differences. Lafferty (cited in Loyd, 1983) found that parents who completed a parent education group had a significant decrease in PSI Child Domain, Parent Domain and Total scores compared to the control group. Plough (cited in Loyd, 1983) used the PSI to determine the effectiveness of brief parent consultation (1 to 8 sessions) in a pediatric practice for mothers of children aged 0 to 10 years who reported experiencing difficulty in child care. A significant decrease on the PSI was found following consultation.

The Adlerian Parental Assessment of Child Behavior Scale (APACBS) (McKay & Hillman, 1979) was developed to assess
parents' perceptions of typical child behaviors. The scale has 32 items and uses a 7-point Likert-type response scale. Parents rate their children's behaviors on a continuum from "always" to "never." Both responsible and irresponsible behaviors are represented in the scale. Scores can range from 32 to 224 with high scores representing more responsible behavior.

Content validity of the APACBS was assessed by three judges familiar with Adlerian-based programs. The Cronbach alpha test for internal consistency ranged from .90 to .91. The Pearson r test for stability over time yielded a coefficient of .97 (McKay & Hillman, 1979). This instrument was used in approximately one-fourth of the 42 studies of the STEP Adlerian parenting program reviewed by the American Guidance Service (1985).

No instrument was found that identified parental stressors of parents of LD children, so an open-ended question was included on the data form (Appendix B) given to the parents during the pretesting session.

Active Parenting Program

The group leader for the Active Parenting program was the researcher of this study, who is a doctoral candidate in counseling. She has five years of counseling experience, has led several Adlerian parent groups in the public schools, and has attended a leadership training workshop for the Active Parenting program.
The Active Parenting (Popkins, 1983) program was selected for use in this study because it is designed to teach Adlerian principles. Although the program is commercially available, it had not been used in empirical research prior to this study (Appendix A). Active Parenting uses a multi-media approach and includes readings, discussions, group problem solving, role play, and homework assignments. Each session emphasizes one main principle of Adlerian parenting psychology. The first three sessions are designed to strengthen the parent-child relationship and to teach the concepts of democratic parenting, encouragement, and recognition of children's goals. The fourth and fifth sessions emphasize development of responsibility in children through logical and natural consequences, problem solving and communication skills. The sixth session focuses on how family councils can enhance democratic parenting principles. The experimental group of parents in this study followed the structure provided by the program (Appendix C). The leader's guide for the Active Parenting program outlines objectives and activities for each session.

The experimental group met for six two-hour sessions during the Fall of 1985. In order to encourage regular attendance, child care was provided and parents were asked to sign an attendance agreement (see Appendix D). One week after the conclusion of the program, a makeup session was
provided for the three parents in the experimental group who had missed a session.

The control group was asked to come to the meeting place for the pretesting and post-testing only, but were offered the opportunity to participate in a parenting group in January, 1986.

Data Collection

Publicity about the Active Parenting program was begun one month before the parenting group was scheduled to begin (Appendix E). Parents who filled out an application and who met the criteria for inclusion in the study were notified by telephone regarding time and place of the first meeting of the group to which they had been assigned.

Both the PSI and the APACBS were administered to the parents of the experimental and control groups together immediately before the first session of the parent education group and within one week after the parenting group was completed. Parents were given a packet which included a brief demographic information sheet with a section on perceived stress in parenting LD children (Appendix B); a human subjects release form (Appendix F); an attendance agreement (Appendix D); and the PSI and the APACBS instruments. The order of the PSI and the APACBS were alternated with half of the packets presenting the PSI first, and the other half with the APACBS first. The members of the control group were dismissed from
the first meeting after completing all of the forms in the packet.

After the packets of information were completed, the treatment group remained two hours for the first of the six Active Parenting sessions. Parents in the experimental group who did not attend the first session for the administration of the pretests were not used in the data analysis to insure that subjects were unaware of the content of the parent group for the pretesting. Two fathers were not present for the first meeting, and were dropped from the data pool, although they attended the classes.

The treatment group and the control group met together following the final session of the parenting group for the post-test administration of the instruments. Only the parents in the treatment group who had completed at least five sessions of the Active Parenting program completed the post-tests. The procedure used during the pretest session was followed for the post-test. The three parents in the experimental group who attended the make-up session one week after the conclusion of the program took their post-tests at the conclusion of the make-up session. Make-ups for any pre- or post-tests of the control group were given individually by appointment.


CHAPTER III

RESULTS AND DISCUSSION

This chapter includes the findings of this investigation, discussion of related findings, and recommendations based upon the findings.

Analysis of Data

Hypotheses 1 through 4 were tested using analysis of covariance with the pretests as the covariants. The level of significance for Hypotheses 1 through 4 was set at .10 for several reasons. Croake and Glover (1977), in their critical review of outcome studies in parent education, commented that researchers have limited their concern only to Type I errors. They have recommended more consideration of the possibility of Beta error, and suggested use of less stringent levels of significance. The purpose of this study was to investigate practical possibilities in an area with little data, and with a relatively small sample size. Since this study is the first to use the Active Parenting in research, and the third to use the PSI for outcome research, it is essentially a pilot study in which trends are of more importance than concern for Type I error. For all those reasons, a Type I error was risked by choosing a liberal level of significance for the analysis of covariance (Borg & Gall, 1983; Ferguson, 1981; Isaac & Michael, 1975).
Hypothesis 5 was tested by correlating the Total Stress Score on the PSI of each parent with that parent's scores on the APACBS to obtain a Pearson product moment coefficient. The level of significance was set at .05.

The research question responses were listed, counted, and categorized for discussion.

Demographic Information

Twenty subjects, representing 15 families in the experimental group and 20 subjects, representing 16 families in the control group, completed the demographic sheets and all instruments. The demographic data are reported in Table I. Since the subjects were randomly assigned to the groups, no attempt was made to match the groups on the demographic variables.

The mean age of the LD child in the experimental group was 10.06 with a range from 5 years to 14 years, and the mean age of the LD child in the control group was 9.80 with a range from 7 years to 14 years. A t-test was done to compare the ages of the children in the group, and no significant difference was found.

The groups appear to be comparable in terms of types of respondents, family structure, size of family, birth order of the LD child, and grade placement of the LD child and type of school placement.
### TABLE I
DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td><strong>Respondent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Mother</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>Natural Father</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Stepmother</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stepfather</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Adoptive Mother</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Family Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Parent</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Both Parents</td>
<td>13</td>
<td>75</td>
</tr>
<tr>
<td>Stepfamily</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Two</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Three</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Four</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>LD Child's Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oldest</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Youngest</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td>Middle</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Only</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td><strong>Type of Placement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private School/LD</td>
<td>12</td>
<td>70</td>
</tr>
<tr>
<td>Private School</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Public School/no help</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Public School/less than 1/2 day help</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Public School/more than 1/2 day help</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Mean Grade of LD Child</strong></td>
<td>4.37</td>
<td></td>
</tr>
<tr>
<td>Range K-8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hypotheses

Hypothesis 1 stated that parents in the treatment group would have significantly lower adjusted Total post-test scores on the Parenting Stress Index following treatment than parents in the control group. Table II shows the pretest and post-test means, standard deviations, and adjusted means for the experimental and control groups.

