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# CHAPTER ONE

## INTRODUCTORY ORIENTATION

### 1.1 INTRODUCTION

Although there was a gradual awareness of learning disabilities more generally after World war 2, it was not until the late 1960's that comprehensive assessment and special education were provided in schools. Several factors fostered such programmes in the USA, including legislation, parental pressure, teacher preparation and the development of professional organisations (Rockford & Archer 1991:53-72). According to Smith (1994:3) several forces came together to catalyze the birth of learning disabilities as a new field in special education.

For those of us who have spent the better part of our careers teaching, researching and writing about learning disabilities, it is perhaps easy to overlook the fact that learning disabilities as a field is still relatively young. Samuel Kirk (Hallahan & Cruickshank 1973:56) is often credited with introducing the term "learning disabilities" at a parents' meeting in 1963. The following year the Association for Children with Learning Disabilities was formed. It was not until 1969, however, that the federal government (U.S.A) officially recognized a category in the Children with Specific Learning Disabilities Act, Public Law 91-230 (Hallahan & Cruickshank 1973:56; Wiederholt 1974:103-152).

Although much of the early work in learning disabilities was based on previous work with children with mental retardation, brain injury and aphasia, it is easy to say that active, professional attention towards children with learning disabilities did not emerge until the mid to late 1960's. Thus, we have been engaged in the formal study of learning disabilities for only 20 to 30 years. Although 20 to 30 years may seem a long time to a culture obsessed with youth, it is not much more than an eye blink to scientists engaged in serious study of a phenomenon as complex as learning disabilities, or to educators grappling to come up with the best ways to identify and educate these children.

In 1976 (when the federal government, USA first started keeping figures on the number of students with handicaps served) they were only seven years beyond the formal federal recognition of the learning disabilities category. In addition, the federal governments issuance of regulations on diagnosing learning disabilities in 1977 coincided with the mandate for localities to report figures on numbers of students served (Hallahan 1992:524).

It is reasonable to conclude that the relative youth of the learning disabilities category has had something to do with the increase in the prevalence of students identified for learning disability services. In the late 1970's parents and professionals, as well as the federal government, were only beginning to comprehend learning disabilities. They were wrestling with how best to identify and serve students with learning disabilities. It is possible that in the late 1970's not all students with learning disabilities were being identified for services. Perhaps with each successive year parents and school personnel became more and more adept at recognizing

children with learning disabilities, until by the late 1980's and early 1990's, they had begun to identify nearly all students to be served as learning disabled (Hallahan 1992:524).

A longitudinal analysis of prevalence data is consistent with this interpretation. As noted in the quote from the 13<sup>th</sup> annual report to Congress, the rapid increase in prevalence has slowed in recent years. The report uses the adverb "somewhat". Hallahan (1992:524) argues that a more appropriate modifier is "substantially". Yearly prevalence rates for learning disabilities have been almost one-sixth as much as they were prior to 1983-1984 (US Department of Education, 1990).

The dramatic increase in students served as learning disabled. As a result of the reflection of professionals' and parents' growing recognition of the condition of learning disabilities and how to deal with it (Hallahan 1992:524).

There is growing concern for children and youth with learning disabilities. The enigma of the youngster who encounters extreme difficulty in learning is however not new. Children from all walks of life have experienced such difficulties throughout the years. In fact, some of the world's most distinguished people had unusual difficulty in certain aspects of learning (Lerner 1989:4).

Nelson Rockefeller, who served as vice president of the United States and governor of the state of New York, suffered from severe dyslexia, which is extreme difficulty in learning to read. His poor reading ability kept him

from achieving good grades in school, and the affliction forced him to memorize his speeches during his political career (Time, Sept 2, 1974). Rockefeller says "... after coping with this problem for more than 60 years, I have a message of hope and encouragement for children with learning disabilities - and their parents" (Lerner 1989:12-14).

As a child, Thomas Edison, the ingenious American inventor, was called abnormal, addled, and mentally defective (Lerner 1989:4). Auguste Rodin, the great French sculptor was called the worst pupil in his school. Woodrow Wilson, the scholarly 28<sup>th</sup> president of the USA, did not learn his alphabet till he was 9 years old and did not learn to read until age 11. Albert Einstein, the mathematical genius, did not speak until age three.

According to Lerner (1989:6) it is important that we recognise that interpretations of the learning problems of these historic figures are derived from biographical data. She cautions about the vulnerability of posthumous diagnoses. Yet we do know that some children are both learning disabled and gifted. These persons of eminence fortunately were somehow able to find appropriate ways of learning, and they successfully overcame their failures. Many youngsters with learning disabilities are not so fortunate.

During the past quarter of a century, community services have begun to reflect social ideals of normalization, empowerment and enfranchisement for persons with disabilities. However families have not been included actively in efforts to open the mainstream of society to citizens with disabilities, despite the fact that they are the primary and often lifelong

support for most persons with developmental disabilities (Singer & Irvin 1989:3).

Historically, society has largely treated people with disabilities as if they fell into a special class of human beings not entitled to the same rights and opportunities accorded to other individuals. This devaluation was, and often still is reflected in the services available to them and their families (Biklen & Knoll 1987:3-24). Fortunately, the late 1980's have seen a growing awareness of the abuse that can be festered by this kind of differential treatment and a concomitant growth in the movement of parents and self-advocates demanding recognition and respect. These forces have contributed to a reorientation of services to people with special needs and their families, away from the specialized and the segregated towards the typical and the integrated.

Specifically in the area of services for families one might see a reaffirmation of the fundamental rights of children and families (Taylor, 1989:41). The role of parents in creating and maintaining quality services should be obvious. Parents have the keenest motivation for bringing about individual and systematic change for people with developmental disabilities, and banding together, they may have the power to change the actions of governments and the attitudes and daily functions of society (Warren & Warren 1989:55).

X No succinct model presently exists through which one can develop an empirical understanding of families of learning disabled children. Rather, investigators have seemed to rally around the concept of anticipated

pathology in these families. Pathological adaptations are generally assumed to be a function of the stress associated with the presence of a learning disabled child, and have led to the development of a stress-reaction hypothesis to explain maladaptive family functioning. If one subscribes to the family systems theory that family members interact in a transactional manner, it follows that a child's learning disabilities would have ramifications on the parents, family system and siblings (Dyson 1996:280).

Although the stress associated with the presence of a retarded child is an important consideration, its impact on the family is likely to be related to the family members' cognitive appraisal of the stress situation and the families' coping resources which include the broad categories of health/energy/morale, problem-solving skills, social networks, utilitarian resources and general and specific beliefs. In turn, the families' coping resources and function are like to be mediated by the ecological systems within which they must interact and be acted upon. Such ecological systems include not only the immediate environments of home, schools, agencies, neighbourhoods, workplaces, and social networks, but also the interrelationships among these ecological systems as well as the institutionalized attitudinal patterns of the culture and subculture manifest in these systems (Crnic *et al* 1983:126).

Singer and Irvin (1989:3) feel that two major ideas have emerged from the study of families : the roles of the family stress and the concept of family life cycle. According to Schilling, Gilchrist and Schinke (1984:47), parents of developmentally disabled children experience more stress, often exacerbated by faulty, misunderstood coping efforts that increase conflict

in the family. Practitioners working with such families encounter a host of problems requiring personal and social resources.

Researchers have investigated how families manage stress, and in particular, how they cope with the multiple stresses of rearing a learning disabled child. Promising areas of inquiry include personal coping strategies employed in buffering and the role of social supports in avoiding and minimising stress (McCubbin 1979:237). Raising a child with a learning disability can be at times, both physically and emotionally exhausting. It is therefore important that parents have external sources of support, from other family members, friends, school, staff, or parent or professional organizations (Waggoner & Wilgosh 1990:97).

Current stress and life cycle theories acknowledge the importance of family coping skills and community resources for facilitating positive adaptation to disability. In practice it has been found that many families can and do adapt successfully and, as a consequence, view their disabled relative as an important and valued member of the family. From experience it has been found that while many families do cope, others do not. At the same time stress theory has directed our attention to circumstances that weaken families and exacerbate distress. Therefore, preventive as well as ameliorative services are needed to assist families. When both family stress and life cycle are considered, the need for changing services over time is apparent (Singer & Irvin 1989:3).

In some areas, remedial facilities such as remedial teachers and remedial centres are not available; therefore parents of learning disabled children

need to be better equipped with knowledge of, for example resources that are available, such as parent training workshops.

## **1.2 INVESTIGATION OF THE PROBLEM**

In the investigation of the problem, attention will be given to the awareness and dissertation of the problem, after which the problem will be stated.

### **1.2.1 Awareness of the problem**

The writer has worked as a psychologist since 1975 and has found that families vary widely in how they respond to stressful events when there is a family member with a learning disability. These stressful events may interfere with some families' ability to cope well and some families may even be strengthened by this experience. Much would depend on family coping, support and intervention.

Gallagher *et al* (1983:10) reviewed the literature on the stress experienced by families of children with handicaps, and concluded that these families not only face the normal pressures and tensions of family life in our present society, but also must adjust to the presence of a child with a handicap. They described such families as facing a unique set of problems and stressors, a better understanding of which can only enhance the relationship between professionals and the parents, since these families spend a significant amount of time in interaction with professionals (Waggoner & Wilgosh 1990:97).



Because educators are recognising the importance of involving the parents in the remediation process, it is necessary to understand all the concerns of these families (Faerstein 1981:420). Hence the focus of this research will be on the experiences of such families at home, within the school setting, and in the community.

Stress and coping theory suggest that differences in families' reactions to learning disabilities may be related to the amount and quality of resources available to them. Among those resources is the family's perception of the event, which involves cognitive adaptation using certain coping skills that will help them think about stressful events in a way that makes them feel better. Another resource would be professionals who would help the family cope as suggested by Slater *et al* (1989:161). The professional's role in his or her work with the family would be that of a facilitator, strengthening the ability of the family to gain access to needed services while increasing what Summers, Behr and Turnbull (1989:27) call the family's mastery of coping with a learning disabled child. Slater *et al* (1989:161) describe several new roles that professionals should play, including systems assessors, systems convenor, systems evaluator, systems trainer and family therapist.

Hanson *et al* (1989:207) stress the co-ordination role, the virtues of collaboration, and note the importance of service mobilization. The revamping of service systems must include the design of mediating structures that have the ability to draw together the diverse services needed by families. No one agency, whether it is the school system, the welfare system, or the disability caretakers will be able to meet all the needs of the

family at the varying developmental stages (Bradley 1989:354). This research will encompass study of the above aspects.

From experience it has been found that parents have difficulty in accepting that they have a child with a learning disability and that they are unaware of specific coping mechanisms they could acquire from professionals. Some examples of these professionals are special class teachers, remedial teachers, psychologists, social workers and support services. Many parents are unaware that they are able to observe lessons being taught, interact with other parents who have learning disabled children, participate in talks and seminars.

In the researcher's line of work with parents of learning disabled children, she had found that the initial contact with parents was extremely stressful as parents were unaware of how to cope firstly with the fact that their child has a learning disability and secondly with how to go about assisting their learning disabled child. Once parents are provided with ongoing counselling on coping with their stress and stress management, and after the child's psycho-educational assessments and remedial measures are implemented, there has been significant positive feedback from parents and children.

The study embraces the relationships between perceptions and family well-being using Ellis's Rational-emotive therapy (which aims at bringing persons with emotional problems to rational insight about their emotions), thereby contributing to a better understanding of the role of perception in family coping. The researcher would also use Ayurvedic principles as this

would encompass completely a holistic approach to life (Svoboda 1980:1). As the term Ayurveda is a new term for Westerners, it is necessary to provide explanation and meaning to Ayurveda.

Ayurveda is a Sanskrit word which means the 'Knowledge of Life'. Its roots are buried deeply in the ancient culture of India. Ayurveda is an all-encompassing science which combines scientific facts and profound empirical observations of man and his connection to the Cosmos through the basic elements which are found in all life-substances. These substances in nature, according to Ayurveda, are considered to have healing qualities, and are used to treat the disordered life-principles (Svoboda 1980:1). According to Devaraj (1992:V11) Ayurveda is concerned with the well-being of the human community. Ayurveda has a vital role in ensuring mental and physical well-being. According to Hindu mythology, Ayurveda is described as the medicine of the gods, just as the Egyptian and Greek medicines were of Thoth and Apollo (Dube, Kumar & Dube 1985:13-22). Ayurveda is a healing system widely practiced throughout South Asia (Trawick 1991:121). Thus the researcher has given in detail the awareness of her problem of her research and the dissertation of the problem will be outlined.

### **1.2.2 Dissertation of the problem**

So much research has been done with children who are learning disabled, therefore it is the intention of the researcher to assist in the management of these children. The best way would be through the parents so that both parent and children could live a better and meaningful life.

All families experience stress from time to time. Many care-giving families are subject to added stressors or reduced coping resources because of the demands of caring for a family member with disabilities. Stress theory provides a normative framework for understanding family problems, and it offers a basis for organising preventive and ameliorative support and education efforts (Singer & Irvin 1989:3).

Families who have a member with a disability have long been objects of pity. Society as a whole tends to view the presence of a child with disability as an utterable tragedy from which the family may recover (Summers *et al* 1989:27).

Although much has been done for disabled persons, their families have not always been included. Recent literature (Singer & Irvin, 1989:4) have suggested the multi-disciplinary team of professionals and family to improve coping on the part of the parents and also on the part of the child.

Shapiro and Forbes (1981:449) have found that the attitude towards parental involvement is commonly advocated, its translation into practice varies widely. There is need for systematic presentation of the available studies of training programmes for parents of learning disabled children.

The researcher has vast experience as an educational psychologist and with parental counselling programmes; and would be able to provide many success stories. What worries the researcher, is the ignorance on the part of the parents before they start therapy and that much of their fears would

have been alleviated had professionals, doctors and teachers given some direction.

The day to day experiences of many thoughtful service providers have cast doubt on the universal validity of that perception about families who have members with disabilities.

To be sure, one encounters families who seem to fit the stereotype i.e. who are unable to cope with the emotional implications of disability and/or the daily demands that are placed on them as a consequence of the disability. There are other families who do quite well, with or without interventions from service providers. These families are said to have made a positive adaptation to their child with a disability (Summers *et al* 1989:27).

Seldom are research literature or the textbooks designed to prepare practitioners to work with families who have members with disabilities. Families who successfully meet the challenge of a child with a disability have much to teach us, so that we may provide support to those who are struggling, and also about our own attitudes of people with disabilities.

### **1.2.3 The problem stated**

The researcher's extensive contact and experience with children in both the educational setting as well as in her private practice as an educational psychologist initially made her aware of the phenomenon of the extreme stress of parents with learning disabled children. She found that parents

were stressed not only because their child was learning disabled but also because they were unable to deal with the stress itself.

The stress parents experience when they discover that their child is learning disabled is due to them having insufficient knowledge about the disability. The question arises if parents will experience less stress, or will be able to cope with the stress if they are taught cognitive coping strategies.

It can be hypothesized that parents who have learning disabled children can be taught cognitive coping strategies. As parents have had inadequate experience with regard to learning disability, effective parenting programmes (individual and group sessions) using Rational-emotive therapy, may help improve their ability to cope in a more positive way with the child's disability. By adopting these approaches, this in turn would have a positive effect on their families and service providers. Of particular interest to the researcher is the use of Ayurvedic philosophy which adopts a holistic approach to therapy. Therefore the specific statement of the problem is **that parents of learning disabled children would be able to better cope with stress and manage their learning disabled child more effectively when they are exposed to Rational-emotive therapy and Ayurvedics.**

### **1.3 THE AIM OF THE STUDY**

The focus of this investigation is on cognitive coping strategies of parents who have learning disabled children. The study is designed primarily to investigate the hypothesis that parents who have learning disabled children

can be taught cognitive coping strategies pertaining to their stress and management of their child's learning disability.

Aid to parents of learning disabled children, will include the family situation (parents and siblings) and incorporate a theoretical investigation on cognitive coping strategies. Empirical studies on the impact of children with learning disabilities on their family attitudes are varied in their responses to their children and the challenges surrounding them. Recent research has focused on identifying variables that distinguish families that are resilient in the face of these challenges, from those who are less successful.

After a thorough literature investigation, a therapeutic aid programme (**Chapter 4**) based on the literature will be described. Research in the area of cognitive adaptation suggests that the ability to perceive positive benefits, to compare oneself favourably with others, to identify a perceived cause, and to perceive that one has mastery or control over the situation, are related to positive coping. Use of these cognitive coping strategies allow to make that situation seem less stressful. Positive coping is demonstrated by lower levels of depression and stress and more active involvement in service programmes, among other outcomes. However, research studies along this line have primarily been conducted among populations other than families of children and adults with disabilities e.g. cancer patients.

**Chapter five** will include the research design and **Chapter six** a report of the implementation of programmes whereby an aid programme will be

applied to a number of parents of learning disabled children and how they were aided. The researcher will be able to determine whether the programme was effective by a pre and post test of parents level of stress. **Chapter seven** will report on the findings, conclusion and recommendations of the research.

The overall purpose of this research is to develop self-reported use of cognitive coping strategies and to examine their relationship to outcome measures of family well-being and stress among parents who have children with learning disabilities. Specifically the research has the following major objectives:

1. Develop self-report measures of positive contributions and social comparisons.
2. Conduct a validation study among parents who have children with disabilities (from birth to 12 years) to determine relationships of these measures to social desirability and to measure stress and family well-being.
3. Conduct post-hoc analyses on the data among respondents who are parents of younger children, ages birth to six, with learning disability, to identify:
  - a. patterns of response on the coping measures as distinguished from respondents from 7 to 12 years and
  - b. differences between mothers and fathers in self reported use of these coping strategies in their relationships to stress and family well-being.



## **1.4 SIGNIFICANCE OF THE STUDY**

This research will make a contribution to cognitive coping theory by further delineating and refining the dimensions of coping. The use of these coping strategies will provide a vehicle for more in-depth quantitative investigation of this phenomenon, which has previously been studied largely through qualitative methodologies. Findings will lead to an enhanced understanding of these disabilities by examining the relationship of these strategies to stress and family well-being. Furthermore the these coping strategies by families of children with learning disabilities by examining the relationship of these strategies to stress and family well-being. In addition the patterns of use of these strategies could be made across various independent variables e.g. sex of parent, participation/non-participation in support groups, income etc.

This line of research has implications for:

- 1) developing interventions that assist families to enhance their use of cognitive coping strategies
- 2) developing training programmes to help professional's increase their understanding of cognitive strategies and ways to facilitate the use of these naturally occurring processes among families of children with disabilities
- 3) in-depth investigation of these coping strategies among families of children with learning disabilities.

Although much has been done for disabled persons, their families and service providers have not been included. The research is intended to be useful, also, for family service providers, students who are preparing for work with families, and parents and their allies who are advocating for support service.

## **1.5 EXPLANATION OF TERMS**

There is a need to define the terms that are essential to the study in order to give the reader a clear conception of the problem and the approach to this investigation. The first general broad definitions will be given but this will be restricted, where applicable, to suit the context in which they are used. Terms such as learning disability, Rational-emotive therapy, Ayurvedic Philosophy, psychotherapy, coping skills, cognitive coping and stress will be used in the out-lying chapters.

**Learning disability (LDA):** when a child who has average or above average intelligence is unable to cope with his/her school programme. A child's learning disability presents pervasive and complex dilemmas for the family. Both educators and family therapists have come to recognise that effective responses to the child's learning and behavioural needs require an understanding of the effects of the child's disability on the family's system (Falik 1995:335-341). It is frequently mentioned that many children with learning disabilities have psychosocial adjustment problems such as hyperactivity, problems with aggression, difficulties in social interactions, and low self-concept, at least as it relates to academic competencies (Michaels & Lewandowski 1990:446).

**Rational-emotive therapy (RET):** brings persons with emotional problems to rational insight about their emotions, thereby contributing to a better understanding of the role of perception in family coping. RET is a cognitive-behavioural therapy approach founded by Albert Ellis (1962:10) that theorizes that emotional and behavioural problems are mainly caused by irrational beliefs (Guttermann 1992:440). According to Weinrach (1996:326) RET is regarded as both a counselling theory and a philosophy. RET is a humanistic, existentially oriented approach designed to assist clients to make a profound philosophic change. RET considers an appropriate or healthy emotional reaction as one that is helpful, as opposed to harmful. The addition of the word behaviour in Albert Ellis's system of therapy now called Rational-Emotive-Behaviour Therapy (REBT) is in recognition that behaviour is and has always been an essential aspect of his theory (Corsini 1995:5). REBT encourages our goals, desires and inclinations and urges us to minimize our disturbances and proceed onward to greater self-actualization. It therefore fosters this important dual aspect of psychotherapy and counselling (Ellis 1996:119).

**Psychotherapy:** Counselling the parents of the learning disabled child includes giving assistance with both practical and emotional issues. Counselling can be referred as a continuum with psychotherapy at the one end aimed at helping the parents to become aware of and explore their feelings, anxieties and defence mechanisms (Joubert 1987:17). Counselling aimed directly at parents of students is also becoming far more widespread than in the past. Informational programmes, psychotherapeutic

programmes for parents and their children, and parent training programmes were all increasing in use (McCarney 1987:37).

**Ayurvedic philosophy:** Ayurveda has a vital role in ensuring mental and physical well-being. What allopathy is to the West, Ayurveda, the science of indigenous medicinal plants, is to the East (D'Souza *et al* 1992:114). Ayurveda generally advocates multipronged therapeutic strategy comprising of both purificatory and palliative as well as internal and external drug administration for lasting relief to the patient (Ramu *et al* 1992:1-16). Balodhi (1989:49) states that ancient Indian treaties have been the fountain head of pragmatic thinking including that of community mental health, they have always been the guiding source for India's social, religious and cultural behaviours. It is in the area of Ayurvedic education that one sees very clearly the extent to which the forms and content of Western medicine were absorbed by the profession of Ayurveda.

**Coping skills:** The term "coping" is usually used to describe an individual's ability to "get on in life". Certain coping processes increase the risk of maladjustment and disturbance and certain reduce the risk of an unfavourable development (Mutzell 1994:75). According to Margalit *et al* (1992:202-209) coping can be defined as cognitions and behaviours used by the individual in evaluating stressors and initiating activities with the aim of decreasing their impact. The three most important coping skills parents may use to help their learning disabled child are: being alert, support and encouragement, working with the school.

**Cognitive coping:** means thinking about a particular situation in ways that enhance a sense of well-being. Cognitive therapy helps parents with anxiety neurosis to identify their automatic thoughts or the “things they tell themselves” (Beck & Rush 1985:358).

**Stress:** Stress arises from any conflict between demand on a person and his ability to cope; or what he thinks a demand is; and what he thinks his ability is; an imbalance causes stress (Jones 1991:194). Many parents may suffer stress relating specifically to bringing up their offspring. Parenting a child with special educational needs may be associated with an added burden of stress. Twenty-four hour caring and an extended period of infancy can result in, demands on physical stamina, social embarrassment, and a breaking of family developmental expectations. Such strain may result in family discord.

## 1.6 DEMARCATIION

The researcher will randomly select five sets of parents from a population of four hundred parents who have children with learning disability. The parents will be from the greater Durban area belonging to the Asian population. The research was open to all population groups. The researcher would use cognitive coping skills of parents so that it would enhance their sense of well-being and in turn improve their learning disabled child's too!

## **1.7 PROGRAMME OF STUDY**

The researcher intends to apply a theory to explain cognitive adaptation among individuals who experience the long term challenges associated with parenting children with disabilities.

The research programme consist of the following chapters:

**Chapter two:** Learning disabilities describing causes and manifestations and the contribution to stress of parents.

**Chapter three:** Aid to parents of learning disabled children will include the family situation.

**Chapter four:** Design of a cognitive coping skill programme. Cognitive coping strategies would be used to help parents to be less stressful.

**Chapter five:** Research design will describe the research in detail.

**Chapter six:** Report of implementation of the programme will be described.

**Chapter seven:** Report on findings, conclusion and recommendations of the research will be given in detail.

## 1.8 CONCLUSION

The research on cognitive coping strategies with parents of learning disabled children began as a result of the researchers personal interests and observations that many families not only cope successfully with the challenges associated with disabilities, but seem to make a transition to higher levels of well-being.

With family stress and coping theory and cognitive adaptation theory as the framework for research design and instrument construction, the researcher embarked on a course of empirical study to measure perceptions and investigate their relationships to successful coping outcomes. If greater understanding can be incorporated into the training of those who work with these individuals and families, it is possible that services can be planned and provided that are more sensitive to natural coping processes and that encourage positive adaptation.

In this chapter an orientation is given to the background of the problem, statement of the problem, aim, importance and programme of the study. The different terms have been explained and the research has been demarcated. To be able to research coping mechanisms for family of LDA (learning disability) it is necessary to know what LDA implies and for that reason chapter 2 will be used to report on the phenomenon LDA.

## CHAPTER TWO

### LEARNING DISABILITIES

#### 2.1 INTRODUCTION

According to Shelby (1994:11) one child out of every ten in the United States has a learning disability. This can be a very traumatic phenomenon for parents to deal with, but these children can and do learn, given the proper help.

This chapter focuses attention on: definition of learning disabilities, causes of learning disabilities, manifestations of learning disabilities and contribution of learning disabilities to the stress of parents.

#### 2.2 THE CONCEPT OF LEARNING DISABILITY

The term **learning disabilities** evolved from labels to **brain injury** and **minimal brain dysfunction** (Smith 1994:71). Learning disabilities are a complex of subtle, interrelated problems that affect many areas of a child's learning and development over long periods of time, possibly for life (Hammill 1990:74-84). In order to be classified as having a learning disability Shelby (1994:17), indicated that a child must have at least average intellectual potential and be functioning below that which is expected on the basis of his intellectual potential. In addition, the child must show these academic deficiencies in spite of having had adequate learning opportunities. This means that youngsters are included who do very well



in some ways, but are having difficulty in at least one subject. Each child's needs are unique, which is why they learn best if individualized programmes are set up for them.

Lerner (1989:6) points out that the term "learning disabilities" was first introduced in 1963 and that although it had immediate appeal and acceptance, the task of developing a definition proved to be a challenge. According to Lerner (1989:6) a definition is "..... impossible to define, but you always know it when you see it."

According to Rockford and Archer (1991:55) a learning disability (LD) is a handicap which affects the manner in which individuals take in information, retain it, and express the knowledge and understanding they possess.

Probably the most widely used definition is the one incorporated in Public Law 94 - 142, or the Education for All Handicapped Children's Act (1975), and the Reauthorization of the Education of the Handicapped Act (1986), (in Rockford & Archer 1991:55) .

There are actually two parts to the federal definition. The first appears in the major body of the rules and regulations of Public Law 94 - 142 and was adapted from a 1968 report to Congress of the national Advisory Committee on Handicapped Children (in Lerner 189:6).

This definition reads: Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in

using language spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage (Hallahan *et al* 1985:14).

The second part of the definition is considered operational and appears in a separate set of regulations applying to Public Law 94 - 142 concerned with learning disabilities (US Office of Education, December 29, 1977). It states that a student has specific learning disability if the student does not achieve at the proper age and ability levels in one or more of several specific areas when provided with appropriate learning experiences, and the student has a severe discrepancy between achievement and intellectual ability in one or more of these seven areas:-

- a. oral expression
- b. listening comprehension
- c. written expression
- d. basic reading skill
- e. reading comprehension
- f. mathematics calculations
- g. mathematics reasoning.

To summarize, the federal definition of learning disabilities in Public Law 94 - 142 contains the following major concepts:

- 1) The individual has a disorder in one or more of the basic psychological processes. (These processes refer to intrinsic prerequisite abilities such as memory, auditory perception, visual perception and oral language).
- 2) The individual has difficulty in learning, specifically, in speaking, listening, writing, reading, word recognition skills and comprehension, and mathematics (calculation and reasoning).
- 3) The problem is not primarily due to other causes, such as visual or hearing impairments, motor handicaps, mental retardation, emotional disturbance, or economic, environmental, or cultural disadvantage.

A severe discrepancy exists between the student's apparent potential for learning and low level of achievement (Lerner 1989:7).

Since the definition within Public Law 94 - 142 was formulated, many other definitions have been proposed by various groups and organisations. A definition that is proving to be influential was proposed by the National Joint Committee on Learning Disabilities (NJCLD, 1987), an organisation of representatives from several organisations and disciplines involved with learning disabilities. The NJCLD definition states that: Learning disabilities is a generic term that refers to disorders manifested by significant difficulties in the acquisition and the use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are inherent in the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly

with other handicapping conditions (e.g. sensory impairment, mental retardation, social and emotional disturbance, inappropriate instruction, and psychogenic factors), it is not the direct result of those conditions or influences (Vogel 1983:197-202).

To summarize, the NJCLD definition contains the following concepts:

1. Learning disabilities are a heterogeneous group of disorders (individuals with learning disabilities exhibit many kinds of problems). The problem is intrinsic to the individual (learning disabilities are due to factors within the person rather than to external factors, such as the environment or the educational system).
2. The problem is thought to be related to a central nervous system dysfunction (there is recognition of the biological basis of the problem) (Lerner 1989:8).

As the field has gained recognition, many countries have developed their own definitions of learning disabilities. Most countries have programmes for learning disabilities e.g. Ontario Ministry of Education (1984) in Canada and the Warnock Report in England identifies and defines children with specific learning disabilities.

A definition of specific learning disabilities, as suggested by the Board of Directors of the Association for Children and Adults with Learning Disabilities (1984:52), is "... a chronic condition of presumed neurological origin which selectively interferes with development, integration, and/or demonstration of verbal and/or non-verbal abilities. Specific learning

disabilities exist as a distinct handicapping condition in the presence of average to superior intelligence, adequate sensory and motor systems, and adequate learning opportunities. The condition varies in its manifestations and in degree of severity. Throughout life, the condition can affect self-esteem, education, vocation, socialization, and/or daily living activities.”

Barsch’s definition of learning disability is a concise one: “a child with a learning disability is one with adequate mental ability, sensory processes and emotional stability who has specific defects in perceptual, integration of expressive processes which severely impair learning efficiency. This includes children who have central nervous system dysfunction which is expressed primarily in impaired learning efficiency” (Neurological and Sensory Disease Control Program, 1969:24-28). To this, Kaslow and Cooper (1978:42) add that they do not go along with the frequent assumption that the disorder exists in and of itself, relatively independent of factors in the child’s external environment, rather family dynamics and structure provide the context in which the child with his disability resides.

According to the definition given by the Southern African Association for Learning and Educational Difficulties (SAALED), a specific learning difficulty is a permanent disorder which affects the manner in which children with normal or above average intelligence take in, retain and express information, thus creating a significant delay in one or more areas of learning. Incoming or outgoing information may become scrambled as it travels between the eye, ear or skin and the brain. It is often inconsistent and may present problems some days but not all, or may be noticeable at different stages in a child’s life, but not all (Bateman 1995:13). Although by

definition the term specific learning disabilities excludes children whose learning problems are primarily the result of emotional disturbances, a strong association with emotional problems is frequently reported (Schachter *et al* 1991:323).

The learning disabled (LD) child is one who possesses at a least low average intellectual ability and is not learning to his capacity. His lack of performance (generally in maths and/or reading) is at least six months behind in the primary grades and 18 months to two years in the upper elementary grades. The diagnosis of learning disability applies only to academic learning, since learning disabled children often exhibit strong abilities in non- academic areas. Learning disabilities vary by severity and by area of deficiency. The learning disabled child is often able to learn many things but has great difficulty with specific kinds of learning (Pecaut 1991:29).

Lerner (1989:18) identifies four disciplines that make major contributions to the study of learning disabilities, namely education, psychology, language and medication. In addition, other professions in the helping and research fields participate in an advance with the work done for the learning disabled. Such a mingling of professions has resulted in multidisciplinary breadth to the body of thought concerning learning disabilities.

