

GROUP TREATMENT FOR THE PARENTS OF CHILDREN WITH LEARNING-DISABILITIES

As a means of changing the attitudes of parents towards such children, and the effect of such a change on the remediation of the learning disability.

by

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ABSTRACT

A research was done on the attitudes of parents towards learning-disabled children and on the behaviour rating of the children by their parents (experiment A) and on group treatment for parents of learning-disabled children (experiment B).

EXPERIMENT A

The experimental group consisted of parents of 28 learning-disabled children. The children were in sub A, B, or std I, attending regular primary schools and received remedial tuition. The control group consisted of 30 parents of children who achieve normally. The two groups were matched for socio-economic status, family structure, age and sex of child.

The attitudes of the two groups of parents were compared with the help of the Hereford Parent Attitude Survey (1963). It is designed to measure the dimensions of attitudes of parents towards their children. The scale consists of five subscales measuring: confidence in parental role, causation of child's behaviour, acceptance of child's behaviour and feelings, mutual understanding and mutual trust. Every subscale contains 15 items, each of which is rated on a five point scale ranging from +2 to -2. The sum of the item score in each area serves as the parent's total score for that attitude area. The higher the score the better the attitude.

It was found that:

Parents of normal achieving children scored higher on the subscales measuring understanding, causation and on the total score of the attitude survey than parents of learning-disabled did.

The parents' behaviour ratings of their children were compared with the Parent-Teacher Behavior Rating Scale for Underachieving Children by Rie (1976). This scale measures overt behaviour characteristics of children. It consists of seven subscales, measuring: activity, achievement, sociability, attention, distractibility, disruptability, and need-achievement. Each subscale contains five items each of which is rated on a five point scale of frequency of occurrence. The higher the score the more favourable the behaviour.

It was found that:

experimental group parents rated their children's behaviour less favourably on each subscale than parents in the control group.

EXPERIMENT B:

Mothers of learning-disabled children were divided into three groups: experimental group A, the counselling group; experimental group B, the teaching group; and control group C, the non-treatment group. Group A participated in supportive, reflective group counselling, the discussions were 'parent focussed'. The characteristics of a learning-disability were explained to the parents in group B, discussions were 'child focussed'. Parental attitude and behaviour measures taken after treatment were compared with the previous measures. Teachers moni-

tored the behaviour of the children with the same behaviour rating scale on a weekly basis, while treatment took place.

It was found that:

Mothers in group A scored higher after treatment on the attitude subscale measuring 'trust' than before treatment.

Teachers found that behaviour of children whose parents participated in group B improved significantly.

The results of the study indicate that if treatment procedures based on counselling and teaching methods are combined, attitude change of parents and behaviour improvement in children will be facilitated.

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Carly Vosters

Chapter 1

INTRODUCTION AND AIM OF STUDY

The purpose of this study is, firstly, to investigate whether there is a difference in attitudes between parents with a learning-disabled child and parents who do not have a child with such a handicap, and to investigate whether the parents in these two groups rate their children's behaviour differently; secondly, to investigate ways of changing the attitudes of parents with a learning-disabled child and the effect of such a change in attitudes on the remediation of the learning-disability.

The study will investigate two treatment modalities of helping the parents of a learning-disabled child develop more constructive attitudes towards their child, thereby helping the parents to deal more adequately with the problems they encounter at home. The first treatment modality is based on reflective group counselling techniques for parents of learning-disabled children, the focus of attention will be on the needs of the parents. The second treatment modality will be based on educational techniques, the focus of attention will be on the needs of the child. A group of ^{teacher} parents of learning-disabled children will be given a series of lectures during which films will be shown, and an opportunity given for the asking and answering of questions. ✓

The question is, will a positive change occur in the child's behaviour patterns and academic performance as a result of treatment procedures for their parents? }

The present study developed out of a growing concern about the influence of the parent-learning-disabled-child relationship and the attitude of parents on the development of the learning-disabled child's whole personality - according to Humphries (1980) a neglected topic in the learning-disabilities field.

^{The school's environment}
 Gillet (1979) explained that "the family environment can exert a favorable or an adverse influence on this (child's) progress. This influence is generally based on

the kinds of experiences the child encounters; the feedback he receives about his participation in these experiences; and to what extent family members accept him as a person" (p.157-158). Bryan (1981) stated that the low or unrealistic expectations parents often have of their learning-disabled child will influence the child's achievements adversely. This, Bryan explained, is partly the result of the fact that learning-disabled children "attribute their success to forces outside their control" (p.181) and partly because "parents are more likely to punish than praise achievement" (p.181). J. Houston-McMillian (1976) found that the communication between a learning-disabled child and its family was "less than optimally facilitative" (p.57) which, she concluded, leads to the development of a low self-esteem of the child.

The above described and other research findings led the present investigator to assume that the attitude of parents towards their learning-disabled child is different, more negative, than the attitude of parents towards their normal achieving children. This assumption was reinforced by a study of Wetter (1972) in which he found that mothers of learning-disabled children differed significantly from other mothers in their attitudes of overindulgence and rejection towards their child. Wetter also stated that the attitude of parents towards a learning-disabled child is "of importance in the rehabilitation and treatment of the child" (p.490).

The point of departure for the present study is the assumption that if the attitude of parents towards their learning-disabled child is negative, it is not enough to organise remediation programmes for learning-disabled children within the educational setting only, but that one must also look at the child within its whole environment, and specifically at the parent-child relationship. Sameroff (1975) described the development of a child as a function of contributions of both constitutional and environmental factors which affect each other. He saw development as a 'transaction' in which various influences such as the child's learning disability and the home environment not only affected but also changed each other. The learning difficulties changed the child's environment and this modified environment acted upon the child to produce further change. Kearsly (1979), looking at family interactions, pointed out the mutually reinforcing yet transforming effects of the child and its family. The child's problems, he said, lead to changes in the behaviours and attitudes of parents towards their child, which in turn could lead to further limitations in the child's development.

Eisenberg (in Birch, 1964) wondered what the impact would be "on the development of maternal feelings of having a child who does not respond as he should, who is a source of frustration rather than pride" (p.70). Adamson (in Adamson, 1979) pointed out that deviant ego development, which may be the result of lack of intactness of the child's central nervous system, could result in lack of responsiveness by the mother, and foster an ongoing disturbance in the parent-child relationship.

To illustrate that the nature of the transactions that take place between the child and the social milieu in which it lives is important for the child's development, we can look at how one of the earliest relationships between a mother and her child is formed: sucking movements which are usually learned before birth may not have been learned as a result of minimal brain dysfunction. The child, as a result, will reject the nipple or the bottle when being fed, although it may be hungry. The mother soon becomes frustrated, and a relationship of tension, instead of a satisfying positive relationship, will build up between mother and child during feeding sessions. The failure to nurse may become the cornerstone for reinforcing other failure experiences when the child should begin to sit, crawl, walk, talk, etc. The parents tend to feel defeated and threatened and, because they don't know the reason for the problem they face, misconceptions arise, which from this early stage form the basis of unsatisfactory attitudes towards the child. (From Cruickshank, 1967)

Whitford (1982) in his study on family stability and the learning-disabled child, suggested that "social and interactive factors are associated with learning-disabilities" (p. 242). He added that this implies optimism for improving achievement of the learning-disabled child. The parents are the ideal people to become actively involved in changing the socio-emotional environment for the child.

The need for parental involvement in the treatment programme for their learning-disabled child has been pointed out repeatedly: For example Thompson (in Kirk and McCarthy, 1975) said "since the personalities of parents exert significant influence on the personalities of children, the major aim must be to assist parents in solving their own personal problems. In this way, parents would provide a healthy, reclaiming environment for the children" (p. 361). He found parents to be in desperate need "for information and aid for their children's conditions, for themselves and for social action" (p. 361). Guerny (1967)

quoted from a recommendation made by the Educational Policies Commission in 1962: "So great is the impact of parents on the attitudes and aspirations of children that parent education must be considered a primary responsibility" (p. 66).

However as McDowell (1976) pointed out: "In reality, parent counselling has received little more than lip service . . . once the screening or intake interview has been completed, parental contact is relegated to minimal reporting, in terms of the status or progress of the child" (p. 6). He added that a child-centred orientation is extremely important, but that it should not occur without "ongoing program-parent interactions which attend to the needs of the parents as well" (p. 7). And things have not changed as Bryan (1982) could still say "Despite the recognition that parental behaviours have a significant impact on the child's intellectual and emotional growth, parents have been essentially excluded from the . . . intervention process" (p. 149).

Adamson (1972) is one of the researchers who saw the importance of parents helping their learning-disabled children to achieve socially, emotionally and educationally. He successfully organised a programme in which parents were taught how to structure their home, how to deal with the learning-disabled child's emotional problems and how to build a bridge between the child and the school. It is important, said Adamson, that parents and children work together to improve the situation.

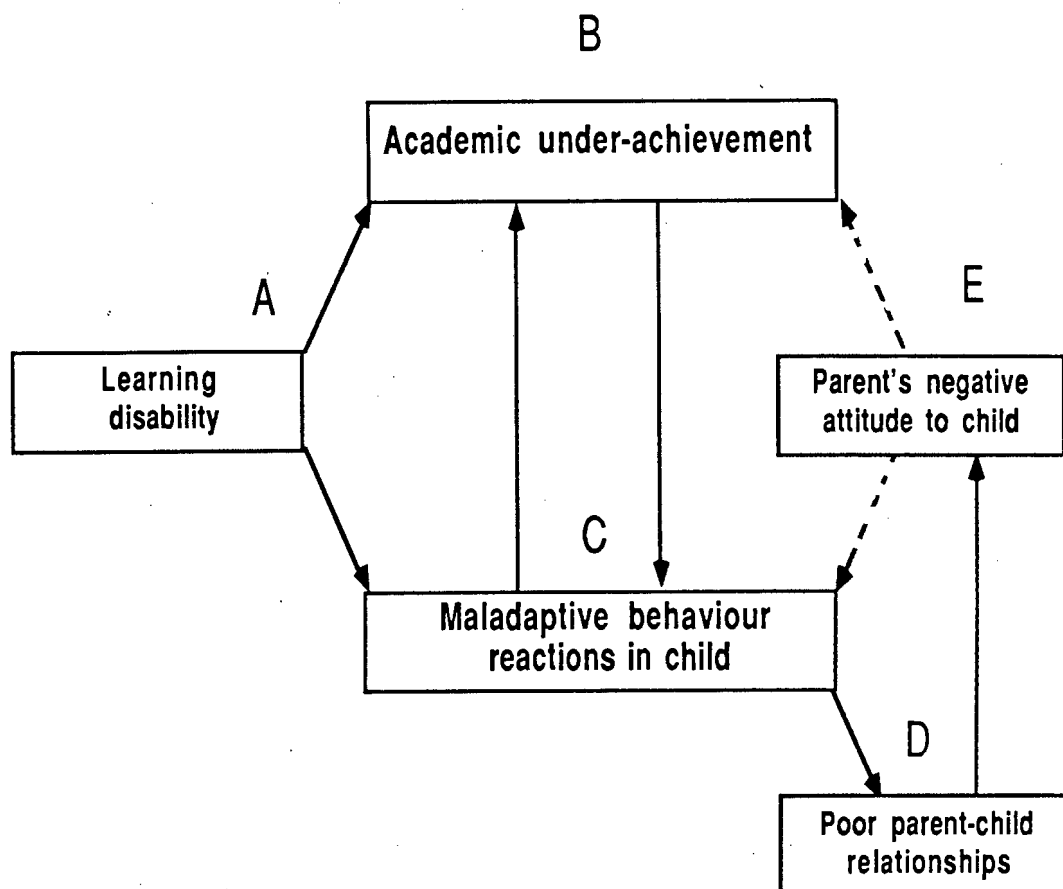
Experience with the education of learning-disabled children, the above mentioned research and other studies made the present researcher aware of the learning-disabled child's social, emotional and behavioural problems which have a negative influence on parent-child relationships and in particular on the parent's attitude towards their child. This awareness led to the present investigation in which it is assumed that there is a relationship between parental attitudes and a child's emotional development, that parental attitudes influence the way a child feels about himself and how he will achieve at school and in life, and that it is important not only to focus on remediation programmes for the child but also to find a way to help parents to develop more facilitative, positive attitudes towards their learning-disabled child. It was further assumed that reflective counselling groups for parents will provide the means for the parents to learn to understand their child and its problems better, to accept the child for what it is, to show tolerance for its

What
to stop
love you
the parents

defects and to come to terms with the difficulties involved in parenting a learning-disabled child. This understanding of the child and its problems will hopefully lead to better parental attitudes towards the child and to subsequently higher academic achievements for the child.

The interaction between parental attitudes and the child's academic achievement and behavioural adjustment can be summarized schematically as follows:

Figure 1A Interaction parental attitudes – child's behavioural adjustment – child's academic achievement



The assumption is made that if E, the parents' negative attitude towards the child, changes into a positive attitude, C, the maladaptive behaviour reactions in the child will change, which in turn will change B, the child's academic underachievement, which will facilitate remediation of the learning-disability.

Chapter 2

WHAT IS A LEARNING-DISABILITY

In conducting research involving children with a learning-disability one immediately encounters the problem of explaining what a learning-disability is. It is discouraging to read in as recent a work as Bryan's (1982) that there is still little agreement on what conditions constitute a specific learning-disability.

Confusion regarding definitions is partly due to the fact that researchers have come from widely different professional backgrounds, including general and physical educators, neurologists, optometrists, pediatricians, physical therapists, psychologists and occupational therapists. Each of these groups of researchers looked at the problem from a different point of departure or field of interest and formed their own definition. This involvement of people from different professions is reflected in the variety of terms used by the different professions to denote the same syndrome: brain-injury, minimal brain-damage or -dysfunction, learning-disability, specific learning-disability, psychoneurological learning-disability, perceptual disability, educational handicap, reading disability, underachievement, and others. The inability of investigators to come to an agreement regarding a term acceptable for everyone, has added to the confusion. In fact, the terms have been so widely criticised that it may be advisable not to use them at all. Other reasons for the confusion regarding a definition and term are the wide range of different characteristics that a child who is termed learning-disabled may or may not display and the uncertainty regarding the etiology of the problem. One of the major questions that has emerged here is: can one differentiate between learning-disabled, emotionally disturbed, environmentally deprived and mentally retarded children? Nevertheless, an attempt will be made to give a short account of the attempts made by various researchers to define the term 'learning-disability'.

As stated above, different investigators have used different approaches when

defining learning-disabilities. These approaches seem to fall into three main categories. First, there was the medical disease approach which emerged before and during the 1960's. Definitions emphasized the etiology of the problem. Two major schools of thought emerged within this approach: the one tried to identify a deficit of part of the brain, the deficit school, while the other explained that learning-disabilities were the result of a developmental lag of part of the brain, the developmental school. Both hypothesized an inherent medical, neurological or psychological disorder which impedes the learning process, and both assumed that if the cause can be eliminated the symptoms will disappear. Then, during the 1970's, definitions formed within an educational approach emerged. This approach was more pragmatic and emphasized the behavioural aspects of the learning-disability and the remediation procedures. In the 1980's a third approach emerged, in which the problem was looked at from a transactional point of view. Within this model the question was raised as to whether there was in fact such a thing as a homogeneous group of children who could be categorised as learning-disabled. No actual definitions were formed but an attempt was made to describe as accurately as possible, the child with specific learning problems.

2.1 THE MEDICAL APPROACH

Towards the end of the 19th Century, more value was placed on education, formal education became compulsory. Educators faced a new problem with children who showed a retardation in intellectual development and sometimes a definite mental deficit in learning and understanding, yet were not crippled nor so deficient as to need institutionalisation.

2.1.1 Deficit School

Orton (1937) was one of the first researchers to become interested in these children who were diagnosed as mentally retarded, many of whom, he discovered, suffered from language delays and disorders. He explained that problems with the acquisition or development of language may hamper a child's learning ability. He stated that "any disorder in normal acquisition of spoken and written language serves as a severe hindrance to academic advancement and often

also lies at the roots of serious emotional disturbances" (p.12). But this does not mean that they were mentally retarded. He examined the brains of brain-injured adults who showed patterns of language disturbances similar to those of the children he had studied. "The very close parallelism which exists between the symptoms to be seen in adults who have suffered a loss in language as a result of brain-injury and those to be seen during the development of the language faculty in some children suggests very strongly that we are dealing with a disturbance of the same physiological process in both instances" (p. 66). He pointed out that dyslexia was probably caused by faulty cerebral dominance and not by the faulty development of a particular area of the brain. He demonstrated that children with a developmental defect in language often showed mixed laterality for example left eye but right hand preference, a demonstrable mixture between right and left motor preferences. He also related reading problems to language problems, and pointed out that a child who could not write might have slow motor movement or be unable to form letters properly.

While Orton had looked specifically at language deficits, Strauss (1947) and Lethinen emphasized the importance of the perceptual skills of the child for learning. After reading Goldstein's work about brain-injured soldiers (World War 1) they came to the conclusion that those children who showed no motor defect, no gross neurological impairment, and who had a conspicuous lack of intelligence, showed remarkably similar features to people with known brain-injury, and might therefore also be suffering from brain-damage. They thought that this brain damage affected the perceptual skills of the child. The five behavioural characteristics Goldstein identified in the brain-injured soldiers were, as quoted by Stauss: forced responsiveness to stimuli, figure background confusion, hyperactivity, meticulousity and catastrophic reaction. All of these today are still seen as characteristics related to children with a learning-disability.

Strauss and Lethinen, as a result of these findings, distinguished between two types of retardation, 'endogeneous' and 'exogeneous' mental retardation. In the first type, mental retardation was seen as being due to family and environmental factors. Children who suffered from the syndrome of exogeneity of mental deficiency on the other hand, came from families with parents and siblings of normal mentality, but they showed a history of prenatal, natal or postnatal damage to the brain, and would possibly show slight neurological signs in a medical examination but no conspicuous motor impairment. Lerner (1976) explained that

exogeneous mental retardation was not due to an inherent pattern, not to the genetic structure of the brain, but to an injury that occurred outside the genetic structure. Strauss and Lethinen added that these children could be clinically diagnosed by their mental retardation, by a history of brain-injury, minor neurological symptoms and conspicuous organic behaviour. They also stated that certain of their characteristic features were discovered among children with cerebral palsy, and among children of normal intelligence who displayed peculiar behaviour. All these children, irrespective of their placement on the Binet Scale of Intelligence and with or without a diagnosed brain-lesion, were labelled by Strauss and Lethinen as 'brain-damaged' or 'brain-injured'. They created in this way a new category of exceptional children, children who showed a common pattern of behaviour, yet who before had been misclassified into various other categories such as mental retardation, emotionally disturbed, autistic, aphasic or behaviourally maladjusted. To describe these children Strauss and Lethinen formulated the following definition :

A brain injured child is a child who before, during or after birth has received an injury to or suffered an infection of the brain. As a result of such organic impairment, defect to the neuromotor system may be present or absent; however such a child may show disturbances in perception, thinking and emotional behaviour, either separately or in combination. These disturbances can be demonstrated by specific tests. These disturbances prevent or impede a normal learning process. Special educational methods have been devised to remedy these specific handicaps. (p. 4)

Although the term 'brain-injured' became severely criticized in later years, and did not refer to as homogeneous a group of children as Strauss and Lethinen appeared to have thought, these two researchers contributed much to the research involving children with learning problems. Their work filled a great void within this field. They learned much about the way these children hear, feel and understand their world. They created an awareness among educators of the child with so-called exogeneous mental retardation, and they compiled special educational methods which were based on the diagnosed strengths and weaknesses of the child, thereby increasing the child's academic achievements.

2.1.2 Difficulties Arising around the Terminology Regarding Children with a Learning Problem

It may be appropriate to first discuss the problems which arose out of using the

term 'brain-injured'. The main objections against the use of the term were that (1) it was too encompassing a term, it did not differentiate between children with cerebral palsy or epilepsy and the children without known brain-damage. And that (2) it emphasized the etiology of the problem instead of the symptoms and the remediation thereof. To overcome these problems the prefix 'minimal' was added by Clement in 1966 (as explained by Lerner, 1976) in order to make the term less frightening for parents and children and to differentiate between gross neurological impaired children, i.e. children with epilepsy or cerebral palsy and children with minimal brain impairment that affected behaviour and learning in a more subtle way. Because the behavioural deviations of these children was more subtle it was assumed that their brain damage was probably less severe. At the same time, to make the term less stigmatising, the word 'injured' was replaced with the word 'dysfunction'. 'Dysfunction' served to soften the neurological implications, and avoided specifying whether there was actual tissue damage, yet implied that the brain was in some way malfunctioning. Due to this malfunction the child showed deviant instead of appropriate behaviour. But later, to underline the misuse of the term, Hallahan (1976) argued that the malfunctioning of the brain did not have to be the result of brain damage, it might be the result of abnormal learning experiences or emotional disturbance. After all, all behaviour is in some way represented in activity of the brain.

The term 'minimal brain dysfunction' (MBD) was used until researchers and the parents of such children became more and more dissatisfied with the term, as often no actual brain damage could be diagnosed. As Cruickshank (1968) pointed out, brain damage can only be inferred through observation of the child's behaviour, through analysis of the child's reactions to learning situations, and through using psychological tests of sample behaviour. As Bryan (1982) explained, calling these children brain-injured is based on circular logic, brain-injured children may have learning-disabilities but that does not mean that learning-disabled children have brain injuries, even if the two groups do show similar characteristics.

Dissatisfaction with the term 'MBD' led researchers within the educational field to look for a more realistic term. As a result Kirk and Bateman (1962) coined the terms 'learning-disability' and 'special learning-disability'. These terms, as Lerner (1976) pointed out, emphasize the educational character of such a disorder. "It focusses on the problems the child faces, not on the causes" (p. 24). Kirk (in Kirk and McCarthy, 1975) explained:

Recently I have used the term 'learning-disabilities' to describe a group of children who have disorders in development of language, speech, reading and associated communication skills needed for social interaction. In this group I do not include children who have sensory handicaps such as blindness or deafness, because we have methods of managing and training the deaf and the blind. I also exclude from this group children who have generalized mental retardation. (p. 9)

Kirk's definition of learning-disabilities and those which follow make a clear differentiation between children who are mentally retarded or physically handicapped, and those who have learning-disabilities. The term 'learning-disability' was not meant to be all-inclusive. It became increasingly reserved for children who had difficulties in learning, who underachieved, yet who were not mentally retarded nor sensorily impaired. Many researchers, in their attempts to make the term 'learning-disability' refer to as homogeneous a group of children as possible, have also tried to exclude children who are culturally deprived or emotionally disturbed. Researchers within the medical model nevertheless still currently use the term 'minimal brain dysfunction' which they see as a more encompassing term. It does not necessarily exclude children with mild mental retardation or mild neurological disorders. It is mainly used when describing hyperactive children, as Rie (1980) pointed out. The learning-disability is seen as one of the symptoms of MBD. In the present investigation the term 'learning-disability' will be used.

2.1.3 Further Research within the Deficit School of the Medical Approach

Cruickshank (1967) originally conducted remedial work similar to that of Strauss. At first he concentrated on children with cerebral palsy of near normal, normal and above normal intelligence, but later shifted his attention to children of normal intelligence who showed poor figure-ground relationships due to distractibility, the type of children defined by Strauss as suffering from exogeneous mental retardation. He divided the children with exogeneous mental retardation into three groups: educable mentally retarded children, emotionally disturbed children and learning-disabled children with no known brain injury who demonstrated characteristics similar to those of children with known brain injury. He pointed out that these children all respond to the same type of educational and psychological programmes of treatment. Although he fully realized that it was not always possible to demonstrate conclusively the presence of an actual brain injury or lesion and he acknowledged the problems concerning the label of MBD for such children, he insisted on using the term 'brain-injured'. He said this term

puts "the problem in the centre of the diagnostic dimension in which realistically it probably is" (p. 5). He went so far as refusing to add the prefix 'minimal', saying it was confusing and minimised the problem which might, as a result, be seen as less serious, while he felt that in reality "these children present the most complicated of all learning and adjustment problems; their problems are as great as any other class of handicapped children. There is nothing minimal about their brain dysfunction." (p. 5)

Johnson and Myklebust (1967), still working within the medical approach but accepting the term 'learning-disability', extended the term to 'psychoneurological learning-disability'. They pointed out that, initially, the manifestations of the disability were most often behavioural and not neurological: "The most observable symptoms are psychological in nature. The central feature of the condition is the learning-disability" (p. 8). Yet, they added, the child's achievement and behaviour had been disturbed as a result of some dysfunction within the brain which resulted in altered processes of understanding and of the use of spoken and written language, but not in a generalized incapacity to learn. They saw the basic causes of learning-disabilities as organic or 'neurological' involving the Central Nervous System (CNS), but emphasized at the same time the behavioural component, or the 'psycho' to which they referred. They came closest to forming a definition when they stated that the basis of homogeneity for handicapped children having a psycho/neurological learning-disability was:

the fact of adequate motor ability, average to high intelligence, adequate hearing and vision and adequate emotional adjustment together with a deficiency in learning (p. 9).

In South Africa the Committee of Inquiry into the education of children with minimal brain dysfunction (Murray, 1969) accepted the following definition:

Children with minimal brain dysfunction have average or above-average intellectual ability, and the motor function, vision, hearing and emotional adjustment are adequate, but they manifest specific learning-disabilities or behavioural disabilities which are associated with deviations of the function of the central nervous system. Dysfunction in the central nervous system manifests itself in different ways and in various combinations of the deviations mentioned below:- the impairment, namely, of perception, conceptualisation, language, memory, control of attention, impulse, and motor function. (p. iii)

This definition has not been amended since and is still accepted as a guide for identifying learning disabled children.

identifying learning disabled children.

Adamson (in Adamson, ed., 1979), still believing in a physical cause for learning-disabilities, pointed out that there were no structural abnormalities in the CNS but that the symptoms were the result of a dysfunction related to biochemical, electro-chemical and molecular-chemical systems within the neurons of the brain which resulted in a lack of intactness in the higher cortical levels. This interfered with important learning and behavioural functions like motility, language perception, memory, attention and cognition.

Although it has not been possible through direct evidence to link brain-damage with learning-disabilities, certain areas of the brain have been demonstrated, with the help of more refined measuring instruments, to be relevant to the understanding of learning-disabilities. Specifically, areas related to speech and language production and to perceptual skills have been identified. For example, Wender (in Knight 1979), looking at research conducted with adopted children, found the existence of a genetic component in hyperactivity, a characteristic of learning-disabilities. Others, like Hughes (in Knight, 1979) suggested that there is a higher incidence of E.E.G. abnormalities in hyperkinetic children including the 6-7 and 14 per second positive spike phenomenon and excessive occipital slowing, and he often found an epileptiform activity in children with learning disorders with defects of attention. Witelson (in Knight, 1979), looking at the functions of the hemispheres, found that in dyslexic boys there was an atypical pattern of right hemisphere specialisation for spatial processes, and a dysfunction in left hemisphere processing of linguistic functions. It must be stated that the above quoted studies are tentative and do not arrive at any definite conclusions.

2.1.4 The Developmental Approach

A second group of investigators, still within the medical approach as they also identified the locus of dysfunction as being internal to the child, denied that there was actual brain damage which resulted in minimal brain-dysfunction. They explained that the problems were the result of immaturity of the patterns of the CNS which resulted in symptoms similar to those of brain-injury.

Satz and Van Nostrand (1973) for example viewed dyslexia as the result of a delay in sensori-motor abilities and conceptual linguistic abilities, which is caused by a

that the acquisition of developmental skills that are fundamentally age-linked are delayed for the learning-disabled child, that such a child is developmentally similar to a younger 'normal' child and that the child will 'catch up' with its age mates. Satz went on to explain that there is no loss of function, but because maturation functions are slowed down milestones will be acquired later than normal. This will have a crucial influence on the child's learning capacity. For example, if a child has not learned how to decode letters and sounds at the age of six, he will not be able to learn to read. Satz also stated that the nature of the disorder varies with age. A small child will show perceptual problems which will be overcome as the child grows older, but then the child may develop linguistic difficulties. This accounts for the behavioural variabilities that learning-disabled children display. Bryan (1982) explained that there is no shift in the way the brain works, but that parts of the brain, needed to learn a certain skill, mature at different rates. This, according to Bryan, results in the strange array of skills and deficits observed in learning-disabled children. For example, the child's conceptual development may be slow which will influence its reading skills; or the child's visual-auditory memory may be impaired so that there is no memory carry-over.

Ross (1967), being more specific, reserved the definition of learning-disabilities to identify children who have difficulties in sustaining selective attention as a result of a delay in the child's development. He stressed that a learning-disability is not an irreversible deficit, but a form of intellectual immaturity. There is no absence of learning as the child is able to learn under carefully controlled conditions. He stated:

Learning-disabled children are children who experience difficulties in the acquisition of academic subject matter despite the fact that they are of at least normal intelligence and have no demonstrable physical, emotional or social handicap (p. 4).