| TABLE II |
| MEANS AND STANDARD DEVIATIONS FOR THE TOTAL SCORE ON THE PARENT STRESS INDEX |

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group N = 20</th>
<th>Control Group N = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>281.90</td>
<td>272.30</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>41.16</td>
<td>61.67</td>
</tr>
<tr>
<td>Post-test:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>283.80</td>
<td>266.50</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>42.16</td>
<td>54.56</td>
</tr>
<tr>
<td>Adjusted Mean</td>
<td>280.31</td>
<td>269.98</td>
</tr>
</tbody>
</table>

The MANOVA procedure to test for the assumption of homogeneous slopes was satisfied, so analysis of covariance was used to test significance of group differences. The results of the analysis of covariance are reported in Table III.
TABLE III

ANALYSIS OF COVARIANCE FOR THE TOTAL SCORE ON THE PARENTING STRESS INDEX

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within</td>
<td>21421.53</td>
<td>37</td>
<td>578.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regression</td>
<td>68752.66</td>
<td>1</td>
<td>6872.66</td>
<td>118.75</td>
<td>.00</td>
</tr>
<tr>
<td>Constant</td>
<td>3272.53</td>
<td>1</td>
<td>3272.53</td>
<td>5.65</td>
<td>.023</td>
</tr>
<tr>
<td>Group</td>
<td>1058.26</td>
<td>1</td>
<td>1058.26</td>
<td>1.82</td>
<td>.185</td>
</tr>
</tbody>
</table>

The data indicated that the group interaction is not significant at the .10 level, so Hypothesis 1 is not supported. The treatment group did not have significantly lower adjusted post-test scores on the PSI following treatment.

Hypothesis 2 stated that the parents in the treatment group would have a lower adjusted post-test score on the Parent Domain of the Parenting Stress Index following treatment than parents in the control group. Table IV shows the pretest and post-test means and standard deviations, and the adjusted post-test means for both groups.
TABLE IV
MEANS AND STANDARD DEVIATIONS FOR THE PARENT DOMAIN OF THE PARENTING STRESS INDEX

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group N = 20</th>
<th>Control Group N = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pretest:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>135.80</td>
<td>135.60</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>22.65</td>
<td>34.76</td>
</tr>
<tr>
<td><strong>Post-test:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>138.70</td>
<td>130.80</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>23.90</td>
<td>33.02</td>
</tr>
<tr>
<td>Adjusted Post-test</td>
<td>138.62</td>
<td>130.80</td>
</tr>
</tbody>
</table>

The MANOVA procedure indicated that the assumption for homogeneity of slope was satisfied, so analysis of covariance was done to test the hypothesis. The results are reported in Table V.

TABLE V
ANALYSIS OF COVARIANCE FOR THE PARENT DOMAIN OF THE PARENTING STRESS INDEX

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Regression</td>
<td>10656.59</td>
<td>37</td>
<td>288.01</td>
<td>72.62</td>
<td>.03</td>
</tr>
<tr>
<td>Constant Group</td>
<td>20916.80</td>
<td>1</td>
<td>20916.80</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1172.12</td>
<td>1</td>
<td>1172.12</td>
<td>4.06</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>599.08</td>
<td>1</td>
<td>599.08</td>
<td>2.08</td>
<td>.27</td>
</tr>
</tbody>
</table>
The .10 level of significance set for group interaction was not met; therefore, Hypothesis 2 is not supported. The treatment group did not have significantly lower adjusted post-test scores on the Parent Domain of the PSI following treatment.

Hypothesis 3 stated that parents in the treatment group would have a significantly lower adjusted post-test score on the Child Domain of the Parenting Stress Index following treatment than the control group. Table VI reports the pretest and post-test means and standard deviations and the adjusted post-test means.

TABLE VI
MEANS AND STANDARD DEVIATIONS FOR THE CHILD DOMAIN OF THE PARENTING STRESS INDEX

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 20</td>
<td>N = 20</td>
</tr>
<tr>
<td>Pretest:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>146.10</td>
<td>137.70</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>23.36</td>
<td>28.62</td>
</tr>
<tr>
<td>Post-test:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>145.10</td>
<td>135.70</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>22.14</td>
<td>28.62</td>
</tr>
<tr>
<td>Adjusted Post-test</td>
<td>141.73</td>
<td>135.70</td>
</tr>
</tbody>
</table>

The MANOVA procedure indicated that the assumption of homogeneity of slope was satisfied, so analysis of
covariance was done to test the hypothesis. The results of the analysis of covariance is reported in Table VII.

TABLE VII

ANALYSIS OF COVARIANCE FOR THE CHILD DOMAIN OF THE PARENTING STRESS INDEX

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Regression</td>
<td>5240.07</td>
<td>37</td>
<td>141.62</td>
<td>138.69</td>
<td>.00</td>
</tr>
<tr>
<td>Constant</td>
<td>19641.92</td>
<td>1</td>
<td>19641.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>1057.54</td>
<td>1</td>
<td>1057.54</td>
<td>7.46</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>70.10</td>
<td>1</td>
<td>.49</td>
<td>.49</td>
<td>.48</td>
</tr>
</tbody>
</table>

The F value for group interaction was not significant; therefore, Hypothesis 3 is not supported. The treatment group did not have significantly lower adjusted post-test means on the Child Domain of the PSI following treatment.

Hypothesis 4 stated that the parents in the treatment group would perceive their children's behavior with higher adjusted ratings on the Adlerian Assessment of Child Behavior Rating Scale following treatment than parents in the control group. Table VIII shows the pretest and post-test means, standard deviations, and adjusted post-test means.
### TABLE VIII
MEANS AND STANDARD DEVIATIONS FOR THE ADLERIAN PARENTAL ASSESSMENT OF CHILD BEHAVIOR RATING SCALE

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Experimental Group N = 20</th>
<th>Control Group N = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>Pretest:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>115.50</td>
<td>124.35</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>25.89</td>
<td>20.93</td>
</tr>
<tr>
<td>Post-test:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>120.10</td>
<td>125.80</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>20.53</td>
<td>23.28</td>
</tr>
<tr>
<td>Adjusted Mean</td>
<td>123.37</td>
<td>122.52</td>
</tr>
</tbody>
</table>

The MANOVA procedure which tested for homogeneity of slope was satisfied, so analysis of covariance was used to test the hypothesis. The results are reported in Table IX.

### TABLE IX
ANALYSIS OF COVARIANCE FOR THE ADLERIAN ASSESSMENT OF CHILD BEHAVIOR RATING SCALE

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within</td>
<td>6747.01</td>
<td>37</td>
<td>182.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regression</td>
<td>11571.98</td>
<td>1</td>
<td>11571.98</td>
<td>63.45</td>
<td>.00</td>
</tr>
<tr>
<td>Constant</td>
<td>1639.11</td>
<td>1</td>
<td>1639.11</td>
<td>8.98</td>
<td>.00</td>
</tr>
<tr>
<td>Group</td>
<td>7.12</td>
<td>1</td>
<td>7.12</td>
<td>.03</td>
<td>.84</td>
</tr>
</tbody>
</table>
The F value for group interaction was not significant; therefore, Hypothesis 4 is not supported. The treatment group did not have significantly higher adjusted post-test scores on the APACBS following treatment.

Hypothesis 5 stated that there would be a positive relationship between parental stress as measured by the post-test Parenting Stress Index and children's behavior as measured by the post-test of the Adlerian Assessment of Child Behavior Rating Scale. This hypothesis was tested using the Pearson product moment correlation. The correlation was .70, which is significant beyond the .001 level, indicating a relationship between parental stress and perception of child behavior; therefore, Hypothesis 5 is supported.

