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The effects of a group advocacy program for parents of learning disabled children

Skyer, Gilbert David, D.S.W.

City University of New York, 1988

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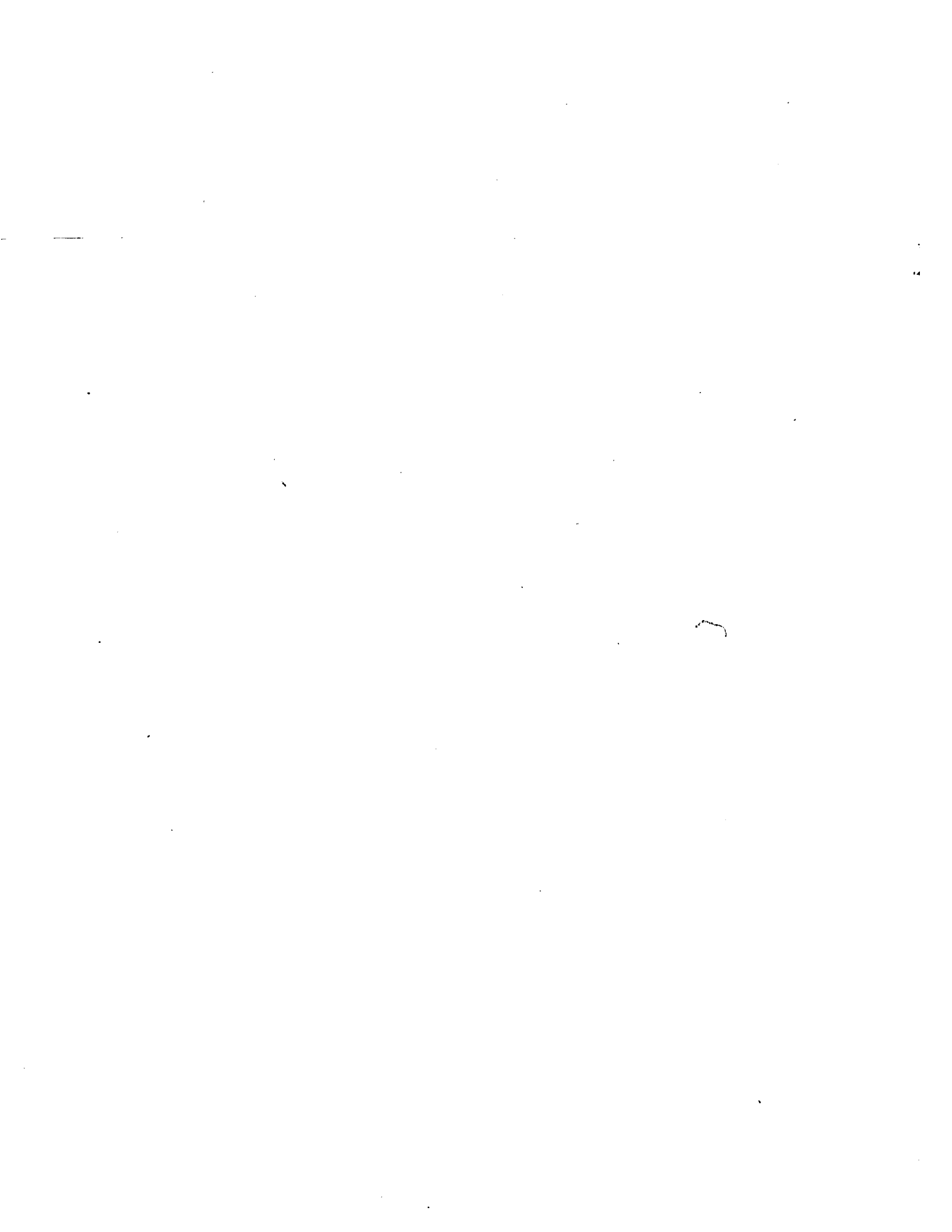
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A

THE EFFECTS OF A GROUP ADVOCACY PROGRAM
FOR PARENTS OF LEARNING DISABLED CHILDREN

by

Gilbert David Skyer

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

1988


1988

GILBERT DAVID SKYER

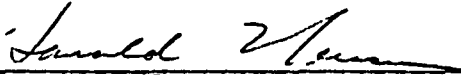
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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the Degree of Doctor of Social Welfare.

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Abstract

THE EFFECTS OF A GROUP ADVOCACY PROGRAM
FOR PARENTS OF LEARNING DISABLED CHILDREN

by

Gilbert David Skyer

Adviser: Dr. Charles Guzzetta

The Group Advocacy Program for parents of learning disabled children was designed to focus on two elements associated with empowering a parent to advocate for an appropriate education of a learning disabled child. The first element the parent required was information regarding how to address issues and individuals within the school system.

The second element the parent required was a working understanding of the child's particular disability, so the parent could more effectively advocate for the child in the school system. That element of understanding was identified as central to giving the parent sufficient insight to facilitate an effective educational experience for the child involved.

In order to ascertain the impact of a parent advocacy program on the advocacy attitudes and behaviors of parents of LD youngsters, a group of parents was seen weekly for a period of six months. These parents were exposed to the par-

ent education curriculum in a setting where the group leader used the Theme-Centered Interactional Method of Ruth Cohn (1972) in order to discuss a range of related topics in each of the sessions. Cohn's Theme-Centered Interactional Method was found to offer the necessary context and process to encourage and maintain a good balance between both educational and therapeutic models.

A three-part questionnaire was developed to measure the impact of the program on parent knowledge and attitudes regarding their LD children. This questionnaire measured gains in the participant's knowledge and attitudes toward learning disabilities. The specific positive behaviors practiced as a result of these group meetings were also measured. These behaviors were further analyzed to determine the degree to which the gains were directed more toward the community, more toward the children, or if the gains were directed relatively equally.

The results indicated that positive changes were made by all parents who participated in the group sessions. These positive gains occurred in their behavior, as well as in their fund of information and attitudes. While related gains were identified, the most significant gains were made in the area of direct child advocacy.

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Phyllis Caroff, D.S.W.
Abraham Haklay, Ph.D.

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Director: Lillie Pope, Ph.D.
Associate Director: Abraham Haklay, Ph.D.

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PREFACE

This project was about planned change. The focus of the project was to empower parents of learning disabled children to discover how they could impact significantly on the lives of their learning disabled children. This intent was not necessarily directed at achieving rehabilitative or symptom-reductive effects. It was aimed at equipping parents with the skills and opportunity to become increasingly resourceful in their efforts to understand and negotiate for their children's educational needs.

The approach utilized to empower the parents of learning disabled youngsters was identified as social learning (Goldstein, 1981). The process of social learning integrates two distinct definitions. The term "social" refers to the interaction in the interpersonal context of change, and includes all family, groups, and collective interactional and/or interdependent relationships. "Learning" refers to those cognitive processes that comprise productive, future-focused problem-solving, change and growth.

In the context of social learning, change is both a process and product of a new self-reconceptualization. This also includes one's role, relationships, and goals. Above all, it includes the need to validate personal and shared values, and to take effective, informed control over conditions that effect one's life.

The concept of social learning is based on the perspective that human learning is purposive and goal-directed, provoked by proactive impulses originating in the self. In the instance of designing and implementing a program targeted at empowering parents of learning disabled children, the focus is on addressing the parental need to cope with their present as they understand it, and the future as they envision it (Goldstein, 1981).

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CHAPTER I

INTRODUCTION

The nature, assessment and management of learning disabilities in school-age youngsters remains a subject of considerable debate (Palmer, 1983). While educators, clinical psychologists, neurologists, and social workers continue to investigate the factors contributing to school failure in children who do not present clear neurological evidence of brain damage, parents struggle with considerable confusion and concern over the process and outcomes of educational and psychological testing conducted or suggested by school officials.

Difficulties encountered by parents are understandable, considering the fact that professionals in the arena of medical care, education, psychology and social welfare are often confounded by the fact that children with IQs of 80 or more, who show evidence of some motor or perceptual difficulties, but who show no evidence of central nervous system (CNS) damage, can develop histories characterized by chronic school failure, and/or the inability to read.

The study of learning disabilities continues unabated, as researchers and educators seek to cut through the problems in definition, characteristics, etiologies and valid taxonomies (Mykelbust, 1980). As a relatively new field of study gaining momentum only in the last decade, it is to be expected that terminology, assessment, etiological study

and intervention concepts should be redefined continually, as new research supports or contradicts previous studies and findings.

The intensity of the debate and exploration is further fueled by the fact that the study of learning disabilities has drawn the interest, attention, and involvement of professional and non-professional groups alike. These groups include psychologists, educators, politicians, advocates for the handicapped, parents, attorneys, social workers, and physicians variously educated in neurology, pediatrics, psychiatry, general practice, and trauma, among other specialties. Although each group may have a special set of concerns that sets it apart from the others, three distinct aggregates do emerge from all the different sub-groups: (1) parents who represent the organized nonprofessional establishment; (2) teachers, social workers, psychologists, and other school personnel; (3) academicians and theoreticians, who constitute the most prolific of the three groups in their record of journal publication regarding studies of learning disabilities. It is therefore important to consider the possibility that literature hypothesizing on the nature, assessment, and treatment of learning disabilities reflects the perspective of their originators, who are not the school-based professionals or the parents charged with the primary responsibility of testing and teaching learning disabled children (Weiss, 1976).

The result is that comparatively little information is published regarding the parent's role in helping to assure that the learning disabled child is appropriately identified and educated. Traditionally, parents have successfully exercised their power and insight individually or in groups by pressuring school or political officials to help the children receive the best possible education, whether the children are learning disabled or otherwise in need of special educational services.

Parents' considerable record of achievement in this area of advocacy seems to be attributable to three basic factors: (1) parents by and large have a vested interest in the overall development of their children; (2) parents are often aware of the fact that their children are experiencing learning or behavioral problems that would warrant special help long before school authorities advise the parents of their own, independent observations; (3) legislators, school boards, and other visible officials elected or subject to public appointment are substantially more responsive to demands articulated by parents than to demands expressed by a handful of professionals, primarily because parents represent a potent block of voters (Ravitch, 1983).

In an arena where methods of assessing and defining learning disabilities are still subject to substantial and contradictory debate, educators, politicians, parents, and,

most importantly, children, have been forced into the often untenable circumstance of attempting to cope with and ameliorate a problem that many maintain still defies quantification (Palmer, 1983). That means that educators, educational test givers, psychologists, social workers, and legislators have been charged with the responsibility of creating remediation and support technologies even as assessment technologies are still being developed and refined.

As might have been predicted, parents, children, educators, psychologists, and social workers have struggled with the reality that children have been tested and educated in a less than optimal fashion both during and since the years when learning disabilities were first explored as a possible obstacle to ability-appropriate learning. Testing and remedial programs have not always been conducted appropriately, and communication between parents and educators has often been belated, indirect, insubstantial, accusatory, adversarial, and finally characterized by mistrust on both sides.

On the one hand, parents complain that school officials and psychologists hold back information, unfairly label their children, and act with impunity in matters that can effect the present and future of their children. On the other hand, educators, psychologists and school social workers report feeling uncomfortable in sharing their test-

ing procedures, findings, and detailed recommendations with parents, despite the fact that these professionals are charged, by law, to disclose such information to a child's parent or legal guardian.

The etiology of their discomfort may be that the technology of assessment and remediation is still being developed, and is subject to criticisms calling it imprecise, racist, sexist, biased, unprofessional, and inconsistent (Ravitch, 1983). Regardless of why educators and other professionals feel uncomfortable sharing assessment and educational information with parents, the fact remains that the parents are forced to find information about such matters from sources other than the school. Parents are privy to enough such popularly-published information to mobilize them to protect their children from inappropriate educational testing or placement. Educators, psychologists, and social workers who avoid parents seeking answers simply confirm parents' fears that the school officials have something to hide.

When school officials misinform, avoid, intimidate or simply fail to respond adequately to parents of children with learning problems, those parents may feel increasingly angry, bereft, defensive and isolated in regard to their children's educational needs. When a child of normal intelligence develops through each stage of early childhood without significant event, it can be extremely difficult

for his or her parents to accept that the same child is not learning at an appropriate rate in school. Some parents react by denying or avoiding the possibility that the child is experiencing learning difficulties. Others may become completely focused on the problem, perceiving it as a disability that renders the child substantially and irreversibly dependent (Palmer, 1983; Phillips, 1978).

In other cases, parents insist that the child will outgrow the disability, and that the school should proceed with the child's education regardless of any temporary difficulties the child may encounter. Although certain motor difficulties may be attributable to developmental lag, there are other learning, perceptual and motor problems that do not disappear over time. In such matters, parents can react out of a combination of misinformation, anxiety, and frustration in coping with a large system of professionals who are not meeting the parents' needs for support, concrete data, and insight into helping their children.

If parents and educators are locked in conflict, the child may remain unserved for the duration of the difficulty. The child ultimately goes home to the parent, who may expose the youngster to opinions and feelings that are hostile to the school, which can have the resulting effect of further disrupting the child's ability to learn. The parent may spend months or years trying to circumvent educational plans developed by the school professionals, and

the child who does have a learning problem will generally go unserved in the interim, unless the school successfully charges the parent with educational neglect.

Whether a parent actively fights the school, withdraws into avoidance, or struggles with feelings of confusion and helplessness, the fact remains that parents and school professionals often place themselves on opposing sides despite the fact that they share certain crucial goals in regard to promoting the well-being of the child (Richin, 1986).

While the educators and the parents struggle to bring their respective roles into harmony in educating the learning disabled child, the role of the social worker remains largely undefined in regard to learning disabled students.

It is possible that such role clarification has been delayed since there is no clarification of a practice model for integrating the school, special education, and the needs of parents whose children are learning disabled. The absence of such a practice model notwithstanding, The Education for All Handicapped Children Act: Public Law 94-142 mandates that parents must be included in any decisions that impact on their child's education and future.

As a result, parents who might have left the entire process to the school officials are forced to participate to some degree in the decision-making process, and school officials who might otherwise attempt to circumvent matters of parental discretion and authority are forced to include

parents in all matters related to testing and placement. One practical implication of this relatively recent mandate is that parents are experiencing increased pressure to make informed choices and to work as partners with school professionals (Richin, 1987).

Since parents have been given both the freedom and responsibility of participating in key educational decisions effecting the lives of their children, it is the challenge of this decade to equip those parents with the skills they need to execute thir task with dignitiy and confidence. It was toward that end that this project was directed.

RECOGNITION OF CHILDREN'S LEARNING DISABILITIES

Assessment of learning deficits identified as delayed cognitive development is rooted in the early clinical psychology movement that focused intensely on the testing of mental function (Watson, 1953). "Because some retarded children did demonstrate evidence of brain damage in their wizened or gigantic skulls, it was argued that all other retarded people must also have diseased or deficient brains, evidence of which was undetectable at the time," (Palmer, 1983).

Until the mid-1970's, children who did not perform within normal range on IQ tests were often labeled as suffering from brain damage, despite the fact that no medical or mental health professional could substantiate the find-

ings positively. "Many were intellectually normal children who had been abandoned or had become, for other reasons, wards of the court and were too depressed and angry to pay attention to IQ tests," (Palmer, 1983). The pattern of attributing abnormal cognitive functioning or development to brain damage even when such damage could not be clinically validated became the framework for assumptions regarding the notion of minimal brain damage or dysfunction, otherwise identified as learning disability.

The concept of minimal brain damage or dysfunction was given much credibility by Strauss (1947), who developed a taxonomy of observations regarding children's learning which became the forerunner of most symptom criteria of learning disabilities today. It was Strauss (1947) who clearly advanced the concept that injury or anoxia suffered before, during, or after birth was the root cause of perceptual, cognitive, motoric, and emotional disturbance. He noted that such brain damage was highly correlated with hyperactivity, perceptual problems, and attentional deficits.

Strauss' seminal work in the study of learning deficits led to the development of the term "Strauss Syndrome," which was used to describe children whose test results and learning patterns were identified as indicative of brain injury. Like much of the early work in educational testing and learning assessment, Strauss clearly placed heavy

emphasis on the belief that learning dysfunction was highly correlated with neurological damage.

Samuel T. Orton (1937) another early investigator, also concentrated on the neurological etiology of learning deficits. He proposed that lateral dominance was the basic problem in dyslexia. As a neurologist, he postulated that the two hemispheres of the brain act as mirror images to each other. Orton's research supported the notion that the left hemisphere is dominant in terms of storing memory tracings. This dominance, it is argued, then causes the right hemisphere to suppress mirror image tracings. When no lateral dominance exists, confusion develops, (Howell, 1981). Letter reversals and inversions are the obvious results of this condition, and are notable symptoms of dyslexia.

Although current research suggests that mirror image suppression is a difficult concept to support (Howell, 1981), Orton's theories are still widely accepted by people who remain in positions of considerable authority and influence in education and educational psychology. In fact, a substantial portion of seminal research into the etiology and assessment of learning disabilities was universally conducted on the assumption that the cognitive, perceptual, or motoric problems impeding learning were attributable to brain damage (Rabinovitch, 1959)

It was variously argued that children with learning

problems and basically normal IQs were victims of anoxia at birth, or some other trauma that damaged the association centers in the parietal lobes of the brain. Such theories met the researcher's need to identify a reason why intelligent, responsive students might experience symbol recognition problems that could ultimately interfere with their ability to acquire the most basic reading skills.

The unswerving research commitment to the concept of minimal brain dysfunction became increasingly difficult to defend, as researchers in medicine, psychology, education, and human development found it increasingly difficult to argue for the presence of cortical damage when no clinical evidence could be found (Jordan, 1976). In the absence of such damage, the term "dyslexia" gained popularity, as professionals sought to identify a dysfunction that could cause even those children with very high IQs to reverse or invert symbols, and thus fail to learn how to read.

In an effort to coin a term appropriate to capturing the concept of learning deficits, Samuel Kirk proposed the term "learning disabilities," since the inability to learn at an age and intellect-appropriate rate seemed to be the one common denominator among all the groups of children represented by the various disabilities. The term was rapidly and widely accepted by educators and psychologists grasping for an expression that would be accurate, defensible, and helpful in developing remedial programs,

(Siegel, 1982).

In this history of understanding learning disabilities in children, one date stands out as pivotal in the coalition of informed forces working to help children whose learning was either abbreviated or aborted by disabilities that left them behind as their peers moved ahead. On April 6, 1963, the Fund for Perceptionally Handicapped Children and the American Orthopsychiatric Association sponsored a meeting in Chicago for the express purpose of organizing a national parent group to help accurately assess and remediate learning problems in school-age children.

As a result of this meeting, the Association for Children with Learning Disabilities was formed. Members included both parents and professionals, and together they created what would become a key organization that popularized a term that reflected a movement away from the notion of brain damage, and toward the understanding that learning disabilities are often indicative of some neurological deficit that may involve interactive social, emotional, psychologic, and/or motor problems that could be developmental, and, most importantly, responsive to remediation and support.

As parents and professionals were coalescing in the early part of the 1960s, other researchers were exploring the matter of learning deficits in terms of missing stages in neurological development. This direction suggested that

the treatment follow the same phylogeny of developmental stages (Delacato, 1963). This approach, referred to as patterning, was helpful in some cases, but lacked sufficiently broad application to withstand use in a wide variety of learning disability problems (Jordon, 1976).

As definitional taxonomies for the terms were developed, broader and broader categories of problems had to be included. This caused researchers to revise definitions to include an increasingly wider scope of learning problems and behaviors (Kaluger, 1969). In the continuing effort to establish criteria to measure the nature and extent of a learning disability, the specific problem of dyslexia was defined as involving reading, spelling, or writing problems in four separate diagnostic categories. This designation reached beyond the notion that dyslexia was a matter of brain dysfunction, and included the possibility that factors such as the entire nervous system, cultural variances, and educational background or experience could impact separately or interactively in the presence of dyslexia (Bannatyne, 1954).

Current studies suggest that behavioral and cognitive function factors, unrelated to CNS function or minimal brain dysfunction, could be substantially more significant in the development and entrenchment of learning disabilities than are any central neurological factors (Paine, 1968; Duane, 1974).

