THE EFFECT OF A HUMANISTIC EXPERIENTIAL THERAPEUTIC GROUP PARENT EDUCATION PROGRAM ON THE SELF-ACTUALIZATION LEVELS OF PARENTS OF PRESCHOOL HANDICAPPED CHILDREN

by

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CHAPTER I

INTRODUCTION

The birth or diagnosis of a handicapped child is usually an unexpected traumatic event in a family's life. It brings about stress, grief, chronic sorrow, and interpersonal role conflicts between family members. Parents are constantly faced with how they can promote the maximum potential of the handicapped child and still promote the self-actualization of the rest of the family members. As parents go through grief work and role changes, periods of disequilibrium are experienced which may necessitate the need for professional intervention.

While many studies (Kew, 1975; McMichael, 1971; Webster, 1977; Younghusband, 1971) offer descriptive data and recommendations for interventions with parents of handicapped children, few have attempted to assess the outcome of treatment programs (Hale, 1979; Rankin, 1957; Tavormina, 1975). In order to provide essential and appropriate service, studies to assess the effects of interventions with parents are basic and indispensible. The purpose of this study is to test the effects of a therapeutic/educative approach to therapeutic interventions with parents of preschool handicapped children.

Scope of the Problem

In January 1981, the Bureau of Education for Handicapped, Washington, D.C., reported approximately 3.8 million identified handicapped children (age 3-21) in the United States. Presently, more than ten per cent of Oregon's childhood population is diagnosed as having a handicapping condition (PL 94-142, Child Census, Oregon Department

and marital discord, these parents suffer from the emotional reactions of helplessness, guilt, depression, and loss of self-esteem (Baum, 1972; Curran and Swann, 1964; Hale, 1979; Kew, 1975; McMichael, 1971; Solnit and Stark, 1961; Tizard and Grad, 1961; Younghusband, 1971).

Webster (1979) has stressed that parents of children with handicaps have different strains imposed by having to provide for their children's special treatment or education and these stresses seem to generally be precipitants of family maladjustment. McMichael (1971) concluded in her research that the birth of a handicapped child increases parents risk for developing mental and emotional disorders.

Treatment Approaches for Parents. Professionals working with parents of handicapped children have outlined various approaches to help parents deal with the increased stresses that develop in a family with a handicapped child. Approaches include an educational experience (Adams, 1977), a psychotherapeutic process (Miller, 1977), and those that range between these poles (Hale, 1979; Tymchuck, 1975).

Treatment approaches seem to be following a trend away from seeing parents of handicapped children as a unitary phenomenon to be approached in one standard way. Beginning research indicates that an approach to parents that combines both dynamic and educational concepts will be better accepted and more effective (Blatt, 1957; Hale, 1979; Tavormina, 1976; Tymchuck, 1975).

Significance of the Study

In a family with a handicapped child, the ability of family members to function appropriately within the family unit and the ability of the family unit as a whole to remain functional are threatened.

Parenting of a handicapped child involves stress and the learning of new roles. These stresses place the family at risk and can result in poor development of family members with a resultant decrease in actualization for the parents.

Because nurses have direct contact with handicapped children and their parents in a variety of health care and community settings, they may be key professionals in identifying high-risk families. The mental health nurse specialist's educational background in nursing, with both a physiological and psychological emphasis, gives her a distinct advantage in understanding and treating the difficulties of these high-risk families.

Problem Statement

One approach to prevention of problems for handicapped children is the treatment of the child's parents who provide the environment in which the child grows and develops. As a result of studies (Kew, 1975; McMichael, 1971; Younghusband, 1971) data are now available that identify factors which may impede self-actualizing growth of parents of handicapped children. However, it is not known if therapeutic intervention combining both dynamic and behavioral concepts is the best method of responding to the needs of this group.

This study will investigate the effects of a humanistic experiential therapeutic group-parent education program on a group of parents of preschool handicapped children. The treatment program consists of experiential therapy, didactic instruction in child development and behavior management, and information sharing between the parents and professionals.

CHAPTER II

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

This chapter reports the viewpoints of authorities on subjects related to this study and summarizes the results of related research in the following areas: (1) characteristics of the self-actualizing person; (2) impact on parents of a handicapping condition in their child; (3) needs of parents and implication for intervention; (4) views of the family as a system. Additionally, the conceptual framework, research hypothesis, and definition of terms are presented.