Research Question

Parents were asked to identify the stressors they felt as parents of LD children by writing perceived stressors on the Data Sheet (Appendix B). The responses of the parents in this study were then compared to items on the PSI and the APACBS.

The question regarding stress on the parent data form was open-ended. Some parents listed many stressors, while others mentioned only a few. For purposes of discussion, the stress responses are categorized as LD concerns, parent concerns, and child characteristics.
The LD concerns are those stressors not mentioned in the Parenting Stress Index or Adlerian Parental Assessment of Child Behavior Scale because they refer to those problems particular to parents of children with special needs. The six stresses identified by parents in this category include getting answers from professionals about the child's problems, working with the educational system, medical and medication problems, special schooling, and different holidays (due to private and public school calendars). By far, the most frequently mentioned response in this category was financial stress, which was mentioned by 25 percent of the respondents.

The parent concerns are those stressors related to parental roles, personal concerns and practical problems of parenting. Twenty-four different parenting stressors were mentioned. The most frequently mentioned were worry about the child's success in life, coping with the child's problem in relation to siblings, and having enough patience to deal with the child. Other stressors included parenting role concerns, personal feelings, and practical problems. Table X lists the stressors included in the parenting category of responses. Eight of the 24 responses were included in the PSI or APACBS. The frequency of the response for each stressor and corresponding PSI or APACBS items can be found in Appendix G.
### TABLE X

**PARENT STRESSORS IDENTIFIED BY PARENTS OF LD CHILDREN**

<table>
<thead>
<tr>
<th>Role Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patience</strong></td>
</tr>
<tr>
<td>Knowing how to help</td>
</tr>
<tr>
<td>Coping with other siblings about the LD child</td>
</tr>
<tr>
<td>Not knowing how to help</td>
</tr>
<tr>
<td>Having to repeat or break down directions</td>
</tr>
<tr>
<td><strong>Discipline</strong></td>
</tr>
<tr>
<td>Answering LD child's questions about LD</td>
</tr>
<tr>
<td>LD child is not as easy to train</td>
</tr>
<tr>
<td>Dealing with unpredictable behavior</td>
</tr>
<tr>
<td>Sorting out what is LD and what is not</td>
</tr>
<tr>
<td>Trying to meet child's emotional needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry about child's success</td>
</tr>
<tr>
<td>Fear of handling the problem wrong</td>
</tr>
<tr>
<td>Parent's self-esteem</td>
</tr>
<tr>
<td>Peer pressure from other parents</td>
</tr>
<tr>
<td>Burden of parent to think and act for the child</td>
</tr>
<tr>
<td>Feelings of helplessness</td>
</tr>
<tr>
<td>Marital stress</td>
</tr>
<tr>
<td>Feelings of anger, frustration, and discouragement</td>
</tr>
<tr>
<td>Feeling like a bad parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practical Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping with homework</td>
</tr>
<tr>
<td>Loss of sleep</td>
</tr>
<tr>
<td>Time needed for attention</td>
</tr>
</tbody>
</table>

The child characteristics are those stressors identified by parents in the study describing behavioral, emotional, or learning characteristics of LD children. Sixty-eight different child characteristics and/or behaviors were mentioned; therefore, similar characteristics were combined. The most frequently mentioned child characteristics that were
stressful to parents of LD children were disorganization, rude or disrespectful behavior, difficulty getting along with peers, frustration, poor self-concept, fighting, and communication problems. All of the child characteristic responses are listed in Table XI. Sixteen of the 36 identified stressors were included on the PSI or APACBS. The frequency of each response and corresponding APACBS or PSI item numbers can be found in Appendix G.

### TABLE XI

**CHILD CHARACTERISTIC STRESSORS IDENTIFIED BY PARENTS OF LD CHILDREN**

<table>
<thead>
<tr>
<th>Behavioral/Emotional Characteristics</th>
<th>Learning Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rude; disrespectful</td>
<td>Fights</td>
</tr>
<tr>
<td>Poor peer relationships</td>
<td>High activity level</td>
</tr>
<tr>
<td>Lack of responsibility</td>
<td>Sleep problems</td>
</tr>
<tr>
<td>Short attention span</td>
<td>Tries too hard</td>
</tr>
<tr>
<td>Procrastinates</td>
<td>Doesn't listen</td>
</tr>
<tr>
<td>Doesn't follow through</td>
<td>Whines</td>
</tr>
<tr>
<td>Disregard for others</td>
<td>Follower</td>
</tr>
<tr>
<td>Self-centered</td>
<td>Blames others</td>
</tr>
<tr>
<td>Silly behavior</td>
<td>Gives up easily</td>
</tr>
<tr>
<td>Frustrated</td>
<td>Poor self-concept</td>
</tr>
<tr>
<td>Angers easily</td>
<td>Hurt by others</td>
</tr>
<tr>
<td>Nervous</td>
<td>Depressed</td>
</tr>
<tr>
<td>Mood changes</td>
<td>Limited understanding</td>
</tr>
<tr>
<td></td>
<td>Poor memory</td>
</tr>
</tbody>
</table>

In total, 25 of the 67 (approximately 35 percent) different parenting stressors identified by the parents of LD children were included on one of the two instruments used in this study.
Related Findings

Parenting Stress Profiles

The review of the literature indicated that practitioners believe that parenting an LD child is stressful (Briard, 1976; Faerstein, 1981; Kaslow & Cooper, 1978; Miller & Myers-Walls, 1983; Schaffer & Schaffer, 1982; Silver, 1974), but only one study was found that empirically examined stress of parents with LD children (Heibert, Wong, and Hunter, 1982). No studies were found using a parenting stress index to validate those observations. Abidin (1983), in his manual for the PSI, described the research that had been done with various populations of parents, including parents of mentally retarded children, hyperactive children, preschool children, children with chronic illness, cerebral palsied children, and normal children. However, he did not have data on parents of LD children. Therefore, stress profiles of parents of LD children were examined.

Since the PSI Manual has norm scores for the general population, as well as various parent populations, the scores of subjects of this study were compared to those published norms. Appendix H shows a profile for the entire sample of parents of LD children (n = 40) in this sample, the norming sample of the general population (n = 600), and a sample of parents of hyperactive children (n = 60) included in the PSI Manual (Abidin, 1983). The mean pretest scores were used in this comparison so that the effects of the parent education
The parents in this study had total mean score on the PSI total of 277.60. The mean score of the norming sample was 221.1. The z score of the parents in this study was 1.45 indicating that total score on the PSI was almost one and
one-half standard deviations higher than the mean score of the norming sample.

The parents of LD children in this study had mean scores on the Child Domain of 141.90. The mean score of the norming sample was 98.4. All of the subtests had z scores over 1.0, and Acceptability and Demandingness had z scores over 2.0. The total z score for the Child Domain of the PSI for parents of LD children was 2.26. The subscales of Attachment and Competence were almost one standard deviation from the norming mean. The mean of the norming population was 122.7 and the mean for parents with LD children was 135.70.