Such studies require further investigation and replication. At present, however, the assessment of learning disability continues to be considered interchangeable with the assessment of brain dysfunction or damage (Palmer, 1983) Such testing efforts are often advanced when a child presents one or more the following conditions:

(1) the child is failing to learn at the pace indicated by his or her IQ (special focus on those instances where the child fails to learn how to read at an age and developmentally-appropriate pace);

(2) The child's IQ is 80 or above;

(3) There is no concrete neurological evidence of brain damage, but the child may present motor or perceptual evidence of a non-specific neurological deficit.

A child's failure to learn has been variously attributed to problems of allergy, nutrition, teacher expectation, teacher bias, student anxiety, student indifference to school mandates, family violence, child sexual abuse, alcoholic family system dynamics, cultural differences, the child's emotional problems, and developmental lag, to cite just a few of the causative factors identified as positively correlated with learning deficits in children, (Brookover, 1982; Dunn, 1983; Rutter et al, 1979; Davies, 1982; Philips, 1978). Generally, it can be argued that there are interactive variables which combine to impact on a child's learning ability at any given point in his or her

school career. One of those variables may be a cognitive, perceptual, or motor problem that may be related to brain dysfunction.

Despite the current research and growing body of often conflicting knowledge regarding the assessment, nature, etiology, and remediation of learning disabilities, it is crucial to emphasize that the lack of a single, homogeneous definition of learning disabilities does not in any way diminish the existence of such disabilities. The various explanations and symptoms of these disorders may currently perplex educators, frustrate children and parents, and confound researchers, but all those factors simply indicate that further intensive study is required to better understand how to measure and remediate learning disabilities.

While the body of knowledge regarding learning disabilities continues to evolve, school systems remain charged with the obligation to respond to the needs of children who present apparent learning deficits. School systems must use the tools at their disposal to assess and remediate learning disabilities, while they embrace their responsibility to continually re-educate themselves regarding advances made in this new and growing field of study. In this fashion, school systems can continue to serve children to the best of current ability, while they continue to perfect their skill and expand their fund of information regarding the nature, etiology, and remediation of learning

disabilities in school-age youngsters.

At present, school systems are often free to establish their own approaches to and procedures for assessing and remediating learning disabilities. Some school districts operate on the philosophy that new information must always be integrated into the assessment and remediation program, and some operate on a much more informal basis. That informal basis can leave much of the problem identification, assessment, and parent contact to school professionals who are trained in their field, but untrained in working with learning disabled children.

In such school systems, individual teachers or administrators may have the latitude to inform parents that their children have perceptual disorders, learning problems, or motor coordination deficits without necessarily having the standardized test scores available to support such observations. Parents receiving such unsubstantiated assessments often seek private consultations that often prove to invalidate the informal assessments made by school professionals untrained in the skill of administering and interpreting standardized tests (Skyer, 1982).

In the closing years of the 1980s, school systems, parents, and children continue to struggle with the imperfect and often inconsistent methods and procedures for assessing and remediating learning disabilities. Trained diagnosticians must look beyond poor reproduction on the

Bender-Gestalt, or poor performance on Halstead-Reitan or Luria batteries. Children who suffer from delayed motor development often produce poor reproductions on the Bender-Gestalt, and children who are depressed or hyperactive may resist the requirement of sitting through the entire Halstead-Reitan or Luria batteries.

Trained diagnosticians are alert to these facts, and their test administration and interpretation are affected accordingly. Their professional reports on the child's learning abilities and disabilities should be supported by the best information available to professionals. The diagnostician who integrates all the indicators, and remains in touch with current insight into learning disabilities, is a diagnostician who will best serve children by conducting tests with a maximum degree of reliability, consistency, and equity. A detailed overview of the nature of that current status of learning disabilities follows.

CURRENT STATUS OF THE PROBLEM

Although there is much disagreement among professionals currently involved in researching or practicing the assessment, nature, or remediation of learning disabilities in school-age youngsters, they do agree that there is a significant number of intelligent individuals who have difficulty achieving even average performance levels on specific and varied learned tasks (Lynn, Bluckin, and Kripke, 1979).

Although these same professionals would likely debate the degree to which each indicator or measure can be relied upon, they would be likely to agree that the following considerations play an important part in the general professional debate regarding the etiology, nature, assessment, and remediation of learning disabilities:

a) the boundaries between normal and pathological variations in performance;

b) how high a score a child can achieve on a standard intelligence test before one ought to be surprised at poor performance;

c) whether standard intelligence tests are appropriate diagnostic tools;

d) how many different types of learning disabilities can be identified and distinguished from each other;

e) what causes learning disabilities;

f) how to distinguish deficiencies in performance due to emotional problems, inadequate training, inadequate education, delayed development, or permanently retarded development;

g) the means of remediating learning disabilities;

h) the effectiveness of remediation strategies;

i) how learning disabilities should be defined to assure fair access to social benefits and financial resources, and still assure that no individual is inappropriately labeled (Lynn, Bluckin and Kripke, 1979).

The wide differences in opinions and concerns expressed by researchers, educators, psychologists, and other professionals involved in the educational measurement of learning ability and disability are attributable in some part to the fact that each group of theoreticians and practitioners comes from a somewhat different orientation (Faerstein, 1981; Goodlad, 1983; Palmer, 1983; Ravitch, 1983; Sarason, 1979). However, the primary reason for the differences in interpretations regarding the nature, etiology, assessment, and remediation of learning disabilities is that this particular field of study is still comparatively new (Ravitch, 1983).

The past decade has witnessed certain changes in professional perspectives on learning disabilities, with concomitant changes in public law and perception of children's rights to education. For example, the theoretical foundation for study has shifted away from the emphasis on the unproven but popular concept of organic etiology, and has been re-directed at a more developmental model subject to remediation over time.

Given the notion that remediation is increasingly possible, new strategies to help children understand and overcome learning disabilities have been put into place. Such programs have enjoyed varying degrees of success as professionals, parents, and students alike continue to learn more about how to identify, defeat, and/or cope with certain

learning disabilities. Passage of Public Law 94-142 helped generate a flow of public funding from the federal, state, and local authorities, all directed at helping children with learning disabilities better understand and overcome their particular learning problems.

In the wake of increased attention and funding for such programs, more professionals are identifying more cases of learning disabilities as they explore the nature of learning problems without having to be concerned about whether other school or mental health professionals will agree that the child is teachable or acceptable in the mainstream.

Increased parent involvement remains a factor which many professionals do not yet know how to utilize to the best advantage of the children, and do not yet understand how to respond to on professional terms. However, it was parent organization and vocalization of parental concern that helped motivate elected officials throughout the nation to pass PL 94-142, thus providing public funds to serve all learning disabled children. This welcome change from decades of service deprivation was attributable in large part to the organization of parents and professionals who found support from each other in at least one of the three leading organizations committed to the better understanding, protection, and education of learning disabled school-age youngsters.

These three organizations are the Orton Society, the Association for Children with Learning Disabilities (ACLD), and the Division of Children with Learning Disabilities of the Council of Exceptional Children (DCLD). Of these three, the ACLD has been and continues to be the largest and most powerful in effecting change for learning disabled children by advancing the popular understanding that learning disabilities are real, deserving of professional attention in areas of research, assessment and training, and further deserving of special support services directed at empowering school age children who struggle daily to overcome these learning deficits, with services offered directly to children, or indirectly, through working with the parents of LD children.

The ACLD is chiefly responsible for the wide acceptance of the term "learning disability," (Hallahan, 1983). The other two organizations are somewhat smaller, more professionally oriented, with memberships that include more psychologists, social workers, educators, physicians, speech specialists, and nurses than non-professional parents of school-age learning-disabled children.

It is important to note that there are distinct differences in group agendas. DCLD and the Orton association are primarily committed to identifying new remediation techniques and resolving theoretical differences. ACLD directs its considerable power and influence at identifying

the fact that learning disabled children require services, and that those services must be made available to all children in need.

Political differences between the two different types of groups have been noted in the literature, which reflects the Orton and DCLD emphasis on the research and theory, and the ACLD emphasis on retaining the phrase "learning disabled" as the least stigmatizing and therefore most acceptable terminology to label children who experience performance deficits in learning (Lynn, 1979).

One political, social and theoretical point of contention that remains central to groups dominated by parents and by professionals, respectively, is the issue of labeling. From the researcher's point of view, general labeling practices focusing on non-specific identification can impede exploration of a child's actual learning needs, and can stigmatize the child in the process. Parent groups, on the other hand, are quick to point out that the gross labeling process has helped the public, and the government representatives, to respond to identified, general educational needs by assuring that benefits and services continue to improve. Parent groups also attribute public awareness of learning disabilities to the fact that the label itself is serviceable, general, and still appropriate.

Parent groups in general, and the 50,000 member ACLD

in particular, can claim considerable responsibility for the two most significant pieces of legislation ever to influence children with learning problems: PL 91-230 and PL 94-142. Each of these laws goes beyond the traditional emphasis on retarded or physically disabled children, and includes specific recognition of the learning disabled school-age youngster. The latter, which went into effect in 1976, represented a quantum leap in the scope of service enjoyed by the learning disabled.

Like most new legislation, the law remains open to interpretation that will likely be narrowed in court decisions and continued legislation. However, the primary intent of the law will remain fixed: that children have a right to an education in the least restrictive and most appropriate environment, with that environment featuring those supports and services necessary for the child to learn at an appropriate pace.

By detailing specific handicapping conditions, ranging from retardation to physical handicaps to learning disabilities, and mandating involvement of parents and professionals in the instruction and support of handicapped children, passage and wording of the law invited input from social workers, whose model of intervention and support focuses on bringing special services to a particular client population.

Expressing as it does a clear mandate for parents pro-

professionals, children and community members to work together to understand and overcome handicapping conditions, and so enhance the education of those children, PL 94-142 opened the door for social workers to present their ecological model, that brings all these elements together.

Although PL 94-142 was an act of federal legislation that charged local districts with program oversight, it was the first such legislation that was specifically prescriptive, detailing precisely what steps school professionals should take in their response to the new law. Mandates regarding parent access to information, student access to related services, a child's stated right to receive an education in the least restrictive environment, and parent involvement in decision-making were widely applauded by child-advocacy groups comprised mostly of parents. At the same time, professional groups warned against such strongly prescriptive legislation that made it a fundamental right of every child to receive services, even if the professionals were unsure about how to implement or evaluate those services (Ravitch, 1983).

With related services so poorly understood and yet so clearly a civil right to which each involved child was entitled, there was a foreseeable proliferation of hastily packaged support services that inadequately served the children and parents who are entitled to more. On the one hand, progress was made in identifying and protecting the

rights of the handicapped. On the other hand, some very poor and inadequate programs were hastily implemented as schools rushed to meet deadlines, since failure to apply for program approval before the deadlines cost them dearly in federal funding (Ravitch, 1983).

Even as the law has been refined, re-interpreted, narrowed, and explored in order to achieve better understanding, the relationship between parents and educators who serve the learning disabled has been marked by considerable conflict and confusion. Parents are more informed in regard to their rights, and the rights of their children, and professionals in schools often feel at a disadvantage, struggling with less information than they would like to have as they devise remediation and assessment approaches that still require parental consent and input. That requirement can and does cause professionals to feel resentful of parents they often view as uninformed and inappropriately aggressive (Richin, 1987; Ravitch, 1983). This problem is particularly true for parents and professionals working with learning disabled children, since the law mandates that these parents approve the educational plans and related services for their children (Constable, 1982; Pope, 1980).

Dane (1985) has noted that the requirement for parental input and approval has had the unfortunate effect of increasing the rift between parent and professional, as

each struggles to determine what steps truly serve the best interests and needs of the child. As the law was designed to enhance the working relationship between parent and school, it is disturbing that the opposite effect has become increasingly manifest.

In an environment of home-school cooperation and mutual support, children experience greater school achievement than when the relationship is characterized by conflict and misunderstanding. At present, this environment is lacking, while well-informed as well as ill-informed parents become involved auditors of the educational system, with the potential to increase or decrease the gulf between the two parties that have one key variable in common: the educational needs of the child.

Since academic achievement has been consistently correlated with positive parent-school relations (Goodlad, 1983), and since the Education for All Handicapped Children Act requires that parents and educators enter into a partnership in the education of the exceptional child, it would behoove both parents and educators to explore different means of turning conflict into cooperation.

The discussion about such cooperation is no longer academic: PL 94-142 has mandated that, at least in the case of learning disabled youngsters, parents be included in the decision-making. Educators as well as parents and children would therefore benefit if the parents were given the

information and support necessary to empower them to become informed participants in their children's education. Given the current tension between parents and school system authorities charged with the responsibility of working with learning disabled children, it is reasonable to assume that more effective educational linkages will be required for those parents who are involved.

One of the most successful such linkages is the parent support and training group, which serves as a forum where parents can derive child-advocacy skills specific to the educational, social and developmental needs of their learning disabled children. The Guided Thematic Curriculum used in this study was implemented in a small group headed by a clearly-defined leader, precisely because the small, informal group has been found to be a setting that promotes substantial gains in goal achievement (Glasser, Sarri and Vinter, 1974; Hare, 1976). The value of implementing a program designed to help empower participants to change specific aspects of their life is rooted firmly in the tradition of social work (Germaine, 1983; Gordon, 1970).

THE SMALL GROUP SETTING AND PARENTS OF LD CHILDREN

There was abundant evidence supporting the possibility that participating in a small, organized group could help individuals acquire new skills and information important to their social roles (Borgatta and Baker, 1981; Turner, 1977; Hare, 1976; Bass, 1960). Furthermore, there was a substantial

amount of literature supporting the observation that measurable changes experienced by members of small groups could be attributed in part to the interactive dynamic that can take place, combined with supportive direction by the group leader (Hare, 1976; Olmstead, 1959; Bales, 1950).

In developing a structure for a small group of parents of learning disabled children to acquire more information and support in their efforts to understand and educate their children, it was found that group participation and group size would effect the ability of the members to achieve the goals of the group (Zastrow, 1983). In addition, it was found that homogeneous groups with unobtrusive but supportive leaders were found to be valuable in helping group members interact with each other in the group, encourage each other to remain hopeful and strong, and to acquire new, positive skills, attitudes, and information (Turner et al, 1977).

Within the context of a small, formal group, individuals have found considerable support, strength, guidance, and information critical to helping them function within their families, and within the larger community (Ridgeway, 1983). "If, as an adult, you feel that you are having difficulty in relation to some aspect of society, and if your friends and family are unable to help you (overcome that difficulty), one thing you might do is turn to specially constructed primary groups designed to retrain people's everyday habits of dealing with others and society," (Ridgeway, 1983).

Within this primary small-group setting, it is possible for the members to achieve the goals they have set if: (1) the leader is able to create and sustain a supportive atmosphere by managing conflict and encouraging task-focused cooperation; (2) the members communicate honestly and openly; (3) the group focus is subject to measure and assessment, so the members as well as the leader can ascertain progress or lack of progress.

The data suggest that small primary groups designed to help the members acquire new skills and insights in order to effect measurable change in their lives are often considered very rewarding to their members. "It has been found that 78 percent of the participants reported positive change, and 64 percent still believed that to be true six months later... Such primary groups do address a set of needs that people appear to increasingly feel. People must learn to change themselves in response to changing demands placed on them by society. Given their limited resources and specialized natures, the usual family and friendship groups are not always sufficient to the task. As a result, there is a real place for such small groups in our society," (Ridgeway, 1983).

Given the established success potential of small, problem-solving, training-focused groups organized to help adults adjust to new demands on their social roles and functioning (Turner, 1977), it was determined that the small group setting might be suitable for covering the Guided Thematic Curriculum designed to help parents of learning disabled children learn

more about how to parent and advocate for those children.

Since the Guided Thematic Curriculum utilized in this project was structured to promote change in parents who wanted to better understand, parent, and advocate for their learning disabled children, the role of the leader as a source of change required special investigation as the project was formulated. In conjunction with the purpose of social group work, "leadership is defined as the observed effort of one member to change other members' behavior by altering the motivation of the other members or by changing their habits," (Bass, 1960). According to this definition, it is possible for a small group to contain both a formal leader, and individuals who can assert leadership as helpers in the process of empowering another member to undergo a specific type of change.

The ability of a leader to effect change appears to be substantially related to that leader's ability to identify issues that are meaningful to the group members, and to demonstrate a clear ability to help the members overcome anxiety in facing and coping with stressful problems. "If a leader unobtrusively interacts with other members to help members sustain an affirmative perspective regarding the outcome of the member interaction or efforts, then the leader can expect that the members will be more likely to successfully attempt change. If, on the other hand, the difficulties of the group are too great, members expectations of failure may make the group sufficiently unattractive to cause the members to withdraw from

it, rather than attempt to solve the problems," (Bass, 1960).

In order to help keep the group intact and rewarding to the members, the small group worker or leader must help the group members to break down large obstacles into smaller, more manageable problems that can be understood and overcome. In the process, the worker interacts directly with each member in order to modify his or her behavior, intervenes in the group in order to create or enhance group conditions helpful to the member, or acts upon the environment outside the group in a way that will be helpful to the member. (Turner, 1977). The worker-member interaction is identified as direct influence of the worker, and the worker-group interaction is identified as the indirect influence of the worker.

Since it is also the leader/worker's responsibility to select the group participants, that individual must make specific, informed choices regarding group size, meeting frequency, content of group focus, and goals of the group, as well as "the degree of homogeneity and heterogeneity sought with regard to specific member attributes, depending on the function of the agency, the anticipated purposes of the group, and the kinds of problems for which members seek or require help," (Turner, 1977).

In this demonstration, it was determined that all group members would be parents of learning disabled elementary-school age children involved in the agency program targeted at helping learning disabled youngsters. It is possible that a

single, common characteristic can unite people even when the population presents otherwise broadly diverse background and orientation (Hare, 1976). This has been found in work with groups as diverse as parents of dying children (Kubler-Ross, 1983), adult children of alcoholics, (Woititz, 1983), children and adult children of abuse (Gil, 1984), and parents of children who are mentally retarded (Berg et al, 1984). These sources support the suggestion that differences in sex, race, religion, income, economic background, place of residence, education, and other demographic characteristics can be superseded by the presence of a single shared characteristic found to be important to all members involved.

In view of the literature reviewed in this section, it is reasonable to suggest that learning disabled children could expect more support and advocacy from their parents if their parents had an opportunity to get support, training and guidance in a small group setting. This is particularly true in view of the nature of the unmet need experienced by the target parent population. The nature of that unmet need addressed in the context of this project is developed in the following section.

CHAPTER II
NATURE OF THE UNMET NEED

Parent Involvement

Educational service delivery systems to learning disabled children were originally constructed on the assumption that the remediated child would be the client, and that the client would emerge from the process intact. There may be some residual weakness in language processing, coordination, reading, spelling, or computational skills, but such deficits would be essentially insignificant. It was only as the first generation of remediated children reached adulthood that the problems of ego development, emotional stability and social skills became evident.

Since the early 1970s, the formal school view toward parental involvement has shifted from unofficial taboo to official endorsement. However, a shift in public policy does not necessarily mean that practical application is forthcoming. Although parental involvement is both advocated and mandated by schools throughout the country, the translation of concept into action often leaves certain gaps in service and support. Each learning disabled child has at least one parent or guardian who must, by law, contribute to the educational planning for that child. It would seem that programs designed to help parents execute such a task would be at least large enough to accommodate the number of parents involved.

Unfortunately, the history of parent-school relations has not typically been based on such a partnership premise. Court decisions over the past two decades (e.g., *Arreola v. Board of Education* and *Guàdalupe v. Board of Education*, 1972) each stressed that (1) parents had to be notified of special educational testing and placement; (2) parents could challenge the testing and placement; (3) an injunction could be enacted to suspend all related classroom operations and reimbursement for same in those cases where school officials failed to provide parents with those rights (Brookover, 1982).

With such a recent history of conflict and difficulty, it may be expected that the relationships between parents of LD children, and school officials might be strained. Despite this strain, programs continue to be developed, tested, and refined to provide parents with a forum within which they can get the information and support they are entitled to receive. Although the programs may vary widely in research base, scope, and access to parents, major program types seem to emerge from an overview of such program developments. First, there is the program devoted to parent counseling, preparing the parent to make an effective choice in the educational decisions that will be necessary for the child. Second, there is the model that focuses on training parents to tutor their own children.