Self-Actualizing Person

Schulman (1980) suggested that using a model of psychological functioning based upon healthy individuals is a better method to view individuals experiencing extreme life stresses than a model based upon troubled individuals. Belkin (1980) in his review of the major psychotherapeutic models points out that Abraham Maslow, and other humanistic psychologists, proposed studying the healthy individual and deriving a holistic view for the psychology of a person from that perspective.

Maslow (1954, 1962) developed the idea of the self-actualizing person — a person who is more fully functioning and lives a more enriched life than does the average person. The fundamental thesis of Maslow's theory includes the concepts of self-actualization, growth, and a hierarchy of basic needs. In the hierarchy of basic needs, lower level needs must be experienced before actualization can be experienced.

Maslow (1962) theorizes that man's universal needs exist in a hierarchial relationship to each other and that these needs are both physiological and psychological in nature. As stated by Maslow the hierarchy of needs is as follows:

1. physiological needs
2. safety and security needs
3. belongingness and love needs
4. esteem needs (both from self and from others)
5. growth needs

Beyond the growth needs, at the apex of the developmental process, the state of being known as self-actualization is found. Maslow further hypothesizes that the first four levels of needs are "deficiency" needs. Whereas those who are able to satisfy their basic needs are healthier and happier individuals, those frustrated in their attempts to satisfy these needs are apt to develop psychopathological symptoms (Shostrom, 1976).

Shostrom (1967) described a self-actualized person as a person who appreciated himself and his fellow man as a person or subject with unique potential i.e., an expressor of his actual self. He stated that "The actualizer's philosophy of life was marked by four characteristics: honesty, awareness, freedom and trust".

Shostrom's (1966) research found that the orientation of the self-actualizing person tended to lie between the extreme other and extreme inner-directed person. The self-actualized person tended to be less dependent or deficiency oriented than either extreme and tended also to have more of an autonomous self-supportive or "being" orientation. The

source of his actions was essentially inner-directed, but he was sensitive to people's approval, affection and good will. He was free, but this freedom did not result from rebellion or from pushing against others and fighting them. He transcended complete inner-directedness by critical assimilation and creative expression of his earlier principles of living. He discovered a mode of living which gave him confidence. It appeared as though he had liberated himself from rigid adherence to social pressure and expectations to which the non-self-actualized person conformed.

In other words, the self-actualizing person is one who is moving in the direction of reaching and achieving his highest potentials. The investigations by Maslow (1962) identified the following distinguishable personaltiy characteristics of self-actualizing people:

1. They are realistically oriented.
2. They are spontaneous in thinking, emotions, and behavior.
3. They accept themselves, other people, and the natural world for what they are.
4. They are problem-centered rather than self-centered in the sense of being able to devote attention to a task, or mission that seemed peculiarly cut out for them.
5. They have a need for privacy and even seek it out on occasion needing it for periods of intense concentration on subjects of interest to them.
6. They are autonomous, independent, and able to remain true to themselves in the face of rejection or unpopularity.
7. They have a continuous freshness of appreciation and capacity to stand in awe again and again of the basic goods of life; a sunset, a flower, a baby, a melody, a person.

8. They have frequent "mystic" or "oceanic" experiences, although not necessarily religious in character.

9. They feel a sense of identification with mankind as a whole in the sense of being concerned not only with the lot of their own immediate families, but with the welfare of the world as a whole.

10. Their intimate relationships with a few specically loved people tend to be profound and deeply emotional rather than superficial.

11. They have democratic character structures in the sense of judging people and being friendly not on the basis of race, status, religion, but rather on the basis of who other people are as individuals.

12. They have a highly developed sense of ethics and are inclined to choose their behavior with reference to its ethical implications.

13. They have unhostile senses of humor which they expressed in their capacity to make common foibles, pretensions and foolishness the subject of laughter, rather than sadism, smut, or hatred of authority.

14. They have a great fund of creativeness.

15. They resist total conformity to culture.

Impact on Parents of a Handicapping Condition in Their Child

The literature is replete with descriptive studies and statements of parents of handicapped children. Most of the literature is of an observational nature describing and listing stages in the parents progress in dealing with their feelings and the increased stresses.

The emotional reactions of a handicapped child's parents vary and change as the child develops. These families may suffer from a number of stresses related to changes in life styles such as poor health and economic strains. The most common emotional stress appears to come from parental feelings of guilt, anxiety, helplessness,

embarassment and loss of self-esteem (Kew, 1975; McMichael, 1971; Younghusband, 1971). These stresses are common in persons having deficits in level one to four of Maslow's needs hierarchy.