There are certain characteristics seen more often in children with learning problems than in the general school population. Boys are more likely than girls to have learning disabilities by a ratio of about eight to one. About one-third of youngsters with learning disabilities also have problems with

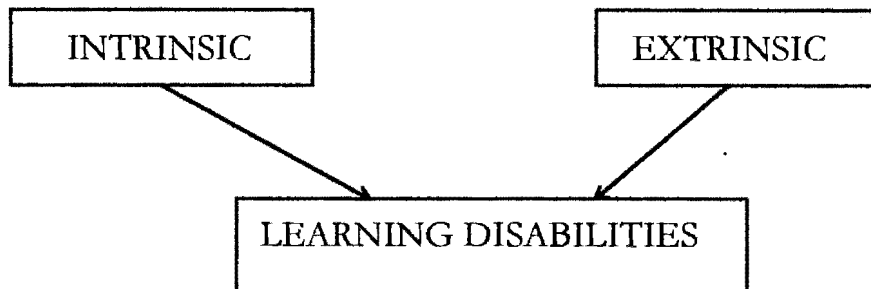
physical co-ordination i.e., such skills as walking and skipping develop little later than average (Shelby 1994:17).

### **2.3 CAUSES OF LEARNING DISABILITIES**

What causes specific learning difficulties is unknown. Although there are many theories, and one must look at a combination of factors acting together to contribute to learning disability. Research indicates that both genetic and environmental factors have a part to play, with socio-economic deprivation causing an increase in some cases (Bateman 1995:14).

Before diagnosis, other recognised causes of poor academic achievement must be excluded, including sensory impairments (vision and hearing defects), motor handicaps (such as cerebral palsy and muscular dystrophy), environmental disadvantage (poor teaching, prolonged or frequent absence from school, adverse cultural factors) and emotional disturbances. It is established that in the great majority of cases genetic factors seem to be the over-riding cause of specific learning difficulties, and a child with a specific learning difficulty is likely to have a close relative who has experienced school-related problems. More boys suffer from the problem than girls, the ratio being three to one (Bateman 1995:14). The ratio according to Bateman differs from that given by Shelby which is eight is to one. This difference could be attributed to the different year of research and different ages. But what is of relevance is that more boys than girls have learning disability.

Many possible causes of learning disabilities have been suggested (Hallahan *et al* 1985:17). There are intrinsic and extrinsic factors.



### 2.3.1 Intrinsic factors

Some of the causal factors of learning disabilities are intrinsic to the individual. Among them are:

- a) genetic factors;
- b) brain injury (due to physical trauma or lack of oxygen before, during, or soon after birth);
- c) biochemicals that are missing (e.g. chemicals necessary for proper functioning of the central nervous system);
- d) biochemicals that are present (e.g. food additives such as dyes' or food substances such as sugars);
- e) environmental factors such as lead or fluorescent lighting (Hallahan *et al.* 1985:17).



There is growing body of literature linking substance abuse in pregnant women to developmental disabilities in their offspring. For example, researchers have accumulated an abundance of evidence that alcohol abuse leads to a variety of physical and mental abnormalities (Schultz 1984:109-110). More controversial are the effects of crack cocaine, a substance whose use has increased dramatically. There is strong evidence that pregnant women who use cocaine, especially when they use it along with other drugs, such as alcohol and marijuana, as they often do, place their unborn infants at risk for developmental disabilities (Chasnoff 1991:113-123; Chasnoff *et al* 1992:284-289).

Although some of these disabilities may not be as pronounced as the popular media have proclaimed, it is plausible that a women's cocaine use during pregnancy would lead to learning disabilities in her child.

### **2.3.2 Extrinsic factors**

Some of the casual factors of learning disabilities are extrinsic to the individual. A few examples of the extrinsic factors are:

- a) psychological or social influences such as cultural differences or disadvantages;
- b) inadequate instruction
- c) poor parenting (Hallahan *et al* 1985:17).

Although many children struggle to read or spell, teachers and parents must know when the struggle goes beyond what is normal. Often a parent can

identify a problem when he or she knows that the child is brighter than his reading or spelling indicates (Bateman 1995:14).

According to Bateman (1995:14) the challenges for the next generation of educators who deal with learning disabilities include accommodating greater numbers of children who experience learning problems. It would appear that an ever increasing pollution of the earth, the widespread, continuing abuse of drugs and alcohol, the lack of parental care in this country (the USA), increasing numbers of children raised in poverty, and the appalling decline in the quality of American education - to mention only a few factors - will ensure a rising number of children with learning disabilities in the near future.

Hallahan (1992:524) hypothesizes that social/cultural changes over the past 20 to 40 years may have led to an increase in the prevalence of learning disabilities in two ways. First social/cultural changes have put the development of children's central nervous system (CNS) at an increasing risk of disruption. Second, they have placed an increasing degree of stress on their families - a stress that has had deleterious consequences for children's social support networks.

According to Hallahan (1992:524) of all the categories of disability, learning disabilities is one of the most sensitive barometers of the bio-medical status of children and the psychosocial climate in which they live. In other words, if you take the human organism and subject it to biological and psychological stress, it will usually take less of that stress to result in

learning disability than to result in another type of disability (e.g. mental retardation and behaviour disorder).

Just as today's children have many more diversions and stress in their lives, so too, do their parents. On top of concerns about raising their children in a society beset with ever increasing levels of teenage suicide, drug abuse, sexually transmitted diseases, and so forth, today's adults must cope with the threat of nuclear war, the information explosion, a threatened environment, and economic instability. Perhaps most difficult for today's parents is the fact that they have significantly less to deal with these problems and those of their children (Leete-Guy & Schor 1992:516).

Elkind (1988:3) reached conclusions regarding the impact of social/cultural factors on children and their families. He posited that children are being forced to grow up too fast:

The concept of childhood, so vital to the traditional American way of life, is threatened with extinction in the society we have created. Today's child has become the unwilling, unintended victim of overwhelming stress - the stress borne of rapid, bewildering social change and constantly rising expectations.

The contemporary parent dwells in a pressure-cooker of competing demands, transitions role changes, personal and professional uncertainties, over which he or she exerts slight direction. We seek release from stress whenever we can, and usually the one sure ambit of our control is the home. Here, if nowhere else, we enjoy the fact (or illusion) of playing a

determining role. If child rearing necessarily entails stress, then by hurrying children to grow up, or by treating them as adults, we hope to remove a portion of our burden of worry or anxiety and enlist our children's harm in acting thus - on the contrary, as a society we have come to imagine that it is good for young people to mature rapidly. Yet, we do our children harm when we hurry them through childhood (Elkind 1988:3). According to Haager and Vaughn (1995:205) individuals with learning disabilities frequently experience difficulties with social competence is a consistent finding across various age groups and settings.

For children blessed with few or no biomedical factors putting them at risk for learning disability and who have a well organized familial support system, the myriad social/cultural opportunities may, of course, be truly enriching. Ironically, it may be that such children's abilities to take advantage of these opportunities may sharpen the contrast between them and children who have less intact neurological structures and/or less structured and supportive familial supports. The fact that children who are more well-endowed neurologically and who have supportive families still outnumber those less fortunate may serve to perpetuate and exacerbate the problems for those who are experiencing the failure (Hallahan 1992:527).

Because so many are benefiting, or at least perceive themselves as benefiting, from a more complex and varied environment, society may be escalating the availability of activities that are distracting and dysfunctional for children with learning problems. What makes the impact of social/cultural changes even more dramatic is the notion that they have an interactive rather than simply an additive effect on children's learning.

Hallahan (1992:527) hypothesizes that an increase in either CNS dysfunction or a decrease in social support leads to an increase in the prevalence of learning disabilities. If both have happened, as I have hypothesized, then the likelihood that the prevalence of learning disabilities would increase substantially.

Based on physiological factors, a certain percentage of the population is at risk for developing a learning disability. Given enough social support and/or a non-stressful lifestyle, however, some of these individuals may function well and never be identified as having a learning disability. Those with less social support and/or a more stressful lifestyle, however, may experience enough school failure to qualify as learning disabled. Another way of saying this is that a child scoring a 7 out of 10 on a hypothetical scale of CNS integrity might not develop a learning disability if his or her social support is only a 5, this may not be enough succour to keep the child from exhibiting a learning disability (Hallahan 1992:527). Over the past two decades, researchers have considered approaches for helping families to address the challenging behaviours of their family member with disabilities (Dunlap *et al* 1994:206).

## **2.4 MANIFESTATIONS OF LEARNING DISABILITIES**

A learning disability denotes a range of primary difficulties in the academic subjects and secondary problems in social and emotional domains (Mercer 1986:173-204). Children with learning disabilities have been found to have lower self-concept, more anxiety (Margalit & Zak 1984:537-539) and lower

peer acceptance (Priel & Leshem 1990:637-642) than normally achieving children.

Perhaps the most socially significant feature of learning disability is its invisible and seemingly benign nature (Dyson 1993:235-252). Typically present in a child with normal intelligence, learning disabilities constitute an intellectual handicap that is hidden (Faerstein 1981:420-423). Delayed and conflicting diagnoses are common, leading to belated intervention. Meanwhile, the invisible disability may create intolerance toward the child by the family and the general public (O'Hara & Levy 1984:63-77).

Learning disabilities may also generate false hope in the parents who may initially respond to the diagnosis with denial of, and ambivalence about, the child's disability and unrealistic expectations for his or her academic performance (Dyson 1996:280). These conditions would highlight parental stress (Abrams & Kaslow 1976:35-39). Some studies have confirmed that mothers of boys with learning disabilities are more anxious than mothers of normally achieving boys, and that families with a child with learning disabilities emphasize more control, orderliness and personal achievement but allow less free expression of feelings than families of normally achieving children (Margaret & Heiman 1986:841-846). A greater amount of parenting stress has been found in mothers of children with learning disabilities than mothers of children in general education classes (Fuller & Rankin 1994:583-592). In addition, family malfunctioning and deviation from the normal range of family cohesion and adaptability have been reported (Michaels & Lewandowski 1990:446-450). It has been reported that although families experience emotional strain and isolation related to

having a child with learning disabilities they also have positive family experiences (Waggoner & Wilgosh 1990:97-113).

According to Silver (1989:319) learning disabilities are a reflection of dysfunctional results in a discrepancy between the child's or adolescent's potential ability and his or her academic performance. It also interferes with every stage of psychosocial development and with peer and family relationships. Children and adolescents with learning disabilities may have related difficulties that compound the clinical picture. About 15% to 20% will have attention deficit - hyperactivity disorder (ADHD). Most will show evidence of secondary emotional, social and family problems, i.e. the emotional, social and family problems are not causing the academic difficulties. They are the result of the academic difficulties and the secondary frustrations and failures experienced by the individual plus the frustrations and failures experienced by the parents. Thus, when a clinical evaluation is done, it is necessary to assess the total child or adolescent in his or her total environment, not just in the school. Unless the related problems are recognised and addressed, efforts to help will be less than successful.

Learning disabilities interfere with such school tasks as reading, writing, and arithmetic. They may also interfere with baseball, basketball, hopscotch, jump rope, setting the table, reading a menu or TV guide or making small talk. Learning disabilities contribute to life disabilities, interfering with all aspects of life. Except for those few with a maturational delay, the learning disabled child will become the learning disabled adolescent and, later, the learning disabled adult.

The longer the child has had school problems with an undiagnosed learning disability, the more likely that the child, parents and school professionals are frustrated and angry with one another about the struggle around the child's problems (Daniels-Mohring & Lambie 1993:7).

Learning disability must be seen as a chronic disorder. If the individual also had ADHD, the resulting hyperactivity, distractibility, and/or impulsivity may interfere with school, peer interaction and family life. Approximately 15% of ADHD children will continue to lessen but not the distractibility or impulsivity. It is estimated that about 1% will continue to be ADHD adults. Weiss and Hechtman (1986:319) report a higher figure with one-third to one-half of ADHD children still showing symptoms as adults. Thus, this related disorder must be seen as a life disability and may become a life-long disorder. Hyperactivity is a particularly distressing and demanding disorder for parents to have to cope with, but there is much they can do to help minimise the situation (Bateman 1995:16). According to Stanford and Hynd (1994:243) this disorder is one of the most common reasons for referring children for psycho-educational evaluation, and is one of the most prevalent childhood psychiatric disorders.

#### **2.4.1 Early manifestations**

Most often, the difference between what parents and teachers think a child should be achieving and the level at which he is actually achieving is the first clue that something may be wrong. He seems bright and expresses himself well, but in kindergarten he had trouble learning the alphabet or its



associated sounds. He may be clumsy and have trouble holding his pencil. He may lean on people because he is unsure of where he is in space. He may ask inappropriate questions because he is impulsive and does not realize that there is a time and place for everything (Cordoni 1987:11).

The early manifestations of learning disorder according to Kaslow and Cooper (1978:42), may affect developmental milestones such as understanding, expressive language, grasping, walking, and later reading, writing and the ability to do arithmetic. Some learning disabled children have short attention spans, are impulsive and hyperactive. An early developmental occurrence is the smiling response. The smile is a social response and requires the perception of the smiles of others. The learning disabled child may incorrectly perceive the facial expressions of others and therefore not return the smile. Thus the mother-child feedback system becomes distorted and disappointing.

Research on learning disabilities began almost simultaneously with the awareness that some children had unusual difficulty learning despite their apparently adequate mental and sensory endowments (Stephenson 1992:539). Since the 1970's there has been growing effort to understand how the family may be affected by the pressure of a child with learning problems (Ditton, Green & Singer 1987:75-87). According to Fuller and Rankin (1994:583) there is a need to understand the relationship within and around families, including the affective aspects of the parent-child relationship. A review of the parenting literature suggests maternal variables affect child behaviour and child variables affect maternal behaviour, so identification of family systems variables that influence



parent-child functioning are of central importance. It is important, then, to evaluate the family system and the amount of stress being experienced to provide better services to a child and his parents.

Therefore families with a child who has developmental delays experience a variety of stressors and stress reactions related to the child's handicap (Orr *et al* 1993:171). Two major sources of stress emanating from the child include behaviour problems and number of handicapping conditions (Cameron & Orr 1989:137-144). In addition, Beckman (1983:150-156) reported that the child's characteristics of responsiveness, temperament, repetitive behaviour patterns, and need for greater care increased stress in parents of infants with handicaps whose mean age was 21,6 months. In a study of older children (mean age 83 months), Frey, Greenberg and Fewell (1989:240-249) found that sex of children (boys) and low levels of child communication both increased parental stress. Some of the typical parent stress reactions studied by researchers include chronic sorrow, social isolation, low self-esteem, depression and marital problems. Although the passage of time will likely mitigate the effects of some stressors and make responses to them more routine, it is also likely that the changing nature of the child and the increasing expectations associated with growing older should generally increase the magnitude of stress that parents experience (Orr *et al* 1993:171).

## **2.4.2 Types of learning disabilities**

Cordoni (1987:1-2) states that there are many types of learning disabilities; namely .... Dyslexia, dysgraphia, dyscalculia and expressive and spoken language disabilities.

### **2.4.2.1 Dyslexia**

The learning disabled child may have problems trying to read alphabet symbols as they are formed into words. Dyslexia is a developmental disorder that affects people of all ages, but its symptom profile changes with age. Most dyslexic children have difficulty using a phonic approach to reading and their spelling often fails to represent the sound structure of target words (Snowling 1997:197).

Reading performance requires use of phonological, syntactic and semantic skills. Phonological skills are used when readers convert written words into their oral - language equivalents; these skills are most obvious when students read aloud (Hallahan *et al* 1985:202).

Syntactic skills involve using the grammatical structure of written material to aid reading. Semantic skills refer to those aspects of language knowledge that help readers to use meaning and to understand what is being read. Capable readers use all of these skills in a smoothly functioning way, drawing on each of them to a greater or lesser degree at various times as the need arises. Learning disabled readers may have difficulty with any or all of these skills (Hallahan *et al* 1985:202-203). Clinical experience shows

that, with regard to dyslexia, it is a fallacy to wait and see how the child develops. A delay at the start of learning to read can quickly develop into a considerable reading disorder if unattended (Snowling 1997:199).

#### **2.4.2.2 Dysgraphia**

Writing for the learning disabled is slow and laboured and his school work is rarely finished on time. He spends most of his recesses finishing the work other children finished long ago. This child may have dysgraphia: a difficulty with the visual-motor processes called writing (Cordoni 1987:12).

Handwriting has long been an area of interest to those concerned about learning disabilities. Perhaps this is because pupils with writing disabilities produce clearly deviant writing - scrawling letter formation, for example (Hallahan *et al* 1985:236).

Written expression requires skills in three major areas: handwriting, spelling and composition. Although it is probably true that the expression of one's thoughts and feelings is more important than the mechanical aspects of writing, illegible handwriting, misspelling and grammatical inaccuracies make it very difficult for a reader to understand the meaning of a written product (Hallahan *et al* 1985:236).

Learning disabled students often have more severe deficits in spelling than in reading. In reading, context and other cues help one to decode a word, but in spelling, one must produce the word after hearing or thinking it. As

a consequence of their difficulties with spelling, learning disabled students find writing tasks both laborious and aversive (Hallahan *et al* 1985:243).

Even if they have adequate handwriting and spelling skill, students may still find it hard to use writing to communicate. Although it is unusual to encounter a student report that is neatly penned, correctly spelled, and still incomprehensible, obviously there is more to written expression than spelling and handwriting. Students must also learn to write sensible and orderly prose that is consistent with grammatical conventions (Hallahan *et al* 1985:251).

Bereiter (1980:73-93) state that the compositions of learning-disabled students are usually shorter, include fewer different types of words, are composed of less-complex sentences, and have other characteristics that mark them as less mature than those of their peers. Presently this is still the case in 1997.

#### **2.4.2.3 Dyscalculia**

An individual may read very well, but has difficulty in mathematics. Although he loves his science and reading classes, when it is mathematics time he cannot stay in his seat and causes all sorts of trouble in class. He does not understand the symbol system of mathematics and finds a great deal of frustration with this class. He does not understand why he is so good in science and has such trouble with mathematics. He is a person with dyscalculia; difficulty with mathematics (Cordoni 1987:2).

Disabilities in reading and writing are often accompanied by disabilities in arithmetic and mathematics. During the first 20 years of the field of learning disabilities, there was little focus on problems with arithmetic computation and the learning of mathematical concepts. More recently, however, there has been increased emphasis on these areas (Hallahan *et al* 1985:266). Hatcher *et al* (1994:41-57) have shown that training in phonological awareness combined with a structured reading intervention is an effective form of treatment for poor readers.

Arithmetic and mathematics disabilities, are common among pupils labelled as learning disabled. The problems these pupils experience include difficulties in skills such as counting, writing numerals, and learning basic associations (e.g. number numeral relationship). Furthermore, they are easily misled by irrelevant aspects of problems and some of the vocabulary that is often used in arithmetic problems. McLeod and Armstrong (1982:305) found that two out of three learning disabled children were in special education primarily because of learning disabilities in reading and mathematics.

#### **2.4.5 Expressive and spoken-language disabilities**

A given individual may have one or several areas that are very hard for him, such as problems in understanding what people are telling him to do. To others, it may seem that he is not paying attention. In these language related disorders, a person may understand some of what is said to him, but not all, causing others to accuse him of not paying attention. Conversely, he may understand what is said but he cannot remember it long enough to

do what he has been told. Another, may know and understand what he is to do but cannot tell you about it, for his expressive skills are affected (Cordoni 1987:2).

## **2.5 CONTRIBUTION OF LEARNING DISABILITY TO THE STRESS OF PARENTS**

✓ One of the most difficult tasks facing parents of learning disabled children is the acceptance of the individual child with his or her disabilities and special needs. The sooner parents adjust to the child's disability, the more realistic they can be in terms of assessing needs and being motivated to seek help. By doing so, the likelihood of attaining the child's potential and achieving healthy family functioning is increased. The process of acceptance can be made easier by effective supportive services (Grieve & Mphelo 1993:181).

✓ Margalit and Raviv (1983:163-169) present the suggestion that parenthood itself may be regarded as a crisis; one would suspect then that the crisis of having a learning disabled child could be overwhelming. The nature and course of parents' responses to this crisis appear varied, but we are only beginning to learn why some parents adjust relatively quickly whereas others experience prolonged distress (Crnic *et al* 1983:125-138; Gallagher *et al* 1983:10-19).

✓ A crisis in the family is a situation in which the family's normal problem-solving skills lose their previous efficiency, and the usual support resources are no longer adequate (Margalit & Raviv 1983:163-169). It is not

surprising, therefore, that the interactional patterns of family members are in a temporary state of disequilibrium. Faber (1962:227-246) described two types of crises i.e. the tragic crisis in which aims, aspirations and the anticipated "happy family life" are frustrated; and the role-organization crisis, in which parents have to cope with problems of prolonged care, and as a result, the normal family lifecycle is arrested.

Many of the sources of stress for parents of learning disabled children are well documented. It is generally accepted, that the learning disabled child imposes a unique kind of stress on the family (Bernheimer *et al* 1983:171-180). Korn *et al* (1978:299-326) suggested that "the stresses.... are seen as persistent, long term, frequently changing as the child grows, and a problem for which many parents find no relief." A variety of negatively interpreted reactions have dominated the professional perspective of parent behaviours: overprotection, denial, and shopping behaviour. From the parents' perspective, however, these behaviours may be considered valid and appropriate.

Parents and professionals are encouraged to work together in serving learning disabled children - this partnership is conceptualized as being advantageous to the handicapped child. ) However, the differing perspectives of parents and professionals may potentially result in conflict, misunderstanding and bitterness. Bernheimer *et al* (1983:177-180) reveal three specific stress points:

- the time of initial diagnosis,



- the point at which help is first sought, and
- the period of transition from an infant program to pre-school programme.

Information is provided on the problems perceived and experienced by parents at each level by professionals when working with each other. The following are the **most stressful periods of parents** with learning disabled children:

- diagnosis of handicapping conditions
- obtaining the initial services
- the period of transition from an infant programme to pre-school programme.

### **2.5.1 Diagnosis of handicapping conditions**

The identification of a child with a disability is usually a stressful event for the parents. The process of sharing this diagnosis is a time when the parent-professional relationship is established; thus, it is particularly important that professionals be sensitive to parent perceptions of this event. Data from a support system study in 1980 yielded insight into the problems and stresses of parents at the time of diagnosis. The results indicated that parental experiences varied greatly, depending upon the nature of the child's handicapping condition. Daniels-Mohring and Lambie (1993:1) state that parents may need to obtain evaluations of the child, medical follow-up and special tutoring.

Much depends on the age at which diagnosis is made, the seeking of second opinions, and the role played by parents vis-à-vis professionals. Handicapping conditions also influence the parents seeking of additional opinions. The lack of a specific diagnoses are problematic for mothers of children (uncertain aetiology). Professionals often negatively interpret the seeking of additional opinions by parents (Anderson 1971:3-5). This may be due to their subjectivity. However, for parents of delayed children without a specific aetiology, securing additional medical advice would seem logical and justifiable.

The way in which professionals share the diagnosis with parents are a source of stress, regardless of the nature of the child's handicapping condition. Some parents relate that the diagnosis are not shared with compassion or sensitivity. Others feel that professionals lack respect for the child as well the parents. Professionals are frequently viewed as unresponsive to the parent's need to talk, to ask numerous questions, and to be told the answers over and over again. Problems in communicating with professionals also emerge when parents are trying to make sense of the diagnosis. Parents are eager to know what the handicap will mean in terms of their child's future development (Bernheimer *et al* 1983:179).

Parental stress associated with the sharing of a diagnosis has implications for professionals. The seeking of second opinions may reflect uncertainty or confusion regarding the content of the initial diagnosis. The "shopping behaviour" of parents, typically viewed as denial or neurotic behaviour, may be an adaptive attempt to obtain a consensus or majority view. The

experiences described by parents indicate a need to incorporate parental perspectives into training programmes for health professionals. The assessment of family variables has also become important with regard to learning disabled children (Fuller & Rankin 1994:583).

### **2.5.2 Obtaining the initial services**

A second period of parental stress involves the securing of initial help or intervention for the handicapped child (e.g. infant development programme, speech therapy, pre-school education etc.). The nature of the child's handicapping condition proved to be important in determining the timing and type of service received. For the child, a delay in receiving specialized assistance may signify lost time and possibly lost potential. For the parent, the delay may augment the stress of coping with their child's handicap. The securing of services created strains in the parent-professional relationship. The professional providing the diagnosis was frequently unable to direct parents to services and intervention (Bernheimer *et al* 1983:179).

Typically the search for services was initiated and co-ordinated by the parent, who often returned to educate the professional. The link to services was often even more complicated for parents of delayed children, since the best way to intervene frequently varied with the perspectives of the professional (e.g. educator, physician, therapist, etc.) contacted. It appears that information on community resources and educational programs available for young, handicapped children is not being properly disseminated. Available community resources should be compiled and

distributed to health-related professionals, hospital clinics and parent organisations (Bernheimer *et al* 1983:179).

### **2.5.3 Transition from infant to pre-school programmes**

The transition from early intervention programmes to pre-schools appear to be times of stress for parents of handicapped children (Hanson 1981:37-44). The transition often involves relocating from small, relatively protected environment to a larger, unknown setting. Parents seeking an appropriate pre-school placement usually find a larger number of choices but less direction in making that choice. Thus pre-school selection may require more active decision-making on the part of the parents and further add to parental apprehension and anxiety about making an appropriate pre-school choice.

Darling (1979:54) suggested that parents of learning disabled children experienced two phases of “seekership”:

- a phase in which they seek appropriate information regarding a diagnosis; and
- a phase in which they seek appropriate solutions (programmes, physicians, etc.).

Research findings by Bernheimer *et al* (1983:179) suggested the parents of developmentally delayed children were frequently involved in the second phase without the necessary data on which to act appropriately. As these children often exhibited “islands of normality” and variable performance

on developmental measures, some parents had difficulty with the appropriate selection of a pre-school.

In effect, parents are forced to function as case managers without an adequate knowledge base (Bernheimer *et al* 1983:179-180). Reviews of parent interviews suggest that parents and professionals may hold divergent views of the pre-school child. The parent may view the child's limitations as primarily cognitive and therefore seek a pre-school which emphasizes preacademic skills. The professionals on the other hand, may perceive similar limitations, but is more accepting of them and prefers a programme which places more emphasis on social competence. This parent-professional conflict may emerge despite a previously supportive relationship when the child was in an infant program. The parent may feel betrayed by the professional, while the professional feels unappreciated by the parent.

The selection of a specialized or a mainstream pre-school is a dilemma encountered by parents of handicapped children. Unfortunately, research data do not provide clear-cut answers (Hanson 1981:37-44). Parents may become bewildered and confused while attempting to make the most appropriate selection. The data further suggests a need to be sensitive to individual differences among parents of handicapped children, as well as to differences among the children themselves. For some families, parent groups may offer a means of support, for others, they may create additional stress.

#### **2.5.4 The influence of parents on learning disability**

X It is commonly accepted that both mothers and fathers are deeply affected by the presence of a learning disabled child in the family (Margalit & Raviv 1983:163). Mothers, however, have been found to be more vulnerable since they carry a greater burden of caring for the child. Even after outlining concerns about describing parents changing responses to a child's disability, Featherstone (1980:21-22) states that:

Parents of disabled children share unusual reactions to disability. A few have always had warm, protective feelings for the handicapped. Others feel threatened, uncomfortable, or even repelled in their presence. Certainly the idea that parents experience several stages of adjustment in coping with the birth of a learning disabled child is not new, and had appeared intermittently in the professional literature since the mid-1950's.

People with learning disabilities tend to mature emotionally more slowly than their non-handicapped peers. Partly because of this faltering many parents fall into the trap of doing more for the child than they should. Although the child may be allowed to do more for himself as he matures he will be doing much less than his non-handicapped peers. The result is an immature adolescent and adult, unable to function adequately in the adult world.

As parents and teachers, we must begin to understand what we are doing when we take messages for them, write their papers, and thus demand far

less of than they are capable of being. How are they ever to grow up, to take responsibility for their own actions, unless we slowly, carefully wean them and teach them the skills for adult life? Perhaps they are not fully capable at this point, but they will never be unless we love enough to make them try (Cordoni 1987:6). According to Mabunda (1991:10) the parents of learning disabled children face a life-time of adversity. It is unfortunate that because of the burdens of parenting such a child and the corresponding pressures that teachers face in assuming broader role functions, parents and teachers often find themselves at odds with each other - adversaries rather than collaborators.

#### **2.5.5 Parenting**

The stressful impact of disabled children on their parents has been widely reported with an emphasis on parents' negative responses and maladaptive behaviours (Burden & Thomas 1986:140-145). Recent studies of resources and coping suggested a different approach which highlights the family's capacity for successful adjustment and growth (Darling 1988:141-158, Rodger 1987:167-170, Margalit & Ankonina 1991:289-299).

Cordoni (1987:7) points out that parents feel pain, frustration, fear and guilt when they discover that they have a learning disabled child. Often, one of the first questions parents ask when they discover that their child is learning disabled is, "What was the cause?". Also implied is "Am I somehow to blame?". Because people expect, subconsciously at least, punishment for their sins, parents sometimes feel that such a child is God's punishment, especially if the child was unwanted. All of us have within us

feelings of inadequacy. Parents wonder if this problem is in some way related to something they have done or not done.

In attempting to understand the underlying factors determining parental reactions to the birth of a learning disabled child, each parent's own personal characteristics must also be taken into account (Levitz 1993:52). These personal characteristics of the parents will also determine their reactions to and feelings about coping with a learning disabled child. According to Turnbull and Turnbull (1993:38), "... these personal characteristics can be strengths or drawbacks for the family as a whole. Each family member has a state of mental and physical health that affects his or her tolerance to stress, an intellectual capacity to understand what is happening and styles of coping with pressure. All of these affect the family's reaction to an exceptionality..."

Usually the only frame of reference that parents have is how they themselves were raised. We all remember how we were treated by our parents; when they spanked us and what we got away with. Some of us came from loving, caring homes where we felt loved and cherished at least most of the time. Others of us vowed we would never raise our children the way we were raised. Most of us do, however as we know no other way (Cordoni 1987:36).

How an individual family member handles stress will also affect his or her attitudes to a learning disabled child. The arrival of a learning disabled child can demand great adjustments (Levitz 1993:53). According to Peterson (1987:423) the manner in which parents react to stress depends



on the severity of the disability, the stability of the family, the amount of the internal support within the family, the amount of external support, and the availability of services such as medical, educational and counselling.

Cordoni (1987:37) feels that most of what fathers hear is second-hand. Solutions sometimes seem simple to him - more discipline, watch the child more closely, be more strict - he does not realize that these are not necessarily solutions for the special child. He is working hard all day; why must he come home to hear how his wife cannot handle a little child? Mother then retaliates from this attack upon her child-rearing abilities, "If you were ever home," "If you ever played with him," and so forth. Everyone is miserable, especially the child, because he knows they are arguing about him again.

For most parents, the knowledge of the child's disability may have only been a faint suspicion before he entered school. How alert they were depends on several factors:

- whether they had older children with whom they could compare him,
- the nature of his disability
- and how helpful their paediatricians were.

For some parents, the first call from the school is a surprise, for others it is a confirmation of their worst fears (Cordoni 1987:37). According to Levitz (1993:52) in a situation where a family places great emphasis on cognitive development, and members of the family work in professional settings requiring a higher level of education and cognitive functioning, reactions

may be quite different from those in families who place less emphasis on cognitive skills and more emphasis on the development physical attributes.

The conference at school is usually held with a school psychologist or a learning disability specialist, and suddenly parents are hearing about a condition they never knew existed, hearing terms they do not understand. In a little while they go home, grateful perhaps, that at last something will be done, but confused nonetheless. If both parents were present, discussion is easier, but usually it is the mother giving the father second-hand information again, much of which she may not understand herself. Sometimes the diagnosis comes as a relief, because the fears are often worse than reality. In general, mothers appear to accept the diagnosis more readily than most fathers are able to. They have usually spent more time with the child, they have sensed something was wrong and are thus more prepared. According to Daniels-Mohring *et al* (1993:10) support groups are invaluable in helping parents with acceptance and grieving.