According to Abidin (1983), author of the PSI, a total score of 250 or higher for parents of children over three years of age, a score of 122 or higher on the Child Domain, and a score of 153 or higher on the Parent Domain represent critically high levels of stress. Of the 40 participants in this study, 28 (70 percent) had total scores above 250, and sixteen of those were above 300. On the Child Domain, 30 parents (75 percent) had scores above 153. All of the parents with scores in the critical range for the Parent Domain also had scores in the critical range for the Child Domain (32 percent) which is, according to Abidin, indicative of crisis situations.
PSI Pretest/Post-test Changes

The size of the sample in this study is too small to do multiple analyses of covariance with statistical confidence but, in an effort to understand the possible dynamics of using a parenting group with a population with elevated stress scores, an analysis of covariance was done for all subscales. The results are, of course, speculative. Table XIII reports the means and standard deviations for the pretest and the post-test, and the adjusted post-test scores. Group 1 is the experimental group, and Group 2 is the control group.

**TABLE XIII**

MEANS, STANDARD DEVIATIONS, AND ADJUSTED POST-TEST SCORES FOR SUBSCALES OF THE PSI

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group 1 Pretest</th>
<th>Group 1 Post-test</th>
<th>Adjusted Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Adaptability</td>
<td>34.60</td>
<td>6.31</td>
<td>35.95</td>
</tr>
<tr>
<td>Acceptability</td>
<td>20.80</td>
<td>4.74</td>
<td>20.20</td>
</tr>
<tr>
<td>Demandingness</td>
<td>29.75</td>
<td>6.38</td>
<td>29.20</td>
</tr>
<tr>
<td>Mood</td>
<td>14.45</td>
<td>3.31</td>
<td>14.60</td>
</tr>
<tr>
<td>Distractability</td>
<td>31.25</td>
<td>6.24</td>
<td>30.10</td>
</tr>
<tr>
<td>Reinforces parent</td>
<td>15.26</td>
<td>4.47</td>
<td>15.05</td>
</tr>
<tr>
<td>Depression</td>
<td>21.30</td>
<td>4.75</td>
<td>20.85</td>
</tr>
<tr>
<td>Attachment</td>
<td>16.05</td>
<td>4.19</td>
<td>16.10</td>
</tr>
<tr>
<td>Restrictive</td>
<td>20.55</td>
<td>5.34</td>
<td>22.30</td>
</tr>
<tr>
<td>Competence</td>
<td>34.00</td>
<td>7.04</td>
<td>34.70</td>
</tr>
<tr>
<td>Isolation</td>
<td>13.10</td>
<td>4.62</td>
<td>13.60</td>
</tr>
<tr>
<td>Spouse</td>
<td>18.80</td>
<td>5.27</td>
<td>20.50</td>
</tr>
<tr>
<td>Health</td>
<td>12.00</td>
<td>4.26</td>
<td>10.65</td>
</tr>
</tbody>
</table>

*Homogeneity of slopes not satisfied
TABLE XIII—Continued
MEANS, STANDARD DEVIATIONS, AND ADJUSTED POST-TEST
SCORES FOR SUBSCALES OF THE PSI

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group 2 Pretest</th>
<th>Group 2 Post-test</th>
<th>Adjusted Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Adaptability</td>
<td>32.30</td>
<td>9.01</td>
<td>32.05</td>
</tr>
<tr>
<td>Acceptability</td>
<td>20.80</td>
<td>4.09</td>
<td>20.80</td>
</tr>
<tr>
<td>Demandingness</td>
<td>27.20</td>
<td>8.03</td>
<td>26.25</td>
</tr>
<tr>
<td>Mood</td>
<td>13.20</td>
<td>4.50</td>
<td>13.85</td>
</tr>
<tr>
<td>Distractability</td>
<td>29.80</td>
<td>7.30</td>
<td>28.50</td>
</tr>
<tr>
<td>Reinforces parent</td>
<td>14.40</td>
<td>5.72</td>
<td>14.75</td>
</tr>
<tr>
<td>Depression</td>
<td>21.45</td>
<td>7.20</td>
<td>21.05</td>
</tr>
<tr>
<td>Attachment</td>
<td>15.15</td>
<td>4.71</td>
<td>14.65</td>
</tr>
<tr>
<td>Restrictiveness</td>
<td>19.90</td>
<td>7.75</td>
<td>18.15</td>
</tr>
<tr>
<td>Competence</td>
<td>35.80</td>
<td>8.33</td>
<td>33.20</td>
</tr>
<tr>
<td>Isolation</td>
<td>13.30</td>
<td>4.81</td>
<td>13.85</td>
</tr>
<tr>
<td>Spouse</td>
<td>18.05</td>
<td>6.17</td>
<td>18.15</td>
</tr>
<tr>
<td>Health</td>
<td>11.95</td>
<td>3.20</td>
<td>11.75</td>
</tr>
</tbody>
</table>

*Homogeneity of slopes not satisfied

The two subscales which appear to be significantly different following treatment were Restrictiveness (F = 6.90, p < .01), and Competence (F = 4.12, p < .05), with the lower stress score reported by parents in the control group.

Also, in an effort to study the pattern of change in relationship to initial stress scores, a scattergram was done to compare pre- and post-test scores for the PSI total score, Child Domain, and Parent Domain. The scattergrams are included in Appendix I. Again, the group size is too small to draw firm conclusions, but the scattergram for the PSI total for Group 1 does not follow the pattern of the other scattergrams. Visual inspection of the scores in the upper ranges of the initial stress scores seem to follow a
curvilinear pattern, while scores in the lower ranges do not. This sample is too small to test confidently with statistics for differential effect.

**Relationship of PSI and APACBS**

Hypothesis 5 only examined the relationship of the total PSI score to the APACBS scores, but analyses of the relationship between each domain of the PSI to the APACBS was also done. Abidin (1983) constructed the PSI based on the theory that parenting stress was related to perception of children's characteristics. Therefore, since the APACBS measures perception of children's behavior characteristics, the relationship between the PSI Parent Domain and the APACBS was explored. A Pearson product moment correlation of .43 was obtained, which was significant at the .003 level.

Since relationships have been found between the PSI and other behavior checklists (Loyd, 1983), the relationship of the Child Domain of the PSI and the APACBS was also explored. Both instruments measure parental perception of child characteristics, but the PSI Child Domain items are general ("my child bothers me a lot"), whereas the items on the APACBS are more specific ("cleans up after fixing a snack"). The Pearson product moment correlation was .68, which is significant beyond the .001 level.
Discussion

This study was the first to use the Active Parenting program in empirical research, the first to measure parental stress of LD children, and the first to study the effectiveness of an Adlerian parent education program for reducing parental stress. Some of the results of this study are difficult to relate to previous findings on these topics, but will be related to tangentially related findings.

Demographic Data

The families used in this study were recruited through articles in suburban newspapers and through organizations and private schools for children with learning disabilities. As a result of these recruitment procedures, the majority of the children of parents in this sample attended private schools for LD children. During the discussion periods of the Active Parenting program, some of the parents mentioned that they sent their children to special private schools because of the severity of their child's problem, or because of dissatisfaction with the public schools' remedial education programs. The special school placement of these children and the parents' comments might indicate that this sample of parents had children with learning problems more severe than other samples of parents of learning disabled children attending public schools.
The majority (68 percent) of children in both groups came from intact natural families. Forty-eight percent of the sample had families with two children. The most frequent family position of the LD child was the youngest (45 percent). This percentage of youngest children reflects Adlerian theory regarding birth order. According to this theory, the youngest child will either try to overtake older siblings or remain a baby, expecting help, service and consideration from others (Dinkmeyer, Pew, & Dinkmeyer, 1979). Children with a handicap may also be pampered and believe that attention is received for lack of performance. They may demand the service of others because so much is done for them, or become helpless because others will care for them when they are frustrated (Zuckerman & Zuckermann, 1982). The demanding and irresponsible behaviors common to discouraged children were reflected in this study by the parental perceptions of the characteristics of their LD children on the APACBS and the PSI.