According to Ross, the development of selective attention starts in infancy and develops quickly for some children, but slowly for others. "One can expect some children to be retarded and some advanced in attaining selective attention" (p. 61). In order to help learning-disabled children, one needs to focus attention on the behaviour patterns of development of the child and not on a neurological etiology. Ross emphasized that there is no proof that learning-disabilities are the result of malfunctioning of the brain, but that studies focussing on brain functions of the learning-disabled child have found developmental immaturities and problems on tests of sequencing, intersensory integration and similar tasks requiring attention

to complex stimuli.

It must be stressed that although some investigators (e.g. Ames, 1977) implied that a learning-disability is a matter of maturation, which may be overcome with time, rather than actual difference in potential, longitudinal studies have shown that, although the learning problem itself may have been remediated, this child remains a risk for academic, emotional and social problems such as becoming a dropout from school, or a delinquent, or showing impulsiveness, restlessness or poor social skills. The child has developed slower than other children, he is emotionally immature and has not learned many of the important social skills. The loss may never be overcome without methods of teaching which circumvent the problems.

2.1.5 Official Diagnostic Criteria

Finally, and still within the medical model we come to the definitions given in the DSM III and the ICD 9. Neither the ICD 9 nor the DSM III uses the term 'learning-disability'. The DSM III speaks of 'Attention Deficit Disorder' and 'Specific Developmental Disorder'. Under Attention Deficit Disorder it stresses the difficulties the child has with attention, which may occur with or without hyperactivity. Under the heading 'associated features' the manual states that developmental disorders are common and that in only 5% of the children is the disorder associated with a diagnosable neurological disorder. Mild or moderate mental retardation, epilepsy, some form of cerebral palsy and other neurological disorders are stated as possible predisposing factors. Specific Developmental Disorders may be manifested as a Reading Disorder (Dyslexia), Arithmetic Disorder or Language Disorder of the expressive or receptive type. The ICD 9 differentiates between the hyperkinetic syndrome of childhood, and specific delays in development. The essential features in hyperkinesis are short attention span and distractibility. Specific delays in development are seen as related to biological maturation but also as influenced by non-biological factors. The ICD 9 excludes delay in development due to neurological disorders.

2.2 THE EDUCATIONAL APPROACH

The change in terminology from minimal brain-dysfunction to learning-disability which was brought about by researchers working within this model, was not just the result of dissatisfaction with the term MBD, but of dissatisfaction with the medical model in general. These researchers felt that the medical approach associated learning-disabilities with mental retardation and that they over-emphasized the etiology of the problem. Educators and parents felt the need for a definition based on measures of a child's performance on academic tasks. A definition was needed which would be functional and which suggested means for remediation, that is, it had to be behaviourally orientated. As Lerner (1976) stated: "Just a label provides insufficient guidelines for devising strategies to help the child learn" (p. 44). Investigators working within this approach did not necessarily deny that there might be a dysfunction of the brain but they de-emphasized the etiological aspect, as it was not seen as important for compiling a suitable programme for treatment.

This concern with the actual problems with learning the child faces and the remediation hereof made researchers aware of different aspects that influence learning. Cratty (1969) and Kephart (1971) were among the investigators who stressed that the child's academic achievement depends on its perceptual motor development. Kephart stated that perception supplies the information upon which behaviour is based. Motor information supplies the movements which are the overt aspects of behaviour. If there is no correlation between the two the child will not be able to act on what it has just learned. De Hirsch (1966) mentioned that learning-disabled children have difficulties with the structuralisation and organisation of gestalts. Others, like Orton (1937) and Kirk (1975), emphasized the importance of the language development of the child for learning to take place. Still others, including Dykman (1976), Ross (1967) and the DSM III (1982) stressed disorders of attention. This latter development, in which different aspects of learning were emphasized and seen as the main cause of the learning difficulties by different investigators, also did not contribute to the forming of a clear definition of the problem. On the contrary, these different approaches to learning tended to obscure the concept more and eventually led to Hagin (in Das, 1982) saying that "no one definition can serve all purposes equally well and that different definitions for different purposes will emerge" (p. 55).

One of the first definitions compiled within this educational approach was the definition by Kirk and Bateman (1962):

A learning-disability refers to a retardation disorder, or delayed development in one or more of the processes of speech, language, reading, writing, arithmetic or other school subjects resulting from a psychological handicap caused by a possible cerebral dysfunction and/or emotional or behavioural disturbances. It is not the result of mental retardation, sensory deprivation or cultural or instructional factors. (p. 73)

Kirk (1975) stressed in further research the difficulties the child faced in academic and learning tasks. He said, the child who has the basic potential to learn but does not learn after adequate instruction is probably a child with a learning-disability. He subsequently defined children with learning- disabilities as:

Children who see and hear and who do not have marked general intellectual deficits, but who show deviations in behaviour and in psychological development to such an extent that they are unable to adjust in the home or to learn by ordinary methods in school. The causes of these behaviour deviations have been postulated as some sort of cerebral dysfunction (p. 7).

Bateman (in Hellmut, 1965) emphasized the discrepancy between intellectual potential and actual achievement:

Children who have learning disorders are those who manifest an educationally significant discrepancy between their estimated intellectual potential and actual level of performance related to basic disorders in the learning processes, which may or may not be accompanied by demonstrable central nervous system dysfunction, and which are not secondary to generalized mental retardation, educational or cultural deprivation, severe emotional disturbance, or sensory loss. Frequently these learning disorders seem to fit into one or more of three broad types - reading problems, visual motor disturbance and verbal communication disorders (p.220).

Bateman indicated that a child with an average intellectual ability, who in the first three to four years at school reads one to one and a half years below reading expectancy will need remedial training. In higher grades, a two years discrepancy will be reason for concern. Today, 20 years later, underachievement is still seen as one of the major characteristics by which a child is diagnosed as having a learning-disability.

In order not to exclude any child with a learning problem from remedial tuition the definition regarding learning-disabilities became more and more encompassing.

An example of this trend is the following broad definition given by Richardson (in Birch, 1964):

Children with particular or specific difficulties in learning and/or those whose behavior is such that they cannot concentrate or attend when we try to teach them (p.30).

He added that the distractibilities are usually manifested in the areas of language and/or arithmetic.

Haring and Schiefelbusch (1967) stated: "The term refers not to a particular well defined group of pupils, but rather to those behavioural characteristics that interfere with the acquiring and use of knowledge" (p. 159).

In the United States, in an attempt to bring order to the chaotic array of definitions, the National Advisory Committee in 1968 recommended the following definition to the Bureau of Education for the Handicapped, Office of Education, U.S.A.:

Children with special learning-disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain-injury, minimal brain-dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual, hearing or motor handicaps, to mental retardation, emotional disturbance or environmental disadvantage. (Act of 1969, PL 91-230)

This definition, although ambiguous, is still widely accepted in America as a workable definition within the educational setting. Well known investigators like Bryan (1982), Wallace (1979), Gaddes (in Knight, 1979), Adamson (in Adamson, ed. 1979) and Lerner (1976) still use it for lack of a better definition. Yet many difficulties are encountered in applying the definition, as Wallace pointed out: by what criteria does one define a disorder of listening, thinking, talking or reading, or as Bryan (1982) asked: what exactly is a perceptual handicap?

2.3 THE TRANSACTIONAL APPROACH

Within the educational approach, the learning-disabled child became the responsibility of the schools and the remedial teachers. The child was looked at only within the educational setting, and the treatment was child-focussed. Yet academic problems such as perceptual and conceptual difficulties, specific language disorders, difficulties in auditory and visual memory organisation and information processes which the child faces, are not restricted to the school environment alone, but influence the child's whole life. This approach to learning-disabilities emphasises the important role that developmental and environmental factors play in the etiology of a child with a learning-disability. As Leong (in Das, 1982) stated, both within- and extra-child variables have to be considered. Abrams (1977) explained that a learning-disability is the result of a variety of interrelated factors and that treatment of the child should be directed at the total functioning of the child's psycho-physiological and psychological factors, as well as familial factors, such as values and attitudes of the parents. Even Dykman (1976), although he assumed that learning-disabilities are the result of an inherited lag in development, added that "neutral maturation also depends upon one's life experiences" (p. 781).

Sameroff (1975) expanded on this and suggested investigating learning-disabilities from a transactional point of view. He looked at the child's characteristics, the maternal environment and the cognitive levels and values of the child's social milieu. He implied that learning-disabilities may not exclusively be due to stable in-child characteristics, but that they are also an expression of the transactions between the child and its environment, and that one can expect changes in conditions over time as the child and its environment transform each other. The crucial point in the child's development is the way it interacts with the environment, in particular with its parents, and how the parents communicate with their learning-disabled child. As Sameroff (in Kearsly, 1979) put it:

Although reproductive causalities may play an initiating role in the production of later problems, it is the caretaking environment that will determine the ultimate outcome. At one end of the caretaking continuum, supportive, compensatory and normalizing environments appear to be able to eliminate the effects of earlier complications. On the other end of the continuum, caretaking by deprived, stressed or poorly educated parents tends to exacerbate early difficulties (p. 128).

In other words, certain factors such as the child showing low or high activity

levels, moodiness, unapproachability, irregular sleep or eating habits, and so on, which occurred in the early childhood of a child who is later described as learning-disabled, may have affected the way the child's parents interacted with that child. For example, if a baby is slow to respond to the mother (low activity level), or does not smile or cuddle easily (low in approach), or is irritable (low mood) and inconsistent in habits (irregularity), the mother may possibly become hostile, angry and frustrated. She consequently may be less spontaneous and positive in her reactions to that child than she may have been to a child who smiles easily, eats and sleeps well, and so on. The interactions that occur between the baby and its mother will influence the attachment process as well as the child's cognitive and perceptual motor development. Furthermore, the child may also be inadequately stimulated by its mother. One can draw the conclusion from the above, that constitutional variability in children strongly affects the attitudes of the parents and their style of caring for the child. Keogh (in Das, 1982), influenced by Sameroff's work, explained it well, when he said that the characteristics a child with a learning-disability develops are a function of both in-child and extra-child conditions. The child's abilities and problems are influenced and affected by the nature of its experiences, as well as by the child's biological potential.

The medical approach had considered mainly the etiology in defining a learning-disability, and assumed a cause-effect development. In the transactional approach the problem was no longer seen as being caused by a single etiological factor which could be eliminated with treatment. They preferred to examine the changes that took place during the course of the child's development as the result of interactions that occurred between the child and its environment, factors which mutually influence and change each other. By looking at the child from this point of view it is possible to intervene, if necessary at a very early stage of development, thus preventing a pattern of further negative development.

2.4 RECENT VIEWS ON THE DEFINING OF LEARNING-DISABILITIES

The definitions of learning-disabilities discussed in the preceding pages, have attempted to emphasize that the term should not be used for all children who have

learning problems, and should exclude mentally retarded, emotionally disturbed, culturally deprived and physically handicapped children. All these definitions appear to agree that the term should only be used to describe a specific type of exceptional child, yet they have provided researchers with little help when a homogeneous grouping of children is required from which to select an appropriate representative sample of learning-disabled children for research purposes. The definitions are not specific enough, they are global and too encompassing. As Lerner (1976) explained, the term 'learning-disability' seems to include all categories of mildly handicapped children. Many mildly retarded children, hearing impaired children, emotionally disturbed children and culturally different young people, who exhibit characteristics and symptoms that fit the concept of learning-disability and who responded to material and methods designed for the learning-disabled, are labelled as such. But, as Cruickshank (1983) pointed out, when one's research group is ill-defined, generalization of results becomes impossible. He posed the question as to whether there is in fact such a thing as a *group* of learning-disabled children:

What is a group? - a number of bodies or a collection of subjects, not only of the same chronological age, mental age, intelligence quotient and academic achievement ages, but also individuals with identical neurological lesions, the same environmental backgrounds, parents with methodological approaches, subjects with the same childhood illness histories, and those with identical characteristics on a myriad of other variables? (p. 192)

Keogh (in Das, 1982) pointed out that despite 20 years of research: "We still lack a consistent and agreed upon frame of reference within which to conduct systematic or comprehensive research" (p. 28). The questions we are concerned with are: what should be studied and who should be included in the study sample. Some problems encountered when defining learning-disabilities are:

1. There is lack of sample homogeneity as characteristics and causes vary from child to child.
2. There are differences within samples, as the child experiences different problems at different stages of its life.
3. Most investigators when selecting their sample focus on a single variable, yet the problem is complex and multivariate. If not all characteristics are the same across samples it is difficult to generalize results and to compare different studies.
4. There are difficulties involved in measuring extra-child influences, such as

motivation, affect and other psychodynamic processes.

5. There is a problem differentiating between primary emotional disturbance and learning-disabilities, and separating emotional reactions to learning failure from the learning-disability itself.
6. It is debatable whether a normal I.Q. can be accepted as a crucial criterion or whether organisational and retrieval problems associated with learning-disabilities result in lower scores on I.Q. tests.

2.5 TOWARDS A DESCRIPTIVE DEFINITION USEFUL FOR THIS RESEARCH

As the value of having one working definition for a variety of situations is being increasingly questioned (Rie, 1980), and as no definition seems to be able to serve all research purposes equally well (Hagin, in Das, 1982) the term 'learning-disability' should only be used as an all-embracing concept. Each investigator needs to define the aspects of the learning-disability he is concerned with and needs to specify the variables relevant for that specific study.

For the present investigation, which is concerned with the emotional and social problems encountered by most children who have difficulty learning within a normal school situation, certain characteristics were identified and used as criteria for participation in this research. These criteria for defining a homogeneous group of children with learning problems were based on the criteria or variables which are fundamental to most of the definitions that have been discussed in this chapter. Some of the criteria are: underachievement, difficulties in learning, yet normal I.Q. and absence of physical handicaps, severe emotional disturbance and environmental deprivation.

In attempting to formulate a clear concept of what a learning-disability is, investigators at present have to accept that no one definition which effectively overcomes all the contradictions and difficulties can be formulated. Yet the difference in emphasis between the medical approach and educational approach may be overcome by further developments in the transactional model. This approach seems to bring the two former ones together; it de-emphasizes, yet does not deny, the constitutional factors in a child which may lead to learning problems. This approach relates those factors to events within the child's life which may

influence its further development. It further stresses that interventions at any stage of the child's development in the educational, social or behavioural field, is possible, and helpful. In this way the main concern of the educational approach, treatment of the actual problem, is stressed.

The present investigator takes the concepts described within the transactional model as the point of departure for her research concerning parental attitudes and the academic achievement and behavioural patterns of the children. The concepts of the transactional approach will be elaborated further in Chapter 4 when the relationship between the parents and their child with a learning-disability will be discussed.

Chapter 3

Life Rature

**CHARACTERISTICS OF THE
LEARNING-DISABLED CHILD**

In order to get a clearer picture of what a learning-disability is, characteristics associated with the problem will be discussed. At the outset it must be borne in mind that it is as difficult to describe symptoms and signs whereby the learning-disabled child can be recognised as it is to define a learning-disability. As Bryant (in Das, 1982) stated: "We cannot even be sure who these children are, or by what criteria to recognise them. We know that they are there; we can be certain that their difficulty is serious and all too common. However we are not sure exactly how to spot them" (p. 271). The problem is, as Painting (in Adamson, 1979) said, that a learning-disability is not "a specific disease entity but represents a cluster of symptoms and signs which make up non-specific syndromes" (p. 65). Or as Wender (1972) explained, the term 'learning-disability' refers to a complex, heterogeneous, and sometimes mutually contradictory group of behavioural characteristics, yet with symptoms associated with each other on a greater than chance basis.

3.1 SPECIFIC PROBLEMS REGARDING THE CHARACTERISTICS OF THE LEARNING-DISABLED CHILD

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Each child is different, and not all symptoms are evident in every child. Each child has its own particular pattern of behaviour (Paterson, 1967). The learning problem may be expressed in one child through hyperactive, uncontrolled behaviour, while another learning-disabled child may be shy and withdrawn. One child may be impulsive, while the other is cautious and loathes the new. Some respond to every distraction, others are quiet day dreamers; some are clumsy, while others are deft and agile. Cruickshank (1967), Frostig (in Myklebust, 1972), Larson (1976), Kaslow (1979) and Wallace (1979), among others, stated that the characteristics vary widely and that the only basis of

homogeneity are the difficulties the children encounter in learning. Yet not all children have difficulties in the same area of learning: they could experience difficulties in one or more academic subjects as a result of problems related to listening, thinking, talking, reading, writing, spelling or arithmetic.

The characteristics not only vary from child to child, but can also vary from time to time within the same child. The behaviour of a learning-disabled child can fluctuate within hours or days from extreme happiness to deep depression. The symptoms can appear on some days but not on others. The child can excel on some tasks, and perform like a two-year-old on others. The child may know the material perfectly well the one day, but may have forgotten every bit of it the next day (Kephart, 1971). Lenkowsky (1978) stated that the learning-disabled child may display emotionally unstable, aggressive, defensive acting out behaviour, and that this same child may appear to have a clear, logical scientific mind capable of creating, planning, organizing and developing visual-spatial material in a highly competitive way. It was these irregular behaviours that led Bryant (1978) to call these children "the puzzle children" (p. 9). In addition, children with learning-disabilities show different patterns of symptoms at different ages, a finding on which many researchers base their assumption that the cause of a learning-disability is a lag in the maturation of certain brain functions. The differences in behaviour may depend on the age and cognitive level of the child, as the rate of acquisition and the relative importance of different cognitive abilities change with development. Younger children who are maturationally delayed will show problems concerning perceptual-spatial and cross-model integration, skills which develop ontogenetically early in childhood. The older child, having overcome these problems may manifest impairments in language and formal operation skills as Satz (in Satz and Ross, 1973) explained. Rie (1980), reviewing the literature on this hypothesis concerning maturational lag, found that younger children with a learning-disability, i.e. those aged six to nine years old, were characterised by perceptual problems, and these problems diminished with age. Older children above ten, manifested deficits in integrated language skills deficits. Wender (1972) explained that the change in the manifestation of the problem is not necessarily the result of a lag of maturation of parts of the brain, but is due to normal developmental changes. The behaviour of this child is seen as problematic because it is exaggerated. For example the toddler with a learning-disability will not just be active but will be hyperactive. The problems of a young school child will manifest themselves as attentional and social problems; at

about ten years of age the problem may become an academic one and the child may become antisocial; the child may then be diagnosed as learning-disabled.

The picture of a learning-disabled child is further complicated by the 'hiddenness' of the handicap, a concept used by Cruickshank (1968), Bryant (1978), Grossman (1978), Wallace (1979), and others. The symptoms are difficult to recognize and the child's appearance is normal. There is no obvious physical deformity, no gross motor disability, no mental retardation and no severe speech defects. The child's behaviour and responses are also not abnormal in kind; but, as Wender (1972) pointed out, can however be called abnormal in degree. There is an exaggeration or extension of normal behaviour which manifests as outbursts of excessive anger, or excitement, or as temper tantrums, and so on. As a result of the relative 'normality' of the child's behaviour the symptoms are easily overlooked or explained away. There is also no single test available to pinpoint all of the symptoms, and quantitative test-data don't give useful information regarding attitudes such as fear of failure, or self denigration. These are some of the problems encountered when having to diagnose a learning-disability.

3.2 CHARACTERISTICS

It is important to remember that while not all of the symptoms that will be mentioned are manifested in each learning-disabled child, each child will manifest at least one or more of these characteristics, with attendant interference with the acquisition and use of knowledge. Bryan (1974) pointed out that almost any combination of negative personality traits, behaviour and problems have in theory been associated with learning-disabled children. In order to gain a clear view of the symptoms the present investigator has organized the symptoms into five categories: under-achievement, cognitive problems, emotional problems, behavioural problems and social problems.

3.2.1 Under-achievement

Despite the contradictory findings described above, and the confusion as to what can be regarded as typical characteristics of a child with a learning-disability,

under-achievement is the one characteristic which is generally accepted as the major criterion for diagnosing a learning-disability, which is not caused by mental retardation or by a sensory deficit.

The diagnosis of under-achievement is based on the difference between present academic level as determined by standardized achievement-test scores, or in-class scores on academic tests, and potential or ability to learn, as determined by an I.Q. test. Some investigators, Bateman (1966) being one, stated that if in a child of six or seven years old academic performance in, for example, reading is one year below the child's age level that child can be diagnosed as under-achieving. Others stressed the need for a less subjective, more scientific approach to determine a significant discrepancy between expected and actual achievement. The method most frequently used is the one that was proposed by Myklebust as quoted by Wallace (1979). He compiled the following formula to calculate the learning quotient for a certain subject:

$$LQ = \frac{AA}{EA} \times 100$$

LQ = the degree of learning achieved in relation to intellectual potential for learning.

AA = the achievement age obtained for a certain subject.

EA = expected age and is obtained by adding mental age, grade age, and chronological age and dividing this sum by three.

Myklebust further stated that if one takes an I.Q. of 90 as the lowest level of intelligence to be included in the group of learning-disabled children, a learning quotient of 89 or below will have to be taken as indicative of a learning deficit.

3.2.2 Cognitive Problems

Cognitive problems can be subdivided into perceptual difficulties, attentional deficits, disturbances in activity level and in language disorders..

3.2.2.1 Perceptual-motor difficulties

The child with a learning-disability may have a deficiency in perception which can be (1) visual, (2) auditory, or (3) haptic in nature, he may also have problems with (4) cross-modal information processing; or have a deficiency in motor skills

which may be manifested as (1) poor perceptual motor match, (2) poor fine or (3) poor gross motor skills, (4) poor balance, (5) poor sense of rhythm, lack of (6) laterality, (7) directionality and (8) poor body image.

1) A disability involving visual perception may be manifested in four ways: (a) in perception of the properties of form. The young child may not be able to discriminate between two faces, the mother's and a stranger's face, or later between words or letters. (b) The child may have a problem regarding the relative position of stimuli, and as a result reverse words or letters. (c) Problems with visual closure may be manifested, this means that the child will not be able to fill in missing parts of objects. (d) The child may not be able to see things as a whole, as a Gestalt, and will therefore react only to part of the stimuli. (e) Or the child may have problems with visual background discrimination, it may not be able to screen out irrelevant background stimuli. The child may confuse or reverse the two, or not see any difference between the two. This may distort the child's picture of reality.

(2) The child can also suffer from an auditory perceptual problem. This child may find it difficult (a) to process auditory information, and as a result won't be able to respond to what is being said. (b) The child may not be able to discriminate adequately between sounds, and (c) comprehend or remember the sounds. (d) The child may have difficulties in selecting and attending to relevant auditory stimuli, or in focussing its attention on the important stimuli.

(3) Children with haptic perceptual deficiencies will have difficulties acquiring information through tactile and kinesthetic senses. For example they may (a) not be able to obtain meaning from the things they touch or (b) have difficulties with orientation and coordination. Any stimulation of the skin is experienced as irritating. As a result these children do not learn to discriminate tactilely, which may influence their ability to write and spell as the correctness of spelling is checked with the movement sensations of writing the letters.

(4) Bryan (in Rie, 1980) stated that the child may also have problems with cross modal information processing, for example the inability to integrate information received through visual and auditory channels, or visual and tactile channels into a meaningful concept.

Motor-skill deficiencies may be manifested in:

(1) A poor perceptual motor match. This will lead to lack of eye-hand coordination which makes it difficult for the child to use pencil and paper, to

write, to copy or to build with blocks.

(2) The child's fine motor skills may be impaired, making it impossible to hold a pencil properly, tie up shoelaces or do up buttons.

(3) Or the child's gross motor skills may be impaired. This child will have difficulties skipping, jumping, running, catching a ball and making other movements in which large muscles are involved.

(4) Some children have problems balancing.

(5) Others may not be able to perceive rhythms or reproduce them.

(6) Still other difficulties resulting from motor deficiencies are problems regarding laterality. The child with this type of problem will have no awareness of where an object is in relation to its body. Laterality refers to an inner awareness of the two sides of the body and their differences, as Wallace (1979) explained.

(7) The child with problems regarding directionality won't know right from left, forward from backward, up from down, etc.

(8) Finally, the child may have inadequate body image, and as a result find it difficult to move its limbs in an organised way and to judge where the body is in relation to other objects in the environment. This often goes together with a lack of differentiation between right and left. Hallahan (1976) states that this child may also feel disoriented in space, which may create difficulties in reading such as reversal of words.

3.2.2.2 Attentional deficits

A child who lacks attending skills won't be able to focus its attention selectively or sustain it. The child may respond in a forced way to inessential, irrelevant stimuli. Kagan (in Mussen, 1970) explained that attention and concentration are related, and that lack of attention leads to imperfect registration of events in the short term memory. On the other hand, said Eisenberg (in Birch, 1964), the child may show a forced preoccupation with detail, or perseveration. This refers to an involuntary continuation of behaviour, the child seems unable to shift easily from one psychological activity to another, and gets stuck with a task when that task no longer serves any purpose or is no longer meaningful.

3.2.2.3 Disturbance of activity level

The terms 'hyper-active' and 'hypo-active' behaviour refer to a deviation in tempo, and a deviation in the amount and patterns of motor activity. Dykman

(1970) described hyper-active children as children whose inhibitory processes are weak or deranged with a resulting increase in distractability and impulsiveness. Such children seem to respond impulsively to negative stimuli, and prematurely to positive stimuli. Hypo-active children, on the contrary, show inhibited behaviour. They may stop responding to positive stimuli altogether, they seem lethargic and quiet, and they don't give trouble in class.

3.2.2.4 Language disorders

Language disorders can be a central problem for a child with a learning-disability. Bryan (in Rie, 1980) stated that learning-disabled boys show less linguistic competence than normal boys do. Problems can include the acquisition of language, and the comprehension, performance and production of language, or as Bryan (1982) pointed out, the child may have a deficiency in the perception, coding, or retrieval of information processing. Such children may show a delay in language development or may have a mild speech disorder.

3.2.2.5 Conceptual disorders

Another disorder that learning-disabled children sometimes manifest is a conceptual disorder as Lerner (1976) pointed out. Such children are unable to organize thoughts and materials in a normal manner. They find it difficult to integrate motor, sensory, perceptual, cognitive and emotional functions. They have problems thinking abstractly, and in generalizing information that is needed in order for them to make decisions and to act.

3.2.2.6 Cognitive Style

In addition to the cognitive problems described above, a learning-disabled child may develop a cognitive style which may further impede his academic progress. Stander (1977) pointed out that children from an early age develop a cognitive style, a strategy, used to tackle certain problems which will influence their learning progress. Intellectual as well as non-intellectual components, personality factors and the emotional meaning a certain task has for a child, will influence the way a cognitive style develops. Categories which may play a role in forming undesirable cognitive styles for a learning-disabled child are: the experiencing of a learning situation as a stress situation, level of distractability, hyperactivity, lack of

inhibition, impulsive behaviour, the tendency to make quick, unthoughtful decisions, lack of cognitive integration, the tendency to form over-inclusive categories and emotional lability. "Die leergestremde leerling", said Stander, "vertoon 'n opvallende emosioneel gebaseerde kognitiewe strategie van skolastiese probleemoplossing wat mettertyd op die basis van die onderliggende emosionele labiliteit 'n bepaalde outonomie ontwikkel". (p. 333)

A child who manifests one or more of the cognitive difficulties described above will encounter severe problems in learning. Not only will there be problems in the area of school learning, which after all is only one part of the continuous process of learning involved in growing up, but in all aspects of learning, at school, at home, and in the community. The problem may manifest itself verbally, when the child is involved in tasks such as learning to read, write or do arithmetic, or non-verbally in tasks such as learning to tell the time, learning directions and body orientation, or in adjusting emotionally or socially. When learning social behaviour the child may have problems, for example, with learning the meaning of the facial expressions and behaviour of others. The child may not see what we think we show it, may not hear what we think we say to it, or may not make connections between bits of information. These handicaps will have a great effect on the child's overall pattern of functioning.

3.2.3 Emotional Adjustment

From the cognitive problems described above, all of which impede the child's learning, it follows almost inevitably that the child will develop negative emotional reactions. Many authors, including Beers (in Kirk, 1975), Lerner (1976), Johnson (1967), Weber (1977), Adamson (in Adamson, ed. 1979) and Gold (1979) agree that the emotional problems that many learning-disabled children display develop as a result of their being unable to achieve normally. The emotional problems arise out of the frustration experienced when the child does not do well, yet has tried hard. The child with a learning-disability begins life with few or no emotional problems or obvious handicaps, but the constant failure and ridicule may result in frustration, anger, hostility, poor self-concept and eventually serious emotional problems. These emotional problems are aggravated by the invisibility of the handicap, which leads others to expect the child to behave normally, and often the problem is only diagnosed when the child is in standard

one or even higher, when required to display more advanced communicative skills, affective responses and social and cognitive functions (Richardson, in Birch, 1964). But up to the time that the problem is correctly diagnosed the child will have been grossly misunderstood, accused of being lazy, unmotivated and careless, and will have been punished unfairly for shortcomings which are beyond its control.