The controlled rage parents often feel at the school system, at their spouse, even at their child, the total unfairness of it all, needs to be identified and dealt with. It is real. It is understandable, it is normal. Often, there are several stages parents have to go through in the acceptance of the child's disability. The first is denial that there is anything wrong. Minds and hearts want to reject such an awful idea. After that stage comes a mourning period, for at the time they do not know the implications of the disability for the rest of his life; they wonder what will become of him, and of themselves (Cordoni 1987:39).

Other stages follow: anger, fear, frustration, guilt and acceptance, not necessarily in that order. To go through each of these stages is normal; to stay at one stage instead of growing through it, further handicaps the child and the family. How long parents remain in a stage (and they may be in several at the same time) depends on factors of family situation available resources, support from the school system, severity of the disability, and their own personalities. The responses are as different as night and day (Cordoni 1987:39).

According to Levitz (1993:51) in making an analysis of the impact that a learning disabled child has on parental reactions and feelings, it is of the utmost importance to remember that parents' reactions must be seen in terms of their "... totale lewensituatie" (total life situation) (Kotze' & Folscher 1986:116).

Once parents get into the acceptance stage, they can begin to take effective action (even so much as to relieve their own stress) and thereby assure a productive life for their child. There are many help stations along the way. Parents need to realise and acknowledge the fact that there are ways in which they can function as "normal" families do with the stresses that normal families have. Families with children who have disabilities would benefit particularly from assistance in maintaining a positive family relationship during early childhood and school years (Dyson 1993:238).

## 2.6 CONCLUSION

Research on learning disabilities began almost simultaneously with the awareness that some children had unusual difficulty learning despite their apparently adequate mental and sensory endowments (Stephenson 1992:539).

The prevalence of learning disabilities seem to some observers and commentators to be on a runaway course. Learning disability has become the predominant category in special education. Ever higher prevalence figures are, some special educators feel, threatening a severe backlash in which the field will lose political and economic support because it has grown beyond reasonable proportions (Hallahan *et al* 1985:300).

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Learning disabilities are life disabilities and usually life-long disabilities, interfering with all aspects of the child's life during each developmental stage. Ideally, this invisible handicap can be recognised, diagnosed and treated. Learning disabilities, like any chronic disability, can, if not properly treated, result in a lifetime of frustration, pain and underachievement. Recognition, diagnosis and correct treatment is essential for each stage of psycho-social development (Silver 1989:324).

Learning problems exist in a continuum ranging from insignificant to profound degrees, and one has difficulty determining precisely the point at which a problem of remedial education that can be handled by the regular classroom teacher becomes a learning disability that requires the services of a special educator. One is still left with the problem of setting an arbitrary

cut-off point based on subjective criteria - the same problem one faces in determining who is learning disabled and who is not (Hallahan *et al* 1985:300-301).

Once this has been determined, parents have the responsibility of making sure that their children receive the best possible education and support. As can be noted that learning disabilities affect the lives of parents, therefore it is necessary to provide aid to parents on how to cope with their learning disabled child. Although the desire to include parents and families as partners in the educational process has been strongly stated through the law and in professional literature for many years, only recently has a body of research accumulated about the wishes and needs of parents (Westling 1996:86).

Stephenson (1992:542) suggests that parents of children with learning disabilities learn to become effective advocates for their children by joining parent organisations or by taking classes in parent advocacy.

In this chapter the concept learning disability is defined and the causes of learning disabilities are given. Also included are manifestations of learning disabilities and contribution of learning disability to the stress of parents. How to aid parents of learning disabled children will be discussed in Chapter three.

## **CHAPTER THREE**

### **AID TO PARENTS OF LEARNING DISABLED CHILDREN**

#### **3.1 INTRODUCTION**

The object of this chapter is to deal with literature concerned on cognitive coping strategies. How to aid parents of learning disabled children regarding coping skills and family adaptations will be provided. Furthermore, the elements of two models will be discussed in detail.

According to Dowds, Hess and Nickels (1996:17) the family is an important influence on a child's performance in school. Ideally, the home provides an environment that is actively supportive of the educational goals of the school and this functions as an educational resource. For the child with learning disabilities, the family is perhaps an even more important resource.

Parenting may be regarded as the most essential and possibly the most enduring profession acknowledged by society, yet it is the one in which parents are the least or at most ill-prepared. Parents are required to continuously adapt their parenting to enable their children to respond adequately to the ever-changing demands of society. According to Smith (1991:515) parents influence their children's attitudes, work habits, values, and learned skills through their own attitudes towards learning, through the amount of intellectual stimulation provided in the home, through the kind

of modelling they provide, and through their warmth, acceptance, and support.

Hence preparing children to function in a complex world requires knowledge, skill and dedication. The scope of parents' responsibilities makes it clear that they cannot personally meet all their children's needs. Aid would therefore be necessary. They must rely on those outside the family to assist them with their awesome task. Important allies in this regard are teachers according to Kapp and Levitz (1995:58).

According to Consilia (1978:19) increasing attention is being paid to these children in research centres and clinics, and the findings therefrom are reaching the schools by way of improved training programmes, cognitive learning programmes and inservice workshops on how to aid learning disabled children.

Processes of identifying such children are sometimes inaccurate and not always pertinent to the goals of diagnosis and treatment. Evaluations of the results of assessments are frequently too generalized, e.g. **“child can't spell,”** or **“child does not understand what he reads.”** Such a finding is of little help in programming for remediation.

Programmes have been slow in emerging, partly because of training of experienced persons to ascertain what prevents a child from learning and the subsequent vocation to be used in his/her training (Consilia 1978:19).

What is interesting is a model presented by Kirk and Gallagher (1986:364) which can be used by mental health counsellors to identify children who have learning disabilities. In this model, there are two general categories of developmental and academic learning disabilities i.e.:-

## **A. DEVELOPMENTAL LEARNING DISABILITIES**

### *PRIMARY DISABILITIES*

- attention
- memory
- perception

### *SECONDARY DISABILITIES*

- thinking skills
- oral language skills

## **B. ACADEMIC LEARNING DISABILITIES**

### *READING*

- basic skills
- comprehension skills

### *MATHEMATICS*

- computational skills
- reasoning skills



## *WRITTEN LANGUAGE*

- handwriting skills
- spelling skills
- written expression skills (Kirk & Gallagher 1986:364).

Using this model, effective remedial programmes could be devised to suit individual needs.

As parents or teachers, we need to be extremely aware of the hidden messages we give children, for hidden messages can be as clear to the child as are those which are stated clearly. We must therefore make certain that they know we believe in them and our actions must fit our words. Unthinkingly, we give hidden messages all the time e.g.: a father bragged about how he has saved on his income taxes by manipulating some figures. He was very upset when his son was caught cheating on his economics exams and wondered how he could have produced such a son (Kirk & Gallagher 1986:365).

Sometimes parents feel despair at the problems their children face daily. A good treatment for despair is to get busy. Acting on the feeling that you are doing something about the problem, can be therapeutic. However, because of their children's problems, most parents have had to fight long and hard for services. This makes it more difficult for many to have control over their children as they grow up. Some parents almost seem to fear a loss of control over their children and feel that if they are not right all the time, the child will immediately get into trouble. Sometimes, because of

past behaviour and the students' new freedom, such concern is justified, but at some point in their lives parents have to let them go.

Parents and teachers of learning disabled children may demand too much or too little. As cognitive leaders there are steps we can follow Graham *et al* (1987:20). There is need to give guidance to mental health counsellors regarding their child's learning disability.

As mental health counsellors are asked to provide services to school-age children, especially those with learning disabilities, they need to become more knowledgeable about schools and the role they might play in them. Mental health counsellors should become familiar with local, state and federal regulations that monitor the provision of service to students with learning disabilities. By using the model for identifying learning disabilities, mental health counsellors can make important decisions about their clients' developmental progress, especially at the elementary school level. Finally, as members of a professional team, they can help to promote positive working relationships among teachers and other school's personnel as they work with parents on behalf of these children (Graham *et al* 1987:20). This in turn will be beneficial for the parents in handling his learning disabled child.

Parents require to be assisted with coping skills when they have learning disabled children. Attention will first be given to the coping skills that parents can use to handle the disabled child.

### 3.2 COPING SKILLS

Parents of learning disabled children can use a series of coping skills to assist their child. The three most important coping skills a parent may use are:

- being alert
- support and encouragement
- working with the school.

Parents can help their child by being alert to the learning disability of their child. They have many opportunities to observe behaviour and make assessments of the child. Parents can help their learning disabled child by support and encouragement. They should give attention to the child's feelings especially to expressions of dislike, which may indicate a deeper problem.

Parents should have a good understanding of the learning disabilities and their complex interactions. Parents can gain insight and learn effective ways to help their children by reading, getting involved in professional organisations and talking to teachers and friends regarding the learning disability. This will support and encourage the child (Elston 1993:19).

Parents can also work with the school to ensure that the needs of these special children are being met. Parents can become involved with parent/teacher organisations where the parent can make suggestions on

programme possibilities which will help the learning disabled child (Elston 1993:19).

According to Baum and Owen (1988:110-114) there are four possibilities to assist a learning disabled child:

- Attention should be focused on the disability.
- Learning disabled children should have a supportive environment.
- Strategies should be given to compensate for learning problems.
- Parents should help their children become aware of their strengths and weaknesses and how to deal with them.

Parents have a big role in creating a nurturing home environment for their children, one which will make them feel loved and valued and one which will help them realize they can become important contributors to their community.

Coping includes personal coping as well as social support to coping. Personal coping refers to efforts made by an individual acting as her or his own resource, rather than seeking support, assistance or validation from a social environment (Schilling *et al* 1984:47-54).

Social support is defined as individuals, groups or institutions that provide assistance of varying degrees and forms to help another individual combat stress that tax her or his personal resources. A social network is a set of linkages among a defined set of persons. A social network for parents of learning disabled children include family household members, extended kin

and relatives, neighbours, friends and representatives of social service and educational systems (Schilling *et al* 1984:47-54).

Therefore it is necessary to elaborate on personal coping and social supports in aiding parents with learning disabled children as well as on barriers to personal coping and social support.

### 3.2.1 Personal coping

Personal coping helps parents as they confront the reality that they are responsible for the well-being of their children. In the case of a learning disabled child, parents eventually, or perhaps immediately, understand that their unique responsibility is in one sense their private burden (Featherstone 1980:195). Cobb (1976:300-314) suggested that social support bolster self-esteem which in turn fosters adaptive coping efforts. Few persons cannot recall an instance when social supports - a word of encouragement, an offer to help, a thoughtful comment, - galvanised them into effective personal coping. Social support and personal coping are each important, but linked together become a powerful set of skills (Schilling *et al* 1984:49).

Coping occurs in the context of other psychological processes. Lazarus and colleagues (Lazarus *et al* 1974:249-315) emphasized the process of appraisal as an important mediator related to coping devices. There are responses to both perceived threats and potential avenues of mastery e.g. consider two sets of parents who are told their respective children are developmentally delayed. One couple perceives the child study clinic as a

source of help, a place where the family can receive accurate information and suggestions for therapy. The other couple sees the clinic as a threat. The first couple anxiously awaits their first appointment, the latter never contacts the clinic. As this vignette suggests, coping actions are based upon perceptions of threats and solutions.

If psychological mediators affect the perceptions and responses to difficulties, what are some of the coping mechanisms used to combat stress? Problem solving is a cognitive process that involves selecting solutions from a variety of options. Other effective coping strategies are relaxation's, self-praise and self-instruction and favourably contrasting oneself with others. In contrast to defence mechanisms often described in negative terms, personal coping strategies are viewed as positive responses that can enhance long-term functioning of parents of learning disabled children.

### **3.2.2 Social supports**

The problems presented by a learning disabled child demand an extreme multidisciplinary approach with teamwork within professions, among professions and between professional and lay persons. The most important persons involved in aiding the learning disabled child are the parents and the immediate family of the child.

Parents' support can be directed into three areas namely:

1. A socio-emotional area: which refers to the subjective experience of giving birth to and rearing a learning disabled child.
2. A reality area: referring to real problems arising from caring for, socialising and educating the child as well as from the influence of the child on the basic family functions.
3. An interactive area: which refers to the parents' relationship and interaction with informal and formal systems that the child comes into contact with during his/her different stages of development, such as the extended family, the immediate environment, medical and educational practitioners and institutions (Joubert 1987:17-19).

These three areas are interrelated and have a strong reciprocal influence and all three of them are the concern of the social work profession.

Counselling the parents of the learning disabled child includes giving assistance with both practical and emotional issues. Counselling would be used as a continuum with psychotherapy at the one end aimed at helping the parents to become aware of and explore their feelings, anxieties and defence mechanisms (Joubert 1987:17).

Supportive social relationships are important in most forms of coping. Shuval (1981:337-342) points out that social support can alternate one's subjective perception of a problem, and can act as a buffer once a situation

has been defined as disturbing. For our purposes three levels of social support can be identified. Nuclear family members, close friends and relatives, and other significant persons are often the most basic, enduring and immediate sources of social support. A second level support includes neighbours, more distant friends and relatives and certain professionals and service providers. Although less intimate than the first level of supports, these sources of help typically have regular contact with parents of handicapped children. A third level of support is still less intimate, and is defined by superficial or infrequent contact, often in the context of social institutions (Unger & Powell 1980:566-574).

Although each level of support overlaps with the next, these differing degrees of intimacy require somewhat different interpersonal skills, for example, the first level of support may depend on a consensual norm. A mother may easily ask a close friend to watch her child knowing that this is clearly within the bounds of their mutual expectations. A neighbour might be a second level of support who shares a norm of reciprocity with the parent seeking help. The mother would likely approach her neighbour about child care with some caution, and with the understanding that she will incur a debt to be repaid later. The third level of supports are most distant and may rely on institutional or professional obligations. These supports are typified by a mother seeking services for her learning disabled child through the local association for retarded citizens. Certain support networks may contain elements of each level of support. Parents of learning disabled children have formed many effective self-help and advocacy groups including Pilot Parents, People First, Down's Syndrome



Congress, and the International Association of Parents of the Deaf (Schilling *et al* 1984:49).

Some families are better able to generate internal support and become part of external social networks (McFarlane *et al* 1981: 90-100). The success of families seeking social support, in whatever form, will to a large extent depend on their social competence. Social supports and internal coping mechanisms are closely linked. Social supports can be viewed as complementing personal coping or as another form of coping taking over when mental mechanisms fail or subside (McFarlane *et al* 1981:90-100).

Besides the practical problems presented by caring for the child, teaching him socially expected behaviour presents problems. Mental retardation is always accompanied by perceptual problems. The learning process therefore takes much longer since the child struggles to internalize behavioural norms. This gives rise to frustration in the child, since he struggles to express verbally and to make himself understood. Parents, siblings and neighbours must come to terms with the problems facing the learning disabled child and give the child direction in developing a positive self-esteem (Joubert 1987:21).

The nature of coping which includes emotional coping and cognitive coping will be discussed.

### **3.3 NATURE OF COPING**

The term coping refers to the things people do to increase a (sense) of well-being in their lives and to avoid being harmed by stressful demand (Turnbull & Turnbull 1993:11). Coping can be classified into the following:

- Emotional coping
- Cognitive coping

There are other aspects of coping but emotional and cognitive coping has significance for the topic cognitive coping strategies of parents who have learning disabled children.

#### **3.3.1 Emotional coping**

Parents of a learning disabled child have been considered a rather homogeneous group with similar feelings and reactions to traumatic situations. This assumption has led to a stereotyped picture of the parents ascribing certain standardized, emotional reactions and attitudes to them often labelling them as problem parents' instead of parents with unique and often severe problems created by unique circumstances (Joubert 1987:20).

### 3.3.2 Cognitive coping

The term cognitive coping means thinking about a particular situation in ways that enhance a sense of well-being. According to Joubert (1987:20), people use many different types of cognitive strategies, which include:-

- Making favourable comparisons of ones' situation to others.
- Finding positive benefits from an event or choosing selectively to ignore negative aspects.
- Attributing a meaningful and self-enhancing cause of the event.
- Having a sense of control or influence over the event.
- Finding humour.

Since problems in school are not seen as occurring in isolation, one of the most important components in the overall treatment of the child with learning and/or behavioural problems is the education and counselling of his or her parents. A most promising development has been the use of educational and counselling groups to deal with educational issues and to offer training to parents to produce desirable behaviour in their children (Volenski 1995:124).

Emotional strains are indicate in relationship to such aspects as assessment, lack of self-esteem, and parental feelings of emotional pain (Waggoner & Wilgosh 1990:98). Name-calling, fights, and coalitions are normal experiences for many children in the school setting. The presence of a child with a learning disability greatly affects family dynamics as the demands upon the parents can be numerous and extremely time-

consuming. However Waggoner and Wilgosh (1990:98), indicate that there have also been positive effects, as one mother noted: "It added strength to our family life... The kids have gotten values in a lot of ways well beyond their years, that will stay with them forever, and I think that's great."

Although theory development and research on cognitive coping have been ongoing in the field of social psychology for a number of years, cognitive coping as a research focus is relatively new to the developmental disability field.

Turnbull and Turnbull (1993:1-13) reviewed literature on families and disability and found that children with learning disabilities were almost described as being a major burden to their families. Two types of pathogenic statements in literature were identified by Turnbull and colleagues (Turnbull & Turnbull 1993:1).

The first is a pervasive negative generalization. An example of such a generalization is: **"In most families in which there is a defective member, pervasive guilt permeates the family and is expressed in its characteristic style. The birth of a retarded child, his presence in the home, and even the knowledge that such a child once lived at home, greatly exacerbates his existential guilt"**.

The second type of pathogenic emphasis is the explanation of unanticipated positive findings through a negative interpretation. Wasserman (1983:622) found that: **"... most of the normal brothers and sisters of a group of retarded children were sympathetic, helpful, and**

understanding and did not seem to have been adversely affected by their mentally retarded siblings. It is quite possible, however, that these siblings were outwardly helpful and co-operative while manifesting adjustment problems in other ways”.

Literature from other disciplines provided a theoretical framework about the potentially positive interpretation of disability. According to Victor Frankl (1969:142) and his theory of logotherapy and existential analysis: “We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: The last of human freedoms - to choose one’s own way.

And there were always choices to make. Everyday, every hour, offered the opportunity to make a decision, a decision which determined whether you would not submit to those powers which threatened to rob you of your very self, your inner freedom; which determined whether or not you would become the plaything of circumstances, renouncing freedom and dignity to become moulded into the form of typical inmate. It becomes clear that the sort of person the prisoner became was a result of an inner decision, and not the result of camp influences alone. Fundamentally, therefore any man can, even under such circumstances, decide what shall become of him - mentally and spiritually” (Turnbull *et al* 1993:104-105).

The parallels of this theoretical orientation were highly consistent with the writings of parents of children with disabilities (as contrasted to the professional literature). Clara Claiborne Park, the mother of a child with autism, provided a disability example of the theory advanced by Frankl (1969:143): **"I do not forget the pain - it aches in a particular way when I look at Jessy's friends. Some of them just her age, and I allow myself for a moment to think of all she cannot be. But we cannot sift experience and take only the part that does not hurt us..... Through it we have learned the lesson that no one studies willingly, the hard, slow lesson of Sophocles and Shakespeare - that one grows by suffering. And that too is Jessy's gift. I write now what 15 years past I would still not have thought possible to write: That if today I were given the choice, to accept experience with everything that entails, or to refuse the bitter largesse, I would have to stretch out my hands because out of it has come, for all of us, an unimagined life. And I will not change the last word of the story. It is love".**

Taylor (1983:1161-1173), proposed a theory of cognitive adaptation to explain the adjustment process that individuals use when they experience personally threatening events. She suggested that there are three adjustment themes:

- searching for meaning of the event
- increasing self-esteem, and
- establishing mastery over the event in particular and over one's life more broadly.

In summary cognitive coping has the potential for enhancing the well-being of families. Focusing on what could help families be successful seemed to be a far more productive type of inquiry than the pathogenic emphasis.

Cognitive coping is not the most important coping strategy or the only coping strategy appropriate for families. Rather it is one of many different coping styles that may be useful to families in some situations and not to families in others. It does not replace more instrumental coping such as access to financial recourses, professional services, and social support (Turnbull & Turnbull 1993:2-4).

In reality, parents of learning disabled children are as normal, as average, as neurotic as any other parent before the birth of any other child, all of them having their own unique life experiences, defence strategies, coping repertoire and methods of seeking and utilising assistance. With the birth of the child, they suddenly become one of a group, but in so doing they do not lose their own abilities or shortcomings. This uniqueness of each parent should be explored and recognised by counsellors and therapists in order to be effective and to do justice to the parents (Joubert 1987:20).

Coping can be described as the actual strategies people employ in their efforts to manage stressful life events (Turnbull & Turnbull 1993:124). Lazarus and Folkman (1984:149) distinguished two kinds of coping strategies, namely: problem-focussed coping and emotion-focused coping.

A synthesis of this research reveals two important dimensions regarding the manner in which people cope with stressful events. The first dimension

concerns the type of coping activities people initiate. This dimension pertains to whether the coping activity is behavioural or cognitive in nature. The second dimension concerns the immediate aim of the coping effort. Coping effort can be targeted toward:

- directly altering the precipitating event,
- transforming the implications of an event for well-being, and
- reducing the negative emotional consequences of a stressful event (Brown 1993:124-125).

There appeared to be ample evidence from research in the fields of developmental disabilities, cognitive psychology, sociology and family studies, that cognitive coping has significant potential for making a positive difference in the lives of individuals and families. From the contributions of diverse constituencies, it was also obvious that cognitive coping would be strengthened by a broad analysis. An opportunity for this broad analysis is bringing together theorist and researchers from a variety of disciplines, families, and service providers to explicate key concepts and to discuss important research progress and future directions. Therefore it is necessary to discuss the implications of cognitive coping.

### **3.4 IMPLICATIONS OF COGNITIVE COPING**

Cognitive coping has important implications to assisting parents with learning disabled children. Turnbull and Turnbull (1993:10) undertook to use the five principles to develop a research agenda for the 1990's and chose the topic "Cognitive Coping". The Cognitive Coping Conference



was held in Lawrence, Kansas, in June 1991. The purposes of cognitive coping are:

- To synthesize theory, research, practice and personal experience related to cognitive coping in individuals and in families.
- To conceptualize a research agenda aimed at supporting families to enhance cognitive coping.

The above objectives are relevant to the researcher's purpose of study.

Individual Cognitive Coping and Family Cognitive Coping Research on cognitive coping essentially has two foci: research on individuals and research on family units. Most of the former has been done in the disciplines of cognitive psychology, social psychology and sociology. By contrast, the majority of the latter has been done in the fields of family studies and developmental disabilities. Theorists and researchers with specialization in individual cognitive coping and those specializing in family cognitive coping were included (Turnbull *et al* 1993:10).

An overall orientation has been researched on health and success in families who have members with developmental disabilities. At a theoretical level, Antonovsky (1979:124) best articulates this orientation by his salutogenic perspective which calls for theorists, researchers, families and service providers to identify factors that contribute to families' successful functioning.

This perspective assumes that families inevitably will be faced with stressors but have the potential for active adjustment. Accordingly, the role of service providers is to enhance family strengths rather than to focus solely on deficits. For families the salutogenic perspective implies discovering and learning how best to use one's resources to meet the challenges of life.

The intention is to stimulate research that ultimately would support families to use cognitive coping to enhance their positive well-being which is the intention of the researcher. Therefore family adaptation is of importance.

### **3.5 FAMILY ADAPTATIONS TO LEARNING DISABILITY**

Garland (1993:67) stated that families needed to modify their concepts in a Piagetian sense, assimilating and accommodating, until new realities took on meanings with which families could live. For some families, this process of assimilation and accommodation, or cognitive coping, is repeated over time, with each new piece of diagnostic or developmental information, with each triennial eligibility meeting, with each medical crisis or unanticipated triumph.

The Piacceleration method, which grew out of research projects with learning disabled children, is doubtless only one way to produce cognitive gains (Pasnak *et al* 1991:13).

Garland (1993:68), has seen families who were just learning of the “**difference in their families**”. Many families were not yet coping cognitively, at this difficult time, modifying feelings or understanding in order to lessen the negative impact of the diagnosis.

According to Featherstone (1980:177) families whose children are in newborn intensive care units or are newly diagnosed with a developmental disability are, rather, engaging in daily struggles for survival. That they manage to get out of bed, dress and feed their other children, and meet numerous basic needs each day is testimony to their coping capacity. Other families have been engaged in struggles for survival long before the child with a disability entered the family. Such families continue their struggle with poverty, homelessness, and chronic underemployment or unemployment. Maslow’s (1970:143) theory of hierarchy of human needs, beginning with basic needs for food, clothing, and shelter, provides more guidance than does the cognitive coping literature. It is necessary to discuss existing programmes and interventions to aid parents who have learning disabled children.

### **3.6 EXISTING PROGRAMMES AND INTERVENTIONS**

Of vital importance is the evolution of early intervention and family coping.

#### **3.6.1 Evolution of early intervention and family coping**

A family’s needs and problems cannot be understood except within a wider cultural, political and economic context. This transactional and ecological

perspective has far-reaching implications for all aspects of early intervention, including assessment issues, services must build upon the child's strengths as well as address the child's vulnerabilities, and work within the family system in order to enhance family adaptation, facilitate the development of child competence, and prevent the consolidation of more intractable disorders in later childhood and adolescence (LaFreniere & Dumas 1995:88).

In early intervention, programmes were involved with designing and implementing a variety of strategies for families that professionals believed would be helpful and supportive. Only within the last few years has the notion of family-centred services (Chandler *et al* 1986:233-245; Trivette *et al* 1986:146-267) surfaced, profoundly changing the ways in which we interact with families to support and enhance their coping skills.

Professionals who began programmes for pre-schoolers, infants and toddlers in the late 1960s and early 1970s did so without a substantive body of literature to guide their early innovative efforts. The theoretical rationales on which such programmes were based were, for the most part, limited to developmental theory governing interactions with children. Programmes using developmental prescriptive, Piagetian, or behavioural approaches with children tried to design training programmes for families that would give them the skills needed to use the same approach in teaching their children at home (Garland 1993:69).

Initially, the theoretical base for work with families was influenced by the early work of Faber, Olshansky (1962:190-193), Solnit and Stark (1961:523-

537), and others who described the negative impact of a child with a disability in the family. Kubler-Ross (1969:223), provided another theoretical framework for understanding the feelings of families of children with developmental disabilities. She offered an explanation - anger or denial - when families were less than excited at the prospect of carrying out the behavioural training programmes designed for parents to use at home in the mid-1970s (Heward *et al* 1979:216).

Those whose training was psychoanalytic could easily apply an understanding of ego defense mechanisms to families who seemed to be rationalizing, substituting or intellectualizing (Garland 1993:69). Similarly the researcher is going to use the following theories in her research design viz: Piaget, Frankl, Ayurvedics, Psychotherapy and Rational-emotive therapy.

When aiding parents who have learning disabled children, it is necessary for parents to be aware of the family-centred services.

### **3.6.2 Family-centred services**

Early intervention services are beginning to be driven not by system needs or child needs, but by family needs, as families perceive and articulate those needs (Bailey 1987:59-71; McGonigel & Garland 1988:10-21; Trivette *et al* 1986:146-267). The work bridging between research has given attention to the strengths and resources that families have and can use in meeting their own needs (Affleck *et al* 1985:653-656) and in living their lives in the absence of chronic sorrow (Olshansky, 1962:190). The Infant and Toddler

Program (Part H) of the Individuals with Disabilities Education Act (U.S.A.), formerly known as PL 99-457, is a direct response to that attention. Meyer (1986a:227-254) has emphasized programmes for fathers, siblings and grandparents which can in turn help all family members cope with a child's learning disability.

Regulations for Part H require that participating states provide a multi-disciplinary team assessment of the child's strengths, and needs of family wants, and needs related to the development of the child. Families play a major role in defining their own strengths and needs. All eligible infants and toddlers must have written individualized family service plans (IFSPs), designed by a team in which the family participates. The IFSP must specify the family's desired outcomes or goals for themselves and for their child, and services they will receive to help them reach those goals. This legislation hurttles early intervention programmes forward to the point at which families whose infants and toddlers have disabilities should not have to shop for services that fit. Services will be designed specifically to meet the needs of each individual family, helping them build in their unique strengths to reach their goals (Summers *et al* 1989:27-53).

Booth and Booth (1993:148) feel that parental competence is not just a matter of possessing adequate parenting skills. It is an attributed status which owes as much to the decisions of professionals as to the behaviour of parents. It is situationally determined by the quality or poverty of the environment in which people live. Competence too is socially constructed in terms of the normative standards and evaluative judgements enforced by the wider society, official agencies and their front-line representatives.

These services offer families the opportunity to enhance the cognitive coping strategies and skills described by Summer *et al* (1989:32) that is, casual attribution, establishing mastery, and enhancing self-esteem. The early intervention team works with the family during assessment, during the process of collecting and reviewing records, during regular home visits to ensure that families have and understand the information they need to make informed decisions. Several parents described themselves as becoming experts during the diagnostic period. They gained both mastery and self-esteem by reading - sometimes selectively, sometimes everything they could find (Garland 1993:71). Shelby (1994:12) encourages both the parent and child with a learning disability to believe in success.

The opportunity to participate to the level and extent they desire as members of the early intervention team offers families an opportunity to use the mastery they acquired of necessity as a powerful and satisfying coping strategy. Many families have said that when they became involved in early intervention programmes they felt at last they **“were doing something”** for their children. Other families see their involvement in early intervention as changing their role in reaction to their child from nurturer to teacher. That role change interferes with parents’ definition of themselves and their role relationships within their families.

The most profound change in Garland’s (1993:72) work and that of her colleagues in supporting and enhancing family coping was to follow the parents’ lead rather than to impose their notion of what families must learn to do to cope (Turnbull *et al* 1993:72).

Shelby (1994:11) encourages a “practical” approach in teaching the learning disabled child. She says no one method is best or even universally successful. If her approach were reduced to a phrase, it would be, “find what works for your unique learner”. Support groups are effective when handling parents of learning disabled children.

### **3.6.3 Supporting families’ coping strategies**

Vander Zanden and Pace (1984:45) recognised that informational programmes for parents and their children, and parent training programmes were all increasing in use.

When families join the early intervention team and are received as respected experts on the subject of their children, they are more likely to believe that the demands of the tasks do not exceed their resources to cope. Families seek information, and practice using it in the early intervention setting, and getting reactions and testing a variety of strategies. When they have the respect of the team, they are encouraged to continue to grow and to use those coping skills (Garland 1993:73).

For early interventionists, respect for families does not derive from the information or skills they have acquired but from a professional approach to working with people. Early intervention providers see families when the initial diagnosis is reached and the fact of their children’s disabilities have dealt a harsh blow to their self-esteem. Providing not only services but an environment that inherently enhances self-esteem is central to the relationship between the early intervention system and the family.



Karnes and Zehrbach (1972:6-19) described three necessary prerequisites for parent involvement in a counselling activity:

- The attitude of the professional - there must be a positive attitude about parents' contribution to the growth of their child.
- The recognition that there is more than one way to involve parents - parents have individual needs that must be recognized to help them select the best way to be involved in the educational programme of their child.
- The belief that each parent is capable of growth - the amount of growth of parents will vary.

Fairfield (1983:411-415) stressed that counselling of parents of learning disabled students determine the attitudes, feelings, reactions and concerns of parents.

In parent groups, or through parent-to-parent networks, parents compare notes and find they are not alone, not the only one in the world. Parent groups offer settings in which families can share coping strategies with one another, and can offer suggestions ranging from how to deal with the unrealistic expectations of the extended family to how to find a good dentist. Daniels-Mohring and Lambie (1993:10) encourage support groups as they are invaluable in helping parents with acceptance of their child's learning disability. Schools should provide parents with information about availability of these groups in the community.