The common theme between these two program models is

that the children are the identified clients, and the parents are simply added to the constellation of adults who serve and support the youngster's efforts to learn. Since there is a significant sense of crisis and stress in parenting a child with no identifiable disabilities (LeMasters, 1965), it would be reasonable to hypothesize that parents would undergo significant stress in reaction to the notion of having a learning disabled child, and then having to respond to that disability by working in concert with a host of school officials (Rochowitz, 1979).

There are two fundamental sources of anxiety and stress to which a parent could react once a child is identified as being at risk of having a learning disability. First, there is the issue that the child is damaged in some significant fashion, despite the fact that the child presented no related symptoms as he or she was going through infancy and early childhood. This revelation can cause the parent to experience a crisis of confidence in self or others as he or she becomes concerned about other problems that might be hidden deep inside the child, far from the reach of the caring parent.

In addition to coping with the stress, anxiety, helplessness, and surprise of hearing from a school official that the child -- the extension of self -- is somehow disabled, there is the additional factor of how the parent feels about the school and school authorities. Many par-

ents struggle unsuccessfully to work effectively with schools, because the parents find the school building, bureaucracy, and officials to be intimidating at worst, and baffling at best. Parent anxiety about dealing with the school system at all may be interpreted as parental resistance to cooperating with educators concerned about remediating a learning disability, and the lack of communication continues to grow unabated (Weiss and Weiss, 1979; Goodlad, 1983; Palmer, 1983).

The identification of a learning disability in a child generally precipitates a crisis in the family, as the various family members respond to the new information. French (1977) observes that "a family's internal structure is often hidden and will become apparent only during a crisis. Therefore, critical data about family roles is best obtained from descriptions of behavior during stressful periods in the family history." Crisis presents the family or the individual with an opportunity for change (Maidman, 1986). There is reason to suggest that the identification of a child as learning disabled presents the parents with an opportunity to learn how to become more assertive, inquiring, and informed in assuring that their children are tested and educated in a fashion consistent with the needs of the child and the full range of options presented in the education service delivery system (Maidman, 1986).

The Home Study Institute of Trinity College in Wash-

ington, D.C. has promoted a model of parent-school cooperation that articulates a specific context within which parents can best assure that their children are provided a quality education by helping the parents understand how to monitor and assess the activities of the school personnel responsible for teaching or supervising. "The Home Study Institute begins with a nondeficit model of the family, which is in direct contrast to many home-school programs which adopted a deficit approach. The HSI nondeficit model is based on the following assumptions:

- 1) All children have had meaningful experiences;
- 2) Home environments, no matter how poor, can be a citadel of care and concern for children;
- 3) Parents intrinsically possess the abilities to help their children succeed in school;
- 4) Family concern can be readily translated into practical support for children and schools. Professionals need only to provide the materials and support to enable parents to become more active and skilled participants in their child's education;
- 5) Schools should start with what the family has instead of worrying about what it doesn't have;
- 6) Schools, no matter how understaffed or under-equipped, have the capability of reaching out and affecting parent involvement by using easy, inexpensive materials, without waiting for what probably will not come; organizational change or massive government funding," (Whittaker and Garbino, 1983).

Unfortunately, schools often approach parents on the assumption that parents should simply accept the decision of the school to conduct whatever testing the school deems necessary, and to accept the school's interpretation of that testing. Clearly, such an approach is based on the deficit model of the family, rather than on a clear view of

the family as a system complete with both assets and deficits, many of which can be ameliorated with education and support (Maidman, 1986; Whittaker and Garbino, 1983).

In order to be informed and confident partners in the education of their children, parents require information and guidance from a range of sources, including but not limited to the school itself. At the point where the child is recommended for testing, and at the point where the test results indicate that the child is or is not learning disabled, the parent requires information, collegial support, and cooperation on the part of the school. This set of parental needs are particularly evident when the child is identified as learning disabled (Richin, 1987). Too often, the school provides the parent no more significant role than signing testing and placement papers, attending meetings of the Committee on Special Education, and signing often-unexplained IEPs.

Particularly when the child is identified as learning disabled, parents need information, support, and guidance in order to effectively help their children develop the skills and esteem associated with learning (Palmer, 1983). When the child is classified as LD, the role of the school in the education of the child is altered. In much the same fashion, the role of the parent in the education of the child is altered. The school has specific procedures and strategies to follow in creating that role change. It

would seem reasonable to provide parents with procedures and strategies suitable to the home setting (Whittaker and Garbino, 1983).

Teachers receive training and support in understanding the educational and developmental needs of learning disabled children. Parents of learning disabled children require training and support, as well, in order to best advocate for their children. The crisis setting, when the identification has been made and the educational plans require development and implementation, can be the most propitious moment for parents to receive specific and goal-oriented support and training.

Just as a parent's feelings about learning disabilities and schools effects the ability of that parent to adequately contribute to the child's formal educational program, the nature of the family system is an additional variable that impacts on the ability of the parent to be a productive partner in the education of his or her learning disabled child. The concept that applies to this factor is basically identified as family systems, where the theory is advanced that the family is a functional system characterized by role assignment or creation and relatively stable homeostasis within that role distribution. Any kind of change can threaten the family's equilibrium, particularly if the change involves a redefinition of the role of any given family member or set of family members.

Just as illness may destabilize the family system and place that family in crisis, a school official's report that a child may be learning disabled can have the same destabilizing effect. Some parents respond by infantilizing the child, making it comfortable and even necessary for the child to continue to present learning and attentional deficits (Palmer, 1983). In other families with equally poor problem-solving skills in terms of a child's special educational needs, the parents may simply ignore the school's concern. Such a parent may passively avoid the school officials, or may aggressively engage the school personnel in conflict over even the suggestion of testing. This sort of parental response can develop even in cases where the tangible, concrete evidence of a learning disability risk factor is overwhelming. In such instances, the parent may seem willing to sacrifice the child's academic and intellectual success to the need to maintain a particular role and function balance within the family system (Pope, 1980).

In cases where parents respond by investigating options, seeking help from school and other professional and support-group personnel, and generally seeking to problem-solve along with the school, there can be difficulty in achieving that parent-school cooperation, because such a parent may be articulate and resourceful in pursuing information that the school may feel reluctant to reveal. Once

again, the parent can encounter a bewildering and confounding set of expectations presented by the school, and needs originating with the child, the family, or the self.

No matter how parent responds to the proposition that the child may require special instruction and support to cope with learning disabilities, it is the responsibility of professionals to help those parents overcome their conflict, achieve a new family-system homeostasis, and become competent in helping to make decisions relating to their child's education, even in those instances where the parent chooses to reject or challenge the recommendations of the school. If professionals did provide such support services, family crisis may not disintegrate into marital collapse, family violence, or the destructive cycle of resenting the child, feeling guilty, getting overprotective, and then becoming permissive (Kaslow, 1978).

When professionals approach the parent, equip the parent with information and support, and then work with the parent to present suitable information to the child, the entire family can experience significantly less stress in reaction to the school's concern. The problem is that most education professionals have had little if any training in applying therapeutic skills to working with parents and children to help all family members participate in the process of identifying, assessing, and remediating learning disabilities (Faerstein, 1981; Nordan, 1976).

Parents and children eventually appreciate a professional approach that involves them appropriately in understanding a problem that they cannot see or feel or touch. Learning disabilities confound the most practiced and successful professionals; they are certain to confuse both children and adults who must accept the possibility that a child in the family may be learning disabled. Parents often develop a sense of omnipotence in response to the child's needs, taking on full responsibility for the hidden disorder, and taking full responsibility for helping to eliminate the problem. Other parents may find that the information simply serves to reinforce poor esteem perspectives that are part of the family belief system, especially in relation to the child in question. Whether the child is scapegoated, over-protected, or ignored, the problem is the same: the parent has not become a viable participant in the child's educational progress.

Arnold (1978) found that parents responded positively to professionals who have current information regarding learning disabilities, and who can share that information in specific relation to the needs of their child. On the basis of such research, a growing number of programs for parents of learning-disabled school-age children have focused on parent counseling, with the parent targeted as the identified client, and the assumption being that the parent can learn to advocate for the child's education just

as he or she can advocate for other needs or wants presented by the child. Parents are considered the logical choice as advocates for their children, since they are involved, physically accessible over time, and require no salary for performing the task (Hickey, 1979; Murray, 1973; Pope, 1980).

One such educative counseling approach is called an information program. The factual material presented helps reduce parental anxiety and helps the parents communicate with their children as well as with adults. A measure of parent satisfaction was demonstrated by consistent parent attendance in non-mandatory training programs (McWhirter, 1976). Similar parent satisfaction has been reported in parent education training classes, where child behavior is interpreted as the child's method of signalling a felt need; parents in such programs become equipped to manage the behavior by cutting through child resistance, and focusing on behavior management and clear communication between parent and child (Esterson, 1975; Palmer, 1983).

Regardless of the specific aspects of the program modality, a parent support and training model will succeed if it is designed to equip parents with sufficient support to acquire information and skills, plus a guilt-free understanding that the parent is not to blame for the disability.

SOCIAL WORK INVOLVEMENT AND LEARNING DISABILITIES

Parent involvement is the generally accepted vehicle to stabilize and reinforce achievement for children who are learning disabled. That involvement has been applauded in the literature (Goodlad, 1983; Sarason, 1977) and mandated in the law (PL 94-142).

The lofty goals of parent empowerment and participation are often disturbing to school officials who do not feel equipped with the skills, time, or energy to help the parents become viable, valued partners on the scale mandated by PL 94- 142. However, teachers, school psychologists, and school administrators are not the only human resources who can be utilized in helping parents to advocate effectively for their children. The concept of empowerment reflects a value orientation compatible with generally accepted social work goals of helping people to help themselves. The implication, then, is that as social workers move to transactional or ecological orientations for intervention, they will join parents to help them achieve change in areas that profoundly effect the lives of the parents and their learning disabled children (Costin, 1978; Meares, 1977; Germaine, 1978).

Social workers can help parents identify goals and implement strategies that will allow their children to make better use of educational programs both in and out of school. Social workers can also work toward change by

equipping parents to improve personal coping mechanisms and communication skills, so that the parents can improve their working relationships with the institutions and communities responsible for educating and nurturing their learning disabled children.

Various programs have demonstrated that social workers can help parents reduce or eliminate their confusion, anxiety, lethargy, denial, or resistance by consistently exposing those parents to supportive, informative interactions replete with incrementally delivered challenges to help the mother and/or father advocate more effectively for the learning disabled child in question (Schrafft, 1979; Gitterman, 1979; Willner, 1979). Parents who are able to take advantage of such program support can successfully augment their child's formal education (Dinkmeyer, 1979).

Furthermore, it has been demonstrated that programs designed to help parents as their children grow, change, and present new needs are also successful in helping to empower parents to support their children's educational program. The nature of advocacy must often change as a child moves from early childhood to pre-teen and adolescence levels, with all the resultant physical and environmental changes that take place all around that child -- especially in school. Therefore, parents need a support program that will adjust to their needs in a timely, efficient, effective and equitable fashion (Skyer, 1982).

Having evolved on the basis of a philosophy geared to empowering people to understand and better manage their environment, social work is particularly suited to the task of developing, implementing, and evaluating programs targeted at empowering parents of LD children to become informed and resourceful in relation to the education required by those children. Basically, the purpose of a social work intervention is to bring about a better match between the person and the environment in a manner that encourages growth for the individual and at the same time remediates some aspect of that environment (Germain, 1982; Monkman, 1982). The only difference expressed in the context of this example is that the parent is the identified client, who will in turn advocate for his or her child, rather than for himself or herself exclusively. This difference would hold true in any instance where a parent protects the interests of a minor child, who has no legal status to engage in actions and endeavors that would be appropriate for the parent.

Thus far, it has been shown that social work can stand at the interface between the parent, child, school and community when the issue is empowering parents to advocate better for their learning disabled school-age children. When social workers help parents become familiar with ideas or information central to making important choices about the learning disabled child's education and development,

the social worker succeeds in developing more social competence in that parent. Social competence as a human attribute has been defined as effectiveness with respect to knowing and deciding when to take appropriate action. Social competence has also been associated with the relative autonomy that people require to deal with the internal pressure created by external demands (Germain, 1978).

In addition to providing the foundation for viable decision-making and independent problem solving, social competence is central to developing and enhancing the ability to maintain reasonable relationships with other human beings, systems and nature, without losing sight of one's own needs (Germaine, 1978). These concepts appear non-normative, and therefore appear to apply to any cultural context of situation, for it is the culture and the situation that define the actual substance, content, and nature of competence (Germaine, 1982).

In the arena of medical care and public health, social workers are positioned at the critical juncture where the individual or group in question must make an informed choice to serve his own needs, or the needs of a significant other. In working with parents of learning disabled children, it would be maximally effective for social workers to similarly position themselves at the point of clear and pivotal need: when the parent is informed that the child may need special help or services that will defini-

tely require parental input and decision-making. Unfortunately, no such model has yet been mandated, despite the fact that parents are expected by law to participate in all decisions regarding assessment and remediation of learning disabilities.

Since parents are mandated to contribute substantively to the educational process in such an instance, the educational system must help the parent develop the coping skills necessary to make a valuable contribution to the over-all decision making process. Coping is described as conscious human behavior directed toward managing various transactions in the environment. By definition, coping therefore excludes the many activities and processes which occur below the conscious level (Whittaker and Garbino, 1983). Coping does, however, include that broad repertoire of behavior that can be directed at the environment and which can potentially be brought under conscious control. Thus, coping includes not only those behaviors directed specifically to the school environment, but to those actions undertaken by individuals to take control over what happens, and to use themselves instrumentally in the process (Monkman, 1982).

Coping behaviors are said to be learned, and once learned become established positive or negative patterns of adaptation. Significant repetitions in coping behavior by individuals or groups of individuals suggest locations

which can become areas for intervention (Monkman, 1982). This is particularly true when these interfaces are seen repeatedly and take us beyond the uniqueness of the individual client. Therefore, if we know something about aggregate responses of human coping in a set of circumscribed conditions, we may know something about their response to a special condition. When that concept is taken one step further, social workers can develop additional strategies to teach appropriate responses to sets of special conditions.

If one person can present characteristics that are unique and other characteristics that are shared by all people, strategies can be developed to help all, even if it is necessary to modify those strategies in helping the individual. Thus it is possible to understand and encourage parents of learning disabled school-age children in their efforts to overcome, recognize, and respond to the pressure of being the parent of a learning disabled child, and to the pressure of contributing to that child's educational planning.

From the vantage point of the individual parent or group of parents, coping may rest on minimal amounts of self-esteem and comfort, and larger doses of emotional support from the environment. The motivation to enhance that ability comes not only from an interest in personal growth but from incentives and concrete rewards accrued in the

environment: the children, programs, and community response (Germaine, 1982).

If parents are to develop such refined coping skills, prerequisite program conditions would include, but not be limited to: (1) exposure to experiencing some degree of autonomy; (2) sufficient time and space in the physical and social environment to make decisions and take action. Therefore, at this very strategic interface, the social worker can help the parent to strengthen coping skills by: supporting self-esteem; rewarding motivation and coping efforts; providing resources and information; teaching problem-solving skills; and providing a model for the decision-making process with an eye toward the potent therapeutic problems this condition presents (Germaine, 1982; Wilner, 1979). This orientation advances the proposal that it is legitimate for a social worker to work with parents of learning disabled school-age children.

CHAPTER III

DESCRIPTION OF THE PROJECT

The purpose of this project was to investigate the development and effects of a group advocacy program on the parents of learning disabled children. It was expected that the program would empower the parent to develop and apply skills necessary to advocate effectively for their learning disabled child(ren). To test the outcomes of the Group Advocacy Program, a three-part questionnaire was developed to assess individual participant gains in the areas of information and attitude. A third questionnaire was developed to measure the specific advocacy responses demonstrated as a result of the program. This third questionnaire was a check list of specific advocacy scenarios, providing parents with the opportunity to indicate their responses to a variety of advocacy situations, sub-categorized by direct parent-child interaction and parent-school community interaction, respectively.

Project Site

The Group Advocacy Program was conducted at the Psychoeducational Clinic, Child Psychiatric Department of Coney Island Hospital. The learning disabled children of the parents who participated in the Group Advocacy Program were clients of the learning Psychoeducational Clinic program for learning disabled children.

Program Goal and Objectives

This project addressed the following needs of parents whose school-age children are learning disabled:

1) The need to accept that the learned disabled child is, in fact, learning disabled;

2) The need to accept that the child's learning disability can be improved;

3) The need to help parents better understand their legal rights, and the legal rights of their learning disabled children;

4) The need to understand the nature of their child(ren)'s learning disability;

5) The need to cope effectively by problem solving on behalf of self and child;

6) The need to understand the nature of the school system's responsibility to the child;

7) The need to understand the structure and process utilized by the school in working with children who are learning disabled (e.g., pull-out programs, IEPs, Committee on the Handicapped/Special Education, resource room programs, etc.)

8) The need to apply the necessary information and coping skills in advocating effectively for the appropriate educational testing and placement of their child(ren).

In order to meet those parental needs, this project was designed to achieve the seven key goals, each of which was based on a specific rationale described as follows:

GOAL 1: To provide parents with more information necessary to understand the nature of a learning disability.

RATIONALE: The major thrust of this goal was to help the parents understand the nature of a learning disability. To accomplish this goal, group discussions were conducted in order to establish a functional definition of a learning disability; an update on the current knowledge about the nature and symptoms of learning disabilities, and an overview of student and parent rights to special education, as prescribed in PL 94-142.

GOAL 2: To improve parental attitudes regarding learning disabilities.

RATIONALE: Children with learning disabilities often present academic, social, developmental, behavioral and attitudinal problems that perplex, frustrate and worry parents who have not been educated in coping skills appropriate to helping the parent interact supportively with the child. Parents who find it difficult to accept that a child is learning disabled may therefore find it difficult to accept the child. Community, family and personal values and attitudes may reinforce the parents' disinclination to explore the etiology of the child's learning problems. These values may be obstacles to the ability of the parent to advocate effectively to protect the rights of the child

as well as his or her own rights as a parent.

GOAL 3: To identify and encourage specific advocacy behaviors that would benefit parents and LD children in relation to their education.

RATIONALE: The phrase "specific advocacy behaviors" refers specifically to any positive parental behaviors directed to benefit the child, through the school, family or community. These behaviors could be reflected in the way the parents interacted with the child in the family setting, or by the way the parents interacted with school and community on behalf of the child. Specific advocacy behaviors directed toward the child included, but were not limited, to helping parents: praise their children where effort was shown in school work and other chores; help their children with homework or school-related activities; help their children solve social and academic problems that may have developed in school and/or elsewhere.

For the category designed to help the parents advocate for their children within the community areas for discussion included: information-gathering behavior; assertiveness with school personnel, including members of the Committee for Special Education; assertiveness with other advocacy organizations designed to protect the rights of LD children and/or their parents.

The purpose of this program was to help parents acquire and apply an understanding of their children's educational needs and rights. The thematic curriculum was

designed to help parents develop advocacy skills along with the knowledge and attitudes important to coping more effectively with social, developmental, educational and esteem problems of learning disabled children.

GOAL 4: To develop a curriculum designed to help parents better understand the nature of their child(ren)'s learning disabilities, and then reflect that better understanding in the way they advocate for their learning disabled children, and in the way they express their attitudes toward their learning disabled children.

RATIONALE: Parents of LD children often present the need for a sequential and substantive learning and support process, as they learn new ways to parent the LD child. The construct of the Guided Thematic Curriculum was particularly valuable for this population, since the parents needed the opportunity to have continued input into the organization and content of the program sessions. While remaining focused on achieving the specific goals articulated here, the sequence and emphasis of discussion regarding those goals was determined by the expressed needs and interests of the parents, because the curriculum structure was so flexible.

GOAL 5: to implement the curriculum in a group setting, where parents of LD children could experience the company of their peers and also receive professional support from the group leader.

RATIONALE: Social/peer support networks have traditionally been viable settings for adults to learn individually and collectively, deriving strength from the fact that all the participants share the same basic concerns and

needs.

GOAL 6: To increase the level of service received by LD children involved in new, additional, or continued educational services as a result of the advocacy training received by their parents.

RATIONALE: When a child experiences learning problems sufficiently serious to be identified as possibly symptomatic of a learning disability, parents can experience a wide range of conflicting feelings in response to the learning problem, the school personnel, the child, and themselves. Those feelings can make it difficult for parents to be take action to protect the educational rights and needs of their child. As a consequence, children can be provided inadequate or otherwise incorrect educational services.