Most of the participants in this study were mothers (71 percent), although most of the LD children came from two-parent homes. The overrepresentation of mothers seems to be consistent with Croake and Glover's (1977) observation that parent education is typically mother education.

**Hypotheses**

The results of this study did not support Hypotheses 1 through 3 that Adlerian parent education would decrease
parental stress scores on the Parenting Stress Index. The results of this study contradict the one previous study (Lafferty, cited in Loyd, 1983) that used the PSI as a measure of effectiveness of eclectic parent education for parents whose children attended the Beechgrove Regional Children's Center and found that scores on the PSI significantly decreased following parent education. This apparent contradiction may be due to differences in the populations used in each study, and the differences in philosophy and method of each parent education program.

While changes in parenting stress following Adlerian parent education have not been studied, changes in other parental attitudes of parents of LD children have been examined. Of the studies which examined parental attitudes of LD children, three studies used the Parent Attitude Survey to study parental attitude change of parents of LD children following the STEP program (Hammett, Omizo, & Loffredo, 1981; Kreig, 1984; Williams, Omizo, & Abrams, 1984). Two of the studies found that, while attitudes of acceptance and trust did change, attitudes of confidence and understanding did not change (Hammett, Omizo, & Loffredo, 1981; Williams, Omizo, & Abrams, 1981). Kreig used a shortened version of the STEP program and found no change on any of the Parent Attitude Survey subtests.

Since the PSI measures feelings of competence as a parent, the findings of this study may support the conclusion
of Williams, Omizo and Abrams (1984) that changes in feelings of parental confidence and understanding may require a longer treatment period for parents of LD children because those attitudes reflect longstanding feelings of parental inadequacy.

The group process itself might account for some of the lack of change in both parental stress and perception of children's behavior in this study. During the process of the group, many parents expressed relief that their concerns about their children were not unique. Several mentioned that they realized that their child was not having as much difficulty as some of the children they heard about in the group. Surprisingly, the parents who verbally expressed the greatest satisfaction with the Active Parenting program had increased stress scores on the post-test. Perhaps, as a result of hearing others in the group discuss their concerns about their children, these parents felt freer to rate their children and their feelings more honestly. Another explanation for the lack of significant change could be that stress scores initially increase as parents make changes in their parenting behaviors because the change itself can be stressful, and because parents are more conscious of their attitudes and actions as they implement change. This increased parental sensitivity towards their own behavior and that of their children as a result of parent education has been noted by Hinckle, Croake, Keller, & Arnold (1980).
Failure to find a more positive parental perception of children's behavior following the Active Parenting program may be related to problems in three major areas. These areas include some of the problems noted by other researchers, the structure of the Active Parenting program, and possible pre-test sensitization.

The two major problems noted by other researchers are group size and time of testing. Berrett's (1975) study of the effectiveness of the program might be influenced by group size. Although the size of the experimental group in this study was within the range recommended by Popkin, the author of the Active Parenting program, Berrett's research found significant improvement in the perception of children's behavior only in his small group (n = 5). Other studies were not found that addressed the issue of group size. In this study, however, discussion of personal concerns was limited by the size of the group and the amount of didactic material to be covered each session of the Active Parenting program. This limitation may have decreased the effectiveness of personal application of the parenting principles taught in the program.

Previous research has shown that change in parental perception of children's behavior does not occur linearly, and therefore the time of testing may influence the results (Croake & Burness, 1976; Hinckle, Croake, Keller, & Arnold, 1980). Some researchers have stated a belief that initially
children will try out their parents' consistency with mis-
behavior, and post-testing might occur during the period of
increased misbehavior (Campbell & Sutton, 1983; Croake,
Hinckle, Keller, & Arnold, 1980). Researchers also have
stated that parenting groups change parental attitudes before
changing parental behavior, so that perceived changed in chil-
dren's behavior may not be reflected immediately upon comple-
tion of a parenting program (Berrett, 1975; Campbell &
Sutton, 1983; Croake & Burness, 1976; Fracier & Matthes, 1975;
Hinckle, Croake, Keller, & Arnold, 1980).

Another explanation for the lack of significant change
in parental perception of children’s behavior in this study
may be related to the format of the Active Parenting program
and the time of testing. The first three sessions of the
program were devoted to improving the parent-child relation-
ship, so specific interventions for behavior change were not
introduced until the fourth session. Parents then had only
three weeks to practice new discipline techniques before the
post-test was given. Another problem with the Active
Parenting program and the measurement of effectiveness was
that parents were asked to work on improving only one or two
of their children's behaviors as they learned the new parent-
ing techniques. In order to make large gain scores on the
APACBS, the children would have needed to improve (according
to their parent's perception) on many behaviors. Sixteen of
the twenty parents in the experimental group did perceive positive changes in their children's behavior on the APACBS following treatment. The small changes evidenced by the scores on the APACBS may be a reflection of the format of the Active Parenting program, which emphasized initially changing only one or two behaviors which would only slightly change the score on the APACBS. Statistically significant changes on the APACBS might occur as the parents had more practice and more opportunity to generalize the parenting techniques taught.

Finally, failure to find significant differences in perception of children's behavior between the experimental and control groups following treatment might have been influenced by pretest sensitization. Berrett (1975) did not find pretest/treatment interaction in his study. However, in this study, four parents in the control group verbally mentioned that they found the PSI and the APACBS helpful to them. These parents said the instruments helped them define the problems they wanted to improve with their children. One parent even asked for a copy of the APACBS to keep after the study was concluded. These comments seem to indicate that the pretest could have influenced the behavior of the parents and could have interacted with the treatment.

A significant relationship was found between the total score on the PSI and the APACBS in this study. The significant relationship found between the two measures seems to
support the theoretical hypothesis of practitioners that the perception of children's behaviors and/or misbehaviors and parental stress are related (Abidin, 1983; LeMasters, 1970; Miller & Myer-Walls, 1983; Zuckerman & Zuckerman, 1980). The related finding of a significant relationship between the APACBS and the Child Domain of the PSI seems to support previous findings of a relationship of the Child Domain of the PSI and other behavior rating scales (Loyd, 1983). The positive relationship of the two instruments seems to support the concurrent validity of Child Domain of the PSI and the APACBS.

Research Question

Another major focus of this study was an examination of the stressors identified by parents of LD children. The stressors identified by these parents of LD children seem to support previous findings of the perceived characteristics of LD children reported in the review of the literature. The characteristics identified both by parents in this study and researchers were lack of consideration for others and general negativism (Strag, 1972), academic problems (Boersma & Chapman, 1979), poor self-concept (Bryan, Pearl, Zimmerman, & Matthews, 1982), noncompliant behavior (Doleys, Cartelli, & Doster, 1976), and disorganization, frustration and poor attention (Humphries & Bauman, 1980). Therefore, it appears
that this group of parents of LD children perceive that their children exhibit many of the typical characteristics of LD children identified by researchers and practitioners.

The practical purpose of the research question was to determine if the PSI, the APACBS, and the Active Parenting program identified and addressed the stressors of raising an LD child. Thirty-five percent of the stressors identified by this sample of parents were specifically included on either the APACBS or the PSI. An additional 40 percent of the stressors identified by parents in the sample were not characteristics specific only to children with learning disabilities (i.e., child whines, parent needs patience). However, 25 percent of the stressors mentioned by parents in this study were clearly specific to parents of LD children (i.e., coping with the other siblings about understanding their LD sibling) and were not included on either instrument.