As families acquire new skills in handling, feeding, or teaching, the pleasure and satisfaction they take in even very small developmental gains are real and measurable. If there is one coping skill or strategy that varies most widely among family members it certainly seems to be humour. The ability to laugh at oneself or at the awkward or uncomfortable moments in life is not only a coping strategy but a gift. While no one would find anything funny about having a child with a disability, many family members are able to find humour in their life situation on a daily basis (Garland 1993:75). Therefore it is necessary to determine families' needs.

#### **3.6.4 Determining families' needs**

The home context in which many family-centred early intervention services take place colours the relationship between family and service provider with a unique intimacy.

Programmes that involve parents in assisting their children with completion of work at home should be developed carefully and used cautiously. Given the problems that may ensue in achieving successful parental involvement should not be taken lightly (Salend & Schiff 1989:621). However, training in tutoring techniques succeeded by instructional follow-through by parents has proven effective with students with disabilities according to Shapero and Forbes (1981:499).

Parents confirm the feeling of one mother that home-based services give providers a "sense of family reality. No one can say to you, 'What are your coping skills?'... In your home they see your style and they

**learn how to use what you have to help”**. Parents stress how important it is for providers to understand the impact of events in all family members so that they can help minimize family stress and help enhance family coping (Garland 1993:76).

Salend and Schiff (1989:622) state that parents have often talked of their other children’s concerns about the differences of siblings. They have described older children and adolescents as worrying about their own chances of having children with disabilities. Parents have reported knowing they can change the ways in which extended family and friends perceive their family’s stress by **“being able to handle it”**. However, they also come back to the need to surround themselves with family and friends who support their families and see the good things about their families.

Therefore, providers trying to support and enhance family coping skills are challenged to address the multiple and varied needs of the whole family. Individual family members must be free to choose the early intervention services that meet their individual and collective needs, and those of their other children. As early intervention services that are family centred and that reinforce and enhance coping skills are planned, family member needs from the system have to be learnt and creative ways to be found to meet those needs. Therefore, directions for future research needs to be outlined.

### **3.6.5 Directions for future research**

Early intervention programmes that respond to the intent of recent legislation by developing Individualized Family Service Plans based on

family needs, values, preferences and priorities can provide a therapeutic milieu that fosters the development of family coping and that reduces to the possible stress associated with early identification of a disability. Discovering what precisely it is that we do that is successful or how we can be more supportive is less easy. While the potential for answering important questions related to family coping is inherent in the service setting, few community-based programmes have the financial personnel resources necessary to carry out field-based research. Money and skills are not the only barriers. Methodology and protocol designed in the research environment are often perceived as intrusive and potentially damaging to the relationships service providers to carefully cultivate with families. Early intervention programmes that greet each child and family with unconditional acceptance and appreciation are understandably reluctant to engage in an interview protocol that asks such questions as: **“Were you depressed when you came home from the hospital?” “Have you ever wished your child had not been born?”** (Garland 1993:78).

Green (1990:145) suggested that clinical work with parents would benefit from the use of an analogy in which the family is seen as “the primary classroom experience in a child’s education”. Future studies are needed to examine how negative teaching-interaction patterns, such as those found to characterize the mother-child interactions in families of children with learning disability, develop during the early years, and how they are related to children’s cognitive development and subsequent school functioning. The researcher intends to provide ways on how parents could be assisted in coping with stress when they have a learning disabled child.

### **3.7 HOW PARENTS COULD BE ASSISTED IN COPING WITH STRESS WHEN THEY HAVE A LEARNING DISABLED CHILD**

It cannot be disputed that parents of disabled children face a great deal of stress. However, it is now important for investigations to move away from describing these stressors and their adverse effects. Instead, research should focus on exploring the ways that such families cope, with varying degrees of success, with care of a disabled child. Such work has far greater implications for understanding and improving the ways that these families can be helped, states Beresford (1994:171).

The multiple factors influencing the child's level of functioning and life satisfaction create difficulties of interpretation for researchers trying to draw conclusions about the impact of a child's disability on family functioning. Most researchers have concluded that the impact on the family of a child with disabilities is not because of the physical demands of the child on the family but because of the psychological strain that is created (Clayton *et al* 1994:314).

Practitioners and educators caring for and providing services for children with developmental disabilities need to be cognisant of the stress these children create for parents. Results of the present study suggest that several problematic child characteristics persist over time. The problems associated with the lack of adaptability of the child, the acceptability of the child, and the demands placed on caretakers of children with developmental delays appear to be the major sources of stress for parents (Orr *et al* 1993:175).

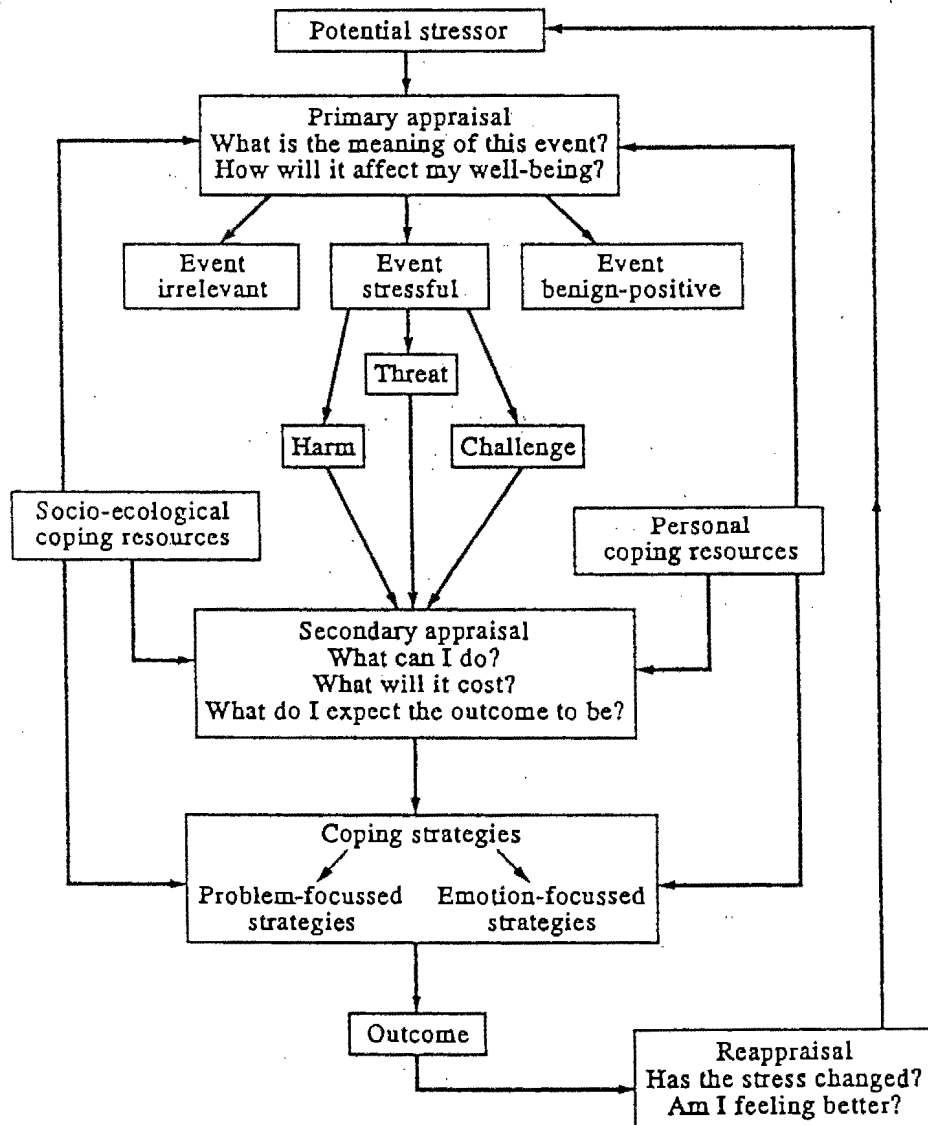
The following models will be used by the researcher when working with parents of learning disabled children: The process model of stress and coping, (figures 1 and 2) and the researchers' own model on cognitive coping (figure 3). The latter model will be discussed in detail in Chapter 4.

### **3.7.1 The process model of stress and coping**

According to Coyne and Smith (1991:404), in the early 1960s a group of psychologists headed by Richard Lazarus developed the process model of stress and coping. By the mid 1980s this model had received considerable research attention which served to validate the model. It is acknowledged as the most comprehensive model of stress coping and adjustment.

The central tenet of this model according to Slaven *et al* (1991:156) is that the process of coping mediates the effects of stress on an individual's well-being. Figure 1 is a representation of this model. All aspects in Figure 1 will be explained.

**Figure 1. THE PROCESS MODEL OF STRESS AND COPING.**



(Beresford 1994:173)

Firstly, coping is a **process** or ongoing complex interaction between an individual and the environment. Secondly, coping is viewed in terms of **management** as opposed to mastery. A realistic view of stress is taken. The model (Figure 1) recognises that not every problem can be mastered.

For example, a common problem faced by parents of a disabled child is their child's incontinence. Mastering this problem would entail successfully toilet-training the child, which is not always possible (Beresford 1994:174).

Thirdly, the definition includes the notion of appraisal. The development of this model coincided with the so-called cognitive revolution in which the emphasis shifted from objective appraisal to one which is concerned with the subject's individual appraisal, that is, how phenomena are "perceived, interpreted and cognitively represented in the minds of the individuals" states Magnusson (1982:23).

Finally, coping is a **mobilization of effort**. It includes both "cognitive and behavioural efforts to manage (reduce, minimize, master or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person's resources" (Folkman *et al* 1986a:572).

The process model of coping is concerned with the coping processes of an individual, as opposed to the family unit. Outcomes are therefore also assessed at this level of analysis. Work in this area has almost exclusively measured outcomes in terms of the parent, as opposed to the child. Measures of parents' physical and mental health have been used. Scores on these measures are taken as indicators of adaptation to the demands of caring for and bringing up a disabled child (Beresford 1994:174). As figure 1 shows, coping resources are a crucial aspect of the coping process.



### 3.7.1.1 Coping resources

The general psychological literature has consistently shown that coping resources account for variance in psychosomatic complaints and psychological distress. Availability of resources states Fong (1991:471) affects the appraisal of the event or situation and determines which strategies the individual can use as shown in Figure 1. Coping resources consist of personal and socio-ecological factors as indicated in the model. Most research has focused on the socio-ecological factors.

Beresford (1994:180) states that personal coping resources have both physical and psychological variables. They include physical health, morale, ideological beliefs, previous coping experiences, parenting skills, intelligence and personality characteristics.

The second group of coping resources are found in an individual's environment or social context. They include the marital relationship, social networks, practical or functional resources and economic circumstances. As with personal coping resources, they can act as risk and resistance factors to an individual's adjustment (Beresford 1994:181).

### 3.7.1.2 Coping strategies

Coping strategies are actions, behaviours and thoughts used to deal with a stressor Folkman *et al* (1986a:571-579). They have two functions: emotion-focused coping and problem-focused coping. **Emotion-focussed coping** serves to ease painful or distressing emotions resulting from the stressor.

**Problem-focussed coping** directed at an external source of stress includes strategies such as using negotiation to resolve an inter-personal conflict, taking a painkiller, asking for practical help. Internally directed problem-focussed coping include cognitive restructuring and mentally disputing irrational beliefs (Folkman *et al* 1986b:992-1003).

There is relatively little research states Eiser (Beresford 1994:192) in the coping strategies of parents caring for a disabled child. One reason is that the process model of stress and coping which emphasizes the importance of focussing on specific responses to specific stressors, has only recently been used in this area of research.

There have been a number of studies on parents' views of which coping strategies are most helpful. The coping strategies found to be helpful by the majority of mothers were:

- a) believing that the intervention programme from which they were seeking help for their child had their family's best interests at heart;
- b) learning how to help their children improve;
- c) believing in God;
- d) talking over personal feelings and concerns with their spouses;
- e) building closer relationships with spouses;
- f) trying to maintain a stable family life;
- g) developing themselves as persons;
- h) telling themselves that they had many things to be thankful for;
- i) doing things with their children;
- j) believing that their children will get better.

This list encompasses a great range of coping strategies, which is extremely helpful to the parent (McCubbin *et al* 1983:359-369).

The previous sections have demonstrated how concepts from the process model of stress and coping (Figure 1) can be used to organize and understand research on families caring for a disabled child.

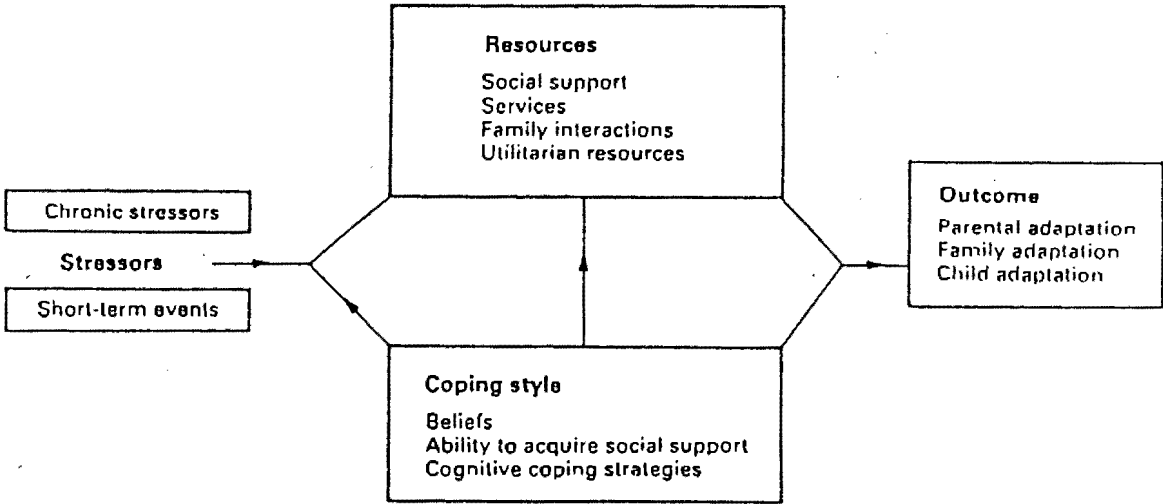
### **3.7.1.3 Intervention**

The process model of stress and coping (Figure 1) has shown that coping resources affect the choice of coping strategy. Social support is a clear example here. Personal coping resources and coping skills affect the availability of social support as a resource, and hence use of social support as a coping strategy. “..... interventions with families under stress need to address the factors which mediate social support and influence parents’ access to and use of social support” (Sloper *et al* 1991:673).

In addition the process model (Figure 1) emphasizes the active role that parents play in dealing with the stresses associated with caring for their child. They are actively coping with their circumstances and seeking out ways to alleviate their situation further (Beavers *et al* 1986:365-378).

McConachie (1994:37) indicates that it is clear that parents with a learning disabled child are likely to be more stressed than parents of non-disabled children. The researcher in turn describes the second model. Figure 2 is a composite research model of stress and coping.

**FIGURE 2. COMPOSITE RESEARCH OF STRESS AND COPING**



McConachie 1994:39

**3.7.2 Composite research of stress and coping**

Much of the recent research on families bringing up a disabled child has explored their coping strategies to deal with stress. The major findings are reviewed in Figure 2, and possible implications for the structure and content of service delivery suggested. Figure 2 emphasises the importance of social support networks, including the relationship between the mother and father, and of quality services in enhancing parental adaptation (McConachie:1993:37).

In Figure 2, a model of stress and coping is outlined drawn from a summary of recent research studies in childhood disability. The groupings of elements such as chronic stressors, short term events, resources, coping style and the outcome are described in brief below.

#### **3.7.2.1 Chronic stressors**

These include behaviour problems in children. Behaviour problems may be of more significance in studies of children with learning difficulties in middle childhood than for parents of young, physically, disabled children (Sloper & Turner 1993:167).

#### **3.7.2.2 Short term events**

The first is stages in the life cycle, such as the child entering school. This is a time of increased stress for many families, whether the disabled child goes into a special or mainstream school. Secondly, there is the factor of life events, shown in the general mental health literature to be a significant element in the generation of stress (McConachie 1994:38).

#### **3.7.2.3 Resources**

Four of the factors most commonly included under the heading resources are listed in the model (Figure 2), namely:

- social support

- services
- family interactions
- utilitarian resources.

There has been a large body of work on the link between mental health and social support. The second factor described is contact with helping services, that is, formal sources of support, information, and treatment. The third factor which has been included in most studies is that of the family interaction style. This aspect of family functioning has repeatedly been found predictive of the level of parental adaptation, and it is usually found that open channels of communication, cohesion, and flexibility concerning roles within a family are protective. Finally, utilitarian resources continue to be predictive (McConachie 1994:39).

#### **3.7.2.4 Coping style**

There have been a number of models proposed for understanding ways of coping, but the analysis of Lazarus (e.g. Lazarus & Folkman 1984:54) is generally the most used. This includes general and specific beliefs, and parents' skills and attitude in dealing with problems. Aspects such as religious faith which can have a profound effect upon parents' attitudes to their child's disability would be included under general beliefs, which is the first area. Parents' ideas about the causation of the child's disability and the extent to which they or other people are perceived as 'at fault' would be included within specific beliefs. The reciprocal nature of the link between stressors (chronic stressors or short term events) and parents' perceptions of those stressors is indicated in Figure 2, namely :

- parent adaptation
- family adaptation
- child adaptation.

The second area includes skills eliciting support. There seems to be additional explanatory power in looking not only at the size of a parent's friendship network and extended family, but additionally at how successful the parent is in eliciting satisfactory support in a time of need. Finally, ways of coping have been examined, including whether a parent is more likely to adopt an attitude of wishful thinking in a crisis, or alternatively to start active problem solving.

Research into coping is complicated by the fact that individuals have many coping styles, and that coping is a dynamic process that changes over time (Kantor *et al* 1997:16).

According to McConachie (1994:40) family adaptation may be included as an outcome measure. Child adaptation has also been used as an outcome, indicating the direct importance of multiple environmental factors upon disabled children's functioning and not just their presumed biological capacity. Some results and possible implications are:

- According to Waisbren (1980:345), satisfaction with social support is regularly found a highly predictive factor. Parents have relatives, friends, church groups and organizations of parents of disabled children, to whom they can turn, then they are likely to have higher levels of positive adaptation.

- In very many of the research studies, the feeling that one's spouse is a support is a factor highly predictive of parental adaptation. The obvious implication is that services should be organized in such a way as to support family cohesion in interventions. In many services for young, learning disabled children there is an attendant danger of excluding the father from feeling competent in handling his child, if he is generally at work and the mother at home when the home teaching adviser or therapist visits (McConachie 1994:41).

A number of studies have suggested that the mechanisms affecting stress differ between mothers and fathers. For example, Frey *et al* (1989:240-249) suggested that greater stress for fathers was related to having a boy and the child having a low level of communication skill. Therefore it is necessary to discuss the role of professional services.

#### **3.7.2.5 Professional services**

Vadasy *et al* (1986:36-44) state that the most straight forward implication of this would be that the role of professionals must be to find ways of supporting the informal network of parents, and not to take over. It may be of great benefit to the parents and child, to provide groups where siblings can meet and talk together, and perhaps also groups for grandparents.



### **3.7.2.6 Coping strategies**

Coping strategies have been found highly predictive of outcome in terms of parental adaptation. Parents who typically use problem-focused strategies, such as planning and making contacts, fare better than parents who use avoidance of problems, or wishful thinking (Sloper & Turner 1992:259-282).

Beck (1976:5-37) states that problem solving skills, and skills in eliciting social support, can be learned. In addition, cognitive behavioural therapy has been suggested as an approach in helping parents re-frame their ideas about their situation such as learning to tell oneself that "I can find a solution to this; asking for help is the right thing for me to do". In addition, it is important for services to approach families in such a way as to increase parents' feelings of control over events, to avoid possible effects of learned helplessness.

## **3.8 CONCLUSION**

Current research, states Marfo *et al* (1992:27-44) into the models of how families cope with having a learning disabled child, suggests a number of implications for how to meet families' individual needs more flexibly. There is the issue of what to include in the initial assessment of child and his or her family. According to Eayrs *et al* (1992:15-29) disability service teams require to have available, reliable and valid measures of family needs, strengths, social networks, coping strategies and satisfaction with services.

In practice, in most local services for families of disabled children, assessment concentrates on child development levels. Parents are not asked about wider-ranging factors even though research has demonstrated consistently their importance to long-term outcome for families and their learning disabled children. The elements required for satisfactory evaluation of services to families have been analyzed (Eayrs & Jones 1992: 15-29).

Rosenbaum *et al* (1992:103-114) state that the ways in which services are organized may owe more to habit and professional assumptions than to clearly examine the varying needs of the population being served. Parents have different ability styles to secure the early support services which are their right when bringing up a young learning disabled child. Aspects of successful services which are valued highly by parents include how accessible professionals are, how available respite care services are, and how much continuity there is over time of the key professionals with whom they have formed relationships. Such aspects may be less well understood by professionals as priorities.

Services which focus primarily in the child may not take into account the impact of programmes on other family members in terms of time, energy and stress. Instead, early support services need to reorganize themselves around concern with general well-being of the family (McConachie 1994:44).

Finally, there are major implications for staff training and development if a family-focussed model of service delivery is to be adopted. A group culture

of accepting constructive criticism will need to be fostered. Arrangements for induction of new staff into the philosophy and procedures of the team will require careful planning. The inclusion of parent representatives in the management committee of the child development service is likely to be essential in keeping a focus on family needs, when the emphasis of the broader management structures is all on budgets (McConachie 1994:44).

Because of some limitations of both the above models (Figures 1 and 2) the researcher will devise her own model (bearing these limitations in mind) and provide important techniques using RET, psychotherapy and Ayurvedics to help parents to overcome their stress. This would in turn aid in learning on how to cope with learning disability and some possibilities on how to solve their stresses.

## CHAPTER FOUR

### DESIGN OF A COGNITIVE COPING SKILLS PROGRAMME

#### 4.1 INTRODUCTION

The object of chapter four is to provide a design of a cognitive coping skills programme, whereby a programme will be designed by the researcher using RET and Ayurvedics.

An important challenge to researchers is to discover why some families cope in the face of severe stress whereas others do not, and to understand those elements of family functioning which make families vulnerable to stress or resistant to stress. Quine and Pahl (1991:68) research findings indicate the child and family variables may lead to stress and inadequate coping. The complex and interrelated nature of child and family variables lend support to the idea that parents should be provided with information services by co-ordinating them through a link person. Sometimes families are unaware of what services exist to help them. From the researcher's experience, such help is often poorly organised and co-ordinated. Research findings of Quine and Pahl (1991:68) indicate that there is a need for a comprehensive method of assessing child and family in order to identify needs and to target resources accurately. Such an assessment would take account of all the factors relating to the specific problems faced by families in order to arrive at suitable intervention strategies.

Both the models discussed in Chapter 3 are effective, but can be improved by incorporating RET and Ayurvedics which the researcher intends to include in her model (Figure 3). In the discussion on the importance of the two therapies (RET and Ayurvedics), reasons will be given for their choice and the shortcomings of other theories will be discussed. Thereafter the researcher will provide her design of a cognitive coping skills programme (Figure 3).

## **4.2 RET AND ITS IMPORTANCE IN THERAPY**

RET was developed by Albert Ellis in 1955 both as a counselling theory and a philosophy. RET is a humanistic, existentially oriented approach designed to assist clients to make a profound philosophic change. RET contends that beliefs contribute to or cause one's emotional reactions. Some beliefs are considered irrational. RET considers an appropriate or healthy emotional reaction as one that is helpful, as opposed to harmful. Although thoughts, feelings, and behaviours interact, RET contends that one's thoughts primarily determine one's feelings (Weinrach 1996:326).

The researcher intends to use RET for several reasons. Although RET therapists utilize all kinds of behavioural methods, they put them squarely within a phenomenological and humanistic framework. Rather than resorting to direct conditioning or reconditioning, as many classical behaviour therapists do, RET practitioners almost exclusively favour the teaching of self-control methods. Moreover, RET also acknowledges the perniciousness of social reinforcement - which is not only used too extensively by scores of behaviour therapists but also has been shown to be

one of the main hidden factors in the therapeutic results that have been obtained in many client-centred studies. Although Rogerian therapists attempt to help their clients to achieve unconditional positive regard they actually reinforce them with appropriate “Uh-huhs” or nods of approval when they say the “right” client-centred things, and they thereby encourage these clients to go, perhaps more than ever, for highly conditional positive regard, and to remain hooked on their dire love needs which compel them to think that they must have other’s acceptances (Ellis 1978:48).

RET, on the other hand, uses reinforcement procedures in a realistic, hard-headed manner, including at times such social reinforcements as the approval of the therapist, other family members, or outside individuals as a specific reward for the individual’s changing his/her obnoxious or self-defeating behaviours. But it virtually never uses reinforcement in its own right - no matter how tempting may be the gaining of quick therapeutic results by its use for clients who lose their symptoms because of operant conditioning or other classical behaviour therapy methods. Often they do very well for awhile; but they have greater tendency to slip back to their old habits of cognitive, emotive, and behavioural dysfunctioning than do those who utilize behavioural methods that are closely allied with cognitive restructuring (Ellis 1977b:2-42).

RET, therefore, teaches individual, marital, family, and group therapy clients to become less liable to the hazards of social conformity to strongly desires but not to absolutely or compulsively need the approval of others, including members of their own family group. It focusses - as just about no other major systems of family therapy do - on helping people to relate

to each other better on a preferential rather than a masturbatory basis. It tries to show clients how, in the final analysis, to be less rather than more conditionable and suggestible, and whereas most systems of psychotherapy - including psycho-dynamic, systems-oriented, and client-centred family therapy-wittingly or unwittingly foster childish dependency of family members on the therapist and/or on each other. RET goes out of its way to discourage this kind of result and to help people train themselves to be much more responsible, self-sufficient and self-accepting, even when they are part of a family structure and would prefer to enhance and enliven their relatedness (Ellis 1978:49).

The most popular forms of family therapy today, psycho-dynamic and systems-oriented therapy, leave much to be desired because they tend to ignore and to lose family members as individuals, as people in their own right. They often fail to help patients to see themselves as the creators and perpetrators of their own intra-personal and interpersonal problems, and not merely as the victims of early childhood upbringing or of contemporary environmental difficulties. A phenomenological-humanistic view of families who come for therapy, such as the client-centred view espoused by Levant (1978:4) would serve as something of a corrective for the one-sided methods of family therapy espoused by most of today's leading practitioners and writers. This view itself, however, omits some of the realities of human individual and group disturbance and consequently ends up as being somewhat ineffectual. A "third force" in family therapy is therefore suggested, which combines a phenomenological-humanistic approach with a highly active-directive attempt to help family members surrender their misperceptions of themselves and others to make profound



philosophic changes in their intrapersonal and interpersonal attitude and behaviours. As an example of this kind of a phenomenological - humanistic and active-directive approach to family therapy, some of the principles and practices of Rational-emotive therapy (RET) are outlined and applied to helping individuals change themselves and help each other within the family unit. In RET family therapy, clients are shown how to acknowledge, understand and minimize their own emotional problems, as well as how to help other family members become more rational, experience more enjoyable and appropriate emotional responses, and act in a less self-defeating and family-defeating manner (Ellis 1978:49).

While many parent education programmes have as their primary goal teaching parents skills in order for them to solve child-oriented problems, RET's approach to parenting recognizes the importance of helping parents reduce their emotional stress associated with parenting as well as teaching parents how to manage child problems and foster the personality development of children (Joyce 1995:55).

More than ever before Rational-emotive behaviour therapy (REBT) finds itself making contributions to, and being recognised for, the understanding of psychopathology and poor mental health as well as the professional practice of counselling and psychotherapy. Its uniqueness in conceptualizing contemporary problems of living and the effectiveness of its change techniques exerts strong hold on its many old fans and adherents while continuing to attract increasing numbers of practitioners. REBT is sharpening its identity both as a theory of psychopathology as well as treatment methodology. It takes an account of its weaknesses (e.g.,



research) and capitalizes on its strengths e.g., theory, therapy, professional and public education, prevention (Bernard 1995:10).

### **4.3 AYURVEDICS AND ITS IMPORTANCE IN THERAPY**

Ayurvedics is one of the world's oldest medicinal sciences, which originated in pre-historic India and is gaining world popularity. Khan (1997:10) of the Ayurvedic Society in New Delhi, India states that Hollywood stars such as Elizabeth Taylor, Demi Moore and Cindy Crawford are among a steadily growing band of Westerners who have discovered the benefits of Ayurveda.

Ayurveda comes from two words in Sanskrit, India's classical language: **ayus** meaning life and **veda** meaning knowledge. It is usually translated as "the science of life".

The guiding principle of Ayurveda is that the mind influences the body. The state of balanced awareness between body and mind creates better health and gives freedom from sickness.

It is perhaps the most ancient holistic system of treatment by natural remedies which makes use of the processes in nature to restore human beings to a state of balance. It identifies the correct way to live at a given moment to overcome special problems of that particular time or of a particular kind of constitution. In Ayurveda, as in all Hindu philosophical teaching, the universe as macrocosm and humans as microcosm are in

direct relationship; they reflect one another and one is always present in the other (Khan 1997:10).

Ayurveda has an immediate connection between the use of senses and the origin of disease. The identity between nature and the self is the foundation upon which all the principles of Ayurveda are built. The well-being and the good health of an individual are dependant on the equilibrium of the three forces that control all physical and mental activity. These forces called Tridoshas or Humours, are a reflection of the Trinity; the principles of creation, preservation and destruction. The Tridoshas or three doshas are called Vata, Pitta and Kapha, respectively signifying air, bile and phlegm, which regulate the intricate functioning of the mind-body system. Vata controls movement and comprehends all the phenomena which come under the function of the central and sympathetic nervous system. To remain alive, the body has to have Vata or motion which allows it to breathe, circulate blood, pass food through the digestive tract and send nerve impulses to and from the brain. Pitta controls metabolism. The body has to have bile which processes foods, air and water through the entire system. The structure and secondary formation of various preservation fluids is controlled by Kapha. The body has to have Kapha to hold the cells together and firm muscle, fat, bone and sinew. These three doshas form the tripod of Ayurveda. If they are balanced in equal proportions in the body, there will be harmony and absence of disease. They keep the physic and the psyche in a healthy condition (Chopra 1991:72).

The practice of Ayurveda has maintained its individuality for centuries with gratifying results. The underlying principle of Ayurveda is detoxification. Application of warmth (swedhana) and oil massage (snehana) to the body promotes better circulation of blood in the system. The function of Ayurvedic products, now being promoted in Europe through a joint export programme between the Government of India and the Commonwealth Secretariat, is to rectify the imbalance of Tridoshas in the system (Khan 1997:10).

If parents and learning disabled children are healthier in both body and mind, they would in turn be able to cope better with the stresses of learning disability. The researcher therefore intends to use the two above therapies in her cognitive coping skills programme (Figure 3, Maharaj 1998:147).

Since learning disability is the stressor, it is closely allied with stress and coping. This would lead to adaptational stages of parents who have learning disabled children i.e. encouraging redefinition. How does it affect parents and family has implications for parent-child relationships, parent-teacher relationships and parent programmes (Figure 3).

#### **4.4 THE STRESSOR**

Stress and coping must be assessed longitudinally, by examining possible changes in styles of adaptation levels of stress and aspects of the stressful experience across a family's life path. A number of writers have postulated adaptational stages parents go through after they learn of their child's

disability. Others remind us that parental stress may be re-negotiated at key developmental points in the child's life cycle (Konstantareas 1991:370).