3.2.3.1 Poor Self-concept

These emotional problems are mainly manifested in a defective, negative self-concept and in a low self-esteem as Anderson (1976) and Wallace (1979) emphasized. Strong ego concepts are formed through success. The learning-disabled child however often learns what it means to fail. The child may achieve poorly in areas like sport and school work, which often leads to a low self-regard and a negative self-concept. Many children with learning-disabilities have been quoted as expressing that they are lazy, stupid, dumb, bad or worthless. They perceive themselves as not being able to achieve, and they consider themselves to be inferior and failures. They blame themselves for this failure but do not believe they can do anything about it. Their own lack of confidence makes them overconcerned about what other people think of them, and they are easily influenced by others. Kaslow (1979) called them 'narcissistic hypersensitive' children. Bryan (1976) stated that failure at school can lead to anxiety and the expression of self-negation. He added (1978) that feelings of school failure breed many other failures: the child may experience self-doubt, uncertainty, guilt, shame, resentment, and a sense of deep inadequacy and worthlessness. Pressure from parents and teachers to achieve better can make the child more insecure, feel more inadequate and anxious, and may create feelings of guilt within the child who may possibly become more and more disorganised. Cruickshank (1967) explained that a positive self-concept is related to a well conceived body-image. "Out of a good and positive body-image comes a good and positive self-concept. Out of warm psychological settings and success also comes a positive self-concept. Out of positive self-concepts come the strong ego-forces which make it possible for human beings to adjust well in the complex society in which we live" (p. 61). He implied that the opposite may be true for the learning-disabled child. As the self-concept of the learning-disabled child is often based on a distorted self-image, the behaviour of that child in society may be ineffective.

Stander (1977) found that the negative self-concept a learning-disabled child so often develops influences his whole personality. It has a destructive, limiting influence on the child's whole development, it leads to an attitude of failure, it makes the child dependent on for example teachers and parents and it will negatively influence his expectations for his future.

3.2.3.2. Mood fluctuations

Another emotional problem the child with a learning-disability may have to contend with is a highly unstable mood. Berry (in Rie, 1980) explained that the child may be happy and cooperative the one moment, but sullen and aggressive the next. The child can be irritable, may cry easily, feel insecure, change from laughter to tears in moments, or may panic when faced with an unknown situation. Freeman (1974) said these children become easily upset over little things, or over excited when they are happy, and their emotional discharge is out of proportion to the situation. When angry feelings and frustrations are turned inwards the child can become depressed and anxious. When they are turned outwards the child can become aggressive, or blame others.

3.2.3.3 Dependency

Another emotional problem which is often seen in children with a learning-disability is that of prolonged dependency, or over-dependency, on adults, in particular on mothers and teachers. These children require excessive assistance and often need to be reassured and helped in activities they should be able to do themselves. As a result the child seldom experiences a feeling of competence and does not gain self-confidence.

These emotional problems described above will, in turn, impede the child's academic achievements. As Wallace (1979) pointed out, children with a positive self-concept achieve better. He also pointed out that self-worth is correlated with overall academic achievement. Mendelson (1971) explained that "low self-esteem reduces children's motivation, so that a child with this feeling is likely to be involved in a vicious circle in which lack of efforts leads to failure, and in turn to further discouragement" (p. 277). Mendelson warned that the complications of low self-esteem and defeatism may outlast the original problems.

3.2.4 Behavioural Problems

Apart from emotional problems a learning-disability can also give rise to behaviour problems. Behaviour problems are difficult to differentiate from 'conduct disorders': The only difference is that the learning-disabled child is not hostile and does not wilfully misbehave. It is rather a matter of the child's behaviour seeming miscalculated. The child feels regretful when its bad behaviour is pointed out to it, yet does not seem to learn from punishment or discipline. Many of the symptoms of cognitive impairment (i.e. hyperactivity, short attention span, distractability, perseveration, disinhibition, inadequate body image, incoordination, etc) thwart the child's efforts to make successful contact with the world. This leads to frustration, to misinterpretation of reality and to bizarre behaviour (Meyers, 1969). And as Strauss (1969) pointed out, a child with a perceptual disability does not receive and evaluate the messages of the sensory organs in the normal way, and as a result, that child's responses to the stimuli will not be normal, which leads to inappropriate and inadequate behaviour. The child does not seem to be able to behave in accordance with environmental demands, nor cope adequately with the demands of life in society. A child, expressing its frustration about academic failure, said: "What's so frustrating is that it is all up in my head but I just can't get my hands to put it on the piece of paper ... Do you know what it is like to be on page 3 when everyone else is on page 15 ... I get mad and feel like giving up".

3.2.4.1 Defensive behaviour

As a result of stress and frustration the child's behaviour may become defensive or failure-avoidant. The child may withdraw in order to avoid frustration, or regress to an earlier stage of its development. They become the 'shadow children' (Bryan, 1978), in that they purposely fade into the background hoping not to be noticed and waiting until the torture of school is over for them. They may also use their diagnosis as a defence to rationalize their lack of achievement and generalize their specific disability to other fields. They may become impulsive, explosive, aggressive or throw temper tantrums. Others may develop psychosomatic symptoms, like stomach aches and headaches, or become hypochondriacs.

3.2.4.2 Hyper-activity

The most unacceptable behaviour is displayed by the hyper-active child. Such a child may display excessive, erratic behaviour and can engage in random activity which seems meaningless. Hyper-active children fidget, touch or move everything, are constantly in motion, and seem driven like a motor, leading Wender (1972) to refer to these children as 'infant King Kongs' (p. 12). The child who lacks inhibition is impulsive, lacks organisation and is unable to delay gratification; its behaviour may be reckless and disordered, it does not seem to learn from past experiences and it does not relate immediate behaviour to the future. Hyper-activity may also be displayed verbally, with the child talking continuously without conveying much meaning. On the other hand the child may be hypo-active, being lethargic, quiet and displaying insufficient motor activity.

3.2.4.3 Delinquency

Many learning-disabled children become aggressive, impulsive liars, they steal, fight, and are rude, destructive or boisterous. Bryan (1982) described them as active, restless and destructive, as obstinate, cheeky, bossy, stubborn, negativistic, disobedient, difficult to discipline, and being resistant to adult domination yet attempting to dominate peers, in short as unpleasant children. Birch (1964) explained "The child confronts the community with not a nice handicap, terms like learning-disability, hyperactivity are translated by the outside world as spoilt, bratty, bad-mannered, ill-behaved, badly brought up, undisciplined, obnoxious and by other children as queer" (p. 11). It is no wonder that several studies, including those by Jacobson (in Weber, 1974), Bachara (1978), McLoughlin (1978), Lane (1980) and Wilgosh (1982) pointed out that learning-disabilities and delinquency are related, and suggested that a learning-disability may lead to delinquency. Jacobson claimed that delinquency grows from schoolroom frustrations, and went on to explain that 94% of the delinquent population suffer from reading retardation, concreteness of thought and hyper-activity, as well as from lack of abstract ability and a general psycho-neurological immaturity. There seems to be a continuity between learning-disabled children, problem adolescents and adults who cannot cope.

3.2.5 Social Problems

Most learning-disabled children function at a social level below their age, and have difficulty forming meaningful interpersonal relationships with parents, teachers or peers. Over a number of years Bryan (1974, 1976, 1977) conducted extensive studies in this field. He reported (1976) that parents and teachers in his research experienced the learning-disabled child as less likeable, and that these adults showed them less affection than they showed towards other children. Children with a learning-disability got less encouragement and praise, but got more negative reinforcement than other children. Teachers and peers seemed to form negative judgements of learning-disabled children, probably as a result of their difficult behaviour. In the same study Bryan reported that peers saw learning-disabled children as less happy, as less fun to be with, as less acceptable and as dirty, frightened, worried, not good looking and not desirable as playmates. The learning-disabled child was found more likely to be verbally aggressive and to emit competitive statements, but less likely to make considerate statements to others. They were also less likely to be asked questions by peers that needed an informative answer. On the whole they were not liked by classmates.

3.2.5.1 Social problems due to lack of perception

It has been suggested by several investigators, namely Johnson (1967), Kirk (1975), Bryan (1977), McGlannan (1977), Barclay (in Das, 1982) that children with a learning-disability are poor people-readers, that is, they are less able to empathize, and less able to perceive social situations appropriately. They seem less aware of the actions and non-verbal behaviour of other people which reveal their attitudes, feelings or intentions, and they seem insensitive to non-verbal cues about what others think about them. This hampers the child in its relations with others, because interpretation of non-verbal behaviour, in particular voice and body-posture, affects one's understanding of others, one's responses, and how one gets along with others. For example, strong positive non-verbal behaviour from others will have a strong impact on the child's self-esteem and interactions. Dickenstein (1980) found that learning-disabled children encounter social difficulties because they find it difficult to put themselves in the position of another person and infer the other's perspective. Their role-taking skills, which Dickenstein saw as the major means by which one person comes to know another person, as a result are defective. This social imperception could be the result of

the same deficits which make learning in school difficult for the child. For example Wiener (1980) found that children with conceptual and spatial disabilities have problems forming positive peer relationships, which, she said, may be the result of inadequate development of social perceptual and cognitive skills. Learning-disabled children are also unaware of their own, possibly negative, non-verbal communication to others, which in turn influences the attitudes of others towards themselves. Such children may seem tactless and stupid. Bryan (1977) stated that understanding non-verbal behaviour requires the same basic learning processes involved in learning to read or write and is subject to cognitive problems discussed above. It is as Johnson (in Hellmuth, 1965) stated: "The inability to read and write affects many skills which are necessary for independence and competence in the everyday world" (p. 273).

Children with learning-disabilities generally would like to be involved with others, to play with others, and so on, but they experience difficulties in this. Stander (1977) found that the learning-disabled child fears to make contact with other people. Lack of self-confidence, a feeling of insecurity make it difficult for him to initiate relationships. Bryan (1974) called them 'unsuccessful extroverts', because although they like to interact, their attempts to do so are unsuccessful. They may find it difficult to understand the rules of a game, or its sequence, and if coordination is a problem such children will be clumsy, and will find it difficult to play ball games. Their behaviour is often inappropriate, or even anti-social, and this can make it difficult for others to be with them. The child often does not act as expected, may show low tolerance for frustration, have temper tantrums, be impulsive, hyper-active or over-dependent.

3.2.5.2 Social problems related to language problems

Lack of verbal ability could be another reason for the social problems experienced by the learning-disabled child. The child may have difficulties assessing the attitude of others through language. Some children do not seem to listen, which makes talking to them difficult. Others cannot express themselves adequately, or they may misunderstand what is said to them. Their use of language may be erratic or they may be tactless and say the wrong things.

3.2.5.3 Under-achievement and social problems

Bryan (1974) explained that lack of acceptance may be the result of low achievement, as achievement seems highly correlated to acceptance. The child's anxiety and expressions of self-negation also may make the child less desirable to have as a friend (Bryan, 1976). Siperstein (1978) on the contrary stated that although such children's academic problems may hamper them socially, they will not necessarily be rejected because of them. Acceptance and rejection depend on other qualities, such as the child's appearance, or abilities in extra-mural activities. Silverman (1983) stated that whether the learning-disabled child sees itself as incompetent or not depends on its reference groups (other learning-disabled children in the same special class, so that he does not feel inferior), and on whether the child enjoys ego-enhancing experiences outside of school.

Johnson (1967) and also Bryan (1982) suggested that the child could learn to make social judgments if taught appropriately. The child has to learn to anticipate the consequences of its own behaviour and the meaning of facial expressions, actions and gestures. Helping the child with a learning-disability to learn social skills was stressed as being as important as academic remediation. One also needs to remember that alleviation of academic skills does not always result in the reduction of poor social behaviour. Children learn these behaviours independently and may find them functional, adaptive mechanisms.

3.3 THE RELATIONSHIP BETWEEN LEARNING-DISABILITIES AND EMOTIONAL MALADJUSTMENT

Although it has been stated above that emotional and behavioural problems are secondary to the cognitive impairment a learning-disabled child encounters, not all investigators agree with this. For example Bryan (1982) stated that the child's emotional problems are primary to its cognitive problems. He said, the child behaves inappropriately, its behaviour is self-defeating in its consequences, and disruptive of social organisations like home and school. The learning problem may be the result of this behaviour.

Until recently, in attempting to find a workable definition listing the characteristics of

the learning-disabled child, investigators have tried to differentiate between primary and secondary symptoms, and have stressed the need to find appropriate tests and means to diagnose and differentiate between learning-disabilities and emotional disturbance. Chandler (1983) for example explained that psychologists should not be afraid to describe these children as 'emotionally disturbed' as these children need, next to remedial tuition, to learn to manage their problem behaviour. She stressed the need for a different programme based on affective education. Yet to differentiate between learning-disabled and emotionally disturbed children has proved to be difficult, as several of the same characteristics are found in both groups. Emotionally disturbed children have been described as emotionally labile, as impulsive, hyper-aggressive, hyper-active, anxious, distractable, as having learning problems associated with attentional difficulties, as defensive, and as being antagonistic towards authority, rules and regulations. The diagnosing of children who are emotionally disturbed versus children who are learning-disabled is highly subjective, and most underachieving children, regardless of their label, receive and benefit from the same remedial tuition.

The question now arises as to whether one can differentiate at all between these two groups of children. Frostig (in Myklebust, 1972) explained that learning-disabilities and emotional disturbance interrelate, and that they can stem from each other. Emotional disturbance does not provide immunity from learning-disabilities, nor the other way around. Emotional and social problems are interwoven with learning-disabilities. Or as Adamson (in Adamson, ed. 1979) emphasized, learning failures in learning-disabled children have led to such intense feelings of self-failure and self-doubt, that the problems in learning have become inextricably enmeshed with associated behaviour problems in their social and emotional development. Stander (1977) explained that the inner insecurity of learning-disabled children which leads to avoiding contact with people, to avoiding unknown situations and to resisting change will impede the quality and quantity of the intellectual curiosity and exploration of the child. Cummings (in Rie, 1980) wondered whether it is appropriate to ask whether the child is emotionally disturbed or learning-disabled. He explained: "The overlapping symptomatology is truly co-determined by the child's psychological organisation and function" (p. 512). Although the child's past experiences are seen as the prime cause of emotional disturbance, and constitutional factors as the prime cause for learning-disabilities, environmental factors play an important role in both. Both learning-disabilities and emotional disturbance have a multiple etiology; for both constitutional and

experiential determinants interact. One should look, when diagnosing a child, "at the unique combination of events and processes comprising an individual disordered-child-in-family-in-community gestalt" (p. 515), and no longer at a simplistic, uni-dimensional, etiological construct and mode of treatment. Cummings' ideas seem to agree with Sameroff's transactional approach in which he looked at the development of the learning-disabled child and the child's interactions within its particular environment, and whereby the etiology of the problem was seen as being multi-dimensional.

The problems of a child with a learning-disability are not only manifested in cognitive characteristics, they also influence the child's behaviour and his social and emotional development. Although the social and emotional problems are complex and difficult to diagnose, the impact they have on the child's academic achievement and further development can not be ignored. In order to facilitate remediation of these non-cognitive characteristics, it seems important to look at the relationship between parental attitudes and the child's emotional and social development and at the way parental attitudes influence how the child feels about himself and how he will achieve at school and in life.

Chapter 4

THE RELATIONSHIP BETWEEN PARENTAL ATTITUDE PATTERNS OF FAMILY INTERACTION AND THE DEVELOPMENT OF A CHILD WITH A LEARNING-DISABILITY

For the present investigation, which intends to approach the problem of learning-disabilities from a developmental transactional model (Sameroff, 1975), the interactions that take place within the family are seen as crucial processes in shaping the child's total personality. This model recognises the significance of the child growing up within the family system, within a culture. Some other investigators who have stressed the importance of the family system for the child's development are Guerney and Busgaglia. Guerney (1967) sees the "Home as the single, most important influence on the intellectual and emotional development of children, particularly in pre-school years" (p. 66). Busgaglia (in Kirk, 1975) explained:

Because it is essentially within the family that a person learns to love or hate, that a person learns how to accept or how to spend his life fearing, learns how to kill or create, learns how to live with life, how to relate or how to be lonely. In the family you learn who you are, you learn what the world is all about, you learn what is expected of you and what you can expect. In other words you learn how to perceive yourself and your world (p. 367).

Some of the research on family interactions, parental attitudes and the influence this has on the development of a child with a learning-disability, will be described in this chapter.

4.1 TRANSACTIONS BETWEEN PARENTS AND CHILDREN

Sameroff (1975, 1975, 1979), in extensive research, pointed out the importance of the relationship between parents or caretakers and the child for the forming of the child's whole personality, its self-concept, the way the child feels about itself, its emotional development, its learning style and how it achieves in school and in life. He said the influence of the caretaking environment is particularly important regarding children with learning-disabilities. Sameroff stressed that one cannot make long-range predictions regarding a child's personality or course of growth and development. There is no direct link between early traumas and subsequent symptomatology, as initial handicaps can be overcome. Whether later disorders develop depends on the transactions between the child and its caretaking environment. He (1975) said that next to socio-economic factors, the parents' perception of the child, and their attitudes, play a major role in influencing pre- and post-natal development. "The effect of birth complications on later development can be remediated by the attitudes of the child's caretakers" (p. 209). If the parents see their child as troublesome, retarded or sick, they may treat it as such.

However, according to Sameroff, not only does the environment influence the development of the child, the child also has an influence on its environment. He speaks of the transactions between the parents and their child. Dysfunctions in the child, which make the child difficult to manage, irritable or unappealing, may lead to neglectful behaviour by the parents. Such dysfunctions can lead to the mother becoming tense or aggressive. If dysfunctions make the child placid, passive or quiet, the mother may have difficulties in making contact with the child, and this may lead to her becoming depressed. It is important to understand, said Sameroff, that although the parents should work out a style of interaction which satisfies the child's biological and social needs and provides safety, their actual behaviour is often elicited by the child's personality. The role of the child is not irrelevant in its development; the child is involved in determining the nature of its interpersonal relationships. According to Sameroff congenital differences in muscle tonus, motility, duration of alertness, vigor of sucking, frequency of smiling, and stability of sleep-waking cycle are all aspects which contribute to the

mother-child relationship. Because parental attitudes change as a result of experiences in parent-child interactions, it is more likely that the negative behaviour of children who show significant developmental irregularities and maladaptions will continue into later childhood.

Sameroff explained that the fact that there are no clear etiological factors related to learning-disabilities has frustrated many of the researchers who work from a simple cause-effect relationship; while if they would work from an understanding of complex developmental processes the picture would become much more clear. This links up with the multi-dimensional model for learning-disabilities as has been described by Cumming (in Rie, 1980).

Other researchers who have investigated the transactions between the family and the child with a learning-disability are Scholom (1980), Frostig (1972) and Kaslow (1978). Scholom posed the question: "What happens in early childhood years that result in a child developing a learning-disability at some point later in childhood?" (p. 131). In children with learning-disabilities he looked at the interaction between the child's temperament or disposition and the environmental variables which aggravate or remediate the problem. He found that boys who had had a low activity level, who were more irregular in their habits, less approachable and more negative in mood, had had less interaction with their mothers. The mother's initiating behaviour had not been rewarded by their infant's reactions, this resulted in lack of communication between mother and child. This lack of communication may affect the attachment process which will have a negative effect on the child's cognitive and perceptual motor development, which in turn can result in a learning-disability. Kaslow explained the importance of the smiling behaviour of an infant on the mother-child relationship. The mother of an infant who smiles seldom, but cries a lot and is difficult to soothe, can as a result, feel inadequate, thwarted and angry, and relate these negative feelings to the child. Frostig stated that learning-disabilities are not the result of organic deviations or environmental causes alone, but are an interplay of environmental circumstances and the child's physiological and psychological make-up.

The above quoted investigators implied that the causes for a learning-disability are diverse. The fault does not only lie with the child (medical model), nor only with the parents (educational, behavioural approach), but also with the quality of transactions between the parents and their child.

4.2 THE FAMILY WITH A HANDICAPPED CHILD

A positive parent-child relationship is important for the development of all children as Brantley (1969) pointed out. He said that a faulty parent-child relationship can hinder a teenager's ability to function successfully in academic and social areas. This is particularly true for the child who is handicapped either physically or mentally. This child will bring extra problems and stress into the family. Telford, Coda and Neuhaus, among others, pointed out the importance of the attitudes of parents towards these children. Telford (1967), referring to the family with a physically handicapped child, explained that the whole family becomes a casualty: whatever happens to one member affects the whole system. When a child acts, the mother reacts, the child in turn reacts to the mother, and the father reacts to his perception of the child-mother interaction. Telford stressed that the emotional climate of the home, and the parents' attitude towards the handicapped child are most important for the child's development. When the atmosphere in the home is reasonably calm and the parents are well-adjusted and able to show normal affection for the child, the prognosis for the adjustment of the problem child is reasonably good. Coda (in Friedman, 1973), added that the influence of the family, in particular the attitude of the parents, upon whom the child depends for physical and emotional comfort and gratification, on the child's attitude towards itself and its adjustment at school, is great. If there are significant role distortions within the family, for example a strong tie between a handicapped child and its mother, which partially excludes the father, the child's social interactions and adjustment at school will be affected. The child may show separation anxiety, throw tantrums or cry excessively. Another example of role distortion occurs when the parents are unable to accept their parental role, and reject their handicapped child, possibly resulting in the child being unable to develop a sense of belonging. The child may feel isolated, withdraw, or develop only a limited ability to relate, and may become generally inattentive. The child may not ask for needed assistance, for example in school, and will have difficulty in conforming to classroom routines. Neuhaus (1969) pointed out that there is a relationship between the emotional adjustment of the deaf child and the attitude of the parents towards their child. He found that improved parent-child relationships resulted in better emotional adjustment in the child, which made it possible for the child to utilize its intellectual endowment more fully at school.

4.3 THE FAMILY WITH A LEARNING-DISABLED CHILD

The problem in a family with a learning-disabled child may be more complicated because often the disability is 'hidden' when the child is small. The parents are often not aware of the disability until the child is older, eight or even ten years old, and expect normal interactive responses from the child. Instead of helping the child to overcome its disability or to teach the child how to live with it, the parents become irritated and angry, and their attitude towards their child deteriorates. Kaslow and Gillet, among others, pointed out the influence the family system has on the learning-disabled child's development. Abrams (1977) and Kaslow (1978, 1979) claimed to have found that no matter what the etiology of the syndrome of the child with a learning-disability, the family system in which the child lives has a great influence. "Parents' handling of the child's characteristic behaviour and learning patterns before the diagnosis, their reaction to the disorder once it is established and how they deal with their own and other family members' realisation of the child's 'specialness' will have an impact upon the child's learning style and self-concept" (1978, p. 41). And Abrams (1977) explained: "the values and attitudes of the parental figures towards the child play an extremely influential role in shaping his receptivity to the learning process" (p. 28). Kaslow also stressed that the disorder does not exist in and of itself, independent of the external environment. The way the child's self-image and sense of body boundaries develop and how the child views important others are initially learned within the family situation. Gillet (1979) maintained that the family can exert either a favourable or an adverse influence on the progress of the child with a learning-disability. The kind of experiences the child encounters, and the extent to which the family accepts that child as a person are important for his development.

4.3.1 Child Rearing Practices

Friedman (1973), Wilson (1975) and others had a closer look at particular child rearing practices which parents of a learning-disabled child developed in order to cope. Although no consistency across research results regarding coping practices could be found, most results indicated that parents do not discipline their learning-disabled child adequately and correctly, their coping styles are inadequate

and erratic. Friedman (1973) explained that parents are the first teacher the child has. Learning styles, working habits, and values about education are all first learned within the family situation. The child who has not learned at home the appropriate behaviour necessary for success in the formal school setting, may develop a learning-disability. Wilson (1975) subsequently investigated what would be appropriate behaviour necessary for success in schools. He found that the ability to inhibit inappropriate behaviour and to delay gratification are important for successful classroom functioning and school achievement. He assumed that by looking at the number of household tasks the children with a learning-disability completed, it would be possible to infer the differences in parental child rearing practices between these parents and parents of normal children. In finding that learning-disabled children completed significantly less tasks than other children, he concluded that mothers of a child with a learning-disability do not control their children's behaviour adequately. They do not punish their children frequently and consistently enough, and do not teach them to delay gratification. As a result the children do not learn to inhibit inappropriate behaviour, and are not able to function under delayed reinforcement schedules. Wilson came to the conclusion that lack of parental control, and inconsistent punishment contribute to the creation of some learning disorders.

Parents have to be careful, said Anderson (1980) that their learning-disabled child does not become a 'tyrant' in the house. According to Anderson, the common pattern of family interactions of a family with a child with a learning-disability is to continually give in to the child's wishes. The child, as a result will learn how to control the family and become a powerful member of the family, constantly wanting to test its power. As a result the child does not learn to cope with frustration, nor to postpone gratification. It will become more and more difficult for these parents to discipline the child and as a result, the child may become the scapegoat, regarded as the source and cause of all family problems. Doleys (1976) found that mothers of learning-disabled children rewarded their children inappropriately, they rewarded behaviour which was actually undesirable. These mothers gave attention to their child when the child left a task uncompleted, or complained about the task being difficult, i.e. they rewarded the child with attention when the child gave up. The mothers also asked too many questions, they 'drilled' the children and tended to make the learning situation at home unpleasant. Doleys found that these mothers were, on the whole, over-tolerant and over-accepting. He stated: " complete attention may be given to the child's

learning-disability while discipline is neglected because the parents perceive non-compliant or disruptive behaviour to be the result of the learning-disability" (p. 374).

Contrary to the research of Doleys, Wilson and Friedman, who found the child rearing practices of parents of children with a learning-disability inconsistent and over-tolerant, Humphries (1980) found that the mothers were more authoritarian and controlling towards their child. They were at the same time also less hostile and rejecting. He concluded saying that the mothers of learning-disabled children are more authoritarian because they sense a need in the child for greater structure and control as a result of the child's awkwardness, frustration, poor attention span, failure at school, and so on. It is not clear why Humphries rated the attitudes of these mothers more positively than the previous researchers did, it may be that these mothers of learning-disabled children had received treatment, accepted their child's handicap, and had learned to deal with it constructively.

Research results regarding the involvement of parents with their learning-disabled child were also not consistent. Some researchers found that parents are overinvolved and overindulgent with their learning-disabled child, others found a great distance between parents and these children. Doleys (1976), for example, investigated whether the relationship between parents and a problem child differed from normal parent-child interactions. He found that the emotional and verbal responsiveness of the mothers of learning-disabled children is inappropriately high, particularly regarding helping the child with school work during the elementary school years. He and also Wetter (1972), found that mothers of learning-disabled children were over-involved with and over-indulged their children. Gerber (1973) and Boersma (1982), on the other hand, both found a significantly greater distance between parents and their problem children than between parents and normal children. Boersma said that parents of low-achieving children seemed to interact less frequently and more negatively with their child, paid less attention to their correct responses than to mistakes and gave them less positive reinforcement. Gerber found the distance between a mother and a learning-disabled or emotionally disturbed son, and between a father and a problem daughter greater than between parents and children who behaved normally. He indicated that this could intensify the problem, because a close mother-son, father-daughter relationship is important for optimal psychological functioning during childhood. Wulbert (1975) came to a similar conclusion when

he found that mothers of children with a language delay were less involved with their children than the control mothers, but added that the lack could be due to the child's impulsive, inconsistent and unpredictable behaviour. The contradictions in the findings of Doleys, Gerber and Boersma, may be due to the fact that Doleys' study involved younger children, five to eight years, while the others looked at the relationship between parents and older children. The mothers in Doleys investigation were still motivated to help their children achieve academically, their involvement concerned mainly school work. Gerber's parents might have become more disillusioned and frustrated, their behaviour might be characterised by a 'giving up' attitude.

It is not only the child's academic achievements which suffer when child-rearing practices within the family are irregular and inconsistent, its social development may be affected as well. Freund (1978) found that mothers who encouraged learning-disabled children to assume various duties around the house produced children who developed superior social skills. He followed up this study in 1979 when he suggested that home environmental processes have a particular influence on the child's social skills. He found environmental profiles of families with a learning-disabled child uneven or spiked. The home environment reflected irregularities and inconsistencies in competence, organisation and performance. The variety of stimulation in these families might be high, the intellectual level average or superior, yet the physical and temporal organisation poor. The schedules were erratic, routines unpredictable and modelling inconsistent. These unpredictable behaviour patterns of parents might aggravate the learning-disability of the child.

4.3.2 Parental Expectations and School Achievement

Another important variable which influences the child's achievement is parental expectations of the child. McWhirter (1976) said that the behaviour and attitudes of any child, but specifically those of children who have a problem, are markedly affected by the knowledge, beliefs and attitudes of the parents and of the family. This influences how the child feels about itself and its achievements in school and life. Friedman (1973) explained that the expectations of parents are important for the development of the child: what the parents insist on and predict, will in fact happen. Bryan (1982) found that parental behaviour has a significant impact on

the child's intellectual and emotional growth. The mothers of children with a learning-disability evaluated their child's academic ability more negatively than the mothers of normal children. He warned that such a negative attitude on the part of the mother could affect the success of special education programmes. Boersma (1982) also looked at the aspects of the self-fulfilling prophecy, he found that the child's expectations of failure were not only based on prior lack of achievement, but also on the achievement expectations of significant others, particularly the parents. Low expectation of significant others seems to lead to a perpetuation of under-achievement.

Although the attitudes of parents towards their children are mainly formed through interactions with their child, they are also determined by cultural and social expectations. Paternite (1976) and Klein (1981) looked at those parental attitudes which are socially and culturally based, and their relationship to the school achievement of the child. Klein explained that dysfunctional parental attitudes can create learning problems, or may interact with the problems and thereby exacerbate them. These attitudes include those (1) Towards authority: parents may disregard authority which may make it difficult for the child to respect their teachers and to listen to them; (2) Towards the child: they may see the child as intellectually limited, as incapable of achieving normal age grades; and (3) Culturally based attitudes, i.e. not appreciating the importance of learning.