The Active Parenting program did address many of the stressors identified by this sample of parents, especially those concerning children's behavior, through the outlined material, and many of the other concerns were brought up during the spontaneous discussion periods allowed in the program. However, many of the parental stressors identified by the parents in this study, which were specifically related to raising an LD child, were not addressed (i.e., answering the LD child's questions about learning disabilities). Since the research question was open-ended, it is not known how
many parents in this study share the stressors identified, so a Delphi approach might be the next step in the process of identifying perceived parental stressors of parents of LD children. The results of the Delphi study would then more clearly indicate the degree to which the PSI, the APACBS, and the Active Parenting program identify and address the perceived stressors of parents of LD children.

Related Findings

The high stress scores obtained by parents in this study lend support to the observation of practitioners that parents of learning disabled children do experience stress far greater than that of the general population of parents (Briard, 1976; Faerstein, 1981, 1986; Kaslow & Cooper, 1978; Miller & Myers-Wall, 1983; Schaffer & Schaffer, 1982; Silver, 1974). These high scores seem to be in contradiction to the findings of Heibert, Wong, and Hunter (1982) that parents of LD children did not have higher anxiety scores on the State-Trait Anxiety Inventory than did parents of normal children. This apparent contradiction may be due to the type of stress measured. The State-Trait Anxiety Inventory does not specifically measure parenting stress or perception of children's characteristics thought to be stressful.

When z scores were used to compare this sample of parents with established norms, the subscales in the Child Domain were more than two standard deviations from the established norms, while the subscales in the Parent Domain
were closer to the norming population on most subscales. The high stress scores on the subscale of sense of competence support the findings of Kreig (1984) that sense of competence on the Parent Attitude Survey was significantly lower for parents of LD children than for parents of normal children.

Abidin, in the PSI Manual (1983), reported that he has observed over a 25-year period that parents with different stress profiles react to professional interventions differently. He thinks that the profile of high stress scores in the Child Domain, and lower stress scores on the Parent Domain, is indicative of stress in the parent-child dyad, which is due primarily to child characteristics which he believes make parenting difficult. Therefore, parent education with emphasis on child behavior is the intervention recommended. Since the parents in this study had a profile of higher stress scores in the Child Domain, the use of parent education with parents of LD children would be considered the appropriate intervention according to the guidelines of the PSI Manual.

The sample for this study was too small to fully investigate the differential effects of a parenting group upon parents with initial high and low stress levels. However, the scattergram of the experimental groups' pre- and post-test PSI scores showed a pattern which appeared different for those parents with initial high stress and those with initial low stress (Appendix I). Other evidence for differential effects of parent education on parenting stress may be found by the results of the analysis of covariance of this
study and Abidin's (1983) clinical observation that parents with elevated stress scores in the Parent Domain might react defensively to parent education. The subscale scores for Competence and Restrictiveness for the experimental group were significantly higher, rather than lower than the control group following treatment. These results are consistent with the explanations given in the PSI Manual regarding parent education for parents with highly elevated scores in the Parent Domain. Abidin (1983) does not give empirical results, but he stated that he has observed through clinical practice with the PSI and parent education that high scores on the subscale of Restriction indicate resentment and anger towards the child and/or spouse, and parents with high scores on that subscale may react to parent education with feelings of guilt. He further stated that parents with high scores on Competence need much emotional support as they learn parenting skills because they have a tendency to feel overwhelmed by the problems of their children and these feelings may be intensified by parent education.

The tendency for this intensification of guilt and anxiety about parenting was evident with this sample of parents. In spite of repeated messages of reassurance and encouragement from Dr. Popkin on the video-tape of the Active Parenting program, the leader, and the program handbook, some parents expressed feelings of incompetence and guilt for past mistakes. Some also felt overwhelmed by the
amount of material presented. In light of these observations, and the results of the analyses of covariance for the sub-tests of Competence and Restrictiveness, professionals working with parents who have extreme stress scores should be cognizant of the possibility of increased feelings of incompetence and restrictiveness and provide additional support, encouragement and opportunity for parents to discuss personal concerns.

The degree of severity of problems and their relationship to change was not addressed in this study, but it would seem logical that extreme scores on the PSI, such as those found in this sample, might influence the rate and degree of parent change as a result of parent education. Parents in this study, according to their scores on the PSI, perceived themselves as incompetent as parents. According to Adlerian theory, discouraged individuals anticipate lack of success, and their behavior actually provokes responses from others that validate and reinforce their interpretation of self (Dinkmeyer, Pew, & Dinkmeyer, 1979). Therefore, the cycle of defeat which is reinforced by family and others is difficult to break.

As more research is done using the PSI, the relationship of change and initial stress scores, and the differential effects of parent education upon stress may become more clear.
Observations

Many practitioners have recommended parent education for parents of LD children because of the need they observed based upon their observations or research findings (Boersma & Chapman, 1982; Doleys, Cartelli, & Doster, 1976; Faerstein, 1981; Kaslow & Cooper, 1978; Schaffer & Schaffer, 1982; Silver, 1974). The question of parent interest has not been directly addressed by these practitioners. This study found, however, that parents of LD children were very interested in this type of parent education group. Ninety-one parents expressed an interest in the group during the recruitment of volunteers. Many of these parents volunteered to participate after the deadline and were not included in the study, but did have the opportunity to participate in the Active Parenting program with the control group in January, 1986. Scheduling and location problems eliminated some parents from participating, but a total of 62 parents did attend the program during one of the two series.

The parents in this study were enthusiastic about the group and the program, and this enthusiasm was reflected in their attendance. A make-up session was held for the experimental group, but only one parent was required to come in order to satisfy attendance requirements. Two other parents chose to make up the one session they missed. Three families dropped out of the experimental group, but two of those dropped out because of job change or illness, and the other
had scheduling conflicts. Some fathers came irregularly because of travel schedules. While these fathers were not included in the data collection of the study, they did participate actively in the discussions. After both series of groups, the parents expressed a desire to continue meeting, and to encourage other parents of LD children to take the course.

The parents seemed particularly glad to have the group just for parents with LD children. They felt that sometimes parents with normal children just did not understand what they were experiencing. While the outline for the Active Parenting program was followed, the discussion periods allowed in the program did reflect some concerns different from those of parents with normal children. For instance, the issue of appropriate school placement was brought up several times. Most of the LD children in this group went to private schools for LD children, and parents had questions about how to help their children understand why they go to special schools, how to help their children develop friendships with normal peers, and when to consider sending their children back to regular education. Other problems brought up, which probably reflect unique concerns of this population, were problems of insensitivity of teachers, peers, siblings, and relatives to the child's problems, difficulty knowing which problems were a result of the learning disability and which were not, how to deal with the child's frustration,
how to deal with personal feelings of guilt about having a child with problems, and medication for the child. The parents in this sample expected the leader to be knowledgeable about these concerns unique to parenting LD children and seemed to appreciate the opportunity to compare experiences with other parents who had similar concerns.