Parents must enter a whole new world of child rearing when their child has a learning difficulty, which can be bewildering and distressing. However, there is much that can be done to assist such children, and there is invaluable support out there for parents. With some basic information on factors affecting the degree of stress now available, we need larger designs with the same group of families to allow collection of data which can be cross-referenced. Hill's (1958:139-150) ABCX model has already been used to some advantage, such as important insight into family life and the ways families react in times of stress. As seen in figure 3, the stressor for the parent is the child's learning disability.

#### **4.4.1 Encouraging: Redefinition**

Although many of the day-to-day problems associated with a learning disability are within families' control to solve, the fact of the disability itself is not. It therefore is a vital part of families' reframing skills to be able to redefine the situation to make it less stressful. Positive redefinition was the coping strategy most often used by families surveyed by Brotherson in 1985. There are two ways in which families can redefine their perceptions of the exceptionality and its impact on them, and a number of ways that professionals can help (Turnbull & Turnbull 1986:311). This is also represented in Figure 3.

Firstly, positive comparisons involve considering the problems and stresses that other people have, and concluding that one's own problems are "not so bad after all" as one mother philosophically summarized this effect:

**Everybody has got a cross to bear. Some people's are a bit heavier than others. You can always look around and see people worse off (Turnbull & Turnbull 1986:311).**

No matter how difficult the exceptionality may seem to an outside observer, many families are amazingly adept at using positive comparisons:

**We're lucky because Carol isn't aware she's different. I know lots of others who are very hurt because they know they're retarded. But Carol is too handicapped to be hurt by her limitations (Turnbull *et al* 1984:31).**

It would certainly be inappropriate to violate confidentiality and point out to parents the specific ways in which their child is less disabled than another pupil. Professionals can indirectly assist families in making positive comparisons, for example one can avoid implying that a particular pupil is the 'worst one' in regard to academic problem, and one of course should take care to highlight the child's strengths. If possible, help families understand that their particular child's problems are not uncommon and that they are shared by many pupils. Such assurances place the problem in a more realistic and less alarming perspective; it helps to know one is not alone.

Another type of redefinition is selective attention and selective ignoring. This involves more attention to the positive aspects of a situation and less to the negative aspects. Contrary to the usual expectations of some professionals, there are positive factors associated with exceptionality and many families recognise this fact. For example, 75 percent of a sample of 25 parents surveyed by Wikler *et al* (1981:63-70) reported that their experiences with disability had strengthened their families.

Parents also need to be recognised for their own contributions and successes. It may be more difficult for parents to see their own positive attributes than those of their children. Parenthood is so deeply rooted in one's self-concept that the advent of a child with a learning disability can have a profound effect on one's self-esteem. The threat to parents self-esteem that accompanies learning disability makes it vital for professionals to point out the successes that parents have achieved and to praise their efforts, no matter how small (Turnbull *et al* 1986:313).

Learning disability affects the parents and family in different ways and contributes to the **stress** they experience. Therefore it is important to investigate the **effect** of learning disability on the parents and family.

#### **4.5 THE EFFECT OF LEARNING DISABILITY ON THE PARENTS AND FAMILY**

Having a child with a learning disability will affect parents and siblings with their day to day living. So if parents and family members learn to cope with their child's learning disability, all will inevitably benefit. In the

discussion of the effect of learning disability (see 3.5) on parents and family attention will be given to parent-child relationships and parent-teacher relationships (as in Figure 3).

#### **4.5.1 Parent-child relationships**

According to Fuller and Rankin (1994:583), it is important to evaluate the family system and the amount of stress being experienced to provide better services to a child and parents. Tests that measure the amount of stress experienced in the parent-child relationship might be a valuable aid to the practicing professional.

Dusek and Danko (1994:413) state that the means of coping are acquired through socialisation processes and have stressed the important role of parents in this regard, placing special emphasis on the child's perception of parental rearing behaviours. They have reported that a perceived warm relationship with the mother insulated the child from negative reactions to stress. More direct evidence noted that 10-year-olds' perceptions of maternal acceptance predicted problem-focussed coping and the use of social support seeking, whereas perceived maternal negativity predicted emotion-focussed coping and the higher use of distraction and avoidance.

Maccoby and Martin (1983:1-101) noted that, for children, authoritative parenting was associated with more positive outcomes in school performance, psychological and psychosocial adjustment, self-esteem, and the like. Baumrind (1991:746-758) found that authoritative parenting, particularly its warmth and acceptance component, has been associated

with higher self-esteem, more advanced identity development, greater school success and better psychosocial adjustment. Steinberg *et al* (1992:1266-1281) attributed these beneficial effects to the healthy sense of autonomy of, psychological orientation to, and active engagement in academics and other work activities, and to positive attitudes about the self and one's competencies that authoritative parenting fosters.

#### **4.5.2 Parent-teacher relationships**

According to Mabunda (1991:10) the parents of learning disabled children face a life-time of adversity. It is also most unfortunate that, because of the burdens of parenting such a child and the corresponding pressure that teachers face in assuming broader role functions, parents and teachers often find themselves at odds with each other - adversaries rather than collaborators. In order to achieve a greater understanding for the parents of learning disabled children, and to be able to assess, recognise and anticipate behaviour unique to such families, it is essential for teachers to become more knowledgeable about them, and about their hopes, joys, disappointments and frustrations.

The shock of the reality of a learning disabled child in the family renders both parents culturally and psychologically vulnerable. In some contexts, a mother might interpret such a child as a reflection of her inadequacy to produce good, healthy children. A large number of parents of learning disabled children view the birth of their child as the loss of the ideal, "bright" child they expected (Mabunda 1991:12).



Professional reactions whether negative or positive, have a potent effect on parents. The teacher should help parents to accept themselves and their child by communicating a sense of caring and concern for the parent. Of equal benefit is the parents' perception that the teacher loves and accepts their child.

Parental acceptance may be manifested in the parents' willingness to participate in parent-teacher associations, to discuss the child's shortcomings with relative ease, to abandon over-protective or unduly harsh behavioural patterns towards their child, to collaborate with the teacher in setting realistic, short and long term goals, or to become involved in advocacy functions and parents' groups (Mabunda 1991:13).

Teachers are often seen as the passive recipients of advice, support and help while being expected to provide for the range of educational needs, including children with learning difficulties. Anyone who has close contact with class teachers know that they have important professional contributions to make about what is helpful to them in meeting children's special needs in education (Richmond & Smith 1990:308).

As the challenges involved in parenthood and the school demands placed on students continue to increase, the continuing need for strong parent-teacher partnership is undeniable. Parents of today's students need a viable means for obtaining support and relevant information that can assist them on the child-raising process. Educators can participate in the provision of such services by organising monthly parent support groups (Miller & Hudson 1994:154).

For students to succeed in today's society and schools, it is imperative that strong partnerships emerge between parents and teachers. Numerous formats for encouraging parent involvement have evolved over the past decade, for example parent training classes, home tutoring programmes, parent-teacher conferences, parent counselling, Individualized Education Plan (IEP) meetings and so forth (Miller & Hudson 1994:151).

Parent programmes are vital for assisting parents cope with their learning disabled child.

#### **4.5.3 Parent programmes**

Optimal teaching interaction includes both cognitive and motivational affective components. Through the use of praise and encouragement, the adult creates a positive atmosphere in which the child's sense of competence is enhanced and he or she is more likely to take on an increasing share of task responsibility (Lyytinen *et al* 1994:186).

According to Dohrn and Bryan (1994:61), children acquire their notions about themselves from three primary sources. First, their experiences play an important role. Second, children's beliefs are influenced by the models set forth by significant others (parents, teachers, peers). Third, children's self-referent thoughts are shaped by feedback from teachers and parents.

Several implications can be drawn from parent programmes. Parents of learning disabled children need support groups to share mutual concerns

and to form bonds with other parents who understand their plight (Volenski 1995:128).

Group meetings have many benefits e.g. they provide a forum for educators to convey general programmes and/or instructional information to parents. Parents who are informed about their child's educational programme are better prepared to work as effective partners with school personnel (Miller & Hudson 1994:154).

Parents play a crucial role in helping their learning disabled child. This has led to efforts to help students with learning disabilities acquire adaptive self-referent thoughts. The most promising outcomes have been efforts based on attribution theory. These studies have focused on:

- changing children's beliefs about the causes of successes and failures,
- increasing children's willingness to persist on difficult tasks, and
- improving children's task performance (Dohm & Bryan 1994:61-62).

#### **4.6 SPECIALIZED INSTRUCTION**

In Britain, New Zealand and America, for example, legislation decrees that the government pay for remedial education, following the principle that every child is entitled to an education suitable to his needs. In South Africa, sadly, special instruction is hard to find. We have an appalling lack of facilities, in a country where the need for remedial education is an ever-growing problem (Bateman 1995:13). Because of the above reasons the researcher decided to develop a programme to assist parents with learning

disabled children using the main theories of the models discussed in Chapter 3. The researcher intends to improve on the models by including Ayurvedics and RET which also consists of psychotherapy. Due to the lack of proper programmes the researcher intends to design a programme for aiding parents. There is also a need for specialised instruction for all learning disabled children and their parents as seen in Figure 3.

#### **4.7 DEVELOPMENT OF A PROGRAMME WHICH FOCUS ON COGNITIVE COPING STRATEGIES OF PARENTS WITH LEARNING DISABLED CHILDREN**

This forms the basis for the development of a programme for providing coping resources for parents who have learning disabled children. The availability of cognitive coping programmes is being investigated by the researcher. There were a number of programmes used and applied in her private practice but they lacked the use of RET and Ayurvedics.

In the following discussion attention will be given to the rationale for the programme, and the use of RET in designing the programme, Ayurvedic philosophy and the expectant parent and family changes (Figure 3).

Because of the lack of facilities in South Africa, there is a greater need for parent involvement in educational programmes especially when they have learning disabled children. The researcher intends to mainly advocate Ayurvedic philosophy, Rational-emotive therapy and how useful these therapies are in aiding parents cope when they have learning disabled children.

#### **4.7.1 Ayurvedics as a basis of the programme**

Ayurvedic way of life follows the principles of Ayurveda which emphasizes a healthy body, soul and mind according to preventative medicine and health care. The vedic learning and traditions passed on to Ayurveda - a science of life. For the first time (Balodhi 1990:52) in the history of Indian thought, philosophical principles were joined together with biological and psychological principles and systematised as science of life, covering a wide range phenomena of anatomy, physiology, pathology, therapy and pharmaceuticals. These included faith healing, RET and psychotherapy.

According to Egnor (1983:937) the Ayurvedic cosmology consists of a modified synthesis of several of the orthodox systems of Hindu Philosophy. Ayurveda is a naturalistic healing system and Ayurvedic physicians are inclined to emphasize the rightness of material life processes and in their treatment of disease to facilitate these processes rather than to oppose them. Ayurvedic theory says that the body evolves through changes which are necessary to purification and liberation of the essences within. The flow of life within the body as long as it is orderly and unobstructed, produces naturally this purification and liberation of essences. It is important, therefore, that the channels of flow remain open, clear and free. The culmination and termination of the flow of life is death, when the soul itself is purified and liberated from its bodily prison.

Ayurvedic practice is based on theories of pathophysiology, diagnosis and therapy that were formulated, systematised and organised into Sanskrit texts dating from the first to the eighth centuries A.D. Ayurveda came to

be practised largely on the basis of oral tradition and apprenticeship training. In 1920 the Indian National Congress - the party of Nehru and Gandhi - passed a resolution favouring government support of Ayurveda; during the 1920's and 1930's many states established schools of Ayurveda and licensing boards regulating its practice. The deliberate linking of Ayurveda with cultural nationalism, along with active political lobbying by its supporters, has been largely responsible for its growth and return to profession status in the twentieth century (Fleischman 1976-1977:282-287).

The purpose of Ayurveda is to tell us how our lives can be influenced, shaped, extended, and ultimately controlled without interference from sickness and old age and in the researchers' case it would involve learning disability. The guiding principle of Ayurveda is that the mind exerts the deepest influence on the body, and freedom from sickness depends upon contacting our own awareness, bringing it into balance, and then extending that balance to the body. This state of balanced awareness, more than any kind of physical immunity, creates a higher state of health (Chopra 1991:6). The researcher intends to use the same principle when guiding the parents of learning disabled children so that they would in turn "look inward", to find that all-important balanced awareness inside themselves" (Chopra 1991:6).

According to Bhurgra (1992:169), the mind, the essence of life is responsible for cognitions. It directs the senses, controls the self, reasons and deliberates. In contrast, the self is conscious, but only by virtue of its connection with the senses. The equilibrium between the self and the mind is paramount to good health. The philosophy and practice of

Ayurveda have much to offer and modern clinicians should take up the challenge.

All these therapeutic approaches viz. RET and Ayurvedics advocate a pastoral care setting, which is best done through the Rational-emotive therapy. This approach would be most beneficial to the parent (Ellis 1971:168-171) as the main psychotherapeutic goals of RET are:

- to leave the client at the end of the psychotherapeutic process, with a minimum of anxiety (or self-blame) and of hostility (or blame of others and the world around one), and
- just as importantly, to give one a method of self-observation and self-assessment that will ensure for the rest of his or her life, the person will continue to be minimally anxious and hostile (Lawrence & Huber 1982:211).

Psychologists who work with parents may be interested in the applications of RET especially in parent consultation. This focusses on helping parents improve their own functioning and especially overcoming emotional difficulties in relation to parenting, which promotes the child's welfare (Joyce 1990:304).

#### **4.7.2 RET as a basis of the programme**

In the discussion of RET as a basis of the programme attention will be given to the nature of RET, the value of RET, and other therapies.

#### **4.7.2.1 Rational-emotive therapy**

According to Kendall and Haaga (1995:169), RET was originated in the 1950's by Albert Ellis after he became dissatisfied with the lack of efficacy and efficiency of psychoanalysis, and the psychotherapeutic approach in which he was trained (Ellis 1957:314-350). Since its development, RET has had a profound impact on the professional practice of psychotherapy, with Ellis being rated by clinicians as among the 10 most influential of all psychotherapists (Warner 1991:525-528).

RET is an active, directive form of psychotherapy. Its primary mechanism of action for reducing emotional disturbance is changing clients' tacit underlying philosophies through disputing methods. Disputing methods involve teaching clients to discover their unrealistic, self-defeating, and irrational thoughts and to develop alternate rational beliefs (Kendall & Haaga 1995:179).

Ellis and Harper (1975:23) maintained that people create their own disturbances and conflicts by engaging in irrational thinking. RET is based on the premises that it is not life events that cause a person to experience extreme distress; rather, it is the way the person views the events that causes the emotional reaction. The implication is that by choosing how to view a given life event, one also chooses one's reactions to it. Negative reactions can thus be avoided. Feeling, thinking and behaving are interactional variables (Webber & Coleman 1988:32).



According to Jones (1991:196) RET is a form of cognitive behaviour therapy that represents an approach to emotional disturbance and stress based in the assumption that most often these stem from faulty or “irrational” evaluations of situations. In very general terms, RET follows Epictetus’ dictum that people are **“disturbed by the way they see events, not by the events themselves.”** RET aims to teach people how to identify unnecessarily disturbing ideas, how to challenge them effectively and replace them with more sensible ideas using verbal, imaginal and behavioural techniques. The ultimate objective, is of course, to help people help themselves toward happier and more effective living (Jones 1991:196). RET assumes that people have the ability to change inappropriate, self-defeating ways of thinking, feeling and behaving.

Disturbed emotional reactions are initiated and perpetuated by a self-defeating belief system that is based on irrational ideas one has cognitively collected and incorporated. RET assumes that since peoples’ irrational beliefs are casually linked to their emotional and behavioural disturbances, the most efficient way of helping them change is to directly confront, challenge and dispute their irrational beliefs (Russell & Morrill 1989:185).

Early in his career Ellis (1958:35) developed the now famous ABC theory of emotional disturbance, see Appendix A (Ellis 1977:74). “A” represents the activating event, stimulus, object, situation or person. “B” stands for the thoughts that the individual has about the activating event. The consequences, “C” are the individual’s feelings (emotions), which result from the event. In the therapeutic process the RET therapists starts identifying the individuals **feelings (C)** about the **activating event (A)**.

Once the feeling has been identified, the therapist proceeds to uncover the **thoughts (B)** precipitating the negative **feeling (C)** (Morris 1989:252).

#### 4.7.2.2 The value of RET

RET model of childhood maladjustment will help to make clearer the rationale for the methods RET prescribes in treating the social, emotional, behavioural and learning problems of school-age children. RET takes extreme cognizance of the wide individual differences observed in the way students in school react to the same event. From a RET perspective, the belief system and the logical reasoning processes of children determine in a fundamental way the extent to which they react adaptively to particular bad events they encounter. RET accepts the findings of the cognitive developmental literature which point to a progressive differentiation and sophistication of perceptual, symbolic-representational and information-processing abilities (Bernard 1990:295-295).

According to Bernard (1990:300) parents can play an important role in the development of different problems of childhood. RET has for many years recognised the importance of parental behavioural/child management skills in the socializing and disciplining of children. The area in which RET has made the greatest contribution to the improvement in parent-child interaction, however, is that of parent emotions. RET has, as one of its basic assumptions when working with parents that when parents become overly upset about their child's behaviour, their behaviour ceases to be effective at best and often can bring about a negative result in the child.

Joyce (1990:304-305) states that RET parent consultation can be applied at one of two levels: indirect service to a child or parent's mental health consultation; indirect service to the child where the parent is the consultee and the child is the client. RET aims to increase parent's ability to solve practical problems of their children (e.g., behavioural, emotional, learning) and achieve the goals of parenting as a consequence of parent's acquiring emotional self-control skills.

In assessing and remediating parenting problems, RET employs a dual analysis of parents' emotional problems and of parents' practical problems. This distinction is crucial to understanding how RET is applied to parenting issues. Practical problems of parents refer to problems parents encounter with their children and are often resolved by parents through the learning and application of specific parenting skills e.g., discipline skills, communication, tutoring (Joyce 1990:305).

RET emphasizes the personal qualities of those offering help. Carl Rogers, perhaps the best known exponent of counselling, characterized the ideal qualities of a counsellor as: accurate empathy, non-possessive warmth and genuine regard (Jones 1991:196).

According to RET, (Smith 1983:156) changes in beliefs should be highly correlated with changes in measures of treatment outcome. Evidence of such relationships would represent a significant advance in the empirical support for the emotive theory of psychotherapy.

According to the theory of RET, emotional disturbance occurs when **individuals demand, insist and dictate**, that they must have their wishes satisfied. Thus, states Ellis, they demand that they succeed and be approved; they insist that others treat them fairly; and they dictate that the universe be more pleasant. If people's demandingness (and not their desirousness) gets them into emotional trouble, they can alleviate their pain through several inelegant and elegant ways (Corsini 1979:202). Some of these behaviours are diversion, satisfying demands, magic and giving up demandingness. In the new model (Figure 3) the researcher will provide strategies to parents to help them with better coping skills regarding diversion, satisfying demands, magic and giving up demandingness.

- **Diversion** implies that just as a whining child can be temporarily diverted by giving him a piece of candy, so can adult demanders be transitorily sidetracked by diversion. Thus, a therapist who sees a man who is afraid of being rejected can try to arrange things so he is diverted into activities such as sports, aesthetic creation, a political cause, yoga exercises, meditation, therapizing his friends, preoccupation with the events of his childhood, and so on. Diversion techniques are mainly palliative, since the individual is still an underlying demander and as soon as he is not diverted he will probably return to his childish dictating all over again (Corsini 1979:202).
- **Satisfying demands** refer to a woman whose insinences are always catered for, making her feel better. To arrange this kind of "solution," a therapist can give her love and approval, provide her with pleasurable sensations, teach her methods of succeeding in getting her demands, or

give her reassurance that she eventually and preferably soon, will be gratified (Ellis 1977:73-82).

- **Magic** means that a boy who demands frequently can be assuaged by magic: by for example, his parents saying that a fairy godmother will soon satisfy these demands. Similarly, adolescent and adult demanders can be led to believe that God will help them; that if they suffer enough on this earth they will indubitably go to heaven and have all their demands satisfied there. Their therapist is a kind of magician who will take away their troubles merely by their telling him or her what bothers them. These magical solutions sometimes work beautifully by getting the true believer to feel better and to give up disturbed symptoms; but they rarely work for any length of time and they frequently lead to eventual disillusionment and sometimes suicide (Ellis 1978:43-50).
- **Giving up demandingness** implies that the most elegant solution to the problems that result from irrational demandingness is to induce the individual to become less commanding, godlike, or dictatorial. The rational psychotherapist tries to induce his clients to acquire minimal demandingness and maximum tolerance. RET practitioners may, at times, use temporary therapeutic “solutions,” such as diversion, satisfying the client’s “needs,” and even (on very rare occasions) magic.

In RET, the attempt to help clients minimize their dictatorial, dogmatic, absolutistic core philosophy is attempted in three main therapeutic ways: cognitive, emotive, and behaviouristic (Ellis 1979b:33-60).

Cognitive therapy attempts to show clients that they had better give up perfectionism if they want to lead a happier, less anxiety-ridden existence. It teaches them how to recognize their shoulds, oughts, and musts; how to separate rational from irrational beliefs; how to use the logico-empirical method of science in relation to themselves and their own problems; and how to accept reality, even when it is pretty grim.

According to Jones *et al* (1987:340) research is beginning to show that effective learners become even more effective when they are taught cognitive strategy techniques.

RET family therapy tends to include a number of highly emotive techniques, including:

- the therapist's giving all the family members full acceptance or unconditional positive regard
- shame-attacking and risk-taking exercises
- rational emotive imagery
- role-playing methods
- dramatic and emotive confrontation
- the use of forceful language by the therapist and of vigorous self-statements by the clients
- a pronounced emphasis on humour (Ellis 1978:47).

#### 4.7.2.3 Other therapies incorporated in RET

Although RET-practitioners concentrate on emotional techniques, a number of other therapies can be utilized and incorporated by the RET therapist. Some of the valuable therapies are emotive-evocative therapy and behavioural therapy.

- **Emotive-evocative therapy**, when used to help change clients' core values, employs various means of dramatizing truths and falsehoods so they can clearly distinguish between the two. According to Kendall *et al* (1995:180) RET employs emotionally evocative procedures for two purposes. As people must become aware of their self-defeating emotions before they challenge the beliefs attached to them, RET uses emotional techniques to help clients become aware of their emotions. RET also uses emotional techniques to make clients' cognitions more vivid. The main emotive methods include rational-emotive imagery, shame-attacking, exercises, role playing, unconditional acceptance, and forceful self-statements and self-dialogues. RET also employs many behavioural methods, most commonly, reinforcement, response cost, assertiveness and skill training, and in vivo extinction to fearful stimuli (Ellis & Bernard 1985:1-30).

Rational-emotive therapists not only teach their clients how to think logically, empirically, and in a manner that helps the self, but also tend to encourage an existentialist and humanist point of view. They believe that humans have a considerable degree of choice in regard to what they think, feel and act upon, but that it requires a great deal of effort and practice, as

well as scientific thinking, for them to achieve any amount of individual freedom and social democracy (Kendall *et al* 1995:180).

The therapist may therefore employ different techniques in applying RET to help the client, namely:

- **role playing:** to show clients exactly what their false ideas are and how they affect relations with others;
- **modelling:** to show clients how to adopt different values;
- **humour:** to reduce disturbance-creating ideas to absurdity;
- **unconditional acceptance:** to demonstrate that they are acceptable, even with their unfortunate present traits, and that they accept themselves fully;
- **exhortation:** to persuade people to give up some of their crazy thinking and replace it with more efficient notions.

The therapist may also use pleasure-giving techniques, such as sensory awareness and being cuddled by another group member, not merely to satisfy clients' unreasonable demands for immediate gratification, but to show them acts that they think, they cannot do, and that they can guiltlessly seek mere pleasure for the sake of pleasure, even though others may frown upon them for doing so (Ellis 1979a:23-27).

Shame-attacking exercises, popularized by Ellis (1979:89) are generally employed with people who are emotionally upset because of the perceived shameful consequences of their behaviour. In these exercises the client is



instructed to do “ridiculous” things, “without feeling ashamed” and to “regard them as adventures”.

- Another therapy utilized by RET therapies is **Behaviour therapy**. It is employed in RET not only to help clients change their dysfunctional symptoms and to become habituated to more effective ways of performing, but also to help change their **cognitions**. Thus, the demandingness that they perform beautifully may be whittled away by the therapist’s giving them assignments, such as to take risks; to deliberately fail at some task; to imagine themselves in failing situations, to throw themselves into unusual activities that they consider especially dangerous.
- RET often employs **operant conditioning** to reinforce the individual’s changing behaviour or changing irrational thinking. The efficacy of psychotherapy with children, particularly cognitive-behavioural therapies has been supported by Casey and Berman (1985:388-400).

The RET theory of psychotherapy asserts that there are many kinds of psychological treatment, and that most of them work to some degree. An efficient system of therapy includes:

- economy of time and effort
- rapid symptom reduction
- effectiveness with a large percentage of different kinds of clients,
- depth of solution of the presenting problems, and
- lastingness of the therapeutic results.

A therapy with these elements may be labelled “elegant” - that is, approaching the ideal of psychotherapy. Clinical and experimental evidence now exists that RET works better than other psychotherapies. Philosophically, RET more intensively combats absoluteness than any other system. Realistic and unindulgent, RET gets to the core of and ruthlessly persists at undermining the childish demandingness (Smith & Glass 1977:752-760).

The treatment procedure would adopt Appendices A to H. Concurrent with RET and Psychotherapy, the researcher will advocate Ayurvedic principles.

#### **4.7.3 Ayurvedic philosophy utilized in the programme**

The researcher uses Ayurvedic Philosophy which is proving very successful in Western Countries to treat her clients. The principle also encompasses psychotherapy.

The principles of Ayurveda, a 5000 year old system of mind and body medicine has recently been restored. Chopra (1991:328) showed how health and sickness in the human body are controlled by awareness at the level of quantum physics, where mind and body are one. Our bodies are constantly changing. We acquire new stomach linings every five days; our skin is new every five weeks; every year, 98 percent of the total number of atoms in our bodies are replaced. We appear the same, yet we are like a building whose bricks are continually being replaced, one by one.

Ayurvedic medicine gives us the tools to intervene at the level where we are being created new each day. The guiding principle of Ayurveda is that the mind exerts the deepest influence on the body, and that freedom from sickness depends upon contacting our own awareness, bringing it into balance and then extending that balance to the body. This state of being, more than any kind of physical immunity, creates a higher state of health.

Some of the daily routine requirements are:

- meditation
- Maharishi Ayurveda exercises: Sun Salute yoga positions
- balanced breathing (Pranayama)
- early rising (at dawn)
- sesame-oil massage.

Ayurveda allows us to eat a balanced diet naturally, guided by our instincts, without turning nutrition into an intellectual headache. Ayurveda recognizes six tastes: sweet, sour, salty, bitter, pungent, and astringent. In Ayurveda a balanced diet must contain all six tastes at every meal (Chopra 1991:213).

According to Maharishi Ayurveda, this is the way to boost ordinary existence to a higher plane. If we handle a few processes correctly, then the body's own tendency to remain in balance will take care of the rest. It is necessary to follow the guiding intelligence of nature and the vast complexity of the body will run perfectly. This in turn will boost ordinary existence to a higher plane. Likewise parents and learning disabled children

could learn in turn to obtain 'perfect health' to benefit all. If one has a healthy body and mind, one would be better able to face the other challenges of life positively (Chopra 1991:329).

Chopra (1991:330) provides a complete step by step programme of mind/body medicine tailored to the individual's needs. One's body type is identified as **Vata**: thin, restless; **Pitta**: enterprising, efficient; **Kapha**: tranquil, steady; or a combination of these three. This body type becomes the basis for a specific Ayurvedic programme of diet, stress reduction, neuromuscular integration, exercises and daily routines. The result is a total plan for re-establishing the body's essential balance with nature - in short, for achieving perfect health.

By practising a healthy way of life, it would in turn offer compelling proof of the power of consciousness and a daring new vision of our own unlimited potential (Chopra 1991:282). This in turn would be beneficial for the parents and learning disabled children. The outcome will incorporate RET and Ayurvedics in the compilation of the programme.

#### **4.7.4 Compilation of the programme**

From the above discussion it is clear that RET and Ayurvedics have multiple benefits in an aid programme. The utilising of RET and Ayurvedics in a programme are showed in Figure 3.

The design of a cognitive coping skills programme will adopt all the principles pertaining to:

- role of the parent on discovering that they have a learning disabled child
- the implications of psycho-educational assessment
- remedial intervention for the child
- home programme for parent
- coping with a learning disabled child
- parental relationships/involvement
- peer/sibling relationships
- family involvement
- extended family involvement
- community involvement
- applying methods that work for you
- use of RET, Psychotherapy and Ayurvedic Principles.

In Figure 3, learning disability is regarded as the stressor. For any parent, having a child that is learning disabled is a stressful event. It is therefore necessary to redefine the situation to make it less stressful. The effect of learning disability on parents and family would have implications for parent-child relationships, and parent-teacher relationships. Therefore parent programmes on how to cope with their learning disabled child is necessary. Children's self-referent thoughts are shaped by feedback from teachers and parents. The most promising outcomes have been efforts based on attribution theory. Coping resources would be utilized by RET

and Ayurvedics. In so doing there would be parental and family changes leading to better management and better lifestyles.

If clients are taught to handle their stress according to the suggested model, it is expected that they will be better able to cope with their child's learning disability. Therefore attention will be given to the expected changes in parents and families.

#### **4.8 PARENTAL AND FAMILY CHANGES**

Using her own model, the researcher has found parental and family changes which benefitted the learning disabled child, parent, family members and educators to a greater extent than techniques in figures 1 and 2.

Previously, fathers have rarely been formally involved with professionals in teaching their learning disabled child. There is a need for repeated, direct contact between professionals and those family members involved in care-taking, rather than an unplanned reliance on mothers to pass on information and skills.

Interactions between parents, individual parent and child characteristics are important in teaching learning disabled children. Many parents seem to act and react in ways which would not fit an optimum behavioural model of teaching. Suggested alterations on the part of parents in a teaching situation (with, for example, increased child success as a goal) would require careful and explicit negotiation between parent and professional. If

professionals encourage a parent to view teaching as helping the child to do something in a 'correct' way, he/she may over-direct the child and be unresponsive to the child's initiations and developing flexibility. The learning disabled child will need enhanced structure in order to learn effectively.

While many parent education programmes (Dinkmeyer & McKay 1982:3-13) have as their primary goal teaching parents skills in order for them to solve child-oriented problems, RET's approach to parenting recognises the importance of helping parents reduce their emotional stress associated with parenting as well as teaching parents how to manage child problems and foster the personality development of children (Joyce 1995:55). Studies by Joyce (1995) are supportive of a rational-emotive education approach to reducing the everyday stresses of parents. Professionals engaged with parent populations may consider cognitive intervention such as the Rational Parenting Programme to be effective in changing parent irrationality and associated emotionality. RET can add to knowledge by seeking to systematize its concepts and constantly testing them against clinical and research observation.

The diversity of responses is encouraging for the future of RET. It is partial proof that the theory is not static but rather in process and evolving (Weinrach 1996:326).

According to Ellis (1993:199) RET holds that humans largely learn their goals and preferences for success and approval from their families and culture and feel appropriately frustrated and disappointed when they fail

and are disapproved. To help people overcome their dysfunctional beliefs and the disturbances that accompany them, RET not only shows them their unrealistic inferences and attributions and how to dispute them but also shows them their imperative musts and demands that usually unconsciously and tacitly underlie and lead to these dysfunctional imperatives. It teaches them how to look for their necessitating on their own, and shows them how to try to ultimately arrive at the “elegant” RET solution to neurosis. It helps to arrange for the rest of their lives, their preferences to grandiose demands and thereby make themselves significantly less upsettable. Therefore the researcher by utilizing the RET principles as Figure 3 indicates, will provide better management and life styles for both parents and learning disabled children.