Paternite investigated whether learning disabilities are related to social and economic status. He found no difference between the MBD children he examined in what are called the 'core symptoms' of a learning-disability i.e. hyper-activity, fidgetiness, inattention, judgment deficits, incoordination, etc, all of which are considered to be inborn. He did however find differences in the secondary symptoms i.e. aggressive interpersonal behaviour, impulse control and self-esteem deficits between the different social economic groups. He related the development of secondary symptoms to parenting style employed in the lower socio-economic classes. One may conclude from this research that secondary symptoms don't necessarily have to develop.

4.3.3 Parental Attitudes and the Learning-disabled Child's Self-concept

The attitudes of parents towards their children and the way parents react to their children's behaviour is closely related to what they expect of their child. As has been explained, low expectations of school work leads to under-achievement, but parents should be aware that the way they react to their child also has a direct influence on the way the child views itself. Several investigators, including Freeman (1974), and Gianotti (1982), examined how the self-concept of the child with a learning-disability is affected by parental reactions. Freeman explained that parental attitudes have a lasting effect on how the child views itself. If the parents see the child as being lazy, no good, a loser and as someone who is troublesome, the child internalizes these feelings and probably behaves accordingly. On the other hand, Freeman explained, the learning-disabled child can succeed in spite of its handicap when the parents help by instilling in the child a sense of pride, motivation and self-confidence. This is achieved by expressing positive feelings, by encouragement, reassurance and affirmation, and through accepting the child's limitations.

But not only low parental expectations may lead to underachievement and lack of self-confidence for the child; high expectations, as Gianotti pointed out, may also have a negative influence on the child. When parents of a learning-disabled child expect too much of their child, the child will experience constant failure and frustration, and will see itself as unable to elicit positive responses from parents. The parents in turn may overprotect the child, or reject him which in turn makes him feel less wanted.

Loney (1975), found that all learning-disabled children show a significantly lower self-esteem than normal children. He assumed that poorly managed MBD boys, who were rejected, neglected, overprotected, overindulged, and who lacked external controls would show a lower esteem than better managed MBD boys. But, although he found a small difference in self-esteem between these two groups, the difference was not significant. In other words, contrary to research done by Gianotti and Freeman, he found that the way parents manage their child with a learning-disability had little influence on the way this child views itself. This may be so for children with actual brain damage, but only further investigation can show whether this is also true for the child without known brain-damage who under-achieves. If parents of a child with a learning-disability

can be made aware of the influence their attitudes and expectations have upon their child's academic achievement and self-concept their interactions with their child may become more positive. They may stop communicating 'giving up' messages and encourage the positive things in the child's behaviour and personality.

4.3.4 Problems encountered at home by Parents of Learning-Disabled Children

"A handicapped child makes a handicapped family" said Faerstein (1981, p. 420). This is also true for the family with a learning-disabled child. Long before the child is diagnosed as learning-disabled, maintains Kaslow (1978), the child presents a problem to its parents. The parents may be confused by the 'differentness' of the child and become frustrated or annoyed by the child's 'abnormal' reactions. The parents may be disappointed that their baby is not the glamorized baby they expected. The child's developmental milestones may be delayed, the child may talk and/or walk late, have a short attention span, be hyperactive, clumsy and unappealing. Some of the most prevailing problems, according to Anderson (in Weber, 1971), are: early and prolonged colic, digestive disturbances, hyperkineses, difficulties in reaching the child emotionally, (the child seems difficult to love), failure to communicate, immaturity, poor co-ordination, poor capacity to empathize, poor comprehension and a failure to provide the parents with significant reciprocal gratification. In addition, such children seem to ignore orders and tasks, are forgetful about their possessions and lose clothes and other items. They may have difficulties in telling a story coherently and may seem confused, they cannot wait their turn during games, are noisy and illmannered in public places and do not act their age. They resent facing new situations and tend to become overexcited, or are timid and afraid. Many like to stick to fixed routines, and become inflexible.

It is obvious from the above that the parents of learning-disabled children face more difficulties in rearing a child with a learning-disability than do the parents of a normal child. Furthermore, the disability puts a strain on the whole family. Edward (in Noland, 1972) explained that the care of such children can be extremely taxing for the parents, their behaviour is incomprehensible, their conduct embarrassing, the treatment for them is costly and the time spent caring for them is extensive. Parents often begin to feel imprisoned (Brutten, 1973);

they feel they cannot go out and leave their child with a baby-sitter, particularly when the child is hyperactive, nor can they invite friends over. Brutton went on to say that parents often see their children as an extension of themselves. They identify with their child's behaviour, so that the child's failure is seen as a blow to their own self-esteem. This makes it difficult for them to see the child objectively and to do the right thing in bringing up the child. Problems such as these, coupled with the parents' feelings of guilt and frustration can lead to the disintegration of the family, often ending in separation or divorce.

Eventually, but often not before the child goes to school, the parents become aware of the discrepancy between their expectations and reality, or else they develop fears about the physical and mental health of the child and seek help. However it often proves to be very difficult for parents to admit that their son or daughter has a learning problem. Kaslow (1978) described the sequence of emotions leading towards acceptance of the fact by the parents. First they experience shock and dismay, and then grief and mourning similar to what is experienced upon the death of a loved one. The mourning usually involves a feeling of disbelief, or denial, followed by guilt, rejection, shame, and finally, hopefully, a positive form of action. The parents may go 'doctor shopping', they may ask why such a thing should happen to them; they may blame themselves; or they may see the child's disability as a punishment for their own deeds. On accepting the problem of their child, the parents may experience great sadness and may want to reject the child, they may feel anger towards their child, and, because they feel that their anger and rejection are unacceptable emotions, they may suppress these and use defence mechanisms such as overprotection, overindulgence and overcompensation. These defence mechanisms will have a further negative effect on parent-child relations. Mothers who become overinvolved with their child, creating overdependency, deprive their child of significant opportunities for growth and development. The child is not allowed to learn from trial and error, and subsequently will not be able to develop its own individuality or accept responsibility for its own learning. In addition the child's own defences and manipulative behaviour in reaction to its learning-disability may be disruptive to the family, and this in turn may create a vicious circle of causes and effects. Abrams (1977) stated: "A child trapped in such a morass has little energy free to invest in the task of learning" (p. 28).

On the other hand as Haring and Bateman (1977) pointed out, if the

learning-disability of a child is not accepted, the child's reality is denied and a situation of mutual frustration and disappointment will be created. They explained that the learning-disabled child is different, that the child does not live up to the expectations of parents and outsiders, which leads to its becoming alienated from others. To deny the problem only serves to make the child, who cannot escape its difficulties, even more insecure. Parents who expect their child with a learning-disability to behave and achieve like other children may pressurize the child unduly, or they may punish the child's lack of compliance. The child will begin to see itself as being different, as being less acceptable. The child may try hard to act 'normally', but such efforts only create anxiety and more abnormal behaviour because anxiety reduces the ability to process experiences and to respond appropriately. Other children may internalize the message about being different and act as a clown, as a fool, and generally be disruptive.

The transactions which take place within the family with a child with a learning-disability may become so distorted as a result of frustration, anger, worry and fear of both parents and children, that they no longer help the child to grow up into a responsible adult. Yet this is not necessarily so. If parents and other significant adults are concerned with the education of the child, if they are aware of the influence their interactions have on the child, early negative forms of the child's behaviour can be dissolved during the transition stages of development, for example when the child moves from a sensorimotor mode of functioning to a conceptual mode of functioning. As Sameroff (1975) stated: "So that reintegration and the formation of new schemata can take place at each new level of maturity" (p. 228-229). But, "when early schemata are not dissolved it will be more difficult for the child to move from one developmental level to the next and this, in and of itself, may constitute a kind of maladaptation" (p. 229). According to Sameroff the process of successful or unsuccessful mother-child relationships is well established by the time the child is one month old. The danger is that once a child is labelled as difficult and troublesome, the label may stick throughout childhood. The child may incorporate the negative image others have of him into its developing self-image and behave accordingly.

Inconsistent child rearing practices, lack of discipline, overprotectiveness or overindulgent behaviour of parents, as well as unrealistic parental expectations and negative attitudes of parents towards their child with a learning problem will influence the child's development. Whether the child will overcome its initial

problems, which may be inherent, will depend on the interactions between the child and its parents. It is important that the nature of the transactions between the developing child and the adults that take care of the child are assessed continually, to determine how these transactions facilitate or hinder adaptive integration as both the child and its surroundings change. This view of child development and the awareness of the diversity of causes for a learning-disability make a diversity of remediation intervention possible throughout the whole developmental process.

Chapter 5

DIFFERENT THERAPEUTIC APPROACHES FOR HELPING THE PARENTS OF LEARNING-DISABLED CHILDREN

Traditionally, within the educational model, children with a learning-disability are treated by a remedial teacher who designs a particular remedial programme for each child. However, from research findings discussed in the previous chapters, it can be inferred that simply treating the child in isolation, for example through remedial tuition only, is not sufficient. The effect of the interaction between the attitudes of the parents and the achievement of the child should be considered as well. One has to focus on the whole child as a physical being, who may or may not have an organic dysfunction, in a social environment, in a psychological manner. As much research has been done in the field of remedial tuition, the present investigator will not consider these programmes, although they are important, but will focus instead on research concerning treatment programmes for the parents of learning-disabled children. In particular programmes which involve group treatment and focus on changing the attitude of parents and on the improvement of parent-child interactions, will be described.

Group treatment for the parents of learning-disabled children can roughly be divided into three basic categories: (1) group treatment making use of teaching parents behaviour modification techniques; (2) educational or informative groups which focus on instructing parents about theoretical aspects of the dysfunction; (3) reflective group counselling in which the needs of the parents form the focus of attention.

5.1 BEHAVIOUR MODIFICATION TECHNIQUES

Studies using approaches that involved behaviour modification techniques have fairly consistently produced improved behaviour in the learning-disabled child. This improvement in behaviour was especially marked when the rewards the parents had used to change the behaviour were as immediate and concrete as possible. Behaviour modification techniques helped the children to control their behaviour and it made them understand that they would benefit directly from self-control.

Patterson (1974) designed a programme involving child management techniques for parents of children with conduct problems. The parents had to first read the theory of the technique; then they had to define, track and record target behaviours; they had to join a parent training group which made use of modelling and role play; and they had to compile a list of actions they would enforce when the child behaved inappropriately. After four weeks of treatment the parents were successfully able to modify their children's problematic behaviour. Wiltz and Patterson (1974) repeated this programme for the parents of aggressive boys. The parents were taught the concepts and language of behaviour modification techniques, the data collecting procedures and skills, and how to utilise these skills, during a five week treatment programme. Wiltz et al, also found a significant decrease in deviant behaviour in the experimental group. Diament (1978) organized groups in which the mothers of learning-disabled children were taught the principles of behaviour modification techniques, in order to be able to deal more effectively with their own specific child rearing problems. The lectures focussed on the use of praise, emphasized positive reinforcements and stressed the need to specify and observe target behaviours. Diament used group discussions, modelling and role-play to teach the mothers how to apply their newly learned skills at home. He found that mothers did learn to use their behaviour modification skills in free play situations, they praised their children more, with the result that the non-attending behaviour of the child was reduced. The mothers reported that they were more able to cope with problem behaviour and that their children's behaviour improved. Feighner et al (1974) described the need for a multi-model treatment procedure for learning-disabled children. They combined

pharmacotherapy, behaviour modification and educational group counselling for family and teacher. They stressed in their discussion of the programmes the importance of teaching parents behaviour modification techniques to eliminate specific maladaptive behaviour in the children. They stated that the goal was to provide consistency of environmental controls to facilitate internalization of controls by the children which would in turn result in more adaptive and socially acceptable behaviour. They did not give an evaluation of the programme as the final results were not yet available.

The behaviour modification programmes described above all showed an improvement in the child's behaviour. This may be the result of the extensive use of praise and encouragement in these programmes, which will improve the self-concept of the learning-disabled child, which in turn may lead to improved behaviour. Yet it must be kept in mind that these programmes were not done in isolation but were more often part of a more extensive treatment plan. It is difficult to say whether behaviour modification procedures alone would have shown the same result, and no long term evaluation has been completed.

5.2 EDUCATIONAL GROUPS

The following studies all made use of some type of teaching method, be it film or lecture, to inform parents about the etiology, the symptoms or the problems related to learning-disabilities. Whether significant change in parental attitudes and/or child behaviour occurred or not, seemed to depend on the educational method used.

Carkuff (1970) involved the parents of emotionally disturbed children in systematic group training in interpersonal skills. He reasoned that if the core of the dysfunction was interpersonal, the core of the treatment programme should be interpersonal as well and that group treatment would be the best helping method for this. He did find a significant gain in level of communication in general between the participants, and specifically in communication between spouses, but these newly learned communicative skills were not generalized to interactions with their children. He suggested that for this to take place parents should be trained specifically to interact with their children. "If we wish to affect significantly the

level of communication between the parents and their children then communication between parents and their children must be practised" (p. 160). Hetrick (1979), in a similar research, investigated whether parental attitudes would change when the parents were taught communicative skills which would facilitate parent-child interactions, during group sessions. He found no significant difference on the semantic differential he constructed specially for this study, nor did he find differences between the achievement scores of children as measured with the WRAT.

Sloman (1978) organised group discussions for some of the parents who participated in a five week fun-orientated camp. These focussed on the general attitudes parents should adopt towards their learning-disabled child. He isolated five factors which he thought to be of particular importance in bringing up learning-disabled children, namely: (1) evaluation of the child, which refers to how the parents react to and define their child; (2) permissiveness of autonomy, which refers to the orientation of the parents towards the child's behaviour and development; (3) mutual affection, or the warmth and interaction between parent and child; (4) hostility of parents towards the child; (5) pressure, especially regarding schoolwork. Sloman measured the attitudes regarding these factors of all the parents before and after the camp with the help of a specially designed semi-structured interview, but did not find a significant difference between the parents of the experimental and control groups. It may be that the camp itself was such an enriching experience for the parents that the discussion groups could not add anything to the whole programme. Sloman did not state whether the attitudes of all parents changed as a result of the camp experiences.

Grilli (1974) organised parents' discussion groups during which crucial data about learning-disability were discussed i.e. the learning-disabled child's affective needs, the cause of learning-disabilities and techniques of parent-child rearing. The groups used brain-storming, force field analysis and problem solving sessions, during which both hypothetical and actual cases were discussed. Parents were encouraged to try their newly learned techniques at home. Grilli measured a significant change in parental attitudes with the Hereford Parent Attitude Survey and concluded that organised discussion groups for parents were an effective means of altering parental attitudes and child-rearing practices. Such changes in the parent ultimately would lead to personality changes in the children as measured by the Missouri Children's Picture Series.

Spector (1975) compared three different types of treatment, namely traditional psychodynamic therapy, parent-child involvement therapy and behaviour modification, to investigate whether the attitudes of learning-disabled children towards their mothers, and of mothers towards their children could be changed, and whether the behaviour of the children would improve. All children reported more positive feelings towards their parents after treatment. The greatest improvement in behaviour was found in the participants of treatment which involved the parents and their children and of behaviour modification procedures. The greatest attitude change of mothers was found when they participated with their children in group treatment. The least attitude change was reported when mothers learned behaviour modification techniques. Spector concluded by stating that, because the behaviour of all of the children improved regardless of the type of treatment that the mothers received, it was possible that training the mothers to be counsellors for their children might be more effective than treating the children.

McWhirter (1976) also found that educating parents in groups was valuable. He used group procedures which were strictly structured. During each meeting the parents were given a half-hour mini-lecture which was illustrated by visual aids and backed up by printed information. After the lecture about one hour was spent on discussion. McWhirter assumed that having more information about learning-disabilities would decrease the parents' anxiety about the child, and that parental understanding of the emotional growth and needs of their learning-disabled child would increase. He based his positive results on the feedback that parents supplied after the group sessions, and did not make use of specific tests or statistical measurements. Hammett (1981) used the Systematic Training for Effective Parenting (STEP) programme of Dinkmeyer and McKay to modify parental attitudes towards their learning-disabled children and to improve parent-child communication and relationships. The STEP also involves parent education group discussions which are highly structured. Parents are taught skills which will facilitate their parental role. Hammett found a significant positive change on the 'accepting' and 'trusting' scales of the Hereford Parent Attitude Survey when testing the parents' attitudes, but no significant change on the scale measuring 'confidence', 'understanding' and 'causation'.

The change in attitudes of parents of children with a learning-disability and subsequent behaviour improvement of the child after educational group treatment is not as consistent as the behaviour change of the children reported when the

parents applied behaviour modification techniques. Both Carkuff and Hetrick found no significant change after teaching the parents communicative skills. One could draw the conclusion that the core of the problem does not lie with the communication between the parents and their learning-disabled child. Some change of attitude took place when the parents participated in the strictly structured groups of McWhirter and Hammett. It depended on the type of parental behaviour the lectures focussed on. For example the STEP programme focusses on the need for parents to accept and trust their child. However no change was found on the 'understanding' scale of Hereford's Survey. Learning to understand the problems of a learning-disabled child is not part of the STEP programme. The most change in child-rearing practices and behaviour of learning-disabled children was found when the parents actually learned more about the specific problems a child with a learning-disability experienced. To help parents to gain more knowledge about their child with its problems seems effective for changing parents' attitudes and for improving the behaviour of learning-disabled children.

5.3 REFLECTIVE GROUP COUNSELLING

Not much research using reflective counselling for the parents of learning-disabled children has been undertaken, as most research concentrates on the needs of the child with the learning-disability. Reflective counselling, on the other hand, is concerned with the needs of the parents in the first place, but indirectly deals with the needs of the children as well.

Perkins (1971) used 'Client Centered' treatment procedures developed by Rogers in group counselling for the mothers of learning-disabled boys. No formal structure for the groups, nor specific information about learning-disabilities was offered to the mothers. The counsellor concentrated on creating an empathic, accepting relationship with and between the parents in order to provide a climate which would make introspection, and an ultimate change in attitude possible. He used four groups: (1) group counselling for boys only; (2) group counselling for boys and their mothers; (3) group counselling for mothers only; (4) a no-treatment control group. He found, like Spector (1975), that the mother's involvement in treatment procedures was the important factor that made change

possible. He reported a significant difference in grade point average and on the self-acceptance scale of the children between the groups in which the mothers received treatment, and the groups in which they did not. There was no difference in academic achievement and self-acceptance between groups for boys only and the no-treatment control group. The newly learned supportive skills and changed attitudes of the mothers were important factors in bringing about this change in grade point average of the boys and in improving the boys' scores on the self-acceptance scale. Perkins concluded that self-acceptance on the part of the child is related to the acceptance of the child by the mother, as feelings about self are initially developed through interaction with the prime significant other, the mother. As Perkins put it: "Certainly one way to help a child is to help the parent" (p. 278).

Tavormina (1974) evaluated the effectiveness of behaviour group counselling and reflective group counselling for parents. She came to the conclusion that reflective counselling for parents could have a generalizable effect on the child's behaviour, especially on the child's school behaviour. Skuy (1980) compared group treatment procedures for parents with learning-disabled children, involving behaviour-reflective counselling with youth counselling for the child with a learning-disability. The youth counselling involved a one to one relationship between a child and an undergraduate psychology student who became actively involved with the child. The group interactions for parents were based on Rogerian techniques which were combined with the teaching of behaviour modification principles, such as shaping, positive reinforcement, contingency management, etc. The parents were encouraged to share their feelings, experiences and problems relating to their learning-disabled child. Parents could indicate what aspect of their child's behaviour specifically worried them, and then, in the group, were taught through modelling and role play of behaviour techniques how to deal with the problem at home. After treatment stopped the parents reported that the group experiences had been very positive, they stated that they had gained greater insight into their children's problems and they no longer held unrealistic expectations. The parents also stated that they managed their children differently (i.e. by spending more time with them, and by using positive reinforcement instead of physical punishment). Yet Skuy did not find a significant difference between the test results of the children on the WRAT nor on the Child's Behaviour Rating Scale by Cassell on the before and after test of both groups. It would have been interesting to see whether the attitudes of the parents

actually changed as a result of the treatment, but Skuy did not measure this.

Although not all of the research described above dealt specifically with children with a learning-disability, the different treatment procedures give an idea of what can be done to ease the task for parents with handicapped children. Approaches using behaviour modification techniques found, not surprisingly, a fairly consistent result of improved behaviour in the learning-disabled child. But researchers using behaviour modification did not investigate whether the attitudes of parents of learning-disabled children actually changed. The present investigator assumes that attitude change is of crucial importance for lasting improvement in the behaviour of children and their academic achievement. Most research has been done with educational programmes for parents of learning-disabled children, probably because parents have asked for this. During these programmes parents were given factual knowledge with the help of films or lectures, about the etiology, symptoms and problems of the learning-disabled child. The results were not consistent, but still indicated a need for this type of programme. Lastly, reflective counselling groups were described. As very little research has been done in this field it is difficult to draw a conclusion, but the positive results of Perkins and Tavormina indicate that further research in this field may be fruitful.

Chapter 6

RATIONALE FOR THE PRESENT INVESTIGATION

Although very little research regarding treatment procedures for parents of learning-disabled children has been done, many investigators stress the need for such programmes. As Kronick (in Haring, 1977) pointed out, it is unrealistic to expect that if a learning-disabled child spends a year in a special class, the child's problem will be totally solved. What the child needs is a carefully planned, long term care programme. The inability to read, write, spell or calculate is one of the most difficult handicaps to handle in our advanced technological society (Bryant, 1978), therefore the more help the child gets the better. Routh (in Rie, 1980) stated that a multi-model treatment approach was essential if one wants to help the learning-disabled child to develop into a competent adult. If one sees learning problems as the result of a variety of interrelated factors, as the present investigator does, it follows that the treatment approach should be multi-faceted as well.

6.1 THE NEED FOR TREATMENT FOR THE PARENTS

From the research discussed in the previous chapters, the present investigator has drawn the conclusion that it is important to involve the whole family, particularly the parents, in the overall treatment of the child. This approach not only helps the child, who can ill afford a parent-child situation that creates further problems, but also helps the parents. As McDowell (1976) stated, it is not enough to have child-centred programmes for learning-disabled children, the needs of the parents have to be considered as well. Doleys (1976) pointed out that the learning-disabled child presents more management problems than other children.

Brutten (1973), before him, had already said that rearing a learning-disabled child is more time consuming and arduous than rearing a normal child. To back up remedial tuition, the child will need lots of attention within a loving, disciplined family. It is therefore assumed that the parents need assistance in dealing with the child's problems as much as the child does. After all, as Armstrong (1983) pointed out, before the child was diagnosed as having a learning-disability, it was the parents who, without proper knowledge, aid or support, had had to cope with the situation, and once remedial treatment has ended it is the parents who are left to cope alone again. Parents, said Thompson (in Kirk, 1975) are immediately involved with the child's disability. The child does not live in a vacuum, the personality of the parents has a significant influence on the personality of the child. Parents can play a crucial role in helping to create a situation for the child in which the child can overcome his or her problems.

In order to be able to help their child parents may have to resolve any problems they have themselves concerning the learning-disability, they have to face the problem and accept it. Many parents need help with this. Most parents, at first, deny that there is a problem. Once they have accepted that there is a problem they may blame themselves and ask what they have done wrong, they may encounter feelings of guilt, fear, shame, embarrassment, bitterness and often failure. They may need help to work through these emotions, they may feel helpless and isolated with their problem. The hopes and expectations they have had for their child will be shattered; this may provoke feelings of anger towards their child and even rejection of the child. They may try to cover up those negative feelings with defences such as overprotection and indulgence. If parents are not helped to work through these emotions their feelings of hopelessness and helplessness will increase and they will start to doubt their own self-worth. Noland (1972) stated that parents may transmit their feelings of fear, guilt and anxiety onto their child. In other words they will not own their problem. Philage (1975) found that statements such as 'he is disappointed in himself', 'I feel sorry for him' or 'he is frustrated' were frequently made when parents themselves felt frustrated or disappointed. It is, as Briard (1976) stressed, the parents who need to be helped towards accepting the child with both his problems and strengths.

Apart from helping the parents to work through their own emotions, Freeman (1974), among others, explained that the parents need counselling and guidance in the day to day realities of having to deal with the child and of having to relate to

the child's needs. The parents particularly may need help in coping with the pressures placed on the family when there are environmental pressures, for example pressures from the teacher to achieve better or problems with peers; and secondary emotional problems such as a low self-concept in the child. Many parents of learning-disabled children are physically and emotionally overtaxed. They need help in learning how to deal with their other children, who often feel neglected; in learning how to cope with daily household chores and in how to maintain a good relationship with their spouses.

Many investigators have suggested that treatment for parents may help them and their learning-disabled child to overcome their problems. For example Shapero (1981) suggested that parent training may help to correct family patterns of interaction which are inappropriate; and that parents can help to solve the complex problems of learning-disabled children and can provide the extended services these children need. McLoughlin (1978) saw parental involvement as " a key component for success in serving learning-disabled children" (p. 37). As Amerikaner (1982) pointed out, through the parents one can deal with the affective and social deficits of the child, and thus indirectly help the child academically. Brutton (1973) stated that parents are the child's major resource: "With skill and compassionate handling by parents and professionals most of them can overcome much or all of their handicap" (p. 11). But without this help from their parents these children could be failures for the rest of their lives. Brutton added that parents may either aggravate the problem, or reduce or correct it. Children need the stability of their parents when they cannot control themselves. For parents to correct or reduce the problem of their learning-disabled child they have to be objective and realistic about the problem. They have to accept the limitations it sets for the child and at the same time they need to be able to recognize the child's strengths, they need to find challenges for the child which are within its capabilities, they need to encourage the child to extend itself, yet they must not expect too much. Parents need to help their child become independent by responding to the child's real needs, rather than to the child's whims.

If parents are helped to learn how to deal with their own tension and frustration and if they learn how to modify their own behaviour in order to help the child, their interactions with the child will become more helpful. They are then able to make the child feel wanted and appreciated within the family, and to keep negative experiences to a minimum. It is the intention of the present investigator to find a

method of treatment for the parents of children with a learning-disability which will give them this much needed help.

6.2 GROUP TREATMENT FOR THE PARENTS OF LEARNING-DISABLED CHILDREN

The present investigator agrees with Arnold (1978) when he said that "the natural tendency of parents to discuss child-rearing problems with other parents can be channelled into a constructive process through group discussions facilitated by professional leadership and appropriate goals" (p. 114). Cain (1976) said that willingness to discuss child-rearing practices is particularly marked when parents share a similar problem and can get support from others in the group who understand.

Freeman (1974) is one of the many investigators who stated that group methods are the most effective means of helping the parents of learning-disabled children. He said it gives parents the opportunity to share their mutual problems, "through group discussion, mutual problem solving techniques are evolved. In addition, the group allows for a healthy discharge of emotions that might not find acceptable expression elsewhere" (p. 55). Ideas can be expressed, insight can be gained and much can be learned through interaction with other parents who might have found ways of successfully dealing with particular problems. Problems which are shared in the group seem easier to accept. Feighner (1974) also said that most parents of learning-disabled children benefit from group treatment. Experiences can be discussed and parents can help each other to work towards their personal adjustment and that of their family. McDowell (1976) stated that parents of learning-disabled children gained support from knowing other families who shared the same problem. Cruickshank (1967) found that parents who had accepted their family problems were available for others as 'big brother' families. He explained that "To be able to talk with someone who has experienced the problem is a wonderful thing" (p. 263).

The value of group treatment for parents of learning-disabled children as stressed by the above quoted researchers, is shared by the present investigator who has decided that group treatment will be the mode of treatment used for the parents of learning-disabled children participating in this research.

6.3 INFORMATIVE VERSUS REFLECTIVE GROUP COUNSELLING PROCEDURES

As the present investigation is specifically concerned with the effects of the interaction between the attitudes of the parents, on the one hand, and the achievement of the child on the other, a treatment had to be found which could improve parental attitudes. The present investigator understands that attitudes, specially when formed through interaction with the attitude object, in this case the learning-disabled child, are difficult to change. However, it is assumed that a change in attitude can be brought about by creating cognitive dissonance through reflective discussion groups. Reflective group counselling will help parents to learn to understand their child and its problems better; as a result the behaviour of the parents, which has not changed, becomes inconsistent with their beliefs about and understanding of the child. This dissonance between beliefs and behaviour should lead to a change in attitude which in turn may lead to behaviour change in the child. When the parents really understand the child's problems, the child ceases to be seen as difficult and the parents cease to see themselves as being inadequate. The parents become more realistic, realising that their child has a handicap and that they as parents can help to overcome it.