GOAL 7: To develop a program that could be replicated by the host agency or other researchers.

RATIONALE: Parents of LD children need to know that they are not alone in their needs, and that they can find the protection and guidance they require in their efforts to effectively parent and advocate for their special son or daughter. The Group Advocacy Program was developed, implemented and evaluated to determine what, if any, components of the program helped empower the parents to become effective advocates for their LD children. Built on a concept of social learning and coping through education the Group, the topics of each Group Advocacy Program session were targeted to meet the parenting needs and concerns of the par-

ticipants.

This project addressed those essential needs by using a curriculum developed for parents whose children are learning disabled. The development, implementation and ultimate evaluation of the program focused on its form and content.

Content and Sequence of the Group Advocacy Program

Sessions

The form of the project was derived from the literature on small group social work, as well as the literature regarding parent effectiveness training, which has been shown to be highly satisfactory to parents when conducted in a small group setting (Gordon, 1970).

Once it was determined that the small group setting could be an efficient, effective, and supportive environment within which parents could acquire new and helpful information, attitudes and skills that would empower them to advocate for their learning disabled children, it was important to establish the specific content of the sessions.

Although the thrust of the Guided Thematic Curriculum is for the leader to present the theme and the group members to respond to that theme, this particular project required that the group leader both establish what themes might be important to the members, and then consult the participants further establish the appropriate order of

those themes. Literature published by the Special Education Parent Teacher Association (SEPTA) and by Palmer (1983) was reviewed in an introductory session with the parents, in order to help the parents establish a basis for considering the concerns and stresses of parenting learning disabled children was reviewed.

In each session conducted for the purposes of this project, specific topics were presented by the leader for discussion, although the topic of discussion was subject to the immediate needs of the participants to talk through a particular problem or idea. The content and focus of the sessions are described as follows:

Session 1: Designed to establish priority interests and concerns among the group, in addition to engaging in the personal introduction and orientation to program expectations.

With the data from the literature disseminated in the session (SEPTA publications regarding child and parent rights) and the input from the parents participating in the program, the remaining 25 sessions covered the themes described as follows: (See Appendix : Parent Group Notes from Group Advocacy Program, for further specific data on session themes):

Session 2: Stating and overcoming confusion and misunderstanding about how learning disabled children struggle to comprehend ideas, tasks, and/or skills that the

non-learning disabled parents and siblings often find relatively simple to grasp.

Session 3: Achieving a better understanding of sibling rivalry when it takes place between learning disabled and non-learning disabled children;

Session 4: Learning how to elevate the learning disabled child's self-esteem, particularly when the child behaves badly at home because he is angry about being different in school;

Session 5: Focusing on parent values and the way parents may best impart those value to their children, without forcing their children to adopt values that the child may find unsuitable (special emphasis on peer relations);

Session 6: Understanding how learning disabilities can become manifest at home and in the community, as well as in school;

Session 7: Examining how children often engage in anti-social behavior, such as stealing, because they feel angry or unhappy.

Session 8: Exploring parent and child reaction to catastrophe and personal risk was explored here, in the wake of the murder of a 17-year-old girl in the building of one of the parents. Special focus on how the learning disability effects coping skills and confidence;

Session 9: Exploring the quantity and importance of homework, and the parent's role in helping with homework;

Session 10: Discussing the nature of the school system, the Committee on the Handicapped, and the other institutional resources to which parents can appeal to in order to assure that their learning disabled children are provided with the needed services;

Session 11: Discussing child and parent frustration with the learning disabled student's progress was covered during this session, with specific emphasis on how the events in a family can support or undermine the child's learning progress;

Session 12: Extending the discussion of the Committee on Special Education, and how the parent feels about participating in meetings of the CSE, as well as how the parents feel about their children's special risks and potential. Particular emphasis was on the learning disabled child's perception of adults who are either family, friends or strangers who might molest the child.

Session 13: Considering how parents can overcome their feelings of helplessness when they meet with teachers to discuss issues regarding the hopes of promotion and school success for their learning disabled children.

Session 14: Considering how the LD label may affect the child in later school or community situations.

Session 15: Parenting skills specific to the need of the learning disabled child at home, with particular emphasis on parents developing such parenting standards and attitudes together. Participants expressed considerable anxiety regarding how inconsistent they might appear to their learning disabled children, when the children were aware that mother may have a different set of attitudes and standards than father, in regard to education and discipline for the learning disabled child.

Session 16: Discussing ideas for summer plans was discussed in this session. Topics included public and private camps and schools for learning disabled children, and the importance of maintaining instructional and social supports, were covered in this session; focus on showing parents how to research public and private programs available to their children.

Session 17: Considering different factors in planning for the future of their learning disabled children, even beyond the death of the parent.

Session 18: Discussing how different parents may learn to cope with anxiety and frustration regarding planning for the future of the learning disabled child, in relation to the child's ability to learn, succeed in school, get good and stable work, and develop and maintain healthy relationships.

Session 19: Evaluating the session thus far, and to discussing both program and personal progress to date.

Session 20: Helping parents explore how to address their own needs, assuming that they would be more competent and comfortable coping with the needs of their children;

Session 21: Helping parents explore peer relations and other intrafamilial and extrafamilial for the learning disabled children.

Session 22: Helping parents consider the bases and value of short-term and long-term planning for the LD child's education and development.

Session 23: Addressing how parents often blame themselves for the fact that their child is learning disabled, and establishing that this is a normal reaction that they parent can let go of after better understanding the etiology and nature of learning disabilities.

Session 24: Focusing on how parents can help the learning disabled child better understand his or her own strengths and struggles in regard to learning. Problems coping strategies to overcome difficulties of children "aging out" of particular programs were also reviewed.

Session 25: Understanding how work at the clinic can help the child understand and overcome limitations associated with the learning disability.

Session 26: Discussing how mothers and fathers can each contribute significantly to helping the learning dis-

abled child, and how families can become stronger as a result. Closure for the entire group process was achieved as each parent reviewed his or her own accomplishments in the group setting, and thanked the members and leader of the group for support and guidance.

CHAPTER IV
PROGRAM METHODOLOGY

Introduction

In order to establish the specific methods utilized in the development, implementation and evaluation of this research project, the following topic areas have been included in this chapter:

- a) Definition of Terms
- b) Setting
- c) Sample
- d) Design Procedure
- e) Description of the Theme Centered Interactional

Method

- f) Description of the Instrumentation
- g) Treatment of the Data

Definitions of Terms

For the purposes of this study, the following terms were defined as detailed below:

(1) Advocacy Behavior: any positive parental actions targeted at causing community change on behalf of the child. These skills could include any positive communication with the school, teacher or social agency when that communication is initiated by the parent, or when parents respond to communication by the community source. Communication could include, but not be limited to, telephone, written, or face-to-face contact. Included in this category of advocacy

behavior would be any positive parent-child interaction oriented toward learning (e.g., "Let's review your homework now!" "Good try!" "You're getting better at this all the time!" "Nice effort. I really am proud of you," etc.)

(2) Educational Gains: any increase in subject's knowledge regarding learning disabilities, including known treatments, diagnostic tools, administrative prerogatives, legal mandates, functions of the Committee on the Handicapped, and nature of learning disabilities.

(3) Parent of the Learning Disabled Child: the parent or guardian of a child who: has been diagnosed as learning disabled or suffering from minimal brain dysfunction or has been recommended for testing to determine presence of same; is a client in good standing of the host agency.

(6) Positive Attitudes about Learning Disabilities: acceptance of known helpful statements and behaviors in relation to learning disabled children. Positive attitudes include feelings, actions, suggestions, and recommendations originating with the subject, or followed through on by the subject, and expressed directly or indirectly to the child and/or community.

(7) Theme-Centered Interactional Method: an educational and curricular model allowing for flexibility for group leader to remain with basic themes, and still introduce, follow, and respond to therapeutic issues and processes, within the Guided Thematic Curriculum.

Setting

The Psychoeducational Clinic, located in the Child Psychiatric Department of Coney Island Hospital, is a public clinic located in New York City. With an 18-year history of serving learning disabled children and their families, it was a highly suitable agency to host a program that combined educative and therapeutic processes to empower parents of LD children to become better advocates for their children.

Sample

The sample was selected based on the ability of the prospective subject to meet at least one of the following criteria:

- 1) status as parent of child in a program at the clinic.
- 2) referral from staff psychologist conducting intake interviews;
- 3) expressed personal interest in understanding more about learning disabilities;
- 4) expressed interest in meeting other parents with similar concerns regarding LD children;
- 5) expressed concern about how to negotiate more effectively for their children's educational rights;

A total of eleven parents participated, representing a total of eleven children. All of the parents had LD children between first and fourth grade: five in grades one and two, and 6 in grades three and four. Of the eleven students

in the clinic learning program, all had either one or two siblings, and no sibling was receiving any form of special education. The Committee on the Handicapped had authorized and conducted evaluation of six of the eleven children whose parents comprised the group. The remaining five had not been evaluated.

Additional information taken from the progress charts of each family revealed that all mothers of the children represented had part-time jobs. Only one family received any form of public assistance. The same progress charts showed that all fathers of the children were skilled or semi-skilled workers. It was further revealed that all families were actively involved in some sort of organized religious group.

A total of ten of the eleven subjects were mothers. While nine of the subjects were married and were within their original family constellation, with both biological parents living with their child, two were either separated or divorced, according to the family history in the progress charts.

Design Procedures

In order to ascertain the degree of change achieved by the parents in the Group Advocacy Program, a one-group pretest-posttest method of evaluation was used. This was accomplished by the use of a three-part questionnaire for information, attitude and behavior. The questionnaire was

administered on three separate occasions (Campbell, 1969).

The first occasion was before the actual group began. This period, called (T_1), was used to establish a baseline of scores against which any subsequent measures could be compared.

At the end of the six-month period of group involvement, the three-part questionnaire was given again. This period (T_2), was used as a direct measure of gains.

A third measure (T_3) was taken three months after the treatment period ended.

In each instance, the questionnaires were administered without group-leader involvement. They were administered by agency personnel for T_1 and T_2 , and were mailed, accompanied by a stamped, self-addressed envelope, for T_3 . Each subject/respondent was asked to complete and return the questionnaire promptly.

The T_3 measures were sent through the mail to minimize any researcher-effect on subject responses. In addition, the third measure was sent in order to determine if the gains that were made could measurably endure through a period of no formal reinforcement. The time periods between test phases were sufficient in length to control for familiarity and practice effects.

The rating scale measured the application of the behavior directed to the child as well as within the community. That item construction enabled the measurement of

gains which may not have shown on the information or attitude variables, and by clearly identifying for the parents a list of the positive behaviors from which they could choose.

Description of the Theme-Centered Interactional Method

In order to establish the effects of the Theme Centered Interactional Method in the group advocacy modality, a variety of specific steps had to be taken. It was important that the subjects receive both direction and support in any effort to gain or apply skills and information. A curriculum written prior to establishing specific group concerns regarding each of the program goals may not have answered the parents' questions. Therefore, the Theme Centered Interactional Method was chosen for its major innovation of a balance that between a clear-cut theme that functions as a stimulus for personal or general discussion within the group (Shaffer, 1974). Thus, themes such as "My Guilt as a Parent," to "The Functions of the Committee on the Handicapped," could be addressed in a timely fashion within the group setting (Cohen, 1972).

This thematic approach provided the group members an exceptional degree of freedom to learn and test skills and information, and still express personal needs and impulses. Since content and nature of the discussion were flexible, it was necessary to keep a record of the degree to which: (a) the planned curriculum was covered; (b) the theme was followed; (c) the group leader remained willing to entertain

the needs and interests of the parents without sacrificing the focus of the theme.

How the Curriculum was Developed

Three basic steps were taken to gather the information necessary to build the curriculum.

1) A survey of primary information sources was conducted to gather current information about directions in learning disability identification, treatment, and impact on the family.

2) An informal survey of organizations for people with learning disabilities, and for parents of children with learning disabilities was conducted (e.g., SEPTA, Special Education Parent-Teacher Organization). ACLD (Association for Children and Adults with Learning Disabilities) representatives were also contacted by telephone, in order to gather more information regarding needs and concerns experienced by parents in coping with the children in the family, or coping with representatives of the schools.

3) Through help from SEPTA and ACLD, it was possible to informally interview learning disabled adults. These adults offered much insight into the feelings experienced by LD children, as they recalled their own experiences as children with learning problems. Each requested that they not be identified as learning disabled in any research or published project.

Topic organization and content was based on rele-

vance, usefulness in relation to the advocacy theme, and the understanding that parents of LD children required practice in expressing themselves regarding their children's needs, and their own needs in relation to those children. The group format and thematic focus allowed them that freedom. Group notes were kept for the 26 sessions of the program, and helped to shape the curriculum.

The guiding ethical consideration that comprised the foundation for this study was the protection of the rights and needs of the children and the parents. It was therefore critical that all curricular and thematic considerations were built on the understanding that the parent was and would always remain a partner in the child's formal education, and therefore requires a forum within which to problem solve and constructively impact on the educational, developmental, social, and family-system dynamics revolving around the learning disabled child.

Description of Instrumentation

To measure how extensively the Group Advocacy Program changed parental store of information, attitudes, and behavior to better manage and solve situations related to the learning disabled child, pre and post-training tests were rated by the parents themselves. These self-report questionnaires were developed as a semantic differential instrument, and required about 20 minutes each to complete (Williamson, 1982).

The validity of the instrument was tested through the following process: the host agency allowed a group of ten parents in treatment in the agency to respond to the questionnaire, and allowed two agency professionals to critique the questionnaire. Furthermore, a test development specialist assessed the face validity of the questionnaire, in order to further establish its validity of measurement. The questions were also reviewed by one member of the doctoral committee. Appropriate changes were made in the instrument.

After the validity of the instrument was determined, the reliability of the instrument was examined through the test-re-test process for the parent group. These occurred two weeks apart with a high degree of correlation occurring on the Pearson Product Moment Correlation Coefficient (Horowitz, 1981) (See Table 1 in Appendix).

As a final check on the reliability of the questionnaire, Crombach's Alpha Statistic was used. This technique intercorrelates each item on the questionnaire with every other item on the questionnaire (Veldman, 1967). The combination of both tests for reliability indicated significant relationships strongly supporting the use of this instrument. (See Table 2 in Appendix).

In order to ascertain any relationship between the group demographics and the outcomes, all demographic information was reduced to a numerical coding system. This procedure enabled a simple statistical review so that actual

characteristics of the parent group could be identified (Williamson, 1982). Each response coded and assigned a numerical value could then be read and easily analyzed (Williamson, 1982) (See Table 3 in Appendix).

In order to elicit maximum information regarding parental feelings and actions that may not have been anticipated in standard close-ended, structured questions, a total of three unstructured, open-ended questions were included in the pre-test - post-test measure, so that changes in tone, attitude and conceptualization of learning disabilities could be marked if the program had sufficient impact.

The structured questions were broken into three individual questionnaires, each of which could stand alone as a separate measure. Each item was weighted on a numerical value of 1 to 3, with 3 representing the most desired response in terms of the group learning process. The structured questions were also phrased positively and negatively, in order to control for any respondent inclination to simply answer in the positive or the negative throughout the survey. The questions were additionally randomized so no special system or order of questions would bias the results.

Treatment of the Data

Measurement of gains, regression, or stagnation in scores gauging (1) store of information; (2) attitude; (3) behavior; (4) behavior/child; (5) behavior community; (6) total score, multivariate analyses were used (Harris,

1975). The purpose of this measurement was to evaluate if there was a significant change from pretest to posttest scores.

Two separate multivariate analyses were completed. The first included the following variables: (1) information; (2) attitude; (4) behavior/child and ; (5) behavior/community. The second included: (1) information; (2) attitude; (3) behavior. This was done to ascertain the relationships between two or more variables, while controlling for the effects of the others. In addition, the effects of variable 6 (total score) were controlled for, since the impact of this variable included the scores of all the variables, and would lead to spurious conclusions. The weight of total score (6) was statistically eliminated in order to reveal other relationships.

The use of a multivariable approach enabled the individual variables to be evaluated independently, against any others. Significance under these conditions placed the results on much firmer ground (Williamson, 1982).

As a check on the multivariate analysis and to strengthen the results, a univariate analysis using correlated t-tests was used. This was done on all variables, to determine if gains were noted on a direct variable-to-variable pre-post check. In this form of analysis, interactive effects are negligible, so each of the 6 variables could be compared for gain scores from the pre to the post

test (Harshbarger, 1971).

A final analysis was conducted to establish exactly where the impact of the group advocacy program was greater: (1) the mean score of the variable for post-community behavior or (2) on the mean score of the variable for post-child behavior. In order to conduct this treatment of data, a univariate analyses (correlated t test) was done (Harshbarger, 1971). This was instituted to specifically compare the child and community behavior variables at the posttest period and to establish where the impact of the program was stronger.

In order to compare the two variables, they had to be statistically equalized and given a standard baseline of measurement. The two could then be compared, taking into account that the different number of items would yield different scores.

In addition, difference scores between the two variables were taken. Difference scores, which represent the amount of gain on each variable, were taken by subtracting the pretest score from the posttest score.

CHAPTER V

RESULTS

Introduction

The purpose of this study was to determine the degree to which parents of learning disabled primary school children would respond to a guided curriculum implemented in a parent-group setting. The curriculum and the implementation process were designed to help parents to better understand and advocate for their learning disabled children.

As is the case in any analysis of results of a very small number of people, it would be inappropriate to suggest that change in two or or even five individual people would be considered statistically significant. However, pre-test and post-test procedures registering gains in keeping with the goals of the program are important to note, and are meaningful, since the comparison was made between the pre-program and post-program attitudes, skills, and information levels of the program participants. This is an established means of deriving meaningful information regarding the potential usefulness of a program (Selltiz, Wrightsman, and Cook, 1976). Progress experienced by a small group of individuals can therefore be identified as sufficiently meaningful to justify further study, which was one of the goals of this project.

Assessment of the program was facilitated by the development, implementation, and statistical treatment of

the outcomes of:

A) a demographic measure

B) an information/attitude/behavior scale was administered at three separate intervals: 1) before the participant entered the program

2) directly after the program was completed

3) three months after termination of the program In order to present the data collected during the survey, pre, and post-test phases of this study, this chapter has been organized as follows:

Findings: Demographic Questions

Findings: Six Variables:

Multivariate Analysis

Univariate Analysis

Average Gains: Final Test

Findings: Strongest Learning Impact Areas

A Report on the Responses to Open-Ended Questions

Findings: Demographic and Attendance Questions

As noted in Chapter IV, there were eleven parents representing a total of eleven children in grades one through four. All children were also enrolled in the learning clinic of the Psychoeducational Clinic of the Psychiatric Department of the Coney Island Hospital. It was found that all parents who attended the program were present for a minimum of 10 sessions, and a maximum of 17 sessions, out of a total number of 26 sessions. The average

length of parental attendance in the group was 14.2 sessions. The children of these parents attended the learning clinic an average of 17.0 months, with a minimum of 5 and a maximum of 26 separate sessions attended. It was found that parents who attended with greatest regularity had children who attended with the greatest regularity.

Findings: Six Variables

The Principle Variables

The principle variables of study in this project were parental:

- (1) information
- (2) attitude
- (3) behavior
- (4) behavior toward child
- (5) behavior in community

Each of these variables was assessed in relation to the parent's advocacy for, concept of, and general parenting of the primary or intermediate-school age learning disabled son or daughter. A sixth (6) variable was developed and identified as the total score, or interactive determinant, representing a comprehensive assessment of the parent's overall development or regression in the key areas of information, attitude, behavior directed toward the learning disabled child, and behavior directed toward the community, in relation to the learning disabled child's needs.

The Measurement Process: Response Rates

These variables were measured through the implementation of a three-stage self-report questionnaire administered to the parent participants of the Group Advocacy Program just before the program's inception, just after its termination, and three months after its termination.

A total of eleven, or 100%, of all pre-test surveys was collected. A total of eleven, or 100% of all post-tests issued immediately after program termination was also collected. Of the post-tests administered 3 months after program termination, only two returned. It was determined that the response rate within this universe was too small to be used as any comparative measure in the overall data analysis. However, the scoring results on those two tests are included in the "Average Gains" portion of this subsection.