Conclusion and Recommendations

The findings of this study indicate that parents of LD children had a high degree of perceived parental stress which did not decrease after participation in the Active Parenting program. Since parents' perception of their LD children's behavior also did not change, the conclusion of this study is that modifications in the Active Parenting program are necessary for parents of LD children. A strong personal counseling emphasis needs to be added to the didactic content of the program because a large number of the parents of LD children have concerns about their parenting and their children that are more critical than those of the general population. A large group discussion format with a heavily structured program does not allow enough time for personal interaction; therefore, the same program with a group of fewer than ten parents would allow more discussion of individual concerns, and might provide more emotional support for highly stressed parents. Because this group was part of a research study, the program outline was strictly followed. In actual practice with parents of LD children,
more allowance needs to be made for discussion of topics particularly relevant to parenting LD children; therefore, more time may be needed to complete the course, or some of the content of the program may need to be shortened. Finally, the PSI and the APACBS together provide much information about parents' perceptions of themselves and their children's behavior which could be used diagnostically to provide services addressing individual needs.

As a result of this study, further research in this area is recommended. This study should be repeated with some modifications. A similar study could be done by parents of LD children who attend public schools to determine if the stress levels on the PSI are as elevated for those parents as they were for parents in this study, and to determine if Adlerian parent education has the same results. Since group size might be a factor in effectiveness of parent groups, this study could be repeated with a much smaller group. A follow-up study of the experimental group after three months could be done to determine if stress levels and perception of children's behavior change after parents have had more opportunity to practice some of the techniques taught in the program.

Many of the children in this study were described by their parents as also having emotional or behavioral problems. Therefore, other studies should identify clearly the
children who also have diagnosed behavioral and emotional
disturbances in addition to learning disabilities to deter-
mine if the sample is truly representative of the LD popu-
lation.

The PSI can be used diagnostically to differentially
group parents in order to determine if different programs
are effective for specific PSI profiles. Comparisons of the
use of parent education with individual, small group, and
family counseling could be made with highly stressed parents
to determine which approach most effectively reduces stress
and changes perceived behavior of children.

The research question in this study began to identify
the stressors of parents of LD children, but further research
in this area might lead to the development of an additional
instrument of stressors specific to parents of learning dis-
abled children in order to address these issues through a
modified parent education program tailored to meet the needs
of parents of LD children.

This study is the beginning of an attempt to understand
parental stressors as perceived by parents of LD children,
and how to help parents reduce that stress. Further research
in this area will help professionals know more about how to
help parents and their LD children more effectively manage
the stress of a learning disability.
References


APPENDICES
September 6, 1985

Sherri Latson
2911 Southern Cross
Garland, Texas 75042

Dear Sherri:

It was a pleasure speaking with you about your dissertation plans with Active Parenting. As I mentioned, our own field testing has not been thoroughly analyzed and there is no other research that we know of. With the growing use of Active Parenting, there is certainly a strong need for research. As the first outside study, you will be making an important contribution to the field of parenting education.

Enclosed are copies of our Parent’s Evaluation and Leader’s Evaluation forms as used in the field test. Our limited analysis is reported in a copy of the enclosed brochure.

Please let me know how things go with your committee, and of course, feel free to call when I can help.

Sincerely,

Michael H. Popkin

Enclosure
APPENDIX B

Data Sheet

Person responding to questionnaires is:
- Natural mother of LD child
- Natural father of LD child
- Stepmother of LD child
- Stepfather of LD child
- Adoptive mother of LD child
- Adoptive father of LD child

Family structure of LD child:
- Lives with single parent
- Lives with both parents
- Parents divorced/separated
- Lives in stepfamily
- Lives with guardian

Number of children in the family ____________

The LD child is the:
- oldest child
- youngest child
- middle child
- only child

Age of LD Child _______

Grade of LD Child _______

School of LD Child ________________

Type of LD Child's Educational Placement:
- Private School for LD
- Private School
- Public School, no special ed services
- Public School, resource for less than half a day
- Public School, resource for more than half a day
- Public School, self contained special education

My child was diagnosed as LD by (type of professional, i.e. school diagnostician, psychologist, etc.): when?

Please write as many stresses as you can think of in parenting an LD child. Put a star by the three that you find most distressful.
APPENDIX C

Active Parenting Program Objectives

Session 1: The Active Parent

A) Introduce members to each other, the leader and the program.

B) Clarify roles of leader and participants.

C) Develop an understanding of the democratic parenting process.

Session 2: Understanding Your Child

A) Define behavior and its influences.

B) Establish the relationship between thoughts, feelings, and behavior.

C) Introduce the four goals of behavior.

D) Introduce the concept of Discouraged and Encouraged Behavior.

Session 3: Instilling Courage

A) Define courage.

B) Illustrate how emotions influence behavior.

C) Introduce participants to both the Discouragement and the Encouragement process.

Session 4: Developing Responsibility

A) Define responsibility.

B) Define roles of responsibility in handling problems.

C) Determine what to do when it's the parents' problem.

D) Understand the use of "I" messages.

E) Understand natural and logical consequences.

F) Provide choices for children.
Session 5: Winning Cooperation

A) Define cooperation

B) Understand problem handling when it's the child's problem.

C) Introduce the group to communication blocks.

D) Develop Active Communication skills.

Session 6: The Democratic Family in Action

A) Introduce the likely outcomes resulting from Democratic Parenting.

B) Introduce the form and structure for using Democratic Parenting.

C) Understand the Active Problem Solving Procedure.

D) Experience a family council in action.

(Popkin, 1983)
APPENDIX D

Attendance Agreement

Parent

I understand that it is important to be present at each session in order to get maximum benefit from the Active Parenting Program. I plan to attend each session, barring unforeseen circumstances. If I must miss a session, I agree to attend a make-up to be given at the end of the six weeks. I understand that child care is provided by reservation.

Signature:
Date:

Leader

I agree to lead six regular sessions and one make-up session of the Active Parenting Program. If I must be absent, a counselor of similar qualifications will serve as a substitute, or a make-up time will be provided. I further agree to make this experience as meaningful and relevant to the members' needs as possible.

Signature:
Date:
ANNOUNCEMENT

Active Parenting Discussion Group for parents of LD children

Here is an opportunity to meet with other parents and a group leader to discuss parenting concerns. The Active Parenting program is designed to help you learn to understand your child's behavior and to develop parenting skills that will encourage responsible behavior. It is a six week program that utilizes videotapes, parent handbooks, and group discussion.

This program is widely used across the country and many parents have found it to be effective. I want to see if it is as effective for parenting LD children. Since this group is a part of a doctoral dissertation, there is no charge for the program. If you choose to participate, you will be asked to fill out some questionnaires anonymously.

Two separate groups will be formed from the applicants. One will meet this fall; the other in January. In order to satisfy statistical requirements, assignments to the groups will be random. You will be notified of your group's meeting dates after all of the applications are in.

One or both parents are welcome. Parents who have children of any age can participate. The only requirement is that your child has been identified as learning disabled. Child care will be provided by reservation.

Dates for Group 1:
Tuesdays 7:00-9:00 October 15-November 19

Place: First United Methodist Church in Richardson, 534 W. Beltline Rd. (near Central Expressway and Beltline—west side of the expressway).

Dates and place for the January group will be arranged for the convenience of the participants.

To reserve your place, please call 495-3802 or return this reservation to Sherry Latson 2911 Southern Cross, Garland, Texas 75042.