Although behaviour modification therapy and educational counselling are effective ways of helping parents with a learning-disabled child the present investigator has chosen reflective group counselling as the preferred mode of treatment, as it deals with the needs of the parents as well as with the needs of the child. It provides the opportunity for parents to work through their emotions, it helps parents to gain knowledge from other parents about the problems the child faces, and it helps them, through discussion with other parents to become aware of more facilitative ways of dealing with their child. The emphasis in this type of counselling is placed on the awareness, understanding and acceptance by the parents, of the child's feelings, and of a similar awareness, understanding and acceptance of their own feelings about parenting a child with a learning-disability. Only when the parents have had the opportunity to work through their own problems and emotions regarding the learning-disability of their child are they able to work at changing the environment of the child into an environment in which the child can be himself and grow. Behaviour therapy and educational counselling do not provide the opportunity for parents to do this. Behaviour therapy stresses that the environment of the child has been ineffective, and this type of therapy aims at

teaching the parents facilitative ways of dealing with the child's behaviour problems. As Brutten (1973) stated, it does not take the personality of the child into consideration, nor does it consider the needs of the parents. Parental education groups, although they provide the opportunity for parents to gain knowledge about the learning-disability, may not be maximally successful either, because they focus on the child only. Parents are not helped to work through their own feelings of grief, guilt and self-blame, nor is there an opportunity to overcome the resulting defence mechanism. Philage (1975) found that the lack of empathy of group leaders for the participants in the group made the parents feel isolated, with the result that they did not learn to acknowledge their feelings of sadness and resentment, but projected these onto their child.

In order to find out whether the attitudes of parents change through expressing their own needs and discussing their own feelings regarding the learning-disability or through helping parents to understand their child better by teaching them facts about learning-disabilities, reflective counselling groups will be compared with educational counselling groups in this research.

6.4 THE GOALS OF TREATMENT

The aim of this investigation is to promote, through reflective group counselling, the growth and self-acceptance of the parents of learning-disabled children, and to change their attitude towards their child.

According to Hereford (1963), personal involvement of the parents in group discussions will bring about this change in attitude. He stated:

Attendance at a series of group discussion meetings on parent-child relations moderated by a (trained but non-) professional leader provides the parents with an opportunity for more

Participation in the discussion. This participation by the parent, plus the climate of freedom, acceptance, and sharing of experiences and ideas provided by the group, leads to more

Personal involvement of the parent. This participation and involvement of the parent in the group discussions brings about changes in Parental attitudes regarding parent-child relations

and child-rearing practices. (p. 38)

It is assumed that this change will take place because it is the aim of the treatment to give parents the opportunity to work through feelings of anger, guilt and tension so that these energies can be re-channelled into constructive areas. The atmosphere of empathy within the groups will make a healthy discharge of emotions regarding the learning-disabled child possible for parents who will experience the support of a group, and the therapeutic effect which this may have. By sharing their problems with others they may see them in a different perspective. Arnold (1978) stated that parents often find it easier to accept empathy, insight, advice or confrontation from another parent with whom they can identify than from a professional. The aim is that parents will learn from each other how to deal with both internal family needs such as disruptive behaviour of the child and with external social pressures, such as neighbourhood prejudices. Parents will become less anxious and more accepting of their child's problems by seeing others with similar or even worse problems, than they have themselves. The aim is to give parents the opportunity to look at their own role as parents, to become aware of the complexity of their parent-child relationship, to explore all aspects of their situation and to gain greater knowledge and understanding of their child's physical and emotional development.

One parent, on being asked by Gargiulo (1976) what advice she could give to other parents of learning-disabled children, stressed the importance of organising groups for parents. "Learning-disabilities are a parent's problem too By meeting with these other parents, you not only help yourself and them, but you are able to help your child" (p. 479).

6.5 PARTICIPATION OF BOTH PARENTS IN GROUP TREATMENT

Mothers and fathers will both be asked to participate in the group discussions, as it was found (Dembinski, 1977) that joint parental responsibility reduced the possibility of family discord, as well as the distortion of information, and instead brought about an increase in the understanding and acceptance of the learning-disabled child. Brutton (1973) among others, explained that fathers often do not understand the problem the child faces. The father who does not

deal with the child as frequently as does the mother is often not aware of the problem. The child may behave better with the father, and for example, make an effort to do his homework properly. As a result the father may criticize the mother, feeling that he can handle the child better than his wife can. He may ally with the child against the mother, which could lead to friction in the marriage and possibly even to divorce. McDowell (1976) also stated that it is important for the fathers to participate, as they may otherwise undermine the growth made by mother and child, and by doing so defeat the counselling effort.

After considering the use of different types of group counselling for parents of learning-disabled children, for example behaviour modification techniques, educational counselling and reflective counselling, the present investigator assumes that reflective group counselling will help parents to develop more facilitative positive attitudes towards their child. It is assumed that reflective counselling groups for parents will provide the means for the parents to learn to understand their child and its problems better, to accept the child for what it is, to show tolerance for its defects and to come to terms with the difficulties involved in parenting a child with a learning-disability. It is also assumed that understanding of the child and its problems by the parents will lead to better attitudes towards the child and subsequently to higher academic achievements and behaviour improvement in the child.

Chapter 7

RESEARCH DESIGN

Evaluative research on the behaviour of man in his real-life setting can never be as controlled as research done in a laboratory. Variables over which the researcher has little or no control will inevitably influence the final results.

In drawing up the final design for this research, much care has been taken to control for as many variables as possible. In particular much thought has gone into controlling the uniformity of subjects and into the standardisation of the experimental variable. Nevertheless the present investigator is aware of the inherent weaknesses of this research, set in a real-life situation, and will discuss this later.

The design involves the use of four groups: The experimental group A, the counselling group; experimental group B, the teaching group; control group C, the no-treatment group; and group D, the non-learning-disabled group.

The attitudes of parents with learning-disabled children towards their children was measured and compared with the attitude of parents who do not have children with a handicap. Secondly, before and after treatment measurements were taken of the attitudes of parents with learning-disabled children, the behaviour and academic progress of the learning-disabled children.

The children themselves were not involved in the intervention programme which was targeted entirely at the parents.

The treatment period took six weeks. Attitude measures of all parents were taken before treatment started and of parents with learning-disabled children again immediately after treatment stopped. All parents rated the behaviour of their children before treatment started and parents with learning-disabled children rated

their children's behaviour immediately thereafter again. Teachers of children with a learning-disability monitored the children's behaviour on a weekly basis during the entire treatment period. A subjective teacher's rating of the learning-disabled children's academic progress was obtained.

7.1 SELECTION OF SAMPLE

7.1.1 The Learning-Disabled Child

As explained above, the term 'learning-disability' refers to a heterogeneous group of disorders for which, as yet, no single, all purpose definition has been found. What Slater (1974) stated about diagnosing Schizophrenia might be said for diagnosing learning-disabilities as well. He explained that there might be "a kind of 'intuition' . . . which escapes our grasp, however detailed our description" (p. 314). And: "We still have to rely on a totality of observation and impressions, and what in one case might be regarded as decisive might in another be discounted as explicable on extraneous grounds". This lack of clarity about what a learning-disability actually is made it difficult to define an adequate sample technique for this research.

In selecting the population sample for this investigation, the guidelines given in the Murray Report (1968) were taken in consideration. As for the Murray Report, only children "whose I.Q.'s are at least average to normal but who have learning-disabilities which retard their progress at school" (p.24) were included. And: "These disabilities are severe enough to necessitate the institution of special measures by the educational authorities to alleviate the learning-disabilities of these pupils"(p. 24).

All subjects participating in this research were parents of children who had been identified by the educational authorities as learning-disabled. The following identification techniques were used by the educational psychologist of the School Clinic:

- Interview with parents in which a questionnaire concerning the child's

developmental history, the child's personality, home situation and scholastic background was completed.

- Teacher's report on scholastic progress and behavioural problems of the child.
- The Goodenough DAP test, Bender or Beery, JSAIS or SSAIS, depending on the age of the child, and HSRC Scholastic Achievement tests if seen as necessary.

In addition a remedial teacher made

- Qualitative scholastic assessments of the child's actual skill deficits.

The criteria for the presence of a learning-disability were:

- Failure to make progress at school despite intellectual ability and strength of motivation, (under-achievement). A difference of two stanines between scholastic performance and verbal I.Q. was accepted as a statistically significant difference between intellectual ability and performance at school.
- I.Q. in the average or above average range, as measured by the JSAIS or SSAIS, despite any discrepancy between verbal and performance scores.
- Diagnosed visual and/or auditory perception problems, and/or motor, and/or concentration problems.
- Academic deficit in at least one learning area, for example reading, spelling or mathematics.

The sample used in this study was drawn from white English speaking children (boys and girls) attending sub A, sub B or std I at a provincial primary school and who were receiving remediation from a remedial teacher. Any children who had a diagnosed conduct or emotional disorder, a defect in one of the sense organs, specific birth problems, hard signs of neurological impairment, or who were emotionally or environmentally deprived were excluded from the study. All children came from two-parent families. Parents who were psychotic, had marginal intelligence or were unemployed were also excluded from the study, as those conditions could affect the procedures.

7.1.2 The Non-Learning Disabled Child

The participants in the non-learning disabled group:

- Were identified by their teachers.

- Attended the same schools and classes as the learning-disabled children.
- Received no remedial tuition.
- Achieved according to their abilities.
- Came from similar family backgrounds as did the learning-disabled child (two-parent families, and similar family structure as far as siblings and place of child in family were concerned) and were matched for age and sex.

It was not possible to control for medication as was originally intended because not enough subjects who did not take medication could be found. This was taken into account when results were interpreted.

7.2 TREATMENT PROCEDURES

All parents of selected children received a personal letter in which the programme was explained and in which they were asked to participate in the research (see appendix I).

Parents of non-learning-disabled children received this letter via the children's teacher. It enclosed an attitude and behaviour questionnaire (appendices II and IV), which they were asked to fill in and to send in the reply-paid, self-addressed envelope, to the investigator of this programme. They did not have to identify themselves.

Personal contact was made with all parents of learning-disabled children who volunteered to participate. The parents, who were blind to the fact that different types of treatment would be given on different evenings, were asked on which one of two evenings they would be able to participate. Whether they were assigned to group A or B, treatment groups, or C, the control group, depended entirely on their choice of evening. (The control group parents could not participate on either of the two suggested evenings.) Three groups of respectively ten participants (experimental group A), nine participants (experimental group B), and ten participants (control group), were formed in this way.

All learning-disabled children received their prescribed remedial tuition.

7.2.1 Experimental group A

The parents of experimental group A, the counselling group, participated in supportive group counselling. This counselling took the form of supportive group discussion based on reflective counselling (Tavormina 1974). The emphasis in this type of counselling was placed on parental awareness, understanding and acceptance of the child's feelings and their own personal feelings about parenting a child with learning-disabilities.

The practical, basic principles for the reflective discussion groups were influenced by Auerbach's (1968) ideas about group counselling. The parents were not told how to bring up their children. No formal structure for the meetings was presented and, although little or no direction was given for topics for each meeting, the parents were encouraged to talk about the living realities of their learning-disabled child, the effects of the learning-disability on the child and the personal meaning this had for each parent. All members shared a common problem in their learning-disabled child; they were able to exchange information about those problems and to express their feelings. The investigator assumed that this would help the parents to think about and to discuss their own problems and feelings in relation to their learning-disabled child and that this would prevent a purely intellectual approach.

The first concern for the present investigation was the immediate need of the parents, to help the parents with their own attitudes towards and feelings about their child and to help them to make decisions themselves about the day to day practical problems they might encounter. Parents were encouraged to try out different ways of handling situations at home and to report on them during the following meeting. (For a more detailed description of group sessions see appendix VI.)

7.2.1.1 The Group Leader

It was necessary, for parental attitude change to take place, that each individual parent participate as much as possible and get personally involved in the group discussions. This was facilitated by allowing the responsibility for the programme to rest with the parents, with each individual member. As Hereford (1963) stated: "With this responsibility comes the ego-involvement and

participation on an emotional level that make possible attitude change." (p. 15) Parents were seen as experienced senior partners in helping their children. Questions of how to handle a particular child were directed to other group members.

The leader was asked not to make interpretations that regressed parents or could make them more vulnerable. She could however ask questions about a parent's perceptions of the child and the effect on the parent thereof.

The status of the leader was almost that of a group member. She shared in the particular problems of the group members in that she had a learning-disabled child herself. It was seen as important that the leader would have an out-going nature, have a genuine interest in other people and be sensitive towards people. She should be able to accept others in a non-judgmental way and, most important, she should be able to listen so that parents could tell other members in their own way about their needs and problems. The leader's task consisted mainly of moderating the discussion and in giving emotional support to the participants. She tried to create an atmosphere of empathy, acceptance, warmth, understanding and confidence (Truax 1967), which made it easier for group members to share their problems with a third party, to come to self understanding and to understanding of their child. The leader avoided blaming or advising the parents and never made them feel like patients in a therapeutic service. The intention was not to change the personality of the counsellee, but: "To help these reasonable well-integrated people to understand and to deal more adequately with the problems growing out of the presence of the deviant child in the family" (Telford, 1967, p. 85).

7.2.1.2 The Venue

The meetings were held in a room which was not too big, in which the parents could feel at home and relaxed and where disturbing influences could be minimised. Participants sat in a circle, so that everyone, including the leader, could see and hear everyone else.

7.2.1.3 Time and duration

The meeting took place on a weekly basis for a six week period. Each meeting

lasted about two hours.

7.2.2 Experimental group B

The practical basic principles for experimental group B, the teaching group, were influenced by McWhirter's (1976) ideas about parents' education groups in learning-disabilities. The parents were shown a film or given a lecture during each meeting, lasting approximately 30 minutes, about learning problems. They were then given the opportunity to ask questions about what they had seen or heard. Visual aids were used during the meetings, for example a blackboard, posters, and samples of materials and music, to illustrate the ideas being presented. A general introduction to the whole problem was given, definitions were discussed and cognitive, emotional, behavioural and social problems were explained. (See appendix VI for a more detailed description of the meetings.)

The leader, a remedial teacher, had good theoretical knowledge of learning-disabilities and accepted full responsibility for the content of the discussion. She was able to answer questions concerning the problems parents encountered and could advise the parents to try out certain educational strategies at home.

7.2.2.1 Time and duration

The meetings took place on a weekly basis, during the same period of time as group A, for a six week period. Each meeting lasted approximately two hours.

7.2.3 Control group, C

The parents in the control group received no treatment initially. They had no contact with group leaders nor with participants in the experimental groups. They will however be given the opportunity at a later stage to participate in reflective group counselling.

7.3 CRITERIA TO EVALUATE OUTCOME

7.3.1 Hereford's Parent Attitude Survey Scale

The parents in the experimental groups were asked during the first meeting and again during the last meeting to fill in the Hereford Parent Attitude Survey Scale (Hereford, 1963) (see appendix II and III). The parents of non-learning-disabled children and the parents in group C, the control group, received these scales in the post and returned them by post.

The Hereford Parent Attitude Survey Scale is specifically designed to measure the dimensions of attitudes of parents towards their children.

The questions on this scale are all important to parent-child relations. The scale contains seven areas to be measured of which this investigator used five, those that concern parental attitudes and behaviour. The scales that were used are:

- Confidence in parental role

This scale refers to the parent's concept of himself. In terms of a continuum, the attitude ranges from the low end - at which a parent feels inadequate, dissatisfied, and unsure, and believes that he lacks the ability to be a good parent - to the opposite end - at which the parent feels sure of himself, adequate to meet the demands of parenthood, and unconcerned about the difficulties of parent-child relations. (This dimension is tapped by questions 1-3-8-13-18-23-28-33-38-43-48-53-58-63-68-73)

- Causation of child's behavior

This scale is concerned with the interpretation a parent makes of his child's behavior, and the extent to which he involves himself as a causative factor. At the end of this continuum is the parent who holds that behavior is inherited or due to supernatural factors, or who takes the position of immutable causal determinism. At the other end is the parent who feels his child's behavior is determined by parent-child interaction, by environmental influences, and by parental behavior and attitudes. (Low scores indicate belief in inheritance and supernatural factors. Questions 4-9-14-19-24-29-34-39-44-49-54-59-64-69-74 are related to this scale)

- Acceptance of child's behavior and feelings

This scale measures the degree to which a parent is satisfied with his child, finds that the child's behavior fits in with his own concepts, and sees the child as an individual in his own right. At the end of this continuum is the parent who overtly and completely rejects his child. At the other end is the completely permissive parent. (Low scores

indicate rejection of the child. This dimension is tapped by questions 2-5-10-15-20-25-30-35-40-45-50-55-60-65-70-75)

- Mutual understanding

This scale might almost be thought of as a communication or interaction variable, although it is not necessarily dependent on the amount of verbal exchange. At the lower end of this continuum is the parent who does not share ideas, attitudes, or feelings with his child; at the upper end is the parent who prizes the reciprocal exchange of both the intellectual and emotional aspects of living. (Low scores reflect lack of meaningful interaction between parent and child as seen by the parents. This dimension is tapped by questions 6-11-16-21-26-31-36-41-46-51-56-61-66-71-76)

- Mutual trust

This scale measures the amount of confidence that parents and children have in each other. At the lower end of this continuum is a parent-child relation marked by suspicion and deceit; at the other end is a relation characterized by mutual confidence and trust. (Low scores indicate lack of confidence and trust between parents and children. This dimension is tapped by questions 7-12-17-22-27-32-37-42-47-52-57-62-67-72-77)

(Hereford, 1968, p. 39-40)

The scores on the scales range from +2 to -2 depending on whether the item is stated positively or negatively. The sum of the item scores in each area serves as the parent's total score for that attitude area. The higher the score the more positive the attitude.

Each item is written in simple, conversational style, a natural expression of thought, so that each statement could easily be understood by each subject.

It is suggested in the manual for the test that a deviant score of above 19 should not be used. It would point to either carelessness in marking responses or to lack of understanding of the items or instructions. (No deviant score of above 19 was found in this research.)

The reliability of each scale has been computed by means of the split-level method. The reliability proved to be well within the satisfactory range of reliability for measuring instruments of this type. An inter-scale correlation matrix has been computed which correlated every scale with every other scale. The correlation coefficients found, ranging from .33 to .62, were high enough to indicate that all the scales are measuring related parents' attitudes, but are not so high as to suggest duplication.

In addition Hereford computed analyses of variance to find out whether age of child, sex of child and parents, and social economic status were related to the attitude measured.

The age of the child was significantly related to the acceptance, trust and causation scales. The younger the child, the higher the scores of the parents on these scales. The present investigator has kept the age range of participating children as small as possible (sub A to std. 1) in order to minimise the influence of this relation.

All parental attitudes in Hereford's study were strongly influenced by socio-economic status. The higher the socio-economic status of the parents the higher the attitude scores. The present investigator selected as far as possible families in the mid-range of socio-economic status by only asking parents to participate who themselves had obtained a matric certificate or equivalent diploma and by being selective about the schools which the children attended.

The sex of the child was not related to parents' attitudes in Hereford's study. It was therefore accepted that in the present study both boys and girls could participate.

Sex of parents however was significantly related to four attitude scales: understanding, acceptance, trust and causation. On these four scales, mothers scored higher than fathers. In addition fathers' attitude scores were more strongly influenced by socio-economic status than the attitude scores of mothers. In taking this significant relationship into account, the present investigator compared attitudes of mothers and fathers, with and without learning-disabled children, separately. And in comparing the before and after treatment attitude scores, only ratings of mothers were used because of the small numbers of fathers participating. (See chapter 9)

7.3.2 The Parent-Teacher Behavior Rating Scale for Underachieving Children

All parents were asked to fill in the Parent-Teacher Behavior Rating Scale for Underachieving Children by Rie (1976) (see appendix IV at the same time that they filled in the attitude questionnaires. This scale is designed for measuring

overt behavioural characteristics of children with learning-disabilities. It was originally designed by Rie and Rie (1976) to measure change in the characteristics of the learning-disabled children after drug administration.

It contains 35 items which are equally distributed among seven subscales intended to elicit judgment of achievement, activity level, attention, disruptiveness, distractibility, need achievement and sociability. Each item is rated on a five point scale of frequency of occurrence of the referred behaviour. All items are stated in the same direction so that a high score represents favourable behaviour and a low score behaviour which adults disapprove of generally; i.e. a high score on the attention subscale indicates good attentiveness. Yet this directionality is not immediately apparent since the items are a mixture of inhibitory as well as acting-out behaviours. The sum of the seven subscale scores is the total behaviour score. The maximum score for each subscale is 25, the total maximum score is 175.

The items were chosen on the basis of understandability. It had to be behaviour which both parents and teachers could observe. The raters were told that their first impressions were the best to express. The scale required only five to ten minutes to complete. Rie (1978) explained that the internal consistency of the scale was established by correlating item scores corrected for contamination with subscale scores. The r values ranged from .41 to .82. Mothers' ratings were correlated to fathers' ratings to determine rater reliability. Teachers' ratings at the beginning of the academic year were correlated with ratings obtained at the end of the academic year. All correlations were significant at the .004 level. To establish reliability, ratings of 43 control children were compared with those of 67 children with learning problems. An analysis of variance demonstrated that the scale distinguishes between these two groups. All F values were significant at .01 level or better. In addition activity level was correlated with leg actometer resulting in an r value of .28. Sociability ratings were correlated with sociograms, showing an r value of .30. Achievement ratings were correlated with a standardized achievement test; an r value of .33 was obtained for spelling, and of .21 for reading comprehension. And, as is apparent from the items, the scale has reasonable face value. Parents' and teachers' ratings were the same for girls, but they differed on their ratings of boys, with the teachers rating the boys significantly lower than the mothers did. This was taken into consideration when results were interpreted for the present research.

Rie found that this scale can be used as an additional clinical instrument for screening children with potential learning problems. He found that children diagnosed as learning-disabled tended to score below 120 on the total scale and below 18 on each subscale. According to the authors, children who score under 110 can be viewed as difficult and troublesome in the classroom and that they have a tendency to underachieve. They concluded that the scale identifies children with behaviour problems, specifying the nature of the problems and enabling one to compare present behaviour with future behaviour in order to measure the efficiency of a given intervention method.

To obtain as objective a rating of the behaviour of the children as possible for the present research, teachers were asked to monitor the child's behaviour on a weekly basis, using the Behavior Rating Scale of Rie, while treatment for parents took place. This would control for the assumption that parents whose attitudes changed as a result of the discussion groups, might rate their children's behaviour differently, even when no actual behavioural change took place. The treatment might only have made the parents more tolerant of the child's behaviour. If the teachers, who had had no treatment, also rated the behaviour differently, it might be accepted that the child's behaviour actually had changed and not just the parents' rating thereof.

7.3.3 Scholastic progress

One month after treatment stopped, teachers were asked to rate whether the children had made scholastic progress since treatment for parents started. Where possible, with children in std. 1, the child's average mark was compared with the class average mark for a particular subject. For the younger child, sub A and B, a subjective rating made by the teacher was used.

7.4 STATISTICAL ANALYSIS

The Randomized Control Group Pretest-Posttest design (Isaac, 1971) was used to calculate the difference between scores for the learning-disabled groups.

	Pre-test	Treatment	Post-test
Counselling group	T ₁	X ₁	T ₂
Teaching group	T ₁	X ₂	T ₂
Control group	T ₁		T ₂

7.4.1 Hereford's Parent Attitude Survey Scale

To measure the difference in attitude scores on the Hereford Parent Attitude Survey Scale between parents with learning-disabled children and parents with children who do not have a learning-disability, the Hotelling t^2 test was used. This test made it possible to study the mean differences of several variables for equality between these two samples.

To measure the differences between the means of the pre-test and post-test scores of the experimental and control groups of learning-disabled children, the Two Way Analysis of Variance (ANOVA) was used. It determined whether there was a statistically significant change in the attitudes of the participants of experimental group A, the participants of experimental group B, and of the members of the control group. Separate analyses were carried out for each of the five scales of the Parent Attitude Survey, as well as for the total attitude scores. An Analysis of Covariance (ANACOVA) was computed for each scale to find out whether medication (Ritalin) taken by the learning-disabled child influenced the mothers' attitudes towards their child.

7.4.2 The Parent-Teacher Behavior Rating Scale for Underachieving Children

The Hotelling t^2 test was also used to measure the difference between the scores of parents with learning-disabled and non-learning disabled children on the Parent-Teacher Behavior Rating Scale for Underachieving Children. It made it possible to test the means of the several variables simultaneously for equality

between the two groups.

To measure the differences between the mean scores of pre-test and post-test of the participants, parents, of experimental and control groups, the Two Way ANOVA was used. It measured whether there was a statistically significant difference between the before and after treatment ratings of overt behavioural characteristics of the children by parents who participated in treatment programme A and programme B and by parents who did not participate in any treatment procedure.

Whether there was a statistically significant difference between the ratings of overt behavioural characteristics of children whose parents participated in programme A by their teachers and by the teachers of children whose parents participated in programme B and whose parents did not participate in any treatment programme, was also measured by the Two Way ANOVA. Separate analyses were made for each of the seven subscales and for the total behaviour rating scores. An ANACOVA was computed to determine whether medication taken by the learning-disabled children had any influence on the behaviour ratings by mothers, fathers and teachers of the children.

7.4.3 Academic Achievement

No statistical method could be used to measure the differences between the teachers' ratings of the children's scholastic progress as no numerical scores were available.

A .05 level of significance was maintained throughout.

Chapter 8

RESULTS

As explained in chapter 7, two explicit hypotheses were tested.

Firstly, investigations were made regarding the differences in attitudes between parents with children who have a learning-disability and parents of children who do not have such a learning-disability; and regarding the differences in behaviour between these two groups of children.

Secondly, it was investigated whether certain treatment procedures would influence the attitudes of parents with learning-disabled children, the behaviour of these children and the children's scholastic achievement.

The children were not actively involved in the present investigation. Any changes in their behaviour or in their scholastic performance were explained as the indirect result of changes that occurred in the parents.

Results were analysed for the total attitude score on the Hereford scale as well as for the five subscales. In general details of only statistically significant analysis are given in the body of the text. Full results are given in appendix V.

8.1 ATTITUDE AND BEHAVIOUR RATING OF PARENTS WITH LEARNING-DISABLED CHILDREN VERSUS RATING OF PARENTS WITH NON-LEARNING-DISABLED CHILDREN

The attitude of parents towards their learning-disabled child was compared with the attitude of parents towards their children who did not have a learning-disability with the help of the Hereford Parent Attitude Survey Scale. In addition parents of learning-disabled children and non-learning-disabled children rated their children's

behaviour with the help of the Parent-Teacher Behavior Rating Scale for Underachieving Children. It was established whether there is a difference in parental attitudes and parents' behaviour ratings of their children between these two groups.

8.1.1 Results of attitude scores of parents

It had been assumed:

- That there would be a difference in attitude between parents of learning-disabled children and parents of children who do not have a learning-disability or other handicap.

Table 8a shows that there is a significant difference between the total attitude scores and between the scores on the subscale 'causation' for parents of learning-disabled and non-learning disabled children.

Table 8a Attitude parents LD – non-LD

Attitude factor	LD group (parents)		non-LD group (parents)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Understanding	13	5.11	14.72	5.11	80	-1.74
Trust	6.63	6.5	8.51	7.24	80	-1.24
Confidence	6.02	5.27	7.87	5.01	80	-1.62
Causation	10.58	4.91	14.38	4.78	80	-3.54 **
Acceptance	9.46	5.92	9.89	5.18	80	-0.35
Total	45.70	20.72	55.38	15.70	80	-2.37 *
N	43		39			

** $p < .001$

* $p < .05$

The parents in the non-learning disabled group scored higher on all the subscales as well as on the total attitude measures than did the parents in the learning-disabled group.

Further analyses of the scores showed that the difference in total attitude scores between parents of learning-disabled and non-learning-disabled children was due

to a difference in attitude between the mothers of the children, (table 8b). The mothers showed a significantly different score on the total attitude score and on the subscale scores measuring 'understanding' and 'causation'. The fathers, on the contrary, (table 8c) only showed a significantly different score on the subscale measuring 'causation', and not on the total attitude score.

Table 8b Attitude mothers LD – non LD

Attitude factor	LD group (mothers)		non-LD group (mothers)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Understanding	13.13	4.5	15.32	2.88	62	-2.34 *
Trust	7.13	5.49	8.35	7.47	62	-0.74
Confidence	6.03	5.16	7.76	5.25	62	-1.33
Causation	10.87	3.91	14.03	4.81	62	-2.86 *
Acceptance	11	4.7	10.47	5.06	62	.43
Total	48.16	15.9	55.94	15.86	62	-1.95 *
N	30		34			

* $p < .05$

The only subscale on which the mothers of learning-disabled children scored higher than mothers of non-learning disabled children is the 'acceptance' scale. On all other subscales mothers of non-learning-disabled children scored higher than mothers of learning-disabled children.

Table 8c Attitude fathers LD – non LD

Attitude factor	LD group (fathers)		non-LD group (fathers)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Understanding	12.69	6.49	10.60	5.59	16	.63
Trust	5.46	8.53	9.60	5.94	16	-0.99
Confidence	6.	5.74	8.60	3.13	16	-2.07 *
Acceptance	5.92	7.07	6	4.69	16	-0.02
Total	40	28.98	51.60	15.71	16	-0.84
N	13		5			

* $p < .05$

Fathers of learning-disabled children scored higher on the subscale 'understanding' than did fathers of non-learning-disabled children. On all the other subscales as well as on the total scale the fathers of learning-disabled children scored lower than the other group of fathers. When interpreting these scores it must be kept in mind that the sample of fathers in the non-learning-disabled group was small, five fathers only. Any generalisation made on the basis of these scores has to be carried out with great caution. Table 8c also shows that although the N in the non-learning-disabled group is considerably smaller than the N in the learning-disabled group, the sd for fathers in the learning-disabled group is considerably larger than the sd for fathers in the non-learning-disabled group. This means that the scores of the fathers in the first group are more widely spread than the scores of the fathers in the second group. This has to be taken into account when results are analysed as it would be normal for a small sample to have a greater variance (Loftus, 1982).