Attitude, Information, Parent Behavior toward the LD Child, and Parent Advocacy for Child in the Community

A multivariate analysis was conducted of the following principle variables: information; attitude; parent behavior with learning disabled child; parent behavior in the community, in terms of the needs of the learning disabled child.

This analysis was conducted in order to determine if there was a significant change in scores between the pre-test to the post-test. The value of the multivariate analysis lies in the fact that it inherently controls for excessive weighting of any one set of data or scores. Since mul-

tivariate analysis precludes the possibility of one set of scores adding an inordinate amount of weight to the outcomes, it substantially reduces the possibility of spurious results (Harris, 1975).

The multivariate statistic utilized was the Wilkes Lambda, which is equal to .098, and can be transformed in RAO's F, which is equal to 16.124, for the purposes of this particular analysis. The RAO's F in this case had 4 degrees of freedom for the hypothesis, and 7 degrees of freedom for the error. The associated probability level was equal to .001, rendering the probability value highly significant.

It was also found that that there was a highly significant and positive change from the pre-test to post-test scores, with the posttest scores higher than the pretest scores for all the principle variables of this study. (See Appendix Table 4).

Information, Attitude and Behavior: A Multivariate Analysis

A second multivariate analysis was conducted to determine if any relationship might exist between the following variables: information, attitude, and behavior. In this instance, the probability is equal to .002, with Wilkes Lambda of .170 converted to RAO's F of 13.012. This multivariate analysis also supports the observation that the subjects experienced a significant and positive change from pretest to posttest scores reflecting pivotal variables of

information, attitude and behavior. (See Appendix Table 5).

The Univariate Analysis

To complement the multivariate analysis of variance conducted to determine the presence and extent of gains made in parent attitude, information, and behavior, a univariate analysis with correlated T tests of the same variables was completed, as suggested by Harshbarger (1971).

It was found that the gains were supported in all three areas at the .001 level of significance (See Appendix Table 6).

Second Posttest Scores

Two parents responded to the second posttest, issued three months following group termination. The two group members who returned the questionnaire for the final (t_3) scoring showed the following scores:

One individual showed an average gain of 19.6 across all 6 variables explored in the process of this study. This is a substantial difference and shows clear, positive change. The second individual remained very stable at the final scoring, with an average gain of 2.2 points across all variables. So, one parent continued to develop proactive advocacy skills and positive perceptions of the child involved, while the other parent appeared to remain as positively concerned and involved as she was at the termination of the group. Neither parent experienced regression

in any item area, which indicates that gains made in the group may remain in place for at least 6 months, even when the group supports are taken away from the parent, and the parent is left on his or her own to cope with the needs of the learning disabled child at home, at school, and in the community.

Strongest Learning Impact Areas: Parent Behavior
with Child and Parent Behavior in Community

This comparative analysis was conducted to determine whether there was a difference in the degree to which the program impacted on the participant's behavior with their children and their behavior in the community, in relation to the needs presented by their children.

The results of this univariate correlated T test showed that the parents knew and reported more child-oriented behavior than community-oriented behavior at the pretest level (Harshbarger, 1971).

At the posttest level, there was still more appropriate child behavior reported, and the gain on the variable was greatest. This significant gain indicates that the program impacted more significantly on the way the parents related directly to their children, as opposed to the way the parents related to the community. (See Appendix Table 7).

Summary of Responses to Structured Questions

Parental responses to the structured, closed-end ques-

tions demonstrated that parental response to their learning disabled children improved significantly when compared to parent answers to identical questions before parental participation in the group. These closed-ended, limited choice questions were developed in order to provide the parent respondents with a set of clear choices from which parents could reference their feelings. In that fashion, the parents were constrained to respond within the sphere of focus possible regarding the project goals.

Although closed-end, limited choice questions serve as viable reference points for respondents to express personal feelings or demonstrate knowledge, the questions restrict the respondent's options. Since the parents had the option of participating actively in shaping the nature and process of the group program, it was important to develop a measure that would elicit parental feelings without restraining expression to a limited set of responses. Therefore, unstructured questions were included in the questionnaire, in order to give the parents an opportunity to answer questions freely, without restraint (Williamson, 1982).

Response to those open-ended questions are presented in "Findings".

Parent Responses to Open-Ended Questions

The open-ended questions developed for this study were designed to provide data regarding any parent response unanticipated or undeveloped in the closed-ended, limited-

choice questions inventory of feelings and knowledge. The open-ended questions were also used as a pretest-posttest measure, to determine the degree to which any qualitative changes in parent response may have been evidence in response to parent participation in the group.

A comparative analysis of the pretest and posttest unstructured questions revealed that participation in the group helped the parents achieve greater insight into the problems of learning disabled youngsters. The comparative

analysis also revealed that parents who participated in the group had more positive feelings at the close of the group than they had before the group's inception. Gains made by parent group members can be attributed to their participation in the Group Advocacy Program.

As seen in both the information and attitudinal areas (See Tables 8 through 10) the areas of change were conceptual and behavioral. A comparison of the pretest and posttest responses demonstrates that the parents who participated in the Group Advocacy Program supports the observation that parents made substantial gains in their understanding of and attitudes toward learning disabilities.

Summary of Results of Open-Ended Questions

The parents who participated in the Group Advocacy Program presented posttest responses demonstrative of significant improvement in their store of information regarding learning disabilities, and in their attitude toward

their children. A comparison of the pretest and posttest scores for both closed-end and open-end questions suggests that the Group Advocacy Program helped empower parents to develop appropriate problem-solving and information-gathering skills appropriate to the needs presented by their learning disabled children.

The closed-end and open-end measures were designed to elicit information regarding the relative changes in knowledge and behavior presented by parents participating in the Group Advocacy Program. In addition, the group leader kept notes regarding group process, specific themes and concerns presented by the parents, and different dynamics that developed as parents presented approach-avoidance behavior toward the concept and practice of changing their behavior. Summaries of those notes are presented in the following section of this chapter.

Informal Observations: Research Log

These informal observations were used to make adjustments in the content and process of the group. Other information observations were integrated into the final curriculum (See Appendix). Although these observations are topically organized, there is no importance attached to the order in which they are presented.

Informal Observations: Topic 1:

Learning Disabilities Are Confusing

Each parent in the Group Advocacy Program freely

expressed frustration with the elusive nature of learning disabilities. The parents agreed that even the teachers seemed to be confused about how a learning disability could effect a given child's performance in school or at home, whether the challenge was academic, skills-related, social, or a combination thereof.

For example, a parent would point out that her child could process information verbally, demonstrate mastery verbally, and yet fail to respond appropriately to a written test regarding precisely the same information. When the group first began, this parent attributed the failure to her child's obstinate nature, which remained resistant to modification, which the parent attempted to ameliorate through the use of corporal punishment or privilege deprivation.

By the close of the program, she was able to explain to her friends, other family members, and her child that the child's learning disability could interfere with her ability to demonstrate mastery in a particular way, and that corporal punishment or the loss of privileges were inappropriate for certain difficulties presented by the child. Some of the confusion reported by the parents was either reduced or eliminated through the information shared in the Group Advocacy Program. The parents were also able to come to terms with the fact that the learning disability may impact variously on a child's performance and ability,

and that the confusion could be expressed and felt without necessarily engendering an overwhelming sense of powerlessness. Through the Group Advocacy Program, the parents discovered that they could seek and apply information that could reduce their confusion regarding their learning-disabled children.

Informal Observations: Topic 2:

How do you tell what is or is not normal behavior in
L.D. children?

Parental concern focused on quantifying the nature of the behavioral expression of a child's disability. Questions developed regarding how difficult it was to distinguish between learning disability-related behavior, and behavior related to problems of growing up. Parents learned that it was possible to become informed regarding age and ability-appropriate behavior, and that such education could come from libraries, other educational resource centers, schools, self-help groups, doctors, social workers, psychologists, developmental specialists, and other individuals and organizations. The parents demonstrated interest in gathering information, weighing evidence, and taking informed and timely action.

Additional Informal Observations

The balance of the informal observations were made in note of parent's concern about gathering concrete information. That information tended to be in one of two catego-

ries: data regarding the nature of the learning disability, and data regarding how best to parent the learning disabled child, including education and health oriented advocacy for the child.

At the onset of the program, the thrust of parental interest appeared to focus on assigning blame for the fact that the child was not learning or behaving as might be expected for a child of that age, physical stature, experience, and intellect. Some parents took the "blame" themselves, while others projected the "blame" onto their spouses or their spouse's side of the family. Still others sought to blame schools, the physicians or the child. Most tended to shift the direction of the blame, depending on which individual or group the parent was experiencing the most difficulty with at any given time.

By the close of the program, the issue of blame appeared to have dissipated. Most comments by parents revolved around gathering information, sharing frustration, identifying new resources for support and information, expressing compassion for the child, and learning new ways to exercise influence significantly on the well-being of the child as well as on the family as a whole. By the final sessions of the program, these comments had virtually disappeared.

The problems of assigning blame essentially became changed toward assessing and appropriately assigning

responsibility for change. The parents learned how and when to take responsibility for fact-finding, decision-making, and action, and how and when to give such responsibility to the child, spouse, school district, family, church, counselor, or other appropriate agency or individual.

Some of the most profound and far-reaching concerns expressed in this area were related to what might become of the child should the parent die, or become unable to provide for him or her. The sense of powerlessness could be reduced, but many questions could not be answered regarding how the child might fare should the parent no longer be available. Certain problem-solving strategies could be developed, such as arranging for guardianship and making financial plans. However, much anxiety centered around this sense of potential helplessness, coupled with the child's helplessness.

Many parents entered the program hopeful that the child could be "cured" of the disability, as a child could be cured of a sickness. It was shown that the child could not be cured, but could be substantially helped. As the possibility of help became more of a reality, the parents were able to relinquish the notion of an cure, and accept the concept of gradual and relative improvement over substantial periods of time.

The fact that even slight improvement could take a

substantial period of time was also the focus of considerable discussion. It was difficult for the parents to accept that it may take a child months or years to develop a skill crucial to appropriate social development or academic success. The Group Advocacy Program helped the parents understand that the children were experiencing similar difficulty with the pace of their progress, and that the pace could be accepted as normal for those children.

The analogy to physically disabled children became a source of some comfort and understanding for the parents, who understood immediately that a child who was crippled could not be expected to make the same physical strides made by a child who was not crippled. Although the outcome of therapy could bring the two children to physical parity, the process necessary to reach that goal would be different for each. This analogy helped the parents understand that their children could improve at their own pace. That made it necessary for parents to develop new ways to interpret success in their children, and alternative routes to deriving satisfaction from their children's success. This was a critical learning process, since the learning disabled children suffered profoundly from the serious problem of poor self-image. As parents learned how to reward and praise their children, and how to demonstrate love for them, the children demonstrated greater love and respect for themselves. Improved interaction between parent and

child became the foundation for future growth and development for the child, the parent, and the family involved.

The log kept by the group leader generally supported the expectation of a positive therapeutic impact of the Group Advocacy Program. Attendance in the program was strongly associated with improved parental skills in coping with such complex issues as the law, Committees on Special Education, the nature of learning disabilities, the future of their children, and strategies for advocacy. Most importantly, the parents no longer felt the need to scapegoat the children or the schools in order to feel powerful or competent. Instead, the parents developed the skills to advocate appropriately, effectively, and efficiently on behalf of their learning disabled child.

Summary of Findings

The results of the administration of the pretest and posttest closed and open-ended questions, combined with the researcher's log notes, all suggest a relationship between improved parent advocacy skills and regular attendance in the Group Advocacy Program.

CHAPTER VI

ANALYSIS OF RESULTS

Introduction

This project was designed to explore whether parents could develop a demonstrably stronger set of advocacy skills that they could apply on behalf of their learning disabled school-age children. The results of this study support the contention that regular attendance in the Group Advocacy Project was positively correlated with development of such appropriate and informed advocacy skills. In all instances, the percentage of gain was great, and more than sufficient for statistical significance.

There were four major categories within which the positive results of this project appeared: (1) parent attendance; (2) demographic data; (3) responses to closed-end and open-end questions; (4) group leader's informal observations. This analysis of results has been organized according to those four data categories. Within each category, the analysis has been built on an explicit discussion connections between research goals, procedures, and outcomes of the project.

The analysis is presented in the context of the parents' commitment to the group, which was demonstrated in the parent attendance record, and amplified in the leader's log.

Parent Attendance

Out of 26 sessions, the average number of sessions attended was 14.36, with a median attendance being 14.78 sessions. The minimum number of sessions attended by any one individual was 10, and the maximum was 17. The group was conducted for 6 months, and there was a maximum of 26 sessions possible. The group was conducted for 6 months.

Attendance at an average rate of 14.5 sessions, with a minimum attendance of 10 and a maximum of 17, represents a 66.3% rate of attendance with a population of parents whose feelings about schools, learning disabilities, learning specialists, physicians and other professionals included varying degrees of anger, disappointment, confusion, and frustration.

Good attendance was variously attributed to the focused nature of the material, the chance to speak out, and the opportunity to express feelings without entering into a psychotherapeutic relationship. Group members stated that this helped them keep certain fears and personal issues to themselves, and focus on the curriculum. The parents observed that they felt no pressure to self-disclose, and therefore experienced less anxiety attending the program than they had experienced when going for therapy.

Group participants stated that the curricular model had served its purpose, and that many of the group members

had reached the point where it was necessary for them to seek a forum suitable to self-disclosure and personal problem solving. In the earlier stages of the program, members appeared highly focused on curricular content, and reported that they were pleased that the group was theme-confined.

However, it was the group dynamic that became the vehicle for self-disclosure and problem-solving behavior oriented toward difficulties not necessarily related to the learning disabled child or advocacy for the learning disabled child. Essentially, the parent group members were evolving into a more traditional support group mode as the end of the program approached.

Such group and individual movement toward more personal and self-revelatory behavior within the group could be associated with an increase in the group's importance to the members. Termination of the program may have caused the group members to experience separation fear. Since this fear can be ameliorated by group focus on future plans, the researcher made sure that group members were referred to other agencies, individuals, or organizations that might have been equipped to address their emergent needs for new types of problem-solving or psychotherapy.

An analysis of group attendance habits revealed that the highest rates of non-attendance occurred in the final

two sessions of the program. This increased rate of non-attendance may have been associated with one or more of the following precipitating factors: separation behavior; participant need for new types of help; the sense that the thematic curriculum had exhausted its usefulness for the member involved; coincidence; resistance to the theme-bound nature of interaction despite development of group skills.

No data-gathering processes were developed, beyond the leader's observation and attendance sheets, to address issues of attendance, so it is not possible to narrow the precipitating factors for non-attendance, beyond those stated above.

Individual group members did appear to develop friendships as a result of the group process, and it is possible that some sharing and problem-solving that developed within the group could be continued in a new form, within the context of a friendship. The identity of these emerged through the demographic data, an analysis of which follows.

The Demographic Data

The parent questionnaire was constructed to assure that all demographic data were presented statistically. That process insured that it would be possible to inter-correlated those demographic variables with the project goals.

The demographic data show that all group members were gainfully employed in public service or labor positions generally categorized non- or paraprofessional. With the exception of two couples, all represented intact current marriages that constituted the family of origin for the learning disabled child. Most of the fathers were employed in full-time day jobs, and most of the mothers were employed part-time. so it was easier for the mothers to attend the Group Advocacy Program meetings. One family was receiving Aid to Dependent Children.

Children identified as learning disabled were the only children in those families who had been tested and diagnosed accordingly, so it is conceivable that other children and adults in those family systems were learning disabled but had not been identified as such. The group members reported that the identified child was the only child with such learning problems in the family. The parents stated clearly that they "could not tolerate" the possibility that other children in the family could require the same sort of educational, social, and emotional support.

It was evident from the outset that the learning disabled child in each of the families had been identified as the needy child, and, in some cases, as the family scapegoat. Parents firmly rejected possibility that similar problems may exist with any of their other children. Each

parent, without exception, also expressed frustration with the public school system, and reluctance to believe that any professional person had made a valuable contribution to the growth and development of their child.

Two of the mothers (and three non-group member fathers) were identified as learning disabled when they were children. All of these parents reported a failure to learn in school. The parents attributed that failure to the school system, which they perceived had labeled them as retarded. All five dropped out of school before age 16, and were successful in finding gainful employment, marriage partners, and respectable positions in their communities. Group members who had not been identified as learning disabled all completed high school. Two had completed secondary-level or post-secondary technical training.

At the outset of the program, those group members who had completed high school agreed that the school system was largely responsible for such problems. By the close of the program, the whole group regularly expressed a grasp of the complexity of learning disabilities, and the difficulties experienced by families, parents, students, and professionals alike in researching, understanding, and coping with learning disabilities.

Discussion of personal backgrounds and other demographic characteristics helped promote discussion of con-

ditions that either enabled or disabled the group members in their efforts to learn and grow in accordance with personal goals. That discussion, in turn, helped focus the parents on how frustrated their children might be by obstacles that appeared to the children to be insurmountable. The parents seemed able to develop a basis for identifying positively with their youngsters.

Responses to Closed-End and Open-End Questions

The program was intended to address the need for parents to accept the learning disabled child as truly disabled, but that learning disabilities are often malleable problems that can be significantly reduced. In addition, the goals of this program addressed needs parents have to understand the following: parent and student legal rights; school responsibilities in relation to the learning disabled child; coping skills; problem-solving skills; strategies to cope with the learning disabled child at home.

All goals addressed one or more parent needs, and all parent needs were identified as variables including: information; attitude; behavior; child behavior; community behavior; total score. Those six-variables allowed for an analysis of the results.

The closed-end and open-end questions were employed using the six-variables structure for two specific reasons. First, the small sample size of parents required

analysis to reduce the risk of biased or artifactual results that could be attributed to the limited numbers. Second, no control group was used, so there was no opportunity to compare the progress of these parents with the changes in parents who had learning disabled youngsters but no particular help in meeting the special educational or developmental needs of those children.

The two factors which subsumed other factors were behavior and total score. The behavior variable subsumed the child and community variables, since all behavior identified was either advocacy oriented toward the child or advocacy oriented toward the community. "Total score" subsumed the following: identified as information, attitude, behavior, child behavior, and community behavior.

In order to determine the impact of the Group Advocacy Program on the parent group, in terms of the goals of the program, three separate statistical analyses were applied: two multivariate analyses; and one univariate analysis. In all cases and in every category, the gain from pretest baseline answers to posttest responses was sufficient to be judged statistically significant at or above the .001 level of confidence.

In the first multivariate test, four variables were measured together, so their combined interactive effects could influence the results. It was not statistically

possible for one variable to have sufficient impact on the others to cause all to appear significant. Significance was powerful, as revealed in the first multivariate test.

The second multivariate analysis involved the integration of two variables into a third, so that the three objectives of parent gain could be viewed. In this calculation, information, attitude, and behavior were analyzed to determine the relative strength of the gain from pretest baseline responses to posttest responses. All three variables reflected gains at or above the .001 level significance. Therefore, the gains could not have occurred by chance.

In this instance, the total score variable and the variables of child-oriented and community-oriented behavior were eliminated, to best control for the possibility that those variables could influence the interaction of the remaining variables, individually or in combination. The results of these multivariate analyses suggest that the effects of the Group Advocacy Program were highly significant, and were wholly associated with the program goals, and parent's needs at the time of the program's inception.

In order to ascertain the effect of the program on the nature of each variable independently, a univariate analysis was completed. In this case, each variable was

tested from pre and posttest responses to determine what gain, if any, had occurred independently of the effects of the other variables. On all variables, the gain scores were sufficient to be highly significant, with no possibility of these gains occurring by chance. These results indicate that each variable showed an independent, not interactive, gain.

The multivariate and univariate statistical treatment was conducted in order to determine the degree to which parent participants in the Group Advocacy Program gained in areas central to their ability to advocate for their learning disabled children. In each category, parents showed significant gains following participation in the small-group program. Since the program goals were based on parent needs, such gains were clearly positive for the parents.

Informal Observations

One notable finding that emerged from the group discussions was that, within the population of participating LD parents, fathers were more likely than mothers to have children evaluated by the Committee on Special Education. All the mothers in the group felt that the fathers were less fearful of exposure and more willing to yield to the school system. The mothers may have been more concerned with the potential ramifications of the labeling, and with the social impact on the chil-

dren. This was repeatedly indicated by self-reports made by these parents within the group.