RET teaches people problem solving, skill training, and social change methods, so that they can modify the environment and the system in which they live. RET is opposed to rigidity, “must-urbation”, one-sidedness, and stasis and strongly favours openness, alternative seeking, antidogma, and flexibility, and it uses empiricism and logic unrigidly to arrive at better (and still imperfect) solutions to world mysteries and to increased human happiness. This kind of scientific outlook, RET hypothesizes, is closely related to what is often called mental health. Although RET holds that people are innately creative and constructive, and that whenever they needlessly upset themselves they also have the tendency and ability to think about their dysfunctional thinking, feeling, and behaving to reconstruct the self-defeating ways they have largely constructed. Therefore the researcher by using her model (Figure 3) will modify and reconstruct the environment in which both the learning disabled child and the parents live in.



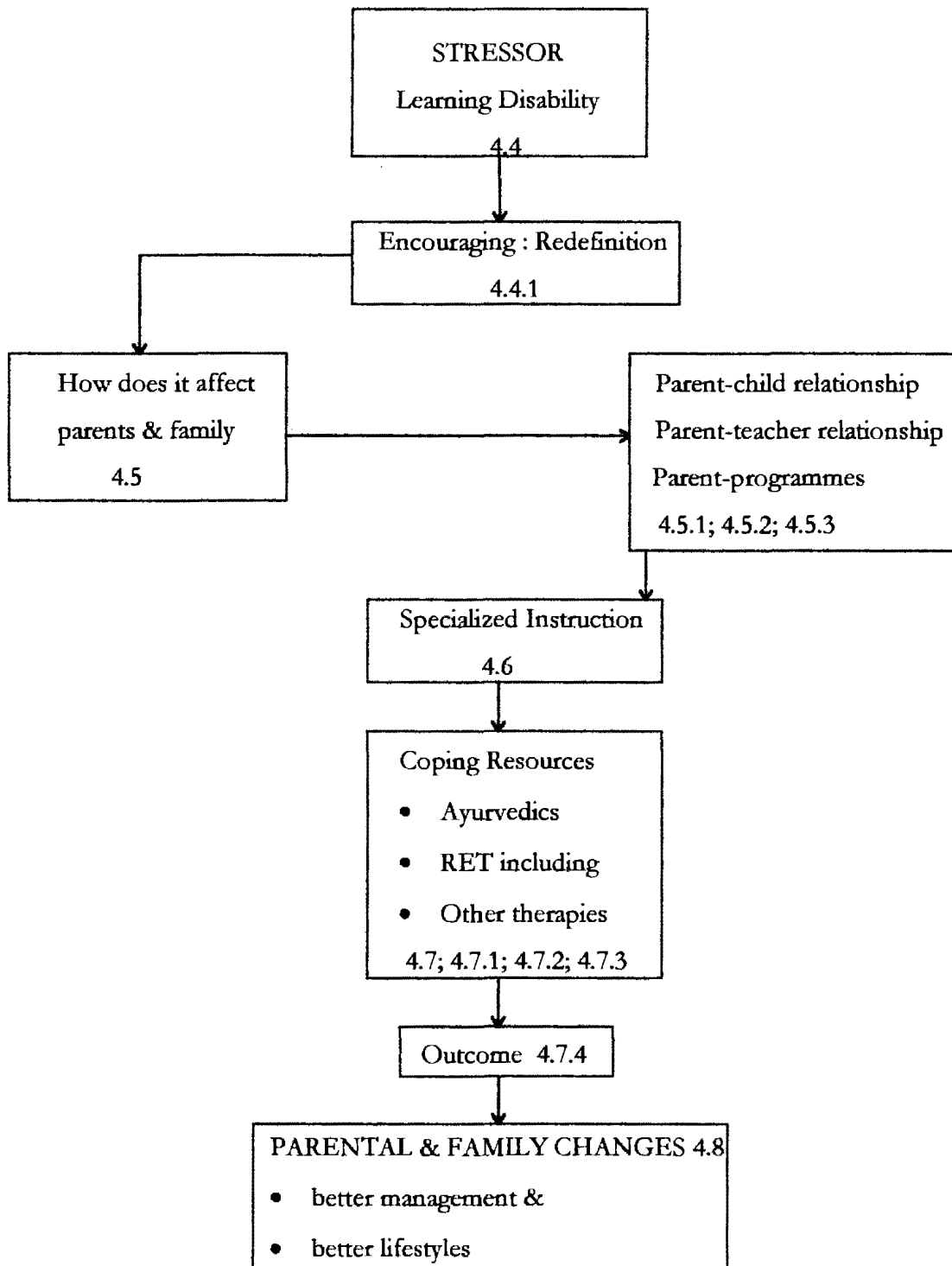
Although the application of RET can become quite complex, Ellis and Abrams (1978:42) have demonstrated that RET encourages relatively short term therapy by stressing directness, a high degree of activity e.g. the therapist, bibliotherapy and specific homework assignments for clients to perform in between the RET sessions. These researchers feel the basic principles and practice can be quickly learned and easily applied in the form of brief therapy by health care professionals (Gandy 1995:37). RET is basically more of an educational model than a medical one (Ellis & Bernard 1986:201). Lassiter (1983:26) has noted that the educational emphasis is more in keeping with the background and training of rehabilitation counselling and has illustrated this emphasis in combination with work adjustment techniques in lifestyle counselling. Gandy and Rule (1983:39) have also illustrated this principle in the adaptation of RET to group counselling with rehabilitation clients. The researcher does not only use RET but also Ayurvedics for effective parenting with learning disabled children.

Ayurveda is the ultimate in holistic sciences, because it takes into account almost all the important natural forces which act on the human being. Herein is contained not only a thorough explanation of how to diagnose, treat disease, and maintain and insure good health, but in addition this knowledge contains the secrets of why man needs to co-operate with nature completely in order to insure his well-being (Svoboda 1980:36). Ayurveda has a vital role in ensuring mental and physical well-being (Devaraj 1992:vii). Thus by incorporating both the RET and Ayurvedics

techniques, parenting coping skills will be beneficial to both parents and learning disabled children.

Therefore the uses of RET and Ayurvedics will sure parental and family changes and contribute to better management and better lifestyles for parents, family and learning disabled children.

**FIGURE 3. RESEARCH ON STRESS AND COPING STRATEGIES**



Maharaj 1998:147 (own compilation)

## 4.9 CONCLUSION

In this chapter the researcher has included RET and Ayurvedics to help parents to cope when they have learning disabled children. Since the 1960's, individuals with learning disabilities (LDs) have been a focus of educational and psychological concerns. These individuals constitute both an academic and social problem of tremendous magnitude. Many learning disabled children continue to have serious problems through their school years and into their adult lives (Gottesman 1979:60-69). However, using the researchers new model (Figure 3) may help both parents and child to cope better with learning disability.

Rational-emotive consultation with parents in groups is based on the principles of Rational Emotive Consultation Education (REE). Rational parenting is to be distinguished from other approaches to parent education (Omizo *et al* 1986:58).

Rational Emotive Behaviour Therapy (REBT) according to Weinrach (1995:296) is a highly popular counselling approach. It is difficult to read a counselling journal without finding articles that incorporate some aspect of REBT. Virtually every graduate programme in counselling and related fields includes REBT as part of its required curriculum. In June 1993, the name of RET was changed to Rational Emotive Behaviour Therapy because Ellis (1993:1) believes that the theory "has always been highly cognitive, very emotive, and particularly behavioural".

According to Vernon (1990:325) not only is rational-emotive education (REE) an in-depth preventative approach, it is also an effective “self-help” strategy. REE utilizes rational or scientific thinking skills that can be applied to increase self-understanding and promote cognitive emotional and behavioural change:

Unlike Carl Rodgers and other existential therapists, who believe that unconditional positive regard can be given by the therapist’s modelling it and accepting clients unconditionally, RET practitioners not only try to give this kind of acceptance to all clients but also teaches them how to give it to themselves. In this way, RET is both a humanistic-existential and a didactic and active-directive (Ellis 1993:200).

Ayurveda is a systematic line of treatment and helps parents and children to cope better with every day stresses. Chapter 5 focusses on the Research Design used in conducting research with parents of learning disabled children using RET and Ayurvedics.

## CHAPTER FIVE

### THE RESEARCH DESIGN

#### 5.1 INTRODUCTION

Because of the success rate of the researcher while working with parents who had children with learning difficulties, and her experience as a teacher, guidance counsellor, school psychologist and a psychologist in private practice for the past thirty years, she has embarked with this research.

There are three methods of research relevant to Psychology of Education:

- the descriptive method
- the experimental method and
- causal-comparative ex post facto method.

The researcher intends to use the descriptive method. This method describes a situation as it is at the time of the study, that is to say, it involves no intervention on the part of the researcher and, therefore, no control. Examples are case studies, surveys, developmental studies, documentary analysis, trend analysis and correlation studies. Information is gathered by means of observation, questionnaires, interviews, and case studies (Mouton *et al* 1985:49).

Research methods can be divided into two broad categories, namely, nomothetic and idiographic research. Of relevance for the researcher will

be the idiographic research which focuses on the single, unique phenomenon or the occurrence and its structural composition (Mouton *et al* 1985:49). A single phenomenon can be subjected to both a nomothetic and an idiographic investigation since both strategies are equally valid from a scientific point of view. Because they concern the person-in-totality, idiographic studies involve a small number of subjects and make use of interviews, observation, projection, media, standardized and unstandardized tests, and report writing (Mouton *et al* 1985:49).

In this chapter, the research design will be outlined. A description of the research sample, and descriptive research methods using idiographic principles will follow. The chapter will consist of the research problem, aim of the empirical research, the research postulate, the research method and research tools. Thereafter, a selection of the sample, application of the programme and processing of the data will follow.

## 5.2 THE RESEARCH PROBLEM

The problem which initialises this research is: **Parents experience stress due to lack of coping strategies with learning disabled children.** The stress which is experienced by the parents can be measured in terms of a level of depression experienced by the parents. The question arises whether parents will be more able to cope if they apply RET and the Ayurvedic philosophy as means of coping. The research problem is to examine: **what the effect of RET and the Ayurvedic philosophy will be on the stress level of the parents with learning disabled children,**

measured in terms of a depression questionnaire. Therefore it is necessary to discuss the aim of the empirical research.

### **5.3 AIM OF THE EMPIRICAL INVESTIGATION**

The primary purpose of this study is:

- to study the cognitive coping strategies of parents who have learning disabled children
- to explore the behaviour on discovering that their child is learning disabled and discuss the consequences of therapeutic measures
- to provide a literature study on the subject for better understanding for the topic at hand
- to compile a set of guidelines for use of parents, teachers, counsellors, psychologists and other professionals who work with children, on how to assist parents cope when they have a learning disabled child
- to conduct a validation study among parents who have learning disabled children to determine social desirability and to measure stress and family well-being, and
- to confirm that parents who have learning disabled children can be taught cognitive coping strategies.

As a secondary aim it is hoped to conduct post-hoc analyses on the data among respondents who are parents of younger children and to identify



differences between mothers and fathers in self reported use of these coping strategies in their relationship to stress and family well-being.

The researcher wishes to achieve her empirical investigation by applying a coping programme for the parents who have learning disabled children. As this is an idiographic research a short discussion of the research postulate will follow.

#### 5.4 THE RESEARCH POSTULATE

In the preliminary literature study it was found that RET and Ayurvedic's can be of great value in the development of coping mechanisms for stress. The following can be postulated for this research: **The application of RET and Ayurvedic's may contribute to the effective handling of stress of parents of learning disabled children.** The research method will follow.

#### 5.5 THE RESEARCH METHOD

The research method will be discussed in detail. The Beck Depression Inventory (Beck 1978:31-33) will be administered to the parents during the first interview and again after twenty weeks.

The Beck Depression Inventory (BDI) (See Table 1) is a simple multiple-choice questionnaire which will take only a few minutes to complete. After the parent/parents have completed the BDI in the 1<sup>st</sup> interview, the researcher will make an interpretation of the results according to the

manual. The score indicates the level of suffering from a true depression and, if so, how severe it is.

Interpreting the Beck Depression Inventory: Now that parents have completed the test, the researcher adds up the score for each of the twenty-one questions and obtains the total. Since the highest score that the parent can get on each of the twenty-one questions is three, the highest possible total for the whole test would be sixty-three (this would mean parents circled number three on all twenty one questions). Since the lowest score for each question is zero, the lowest possible score for the test would be zero (Beck 1978:33). This would mean that the parent circled zero on each question. The researcher can now evaluate the parents depression according to table 1.

**Table 1.**

<i>Total Score</i>	<i>Levels of Depression</i>
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

The higher total score, the more severe the parent's depression. In contrast, the lower the score, the better the parent will feel.

The method used was the test, retest method. The Beck Depression Inventory will be conducted again after 20 weeks after providing parents with therapy using RET and advocating Ayurvedic Principles. Appendices A to H would be used for biographical data, personality data, rational self help form, follow up, a guide for solving emotional and behavioural problems by re-examining your self-defeating thoughts and attitudes and RET Self help form as part of the therapeutic measures.

Traditional parent programming involves participation, training, and education. Participation occurs when parents are actually involved in school classes, activities, fund-raising and other programmes. Training involves actual step-by-step guidance from the professional staff to develop parenting skills and facilitate changes in behaviour that will enhance parent-child interactions (Somers 1987:74).

Parents have a wide variety of needs depending on their situations (cultural, economic, marital, etc.) learning styles and availability. Regarded as essential to early intervention efforts (Boothroyd in Somers 1987:75) parents are now having their areas of special needs identified. Professionals must follow through with this process by providing flexible, creative opportunities for individual parents in families to communicate and grow with their learning disabled children (Somers 1987:75). This is the intention of the researcher as Elder (1986:41) aptly sums up: "All families with a learning disabled child experience some degree of stress. Unmanaged stress can hinder the learning required in family training and prevent the family from functioning adequately as a unit".

The weekly visits will incorporate intensive psychotherapy and strategies on coping with stress using Rational-emotive therapy and Ayurvedic principles. In the interim, their children would have a psycho-educational assessment which would include:

- background information
  - birth history - prenatal, postnatal relevant information
  - medical history
  - developmental milestones
- observation during assessment
- school profile
  - academic performance
  - sporting activities
  - awards obtained
  - interests
- scholastic assessment
  - standardized tests in reading
  - comprehension
  - spelling
  - mathematics
- personality tests
  - Human Figure Drawing

- Kinetic Family Drawing
- Incomplete Sentences
- memory test
  - WISC-R Digit Span Test
- intellectual assessment
  - The JSAIS (Junior South African Individual Scale) will be administered to 5, 6 and 7old year children
  - and above 7 years will be administered with the SSAIS-R Test (Senior South African Individual Scale - Revised).

A detailed report will be discussed with parents and remedial teachers. Thereafter the pupil will be counselled with regard to:

- studying habits
- concentration
- memory
- development of self-confidence.

While the pupils will be receiving remedial therapy, their parents will be provided with coping skills in dealing with their stress pertaining to their child. After twenty weeks the parents will be given the Beck Depression Inventory again to gauge how parents improved with Rational-emotive therapy and Ayurvedic therapy. Both individual and group therapy would

be done depending on the progress of the group and individual parents using principles advocated by the researcher.

For the case material, the researcher will present 5 cases of parents (mothers & fathers) who had difficulty in coping when they discovered that their child was learning disabled, and how with therapy, improvement was noted in coping with stress concerning the child's learning disability. The sample selected will be the cases the researcher handles at her practice.

Research involving the collection of data for the purpose of describing conditions as they exist is called descriptive research (Ary 1979:295). Studies are designed to obtain information concerning the current status of phenomena. They are directed toward determining the nature of situation as it exists at the time of the study. The aim is to describe "what exists" with respect to variables or conditions in a situation.

Conclusions for descriptive studies are based on results of data analysis which interpret by comparison, contrast and cause-effect relationships. Descriptive research is not generally directed towards hypothesis testing. Descriptive research uses observational techniques such as surveys, interviews and questionnaires to collect data. The research design is outlined for the purpose of helping the reader understand the approach used in assisting parents to cope when they have a learning disabled child. The brief discussions on the methods of research is intended to provide a better understanding of research findings and its interpretations. A discussion on the research tools will follow.

## 5.6 THE RESEARCH TOOLS

There are two types of investigation, namely on:

- parents
- pupils.

For parents the Beck Depression Inventory was used, while for children, IQ, reading, mathematics, personality and emotionality tests were used.

Other tools to gain information about children, include:

- interview (purpose, method, etc)
- observation.

Here is a brief discussion of the tests and techniques used in the research method for parents and children:-

- The Beck Depression Inventory: This is a reliable mood-measuring device that detects the presence of depression and accurately rates its severity.
- IQ - tests: The Junior South African Individual Scale (JSAIS) for under 7 year olds and the Senior South African Scale - Revised (over 7 years) were administered.
- Reading Test: The Neale Analysis of reading ability was administered to obtain the child's reading ability.

- Mathematics Test: The Young's Group Mathematics Test and the Schonell's Diagnostic Arithmetic Test.
- Personality Test: The Kinetic family drawing (Koppitz' Norms) and the Human figure drawing, in conjunction with Incomplete sentences were used to determine the child's personality.
- Emotional Test: Draw a Person and Kinetic Family Drawing are both projective tests. They provide the child's mental age, intelligence and family relationships.
- Interview: to obtain information about the child, parents, family relationships and academic problems.
- Observation: during the psycho-educational assessment and parent sessions. Observation may take a variety of forms. The two basic elements are looking at and recording the behaviour of the subject under study (Ary 1979:205). An important requirement for observation is to know the behaviour that is being observed, since a limited knowledge may result in an oversight of many aspects. Bloob (in Ary 1979:206) maintains that it is possible to observe a child talking to and interacting with someone else, and to describe many important and interesting aspects of the situation, but not to provide the information that is necessary for understanding what the child knows.



There are two methods of observing behaviour, namely, observing in a natural or devised setting and questioning subjects about their behaviour. The researcher plans to observe the parents and their child during assessment and psychotherapy (individual and group). Of relevance will be the parents reporting of information pertaining to the matter on hand. The selection of the sample will follow.

## **5.7 SELECTION OF THE SAMPLE**

The research sample will consist of a random sample of local junior primary and senior primary children's parents based in the Durban and greater Durban area. The children's ages would range from 5 to 12 years, and will include both boys and girls who have learning problems. No differentiation will be made in respect of race, culture, religion or socio-economic status. The application of the programme will follow.

## **5.8 APPLICATION OF THE PROGRAMME**

In the application of the programme, the researcher will present five cases (five sets of parents) whereby the Beck Depression Inventory will be administered at first interview and then again after twenty weeks. In the interim parents will undergo interview, counselling, guidance on coping with their learning disabled child and relevant home programmes. All the therapy will be based according to the principles of Rational-emotive therapy, and Ayurvedics. Here the treatment approach will consist of non-directive counselling support groups. These groups according to Hawkins and Singer (1989:71) have centred around goals of reducing feelings of

isolation and grief, establishing friendships, providing information and permitting emotional expression.

This programme will also extend to the family, as Somers (1987:75) states this would capitalize on the family unit as the most important support system. Also the school systems must recognize that families also exist in the larger environment of the communities in which they live. Therefore, parents of learning disabled children, who often feel ill at ease in the school environment, can be encouraged to make use of resources and support systems in their immediate localities. These can range from neighbours and friends to local mental health centres and social, educational and developmental services.

Alternative programming and ways of working with parents need to develop in relation to societal changes of this decade. Programmes for working families and those who lack appropriate resources include focussed time-intensive activities, recreational offerings alternatively scheduled home and community-based programmes, and support systems fostered by parents themselves (Somers 1987:76). This is also the intention of the researcher. Therefore professionals must recognise the changes society has had and will continue to have on families with learning disabled children. Somers (1987:76) feels that parent programming must reflect and be sensitive to these needs. They must strive to adapt with the demands for flexible, creative and effective parent and family programming, as the intention of the researcher.

Stress-management training, consisting of self-monitoring, identification of environmental stressors, relaxation training and coping self-statements, is shown to be effective in a variety of studies (Hawkins *et al* 1989:72).

Since parents of learning disabled children have demonstrated more symptoms of depression and stress disorders than matched groups of parents than non-learning disabled children, and behavioural treatments for depression and stress have been demonstrated in controlled studies to be helpful for other groups of adults, the next logical step is to use the skill-oriented treatments with parents of learning disabled children. Schilling and Schinke (1984:72) called for parent focussed intervention that provide parents with both personal coping skills and enhanced social supports.

Stress-management will be provided to the parents along the following patterns:-

- **Self-monitoring.** The primary goal of introducing self-monitoring is to encourage parents to view stress as a series of separate events or stressors. By understanding that there are specific antecedents to the feelings of stress that they experience, parents begin to see that there are also specific coping skills that may be useful. They then begin to understand the importance of keeping track of stressful events in their lives as a first step in learning to cope with stress (Hawkins *et al* 1989:76).
- **Relaxation.** Relaxation is taught as a coping skill by emphasizing the ways that it could be used throughout the day to keep tension from

building. It is taught in stages. At first parents are coached through a modified form of progressive muscle relaxation. They are directed to alternately tense and release large muscle groups while simultaneously breathing deeply.

- Cognitive modification. The focus in teaching parents cognitive skills is on identifying and then modifying cognitive responses to stressful situations. This technique has proven to be effective in assisting parents to reduce anxiety. Parents are first given examples to illustrate the effect of self-talk on feelings in particular situations.

They are taught to monitor their self-talk by recording in a log book what they said to themselves about stressful events. Then they are taught ways to criticize negative or irrational self-talk and to replace it with more positive responses. Just as with the relaxation skills, emphasis is placed on learning to generalize cognitive skills as well - that is, developing brief thought change strategies that could be used in stressful situations throughout the day.

Cognitive therapy helps parents with anxiety neurosis identify their automatic thoughts or the "things they tell themselves". These thoughts are maladaptive or unrealistic. Training in the collection of automatic thoughts can be accomplished by directing the parents to record the thoughts the parents have between the stimulus situation and the parents' emotional response (Beck & Rush 1985:358). An alternative method to help the parent become aware of such thoughts involves asking him/her to fantasize the precipitating event or events;

(Beck 1970:3-17). Once the automatic thoughts are identified, the parent is increasingly able to view them objectively with his/her more rational belief system. The process of regarding thoughts objectively is called **distancing**. Even after a parent is able to make a clear distinction between his/her internal mental processes and the outside world that stimulates his/her, it may still be necessary to educate him/her regarding procedures for acquiring accurate knowledge. The therapist works with the parent to apply the rules of evidence to his/her conclusions.

Finally, a theme is frequently detectable in a series of such cognitions that can be identified with the parent. Once identified this theme can be assessed, tested, and corrected if maladaptive.

The sequence of cognitive therapy involves:

- a) self-observations that lead directly to the ideation preceding the anxiety (identifying the automatic thoughts or fantasies)
- b) establishing the relationship between such thoughts and anxiety attacks
- c) learning to regard thoughts as hypotheses rather than facts (distancing)
- d) piercing together the assumptions that underlie and generate these hypotheses, and
- e) demonstrating that these rules comprising the belief system are incorrect (Beck 1974:75 - paper presented to the Society for Psychotherapy Research, Denver).

- Social support: Information from the literature suggests (Hawkins *et al* 1989:78) that many families with learning disabled children experience social isolation. The goal of introducing a component on social support in the research is to increase parents' awareness of the role of support from others in managing their own stress. Parents have to agree to keep confidential any personal information divulged in the group, to be supportive of other members, not to pressurize others to talk, to share time equally, and to address each other by first names. After the application of the programme, the researcher has to process the data.

## **5.9 PROCESSING OF THE DATA**

The researcher by means of pre- and post-test administration of the Beck Depression Inventory would interpret and report the data and test findings. It must be noted that twenty weeks of intensive RET and Ayurvedics would have been provided by the researcher to the 10 parents of learning disabled children. The researcher would use ideographic research tests which would then be marked and interpreted according to specific guidelines. By comparing the pre- and post-test results the researcher will determine whether there was an improvement in the parents.

## **5.10 CONCLUSION**

The design of the research was done in this chapter. Attention was given to the research problem, aim of the investigation, the research postulate, the research method, the research tools, selection of the sample, application of the programme and processing of the data. Chapter 6 deals with the report of the findings from the empirical investigation.

## **CHAPTER 6**

### **FINDINGS FROM THE EMPIRICAL INVESTIGATION**

#### **6.1 INTRODUCTION**

By means of idiographic research 5 case studies will be reported. The researcher will give her findings of the pre- and post-test results on the BDI and the results of the programme implemented to parents and their learning disabled children.

#### **6.2 CASE STUDIES**

##### **6.2.1 Parent A**

##### **6.2.1.1 Background**

Shaan (not his real name) is a 10½ year old male and is in grade 6. He was referred for a psycho-educational assessment by his school principal as he was experiencing difficulties in all his subjects at school. Although Shaan experienced learning difficulties from pre-school, both parents thought he would 'catch up' as his twin sister was coping very well academically.

According to Shaan's mother, her pregnancy was full term and delivery was by caesarian section. Shaan was incubated for a day. As a baby he was active and demanded much attention.

Shaan was hospitalized twice, once for bronchitis and another time for diarrhoea. He relates well with his twin sister, but tends to be affected by her being acknowledged for her good behaviour and academic achievements. Because of his difficulty in coping with his class programme, he tends to become angry.

Both Shaan's parents are employed. His mother (37yrs) is in an administrative position at a bank and his father (38yrs) is an operation controller at a shipping company.

Shaan was diagnosed with a learning disability when he was 10½ years old, following 5 years of academic failure and frustration in the regular classroom. Psycho-educational testing performed just prior to his start in remedial therapy revealed that he was two years behind class level in reading and comprehension, and one year behind in mathematics and spelling. His scores on the Senior South African Individual Scale-Revised (SSAIS-R) indicated significant discrepancies between verbal and performance IQ (verbal=90, performance=107), indicating verbal processing deficits. In particular, he had difficulty with short and long term memory, abstraction and word knowledge.

Both the parents were given a detailed account of the test findings. Thereafter Shaan was counselled on proper studying habits, and development of his self esteem. He was then introduced to his remedial teacher who provided one hour individual lessons to him for the next twenty weeks.



### 6.2.1.2 Beck Depression Test

#### The BDI first results on parent A

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	21	Moderate Depression
Mother	31	Severe Depression

### 6.2.1.3 Therapy

Both the parents also attended sessions conducted by the researcher. There were twenty, one hour sessions while their son had remedial therapy. In the twenty weeks, the researcher adopted principles of RET and Ayurvedics to assist with their stress and guide them in handling their child, sibling, peers, family educators and the community. Mother seemed extremely protective over her son. There were indications of extreme caring. The father on the other hand appeared to be greatly troubled and insecure. Both parents were administered with the Beck Depression Inventory, at the time of assessment and after the therapy with RET and Ayurvedics.

### 6.2.1.4 Beck Depression Test - retest

#### The BDI retest results on parent A

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	7	ups and downs considered normal
Mother	8	ups and downs considered normal

Both parents showed an improvement after therapy.

#### **6.2.1.5 Results of parent A**

There was a great deal of stress alleviated by both parents indicating that they were coping better with their child's learning disability. Father improved from "moderate depression" to "ups and downs are considered normal" and mother improved from "severe depression" to "ups and downs are considered normal".

#### **6.2.1.6 Effect on child A**

After 20 weeks of remedial therapy, child A showed a great improvement in his class test results. A reassessment showed reading and comprehension improve by a year and mathematics and spelling by six months. He showed keen interest in school and was more motivated towards learning. He was able to communicate with his peers easily and his behaviour and attention improved.

### **6.2.2 Parent B**

#### **6.2.2.1 Background**

Kiran (not his real name) is the older of two sons. He is 6½ years old (Grade 1) and was referred by his class teacher for a psycho-educational assessment as he had difficulty in coping with his class programme. He

experienced difficulty because he was unable to complete his tasks within time limits. When parents realised that their son was not coping with his class programme, both experienced extreme anxiety. His mother experienced so much stress that she became depressed and had a weight loss of 5kg.

According to his mother, birth was full term and delivery was by caesarean section. Kiran was an active baby and his developmental milestones in walking and talking were reached within normal limits. Kiran attended nursery school and coped well. When he gained admission to primary school, he experienced difficulty in reading and writing and mathematics. He enjoys sports and karate.

Throughout Kiran's assessment, he had difficulty in attending, concentrating and completing tasks.

Both Kiran's parents are employed. His mother (45years) is employed at a leather industry and his father (38years) at a transport company. Both parents were not high achievers. Kiran was diagnosed as having a learning disability when he was 6½ years old. This was discovered after 6 months of academic failure and extreme frustration at not being able to cope with his class programme. Psycho-educational testing performed just prior to his start in remedial therapy revealed that he was 1½ years behind in reading and comprehension and a year behind in mathematics and spelling. His scores in the Junior South African Individual Scale (JSAIS) revealed significant discrepancies between verbal and performance IQ (verbal=108, performance=91) indicating non-verbal processing deficits. In particular

he had difficulty in Missing Parts and Memory for digits suggesting poor figure-ground perception and poor short and long term memory.

Both parents were given a feedback on their son's assessments findings. Kiran was counselled on strategies on how to cope with his problems inculcating proper studying habits and development of his self confidence. He was then provided with remedial therapy for the next 20 weeks by his remedial teacher.

#### **6.2.2.2 Beck Depression Test**

**The BDI first results of parent B**

<b><u>Parent</u></b>	<b><u>BDI Scores</u></b>	<b><u>Diagnosis</u></b>
Father	25	Moderate Depression
Mother	42	Extreme Depression

#### **6.2.2.3 Therapy**

The parents attended twenty consecutive sessions conducted by the researcher. There were twenty, one hour sessions while their son had remedial therapy. In the twenty weeks, the researcher adopted principles of RET and Ayurvedics to assist the parents with their stress and guide them in coping with their learning disabled child, siblings, peers, family, educators and the community. Kiran's mother was extremely depressed at the time her son was being assessed. She also had great difficulty in coping with his learning problems. She had difficulty in eating, was tearful and suffered loss of appetite. His father too, was depressed and had difficulty

in handling his child's learning problems. He was supportive of his wife and his son. Both parents, especially the mother extremely overprotective. Both parents were administered with the Beck Depression Inventory, at the time of the assessment and after the therapy with RET and Ayurvedics twenty weeks later.

#### **6.2.2.4 Beck Depression Test - Retest**

##### **The BDI retest results on parent B**

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	8	ups and downs considered normal
Mother	9	ups and downs considered normal

Both parents showed an improvement after therapy.

#### **6.2.2.5 Results of parent B**

Mothers' appetite showed an improvement after therapy had started. That her child was receiving remedial therapy brought great relief to her, so her anxiety level had greatly improved. Father too, showed an improvement in his handling his child's learning disability. Father improved from "moderate depression" to "ups and downs considered normal". Mother improved from "extreme depression" to "ups and downs considered normal".

#### **6.2.2.6 Effect on child B**

After 20 weeks of remedial therapy, child B showed a great improvement in his work in all his class tests. A reassessment showed that he had improved by a year in reading and spelling. His self-esteem had improved and he was coping better with his learning difficulties. His interpersonal relationships among teachers and peers improved.

#### **6.2.3 Parent C**

##### **6.2.3.1 Background**

Tanuja (not her real name) is the older of two children. She is 8 years old and in grade 3. She was referred by her mother for a psycho-educational assessment as she felt that there was a tremendous decline in her school performance. Although Tanuja experienced difficulty in pre-school, she was only referred for psychological intervention two years later in spite of the fact that both parents knew that she had a learning problem.

According to Mrs. C, birth of Tanuja was at full term and delivery was normal. She was an active baby and her developmental milestones in both walking and talking were reached within normal limits. Her interests were swimming, ice-skating and watching television.

Tanuja had great difficulty in focussing on any task and appeared easily distracted during assessment. She tended to be hasty in her decisions without giving it much thought.