8.1.2 Results of the behaviour ratings by parents

It had been assumed:

- That there would be a difference between the parents' rating of the behaviour of children with learning-disabilities and the parents' rating of children without such a disability.

Table 8d (see next page) shows that there is a significant difference between the parents' behaviour ratings of these two groups of children on all the subscales of the Parent-Teacher Behavior Rating Scale for Underachieving Children as well as on the total behaviour rating scale.

Table 8d Behaviour ratings parents LD – non-LD

Behaviour factor	LD group (parents)		non-LD group (parents)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Activity	16.98	3.27	20.95	1.79	80	-6.72 ****
Achievement	15.74	3.07	20.23	2.45	80	-7.26 ****
Sociability	19.14	2.45	20.76	1.87	80	-3.35 *
Attention	18.02	3.80	21.69	2.61	80	-5.50 ****
Distractibility	15.58	3	19.51	2.47	80	-6.43 ****
Disruptability	16.58	3.17	19.20	2.42	80	-4.17 ****
Need-Achievement	18.9	3.51	22.59	2.66	80	-5.31 ****
Total	120.95	16.59	144.95	11.79	80	-7.48 ****
N	43		39			

**** p < .0001, * p < .05

The behaviour ratings by parents of their learning-disabled children was lower on all behaviour scales than the behaviour ratings by parents of non-learning-disabled children.

Tables 8e and 8f show the difference in ratings between mothers and fathers:

Table 8e Behaviour ratings mothers LD - nonLD

Behaviour factor	LD group (mothers)		non-LD group (mothers)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Activity	16.9	3.52	21.21	1.74	62	-6.32 ****
Achievement	15.87	3.09	20.35	2.59	62	-6.31 ****
Sociability	19.23	2.43	20.78	1.9	62	-2.88 *
Attention	17.87	4.19	22	2.37	62	-4.92 ****
Distractibility	15.4	3.19	19.56	2.54	62	-5.8 ****
Disruptability	16.83	3.16	19.26	2.44	62	3.46 **
Need-Achievement	18.23	3.56	22.56	2.75	62	-5.47 ****
Total	120.33	17.57	145.73	11.76	62	-6.87 ****
N	30		34			

**** p < .0001, ** p < .0001, * p < .05

Table 8f Behaviour ratings fathers LD - non-LD

Behaviour factor	LD group (fathers)		non-LD group (fathers)		df	Hotelling t value for independent groups
	mean	sd	mean	sd		
Activity	17.15	2.73	19.2	1.09	16	-1.6
Achievement	15.46	3.12	19.4	.89	16	-2.73 *
Sociability	18.92	2.59	20.6	1.81	16	-1.31
Attention	18.38	2.81	19.6	3.36	16	-0.78
Distractibility	16	2.61	19.2	2.17	16	-2.42 *
Disruptability	16	3.24	18.8	2.58	16	-1.72
Need-Achievement	20.46	2.97	22.8	.96	16	-1.6
Total	122.38	14.64	139.6	11.8	16	-2.34 *
N	13		5			

* $p < .05$

As for the attitude scores, the difference between the two groups of parents' behaviour ratings of learning-disabled children was due to a difference in rating between the mothers. The scores of the mothers were significantly different on all scales, while the scores for the fathers were only significantly different on the subscales 'achievement' and 'distractibility' and on the total score. The scores of the fathers however must also be interpreted with caution as the sample of fathers of non-learning-disabled children is relatively small (five fathers).

8.2 THE DIFFERENCE BETWEEN ATTITUDES AND CHILDREN'S BEHAVIOUR RATINGS BY PARENTS OF LEARNING-DISABLED CHILDREN BEFORE AND AFTER TREATMENT

Because there were no fathers at all in one of the treatment groups, the test results obtained from only mothers of learning-disabled children who participated in the investigation were subjected to analysis. The differences between experimental and control groups will be looked at and the before and after treatment scores will be analysed.

8.2.1 Before and after treatment attitude scores of mothers

It had been assumed:

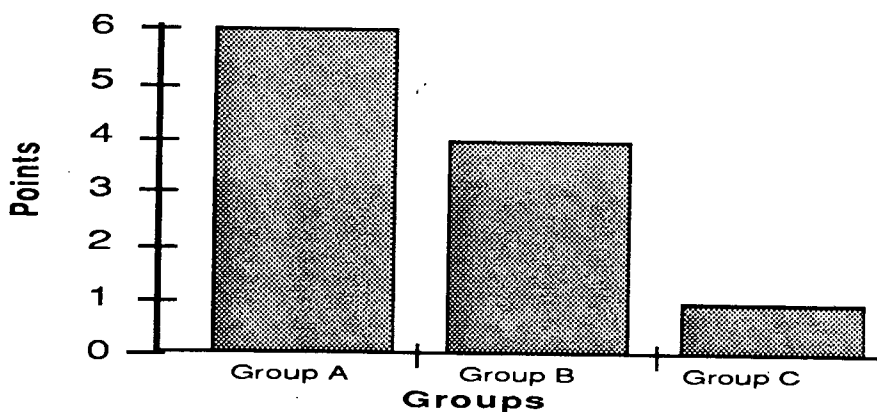
- That there would be a difference in parental attitudes towards learning-disabled children before and after treatment;
- That the attitudes of parents in experimental group A, the counselling group, would improve more than the attitudes of parents participating in experimental group B, the teaching group;
- And that there would be no change in attitudes of parents participating in group C, the no-treatment control group.

However the Two Way Analysis of Variance (ANOVA) computed for the total attitude scales of mothers of learning-disabled children showed:

- That there is no significant difference in the before and after changes for the three groups;
- That there is no significant difference in the attitude scores of the three groups (i.e. the groups are well matched).
- The increase in before and after scores fails to reach statistical significance at the .05 level, it is however significant at the .1 level.

Histogram 8A shows the amount of points the means increased after treatment for the three groups.

Histogram 8A Attitudes change mothers



Computing the Two Way ANOVA for the subscales of the attitude survey filled in by mothers showed that there is a statistically significant difference in before and after scores on the 'trust' scale (Table 8g):

Table 8g Attitude change mothers

Scale	Source	Sum of squares	df	Mean squares	F
Trust	Between columns	53.62	2	26.81	.41
	Error	1777.86	27	65.85	
	Between rows	40.93	1	40.93	6.07 *
	Interaction	34.	2	17	2.52
	Error	182.14	27	6.74	

* $p < .05$

The simple main effect test calculated for the significant results on the 'trust' scale shows that the difference in before and after scores on the scale are the result of an increase in scores of the mothers in group A, the counselling group. The table reads:

Table 8h Attitude change mothers, simple main effect

Scale	Source	Sum of squares	df	Mean squares	F
Trust	B at A2	58.81	1	58.81	8.72 **

** $p < 0.01$ B = treatment A2 = group B, the teaching group

8.2.1.1 The ANACOVA for the attitude scores of mothers

An analysis of Covariance (ANACOVA) was computed to establish whether medication (i.e. Ritalin) taken by the learning-disabled child would have an influence on the attitude scores of their mothers. The only attitude scale influenced by the covariate was the 'trust' scale.

The significantly negative regression of -6.08, $F=7.20^*$ correlation between medication, taken by a learning-disabled child and the mothers' score on the attitude scale measuring 'trust', indicates that the mothers whose children take medication score lower on the subscale of the attitude survey measuring 'trust' than do the mothers of learning-disabled children who do not take medication. The error term and mean from ANOVA to ANACOVA however did not change to such an extent that it affected the pattern of results. The ANOVA therefore was used when scores were interpreted.

* $p < 0.05$

8.2.2 Mothers' before and after treatment behaviour rating scores

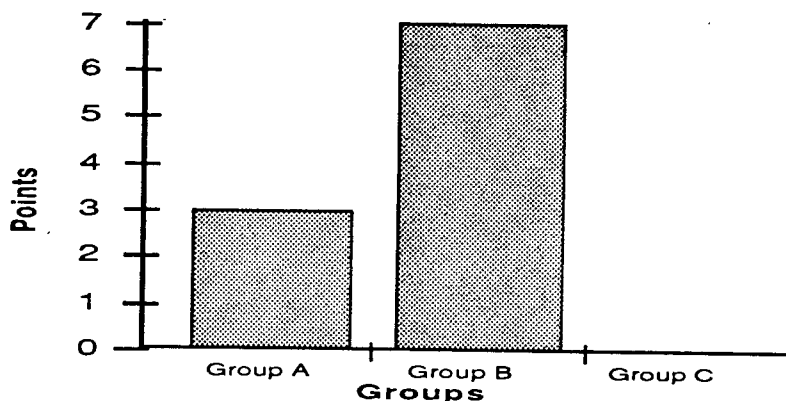
It had been assumed:

- That there would be a difference between the mothers' rating of the learning-disabled child's behaviour before and after treatment;
- That the mothers participating in group A, the counselling group, would rate their children's behaviour higher after treatment than the mothers in group B, the teaching group;
- That there would be no difference between before and after treatment scores by mothers participating in group C, the no-treatment control group.

The Two Way ANOVA computed for this purpose showed:

- That there is no significant difference in the before and after changes for the three groups on the behaviour rating scale;
- That there is no significant difference in the behaviour rating scores of the three groups (i.e. the groups are well matched);
- That, although there is no significant difference between the before and after treatment behaviour rating scores for any of the three groups, the mean of the 'after' scores of group A and B is higher than for the 'before' scores, while the before and after mean scores for group C stayed the same. Histogram 8B shows the amount of points the behaviour rating mean scores increased after treatment for the three groups.

Histogram 8B Behaviour ratings change mothers



8.2.2.1 The ANACOVA and the behaviour rating scores by mothers

An ANACOVA with medication as the covariate showed that there is no significant difference between the behaviour rating by mothers whose children take medication and by mothers whose children do not take medication for their learning-disability. Medication taken by a learning-disabled child does not influence the mother's behaviour rating of her child.

8.2.3 Teachers' before and after treatment behaviour rating scores

It had been assumed:

- That there would be a difference between the before and after treatment behaviour ratings of learning-disabled children by teachers. This difference would depend on the participation of the child's mother in one of the treatment programmes.
- That the teachers would rate the behaviour of a child whose mother participated in group A, the counselling group, higher after treatment than the teachers of a child whose mother participated in group B, the teaching group.
- That there would be no difference between the before and after treatment behaviour rating scores by teachers for children whose mothers participated in group C, the no-treatment control group.

The ANOVA computed for the behaviour rating scores by teachers showed:

- That there is a significant difference in the before and after changes for the three groups on the 'activity' scale, the 'achievement' scale and the total scale of the behaviour rating scale used.
- That there is no significant difference in the behaviour ratings before treatment of learning-disabled children by their teachers between the three groups (i.e. the groups are well matched).
- That there is a significant difference between the before and after treatment behaviour rating scores by teachers on the 'activity', 'achievement', 'sociability', 'attention', 'distractibility' and 'need-achievement' subscales, as well as on the total behaviour rating scale (Table 8i).

8.2.3.1 Analysis of teachers' behaviour rating scores

Interaction results were found on the 'activity' and 'achievement' subscales and the total behaviour rating scale. Main effects were found on the subscales 'sociability', 'attention', 'distractibility' and 'need-achievement'. As interaction F in repeated measures ANOVA really deals with the main effect of treatments (Huck, 1975), a simple main effect test was computed to find the cause of the interaction and the main effects. For all the subscales as well as for the total behaviour rating scores, the after-treatment scores of group B, the teaching group, improved more than the after-treatment scores of group A, the counselling group. The only subscale for which the after-treatment scores of group A improved significantly is the 'achievement' scale.

The Simple Main Effect Test for the scores reads:

Table 8j Behaviour ratings teachers, simple main effect

Scale	Source	SS	DF	MS	F	
Activity	B at A2	77.42	5	15.48	6.98	***
Achievement	B at A1	20.63	5	4.12	2.44	*
	B at A2	52.37	5	10.47	6.20	***
Sociability	B at A2	22.99	5	4.60	2.43	*
Attention	B at A2	33.31	5	6.66	3.64	**
Distractibility	B at A2	41.58	5	8.31	4.08	**
Need-achievement	B at A2	26	5	5.20	2.92	*
Total	B at A2	77.42	5	15.48	6.98	**

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

B = treatment; A1 = group A, the counselling group; A2 = group B, the teaching group.

8.2.3.2. Behaviour monitoring of learning-disabled children by teachers on a weekly basis for six weeks.

Analysis with the Tukey test of the weekly behaviour rating scores of teachers showed:

- That the difference between before and after treatment total behaviour scores became significant during week five of the treatment programme (Table 8k).

Table 8k

	<u>Mean</u>	<u>df</u>	<u>Tukey</u>
Mean 1	109.72		
Mean 2	113.57	6, 110	1.51
Mean 1	109.72		
Mean 3	118.57	6, 110	3.49
Mean 1	109.72		
Mean 4	119.86	6, 110	3.99
Mean 1	109.72		
Mean 5	124	6, 110	5.63 **
Mean 1	109.72		
Mean 6	129.42	6, 110	7.76 **

** $p < 0.01$

8.2.3.3 The ANACOVA and the behaviour rating by teachers

The ANACOVA for the behaviour rating scale of learning-disabled children by their teachers showed that there is a correlation between the 'activity' subscore of the behaviour scale and the covariate medication at .05 level of significance. The negative regression coefficient of -4.03, $F_{4.94} *$ showed that teachers rate learning-disabled children who are on medication lower on the activity scale than they do children who are not on medication. The ANACOVA however is not used for the interpretation of results as the error term has not decreased sufficiently nor has the mean been adjusted sufficiently to affect the pattern of results.

8.3 BEHAVIOUR RATINGS OF LEARNING-DISABLED CHILDREN BY MOTHERS VERSUS TEACHERS

It had been assumed:

- That there would not be any significant difference between the behaviour rating of learning-disabled children by their mothers and teachers.

The Hotelling's t test for independent samples showed: that there is no significant difference between mothers' and teachers' behaviour ratings of learning-disabled children.

The average difference between the behaviour rating scores by mothers and by

teachers before treatment is 3.61, and after treatment -2.16. Both means do show a significantly different p. value on the Hotelling t test. The difference between means before and after treatment does however show that before treatment mothers scored higher than teachers on the behaviour rating scale, and that teachers scored higher than mothers on these scales after treatment procedures.

8.4 PROGRESS IN ACADEMIC PERFORMANCE OF LEARNING-DISABLED CHILDREN BEFORE AND AFTER TREATMENT

It had been assumed:

- That the children's academic achievement would improve if the parents participated in a treatment group.
- That the academic achievement of children whose parents participated in group A, the counselling group, would improve more than the achievements of children whose parents participated in group B, the teaching group.

Analysing the academic performance reports of learning-disabled children as given by their teachers showed:

- That for experimental group A, the reflective group,
 - 50% of the children did not improve
 - 15% improved a little
 - 35% showed a good or "tremendous" improvement.
- That for the experimental group B, the teaching group,
 - 40% of the children improved a little, and
 - 53% showed a good improvement.
 - For the other 7% no reports were available.
- That for group C, the non-treatment control group,
 - 20% of the children showed an actual drop in academic achievement
 - 20% did not improve
 - 20% showed a slight improvement, and
 - 40% of the children showed a good improvement.

As for the scores on the teachers' behaviour rating scale for learning-disabled children the greatest improvement in academic achievement is found in group B, the teaching group. 93% of the children were reported to have academically improved, 50% of the children in experimental group A showed an improvement and 60% of the children in the control group showed an improvement in academic achievement while 20% of the children in this group actually showed a decrease in academic achievement.

Chapter 9

DISCUSSION OF RESULTS

At the outset of this chapter it must be pointed out that the parents participating in this research volunteered to do so. This willingness to participate is probably an indication of their motivation and involvement with their child, their interest in their child's problem and their need to learn more about the problem. From the 87 parents of learning-disabled children who were approached 48 parents did not want to get involved, no reasons being given. In other words 55% of the people being approached participated, which is better than the 40% predicted by the directors of the school clinics. If the investigator's assumption about the nonparticipating parent's lack of involvement with their child's problem is correct then the attitude scores of a randomly selected sample of learning-disabled parents would have been lower than the scores for the parents who volunteered to participate in this research. It would be more difficult to make such assumptions about the behaviour rating scores. The behaviour problems of the children of non-participating parents might have been less overt, the parents might therefore have felt less need to do something about the problem.

Some important differences between parents of learning-disabled and non-learning-disabled children have been observed in the present investigation. Looking at the statistical results obtained from the scores on Hereford's Parent Attitude Survey Scale and the Parent-Teacher Behavior Rating Scale for Underachieving Children it becomes apparent that:

there is a difference between the attitudes of mothers of learning-disabled children and mothers of non-learning-disabled children,
both fathers and mothers rate the behaviour of learning-disabled children lower than the parents of non-learning-disabled children do.

For the learning-disabled groups: a small difference in parental attitudes was found between before and after treatment procedures and an important difference between before and after treatment scores on the behaviour rating test:

the greatest difference in attitude change of mothers after treatment is found on the 'trust' scale, medication (Ritalin) has an influence on the confidence that parents and children have in each other (from the parents' perspective), the behaviour of learning-disabled children is rated higher after treatment by mothers (although not significantly) and by teachers (significantly) of the participants in group B, the teaching group, medication has an influence on the way the teachers rate the learning-disabled children's activity level.

9.1 ATTITUDES OF PARENTS WITH LEARNING-DISABLED CHILDREN VERSUS THE ATTITUDES OF PARENTS WITH NON-LEARNING-DISABLED CHILDREN

9.1.1 Differences between scores of mothers and fathers

Analysing the means and standard deviations of the scores on the attitude scale it becomes apparent that there is a difference between the attitudes of mothers and fathers of learning-disabled children. Mothers have a higher mean and lower standard deviation (sd) on each subscale than fathers. This is consistent with what Hereford found when he analysed the differences between the scores of mothers and fathers. Hereford however found no difference on the scale measuring 'confidence'. A slightly different pattern emerged for parents of non-learning-disabled children. While the total mean for mothers was higher than for fathers, mothers scored lower on the scales measuring 'trust', 'confidence' and 'causation', but much higher on the scales measuring 'understanding' and 'acceptance'. As a result of this discrepancy it seems important to discuss the attitudes of mothers and fathers separately.

It is encouraging to find that the pattern of differences in attitudes between mothers and fathers of learning-disabled children is the same as for parents who do not have a handicapped child (Hereford's sample), particularly if one takes into consideration that Collins (1982) found that mothers of learning-disabled children are more involved with their children than fathers. She explained that mothers often show a lack of competence in rearing their troublesome child. This and the mother's laborious involvement in the child's homework struggles could lead to a

more negative attitude towards their child. The high scores of mothers on the 'acceptance' scale however indicate that mothers are more satisfied with their learning-disabled children than fathers, mothers see the children as individuals and find that the behaviour of their children fits in with their expectations.

The only scale on which mothers and fathers of learning-disabled children have similar scores is the scale measuring 'understanding', while mothers of non-learning-disabled children score much higher on this scale than fathers. Mothers of non-learning-disabled children seem to communicate emotionally and intellectually better with their children than their fathers, mothers share ideas, attitudes and feelings with the children. The amount of interaction mothers and fathers of learning-disabled children have with their children seems however to be practically the same. This and the fact that understanding is the only scale on which fathers of learning-disabled children score higher than fathers of non-learning-disabled children (although not significantly so), may indicate that the diagnosis of a learning-disability actually makes fathers more aware of the need for communication with their children. Collins (1982) found that during the initial interview at the clinic fathers expressed themselves to be much less involved with their children than mothers were. Relating the results of the present investigation to Collins' result findings one may conclude that there may be a tendency in fathers to interact more with their children when the need for this is pointed out by the diagnostic team. It must however be stressed again that conclusions drawn from these results have to be tentative as the sample of fathers of non-learning-disabled children was small.

9.1.2 Differences between attitude scores of mothers

Mothers of non-learning-disabled children scored significantly higher on the total attitude scale than mothers of learning-disabled children. This is mainly the result of the significant difference between the scores on the scales measuring 'understanding' and 'causation'.

The attitude characteristics measured on the 'understanding' scale deal with the quality of communication between parents and children. As has been explained in chapter three communication with learning-disabled children is often difficult and hampered by visual or auditory perceptual problems. This interaction level seems

to be lower for mothers than for fathers. This may be explained by the fact that most of the mother-child interaction seems to concentrate on school work. School work for a learning-disabled child does not only take much longer than for another child, the learning-disabled child also needs more coaching and actual teaching. Add to the above the frustration that builds up in the mother and in the child when the child obviously does not perform according to his apparent ability and their expectations of him, and one sees a pattern of negative interactions. Mothers reported during the discussion groups that even if no homework needed to be done at a particular moment the mothers felt that the child should be learning something, or that the homework had not been done properly, that more coaching should be done. Instead of talking about other things with their children, mothers would ask more questions about school work. Kaslow (1978) reported that mothers often display defensive behaviour, i.e. over-protectiveness, over-indulgence and over-compensatory behaviour instead of communicating their real feelings towards their children. Some mothers participating in the present study, reported that they found it difficult to actually find anything positive to say to their child, although they did know that their child had positive characteristics. The learning problem however seems to overshadow all the more pleasant sides of the relationship, or in Kaslow's (1978) words: "the disability is generalized to the totality of the child rather than just one characteristic of him" (p.43). Fathers, on the contrary, usually come home after homework has been completed, unaware of the little dramas that have been staged during the afternoon and enjoy leisure time with their children in much the same way as fathers of children who do not have a learning problem.

Mothers of learning-disabled children scored significantly lower on the scale measuring 'causation' than mothers of non-learning-disabled children. The scale 'causation' measures to what extent the parents believe their child's behaviour to be predetermined by genetic or supernatural factors (low score), or to what extent they see the child's behaviour as influenced by parent-child interactions and environmental influences. The behaviour of a learning-disabled child is difficult to understand and often unpredictable. The child so often does not behave the way that is expected of him or accepted in society as pointed out by Kaslow (1978), among others. Parents don't understand the reason for this irregular behaviour, they don't recognise themselves as models of this behaviour and feel that they have very little influence on it. The child does not seem to learn from experience,

does not respond to punishment, misinterprets interactions, etc. Apart from the parents' experiences with the child's behaviour they might have been told that their child has a learning-disability caused by MBD, birth injury, trauma or genetic factors. To hear this is often a relief for the parents, who have blamed themselves for their child's problems and feel, as a result, inadequate, and often very guilty. But parents should be made aware that they do play an important role in controlling the behaviour of their child. Collins (1982) explained that although there might be uncertainty in the parents' contribution to the origin of the disability, there is no uncertainty "in the function of parent effectiveness in the conditioning of behaviour" (p. 253). Abrams (1977) talks about the extremely influential role attitudes of parents have in shaping the child's receptivity to the learning process. Parents need to recognise that they have a responsibility here and "parents need to acknowledge their ability to help them" (Collins, p. 265). The low score of mothers as well as fathers of learning-disabled children on the 'causation' scales indicates that parents have to recognise that from the beginning the child is reacting and being reacted to, the way he is reacted to will have a great influence on his development. A learning-disabled child who for example is overprotected or overindulged, won't have the opportunity to learn from his own experiences and mistakes, he will stay dependent.

To summarise: Mothers of learning-disabled children seem to score lower on the total attitude scale and on the subscales 'understanding' and 'causation' than mothers of children who do not have a learning-disability. Fathers of the first group of children scored lower on the total attitude scale and on the subscale causation than the other fathers. This is possibly the result of the more unpredictable behaviour of the learning-disabled children and the lack of meaningful interaction between mothers and learning-disabled children.

No significant difference between the two groups could be pointed out for the other scales. This indicates that parents of learning-disabled children feel as confident in their parental role as do parents of non-learning-disabled children. They accept their children's behaviour equally well and they show the same confidence and trust in their children.

The discrepancy in attitude between parents of learning-disabled and non-learning-disabled children was not as great as was expected. This may indicate that the learning-disability, at least for this group of caring parents participating in the

For the present investigation it is important that both fathers and mothers rate the behaviour of their learning-disabled child lower than do parents of non-learning-disabled children. These results were predicted and explain that the behaviour for at least this sample of learning-disabled children is problematic and disruptive. Similar patterns of maladaptive behaviour of learning-disabled children were described by Meyers (1969), Bryan (1978), Lane (1980), Anderson (1980) and others. These and the present findings enforce the assumption of the present investigator that the child should not only receive academic assistance but should be helped with its behaviour and emotional problems as well. Parents, through better understanding of the problems, may play a crucial role in helping to improve the child's behaviour.

By analysing the scores on the different subscales highly significant differences were found on the subscales measuring 'activity', 'achievement', 'attention', 'distractibility' and 'need-achievement'. The scores on the subscales 'sociability' and 'disruptability', although significant on the 0.05 level, were not as low as the other scores. It may be that academically related behaviour problems like high activity, low achievement and high distractibility are more prevalent than socially related problems. This fits in with the concern mothers showed during treatment for academically-related problems; socially-related problems were hardly discussed at all.

9.3 ATTITUDE AND BEHAVIOUR SCORES BEFORE AND AFTER TREATMENT

In the second part of this study it was investigated whether group treatment for parents of learning-disabled children helps parents to improve their attitudes towards their children, whether the treatment has an effect on the behaviour ratings of learning-disabled children by their parents and teachers and whether treatment for parents has an effect on the children's academic achievement.

Only the attitude scales filled in by mothers and behaviour rating scales filled in by mothers and teachers were used for analysing as not enough fathers, although invited, participated. In group A, the counselling group, no fathers participated at all, in group B, the teaching group, three fathers participated.

9.3.1 Attitude scores of mothers before and after treatment

The only subscale on which mothers in group A showed a significant improvement in attitude was the scale measuring 'trust'. This indicates that mothers in group A grew to show more confidence in their children. The 'trust' scale is also the only subscale on which medication has an influence. Mothers seem to have less confidence in learning-disabled children who take medication than in learning-disabled children who do not have to take medication. This is explainable when one takes into account that children who take medication have usually a severe attention disorder and/or are hyperactive. Mothers explained during counselling that those children were very accident prone, which had made them overprotective of their children. Three mothers, for example, had locked away their child's bicycle after a few days of use. None of the mothers allowed their children to use a train or other public transport for fear of accidents, losing of tickets, taking the wrong train, etc. It is encouraging to find that the counselling treatment did help the mothers to have more confidence in their children. It may have an important effect on their interactions with the child. If the mothers become less protective and restrictive the child may have room to learn from his own experiences and become more independent. As one mother put it: "I have learnt that the worst thing you can do is feel sorry for your child as it also clouds one's judgment and you don't give the child the chance to prove its full potential, you are inclined to want to help which does not give the child the chance to prove to himself what he can actually do by himself."

There was no statistically significant improvement in attitude for the mothers in group B, the teaching group. Treatment in group B was child centred, while the treatment in group A was centred on the needs of the mothers. To get personally involved in discussions about the problem and to be able to express one's own needs seems to be able to bring about greater attitude change than viewing films or listening to lectures about the problem.

An important observation was made however in that the after treatment attitude scores were considerably different from the before treatment scores for the participants in both experimental groups while the scores for the control parents were consistent. Some mothers scored higher on the after treatment scores than on the before treatment scores, others scored lower which detracted from the positive results, and the scores were more scattered, the sd was increased. A similar pattern of results was found in the pilot study done by the present

investigator before the main programme was run. The results in the pilot study showed a significant difference (0.05 level) in strength of responses on the same attitude scales between experimental and control mothers. The experimental group answered more often with 'agree' or 'disagree' while the control group answered with the 'strongly agree' or 'strongly disagree' response. Skuy (1980) also found a wide scatter in test scores after parental intervention on the Bene-Anthony Family Relations test. He attributed this wide scatter of scores to factors such as the parents' different "needs arising from, expectations of and attitudes towards the group, as well as their particular degree of participation and interaction with other group members" (p. 390).

Although Skuy's explanation may be a contributing factor to the wide scatter of scores on the attitude scale found in this study, the present investigator assumes that it could be the result of mothers becoming more aware but less sure of their attitudes. Treatment intervention may have helped the mothers to think about their attitudes, which may bring confusion, but at the same time may be the beginning of a change in attitudes. Attitudes change slowly, it requires a constant provision of positive reinforcement and increasing insight. The treatment programme used for the present investigation involved six group discussions only, which may be too little to show a definite improvement in attitudes on the Hereford Parent Attitude Survey Scale immediately after treatment stopped. The fact that there was an overall improvement in scores, although not significant, is encouraging and warrants further research.