These same parents used the group forum to express their fears that their children would be labeled and placed in special education classes that might be offered in different schools, causing the child to have to transfer from one school to another, or commute between the two schools. Fathers who were identified by their wives as learning disabled did not find such a concern an inhibiting factor in the process of identifying and working to cope with the child's learning disability. The fears of transfer articulated by the two self-identified learning disabled mothers may have been reality - based, since local, elementary school programs often do not include special education classes.

If the self-reports and assessment of spouses were accurate, the differences between the mother and father groups also suggested that the fathers felt the stigma of disability more sharply than did the mothers. At the pretest stage, there was a very strong statistical relationship between community behavior and child behavior, and a moderate relationship was found between information and child behavior. At the post-test level, both relationships held. The variables of community behavior, information, and attitude were not related at the pretest level, but were related at the posttest level.

This generally uniform growth in relatedness suggests the success of the Group Advocacy Program in helping parents become more competent in understanding and advocating for their learning disabled child(ren). The strong relationships between community behavior, information and attitude also support the possibility that posttest gain in one variable assures gain in one or more of the others.

This point was corroborated by another Pearson Correlation between all pretest variables and posttest variables. Using the information variable as a guide, it was noted that pretest information showed a moderate relationship to posttest information. However, when pretest information was compared to all the other posttest variables, no relationships were seen.

The only other variable showing a moderate relationship from pre to posttest levels was the variable total score. This may be explained by the composition of this variable, since it subsumes all other variables. The moderate relationship between pretest and post-test scores does not appear in its component parts, but can be seen in the total score variable result. This appears to be an artifact in the combination of all the variables. It is the only place among all the statistics that weakens the findings. The overall results, however, show positive gains made by this group of parents.

Discussion of Advocacy Behavior: Closed-End Questions

The final statistical application in the program was done to ascertain the factor upon which the program made a more significant impact; namely, the parent's direct relationship with their child(ren), or the parents' direct pro-child advocacy behavior within the community. Improved parent behavior toward the child was often expressed in greater patience with the child, more homework help, and greater tolerance for the child's performance anxiety. If the improvement was in the direction of advocacy within the community, the parents were shown to join more community groups, attend more conferences on the subject of learning disabilities, or act as spokespersons for the problems of learning disabled children.

In order to discover the extent to which the parents demonstrated movement in the direction of increased positive interaction with their LD child and/or their communities, a univariate analysis was used, and correlated t-tests for significance were applied. This analysis revealed that all group members reported more advocacy behaviors toward their LD child than toward the community. The differences between the two were statistically significant at the pre-test and post-test level, a greater difference, indicating greater gain, at the post-test stage.

These data indicated that there were more gains in advocacy behaviors directed toward the child, and that it was precisely on this variable that the greatest impact of the program was seen. This suggests that, for this group, the gains in terms of advocacy were toward parent-child behavior. There was significance from pre-test to posttest levels in the variable of community behavior as well.

Discussion of Open-Ended Questions

An analysis of responses to all three questions reveals attitude and information gains that were decidedly in keeping with the program goals. Post-test parent responses were substantially more affirmative, focused, hopeful and informed. Responses consistently demonstrated that parents recognized the learning problems, and interpreted those problems in an informed fashion, abandoning the previous coping response, which consisted primarily of endeavoring to assign blame to others or self.

Summary of Analyses of Findings

Basically, the parents' posttest responses represent a leap of faith and cognition characteristic of human learning and attitude toward obstacles seen as manageable. Taken in the context of all the other gains made, measured and analyzed in response to the closed-end questions, these responses to open-end statements

add substantially to the importance of the outcomes of this study. The following chapter covers the conclusions that can be offered on the basis of these outcomes.

CHAPTER VII

CONCLUSIONS

Introduction

This chapter has been organized into two main sections: conclusions regarding gains made by parents participating in the Group Advocacy Program and conclusions regarding the nature of the Thematic Curriculum as a vehicle to help a small group of parents of learning disabled elementary school-age children make specific gains in the direction of advocacy on behalf of those LD children.

Gains Made by Parents in the Group Advocacy Program

It is reasonable to conclude that parents made gains in virtually every program goal area, even in those instances where the parents did not attend as many of the sessions as their peers. Parents derived new information regarding the nature of learning disabilities, and they also learned how to seek information in the future. That new information appeared to help them develop new attitudes toward their learning disabled children. Parents who participated in the program were able to learn and apply advocacy behaviors that brought substantial benefit to themselves and their children.

Although much of their child-oriented behavior took place within the context of the family system, between parent and child, parent activity within the community was enhanced to the point that all but one of the children

involved were appropriately placed as a result of action initiated by the parent who attended the group advocacy program. In relation to official acts, these behaviors included participating in IEP conferences, asking questions during meetings of the Committee on Special Education, signing testing agreements, requesting that testing be conducted outside the school setting, permitting transfer of children when necessary, allowing for in-school or out-of-school counseling to help the children adjust to the process and idea of transferring schools, and working with school officials in order to assure that children were placed in resource rooms, where suitable.

In the family setting, these parents found themselves more effective and consistent disciplinarians, more accepting of their learning disabled child's disabilities, and more loving to that child, regardless of the learning problems. Parents reported feeling more tolerant, understanding, supportive and supported in working with their children and with the school officials.

This was not simply acquiescence on the part of the parents. In instances where a child is shown to be learning disabled, parents must struggle with a complex and often conflicting set of emotions that can make them overly acquiescent, resistant or inconsistent in working with the people who are responsible for providing the child with the education to which he or she is entitled. The task of the

program was to help parents become more informed and competent consumers of special education services, while becoming more understanding and constructively supportive parents for their learning disabled children.

As a result of the program, parent interaction with the schools was characterized by increased concern for the children's learning patterns, increased interest in learning more about special education services and student needs, and greater willingness to offer fully informed consent. This behavior represented a substantial change from the avoidance or helplessness that characterized much of the parent behavior identified at the inception of the program.

On the basis of the above observations and the statistical analyses, it is reasonable to conclude that the parents who participated in this program did subsequently identify and engage in advocacy behaviors that brought benefit to the themselves and their children. It is also reasonable to conclude that the curriculum helped parents develop positive attitudes toward the child's educational needs, so that the children involved could receive appropriate educational services.

The statistical analyses demonstrated that more substantial changes took place in the child-oriented behavior than in the community-oriented behavior. However, parent community-oriented behavior was sufficiently enhanced so

that those parents worked with school authorities in order to assure that the child received the educational services guaranteed by law.

Parents indicated their understanding that the child's social and emotional concerns were not necessarily competing imperatives to be stressed at the expense of academic success measured against standards appropriate for the child's ability. This approach to the child's needs and the school's potential showed that the parents made significant gains in regard to the meeting the special needs of their learning disabled children. The balance of the program goals focused on the development and implementation of the curriculum.

The Thematic Curriculum: Conclusions Regarding Development and Implementation

The project goals regarding the curriculum were to:
(1) develop a curriculum that would help parents to understand learning disabilities and to develop positive attitudes and improved advocacy skills to serve the educational needs of their children; (2) implement the curriculum in a group setting, where parents of LD children could experience the company and support of their peers and receive professional support from the group leader.

A tentative curriculum was developed and subsequently modified, according to the expressed needs of the group members. The use of the thematic curriculum approach pro-

vided a stimulus around which the group members were able to organize their thoughts and feelings. The thematic material provided an excellent stimulus around which the group members were able to organize their thoughts and feelings. The content material provided an organizing basis upon which the group leader was able to limit the scope of the discussion, and direct the collective and individual energy toward the prescribed areas.

The thematic curriculum became the vehicle that carried the parents in the program to shared, identified goals. The fact that they shared goals was an important and surprising revelation for the parents, who initially reported strong feelings of isolation and powerlessness in regard to their children's needs. The curriculum was designed to achieve a harmony of needs among the parents, the agency, and the community, which included the school.

With that focus as the foundation for the group process and for instruction, the Group Advocacy Program offered the parents a context within which to acquire the skills and knowledge they were seeking. The support the parents demonstrated for each other was not built into the curriculum, but became an inherent component which the group reported brought its members considerable satisfaction.

Basically, the parents in the group became more informed consumers of services they were already receiving

from the host agency and from the schools. The curriculum helped parents develop the skills necessary to become better partners in the education and development of their learning disabled children. On the basis of the above discussion, it is reasonable to conclude that the goals of the parent were achieved, and that the the goals of this program were also achieved.

The thematic curriculum was a suitable means of meeting the needs of the parent, the child, and the organization, as well as the needs of the school. The statistical analysis supported the curricular success in terms of the results of the posttests. Additional results were logged informally, including reports by agencies, individuals, family members, school officials, the children, and the parents. This feedback helped reinforce the group's efforts, and gave the program leader substantial gratification.

Summary

It is reasonable to conclude that the Thematic Curriculum was an important part of the success of the Group Advocacy Program. However, it cannot be concluded that another model of small group support would not be equally successful, since there was no other group undergoing an alternative process of advocacy training and development because this program was not intended to be an experimental study. The positive results of the statistical analyses,

open-end responses, and informal observations consistently support the conclusion that the program reached all program goals related to positive change in parents, and the consequent success of the program. The final goal was to develop a program that could be replicated. Since the curriculum has been implemented, and the data have been collected and interpreted, the program may be presented again. The next step toward general host agency implementation of the program would be to provide the host agency and other agency with the results of this project.

As group leader, it was possible for me to observe the parents convert their frustration, anger, disappointment, confusion into energy to fuel their actions on behalf of their children. It was enormously rewarding to see a parent apply new information and attitudes in developing a plan to assure that the school provides the right educational services for his or her child(ren). Parents in the program became sufficiently informed and assertive to question teachers about the content and goals of IEPs, and the rationale for placement of their LD children.

That type of child advocacy in the school setting was complemented by increased competency in parenting skills specific to the needs of a family with a learning disabled child. In all, the parents in the Group Advocacy Program presented gains in parenting skills, attitudes, information and knowledge pertinent to learning disabilities.

CHAPTER VIII

RECOMMENDATIONS

The recommendations presented in this section are based firmly on the data and observations gathered as a result of developing, implementing, and analyzing this project. The results supported the expected goals of the program: that the curriculum and the small group forum would interact positively to help group members become more competent advocates for their learning disabled children.

On the basis of those results, it is recommended that the agency receive and review the results of this program, It is further recommended that the agency consider further testing or implementation, on the basis of the results achieved in this project.

In addition, it is recommended that further study be conducted to determine the comparative value of the thematic curriculum in the small group setting with alternative program approaches which might be designed to impart information, improve advocacy skills, improve attitude, or achieve a combination thereof. The target population in such a comparative study should include parents of learning disabled children who are currently enrolled in the same clinic program designed to help those children to learn.

It is further recommended that additional study be conducted regarding the size of the group best suited for

learning through the thematic curricular approach. If the size of the groups remains basically small, it is recommended that the number of groups be increased, in order to facilitate a broader perspective on the outcomes and create the opportunity for comparative study.

The size of the group, and the lack of control or comparison experimental groups could be considered problematic in accepting the conclusions regarding the effectiveness of this program. Therefore, additional study should seek to replicate the program under the same conditions, with the same type of population, but with a greater number of small groups.

APPENDIX

- * Tables
- * Questionnaire
- * Group Notes
- * Thematic Curriculum

Table 1
Correlation Total Score Variable

Variable	Parent Group T ₁	Parent Group T ₂
Total Score	.873	.762

Table 1: The Pearson Product Moment Correlation for the questionnaire reliability on the total score variable

Table 2

Intercorrelation for Principle Variables

Variable	Crombach's Alpha Statistic (Reliability)
a. Information	.856
b. Attitude	.806
c. Total Behavior	.845
d. Child Behavior	.826
e. Community Behavior	.813
f. TOTAL SCORE	.912

Table 2: Shows the reliability scores on all six variables. Each item on the questionnaire is correlated to all other items. The correlation of each subscale is presented separately.

Table 3
Demographic Questions: Scaling Procedure

Questions	Numerical Code 1-30
1. Number of siblings	1 2 3 4 5 6 7 8 9 10
2. Child's current grade	1 2 3 4 5 6
3. Months child attended clinic	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
4. Sessions parent attended Group Advocacy Program	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
5. Marital status	
(1) single	1
(2) separated	2
(3) married	3
(4) widowed	4
(5) divorced	5
6. Was your child evaluated by the Committee on Special Education?	
(1) yes	1
(2) no	2
7. Do any of your other children have learning problems?	
(1) yes	1
(2) no	2
8. Were any of your other children evaluated by the Committee on Special Education?	
(1) yes	1
(2) no	2
9. Are any of your other children receiving Special Education help?	
(1) yes	1
(2) no	2

Table 3 (continued)

Questions	Numerical Code 1-30
10. Learning problems: mother	
(1) yes	1
(2) no	2
11. Learning problems: father	
(1) yes	1
(2) no	2

Table 3: Shows the eleven demographic questions with coded responses 1-30.

Table 4

Multivariate Analysis of Variance #1
Comparing Pretest Scores to Posttest Scores

Source of Variation	Wilkes Lamda	RAO's F	Hypothesis DF	Error DF	P
Pre vs. Post	.098	16.124	4	7	.001

Table 4: shows the highly significant change among variables of information, attitude, parent behavior with learning disabled child and parent behavior in the community.

Table 5

Multivariate Analysis of Variance #2
Comparing Pretest and Posttest Scores

Source of Variation	Wilkes Lamda	ROA's	Hypothesis DF	Error P DF
Pre vs. Post	.170	13.012	1	.002

Table 5: shows the highly significant change among variables of information, attitude and behavior.

Table 6
Univariate Analysis
Correlated T-tests

Variable	Pre Test	Post Test	Gain Score	T Ratio	P
Information	92, 2.60	105.13, 5.72	13.18	5.10	.001
Attitude	60, 5.00	71.27, 3.06	11.27	6.03	.001
Behavior	50.02, 6.35	62.45, 5.75	11.63	4.61	.001
Community Behavior	19.32, 2.75	23.36, 3.47	3.55	3.38	.007
Child Behavior	31, 4.03	39.09, 2.77	8.09	4.31	.001
Total Score	202.32, 14.05	238.91, 15.55	36.09	6.55	.001

Table 6: shows the pre, post gain scores of the six variables. The t-ratio, based on 10 degrees of freedom, is displayed for each variable.

Table 7
Comparisons of Parent Behavior
with Child and Parent Behavior in Community
Correlated T-Tests^a

Variable	Community Mean	Behavior SD	Child Mean	Behavior SD	T-Ratio	Prob.
PRE	1.652	.229	2.214	.237	9.79 ^b	.001
POST	1.2117	.289	2.792	.198	12.42	.001
DIFFERENCE	.296	.290	.578 ^c	.398	3.26	.009

Table 7: shows 't' tests to establish the strongest effect between these two variables.

- ^a adjusted for the difference in the number of items for community behavior and scale for child behavior
- ^b Correlated 't' tests based on 10 degrees of freedom
- ^c significant child behavior gain score

Table 2
Question 1: Describe Your Child's Learning Problems in School

<u>Subject</u>	<u>Pre Response</u>	<u>Post Response</u>
1	Reading problems, misbehavior	She doesn't read as well as possible
2	Memory, slow learner, hates school	Memory retention, inconsistent reading, does not remember to bring homework home
3	She calls one work something else when she is reading	She has problems with reading material; she has a tendency to reverse her words and call them something they are not
4	Don't take her time to do her work.	At some of the work she's slow, at other times, she doesn't take her time, at others she just talks all the time
5	Can't keep still, doesn't pay attention	He doesn't understand arithmetic and spelling and he does not do his hw
6	Not responsible, doesn't behave	Has short attention span, and is a little slow grasping math concepts
7	All areas, math and reading, are a problem	Math and reading problems, behavior is good, everybody likes him, even the principal
8	Has trouble getting the concept	Slow in reading and math, often misses the concept
9	His trouble in comprehension	Has eye-hand coordination problems, very distractable, forgets the next day, has trouble reading
10	His problem is reading and math	Cannot retain what is being taught all the time, mostly in reading
11	She finds it hard to keep up with the work in up in class,	She has problems keeping up in class, and copying hw from the board

Table 9

Question 2: Briefly describe any other problems you have with your child (school friends, homework, behavior, etc.)

Subject	Pre Response	Post Response
1	She screams a lot and cries	She does not get along with her brother, she is a little slow doing hw
2	Does not like anything new, will argue about hw and waste time	Has adapted to school situation much better, and deals with hw now
3	Can become moody at times. With friends she gets well. She does hw well.	Can become moody, but is more interested in her surroundings now. Gets along well with friends.
4	She is a _____ hard-head. You have to repeat everything over and over.	She does better with some friends, but does not like to share. Sometimes she just looks at you.
5	No problems.	Refuses to do hw, has no friends, does not cooperate, wets the bed, and is afraid to stay alone.
6	Behavior in school no good, sometimes forgets hw	Does not behave in school. Disputes with his friends, forgets to bring hw home, or does not do hw
7	Cooperative, behaves OK	Behaves OK, plays nicely with other kids, only problems are schoolwork.
8	None	None
9	Main problem is with friends and inappropriate behavior.	Has trouble understanding other children's point of view. Likes to pretend she cannot do hw so she can get help.

Table 9 (continued)

10	None	Only school. Works and plays well with friends in and out of school
11	Acts like a baby, tries to buy most of her friends, copies her friends	Would still like to be a baby, like her younger brother.

Table 9: shows excerpts of specific responses parents made to second question. Indicates the change from T_1 to T_2 testing periods.

Table 10

Question 3: What has worked best for you in trying to deal with your child's learning problems or any problems you have identified?

Subject	Pre Response	Post Response
1	Not sure	By helping him specifically, when I can
2	Allowing her to work more on her own only when necessary	Reminding her that each day is a new day and a new start as well as reminding myself. Praising her when applicable.
3	Understanding she may have learning problems	Understanding and accepting her condition. More hope for the future.
4	Nothing	Not much. I see a little hope later on.
5	Take away TV	Now I can give him his way. I understand why he follows his younger brother.
6	Take away entertainment	The program seemed to help school and home situations. I sometimes take away privileges for misbehavior at home.
7	Spelling is the worst work. I go crazy every night. Resource room is best for him.	He needs a lot of love and understanding from me, and I give it. Support from the program has helped, and the learning clinic has helped.
8	Works better on one-to one.	The program has taught me and the clinic has taught my child. He shows a great deal of learning and growing.
9	To talk with profession-people and other parents	Learning what is normal behavior and what is not, and what can come from learning being learning disabled. Speaking to the teachers and reading the book "No Easy Answers"

Table 10 (continued)

Subject	Pre Response	Post Response
10	None	A lot of love, and help from the program.
11	I work with her and let her do her own homework	I talk to her a lot more. I try to keep her thinking she can succeed and be anything she wants.

Table 10: shows excerpts of the specific responses made by parents to the third open-ended question. Indicates the change in responses from T₁ to T₂ testing periods.

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 1 DATE October 31, 1983
THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. S Mrs. G Mrs. W
Mr. L Mrs. E
Mrs. M Mrs. R
Mrs. W Mrs. S

FAILED:CANCELLED:

SESSION THEME: Most of this group was spent in introduction and getting familiar. Mr. Skyer explained his purpose in the group and emphasized the information he would present. The group as a whole was very responsive to this and generally stated how they all felt they needed to know much more about learning problems. Various parents took the lead in explaining the problems evidenced by their children and how they responded to their specific needs. The group focused upon the confused messages they received from their children and how difficult and frustrated they felt. They all noted how important it was to talk to other parents who experienced similar problems. The themes given this group by the parents were: "helping our own kids," and "diagnosing our kids." The overriding theme addressed during this session, as seen by the group leaders, seemed to relate to the confusion and misunderstanding these parents showed regarding the learning process among their children.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 2 DATE November 7, 1983

THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. B Mrs. M2
Mrs. L Mrs. R
Mrs. W Mrs. E
Mrs. M Mrs. L2

FAILED:CANCELLED:

Mrs. L3
Mrs. S
Mrs. G

SESSION THEME: Mrs. B started the group at first with a long and confusing presentation about her son, W. Other group members were unsure about what she was stating. The group asked her for clarification regarding W's learning problems. This led Mrs. M into discussion of her niece V who seems to have serious behavior problems. She too took a long time to express the extent and nature of V's problems. The group was generally attentive and offered some solutions to her. The theme of understanding the children and dealing with the confusions about how to treat the kids occurred repeatedly in this session.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 3 DATE November 14, 1983

THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. B
Ms. M Mrs. G
Mr. L Mrs. R
Mr. S
Mrs. W
Mrs. M2

FAILED:CANCELLED:

Mrs. L3
Mrs. E

SESSION THEME: Somewhat of a late start due to PTA breakfast meeting. Discussion was started by Mrs. M1 regarding sibling fighting and how her daughter and son fight constantly. Other parents in the group discussed how their own children fight and how difficult it is to understand this. Mrs. M2 spoke about her own experiences growing up and how she fought with her own brothers and sisters. All the parents agreed but were unable to come to any resolution about what was a normal level of fighting and what was not. Mrs. M1 spoke about some poor marks her daughter had received on her report card and was going to the school to speak with the teacher, who she felt was unfair to her daughter. Ms. M spoke about her son's report card where almost "every single box" in the report card received an "unsatisfactory". She too was going up to the school. The group couldn't understand how this was possible when the school and the teacher knows of her son's problems.