She attended nursery at four years and enjoyed it very much. Thereafter, at pre-school her teacher suggested she repeated a year as she was not ready for grade one. The following year she gained admission to a private school in grade one. She performed at an average level in grade one and two. In grade 3, her performance tended to be far below average as she rushed through her tasks. Tanuja's parents are both employed. Her mother (34 years) is a self-employed business woman and her father (36 years) is employed at the Fire Department.

Tanuja was diagnosed with a learning disability when she was 8 years when in fact she experienced learning problems at five years old. Both parents had reservations about believing that their daughter had a learning problem and initially thought by delaying intervention that their daughter would soon catch up. Psychological testing conducted just prior to her being referred to remedial therapy revealed that she was 1 year ahead in reading and 2 years in spelling, but 2 years behind in comprehension and 1 year in mathematics. Her scores in the JSAIS revealed that she performed at an average level and that she had slightly better performance scores (verbal = 98, performance=104) but maintained average scores in verbal, performance and total IQ. She performed exceptionally well in the memory for digits and form Board suggesting very good short term memory and visual-motor skills. She experienced difficulty in vocabulary and picture riddles indicating deficit in receptive and expressive language skills especially comprehension.

Her parents were provided with a detailed feedback of the assessment's findings. Tanuja was then guided in developing and inculcating good

studying habits which assisted in motivating her in developing her self confidence. The researcher then introduced her to her remedial teacher who provided weekly remedial therapy sessions for the next twenty weeks (one hour per week).

#### **6.2.3.2 Beck Depression Test**

##### **The BDI first results of parent C**

<b><u>Parent</u></b>	<b><u>BDI Scores</u></b>	<b><u>Diagnosis</u></b>
Father	24	Moderate Depression
Mother	27	Moderate Depression

#### **6.2.3.3 Therapy**

The researcher then conducted one hour weekly sessions with the parents for the next twenty weeks adopting principles of RET and Ayurvedics to assist them in coping with their insecurities and denial and guide them in handling their learning disabled child, and so in turn assist sibling, peers, family members, educators and the community. Tanuja's mother appeared to be more anxious and seemed to be demoralized by her husband's authoritative nature. Mother and daughter seem to have a very close and caring relationship. Tanuja's relationship with her father was distant. She appeared to be afraid of him. Both parents were frustrated and distressed to think that their child had learning problems as both of them are high achievers and were confused about their child's educational problems.



Both parents were administered with the Beck Depression Inventory, at the time of assessment and again after providing of RET and Ayurvedics, twenty weeks later.

#### **6.2.3.4 Beck Depression Test - retest**

##### **The BDI retest results on parent C**

<b><u>Parent</u></b>	<b><u>BDI Scores</u></b>	<b><u>Diagnosis</u></b>
Father	2	ups and downs considered normal
Mother	3	ups and downs considered normal

Both parents showed an improvement in their stress levels after therapy.

#### **6.2.3.5 Results of parent C**

Both parents were able to handle their stress of having a learning disabled child better. Father and mother improved from “moderate depression” to “ups and downs considered normal”.

#### **6.2.3.6 Effect on child C**

Child C showed great improvement in her performance after twenty weeks of remedial therapy. She had attained more confidence and was more interested in her school work as her test marks had improved. Her reassessment results indicated that she had progressed by one year in spelling and comprehension and six months in reading and mathematics. Her interpersonal relationship improved among parents and siblings.

## **6.2.4 Parent D**

### **6.2.4.1 Background**

Jivesh (not real name) is the eldest of three children. He has a younger twin sister, and a brother. He is 10 years old and in grade 5. He was referred by his class teacher for a psycho-educational assessment as he felt that Jivesh was experiencing difficulty with his class programme. Jivesh experienced learning problems from pre-school but was referred for psychological intervention 5 years later, although both the parents were aware of his limited progress (indicated by parents).

According to Mrs D (35 years), birth was at full term and delivery was by caesarean section. Jivesh was an active baby. His developmental milestones in both walking and talking were reached within normal limits. His interests included music and television.

Jivesh presented himself as a shy and reserved pupil. He was dependant on direction in completing the tasks allocated to him and seemed unable to work under pressure. He was reluctant to verbalize responses and appeared fearful. He required to show more interest in his work and focus on what he was doing. He began experiencing learning problems from 5 years old. His progress was limited in the Junior Primary phase. In the Senior Primary phase he experienced communication problems because of his introvertedness. In grade 5 he is still experiencing difficulty in grasping concepts.

Mr. D (38 years) is employed as a motor mechanic and Mrs. D is a home executive. Both parents have had secondary education and were average achievers but have high expectations of their son. Parent relationships have been strained because of their son's learning problems.

Jivesh was diagnosed with a learning disability when he was 10 years old. Both parents delayed in having their son assessed as they believed that he would improve. They would have delayed further if his class teacher did not encourage them to seek psychological intervention. Assessment findings revealed that he was 2 years behind in reading, comprehension and spelling and 1 year behind in mathematics. His scores in the SSAIS-R indicated that he was functioning at an average level with better verbal scores (verbal=98, performance=90). He experienced difficulty in seeing part-whole relations, numerical reasoning and visual-motor co-ordination. He also had poor comprehension skills.

Mr and Mrs D were given a detailed report by the researcher on the assessment findings. Jivesh was provided with guidance in proper studying habits and development of his self-confidence. He was then introduced to his remedial teacher who provided remedial therapy sessions for the next twenty weeks. The sessions were of one hour duration.

#### 6.2.4.2 Beck Depression Test

##### **The BDI first results of parent D**

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	19	Clinical Depression
Mother	33	Severe Depression

#### 6.2.4.3 Therapy

In the meantime, the researcher conducted one-hour weekly sessions with the parents for the next twenty weeks adopting principles of RET and Ayurvedics to assist them in coping with their anxiety, stress and denial and guide them in handling their child, so that he could relate better with his sibling, peers, family, educators and the community.

Jivesh's mother appeared to be more stressed than her husband. He seemed to be better able to cope than his wife. He however appeared frustrated by the financial implications. Mother and Jivesh appeared to be afraid of father concerning his learning problems. Although parents have a good marriage they are affected by their son's learning disability.

Mr and Mrs D were administered with the Beck Depression Inventory, at the time of the assessment and thereafter provided with RET and Ayurvedics for the next twenty weeks. They were tested again with the Beck Depression Inventory after therapy i.e. twenty weeks later.

#### **6.2.4.4 Beck Depression Test - retest**

##### **The BDI retest results on parent D**

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	5	ups and downs considered normal
Mother	8	ups and downs considered normal

Both parents showed an improvement in their stress levels after therapy.

#### **6.2.4.5 Results of parent D**

Father and mother were able to cope better in handling their son's learning disability. Father improved from "clinical depression" to "ups and downs considered normal" and mother improved from "severe depression" to "ups and downs considered normal".

#### **6.2.4.6 Effect on child D**

Child D showed an improvement in his academic performance after twenty weeks of remedial therapy. He showed keen interest in his class programme and obtained better marks in all his tests. His reassessment results indicated that he had progressed one year in reading and comprehension and six months in spelling and mathematics. He was more responsible in class and at home.

## **6.2.5 Parent E**

### **6.2.5.1 Background**

Avan (not his real name) is the older of 2 sons. He is 9½ years old and in grade five. The mother referred her son to an educational psychologist after listening to a radio programme on learning disability and recognised that her son had a learning problem.

Although Avan experienced learning problems from grade one he was only referred in grade five as the mother had gained reassurance after listening to a programme on learning disability.

According to Mrs E, birth was at eight months and delivery was normal. Avan was a colicky baby. His developmental milestones in both walking and talking were reached within normal limits. Avan was hospitalized for a week as he was dehydrated. He had his tonsils and adenoids removed. During early childhood he suffered a broken arm. He does have bouts of wheezing.

Avan presented himself as a pleasant pupil. He needed constant support and direction throughout the assessment. He was not always attentive and had to be reminded to focus. Avan's pre-schooling was only for a few months. In the Junior Primary phase his performance was weak. In grade four he had difficulty in English, Afrikaans and mathematics. Presently he has difficulty in all subjects. He excels in sports and has received awards for long jump and athletics.

Mr E (35 years) is employed as a Technician Foreman for a fabric company and Mrs E (34 years) is a home executive. Father seemed to be well educated and the mother's level of education is limited. The family live with their extended family. Father plays a vital role as a breadwinner and provider. Father appears authoritative and the mother is totally reliant on her husband for all her and the families' needs. There seems to be poor marital relationship and communication is limited. Father is very disappointed with his son's learning problems.

Avan was diagnosed as having a learning disability when he was 6 years old, following 3½ years of academic failure and frustration in the regular classroom. The psycho-educational testing performed just prior to his start in remedial therapy revealed that he was 2½ years behind in reading, mathematics and comprehension, and 3 years behind in spelling. His score on the SSAIS-R indicated that there were significant discrepancies between verbal and performance IQ (verbal=99, performance=87) indicating non-verbal processing deficits. In particular he had difficulty in mathematical facts and processes, short and long term memory and visual-motor perception.

#### 6.2.5.2 Beck Depression Test

##### **The BDI first results of parent E**

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	22	Moderate Depression
Mother	26	Moderate Depression

#### **6.2.5.3 Therapy**

Both Mr and Mrs E. attended sessions conducted by the researcher. There were twenty sessions (one hour each) of therapy with parents and twenty sessions of remedial therapy with their son. In the twenty weeks, the researcher adopted principles of RET and Ayurvedics to assist with their stress and guide them in handling their child, siblings, peers, family, educators and the community. Mother appeared inadequately prepared for her son's learning problems. She appeared naïve and succumbed to any suggestions. Father appeared annoyed by his son's inadequacies. Both parents were administered with the Beck Depression Inventory at the time of the assessment and after the therapy with RET and Ayurvedics.

#### **6.2.5.4 Beck Depression Test - retest**

**The BDI retest results on parent E**

<u>Parent</u>	<u>BDI Scores</u>	<u>Diagnosis</u>
Father	14	Mild Mood Disturbance
Mother	17	Borderline Clinical Depression

Both parents showed an improvement in their stress levels after therapy.

#### **6.2.5.5 Results of parent E**

Both parents were able to manage their stress of having a learning disabled child better. Father improved from "moderate depression" to "mild mood



disturbance” and mother improved from “moderate depression” to “borderline clinical depression”.

#### **6.2.5.6 Effect on child E**

Child E showed an improvement in his academic performance after twenty weeks of remedial therapy. He was more motivated towards his school work as he attained better marks for his tests. His reassessment results indicated that he had progressed by one year in reading, comprehension, mathematics and spelling.

### **6.3 COMPARISON OF PARENTS A - E**

All parents were stressed on discovering that their child was learning disabled. All parents showed an improvement in coping with their stress after therapy had started. From test results it was evident that mothers were more stressed than fathers. Mothers showed a greater amount of improvement compared to fathers, as they are more stressed than fathers.

Mother B showed the greatest improvement followed by Mothers D, C, A and E respectively.

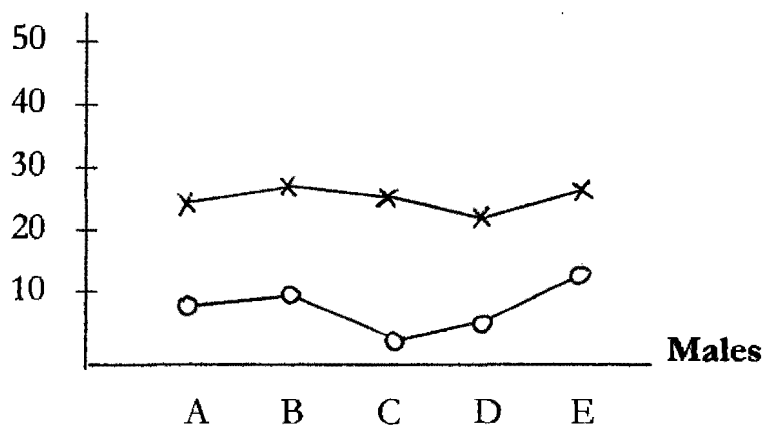
Father C showed the greatest improvement followed by Fathers B, D, A and respectively. Parent B has a couple showed the greatest improvement followed by Parents C, D, A, and E.

The diagnoses for parents before therapy ranged from borderline clinical depression to extreme depression. The diagnoses for parents after therapy ranged from “ups and downs considered normal” to borderline clinical depression. These indicate improvement ranging from 3 levels to 5 levels on the depression scale towards normality (see table 1). The stress levels showing the amount of improvement towards normality was indeed remarkable. This showed the effectiveness of the parent programme using RET and Ayurvedics. The concurrent programme of the remedial teacher’s intervention with the learning disabled child reassured parents showing them that their learning disabled child was improving and that they were able to cope better with their child’s learning disability.

### 6.3.1 Graphs showing reduction in stress levels

#### a) Males

**Stress levels**



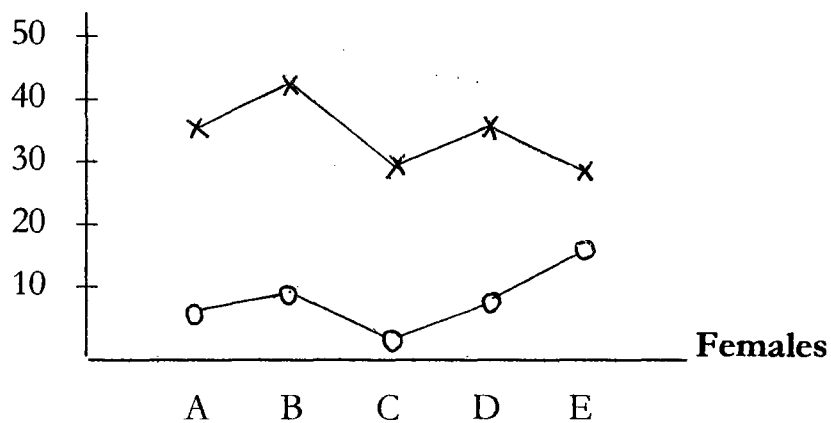
x pre-test BDI scores

o post-test BDI scores

- All males stress levels were reduced.

**b) Females**

**Stress levels**



x pre-test BDI scores

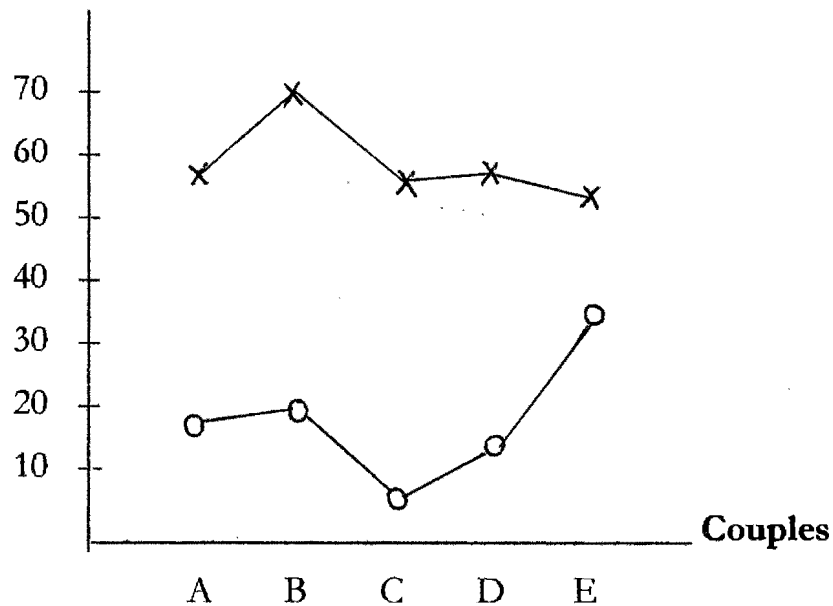
o post-test BDI scores

- Females experienced greater stress levels.

- There was greater improvement with females than males.

### c) Differences among parents

#### Stress levels



x pre-test BDI scores

o post-test BDI scores

- there was a decrease in stress levels amongst all couples.
- those who were more committed to the programme saw better results with their intervention and their child's.
- significant drop in anxiety levels since both parents co-operated with each other.

### d) Discussion on the Beck Depression Inventory (BDI)

The parents were able to fill in the BDI easily following the instructions of the researcher as she discussed the confidentiality of the contents. Many of

their suppressed feelings were revealed previously unknown to the other spouse. Throughout therapy the researcher was able to “work out” their insecurities and replace it with positive feelings, and constructive discussion making skills. The following are depressive feelings recorded in the BDI:

- mood
- pessimism
- sense of failure
- lack of satisfaction
- guilt feeling
- sense of punishment
- self-hate
- self-accusations
- self-punitive wishes
- crying spells
- irritability
- socially withdrawn.

Most parents responded on the BDI more to guilt feelings and sense of failure. More fathers scored higher in the category socially withdrawn, and mothers resorted to crying spells.

## **6.4 CHANGES IN PARENTS**

### **6.4.1 Attitude of parents towards RET**

Throughout the twenty sessions, parents showed a keen interest in the procedure. Each set of parents were shown their irrational beliefs and methods using RET to overcome their irrational beliefs. All 10 parents were prepared to try to overcome their negativity on learning disability. Initially there was much denial, apathy and over-protectiveness from mothers and fathers. After a few sessions there was a definite improvement and eagerness in all the parents because they were learning to cope with their irrational beliefs and were guided with positive reinforcement. All parents were keen to attend sessions as they could see a definite progress in their child's performance in school and his/her attitude towards his school, work, siblings, peers, teachers and parents. Parents too were able to cope with the 'problems' more efficiently and effectively.

The researcher felt it would be useful to start with a preventative approach. This was done by giving parents full information about their child from different educational, psychological and psychiatric perspective. Other evaluations were also reviewed in detail with all parents. They were informed of their child's intellectual potential, level of academic performance, and why he or she is underachieving. Any existing emotional, social, and/or family problems are clarified and related to other diagnoses. A treatment plan was presented, addressing each of the problems using RET principles. Parents are counselled as being the necessary advocate for their son or daughter. In each of the sessions, the

full evaluation is shared with the parents. This interpretative session is the most meaningful time spent by parents and researcher in starting a therapeutic relationship. The final session is a family session whereby siblings must accept and understand their brother or sister and be informed of the proposed clinical interventions.

There was a gradual change in all parents in their attitude towards learning disability, coping with their stress and coping with their child's learning problems. This was due mainly to RET. Parents now showed a more positive outlook towards their child's potential and educational achievements. The remedial intervention with all the children revealed a steady progress in academic achievements and attitude towards learning by both parents and learning disabled children.

#### **6.4.2 Attitudes of parents towards Ayurvedics**

Most of the parents were willing to try out and follow methods using Ayurvedic principles. For many parents, some of the methods e.g. massaging with coconut oil for external cleansing; medicated castor oil once a month for internal cleansing were familiar as the parents or grandparents also advocated these practices emanating from their forefathers. Parents also felt the positive outcome in their own personal life and their relationship with their children. This had positive effects on their relationship with their colleagues and family, and relationships improved among their children, siblings and peers. Parents were able to communicate better with each other (as couples) and with their child. The siblings and peers were able to communicate and relate more easily with

their learning disabled brother/sister/friend. The parents and their families readily followed the principles of Ayurvedics and instilled these values in their learning disabled children, other children and extended families and friends. There was a noticeable difference in the levels of cognitive coping of all parents using RET and Ayurvedics.

## **6.5 RESPONSES AFTER THERAPY**

### **6.5.1 Parents**

Couples were able to communicate better between themselves, their learning disabled child, family, friends and professionals. Siblings were able to relate better among themselves. The learning disabled child improved in all aspects of work and test marks were much higher than before therapy (which was monitored from the child's school progress card). Their general behaviour, attitude towards work and organisation overall showed improvement. The learning disabled children were eager to learn and parents were keen to assist their children. Although progress in academic work was slow, parents felt relieved that improvement was being made. Parents became aware of their strengths and limitations. Relationships improved between parent/researcher, parent/child, parent/remedial teacher, parents and other parents with learning disabled children. Parents appeared more confident of themselves.



Parents were able to attend all sessions using RET and Ayurvedics. Parent E cancelled two sessions but made up later at a convenient time. This couple improved the least as the father was an extremely busy person and the mother tended to be totally reliant on the father for decision making.

Parents appeared to be happier, more talkative and better equipped at answering questions or trying out new ideas. As sessions continued they were able to relate and joke about incidences which they previously were tearful about. Most mothers tended to be less tearful and not as over-protective as they were prior to therapy. Father's ego strengths tended to 'simmer' as they began to cope better with stress and became more realistic of their aspirations towards their children's goals. Parents were at greater ease when they spoke of their child's learning disability. The number of boys to girls 4 to 1 reaffirming that the prevalence of learning disability is greater amongst boys than girls.

#### **6.5.2 Learning disabled children**

Remedial teachers reported that the learning disabled children were now more interested in their subjects both at school and the remedial centre. They appeared more courteous, punctual and worried parents to transport them for their lessons even when parents had other appointments. Their self-concept and attitude towards their works also improved. They tended to work quicker and completed tasks previously left incomplete.

## **6.6 CONCLUSION**

For the researcher, it was useful to start with a preventive approach using both RET and Ayurvedics. After all the relevant information from the educational, psychological and other evaluations were reviewed in detail with the parents, they began to realize that there was no easy quick 'fix it' cure. By informing the parents of their child's intellectual potential, level of academic performance, and why he/she was underachieving, all existing emotional, social, and/or family problems were clarified diagnosed for corrective treatment. The treatment plan was then presented to parents, addressing each of the problems using RET and Ayurvedics.

In the final session providing a family session, the siblings obtained a better understanding of their brother or sister and in turn were informed of the proposed clinical interventions.

It was found that both parents and their learning disabled child were able to use the principles of RET and Ayurvedics in other aspects concerning their work, relationship with colleagues and coping with stress more positively. From the above it can therefore be conclusively deduced that all the marked improvements were definitely as a result of the intervention programme. Chapter 7 focusses on the conclusion of the research and offers some recommendations for parents, remedial teaches and children.

## CHAPTER 7

### CONCLUSION OF THE RESEARCH

#### 7.1 INTRODUCTION

The researcher used RET and Ayurvedics to assist parents in coping with their stress as a result of their learning disabled child. McGuigan's (1992:131) views are highly complementary to those of Albert Ellis who also believes that, people basically want to be happy. He believes that the extent to which people achieve their own happiness is greatly influenced by engaging in rational behaviour and avoiding irrational behaviour. The basic definition of rational behaviour in RET theory means "... that which helps people to achieve their basic goals and purposes, whereas irrational behaviour means that which prevents them from achieving these goals and purposes" (Ellis & Dryden, 1987:4).

RET places a focus on constructive self-interest and unconditional self-acceptance. However, self-interest and self-acceptance demand social interest in order for an individual to help build the kind of society in which one would best live oneself. RET theory hypothesizes that humans have a biological tendency to think irrationally but also have a biological tendency to exercise the power of choice to work toward changing their irrational thinking.

Ayurvedics is concerned with the relationship of man to the external conditions, and their effect on the production and loss of equilibrium upon

one another. It embraces the 'whole man' in body, mind and soul in relation to the mysterious workings of the cosmos. Ayurvedics is an all-encompassing science which combines scientific facts and profound empirical observations of man and his connection to the cosmos through the basic elements which are found in all life-substances. These substances in nature are considered to have healing qualities.

Thus the researcher found beneficial outcomes for parents, learning disabled children, siblings, peers, families and professionals. The purpose of this chapter is to discuss findings which emanated from both the literature and the empirical study. Conclusions are drawn from these findings and some recommendations are made, based on the information gleaned from the research. Deficiencies of the present study will be identified. Finally some guidelines will be formulated, for use by parents, children and teachers. The findings reveal that the aims of the research have been achieved.

In doing this study, the researcher attempted to give attention to parents who had learning disabled children in respect of to the areas regarding cognitive coping strategies by providing therapy using RET and Ayurvedics. An extensive literature study was done regarding coping skills, the nature of cognitive coping and family adaptations to learning disability.

## **7.2 FINDINGS EMANATING FROM THE LITERATURE SURVEY**

The last 20 years has witnessed a virtual revolution in the development of professional services for parents who have learning disabled children. A

cluster of coping strategies and remedial tactics has been widely promoted in professional literature. Included in these commonly suggested approaches are education in regular schools and classrooms, functional and age appropriate curricula, promotion of social relations and friendships. The inclusion of person with disabilities, their parents, family members and friends in planning life goals and activities could be carried out in educational and other settings.

Although the desire to include parents and families as partners in the educational process has been strongly stated through professional and government literature for many years, only recently has a body of research accumulated the wishes and needs of the parents as a whole. This research gives voice to parents as a group in the discussion of the types and degrees of services that should be offered at schools, remedial centres and social services agencies. This is specially relevant in education for a new South Africa. In specialised education, recent planning approaches call for the intense involvement of family and friends in planning and decision-making related to educational programmes for children with learning problems and parental coping strategies. Therefore it is suggested that an appropriate role of the parent of the child with a disability today may be as a consumer. This role stands in contrast to earlier roles in which parents were considered by professionals to be persons in need of psychological counselling and services, as implementers of behaviour modification programmes, or as home teachers of their child with a disability. With few exceptions, (Turnbull & Turnbull, 1978; 1985), until recently there has been little systematic inquiry into the desires of parents (Westling 1996:86).

### **7.2.1 Parental feelings towards RET**

The following feelings were expressed:

- keen and interested
- gave examples and worked out problem solving strategies in the RET forms
- discussed problems easily with their spouses, especially mothers
- fathers were at first hesitant to discuss their stresses
- brainstorming assisted the therapeutic process
- working jointly was effective
- work was taken to solve at home so programme was continuous
- self concept improved with the better coping of stress
- the whole family and teaching personnel were involved improving communication all round
- when parents began to realise their irrational beliefs, they felt greatly relieved
- guilt feelings diminished.

### **7.2.2 Parental feelings towards Ayurvedics**

Parents expressed the following feelings towards Ayurvedics:

- parents were eager to follow programme
- many of the methods and practices were familiar to parents as they were all of Asian origin and their parents or grandparents had informed or practised some aspects of Ayurvedics.

### **7.3 FINDINGS DERIVED FROM EMPIRICAL INVESTIGATION**

Because of the economic constraints, back logs in education among the different groups in South Africa, difficulties experienced by teachers, specialised teachers and principals, the researcher found her approach via RET and Ayurvedics extremely useful. Because parents, teachers, researchers and learning disabled children were all involved in the programme, it was evident that all could see changes in emotional stability and educational improvement.

There were noticeable changes in all parents, learning disabled children and Remedial teachers. All participants were able to discuss the significant changes among their colleagues, friends and families.

An aid programme combining RET and Ayurvedics was applied and resulted in the following significant changes:

- parents coped with stresses more positively
- parents were able to handle their children more effectively
- a better relationship existed between parent and professionals
- family relationships improved
- siblings understood their learning disabled brother/sister better
- better peer relationships were observable
- family, extended family and friends understood and coped better about a child's learning difficulties

- parent relationships improved between themselves, learning disabled child and siblings
- parent's output at work and relationships with colleagues improved
- parents and children were more goal directed
- parents were able to cope with other problems more efficiently
- the remedial teacher was able to be more optimistic towards the learning disabled child's performance
- the behaviour and outlook towards life was more positive for the parents, learning disabled child and remedial teacher
- parents easily referred their friends and relatives to the centre.

#### **7.4 FINDINGS BASED ON THE RESULTS OF BDI (Post-test results)**

There were significant changes amongst all parents in the research programme. All parents involved with the programme showed an improvement in their stress levels. The research showed:

- increased coping levels among males
- increased coping levels among females
- increased coping levels among all couples
- those individuals more committed to the programme benefited more.

All parents were able to cope better with their stress levels and so were able to cope better with their child's learning disability.



## **7.5 SIGNIFICANT OTHERS INVOLVED IN THE PROGRAMME**

There were significant others involved in the programme.

### **7.5.1 Learning disabled children involved in the programme**

Learning disabled children showed a rapid improvement in:

- academic performance
- in attitude towards schoolwork
- their self-esteem
- communication
- in their interpersonal relationships among teachers, peers, siblings, parents
- in being able to complete tasks
- their responsibility in class and home
- in their behaviour and
- in their general outlook.

### **7.5.2 Remedial teachers**

Remedial teachers were able to report that they were:

- more positive results of the learning disabled children in their learning ability
- able to work better with the learning disabled children

- able to communicate more effectively with the learning disabled children, parents and siblings.

## **7.6 DISCUSSION OF THE PROGRAMME**

Most children (except 1) continued with the programme for the 3 and 4 terms. Parent E and learning disabled child did not continue with the therapy as parents had transport difficulties. The parents were eager to follow the programme as they were for the first time better able to cope with their stress knowing that their child was learning disabled. They were amazed to see how their learning disabled children were better able to cope with their class programme. They also became aware of their limitations and their child's limitations as well. After the programme, parents became independent, had very little contact with the researcher and discussed their child's programme directly with the remedial teacher.

There were parental fears. Parents felt that if they terminate remedial therapy, then:

- the learning disabled child will have difficulty in coping with the class programme
- the learning disabled child will retrogress
- the parent will not be able to effectively help their child.

Therefore 4 of the 5 sets of parents continued for 3 terms more with the therapy for the child. All parents did have contact with the researcher after

the programme concerning anxieties about their child or how they could assist their child at home.

## **7.7 CONCLUSION OF INVESTIGATION**

Parents have a critical role to play in helping their learning disabled child. They need to understand how the specific learning disabilities impact on family activities. With knowledge, parents can both avoid problems and assist their child. The use of RET and Ayurvedics in the counselling and remedial intervention proved beneficial for all who participated in the study both directly as well as indirectly.

Learning disabilities, like any chronic disability, can, if not properly treated, result in a lifetime of frustration, pain and underachievement. Recognition, diagnosis, and correct treatment is essential for each stage of the learning disabled child's psycho-social development. It was interesting to note that 3 out of 5 parents had caesarean section births, 1 had 8 month pregnancy and only 1 normal pregnancy. This indicates that birth history may have implications for learning disability.

It was found that professional reactions whether negative or positive have a potent effect on parents. The researcher/remedial teacher helped parents to accept themselves and their learning disabled child by communicating a sense of caring and concern for the parent. Of equal benefit was the parent's perception that the Remedial teacher loves and accepts their learning disabled child.

Parental acceptance were manifested in the parents' willingness to participate in parent-teacher groups, to discuss the child's shortcomings with relative ease, to abandon over-protective or unduly harsh behavioural patterns towards their child, to collaborate with the teachers in setting realistic short- and long- term goals, or to become involved in advocacy functions and parents' groups.

Parents of learning disabled children and the professionals who work with them need to acquire an optimistic, growth-oriented, yet realistic view of such children and their families. It is only through the adoption of such a philosophy that distortions regarding the reality of such a child can be kept to a minimum.

## **7.8 IMPLICATIONS OF THE STUDY**

The researcher has attempted to discuss the benefits of the study. As the challenges involved in the parenthood and the school demands placed on learning disabled children continue to increase, the continuing need for strong parent-teacher partnerships is undeniable. Parents of today's children need viable means for obtaining support and relevant information that can assist them in the child raising process. Therefore educators should participate in the provision of such services by organising monthly parent support groups.

Parent meetings have many benefits as they provide a forum for educators to convey general programmatic and/or instructional information to parents. Parents who are informed about their child's educational

programme are better equipped and prepared to work as effective partners with school personnel.

Parent meetings also provide parents with opportunities to share their experiences with other parents who are experiencing similar challenges. This process helps both the parent who is sharing and the therapist who receives the information. Parents who are able to help other parents frequently experience a sense of increased self-esteem and healing. It is very rewarding to realize that the time and effort spent improving the life of a child with special needs may also benefit other parents and their children. Parents talking to other parents often assist in the development of insight concerning a child's problems.