Name ____________________________
Address ____________________________

Phone ____________________________ Age of learning disabled child _____

Number of children who will come for child care and their ages:

99
Informed Consent

Parents who volunteer will be randomly placed in an October group or a January group. All parents will fill out two questionnaires before and after the parenting group. Questionnaires will be confidential. There is no physical, psychological or social risk involved. Parents will benefit from learning parenting skills, and from sharing common experiences with other parents. If you have questions, please contact Sherry Latson 495-3802. All volunteers are free to withdraw their consent and to discontinue participation in this project without any penalty.

NAME OF SUBJECT: ________________________________

1. I hereby give consent to Sherry Latson _______ to perform or supervise the following investigational procedure or treatment:

Active Parenting Program

________________________________________________________________

2. I have (seen, heard) a clear explanation and understand the nature and purpose of the procedure or treatment; possible appropriate alternative procedures that would be advantageous to me (him, her); and the attendant discomforts or risks involved and the possibility of complications which might arise. I have (seen, heard) a clear explanation and understand the benefits to be expected. I understand that the procedure or treatment to be performed is investigational and that I may withdraw my consent for my (his, her) status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure or treatment designated in Paragraph 1 above.

DATE: ____________________________

SIGNED: __________________________ WITNESS: __________________________

SIGNED: __________________________ SUBJECT: __________________________

or

SIGNED: __________________________ WITNESS: __________________________

SIGNED: __________________________ PERSON RESPONSIBLE: __________________________

Relationship: __________________________

Instructions to persons authorized to sign:

If the subject is not competent, the person responsible shall be the legal appointed guardian or legally authorized representative.

If the subject is a minor under 18 years of age, the person responsible is the mother or father or legally appointed guardian.

If the subject is unable to write his name, the following is legally acceptable:

John H. (His X Mark) Doe and two (2) witnesses.
## APPENDIX G

### Stressors Identified by Parents of LD Children

**Parenting Concerns**

<table>
<thead>
<tr>
<th>Concern</th>
<th>No. of Times Mentioned</th>
<th>PSI/APACBS Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry about child's success</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Patience</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Coping with other siblings about the LD child</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Having to repeat or break down directions</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Knowing how much to help</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Fear of handling the problem wrong</td>
<td>2</td>
<td>PSI # 77, 78</td>
</tr>
<tr>
<td>Not knowing how to help</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Answering child's questions about LD</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dealing with child's unpredictable behavior</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Helping with school work</td>
<td>1</td>
<td>PSI # 99</td>
</tr>
<tr>
<td>Loss of sleep</td>
<td>1</td>
<td>PSI # 75</td>
</tr>
<tr>
<td>Parents' self-esteem</td>
<td>1</td>
<td>PSI # 46</td>
</tr>
<tr>
<td>Worry about child's behavior problems</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Peer pressure from other parents</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Burden of parent to think and act for the child</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discipline</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Parenting Concerns (continued)

<table>
<thead>
<tr>
<th>Concern</th>
<th>No. of Times Mentioned</th>
<th>PSI/APACBS Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time needed for attention</td>
<td>1</td>
<td>PSI # 47</td>
</tr>
<tr>
<td>Sorting out what is LD and what is not</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>LD child is not as easy to train</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Trying to meet child's emotional needs</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Feelings of helplessness</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Marital stress</td>
<td>1</td>
<td>PSI # 85</td>
</tr>
<tr>
<td>Feelings of anger, frustration and discouragement</td>
<td>1</td>
<td>APACBS # 24-27</td>
</tr>
<tr>
<td>I feel like I am a bad parent</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
## Child Characteristics Perceived as Stressful

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of Times Mentioned</th>
<th>PSI/APACBS Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rude, disrespectful</td>
<td>8</td>
<td>APACBS # 12</td>
</tr>
<tr>
<td>Frustrated</td>
<td>8</td>
<td>PSI # 34</td>
</tr>
<tr>
<td>Ability to get along with peers</td>
<td>8</td>
<td>APACBS # 6,7,18</td>
</tr>
<tr>
<td>Poor self-concept</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Disorganized</td>
<td>7</td>
<td>PSI #3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>APACBS #2,3,13,30</td>
</tr>
<tr>
<td>Fights</td>
<td>7</td>
<td>APACBS # 6,7</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td>APACBS # 20</td>
</tr>
<tr>
<td>Angers easily</td>
<td>4</td>
<td>PSI # 34</td>
</tr>
<tr>
<td>Needs constant attention</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>High activity level</td>
<td>4</td>
<td>PSI # 2, 7</td>
</tr>
<tr>
<td>Lack of responsibility</td>
<td>4</td>
<td>APACBS # 3,8,11,15,23,30</td>
</tr>
<tr>
<td>Short attention span</td>
<td>4</td>
<td>PSI # 2, 4</td>
</tr>
<tr>
<td>Procrastinates</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Academic problems</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td>3</td>
<td>APACBS # 31,32</td>
</tr>
<tr>
<td>Tries too hard</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Limited understanding, difficulty mastering something</td>
<td>3</td>
<td>PSI # 23</td>
</tr>
<tr>
<td>Immature</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Whines</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Doesn't listen</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Doesn't follow through</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Characteristic</td>
<td>No. of Times Mentioned</td>
<td>PSI/APACBS Item No.</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Disregard for others</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Follower, gives in to peers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gives up easily, lacks motivation</td>
<td>2</td>
<td>APACBS # 28</td>
</tr>
<tr>
<td>Poor memory</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Doesn't recognize danger</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Violent</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Self-centered</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hurt by others</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nothing is ever enough</td>
<td>1</td>
<td>PSI # 14</td>
</tr>
<tr>
<td>Loud</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mood changes</td>
<td>1</td>
<td>PSI # 20</td>
</tr>
<tr>
<td>Blames others</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Silly behavior</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
## Other Concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>No. of times Mentioned</th>
<th>PSI/APACBS Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial concern</td>
<td>10</td>
<td>PSI # 92</td>
</tr>
<tr>
<td>Special schooling</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Dealing with the education system</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Getting answers from professionals</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Medical problems of child</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Different holidays</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Coping with people who don't understand</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Carpooling</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX H

**Parenting Stress Index**

Profile Sheet and Norms—Form 8

R. R. Abidin—University of Virginia

**PARENTS OF HYPERACTIVE CHILDREN**

Parents Name

Parents Sex

Parents Date of Birth

Childs Name

Childs Sex

Childs Date of Birth

Date

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL STRESS SCORE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHILD DOMAIN SCORE**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Raw Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PARENT DOMAIN SCORE**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Raw Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LIFE STRESS**

(Optional Scale)

<table>
<thead>
<tr>
<th>Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**PARENTS OF LD CHILDREN**

N = 60

Total Score 274; SD 38.1

**TOTAL STRESS SCORE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHILD DOMAIN SCORE**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Raw Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PARENT DOMAIN SCORE**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Raw Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LIFE STRESS**

(Optional Scale)

<table>
<thead>
<tr>
<th>Score</th>
<th>Percentile Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Abidin 1963*
APPENDIX I

GROUP 1

DOWN PSI1

219.0 232.0 247.0 261.0 275.0 289.0 303.0 317.0 331.0 345.0

ACROSS PSI2

273.0 263.4 248.8 234.2 219.6 205.0

GROUP 2

DOWN PSI1

385.0 364.0 343.0 322.0 301.0 280.0 259.0 238.0 217.0 196.0 175.0

ACROSS PSI2

357.2 336.4 321.8 307.2 292.6 278.0 263.4 248.8 234.2 219.6 205.0

107
BIBLIOGRAPHY