This group largely focused on the difference between a normal level of negative behavior among siblings and an abnormal level. When that interaction becomes pathological was tabled for future discussion.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 4 DATE November 21, 1983
 THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. L3
 Mrs. L Mrs. R
 Mrs. M2
 Mrs. W
 Mrs. B1
 Mrs. B2

FAILED:CANCELLED:

Mrs. L2
 Mrs. G
 Mr. L

SESSION THEME: The group spoke about how rivalry between siblings is a common problem. Issues were raised by Mrs. W and Mrs. M1 about how the child with a learning problem should be handled since they both have special difficulty with this. The group essentially discussed how the child with a learning problem brings their problems into the home, and when they do, how much preferential treatment should they get. Some group members felt that due to special problems they cannot be expected to behave like their normal children. Other parents felt that they should be expected to function like all the other children. The discussion eventually moved into how much of a child's school (academic) problem is translated into behavior at home. This was discussed by all the parents with each examining their own personal situation. The basic themes discussed were as follows: (1) Do kids with learning problems get special treatment, and (2) How do learning problems seen in school get translated into home problems.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 5 DATE November 28, 1983

THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. H Mrs. S.
Mrs. B Mrs. R
Mrs. L Mrs. E
Mrs. M1
Mrs. M2
Mrs. W

FAILED:CANCELLED:

Mrs L2
Mrs. L3

SESSION THEME: The group began a discussion about the friendships their children have. Mrs. H discussed the fact that her son Kevin has few friends. She wishes he had more and she pushes him to make friends. Other group members felt she pushed him too hard. They stated overall that he will make friends when he is ready and that these are her values, not his. The general question about parent involvement and children's friends was discussed. The group stayed with this theme throughout the session with many viewpoints presented. This was a good session with the parents introducing other issues such as "How values change over a period of time," and the importance of "having your spouse involved" with the problems of children.

Theme for this group -- the values parents have and how they are superimposed on their children.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 6 DATE December 5, 1983

THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. L1 Mrs. R
Mrs. L2 Mrs. E
Mrs. M1 Mrs. G
Mrs. W Mrs. L3
Mrs. B Mrs. S
Mrs. M2

FAILED:CANCELLED:

SESSION THEME: Group discussed the holiday and how their kids with learning problems related to this. Most of the parents did not feel their L.D. kids' reactions to holidays was any different than other siblings. One mother noted her daughter is overwhelmed by these holidays and doesn't know how to act. The group also continued the discussion on the friendships of their children. The general consensus seemed to be not to push too hard and to leave the kids alone. Different parents presented examples of how their kids related to friends. This lead to the question of can a kid with a learning disability lead a normal life in the future. Most were quick to state yes. Some reservations were noted by a few parents. This subject will be continued at a later time.

Theme of this group: Does my child's school learning problem show up in other areas? If so, to what extent?

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 7 DATE December 12, 1983
 THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. B
 Mrs. M2 Mrs. L3
 Mrs. L Mrs. E
 Mrs. W Mrs. G
 Mrs. L Mrs. R

FAILED:CANCELLED:

Mrs. G

SESSION THEME: This group started late due to bad rain and parents' late arrival. Mrs. M1 spoke at great length about V; the problem of stealing. Many of the other parents noted that they had similar problems. The question was asked, if this stealing was impulsive or pre-meditated. The group discussed the issue of impulsivity and its relationship to learning disabilities. Eventually the group came to realize that the stealing was more symptomatic of other problems. In this case the group felt that a good deal of V's problems in school and elsewhere is connected to her poor relationship to her real mother.

The theme of this group seemed to be: that the problem seen on the surface may not be the real problem at all.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 8 DATE December 19, 1983
THERAPIST Gil Skyer SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. L2
Mrs. M2 Mrs. R
Mrs. W Mrs. E
Mrs. L Mrs. G

FAILED:CANCELLED:

Mrs. B
Mrs. S
Mrs. G

SESSION THEME: Late start due to PTA meeting. Mrs. M2 discussed how in her building a 17 year old girl was murdered. The group was very upset and spent a good deal of time discussing this event. One mother suggested that these "things" do not really affect kids with learning problems. Others did not feel this at all. Some felt the kid with a learning problem is more frightened by such things. The remaining time was spent discussing to what extent children with learning problems are affected by the world around them. What eventually came out was that often kids with learning problems are more concrete and see things differently. The group was interested in this and wanted to pursue it further.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 9 DATE January 9, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. L3
Mr. L Mrs. E
Mr. S Mrs. R
Mrs. L
Mrs. M3

FAILED:CANCELLED:

Mrs. W
Mrs. M2
Mrs. B

SESSION THEME: How much homework should the parent do for the child? It is fair for the parent to do the child's homework?

Mr. S spoke about his daughter and how she is not progressing. He feels she can do more of the homework she is assigned. He doesn't want to help her anymore because she is not learning. Other group members discussed to what extent they help their children. The group also spoke about the expectations they have for their children and what will occur to them once they are grown up. The group encouraged Mr. S to have his daughter evaluated for special education since he feels she has not progressed. Mrs. L noted that her husband has a learning disability but he is ashamed of it. That is why he has such difficulty helping his child with homework.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 10 DATE January 30, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. R
Mrs. B Mrs. E
Mrs. S Mr. L
Mrs. W
Mrs. L

FAILED:CANCELLED:

Mr. L
Mrs. M2
Mrs. M3

SESSION THEME: The theme of this group was focused around the SBST and the COH. The parents emphasized how important it was to use their power to obtain the best services for their children.

Mrs. S opened the group with a discussion of the events which occurred in order to get her daughter evaluated by the COH. She noted how her request was not taken seriously, she stated "because the request was not in writing." The group reacted to this and pointed out that it was not necessary. They felt the schools try to intimidate parents and you must not respond to this. The rest of the group was spent in discussing exactly how to handle the COH and what steps to follow. The areas covered were the COH evaluation, the evaluation conference, not to sign anything quickly, the parents' right to read the record, and the parents' right to agree with the recommendation. Both Mrs. B and Mrs. S noted they received "holdover" letters about their children. They were advised by the group to investigate these very carefully.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICESTYPE OF GROUP Parent SESSION # 11 DATE January 3, 1984THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.PRESENT:

Mrs. K Mr. L
Mrs. S Mrs. L2
Mrs. G Mrs. W
Mrs. R Mrs. B
Mrs. L Mrs. M1
Mrs. E

FAILED:CANCELLED:

SESSION THEME: Why is improvement so slow?

Mrs. K opened the session with some personal problems between her and her ex-husband. She feels that a custody battle may develop between them. Her son is doing well and she will not agree to any changes. This took the group into a variety of areas such as: how kids react to divorce, how kids split parents and play one against the other, and how success can be measured. This group needed with a variety of open questions which will be continued at the next group. Mrs. K has a series of personal problems which would dominate the group if not contained. She speaks of seeking individual help in the clinic. The group has encouraged her to do this.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 12 DATE January 10, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. S
Mrs. R
Mrs. E

FAILED:CANCELLED:

Mrs. B Mrs. W
Mrs. M1 Mrs. L3
Mr. L Mrs. M2
Mrs. G Mrs. L2

SESSION THEME: Worries about kids. Specific options a parent has when they attend a COH hearing.

Mrs. S discusses here son (S) and how his COH conference is coming up. She notes her fears and talks about her various options. She also discussed her final acceptance that her son has a learning problem. She noted how hard it was to accept this even though she knew it "right from the start." Different parents shared their fears about a lack of progress among their children. The discussion finally developed into having a commitment to help you child and not giving up. Mrs. E spoke about the TV show concerning incest and how she worries about such a thing. The group discussed this and all showed a concern about this problem.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 13 DATE January 17, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. K Mr. L
Mrs. S Mrs. M2
Mrs. R Mrs. W
Mrs. G Mrs. B
Mrs. L

FAILED:CANCELLED:

Mrs. E
Mrs. M1

SESSION THEME: Concerns that children would be left back and that parents could do nothing about it. The general theme of this group had to do with powerlessness some parents feel in regard to the board of education.

Mrs. S spoke about the problems she was having with the COH. She states the school wants to place her son (S) in "special education, HC30" and she does not agree. She feels the resource room would be sufficient at this point. The group encouraged her not to make any quick decisions and to review the material carefully. The group noted that parents do not have to be pushed around by the board of education and that you "have to open your mouth."

Mrs. G talks about her fears that T is much too preoccupied with death. She states he never talks about this at home, only at the clinic. She worries that when he sees the clinic psychiatrist he will describe "new" problems she will have to face. She is very upset at this prospect. The group spent some time talking about cabbage patch dolls and how silly the whole thing is.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 14 DATE January 31, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. R Mr. L
Mrs. A Mrs. L3.
Mrs. K Mrs. B
Mrs. E Mrs. W
Mrs. L
Mrs. G

FAILED:CANCELLED:

Mrs. S

SESSION THEME: The identification of the L.D. child leads to a labeling process which affects the child in the future.

Mrs. L opened the group with a discussion about problems her child (P) was having. He is being picked on by another child and getting blamed for fighting. She felt that he is labelled because he has a learning problem. Other parents agreed that once a child is singled out everything that occurs in the class is "blamed upon them." Each parent was able to relate a story in which case their child was accused wrongly. They all felt their children were scapegoated. This led to a series of questions about the value of special education and the COH process. Parent rights were reviewed once again and Mrs. R was given specific instructions about what not to do when meeting the COH team.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 15 DATE February 7, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. E Mrs. B
Mrs. K Mrs. M1
Mrs. R Mrs. M2
Mrs. S Mrs. L3
Mrs. G

FAILED:CANCELLED:

Mrs. L
Mr. L

SESSION THEME: Is it necessary for a husband and wife to be consistent about discipline for the child? What happens when they are inconsistent?

The group opened with members asking questions about fees. Some mothers pay a fee and others do not. Someone raised the question of recreation programs and summer camps. A few of the mothers asked about camp programs for their children and who could recommend such programs. Different group members discussed their experiences with summer camp programming. The discussion turned back to differences in the way mothers treat their L.D. kids as compared to fathers. This had come up earlier. This generated a long discussion about husband and wife relationships and how men are less sensitive to the problems of the L.D. child. It also generated a discussion about differences various group members have with their husbands and boyfriends. The group was very anxious to talk about these issues and seemed to need an environment to listen to their problems.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 16 DATE February 14, 1984
THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. R Mrs. B
Mrs. G Mrs. W
Mrs. E Mrs. M2
Mrs. L1
Mrs. L2
Mrs. A

FAILED:CANCELLED:

Mrs. K
Mrs. S

SESSION THEME: The importance of summer recreation camps.
Separation issues and how parents deal with them.

The group opened with members discussing if it is wise to send children with learning problems to recreation camps. Mrs. L2 presents a situation in which the clinic recommended a camp and her son was very unhappy there. She felt the clinic was "wrong in recommending this camp." Other parents discussed more positive experiences their children had. This led to a discussion of separation problems and how overprotective parents of learning disabled children can be. Mrs. L1 became involved at this point and spoke of her frustration with her son V and how difficult he is due to his hyperactive personality. She was given a lot of support from the group and was assured that they all had gone through the problems she is experiencing. They noted things will settle down once her son is in the clinic a while. She is a very nervous woman which came across very clearly. This was a very active group with a great deal of cross conversation and a good deal of action.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 17 DATE February 21, 1984
THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT: FAILED:

CANCELLED:

Mrs. K Mr. L
Mrs. L1 Mrs. B
Mrs. G Mrs. M1
Mrs. S Mrs. M2
Mrs. L2

Mrs. R
Mrs. E

SESSION THEME: Concern with the future of our children. What will the future bring?

Only some of the parents in this group were able to connect with this subject. Mrs. S discusses the issue of separation and how she doesn't want her son S to grow up. She knows she is very overprotective but cannot seem to "stop it." She discussed different arguments she had with her boyfriend as a result of this. Mrs. L1 was very connected to this problem. She has the same feelings and also discussed arguments with her husband about it. The group generally discussed the future but was unable to make the direct connection to separation problems now and how that is related to the future. The topic of death and dying also surfaced in this session. There are issues which will be continued in the future. Most significant was the way the group was able to focus these things upon how it can affect the learning habits of their children.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 18 DATE February 27, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. B Mrs. E
Mr. L Mrs. L2
Mrs. W Mrs. M1
Mrs. S Mrs. M2

FAILED:CANCELLED:

Mr. S
Mrs. M
Mrs. L3

SESSION THEME: "Expectations for the future of children with learning problems can be very poor."

This quote from one of the parents in the group summed up what seemed to be the theme of this session. Most of the parents spoke of frustrations and feelings about what the future will bring for their children. A number of parents noted that their children were already being left out of things because they had learning problems. They anticipated that by the time they are in high school things will be worse. The group session stayed with this theme throughout with all the parents making various contributions. Mrs. W summed up her feeling as follows: "I want her to feel good about what she is doing, that's all."

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 19 DATE March 5, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M Mrs. L3
Mr. L Mrs. B
Mrs. L Mrs. E
Mrs. W Mrs. G
Mrs. S

FAILED:CANCELLED:

Mrs. B
Mr. S

SESSION THEME: Look at what we all have gone through and were able to overcome it.

Mrs. L spoke at length about how hopeless she felt about her daughter when she first came to the clinic. Now, three years later, she notes her daughter is doing better and is almost to grade level. What's more important, she notes, is that her daughter has a positive attitude about her ability. She feels good about herself and feels she can learn. The group revolved around the theme of all the parents have suffered problems with their children but have overcome it. It was very positive and reassuring. They felt there was now some hope and that the clinic had made the difference. Two mothers felt they would like to be outreach workers and let others know how things can work out.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 20 DATE March 6, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT: FAILED:

CANCELLED:

Mrs. K Mr. L
Mrs. S Mrs. L3
Mrs. G Mrs. M1
Mrs. R Mrs. E
Mrs. B Mrs. L

Mrs. L

SESSION THEME: Growing up too early. Do children with learning problems respond to environment too quickly? Are they affected by cultural influences more readily than children without learning problems.

This was a general kind of group with no clear focus. Mostly the parents spoke about how children are influenced. Some discussion regarding the rights of a parent to get a child's class changed. Most of the mothers noted that they needed a group which will focus on their own personal problems and not related to their children. They all felt they are too involved with their children's problems. This leaves little space for their needs.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 21 DATE March 12, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. W Mrs. E
Mr. L Mrs. L3
Mr. S Mrs. G
Mrs. M1 Mrs. M2
Mrs. B Mrs. L
Mrs. M2

FAILED:CANCELLED:

SESSION THEME: How do we handle the situation when the L.D. kid matures more slowly than his or her friends? We may come to a point where they do not fit in.

This group started slowly with various discussions about TV privileges and how to get more control over our children. Eventually the subject of the maturing L.D. child was raised. This led to discussions about the fears many of the parents have of their kids not fitting in with "normal" adolescents.

There was also a great deal of fear among the parents of girls. They felt that as they get older they will be taken advantage of by boys. This stimulated a great deal of lively conversation and some options were discussed. Most of the parents felt the best thing to do it to keep in touch with other families who have L.D. children. They would encourage their children to be friends with other children who have learning problems.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 22 DATE March 19, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT: FAILED:

Mrs. L Mrs. E
Mrs. M1 Mrs. S
Mr. L Mrs. R
Mrs. M2
Mrs. W

CANCELLED:

Mrs. B
Mr. S
Mrs. L3

SESSION THEME: Will problems of my child carry over into adolescence and how do my child's learning problems affect the other siblings.

Group started with general discussion about how problems of learning disabled kids will carry on into adolescence. Mrs. L discusses her daughter's poor social judgement and how she feels that will be a problem for a long time. Group discussed progress and how just when you "think your kid has made it something happens and you feel you're right back where you started from." The group discusses the "ups" and "downs" of learning and how slow things can move. Mrs. L raises a question about her son and how she feels her daughter's learning problem is embarrassing him. This triggers a flood of feelings among all the group members regarding the effect the child with the identified problem has in all the family. All the group members give examples of how devastating this can be to other siblings. The group ends on an unresolved note, suggesting much more to discuss in this area.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 23 DATE March 20, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. S Mrs. B
Mrs. E Mrs. L3
Mrs. L1 Mrs. M1
Mrs. K
Mrs. L2
Mrs. G

FAILED:

CANCELLED:

Mrs. R
Mrs. B

SESSION THEME: How much do we blame ourselves for the problems of our children?

Group discusses various issues related to report cards. Some of the parents very happy with the results although some were not. Most felt that they needed to speak with school to determine if their child would be left back. Mrs. K spoke a great deal about the problem she is having with all her children. The group tried to give her advice but could not get a handle on her problems. There seemed to be a reluctance of various group members to present issues and things just bounced around with no specific direction. Blaming oneself for the failures of our children came up here and there, but seemed too potent an issue for the group to deal with directly.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 24 DATE March 26, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. M1 Mrs. E
Mr. L Mrs. R
Mrs. B Mrs. L2
Mrs. S

FAILED:

Mrs. M2

CANCELLED:

Mrs. W
Mrs. L

SESSION THEME: Secondary problems associated with child becoming aware of their own learning problems.

Mrs. M1 discusses how her daughter may be left back if she fails the reading test. She notes how at this point she is more worried than when she was younger. Group discusses how the children themselves are becoming aware of their disabilities. This leads to a discussion regarding all their new problems. The group felt this can lead to various social and emotional problems. They all felt worried about this and perplexed about any solutions.

Some discussion occurred about aging out and at what point the Board of Education stopped responsibility. The group was generally surprised to note that the Board of Education was responsible to the child's 21st year provided they are certified Special Ed.

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 25 DATE April 9, 1984

THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. B Mrs. L3
Mr. L Mrs. E
Mrs. W Mrs. S
Mrs. L Mrs. M1

FAILED:CANCELLED:

Mrs. M1
Mrs. M2
Mrs. M2

SESSION THEME: Does work with the children at the clinic affect their social development in a positive way?

The group began with some questions about how the reading tests may not be fair to L.D. kids. Some of the parents felt that there is too much anxiety among their children. Often they "somehow" do not "show up well." This developed into a discussion about social development and how the reading clinic affects all areas. The group tried to isolate what aspects of the program had its greatest impact. All group members agreed that in terms of the effects on parents, the interactions in the waiting room were the most significant. Mrs. W discusses incident last week when she was not bringing in her daughter but came to sit in the waiting room anyway. She says she "just wanted to talk to the other mothers."

Signature of Therapist:

CONEY ISLAND HOSPITAL
CHILD PSYCHIATRY SERVICES

TYPE OF GROUP Parent SESSION # 26 DATE April 10, 1984
 THERAPIST Gil Skyer/A. Haklay SUPERVISOR Abraham Haklay, Ph.D.

PRESENT:

Mrs. L Mrs. B
 Mrs. K Mr. L
 Mrs. S Mrs. W
 Mrs. M1

FAILED:CANCELLED:

Mrs. E
 Mrs. R
 Mrs. G

SESSION THEME: Discussion of how husbands relate differently to children.