9.3.2 Before and after treatment behaviour rating scores of mothers and teachers

9.3.2.1 Behaviour rating scores by mothers

Mothers rated the behaviour of the children before treatment and immediately thereafter. Contrary to what was expected no significant change was found between the before and after scores for any of the three groups. It must however be noted that the scores on the behaviour scale of learning-disabled children as rated by mothers in the experimental groups had improved, while the scores from mothers in the control group stayed the same. The scores by mothers in group B, the teaching group, improved considerably more than the scores of mothers in group A, the counselling group. The lack of significant change may be due to the

short duration of the treatment procedures. Mothers had not been given enough time to change their attitudes towards their children. It could not be measured whether a change in attitude would have a beneficial effect on the children's behaviour.

9.3.2.2. Behaviour rating scores by teachers

An analysis of the teachers' behaviour ratings of the learning-disabled children showed a highly significant improvement in the behaviour of children whose parents participated in group B, the teaching group. These results indicate that for parents to participate in a treatment programme which is based on giving parents information about learning-disabilities has a positive effect on the teacher's ratings of the children's behaviour. Not only did teachers of group B rate the children's behaviour more positively, mothers in group B rated the behaviour also considerably higher than the mothers in group A. These findings are consistent with the research findings of Grilli (1974) and McWhirter (1976). Both of them found that the behaviour of learning-disabled children changed after parents participated in child centred discussion groups. The behaviour of the learning-disabled children whose parents participated in the teaching group seemed to have improved significantly. The behaviour of children of parents who participated in the counselling group or in the control group did not change.

A Tukey test was computed to find out when the behaviour of the children started to improve. For the first two weeks the ratings were the same, after the second week the mean for group B increased and became significantly different from the first mean after the fourth week.

It was considered whether the participation of four fathers in group B had any influence on the improved behaviour ratings by teachers of this group. Did the behaviour ratings by teachers of children whose fathers participated in the teaching group improve more than the behaviour rating of children whose fathers did not participate? Although the scores for the children whose fathers participated were slightly higher than for children whose fathers did not participate the student t test computed showed that the difference was not significant. At this stage, bearing in mind that the sample was small, one has to conclude that fathers' participation (or not) in the teaching group makes no difference to the teacher's behaviour ratings of children.

Attitudes of parents and behaviour of learning-disabled children seem not as closely related as the present investigator assumed. The attitudes of parents in the counselling group did improve to a certain extent but the behaviour of their children did not. The opposite was found for the teaching group, attitudes of parents did not improve, but the behaviour of the children improved significantly. The content of the discussion in the teaching group focussed on the behaviour of the child; characteristics of the learning-disabled child were explained; academic, social, emotional and behaviour problems were pointed out. Mothers as a result became more aware of their children's behaviour and their problems and seemed to have learned to direct their children's behaviour in a more positive way.

9.3.2.3 Covariate medication on behaviour ratings.

The ANACOVA, covariate medication, computed for the behaviour ratings of mothers was not significant for any scale. The lack of effect of medication on mothers' behaviour ratings of learning-disabled children is surprising. It was expected that learning-disabled children who are taking prescribed medication for their problem would differ from other learning-disabled children on at least some of the seven behaviour scales of Rie (1976). The present investigation however shows that the behaviour discrepancies are not apparent at home, but they are apparent at school.

Teachers rate the behaviour of children who are on medication significantly lower (0.05) on the activity scale. Teachers also rated the children's behaviour considerably lower on the subscales 'attention' and 'distractibility' (significant level of 0.0592 and 0.0594 respectively). This seems to indicate that the behaviour of learning-disabled children who are on medication is particularly troublesome at school. To be able to pay attention, to curtail one's activity and not allow oneself to be distracted are values more appreciated at school where the child is expected to sit still, to get involved etc., than at home where troublesome behaviour is less noticeable.

The lack of improvement in behaviour for the children in group A, the counselling group, may, apart from the fact that the treatment was not as child focussed, be the result of the artificial inflating of the initial behaviour scores through medication. In group A six children were on medication, only one in group B and two in group C. The behaviour of the children who were on medication would have

been rated much lower, according to their teachers, had they not been on medication. Medication not only improves behaviour artificially (O'Leary, 1980, Rie, 1976), it makes behaviour less susceptible for other influencing variables like parental treatment and attitude change. Whether group counselling for parents of learning-disabled children will affect the behaviour of the children will have to be investigated with further research. For the present investigation it was not possible to obtain enough subjects who were not on medication. To ask the children to refrain from taking medication would have been unethical. The variables of the present investigation would have been better controlled if the parents of children on medication had been divided between the three groups. It was however due to chance that most of the children of the participants in group A were taking medication. Only during the first meeting could it be established which children were on medication. The involved parents were not able to participate on the other available evening.

9.3.2.4 Mothers' versus Teachers' behaviour ratings

The present investigator found that although teachers rated the behaviour of the children slightly lower before treatment than the mothers did, there was no significant difference between the scores. Rie (1978) however found that teachers rated boys significantly lower than the boys' mothers did. In other words the teachers participating in this research rated the children's behaviour higher than the teachers in Rie's research. This may be the result of the relatively high ratings by teachers of children who are on medication. As explained above the initial behaviour ratings by teachers of children who are on medication are higher than the ratings would have been had these same children not been taking medication. The total mean of teachers' behaviour ratings is as a result artificially inflated, although the behaviour of children on medication is still rated slightly lower by the teachers than the behaviour of children not on medication as the ANACOVA showed.

It is of interest to add that teachers rated the behaviour of children higher after treatment than mothers did. The difference between mothers' and teachers' rating however was still not significant.

9.4 ACADEMIC ACHIEVEMENT OF LEARNING-DISABLED CHILDREN

It was impossible, for practical reasons, to obtain objective test results of academic achievements of the children of participating parents. The present investigator intended to do achievement tests with all the children before and after treatment. This proved impossible however as many parents disliked their children being subjected to any more testing procedures. The parents stated that they were willing to participate themselves if the children were not going to be involved. The general objection was that the children had been through enough testing and that this had not always been a pleasant experience for them. As a result only subjective academic reports of teachers could be used.

Analysis of the teachers' reports shows that the children in group B improved more academically than the children in group A, the counselling group. This is in agreement with the improved behaviour rating results of the same children. The teaching method was more beneficial for children's overall improvement, academically and behaviourally, than the counselling method. The academic improvement of group A participants must be described as a to-be-expected improvement as a result of remedial teaching. It is however important to note that the academic standards of none of the children in the treatment groups dropped. If the control group results are normal for the average group of learning-disabled children who receive remedial teaching but no other form of intervention, 20% of the children in the treatment groups could have been expected to drop as well. It may be concluded that learning-disabled children whose parents participate in some form of group treatment have less chance of dropping their academic standards than children of parents who do not participate in any treatment procedure.

9.5 GROUP LEADERS

It might be argued that allowing different group leaders to facilitate the two treatment procedures is an uncontrolled variable influencing the results. The change in attitude and/or behaviour might be explained as being dependent on a particular leader's personality and not on the treatment procedure. The present investigator was fully aware of this complication, but it was argued that the

different treatment methods demanded different types of personalities as group leaders. In fact the personality of the group leader was seen as part of the type of treatment administered, as explained in chapter 5. For group A, the counselling group, it was seen as important that the group facilitator had a learning-disabled child herself, so that she could empathize fully with the problems of the participants; as one group member reported: the leader "by relating her own problems with her children made one feel so much better". The most important characteristic for the group leader in group B, the teaching group, was that she had sound knowledge of what a learning-disability is and that she could relate this knowledge to the participants.

It is important however that the participants in both groups experienced their group leader as satisfactory. To estimate this participants were asked to rate the competence of their leader on a 1% (hopeless) to a 100% (outstanding) scale. The leader of group A was rated as 88% competent, the leader of group B as 90% competent. Both are very high ratings, indicating that the leaders were seen by the participants as equally capable of facilitating their group. One may conclude that the 'Halo' effect which may have occurred should be the same for both groups.

9.6 MOTHERS' SUBJECTIVE EVALUATION OF TREATMENT METHODS

In contrast to the lack of significant change in attitudes of mothers and behaviour of children for both experimental groups most mothers were very positive about the treatment procedures. Mothers were asked at the end of the fifth meeting to evaluate the treatment procedure, to write a report about it at home and bring it to the next meeting. All mothers did this. The following questions were suggested to help the mothers to focus, but they did not have to answer the questions rigidly: Was it a challenge, was it a positive experience, did you learn anything new, did you view your child's problems more clearly than before, do you think groups like this should be organised for all parents of learning-disabled children, have you any suggestions for a better approach? The mothers were fully aware that they were participating in a research. They were told that their remarks would form part of the evaluation of the whole programme and that it was important to be as objective and honest as possible.

The reports of mothers participating in group A and B were overwhelmingly positive. The only negative remarks that most mothers made were that the leaders should try to stick more to the problem concerned. One mother wrote: "I did feel constantly that Ms had a lot more to say and that when the discussion group departed from the subject of learning problems and entered the area of child-rearing, we should have been politely silenced. I do feel that is the power and duty of a leader!" Apparently the discussion sometimes became side tracked and it was difficult to focus on the problem again.

It is impossible to give a full account of the reports, but some of the more important points will be discussed and parts of the reports quoted.

The first aspect that came to the fore is that the mothers no longer denied that their child had a learning problem. One mother who left after the first meeting saying: "I don't really belong here, my child has not got such a problem" started her report with the sentence: "As the mother of a nine year old learning-disabled son" Another mother stated: "Yes I see the problem more clearly and from a far more sympathetic angle". And: "With this acceptance came a deeper empathy for my child and the positive challenge that I would find other methods to help him achieve his potential." "I previously consoled myself that when we had overcome this reading problem, all would be well. I now realize that it may well be an ongoing problem and that he may never learn to read as I would like him to but that with the use of other audio-visual aids he will LEARN." Another mother wrote: "I found it quite a challenge to be completely honest with myself."

The following quotations relate to the fulfilment of needs parents of learning-disabled children were assumed to have:

"What a blessing to be able to sit down with a bunch of ordinary people with the same problem as you and talk about the whole thing where it is the accepted norm and you don't feel like someone with a freaked out problem The odd little bits of information of 'try this or do that' are all things that someone with the same problem has already tried or benefited by. It's not just the hit and miss and frustration of dealing with the whole thing by yourself. Sharing a load is always so much easier when you find the right place to do it." "One is too embarrassed to confide in a friend who has a star child, and who simply would not understand." Or as another mother put it: "These group discussions have had a

positive effect in that everyone was able to speak freely about their children's problems with others who were sympathetic as many were experiencing similar problems. This made me reconsider a few of my own attitudes towards my son." Mothers found it really consoling to talk to other people with the same problems, who understand, it made them feel less isolated. The feeling that one cannot explain the problems you face with anyone, not even your best friend, because they would not understand was expressed time and time again.

Relief of guilt is another emotion expressed by mothers. One mother wrote: "A big relief has been the recognition that this anxiety and lack of confidence is due to his own frustration and is not MY fault."

The mothers in group B expressed that they found the lectures and films very helpful. "Films were interesting . . . they helped to identify particular problems of one's own child." And "practical advice about methods of teaching, teaching aids like tapes were very useful."

In answer to the question 'should more groups like this one be organised', mothers wrote: "Yes, the sooner the better." "These meetings are a must and should definitely not be missed." "Definitely, this type of thing is invaluable to parents . . . I feel the more one can learn about a problem the easier it is to face and therefore deal with it." "The need for this type of group chatting is a very real thing. I feel that it fills the gap between teachers, clinics and the actual families involved . . . This sort of discussion method would help many mothers, parents, children and in the long run the clinics and teachers too."

One mother ended her report: "I really looked forward to Wednesdays."

Another summed up: "I would not have missed these discussions for anything as I now view the whole situation quite differently and now try to put myself in his place instead of criticizing and getting us both more and more frustrated and unhappy. Our relationship seems to be normalizing now." And a last quote: "I shall definitely be looking for the cause of an upset while trying to sort it out".

It was found that the longer the parents had been aware of the problem the less need they showed for the discussion groups. These parents however stated that, had they had this sort of help before, they would have made fewer mistakes; a lot of hardship and misunderstanding could have been prevented. They were however pleased to have been part of the procedures and were very helpful

towards other parents.

Some of the parents decided to contact their schools and tell the remedial teachers that they would like to be 'contact' parents and support in turn other parents of learning-disabled children. The parents participating in group A decided to come together regularly, on a monthly basis during the next year.

The goals of the treatment as described in chapter 6 seemed to have been met to a great extent by both groups. Mothers did feel relief in sharing their emotions and problems with others. They did have the opportunity to accept their child's dysfunction more fully. Discussions did help them to cope with their day to day difficulties and they did gain greater knowledge about their child's development. The fact that little or no attitude change could be measured does not mean that there is no need for a parent centred treatment intervention for parents of learning-disabled children.

Chapter 10

CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

10.1 EVALUATION OF THE PRESENT RESEARCH

In order to give an evaluation of the present research procedures it is important to look at the assumptions that were made at the beginning of the investigation: are the questions that were asked being answered? It was asked: Is there a difference between attitudes of parents with learning-disabled children and parents who do not have a child with a handicap. And is there a difference in behaviour between learning-disabled and normal achieving children? Is there a need for treatment of parents of learning-disabled children, are counselling groups and/or treatment groups as described in this research adequate means to fulfil this need? Is it possible to change attitudes of parents, to improve behaviour of learning-disabled children and to improve the academic standard of learning-disabled children through group intervention for parents of the children?

A significant difference between attitudes of parents and a highly statistically significant difference in behaviour ratings of children by parents was found between the parents of learning-disabled children and parents of children who do not have a learning problem. These research findings strongly suggest that the learning-disabled child does have a behaviour problem, that educating a learning-disabled child is more problematic and more stressful than bringing up a child who does not have such a problem.

The results found in the second part of the investigation do indicate that parents do need special help in bring up their learning-disabled child and that group treatment may provide this help for parents.

The discussions which took place between mothers of learning-disabled children

during treatment showed that mothers of learning-disabled children do feel a need for assistance in dealing with their child. The mothers expressed the need for breaking through the feeling of isolation which they experienced as the result of the problems; they expressed a great need for talking to other people who would understand their problem. Learning-disabled children do present more management problems than other children, mothers needed advice and support in dealing with the problems. Mothers also expressed that they needed help in coming to terms with the problem themselves. The diagnosis of the learning-disability often came as a surprise to the mothers. How do I view my child now, what does a learning-disability mean, what can I expect, I feel guilty, my attitude to my child is negative, what have I done wrong, can I do anything to help, were questions that mothers asked and needed an answer to.

The present investigator is aware that subjective reports have to be interpreted with care. Feelings about the success of the programme may have been exaggerated and, as Skuy (1980) explained, the impression parents communicated of improvement may be due to a "hello-goodbye" effect. The reports however were written in such detail and with such care, with such understanding of the positive as well as of the negative aspects of the treatment programme that it would be wrong to ignore them in the evaluation of the programme. Besides, the subjective reports are not entirely contradictory to the statistical results found on the attitude test of parents and the behaviour rating tests of the children.

A significant change in attitudes was found on the attitude scale measuring 'trust' for participants in group A, the counselling group. This indicates that group counselling treatment for parents of learning-disabled child does affect the attitude parents have towards their learning-disabled child. In addition a highly significant change in the behaviour rating by teachers of learning-disabled children in group B, the teaching group, was found. The child-centred group discussions of parents in group B did have a positive effect on the behaviour of the children. Treatment procedures used in group B probably also had a positive influence on the academic standards of the children in that group.

Considering the subjective reports as well as the objective results of the present investigation it may be said that group treatment for parents of learning-disabled children is a valuable approach for providing the help that parents of learning-disabled children need. It did not only help the mothers to come to terms

with their own feelings about the problem, mothers also learned to understand their child better which did have an influence on the children's behaviour.

These findings are consistent with Sameroff's (1975) theory in which he explained that although learning-disabilities may have a genetic or organic basis, positive caretaking conditions can serve to break the linkage between early trauma and later disorder. Sameroff stressed the importance of the transactions between the child and his caretaking environment. If the mother of the child, an important caretaker, is able to improve her interactions with her child, the child will react differently. In this study improved interactions of mothers led to improved behaviour of children. The more positive actions and reactions, transactions, that take place between mother and child may have far reaching results for the child's further academic, social and personal development.

10.2 POSSIBILITIES FOR FURTHER RESEARCH

The tentative, positive results found in this study lead to several possibilities for further research.

An interesting area for research would be to find out whether treatment programmes as described above will affect the child's self-concept. Stander (1977) pointed out that the personality of the child is so affected by the learning problem that the child should first be helped to improve his self-concept, even before remediation takes place. Parents who have worked through their own needs regarding the problem, and who understand the problem may be important agents in helping to improve the child's self-concept.

Similar treatment programmes could be organised for teachers of learning-disabled children. Teachers are the second most important caretakers of the children and play a very influential role in the children's life. Teachers, like parents, face particular management problems when they have a learning-disabled child in their class. To be able to express their needs and to discuss the problems they encounter with other teachers may be beneficial for both themselves and the children.

Another way of improving on the present study will be to conduct a longitudinal investigation. Time factors did not allow the present investigator to test the attitudes of parents and the behaviour of children some months after treatment stopped. Yet it is important to find out whether the attitude and behaviour change is consistent over time and whether attitude change on all the subscales can be measured some months after treatment. If attitudes change slowly the change may only become apparent some time after treatment has elapsed.

10.3 SUGGESTIONS FOR APPLICATION OF THE STUDY

From the feedback given by mothers who participated in the treatment groups it became clear that to organise groups, similar to the ones described above, will be helpful for parents of learning-disabled children. Taking the suggestions of mothers for improvement on the present treatment procedures into consideration the programme could be organised as follows:

Treatment procedures based on counselling and teaching methods could be combined. Mothers in group A, the counselling group, expressed the need to gain more knowledge about what a learning-disability is, and to obtain more advice on how to handle certain practical situations. Mothers in group B, the teaching group, felt however that they had not had enough time to discuss their own particular problems, they needed more unstructured time than what was provided. Discussion groups should be organised on a weekly basis for eight weeks instead of six weeks. Each meeting should start with a half hour lecture or film about learning-disabilities, after which free discussion could take place.

Furthermore, more efforts should be made to persuade fathers to participate in the discussion groups, although there is no evidence that the absence of fathers made any difference to the results. Many investigators however, Gargiulo (1976), Kaslow (1978), Dembinski (1977), and Collins (1982), do explain the importance of the participation of both parents in treatment procedures. Fathers have also to accept the responsibility associated with a learning-disabled child. Arnold (1978) for example explained that fathers need to be drawn into more active management

of the child, especially when the child is a boy. Fathers frequently are the task orientated and achievement models for their children, which is particularly important for a learning-disabled child. Mothers expressed during the meetings that their husbands had not accepted that their child had a problem. Fathers often seem to blame the mothers for the problem. Mothers are seen by their husbands as overprotective, too emotional, and too 'pushy'. Lack of acceptance and involvement of fathers with the learning-disabled child may lead to marital stress. Kaslow (1978) explained that mothers may ally themselves with their learning-disabled child against the father, who may as a result escape into work and other activities. Yet it is important for parents to draw one line in the education of their children, this counts even more so for the education of a learning-disabled child. Collins (1982) explained that children with a learning-disability require special assistance which mothers cannot be expected to provide alone, they need help from others, in particular from fathers. One mother in the group suggested that the group facilitator should visit the individual families to explain to the fathers the importance of their participation. Participation of fathers in the discussion groups may make them more aware of the needs of mothers and the child and prevent unnecessary strain on parent-child and marital relationships.

To summarize: The results of the present investigation indicate that group treatment for parents of learning-disabled children does fill a gap in the remediation procedures of learning-disabled children. Mothers explained that it was helpful to discuss their problems with other mothers who face the same problems and that the treatment provided the opportunity to work through their own feelings and frustrations regarding their learning-disabled child.

The statistical results do not provide us with enough evidence to conclude that the attitude of parents changed adequately as a result of the treatment procedure, except for the results on the subscale measuring 'trust' for participants in group A, the counselling group. Teachers however rated the behaviour of children in group B, the teaching group, significantly more positive after treatment than before. In addition the children whose behaviour ratings had improved also improved their academic standards.

The positive results found suggest that the treatment procedures devised for the present study warrant further investigation.

APPENDIX I

LETTERS TO PARENTS/HEADMASTERS ETC

I.1 Letter to all parents with learning-disabled children

Dear parents,

As a parent of learning-disabled children I became aware of the special difficulties we as parents face at home with our children and I decided to study psychology to get to know more about the problem.

At the request of many parents who, like me, felt the need for guidance in bringing up our children, I am organising discussion groups for parents with children who have a learning problem.

The discussion groups will give us the opportunity to gain more understanding of the difficulties our children face at school and will make it possible to talk to other parents who face similar problems with their children. This may help us to deal more adequately with both internal family needs, such as disruptive behaviour of the child, and with external social pressures, such as prejudices of friends and neighbours.

The groups will meet once a week for six weeks, at a time which will be convenient to all, probably in the evening.

As the discussion groups will be part of the requirements for my master's degree in psychology, which I am currently doing through the University of Cape Town, you will be requested to fill in some questionnaires. You can however feel assured that the answers to your questionnaires as well as what will be discussed in the groups will be treated as strictly confidential. To assure you of the confidential nature of the programme I will quote you the conditions the Department of Education stipulated:

1. No pupil/school psychologist/head of the school clinic is under any obligation to co-operate in the research in any way.
2. No pupil, school psychologist, head of the clinic or school may be identifiable in any way. (Nor will the parents be identifiable.)
3. All arrangements in connection with your project must be undertaken by yourself. (This, of course, does refer to me, not to you as parents.)
4. The written permission of the parents/guardians concerned must be obtained prior to their children being required to take part in the research programme. (However the children will not participate in the discussion groups.)

I believe that this will be a worthwhile programme from which our children will benefit.

If you are willing to participate in this programme, please fill in the slip below, and return as soon as possible in the envelope provided. If you have any questions regarding the programme, please feel free to contact me, telephone 45-2955, preferably in the evening.

Yours sincerely,

Carly Vosters

Yes, I am interested in joining your discussion groups for parents of children who have a learning problem. I await further details from you.

Name : _____

Address : _____ Tcl. _____

1.2 Letter to the headmaster of the schools attended by learning-disabled children:

Dear Sir,

Re: Master's degree Psychological research regarding parental attitudes towards children with a learning-disability

I am writing a thesis for an academic master's degree in psychology at the University of Cape Town. My research is concerned with the negative influence which a learning-disabled child's social, emotional and behavioural problems have on parent-child relationships and in particular on the parent's attitude towards their child.

I hope to be able to help parents with learning-disabled children, through group counselling, to develop more facilitative, positive attitudes towards their child.

I have obtained the permission of the Cape Department of Education, to go ahead with my research. With the co-operation of the head of the school clinic, I have learned that some parents of children attending your school may be able to benefit from such a programme. These parents will be contacted by me. If they are willing to participate I would like your permission to do a short scholastic test with the children. I would also like to ask their teachers to fill in a short behaviour questionnaire, which should not take them more than ten minutes to complete.

I believe that this will be a worthwhile programme from which the children will benefit and bearing in mind that your teachers are very busy I would really appreciate your help in this matter.

Yours sincerely,

Carly Vosters

I.3 Letter to parents with non-learning-disabled children:

Dear Parents,

I am currently writing a thesis for a master's degree in psychology at the University of Cape Town and would like to request your help.

The requirements of this thesis are:

- Measuring the attitudes of parents of children with a learning-disability.
- Measuring the attitudes of parents, like yourself, who have children without a handicap.
- Rating the behaviour of these two groups of children.

I have obtained the permission of the Education Department and of the headmaster of the school your child is attending to approach you and to request your help in completing the enclosed questionnaires. Could you return them to me in the envelope provided?

Your replies will be strictly confidential; you don't have to fill in your name and address as this is of no importance for this research. I would however like you to state whether you are the father or the mother.

I hope you will be willing to co-operate because I believe that the results of this research will be beneficial to families with learning-disabled children.

Please feel free to contact me should you require more clarification, telephone 452955.

Yours sincerely,

Carly Vosters

I.4 Letter to control group parents with learning disabled children
(Initial measurement)

Dear parents,

Enclosed please find the questionnaires you so kindly agreed to complete.

May I request that, if possible, the father and the mother fill in these questionnaires independently and that you return them to me at your earliest convenience.

I should like to confirm again that your answers will be treated as private and confidential, and will be handled by myself only.

I sincerely hope that my research will prove to be useful and that the results will ultimately be of help to you and your child. I would also like to thank you for the good response and support I have received so far.

Yours sincerely,

Carly Vosters

I.5 Letter to control parents with learning disabled children
(Final measurement)

Dear Parents,

My research is nearing its completion and I should like to thank you for your co-operation and good response to my first questionnaires.

Enclosed please find a last set of questionnaires (which are the same as the first), and once again may I ask you to complete these and return them to me in the enclosed, paid envelope.

I appreciate that it is a tedious and time consuming task, but without this second set of answers my research will not be complete and will not be accepted by the authorities at the university.

Assuming that you would like to know the outcome of this research I will send you a summary of the results as soon as they are available at the beginning of next year.

Yours sincerely,

Carly Vosters

NAME:

DATE:

Please mark the appropriate block with a ✓

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
1 Parents have to sacrifice everything for their children.					
2 Parents should help children feel they belong and are needed.					
3 Taking care of a small baby is something that no woman should be expected to do at all by herself.					
4 When you come right down to it, a child is either good or bad and there is not much you can do about it.					
5 The earlier a child is weaned from its emotional ties to its parents the better it will handle its own problems.					
6 Most of the time giving advice to children is a waste of time because they don't take it or don't need it.					
7 It is hard to let children go and visit people because they might misbehave when parents are not around.					
8 Fewer people are doing a good job of childrearing now than 30 years ago.					
9 With all a child hears at school and from friends, there is little a parent can do to influence him.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
10 If a little girl is a tomboy, her mother should try to get her interested in dolls and playing house.					
11 A child has a right to his own point of view and ought to be allowed to express it, just as parents express theirs.					
12 If children are quiet for a while you should immediately find out why.					
13 It's a rare parent who can be even-tempered with the children all day.					
14 Psychologists now know that what a child is born with determines the type of person he becomes.					
15 One reason that it is sad to see children grow up is because they need you more when they are babies.					
16 The trouble with trying to understand children's problems is that they usually just make up a lot of stories to keep you interested.					
17 A mother has a right to know everything going on in her child's life because her child is part of her.					
18 Most parents are not sure what is the best way to bring up children.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
19 A child may learn to be a juvenile delinquent from playing games like cops and robbers and war too much.					
20 There is no reason why a child should not learn to keep his clothes clean very early in life.					
21 If a parent sees that the child is right and the parent is wrong, they should admit it and try to do something about it.					
22 A child should be allowed to try out what it can do at times without the parents watching.					
23 It's hard to know what to do when a child is afraid of something that won't hurt him.					
24 Almost all children are just the same at birth; it's what happens to them afterwards that is important.					
25 Playing with a baby too much should be avoided since it excites them and they won't sleep.					
26 Children shouldn't be asked to do all the compromising without a chance to express their side of things.					
27 Parents should make it their business to know everything their children are thinking.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
28 Raising children isn't as hard as most parents let on.					
29 There are many things that influence a young child that parents don't understand and can't do anything about.					
30 A child who wants too much affection may become a "softie" if it is given to him.					
31 Family life would be happier if parents made children feel they were free to say what they think about anything.					
32 Children must be told exactly what to do and how to do it or they will make mistakes.					
33 Parents sacrifice most of their fun for their children.					
34 Many times parents are punished for their own sins through the bad behaviour of their children.					
35 If you put too many restrictions on a child, you will stunt his personality.					
36 Most children's fears are so unreasonable it only makes things worse to let the child talk about them.					
37 It is hard to know when to let boys and girls play together when they can't be seen.					
38 I feel I am faced with more problems than most parents.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
39 Most of the bad traits children have (like nervousness or bad temper) are inherited.					
40 A child who misbehaves should be made to feel guilty and ashamed of himself.					
41 Family conferences which include the children don't usually accomplish much.					
42 It's a parent's duty to make sure he knows a child's innermost thoughts.					
43 It is hard to know whether to be playful rather than dignified with children.					
44 A child that comes from bad stock doesn't have much chance of amounting to anything.					
45 A child should be weaned away from the bottle or breast as soon as possible.					
46 There's a lot of truth in the saying "children should be seen and not heard".					
47 If rules are not closely enforced children will misbehave and get into trouble.					
48 Children don't realize that it mainly takes suffering to be a good parent.					
49 Some children are so naturally headstrong that a parent cannot really do much about them.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
50 One thing I cannot stand is a child's constantly wanting to be held.					
51 A child's ideas should be seriously considered in making family decisions.					
52 More parents should make it their job to know everything their child is doing.					
53 Few parents have to face the problems I find with my children.					
54 Why children behave the way they do is too much for anyone to figure out.					
55 When a boy is cowardly, he should be forced to try things he is afraid of.					
56 If you let children talk about their troubles they end up complaining even more.					
57 An alert parent should try to learn all his child's thoughts.					
58 It's hard to know when to make a rule and stick by it.					
59 Not even psychologists understand exactly why children act the way they do.					
60 Children should be toilet-trained at the earliest possible time.					
61 A child should always accept the decision of his parents.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
62 Children have a right to activities which do not include their parents.					
63 A parent has to suffer much and say little.					
64 If a child is born bad there's nothing you can do about it.					
65 There's no acceptable excuse for a child hitting another child.					
66 Children should have a share in making family decisions just as the grownups do.					
67 Children who are not watched will get into trouble.					
68 It's hard to know what healthy sex ideas are.					
69 A child is destined to be a certain kind of person no matter what the parents do.					
70 It's a parent's right to refuse to put up with a child's annoyances.					
71 Talking with a child about his fears most often makes the fear look more important than it is.					