Most professionals, including direct service providers and administrators cannot fully comprehend the challenges faced by parents of children with learning disabilities simply because they have not had such an experience. By using RET and Ayurvedics with parents who have children with learning disabilities, significant others benefitted including parents, professionals, family, extended families and friends. Many parents were able to relate what they are satisfied with, and what they are lacking. Service providers believe that they should attempt to meet the needs of consumers, and they must be critically aware of the needs and desires of learning disabled children, their parents and care givers.

## **7.9 MATTERS REQUIRING FURTHER RESEARCH**

As the researcher works with predominantly Asian population, the research procedure was conducted only with Asian parents. The researcher had great difficulty in obtaining both parents for the counselling procedure from the other race groups. Therefore, further research should be done using all race groups in S.A. so that parents and learning disabled children would be able to benefit from each other. This in turn would improve race relationships and we would be able to work collectively as a South African population.

It would be interesting to obtain results from single parent families, and comparisons made between mothers and fathers of single parent families.

Further research should be done comparing boys and girls concerning their ratio, learning styles and differences on child rearing patterns.

It would be interesting to note the differences of other race groups' attitudes towards Ayurvedics which is an eastern and scientific philosophy.

## **7.10 CONTRIBUTIONS OF THIS STUDY**

This study and research findings have tremendous benefits for:

- all aspects of specialised education
- parents coping with their learning disabled child

- better sibling and family relationships
- better parent-teacher relationships
- better teacher/learning disabled child relationships
- better coping with all concerned with the programme and their extended families and friends
- the self-esteem of parents, learning disabled children and their siblings
- all those concerned with education in a New South Africa.

## **7.11 CONCLUSION**

The research findings have a tremendous impact for all professionals and parents involved in learning disability. This definitely has implications for Education in a new South Africa for specialized educators and the South African population as there are many educational problems. This research was embarked as a therapeutic process conducted by an educational psychologist. It is hoped that parents and professionals will adopt these techniques or that they will modify them to meet their respective needs. In either case, the projected outcomes are very positive and worth the time and effort required.

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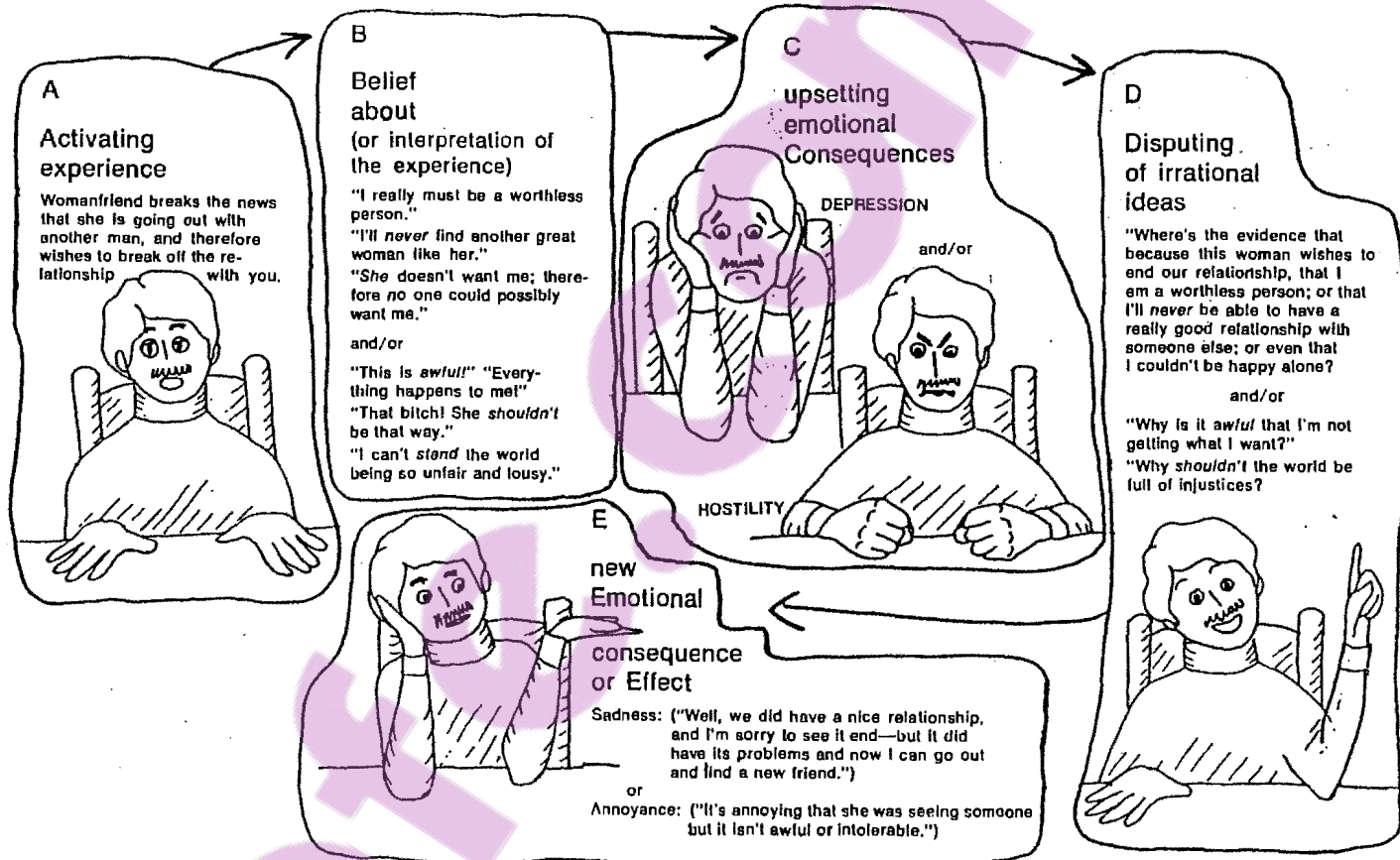
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# Rational-Emotive Therapy's A-B-C Theory of Emotional Disturbance

"Men are disturbed not by things, but by the views which they take of them."  
— Epictetus, 1st century A.D.

It is not the event, but rather it is our interpretation of it, that causes our emotional reaction.



## APPENDIX B:

### Biographical Information Form

Date \_\_\_\_\_  
mo. day yr.

Name \_\_\_\_\_  
(last) (first) (middle)

**Consultation Center**  
**Institute for Rational-Emotive Therapy**  
45 East 65th Street • New York, N. Y. 10021

### **Biographical Information Form**

**Instructions** To assist us in helping you, please fill out this form as frankly as you can. You will save much time and effort by giving us full information. You can be sure that, like everything you say at the Institute, the facts on this form will be held in the strictest confidence and that no outsider will be permitted to see your case record without your written permission. PLEASE TYPE OR PRINT YOUR ANSWERS.

1. Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
mo. day yr.

2. Address: \_\_\_\_\_  
street city state zip

3. Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

4. Permanent address (if different from above) \_\_\_\_\_  
\_\_\_\_\_

5. Who referred you to the Institute? (check one)

\_\_\_\_\_(1) self \_\_\_\_\_(2) school or teacher \_\_\_\_\_(3) psychologist or psychiatrist \_\_\_\_\_(4) social agency \_\_\_\_\_(5) hos-  
pital or clinic \_\_\_\_\_(6) family doctor \_\_\_\_\_(7) friend \_\_\_\_\_(8) relative \_\_\_\_\_(9) other (explain) \_\_\_\_\_

Has this party been here? \_\_\_\_\_Yes \_\_\_\_\_No

6. Present marital status:

\_\_\_\_\_(1) never married \_\_\_\_\_(2) married now for first time \_\_\_\_\_(3) married now for second (or more) time  
\_\_\_\_\_(4) separated \_\_\_\_\_(5) divorced and not remarried \_\_\_\_\_(6) widowed and not remarried

Number of years married to present spouse \_\_\_\_\_ Ages of male children \_\_\_\_\_ Ages of female children \_\_\_\_\_

7. Years of formal education completed (circle number of years):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 more than 20

8. How religious are you? (circle number on scale that best approximates your degree of religiosity):

very average atheist  
1 2 3 4 5 6 7 8 9

9. Mother's age: \_\_\_\_\_If deceased, how old were you when she died? \_\_\_\_\_

10. Father's age: \_\_\_\_\_If deceased, how old were you when he died? \_\_\_\_\_



11. If your mother and father separated, how old were you at the time? \_\_\_\_
12. If your mother and father divorced, how old were you at the time? \_\_\_\_
13. Total number of times mother divorced \_\_\_\_ Number of times father divorced \_\_\_\_
14. Number of living brothers \_\_\_\_ Number of living sisters \_\_\_\_
15. Ages of living brothers \_\_\_\_ Ages of living sisters \_\_\_\_
16. I was child number \_\_\_\_ in a family of \_\_\_\_ children.
17. Were you adopted? \_\_\_\_Yes \_\_\_\_No
18. What kind of treatment have you previously had for emotional problems?
- \_\_\_\_ hours of individual therapy, spread over \_\_\_\_ years, ending \_\_\_\_ years ago.
19. Hours of group therapy \_\_\_\_ Months of psychiatric hospitalization \_\_\_\_
20. Are you undergoing treatment anywhere else now? \_\_\_\_Yes \_\_\_\_No
21. Number of times during past year you have taken antidepressants \_\_\_\_
22. Type of psychotherapy you have mainly had (briefly describe method of treatment—ex., dream analysis, free association, drugs, hypnosis, etc.) \_\_\_\_\_
- \_\_\_\_\_
23. Briefly list (PRINT) your present main complaints, symptoms, and problems: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
24. Briefly list any additional past complaints, symptoms, and problems: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
25. Under what conditions are your problems worse? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
26. Under what conditions are they improved? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

27. List the things you like to do most, the kinds of things and persons that give you pleasure: \_\_\_\_\_

---

---

28. List your main assets and good points: \_\_\_\_\_

---

---

29. List your main bad points: \_\_\_\_\_

---

---

30. List your main social difficulties: \_\_\_\_\_

---

---

31. List your main love and sex difficulties: \_\_\_\_\_

---

---

32. List your main school or work difficulties: \_\_\_\_\_

---

---

33. List your main life goals: \_\_\_\_\_

---

---

34. List the things about yourself you would most like to change: \_\_\_\_\_

---

---

35. List your chief physical ailments, diseases, complaints, or handicaps: \_\_\_\_\_

---

---

36. What occupation(s) have you mainly been trained for? \_\_\_\_\_

Present occupation \_\_\_\_\_

\_\_\_\_\_ Full time \_\_\_\_\_ Part time

37. Spouse's occupation \_\_\_\_\_

\_\_\_\_\_ Full time \_\_\_\_\_ Part time

38. Mother's occupation \_\_\_\_\_ Father's occupation \_\_\_\_\_

39. Mother's religion \_\_\_\_\_ Father's religion \_\_\_\_\_

40. If your mother and father did not raise you when you were young, who did? \_\_\_\_\_

41. Briefly describe the type of person your mother (or stepmother or person who substituted for your mother) was when you were a child and how you got along with her: \_\_\_\_\_

42. Briefly describe the type of person your father (or stepfather or father substitute) was when you were a child and how you got along with him: \_\_\_\_\_

43. If there were unusually disturbing features in your relationship to any of your brothers, briefly describe: \_\_\_\_\_

44. If there were unusually disturbing features in your relationship to any of your sisters, briefly describe: \_\_\_\_\_

45. Number of close male relatives who have been seriously emotionally disturbed: \_\_\_\_\_ Number that have been hospitalized for psychiatric treatment, or have attempted suicide: \_\_\_\_\_ Number of close female relatives who have been seriously emotionally disturbed: \_\_\_\_\_ Number that have been hospitalized for psychiatric treatment, or have attempted suicide: \_\_\_\_\_

46. Additional information that you think might be helpful \_\_\_\_\_

## APPENDIX C:

### Personality Data Form - Part 1

Name \_\_\_\_\_

(last)

(first)

(middle)

#### Consultation Center

Institute for Rational-Emotive Therapy  
45 East 65th Street, New York, N.Y. 10021

#### Personality Data Form — Part 1

**Instructions:** Please answer all the following items as honestly as you can, so that we will be able to help you most with your problems. Read each of the items and circle after each one the word **OFTEN**, **SOMETIMES**, or **SELDOM**, to indicate how often you have the feeling that is described in the item. Thus, if you frequently feel quite foolish or embarrassed when you make a mistake when other people are watching, circle the word **OFTEN** in item 1; and if you seldom or rarely feel ashamed to do the things you really want to do if you think others will disapprove of you for doing them, circle **SELDOM** in item 2. Please make sure that you circle one, and only one, word in every item. **DO NOT SKIP ANY ITEMS.** And again, for your own good, be as honest as you can possibly be.

#### Acceptance

- |   |       |           |         |
|---|-------|-----------|---------|
| 1. I feel quite foolish or embarrassed when I make a mistake and other people are watching                    | OFTEN | SOMETIMES | SELDOM. |
| 2. I feel ashamed to do the things I really want to do if I think others will disapprove of me for doing them | OFTEN | SOMETIMES | SELDOM. |
| 3. I feel humiliated when people discover undesirable things about my family or my background                 | OFTEN | SOMETIMES | SELDOM. |
| 4. I feel put down if my house, car, finances, or other possessions are not as good as are those of others    | OFTEN | SOMETIMES | SELDOM. |
| 5. I feel quite uncomfortable when I am the center of people's attention                                      | OFTEN | SOMETIMES | SELDOM. |
| 6. I feel quite hurt when a person I respect criticizes me negatively   | OFTEN | SOMETIMES | SELDOM. |
| 7. I feel uneasy about my looks or about the way I am dressed when I am out in public                         | OFTEN | SOMETIMES | SELDOM. |
| 8. I feel that if people get to know me well they will discover how rotten I really am                        | OFTEN | SOMETIMES | SELDOM. |
| 9. I feel terribly lonely   | OFTEN | SOMETIMES | SELDOM. |
| 10. I feel that I simply must have the approval or love of certain people who are important to me             | OFTEN | SOMETIMES | SELDOM. |
| 11. I feel dependent on others and am miserable if I cannot get their help                                    | OFTEN | SOMETIMES | SELDOM. |

#### Frustration

- |   |       |           |         |
|---|-------|-----------|---------|
| 12. I feel upset when things proceed slowly and can't be settled quickly                    | OFTEN | SOMETIMES | SELDOM. |
| 13. I feel like putting off things I know it would be better for me to do                   | OFTEN | SOMETIMES | SELDOM. |
| 14. I feel upset about life's inconveniences or frustrations                                | OFTEN | SOMETIMES | SELDOM. |
| 15. I feel quite angry when someone keeps me waiting  | OFTEN | SOMETIMES | SELDOM. |
| 16. I feel jealous of people who have better traits than I                                  | OFTEN | SOMETIMES | SELDOM. |
| 17. I feel terribly resentful when other people do not do my bidding or give me what I want | OFTEN | SOMETIMES | SELDOM. |
| 18. I feel I can't stand and must change people who act stupidly or nastily                 | OFTEN | SOMETIMES | SELDOM. |
| 19. I feel that I can't handle serious responsibility                                       | OFTEN | SOMETIMES | SELDOM. |
| 20. I resent my having to make a real effort to get what I want                             | OFTEN | SOMETIMES | SELDOM. |
| 21. I feel very sorry for myself when things are rough                                      | OFTEN | SOMETIMES | SELDOM. |
| 22. I feel unable to persist at things I start, especially when the going gets hard         | OFTEN | SOMETIMES | SELDOM. |
| 23. I feel unexcited and bored about most things  | OFTEN | SOMETIMES | SELDOM. |
| 24. I feel that I cannot discipline myself  | OFTEN | SOMETIMES | SELDOM. |

**Injustice**

25. I feel revengeful toward others for the wrongs they have done	OFTEN	SOMETIMES	SELDOM.
26. I strongly feel like telling off wrongdoers and immoral people	OFTEN	SOMETIMES	SELDOM.
27. I get upset about the injustices of the world and feel that their perpetrators should be severely punished	OFTEN	SOMETIMES	SELDOM.

**Achievement**

28. I blame myself severely for my poor performances	OFTEN	SOMETIMES	SELDOM.
29. I feel very ashamed when I fail at important things	OFTEN	SOMETIMES	SELDOM.
30. I feel anxious when I have to make important decisions	OFTEN	SOMETIMES	SELDOM.
31. I feel afraid to take risks or to try new things	OFTEN	SOMETIMES	SELDOM.

**Worth**

32. I feel guilty about my thoughts or actions	OFTEN	SOMETIMES	SELDOM.
33. I feel that I am pretty worthless as a person	OFTEN	SOMETIMES	SELDOM.
34. I feel suicidal	OFTEN	SOMETIMES	SELDOM.
35. I feel like crying	OFTEN	SOMETIMES	SELDOM.
36. I feel that I give in too easily to others	OFTEN	SOMETIMES	SELDOM.
37. I feel hopeless about my being able to change my personality for the better	OFTEN	SOMETIMES	SELDOM.
38. I feel that I am quite stupid	OFTEN	SOMETIMES	SELDOM.
39. I feel that my life is meaningless or without purpose	OFTEN	SOMETIMES	SELDOM.

**Control**

40. I feel I cannot enjoy myself today because of my poor early life	OFTEN	SOMETIMES	SELDOM.
41. I feel that because I have failed at important things in the past I must inevitably keep failing in the future	OFTEN	SOMETIMES	SELDOM.
42. I resent my parents for treating me the way they did and for causing so many of my present problems	OFTEN	SOMETIMES	SELDOM.
43. I feel that I cannot control my strong emotions, such as anxiety or rage	OFTEN	SOMETIMES	SELDOM.

**Certainty**

44. I feel lost without some higher being or purpose on which to rely	OFTEN	SOMETIMES	SELDOM.
45. I feel that I should keep doing certain things over and over, even though I don't want to do them, because something bad will happen if I stop	OFTEN	SOMETIMES	SELDOM.
46. I feel quite uncomfortable when things are not well ordered	OFTEN	SOMETIMES	SELDOM.

**Catastrophizing**

47. I worry about what's going to happen to me in the future	OFTEN	SOMETIMES	SELDOM.
48. I worry about my having some accident or illness	OFTEN	SOMETIMES	SELDOM.
49. I am terrified at the idea of going to new places or meeting a new group of people	OFTEN	SOMETIMES	SELDOM.
50. I am terrified at the thought of my dying	OFTEN	SOMETIMES	SELDOM.

# RATIONAL SELF HELP FORM

Institute for Rational-Emotive Therapy      45 East 65th Street, New York 10021

INSTRUCTIONS: Please fill out the ueC section (undesirable emotional Consequences) and the ubC section (undesirable behavioral Consequences) first.  
Then fill out all the A-B-C-D-E's. PLEASE PRINT LEGIBLY. BE BRIEF!

**(A) ACTIVATING EXPERIENCES (OR EVENTS)**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

**(B) BELIEFS ABOUT YOUR ACTIVATING EXPERIENCES**

**(rB) rational Beliefs (your wants or desires)**

.....

.....

.....

**(iB) irrational Beliefs (your demands or commands)**

.....

.....

.....

.....

.....

**(C) CONSEQUENCES OF YOUR BELIEFS ABOUT ACTIVATING EXPERIENCES**

**(deC) desirable emotional Consequences (appropriate bad feelings)**

.....

.....

**(dbC) desirable behavioral Consequences (desirable behaviors)**

.....

.....

**(ueC) undesirable emotional Consequences (inappropriate feelings)**

.....

.....

**(ubC) undesirable behavioral Consequences (undesirable behaviors)**

.....

**(D) DISPUTING OR DEBATING YOUR IRRATIONAL BELIEFS**  
(State this in the form of questions)

.....

.....

.....

.....

.....

.....

**(E) EFFECTS OF DISPUTING OR DEBATING YOUR IRRATIONAL BELIEFS**

**(cE) cognitive Effects of disputing (similar to rational beliefs)**

.....

.....

.....

.....

.....

.....

**(eE) emotional Effects (appropriate feelings)**

.....

.....

.....

.....

.....

.....

**(bE) behavioral Effects (desirable behaviors)**

.....

.....

.....

.....

.....

.....

APPENDIX D:

Rational Self Help Form

# SAMPLE RATIONAL SELF HELP FORM

Institute for Rational-Emotive Therapy 45 East 65th Street, New York 10021

## APPENDIX E:

### Sample Rational Self Help Form

A ACTIVATING EXPERIENCES (OR EVENTS)	B BELIEFS ABOUT YOUR ACTIVATING EXPERIENCES	C CONSEQUENCES OF YOUR BELIEFS ABOUT ACTIVATING EXPERIENCES
<p><i>I went for a job interview and I failed to get the job.</i></p>	<p><b>rB rational Beliefs (your wants or desires)</b></p> <p><i>How unfortunate to get rejected! I don't like getting rejected. I wish I had gotten accepted. How annoying! Looks like I'll have difficulty getting the job I want.</i></p>	<p><b>deC desirable emotional Consequences (appropriate bad feelings)</b></p> <p><i>Sorrow and regret Frustration and irritation Determination to keep trying</i></p>
	<p><b>iB Irrational Beliefs (your demands or commands)</b></p> <p><i>1. How awful to get rejected! 2. I can't stand this rejection! 3. I should have given a better interview and got accepted. 4. This rejection makes me a rotten person. 5. I'll never get the kind of a job I want! 6. I'll always do poorly on job interviews.</i></p>	<p><b>dbc desirable behavioral Consequences (desirable behaviors)</b></p> <p><i>Continued search for a job Attempt to upgrade my skills</i></p> <p><b>ueC undesirable emotional Consequences (inappropriate feelings)</b></p> <p><i>I felt depressed.                      I felt worthless. I felt anxious.                        I felt angry.</i></p> <p><b>ubC undesirable behavioral Consequences (undesirable behaviors)</b></p> <p><i>I refused to go for other job interviews. I felt so anxious I functioned badly on other interviews.</i></p>
<p><b>D DISPUTING OR DEBATING YOUR IRRATIONAL BELIEFS</b> (State this in form of questions)</p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p><i>1. Why is it awful to get rejected for a job? 2. Why can't I stand this rejection? 3. What evidence exists that I should have acted better on the interview and got accepted? 4. How does this rejection make me a rotten person? 5. In what way will I find it impossible ever to get the kind of job I want? 6. Why must I always do poorly on job interviews?</i></p> </div>		
<p><b>E EFFECTS OF DISPUTING OR DEBATING YOUR IRRATIONAL BELIEFS</b></p>		
<p><b>cE cognitive Effects of disputing (similar to rational beliefs)</b></p> <p><i>1. Nothing makes it awful to get rejected, even though I find it highly inconvenient. 2. I can stand rejection, though I'll never like it. 3. I can find no reason why I should or must have given a better interview, though it would have proved nice if I had. 4. Rejection never makes me a rotten person—but a person with some unfortunate traits. 5. I won't find it impossible to get a good job, though I may find it difficult to do so. 6. I don't have to do poorly on job interviews always, especially if I try to learn from my errors.</i></p>	<p><b>eE emotional Effects (appropriate feelings)</b></p> <p><i>I felt sorrowful but not depressed. I felt concerned but not anxious. I felt self-accepting. I felt frustrated but not angry.</i></p>	<p><b>bE behavioral Effects (desirable behaviors)</b></p> <p><i>I went for some more job interviews. I started to look into getting some additional training. I registered with an employment agency. I sent out more letters applying for jobs.</i></p>

**APPENDIX F:**

**Follow - Up**

1. FOLLOW-UP. What new GOALS would I now like to work on? .....  
.....  
.....  
.....  
.....  
What specific ACTIONS would I now like to take?.....  
.....  
.....  
.....
2. How soon after feeling or noting your undesirable emotional CONSEQUENCES (ueC's) or your undesirable behavioral CONSEQUENCES (ubC's) of your irrational BELIEFS (iB's) did you look for these iB's and DISPUTE them?.....  
.....  
.....  
.....  
How vigorously did you dispute them? .....  
.....  
.....  
If you didn't dispute them, why did you not do so?.....  
.....  
.....
3. Specific HOMEWORK ASSIGNMENT(S) given you by your therapist, your group or yourself: .....  
.....  
.....  
.....
4. What did you actually do to carry out the assignment(s)? .....  
.....  
.....
5. How many times have you actually worked at your homework assignments during the past week? .....  
.....  
.....
6. How many times have you actually worked at DISPUTING your irrational BELIEFS during the past week?.....  
.....  
.....
7. Things you would now like to discuss with your therapist or group .....  
.....  
.....  
.....



## APPENDIX G:

**A guide for solving your emotional and behavioural problems by re-examining your self-defeating thoughts and attitudes**

A guide for solving your emotional and behavioural problems by re-examining your self-defeating thoughts and attitudes.

**A**

DESCRIBE THE SITUATION THAT CONTRIBUTED TO YOUR UPSET

IF YOU EXPERIENCED ANY OF THE FOLLOWING EMOTIONS GO TO B:  
ANXIETY, DEPRESSION, ANGER, GUILT, SHAME, EMBARRASSMENT  
GO TO C IF YOU ACTED IN A SELF-DEFEATING MANNER.

**C**

DESCRIBE HOW YOU FELT AND ACTED

**B**

LIST ANY DEMANDS YOU MADE OR MIGHT MAKE OF YOURSELF, OTHER(S) OR ON THE SITUATION. LOOK FOR SHOULD'S, OUGHT'S, MUST'S, HAVE TO'S, GOT TO'S.

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

LIST ANY RATINGS THAT YOU MADE OR MIGHT MAKE OF YOURSELF, OTHER(S) OR THE SITUATION IF THE WORST HAPPENS.

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

**D**

QUESTION YOUR DEMANDS

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

RATIONAL ANSWER

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

QUESTION YOUR RATINGS

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

RATIONAL ANSWER

SELF: 1  
2  
3

OTHER(S): 1  
2  
3

SITUATION: 1  
2  
3

NEW FEELING AND ACTION

## APPENDIX H:

### RET Self-Help form

#### RET SELF-HELP FORM

Institute for Rational-Emotive Therapy  
45 East 65th Street, New York, N.Y. 10021  
(212) 535-0822

(A) **ACTIVATING EVENTS**, thoughts, or feelings that happened just before I felt emotionally disturbed or acted self-defeatingly: \_\_\_\_\_

(C) **CONSEQUENCE** or **CONDITION**—disturbed feeling or self-defeating behavior—that I produced and would like to change: \_\_\_\_\_

<b>(B) BELIEFS—Irrational BELIEFS (IBs)</b> leading to my <b>CONSEQUENCE</b> (emotional disturbance or self-defeating behavior). Circle all that apply to these <b>ACTIVATING EVENTS (A)</b> .	<b>(D) DISPUTES</b> for each circled <b>IRRATIONAL BELIEF</b> . Examples: "Why <b>MUST</b> I do very well?" "Where is it written that I am a <b>BAD PERSON</b> ?" "Where is the evidence that I <b>MUST</b> be approved or accepted?"	<b>(E) EFFECTIVE RATIONAL BELIEFS (RBs)</b> to replace my <b>IRRATIONAL BELIEFS (IBs)</b> . Examples: "I'd <b>PREFER</b> to do very well but I don't <b>HAVE TO</b> ." "I am a <b>PERSON WHO</b> acted badly, not a <b>BAD PERSON</b> ." "There is no evidence that I <b>HAVE TO</b> be approved, though I would <b>LIKE</b> to be."
1. I <b>MUST</b> do well or very well!		
2. I am a <b>BAD OR WORTHLESS PERSON</b> when I act weakly or stupidly.		
3. I <b>MUST</b> be approved or accepted by people I find important!		
4. I am a <b>BAD, UNLOVABLE PERSON</b> if I get rejected.		
5. People <b>MUST</b> treat me fairly and give me what I <b>NEED</b> !		
6. People who act immorally are undeserving, <b>ROTTEN PEOPLE</b> !		
7. People <b>MUST</b> live up to my expectations or it is <b>TERRIBLE</b> !		
8. My life <b>MUST</b> have few major hassles or troubles.		
9. I <b>CAN'T STAND</b> really bad things or very difficult people!		

(OVER)

10. It's AWFUL or HORRIBLE when major things don't go my way!	
11. I CAN'T STAND IT when life is really unfair!	
12. I NEED to be loved by someone who matters to me a lot!	
13. I NEED a good deal of immediate gratification and HAVE TO feel miserable when I don't get it!	
<u>Additional Irrational Beliefs:</u>	
14.	
15.	
16.	
17.	
18.	

(F) FEELINGS and BEHAVIORS I experienced after arriving at my EFFECTIVE RATIONAL BELIEFS: \_\_\_\_\_

I WILL WORK HARD TO REPEAT MY EFFECTIVE RATIONAL BELIEFS FORCEFULLY TO MYSELF ON MANY OCCASIONS SO THAT I CAN MAKE MYSELF LESS DISTURBED NOW AND ACT LESS SELF-DEFEATINGLY IN THE FUTURE.



## APPENDIX I:

### The Beck Depression Inventory (Beck 1978:31-33)

#### THE BECK DEPRESSION INVENTORY

##### A). (MOOD)

- 0 I do not feel sad
- 1 I feel blue or sad
- 2a I am blue or sad all time and I can't snap out of it
- 2b I am so sad or unhappy that it is very painful
- 3 I am so sad or unhappy that I can't stand it

##### B). (PESSIMISM)

- 0 I am not particularly pessimistic or discouraged about the future
- 1a I feel discouraged about the future
- 2a I feel I have nothing to look forward to
- 2b I feel that I won't ever get over my troubles
- 3 I feel that the future is hopeless and that things cannot improve

##### C). (SENSE OF FAILURE)

- 0 I do not feel like failure
- 1 I feel I have failed more than the average person
- 2a I feel I have accomplished very little that is worthwhile or that means anything
- 2b As I look back on my life all I can see is a lot of failures
- 3 I feel I am a complete failure as a person (parent, husband, wife)

##### D). (LACK OF SATISFACTION)

- 0 I am not particularly dissatisfied
- 1a I feel bored most of the time
- 1b I don't enjoy things the way I used to
- 2 I don't get satisfaction out of anything any more
- 3 I am dissatisfied with everything

##### E). (GUILT FEELING)

- 0 I don't feel particularly guilt
- 1 I feel bad or unworthy a good part of the time
- 2a I feel quite guilty
- 2a I feel bad or unworthy practically all the time now
- 3 I feel as though I am very bad or worthless

##### F). (SENSE OF PUNISHMENT)

- 0 I don't feel I am being punished
- 1 I have a feeling that something bad may happen to me
- 2 I feel I am being punished or will be punished
- 3a I feel I deserve to be punished
- 3b I want to be punished

G). (SELF HATE)

- 0 I don't feel disappointed in myself
- 1a I am disappointed in myself
- 1b I don't like myself
- 2 I am disgusted with myself
- 3 I hate myself

H). (SELF ACCUSATIONS)

- 0 I don't feel I am any worse than anybody else
- 1 I am very critical of myself for my weakness or mistakes
- 2a I blame myself for everything that goes wrong
- 2b I feel I have many bad faults

I). (SELF-PUNITIVE WISHES)

- 0 I don't have any thoughts of harming myself
- 1 I have thoughts of harming myself but I would not carry them out
- 2a I feel I would be better off dead
- 2b I have definite plans about committing suicide
- 2c I feel my family would be better off if I were dead
- 3 I would kill myself if I could

J) (CRYING SPELLS)

- 0 I don't cry any more than usual
- 1 I cry more now than I used to
- 2 I cry all the time now. I can't stop it
- 3 I used to be able to cry but now I can't cry at all even though I want to

K) (IRRITABILITY)

- 0 I am no more irritated by things than I ever am
- 1 I get annoyed or irritated more easily than I used to
- 2 I am quite annoyed / irritated a good deal of the time
- 3 I feel irritated all the time now

L). ( SOCIALLY WITHDRAWN)

- 0 I have not lost interest in other people
- 1 I am less interested in other people now than I used to be
- 2 I have lost most of my interest in other people now than I used to be
- 3 I have lost all my interest in other people and don't care about them at all