A short discussion occurred on what expectations parents have about how long their children would stay in the learning clinic. Most expected about two years. This led into a discussion of how husbands' views are different. The fathers of the children expect longer stay than mothers. A general broad discussion occurred regarding the differences between how men and women view relationships. The emphasis was on the display of affection toward children. The group is attempting to move toward more personalized content.

Group members say goodbye to each other on this last session of this group.

Signature of Therapist:

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

PARENT INFORMATION QUESTIONNAIRE

THIS QUESTIONNAIRE IS DESIGNED TO PROVIDE US WITH INFORMATION ABOUT HOW MUCH YOU KNOW OF YOUR CHILD'S LEARNING PROBLEM AND WHAT MORE YOU WOULD LIKE TO KNOW. IN ADDITION, WE WANT TO KNOW WHAT YOU FEEL ABOUT YOUR CHILD'S LEARNING PROBLEM AND WHAT STEPS YOU HAVE BEEN TAKING TO HELP.

YOUR ANSWERS WILL HELP US IN OUR PARENT GROUP PROGRAM AND WILL INFLUENCE US IN PLANNING FUTURE GROUPS.

PLEASE FILL OUT THIS QUESTIONNAIRE TO THE BEST OF YOUR ABILITY AND ANSWER ALL QUESTIONS.

THANK YOU FOR YOUR COOPERATION.

ABRAHAM HAKLAY, Ph.D.

GIL SKYER, M.S., M.Ed.

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

PARENT INFORMATION QUESTIONNAIRE

Background

Child's Name: _____

Mother's Name: _____ Father's Name: _____

Names (and ages) of other siblings: _____

Your child's current grade: _____

Date child first attended clinic: _____

Date first attended regular parent group: _____

Occupation of wife: _____ of husband: _____

Current marital status (circle one):

Single Separated Married Widowed Divorced

Has your child been evaluated by the Committee on the Handicapped? _____

Do any of your other children have learning problems? _____

Were any of them evaluated by the Committee on the Handicapped? _____

Are any of these children receiving special education help in school? Please list their names: _____

Did you or your spouse have learning problems in school? _____

Mother _____ Father _____ Both _____ In what grade? _____

If so, please describe: _____

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Briefly describe your child's learning problem in school:

Describe briefly any other problems you have in dealing with your child, such as with school, with friends, with behavior, with homework, etc.:

What has worked best for you in trying to deal with your child's learning problem or any problems you have identified:

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LEARNING PROGRAM

PART ONE - INFORMATION

Please check the appropriate box for each question. Answer all questions.

1. If your child is receiving special education help, your school district is responsible for his or her education between the ages of 5 and 21 years.

Disagree
 Not sure
 Agree

2. Your school district is responsible for locating all children with either learning or other handicapping conditions.

Disagree
 Not sure
 Agree

3. In order to place your child in any special education or remedial programs, your school district must get your consent in writing.

Disagree
 Not sure
 Agree

4. You can insist, if you feel that your child has some learning or other school-related problem, that your district evaluate your child.

Disagree
 Not sure
 Agree

5. Information collected about your child can be shared with concerned professionals, with or without your consent.

Disagree
 Not sure
 Agree

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LEARNING PROGRAM

6. If you believe that your child is not doing well in class or experiencing problems in school, you should bring this to the attention of his or her teacher.
- Disagree
 Not sure
 Agree
7. If you believe that your child is not doing well in class or experiencing problems in school, you may share this information with the principal.
- Disagree
 Not sure
 Agree
8. If you believe that your child is not doing well in class or experiencing problems in school, you may share this information with the guidance counselor.
- Disagree
 Not sure
 Agree
9. The School Based Support Team can evaluate your child to decide whether he or she can remain in the regular class while receiving additional services.
- Disagree
 Not sure
 Agree
10. An assessment of your child's school functioning can be done by either the School Based Support Team or the District Committee on the Handicapped.
- Disagree
 Not sure
 Agree
11. The Committee on the Handicapped is a legal body set up in every school district to help your child get the most appropriate education.
- Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

12. The primary function of the Committee on the Handicapped is to work with the Board of Education in order to identify, evaluate, classify and plan the most appropriate program for your child.

Disagree
 Not sure
 Agree

13. By law, the Committee on the Handicapped consists of a chairperson, school psychologist, teacher or local school administrator, physician and parent of a handicapped child.

Disagree
 Not sure
 Agree

14. If you attend a Committee on the Handicapped hearing concerning your child's educational program, you may bring a husband or wife, but no other relative or any other person of your choice.

Disagree
 Not sure
 Agree

15. No student will be formally evaluated without written consent from a parent. The parent can withdraw consent at any time and the assessment will stop.

Disagree
 Not sure
 Agree

16. No student will be given special education services without a formal evaluation and a determination that the student is handicapped and requires special education services. Parental consent for those services is required.

Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

17. If your child is not doing well in school and is called emotionally disturbed, the Committee on the Handicapped evaluation may not explain all of the reasons for this determination.
- Disagree
 Not sure
 Agree
18. If your child is called Learning Disabled, it means that there is a deficit in his or her ability to receive, organize or express information when reading, writing, spelling or doing arithmetic.
- Disagree
 Not sure
 Agree
19. If Resource Room services are recommended for your child, it means he or she will attend a regular education class and, in addition, will receive at least one or more periods a day of special instruction.
- Disagree
 Not sure
 Agree
20. By law, a child in a Resource Room must receive at least five periods of instruction each week.
- Disagree
 Not sure
 Agree
21. The Individualized Educational Program is prepared for the student when special educational services are recommended by either the School Based Support Team or the Committee on the Handicapped.
- Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

22. The Individualized Educational Program describes the student's specific needs, the appropriate educational goals and the services which will be provided to meet them.
- Disagree
 Not sure
 Agree
23. The Individualized Educational Program should be prepared jointly by the parent and teacher and should be mutually agreed upon.
- Disagree
 Not sure
 Agree
24. The Individualized Educational Program, as determined by the legal Committee on the Handicapped, will begin regardless of the parents' feelings about these services.
- Disagree
 Not sure
 Agree
25. If a student's dominant language is not English, assessments or interviews will be conducted in the language he knows or through an interpreter.
- Disagree
 Not sure
 Agree
26. Parents can give information about their child which can be used at a formal assessment. This can also include reports of other specialists who know the child.
- Disagree
 Not sure
 Agree
27. If written consent for a formal assessment of your child has been given, this consent can be withdrawn at any point during that evaluation and the assessment will stop.
- Disagree
 Not sure
 Agree

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LEARNING PROGRAM

28. During the entire evaluation process, the child should remain in his or her current school placement unless his or her parent agrees to another type of class.

Disagree
 Not sure
 Agree

29. If a parent does not agree with the results of a formal evaluation, the parent has the right to request an independent evaluation which may be paid for by the school system.

Disagree
 Not sure
 Agree

30. Parents have the right to have a private evaluation of their child paid for at their own expense. This information will be considered at a formal hearing about their child's educational placement.

Disagree
 Not sure
 Agree

31. When the formal assessment has been completed, parents are invited to participate in the Educational Planning Conference (E.P.C.). This conference determines the degree of your child's learning disability. Parents have no voice in this conference.

Disagree
 Not sure
 Agree

32. A parent of a child receiving special education help may request a re-evaluation at any time.

Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

33. The Committee on the Handicapped is required to evaluate a child within 30 working days of the date a parent signs the consent forms.
- Disagree
 Not sure
 Agree
34. Parents do not have the right to see their children's school records.
- Disagree
 Not sure
 Agree
35. All recommendations regarding a child's evaluation must be mailed to the parents whether or not the parent was present at the Evaluation Planning Conference.
- Disagree
 Not sure
 Agree
36. A listing of special education programs is available in every school district in the city. Parents can visit these programs and decide if they want their child to attend.
- Disagree
 Not sure
 Agree
37. Your child's teacher has the right to determine whether he or she can participate with other students in assembly, out-of-school trips, lunch and other school activities.
- Disagree
 Not sure
 Agree
38. Your child's educational program cannot be changed unless you are notified.
- Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

39. By law, every child in special education should be evaluated at least every three years.

Disagree
 Not sure
 Agree

40. Parents have the right to insist on receiving a word by word, exact copy of all evaluations of their child before making a decision on his or her placement in special education.

Disagree
 Not sure
 Agree

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LEARNING PROGRAM

PART TWO - ATTITUDES

Please check the appropriate box. Answer all questions.

1. Statements which define my child as being handicapped because of school problems are unfair.

Disagree
 Not sure
 Agree

2. In order to do better in school, what my child needs is some good strict punishment.

Disagree
 Not sure
 Agree

3. The best way to deal with my child's learning problem is to expect less.

Disagree
 Not sure
 Agree

4. It is very unfair for the school to expect my child to do work he or she is unable to do.

Disagree
 Not sure
 Agree

5. I sometimes feel my family expects too much from my learning disabled child.

Disagree
 Not sure
 Agree

6. I feel my child has a learning problem because he just refused to try.

Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

7. It is best to discuss the causes of my child's learning problem with him.
- Disagree
 Not sure
 Agree
8. It's not helpful to get angry at my child when he or she refuses to learn?
- Disagree
 Not sure
 Agree
9. I know my child can learn more if only his or her teacher would get tougher.
- Disagree
 Not sure
 Agree
10. The reason my child is not learning is because the teacher dislikes him or her.
- Disagree
 Not sure
 Agree
11. The best thing to do when a child won't learn is warn him that he will fail in life so that he will know the importance of education.
- Disagree
 Not sure
 Agree
12. I believe the school is doing the best possible thing for my child.
- Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

13. The best thing for me to do when my child is having a school problem is to leave the school alone and let them work it out.

Disagree
 Not sure
 Agree

14. If my child cannot do his or her homework, the best thing to do is to do it for him.

Disagree
 Not sure
 Agree

15. If a child cannot do his or her homework consistently, he is obviously getting the wrong type of work.

Disagree
 Not sure
 Agree

16. If my child's homework is too difficult and he has worked hard at it for a long time, it is alright for a parent to excuse him from that homework.

Disagree
 Not sure
 Agree

17. I do not let my child's learning problem interfere with my caring about him or her as a person.

Disagree
 Not sure
 Agree

18. I feel I am angry at my child much too often.

Disagree
 Not sure
 Agree

19. It upsets me to see my child angry so much of the time.

Disagree
 Not sure
 Agree

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20. At this point I feel I blame my child for too much, even if I'm not sure if he or she is right or wrong.

Disagree
 Not sure
 Agree

21. I feel placing a child in a special class labels that child unfairly for the rest of his or her life.

Disagree
 Not sure
 Agree

22. The people who teach my child are experts in handling children with learning problems.

Disagree
 Not sure
 Agree

23. I feel the school is very cooperative about sharing information about my child.

Disagree
 Not sure
 Agree

24. Down deep, I know my child's learning problems will never improve.

Disagree
 Not sure
 Agree

25. I really have hope that my child will have a job some day.

Disagree
 Not sure
 Agree

26. My true feeling about my child's future is that things look very bad.

Disagree
 Not sure
 Agree

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

27. I often feel the best thing would be for my child to live away at a special school.

[] Disagree
[] Not sure
[] Agree

28. I feel the best thing that ever happened to my child was to get into a learning clinic program.

[] Disagree
[] Not sure
[] Agree

29. My child's uneven performance in school confuses me and makes me angry.

[] Disagree
[] Not sure
[] Agree

30. I sometimes feel the school is blaming me for my child's learning problems.

[] Disagree
[] Not sure
[] Agree

31. I often feel that having to cope with a child with learning problems is just not worth the effort.

[] Disagree
[] Not sure
[] Agree

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PART THREE - BEHAVIORS

Please check the appropriate box. Answer all questions.

1. I speak with my child's teacher:
 never sometimes often
2. I speak to other parents about parents rights:
 never sometimes often
3. I attend organizations for parents of learning disabled children:
 never sometimes often
4. I volunteer in my child's school:
 never sometimes often
5. I attend Committee on the Handicapped conferences if they apply to my child and the school has notified me of the date:
 never sometimes often
6. I speak with my child's principal:
 never sometimes often
7. I attend the P.T.A. meetings:
 never sometimes often
8. I speak out at community functions about problems of children with learning difficulties:
 never sometimes often
9. I let my friends know the difficulties my child is having:
 never sometimes often
10. I speak to my child's guidance counselor to plan for my child's future:
 never sometimes often

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LEARNING PROGRAM

11. I praise my child with learning problems:
 never sometimes often
12. I have taken my child to the doctor to see why he or she does not learn:
 never sometimes often
13. I help my child with his or her homework:
 never sometimes often
14. I spank my child for not learning:
 never sometimes often
15. I insist that my husband/wife go to school with me:
 never sometimes often
16. I punish my child for not learning:
 never sometimes often
17. I praise success:
 never sometimes often
18. I make excuses for my child:
 never sometimes often
19. I tell my child with a learning problem to be more like his brothers or sisters:
 never sometimes often
20. I do my child's homework and let the teacher think it was his:
 never sometimes often
21. I let my child know when he or she is wrong:
 never sometimes often

CONEY ISLAND HOSPITAL CHILD PSYCHIATRY
LEARNING PROGRAM

22. I don't know what to say to my child with a learning problem:
 never sometimes often
23. I accept my child's marks whatever they are:
 never sometimes often
24. I read to my child:
 never sometimes often
25. My husband/wife is too rough on my child with a learning
 problem:
 never sometimes often
26. My husband/wife and I agree about our child's learning problem
 and how to deal with him or her consistently:
 never sometimes often

Thematic Curriculum: For Group Group Advocacy Program

Goal Number One:

To Demonstrate Parents Can Be Trained

Objective (1) Information; Knowledge About Learning Disabilities

I. Overview of Learning Disabilities

1. What are learning disabilities (causes)?
 - a. organic
 - b. psychological
 - c. biological
 - d. hormonal
 - e. chemical
 - f. accidental - traumatic
2. Why is there confusion about learning disabilities?
 - a. no one etiology
 - b. early in field
 - c. subsumed by other fields
 - d. very little known about learning in general
 - e. brain not a structure which can be seen
 - f. individuals have their own learning styles
3. Why is there confusion about learning in general?
 - a. little known about learning
 - b. variations in way people learn
 - c. many theories of learning
 - d. brain not a structure which can be seen
4. Who are the experts in learning disabilities?
 - a. no real experts
 - b. parents make big contributions
 - c. give list of books and resources
5. What are the symptoms of learning disabilities?
 - a. reversals
 - b. sloppiness

- c. non-retention
 - d. eye-hand coordination problems
 - e. hyperactivity
 - f. lethargy
 - g. destruction
 - h. confusion
 - i. developmental lag
 - j. uneven performance
 - k. child tests about normal range of intelligence
6. What are the Organizations of learning disabilities?
- a. ACLD (Association of Children with Learning Disabilities)
 - b. Orton Society
 - c. DCLD (Division for Children with Learning Disabilities)
 - d. Council of Exceptional Children
 - e. Advocates for Children
7. What is the history of learning disabilities?
- a. Orton
 - b. brain-injured children
 - c. MBD (minimal brain damage)
 - d. learning disabilities
 - e. specific learning disability
 - f. specific developmental disability
8. Why are specific academic skills hard?
- a. learning style
 - b. cognitive processing
 - c. confusion about how kids learn
9. Why is homework given?/What is the theory behind homework?
- a. learning
 - b. relearning
 - c. review
 - d. cover material not covered in school
 - e. expanded work

10. What is Public Law 92-142?
 - a. give handout
 - b. school's responsibility
 - c. parent's responsibility
 - d. parent and school team
11. Let's discuss material on Public Law 92-142.
 - a. types of help can get (general education)
 - b. types of help can get (special education)
 - c. resource room -- special school
 - d. evaluation
 - e. COH hearing
 - f. discuss rights of parents
12. What can parents do to specifically help their children?
 - a. talk to teachers
 - b. talk to guidance counselors
 - c. talk to principals
 - d. talk to other parents
 - e. join Special Education PTA

II. Objective (2) Attitudes Towards Learning Disabilities

1. Do kids with learning disabilities get special treatment?
 - a. learning disabilities affect the whole family
 - b. don't hide problems
 - c. talk to siblings about child with learning disabilities
2. How do you approach the school?
 - a. there is a protocol
 - b. teacher first
 - c. guidance counselor
 - d. school psychologist
 - e. assistant principal
 - f. principal

3. How do you feel about your child's school?
 - a. it is a good school
 - b. it is an unfair school
 - c. does school dislike your child
 - d. does school see me as a parent who cares
4. How do you feel about your child's teacher?
 - a. the teacher has it in for him
 - b. teacher is very good
 - c. teacher says he is stupid
 - d. teacher lets him get away with anything because of learning disabilities
5. Can your child do the homework?
 - a. if yes - ok
 - b. if no - speak to teacher, get different homework
 - c. don't struggle with homework child cannot do
 - d. child must be able to do it on their own with support
 - e. don't do the child's homework every night
 - f. avoid situations where child is forced to do homework too hard for him.
6. What about my child's future?
 - a. do you think about work
 - b. do you think about college
 - c. do you think about marriage
7. The hardest thing to do is to view your child's future problems.
 - a. try to visualize
 - b. will my child catch up
 - c. it's too far removed to look at
8. When do you start planning for child's future?
 - a. from the beginning
 - b. what does it appear that my child is good at
 - c. what about now

9. What about your friends?
 - a. join clubs - YMCA
 - b. parents make arrangements
 - c. learning disabled kids often have no peer group as they get older
 - d. special groups
10. Should my learning disabled child go to camp?
 - a. good way to make friends
 - b. parents need a break
 - c. helps separation
 - d. many special camps (residential or day)
11. Does anyone feel angry about having a learning disabled kid?
 - a. general discussion
 - b. don't push too hard
12. Who will think about my learning disabled child when I am gone?
 - a. general discussion
 - b. hard to get in touch with
 - c. does problem get inherited by siblings

III. Objective (3) Specific Advocacy Behaviors Improved By Parents

1. What are your rights as parents?
 - a. Public Law 92-142
 - b. go to the school
 - c. sharing of information law
2. What are your rights, specifically for your child?
 - a. speak to school-based support team
 - b. COH must evaluate my child
 - c. COH must share results with me
 - d. private evaluation can be used
 - e. parent can be represented at COH conference
 - f. parent can refuse placement
 - g. parent can visit placement
 - h. parent can abort process at any time

3. What is best way to deal with schools?
 - a. both parents attend
 - b. fathers get more attention
 - c. be direct
 - d. don't be intimidated
 - e. find the hierarchy of power
 - f. don't allow yourself to be pushed around
 - g. school can be helpful if you approach them with appreciation

4. What is best way to deal with teachers?
 - a. let teacher know you are concerned
 - b. share information with teacher
 - c. ask for reports of progress often
 - d. don't hound the teacher
 - e. communicate with the teacher by letter
 - f. try to develop a relationship with your child's teacher

5. How can a parent deal effectively with the Committee on the Handicapped (COH)
 - a. know your rights
 - b. send communications by letter
 - c. save all material sent to you
 - d. attend all conferences
 - e. know exactly what you are signing
 - f. speak with organization called Advocates for Children
 - g. remember the parent must be in agreement with any placements recommended at the hearing

7. What are some specific advocacy behaviors which are directed to the community?
 - a. PTA
 - b. parent organizations in schools
 - c. attend educational conferences
 - d. support school functions
 - e. join advocacy organizations
 - f. speak up at meetings
 - g. active role in all community endeavors

8. What are some of the emotional and residual by-products among children with learning disabilities?
 - a. misbehavior
 - b. conduct problems
 - c. blamed for everything
 - d. class clown
 - e. passive depression
 - f. loner
 - g. misunderstood; seen as dumb, retarded, etc.

9. Do learning disabilities run in families?
 - a. mother had learning disabilities
 - b. father had learning disabilities
 - c. multiple handicaps among siblings

10. How many feel individual therapy or counseling is important to a parent of a learning disabled child?
 - a. very helpful
 - b. helps parent deal with their own problems
 - c. should be offered by the school
 - d. can stigmatize the family

11. How many feel individual therapy or counseling is important to child with learning disabilities?
 - a. child doesn't always understand
 - b. for some yes, not all
 - c. some children have enough insight
 - d. depends on age of the child

12. Does everyone here feel as if they have gone through a lot?
 - a. we all survived
 - b. it was worth it
 - c. we want the best for our kids
 - d. we want our children to feel good about themselves

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