NO. CONTENT	STRONGLY AGREE	AGREE	UN-DECIDED	DISAGREE	STRONGLY DISAGREE
72 Children have no right to keep anything from their parents.					
73 Raising children is a nerve-racking job.					
74 Some children are just naturally bad.					
75 A child should be taught to avoid fighting no matter what happens.					
76 Children don't try to understand their parents.					
77 A child should never keep a secret from its parents.					

APPENDIX III

SCALES OF THE HEREFORD
PARENT ATTITUDE SURVEY

Parent attitude survey scale No.1 : Confidence

Item number	Item content	Item direction
1	Parents have to sacrifice everything for their children.	-
3	Taking care of a small baby is something that no woman should be expected to do all by herself.	-
8	Fewer people are doing a good job of child-rearing now than 30 years ago.	-
13	It's a rare parent who can be even-tempered with the children all day.	-
18	Most parents aren't sure what is the best way to bring up children.	-
23	It's hard to know what to do when a child is afraid of something that won't hurt him.	-
28	Raising children isn't as hard as most parents let on.	+
33	Parents sacrifice most of their fun for their children.	-
38	I feel I am faced with more problems than most parents.	-
43	It's hard to know whether to be playful rather than dignified with children.	-
48	Children don't realize that it mainly takes suffering to be a good parent.	-
53	Few parents have to face the problems I find with my children.	-
58	It's hard to know when to make a rule and stick by it.	-
63	A parent has to suffer much and say little.	-
68	It's hard to know what healthy sex ideas are.	-
73	Raising children is a nerve-wracking job.	-

Parent attitude survey scale No.2 : Confidence

<u>Item number</u>	<u>Item content</u>	<u>Item direction</u>
4	When you come right down to it, a child is either good or bad and there's not much you can do about it.	-
9	With all a child hears at school and from friends, there's little a parent can do to influence him.	-
14	Psychologists now know that what a child is born with determines the kind of person he becomes.	-
19	A child may learn to be a juvenile delinquent from playing games like cops and robbers and war too much.	-
24	Most all children are just the same at birth; it's what happens to them afterwards that is important.	+
29	There are many things that influence a young child that parents don't understand and can't do anything about.	-
34	Many times parents are punished for their own sins through the bad behavior of their children.	-
39	Most of the bad traits children have (like nervousness or bad temper) are inherited.	-
44	A child that comes from bad stock doesn't have much chance of amounting to anything.	-
49	Some children are so naturally headstrong that a parent can't really do much about them.	-
54	Why children behave the way they do is too much for anyone to figure out.	-
59	Not even psychologists understand exactly why children act the way they do.	-
64	If a child is born bad there's not much you can do about it.	-
69	A child is destined to be a certain kind of person no matter what the parents do.	-
74	Some children are just naturally bad.	-

 Parent attitude survey scale No.3 : Acceptance

Item number	Item content	Item direction
2	Parents should help children feel they belong and are needed.	+
5	The earlier a child is weaned from its emotional ties to its parents the better it will handle its own problems.	-
10	If a little girl is a tomboy, her mother should try to get her interested in dolls and playing house.	-
15	One reason that it is sad to see children grow up is because they need you more when they are babies.	-
20	There is no reason why a child should not learn to keep his clothes clean very early in life.	-
25	Playing with a baby too much should be avoided since it excites them and they won't sleep.	-
30	A child who wants too much affection may become a "softie" if it is given to him.	-
35	If you put too many restrictions on a child, you will stunt his personality.	+
40	A child who misbehaves should be made to feel guilty and ashamed of himself.	-
45	A child should be weaned away from the bottle or breast as soon as possible.	-
50	One thing I cannot stand is a child's constantly wanting to be held.	-
55	When a boy is cowardly, he should be forced to try things he is afraid of.	-
60	Children should be toilet-trained at the earliest possible time.	-
65	There's no acceptable excuse for a child hitting another child.	-
70	It's a parent's right to refuse to put up with a child's annoyances.	-
75	A child should be taught to avoid fighting no matter what happens.	-

Parent attitude survey scale No.4 : Understanding

Item number	Item content	Item direction
6	Most of the time giving advice to children is a waste of time because they either don't take it or don't need it.	-
11	A child has a right to his own point of view and ought to be allowed to express it, just as parents express theirs.	+
16	The trouble with trying to understand children's problems is they usually just make up a lot of stories to keep you interested.	-
21	If a parent sees that a child is right and the parent is wrong, they should admit it and try to do something about it.	+
26	Children shouldn't be asked to do all the compromising without a chance to express their side of things.	+
31	Family life would be happier if parents made children feel they were free to say what they think about anything.	+
36	Most children's fears are so unreasonable it only makes things worse to let the child talk about them.	-
41	Family conferences which include the children don't usually accomplish much.	-
46	There's a lot of truth in the saying, "Children should be seen and not heard."	-
51	A child's ideas should be seriously considered in making family decisions.	+
56	If you let children talk about their troubles they end up complaining even more.	-
61	A child should always accept the decision of his parents.	-
66	Children should have a share in making family decisions just as the grown-ups do.	+
71	Talking with a child about his fears most often makes the fear look more important than it is.	-
76	Children don't try to understand their parents.	-

Parent attitude survey scale No.5 : Trust

<u>Item number</u>	<u>Item content</u>	<u>Item direction</u>
7	It is hard to let children go and visit people because they might misbehave when parents aren't around.	-
12	If children are quiet for a while you should immediately find out why.	-
17	A mother has a right to know everything going on in her child's life because her child is a part of her.	-
22	A child should be allowed to try out what it can do at times without the parents watching.	+
27	Parents should make it their business to know everything their children are thinking.	-
32	Children must be told exactly what to do and how to do it or they will make mistakes.	-
37	It is hard to know when to let boys and girls play together when they can't be seen.	-
42	It's a parent's duty to make sure he knows a child's innermost thoughts.	-
47	If rules are not closely enforced children will misbehave and get into trouble.	-
52	More parents should make it their job to know everything their child is doing.	-
57	An alert parent should try to learn all his child's thoughts.	-
62	Children have a right to activities which do not include their parents.	+
67	Children who are not watched will get in trouble.	-
72	Children have no right to keep anything from their parents.	-

APPENDIX IV

PARENT-TEACHER BEHAVIOR RATING SCALE

Name of child:

YOUR RATING SHOULD BE BASED ON THE CHILD'S PRESENT BEHAVIOR AND FIRST IMPRESSIONS ARE DESIRABLE. THE RANGE OF SCORES IS FROM ONE TO FIVE. READ THE STEM SENTENCE AND GIVE IT ONE OF THESE SCORES. PLEASE ANSWER EVERY ITEM EVEN IF YOU NEED TO GUESS.

Very Often	Often	Occasionally	Seldom	Very Seldom
5	4	3	2	1

COMPARED TO THE AVERAGE CHILD, HOW OFTEN DOES THIS CHILD :

- _____ 1. sit still when he needs to wait his turn?
- _____ 2. answer quickly and correctly when called on or questioned?
- _____ 3. come to you for help in doing things when necessary?
- _____ 4. stick to any activity he selected for himself for fifteen minutes or more?
- _____ 5. stick to any activity without jumping from one thing to another?
- _____ 6. refrain from pulling, pushing, or grabbing other children or adults?
- _____ 7. read or look at picture books by himself?
- _____ 8. behave well when he is with others in a group?
- _____ 9. complete his work assignments?
- _____ 10. respond in a friendly fashion to other children and adults?
- _____ 11. maintain attention when the teacher and/or parent is explaining something to him?
- _____ 12. stick to the subject while talking?
- _____ 13. refrain from bothering other people who are obviously busy?
- _____ 14. watch an interesting classroom movie or television show with good attention?

- _____ 15. stay in his seat during lunch, dinner, or classroom movie?
- _____ 16. show continuous improvements in his reading, writing, and arithmetic skills?
- _____ 17. seek out other children to play with?
- _____ 18. follows the point of a conversation?
- _____ 19. tolerate noises (classroom or playground noises) or movement?
- _____ 20. refrain from hitting or hurting other children?
- _____ 21. learn quickly when interested in the activity?
- _____ 22. refrain from fidgeting or moving around unnecessarily?
- _____ 23. stick to something when it is somewhat difficult or frustrating?
- _____ 24. play with or relate to adults in an appropriate manner?
- _____ 25. look alert when you are having a conversation with him?
- _____ 26. continue his work or task when being annoyed by others?
- _____ 27. refrain from disrupting others by making noises and faces?
- _____ 28. want to learn how to make things or do things?
- _____ 29. exhibit good control over his body movements?
- _____ 30. understands what he hears or reads?
- _____ 31. describe interesting things that have happened to him?
- _____ 32. give a relevant answer to a question?
- _____ 33. stick to his goal or intention to do something?
- _____ 34. refrain from whining, crying, or complaining?
- _____ 35. make things, color or write letters on his own without being asked to do so?

PARENT-TEACHER BEHAVIOR RATING SCALE SCORING SHEET

Item No. Raw Score

Activity

1 _____
 8 _____
 15 _____
 22 _____
 29 _____

Total _____

Achievement

2 _____
 9 _____
 16 _____
 23 _____
 30 _____

Total _____

Sociability

3 _____
 10 _____
 17 _____
 24 _____
 31 _____

Attention

4 _____
 11 _____
 18 _____
 25 _____
 32 _____

Total _____

Item No. Raw Score

Distractibility

5 _____
 12 _____
 19 _____
 26 _____
 33 _____

Total _____

Disruptability

6 _____
 13 _____
 20 _____
 27 _____
 34 _____

Total _____

Need-Achievement

7 _____
 14 _____
 21 _____
 28 _____
 35 _____

Total Score for Scale _____

Name of Child _____

Date _____

Age _____ Grade _____

Filled out by Parent () Teacher ()

APPENDIX V

**ANOVA TABLES FOR PARENTS' ATTITUDE SCORES, AND
PARENTS' AND TEACHERS' BEHAVIOUR SCORES ON
WHICH NO SIGNIFICANT CHANGE WAS FOUND**

I. ANOVA mothers' Attitude Survey subscales and total scale

Scale	Source	Sum of squares	DF	Mean square	F	P
Understanding	Between columns	28.84	2	14.42	.49	.62
	Error	793.09	27	29.37		
	Between rows	3.15	1	3.15	.63	.44
	Interaction	8.63	2	4.32	.86	.43
	Error	136.10	27	5.04		
Confidence	Between columns	129.98	2	64.99	1.55	.23
	Error	1133.70	27	41.98		
	Between rows	1.39	1	1.39	.18	.67
	Interaction	.14	2	.07	.01	.99
	Error	213.00	27	7.88		
Causation	Between columns	5.10	2	2.55	.08	.92
	Error	875.23	27	32.41		
	Between rows	6.54	1	6.54	1.22	.27
	Interaction	11.43	2	5.71	1.06	.35
	Error	145.16	27	5.37		
Acceptance	Between columns	16.23	2	8.11	.21	.80
	Error	1020.49	27	37.79		
	Between rows	2.50	1	2.50	.46	.50
	Interaction	21.05	2	10.52	1.92	.16
	Error	147.68	27	5.46		
Total	Between columns	1.16	2	.58	.00	.99
	Error	13319.76	27	493.32		
	Between rows	124	1	124	3.08	.09
	Interaction	109.76	2	54.88	1.36	.27
	Error	1088.16	27	40.30		

II. ANOVA for Behaviour rating scale by parents of their learning-disabled child

Scale	Source	Sum of squares	DF	Mean square	F	P
Activity	Between columns	50.15	2	25.07	1.27	.29
	Error	532.45	27	19.72		
	Between rows	4.94	1	4.94	2.28	.14
	Interaction	4.94	2	2.47	1.14	.33
	Error	58.65	27	2.17		
Achievement	Between columns	21.01	2	10.50	.55	.58
	Error	512.72	27	18.98		
	Between rows	.37	1	.37	.17	.68
	Interaction	2.90	2	1.45	.67	.52
	Error	58.82	27	2.17		
Sociability	Between columns	.57	2	.28	.03	.96
	Error	251.90	27	9.32		
	Between rows	4.99	1	4.99	1.69	.20
	Interaction	15.02	2	7.51	2.54	.09
	Error	79.72	27	2.95		
Attention	Between columns	5.66	2	2.83	.10	.90
	Error	741.81	27	27.47		
	Between rows	1.71	1	1.71	.54	.46
	Interaction	10.89	2	5.44	1.73	.19
	Error	85.25	27	3.15		
Distractibility	Between columns	58.99	2	29.49	1.93	.16
	Error	411.94	27	15.25		
	Between rows	15.02	1	15.02	3.49	.07
	Interaction	20.76	2	10.38	2.41	.10
	Error	116.16	27	4.30		
Disruptability	Between columns	36.56	2	18.28	.96	.39
	Error	515.18	27	19.08		
	Between rows	.72	1	.72	.17	.68
	Interaction	10.95	2	5.47	1.30	.29
	Error	114.12	27	4.22		
Need-achievement	Between columns	26.18	2	13.09	.56	.57
	Error	628.16	27	23.26		
	Between rows	6.35	1	6.35	1.92	.17
	Interaction	2.98	2	1.49	.45	.64
	Error	89.50	27	3.31		
Total	Between columns	921.78	2	460.89	.76	.47
	Error	16406.81	27	607.65		
	Between rows	142.19	1	142.19	2.53	.12
	Interactions	142.54	2	71.27	1.27	.29
	Error	1517.39	27	56.19		

III. ANACOVA for Attitude scale of mothers

Scale	Source	Sum of squares	DF	Mean square	F	P	Regression coefficient
Understanding	Betw. col.	30.58	2	15.29	.50	.61	-.41
	1st covar.	1.77					
	Error	791.31					
Confidence	Betw. col.	102.12	2	51.06	1.17	.32	-.21
	1st covar.	.48	1	.48	.01	.91	
	Error	1133.21	26	43.58			
Causation	Betw. col.	1.55	2	.77	.02	.97	2.46
	1st covar.	63.19	1	63.19	2.02	.16	
	Error	812.03	26	31.23			
Acceptance	Betw. col.	24.47	2	12.23	.32	.73	-1.19
	1st covar.	14.95	1	14.95	.39	.53	
	Error	1005.54	26	38.67			
Total	Betw. col.	39.85	2	19.92	.04	.96	-5.44
	1st covar.	309.36	1	309.36	.62	.43	
	Error	13010.40	26	500.40			

IV. ANACOVA for Behaviour ratings by mothers of their learning-disabled child

Scale	Source	Sum of squares	DF	Mean square	F	P	Regression coefficient
Activity	Betw. col.	23.33	2	11.66	.59	.56	
	1st covar.	17.38	1	17.38	.88	.35	-1.29
	Error	515.06	26	19.81			
Achievement	Betw. col.	8.45	2	4.22	.22	.80	
	1st covar.	15.49	1	15.49	.81	.37	-1.21
	Error	497.22	26	19.12			
Sociability	Betw. col.	.47	2	.23	.02	.97	
	1st covar.	.03	1	.03	.00	.95	.056
	Error	251.87	26	9.68			
Attention	Betw. col.	7.88	2	3.94	.15	.86	
	1st covar.	45.30	1	45.30	1.69	.20	-2.08
	Error	696.51	26	26.78			
Distractibility	Betw. col.	33.56	2	16.78	1.14	.33	
	1st covar.	30.73	1	30.73	2.10	.15	-1.71
	Error	381.21	26	14.66			
Disruptability	Betw. col.	29.47	2	14.73	.74	.48	
	1st covar.	.07	1	.07	.00	.95	-.08
	Error	514.11	26	19.81			
Need-achievement	Betw. col.	14.88	2	7.44	.31	.73	
	1st covar.	4.04	1	4.04	.17	.68	-.62
	Error	624.12	26	24.00			
Total	Betw. col.	388.25	2	194.12	.32	.73	
	1st covar.	505.14	1	505.14	.83	.37	-6.95
	Error	15901.66	26	611.60			

V. ANOVA for the Behaviour ratings by teachers of the learning-disabled children

Scale	Source	Sum of squares	DF	Mean square	F	P
Disruptability	Between columns	96.94	2	48.47	.46	.63
	Error	2302.95	22	104.67		
	Between rows	16.93	5	3.38	1.36	.24
	Interaction	36.13	10	3.61	1.45	.16
	Error	274.12	110	2.49		

VI. ANACOVA for the Behaviour ratings by Teachers of the learning-disabled children

Scale	Source	Sum of squares	DF	Mean square	F	P	Regression coefficient
Achievement	Betw. col.	105.88	2	52.94	.99	.38	
	1st covar.	88.50	1	88.50	1.65	.21	-1.70
	Error	1125.43	21	53.59			
Sociability	Betw. col.	18	2	9	.18	.83	
	1st covar.	94.16	1	94.16	1.85	.18	-1.75
	Error	1066.15	21	50.76			
Attention	Betw. col.	32.39	2	16.19	.32	.73	
	1st covar.	204.37	1	204.37	3.98	.05	-2.58
	Error	1078.28	21	51.34			
Distractibility	Betw. col.	22.68	2	11.34	.17	.84	
	1st covar.	265.50	1	265.50	3.97	.05	-2.95
	Error	1403.99	21	66.85			
Disruptability	Betw. col.	46.24	2	23.12	.25	.78	
	1st covar.	337.46	1	337.46	3.61	.07	-3.32
	Error	1965.49	21	93.59			
Need-achievement	Betw. col.	155.45	2	77.72	.98	.39	
	1st covar.	104.24	1	104.24	1.31	.26	-1.84
	Error	1668.30	21	79.44			
Total	Betw. col.	2996.53	2	1498.26	.56	.57	
	1st covar.	10108.22	1	10108.22	3.78	.06	-18.21
	Error	56210.76	21	2676.70			

VII. Difference between scores of mothers and teachers

	Mean	sd	df	Hotelling t value	P
Before treatment	3.61	25.67	25	.72	.47
After treatment	-2.16	19.45	24	-.56	.58

APPENDIX VI

DISCUSSION OF PROBLEMS

The following brief description of problems discussed during the group meetings are presented as examples of the issues which arose.

Group A, the counselling group:

It was difficult at first for the mothers to express their real feelings about their child's problem. It was only during the third meeting that the mothers stopped talking about the facts of the problem and expressed their feelings and frustrations. By this time they had got to know each other, felt more at home and trusted each other enough to be more open about their problems, they no longer deviated from the problem discussed, communication became easier and mothers were supportive of each other.

One of the first issues raised was 'failing', a relatively safe issue to discuss. Some mothers already knew that their child had to stay back in the same standard for another year, in other words that their child was going to fail. The mothers themselves had no problem accepting this, but were worried about the way their children would accept it. Should one play it down as a parent, not use the word 'fail', but talk around it? Mothers who had had the experience of a child failing felt that one must be realistic about it and actually tell the child that he or she was going to fail. To avoid the word may do more harm than good, as the child will hear the word from its peers. The parents should rather use the word 'fail' and give an understanding explanation than avoid it. It was further said that after the first couple of difficult days the 'failed' child usually settles well in its new class situation:

Another issue of discussion was the etiology of the learning problem. The mothers were very keen to find a cause for their child's problem, is it hereditary, or the result of a birth trauma? The question that worried the mothers most was: could I have prevented it? Some mothers blamed the use of induction or forceps

during labour and would not allow this again. But it became clear during the discussion that many of the fathers had experienced problems with formal learning at school. Further discussion revealed that most of the fathers (eight out of ten) were running their own business and were successful at it. Despite the lack of formal education the fathers were enterprising, hard working people. The realisation that the fathers of the children may have had a learning-disability as well, yet achieve, encouraged the mothers to be more positive about their children's future.

The possibility of the fathers having a learning problem themselves was related to their lack of interest in the child's problem. The mothers explained that the fathers did not want to recognise that there is a problem nor accept it. Mothers felt that the upbringing and the homework was left completely to them, something they experienced as an extra burden on their shoulders. Grandparents, particularly paternal grandparents, reacted in the same way as the fathers. They see the child as beautiful, clever, cute, maybe boisterous, but as a real boy with whom nothing is wrong. It was discussed that this lack of acknowledgment may be the result of fathers never having accepted their own problem and is probably aggravated by the 'hiddenness' of the problem. Nevertheless mothers felt blamed by their husbands and parents-in-law for the problem. They were told that they were fussy, over worried, over protective etc. This blame reinforced their feelings of guilt and made them worry more as they had nobody with whom they could share the problem. Related to the problem of denial is the fact that people who do not understand the problem expect too much of the child. For example the father may send the child on an errand which the child cannot yet handle, and which will lead to yet another failure experience for the child.

One of the major problems discussed was the behaviour problem. The children were said to be aggressive, to have temper tantrums, to break things, to tease younger siblings to the point of being vindictive, to be excessively jealous, etc. The mothers expressed that they could not understand this behaviour. They wondered whether it was manipulative, or directed at frustrating and irritating the mothers. They also could not understand why their child's behaviour upsets them so much that at times they have felt desperate. Is it because boys should not cry, or are we as mothers too emotionally involved with the child? Why the upset when other people point out the child's misbehaviour? Mothers reported having been so angry with their child, already as a baby, that they had reached the point

of hating it. They could understand how a parent can resort to child battering. They admitted to experiencing a love-hate relationship with their child. The mothers also expressed bitterness about shaken marital relationships which they experienced as a result of the child's problems. For example fathers found it difficult to accept that mothers have had to spend an excessive amount of time with the child who had sucking problems or cried day and night.

The question was: what does one do when one's child behaves so badly and unreasonably? Physical punishment and 'time out' had been tried as a means of regulating the behaviour but was not seen as an ideal way of handling the problem. Mothers were asked to look for a reason for their child's behaviour, why is he frustrated? To look at the day the child has had, has he had frustrating experiences at school, has he failed another test, was he teased by his peers, etc? Mothers were then helped to accept that it is alright for their child to be cross and to express anger, something most mothers experienced as being difficult. It was further suggested that mothers can help their children to canalize the anger outburst in more positive ways, and to prevent the frustration in the child building up too much. One suggestion was to let the child write down what he feels like doing when he is cross and to select one or two less harmful actions which he will be allowed to do next time he loses his temper. This practice seems to diffuse the need for anger outbursts; when one is allowed to be angry, it does not seem so necessary.

Other mothers experienced the opposite behaviour with their children. Some children were not able to express their own feelings at all, not in positive or negative ways, the 'very good' children. The mothers experienced this as being worse. These 'good' children all suffered from psychosomatic illnesses, asthma or allergies. The mothers became aware that the stress the children experienced as a result of the learning-disability may increase the asthma attacks and aggravate the allergies. The mothers decided to talk more with their children about the events of the day in an effort to avoid tension building up. Another treatment method suggested was allowing their children to do yoga.

The conclusion was drawn that a learning-disability is not just an academic problem but also a behaviour and sometimes social problem. The learning-disability seems to influence all the child's life experiences. Mothers expressed that if they had had more knowledge and understanding of the problem at an

earlier age, their relationship with their children would have been more positive and some of the behavioural problems could have been prevented. The need for early diagnosis was stressed.

Medication. Many of the children in the counselling group were taking medication, Ritalin, for their learning-disability. Mothers expressed great worry about the long term effects of taking such medication. Will the child become dependent on the drug, and will their child ever be able to cope in high school when Ritalin can no longer be given. Yet most mothers saw the need for Ritalin and its advantages as the children seemed uneducable without medication.

Homework, one of the most stressful events for most mothers of learning-disabled children. The worry about the child's lack of academic achievement pushed mothers into doing many hours of homework a day with their children. Mothers asked: how long should a child take for homework, how much should parents be involved, how can one stimulate a child to read, to write, should they do work during holidays? Homework seems to create a lot of tension between a mother and her learning-disabled child. Mothers expressed that they became angry and frustrated with their child over homework, they said they were often at their 'wits end' and that they did not know any longer what to do. Children on the other hand had expressed to their mothers that they hated them for pressurising them so much, and that they blamed them for their failure. One mother said that she can now understand her child's feeling of hatred for her; after all, she said, I take the child to school, to an environment which is stressful for him, and when I fetch him I start pressurizing him again about homework. It was explained that normally a child of six to eight years likes to please and is keen to learn. If not, then there must be a reason for his not wanting to learn. The child may have developed from an early age a fear of failure and does not want to try any more. He may have been punished unfairly, he may have been told that he is lazy, or naughty, etc. Some children accept these labels for themselves and act accordingly. Mothers came to the conclusion that they have to distance themselves more from their child. It was suggested they should not work with their child when he has an 'off-day'. One mother had organised a teacher to do homework with her child every day. She shared with the group that her relationship with her child had become much more relaxed, her child seemed less frustrated at home and that there was time to play games and to be with the child without making any demands on him. If homework has to be done with the mother at

home, it was suggested that the mother may sit with the child until he has settled, but then leave him. Another suggestion was to create a quiet place for him to study as children are easily distracted; even a moving curtain seems to disturb some children.

Mothers themselves came to the conclusion at one of the last meetings that they were overprotective of their child and too emotionally involved with their child. They would not allow children to cross roads by themselves, ride their bicycles, some mothers did not even allow their children to take part in the school's sports day or outings. Others checked constantly what their child was doing. In order to overcome the problem of forgetting to take things to school one mother, who wanted her child to become more independent, had put a list in the kitchen reminding the child what to do that day and what to take to school. The child would check this every morning and the mother took no further responsibility for forgotten books, clothes, etc. Mothers were inclined to make the child's problems their own; if the child forgot a book, the mother felt that she had forgotten the book. Brutten (1973) found the same in his study. It was suggested that the children must be allowed to do as much as possible for themselves, the child must learn to find its own way, must learn how to handle problem situations. The mothers could help in setting realistic goals and expectations which may, at first, be below what can be expected from a child of his particular age.

The problems discussed seemed similar to the problems described in chapter 3 of the present study. They provide a valuable insight into the problems parents of learning-disabled children encounter at home.

Group B, the teaching group:

The issues discussed and questions raised in group B, the teaching group, were closely related to the lectures given or the films shown. The lectures and films dealt with the concept 'learning-disabilities'. The diagnosis of learning-disabilities, the etiology, the characteristics (academic, emotional, behavioural and social) and remedial tuition. Due to the nature of the lectures and films the discussions, which were very lively, focussed on the needs of the child, in particular its academic needs. Most of the questions were answered by the group leader but parents also shared their own experiences with each other and offered

solutions to problems.

The first lecture generated thoughts about the importance of a good teacher-child relationship and teacher-parent relationship. Some parents had very positive experiences with their children's teachers. Others however found the teachers less communicative. Not all teachers had recognised the problem immediately and had delayed referring the child to the school clinic. The news of the child needing to be tested had sometimes come as a great shock to parents who had not been aware of their children's lack of achievement. The need for better communication between pre-primary and primary school was stressed. Sometimes the pre-primary school teacher had been aware of a problem but had not passed it on to the primary school teacher, which had unnecessarily delayed the diagnosis.

An explanation was given of how a learning-disabled child experiences his world. For example a child with an auditory perceptual problem may experience his home language, English, as other people experience a foreign language of which they understand little. To illustrate this a Spanish tape was being played. This helped the parents to see the problem through their child's eyes. What is it like to have a learning problem? The different academic problems of the individual children were then discussed and practical advice given.

Doing homework with the children, as for group A, was seen as a real problem. A similar stress situation that developed over homework for mothers in group A had developed for mothers in group B. Some mothers felt that one should force one's child to do homework, to do music practice, etc. Others had tried to get their child interested in, for example, reading through exercises that were experienced as pleasant by the child. Much valuable remedial information was given by the group leader about how to help the child to learn to read, or spell, or how to do maths, and educational games to play were described. It was decided that the mothers should not do more than half an hour's homework with their child per day.

The lecture about emotional problems led to discussions about the 'hiddenness' of the problem which had resulted in unfair punishment, unfair labelling and deep frustrations in the child. It was pointed out that one should look for positive things in the child, even if this is difficult at times, to ignore misbehaviour if

possible and to emphasize the strong characteristics of the child. This would enhance the self-concept and help the child build up his confidence. The children, as for group A, were also seen as more dependent on parents and teachers than other children of the same age. Parents decided to allow their children to do more on their own.

Another issue raised was whether one should promise the child rewards for achievements. The general opinion was 'no', but if you do, set goals very realistically so that the child can achieve them. Parents found that children should rather learn to work for their own benefit, and not for an external reward, rather praise the child after he has achieved something.

Still another question was whether competition in the class situation is beneficial for a learning-disabled child, or would the child learn better when there is not too much pressure put on him, in a more relaxed environment? It was decided that a structured environment is important for the child and that competition may do more harm than good.

Parents related after the meetings that they were pleased with the way problems were handled. They found the discussions relevant to their own needs and the advice given very helpful.

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