As Webster (1979) reminds us, no one teaches people by example or by cognitive input how to be parents of a handicapped child prior to the birth of that child. Only parenting of "normal" children is demonstrated to most of us by our parents. The result is pressure and stress on the parents of the handicapped child in his or her role as mother, father, wife, and husband.

A concern expressed by many parents, especially mothers, is how to provide adequately for the needs of the handicapped child and those of other family members (Barsch, 1968, 1970a, 1970b; Doernberg, Bernard, and Lenz, 1976; Shelton, 1972; Taylor, 1976). There is a need for family harmony and equilibrium. The need to focus attention on one family member easily disrupts such equilibrium, often creating friction and inharmonious relationships. Such unilateral parental involvement with one child can contribute to marital problems thus increasing the potential for marital discord and family problems where children with handicaps are present (Doernberg, Bernard, and Lenz, 1967; Heisler, 1972; McDonald, 1962; Satir, 1967; Taylor, 1976).

Cummings (1966) suggests that fathers have a more difficult time with adjustment than mothers because of the close contact the mothers have with the child resulting in a stress relieving function. Fabrega and Haka (1967) concluded that the fathers in their study seemed more emotionally detached and reserved while the mothers were able to work through their feelings and cope realistically with problems because of their contact with the child.

Numerous authors deal with the effects of a handicapped child on siblings (Fowle, 1968; Gayton, 1975; Hewett, 1978; Kaplan and Fox, 1968; McMichael, 1977; Schreiber and Felley, 1965; Watts, 1969). Siblings of handicapped children have been viewed as exhibiting various symptoms of emotional disturbance, such as guilt over their own normal bodies, anxiety, somatic preoccupations, and excessive fearfulness (Morgenstern, 1966). The importance of this effect is not to be minimized, but literature in this instance will be confined to parental effects. It must be noted, however, that effects upon other siblings will certainly compound the problems of parents of handicapped children.

Writing from a sociological perspective, Kew (1975) emphasized that there is a common tendency on the part of parents of handicapped children to withdraw from social activities. Wider contacts with the community are severely restricted and often curtailed. Kew (1975) talks of the arrest in growth of families of both mentally and physically handicapped children in relation to the wider community. In the families he studied, participation in extra-family relationships and activities were severely restricted. The parents were often tied to their homes, which tended to isolate them from friends and sometimes lead to deep feelings of loneliness. Kew reported that this isolation was exacerbated by the shame some parents felt whenever they took their child out in public.

Tizard and Grad (1961) found that 45 per cent of families with a mentally retarded child living at home had limited social contact. They also found that these families had a lower material standard of living and considerably more management problems than families without handicapped children. In Schonell and Watts' (cited in Kew, 1975) Australian study, 50 per cent of families reported that the handicapped

child had an adverse effect on their capacity to visit other homes, and 22 per cent reported that it had an adverse effect on their selection of people to visit their home.

Reports to the Carnegie Trust (1964) in England, shows that stress arising for parents and family is not all emotionally determined, but may have a physical basis. Poor living conditions are referred to by Curran and Swann in the Glasgow Study (1964):

> So great was the complicating effect of the bad environmental conditions in which many of the children lived, that it was well-nigh impossible to study the problems inherent in the defect itself, for these were often obscured by super-imposed difficulties and side-effects resulting from the conditions in which the family lived. (p. 19)

Curran and Swann (1964) comment on the poor health of the parents often resulting from the excessive care needed for the handicapped child. This in itself becomes further stress to the family. All three reports to the Carnegie Trust (1964) comment on the parents' inadequate understanding of the problems concerned with physical handicaps, and on the paucity of advisory services to help them.

Need of Parents and Implications for Intervention

A combination of the above factors is possibly responsible for research findings such as McMichael (1971) who reported that 56 per cent of parents of handicapped children in her study experienced moderately severe anxiety and failure to adjust to their handicapped child to such a degree that referral for psychotherapeutic treatment was necessary. Webster (1979) concluded that it was not enough that the health care teams and the educational systems devise interventions to aide the child if the child returns to a family unable to provide an optimum environment

for his future development.

Parents of handicapped children report that they need time to talk, to be counseled, but that support does not seem to be built into programs. As a result, many parents have sought out private counseling because they viewed professionals with whom they worked as not interested or unable to counsel them (Larson, 1980).

Major Approaches to Helping Parents

Professionals working with parents of handicapped children are confronted by the cognitive and emotional dimensions of these parents. They recognize that parents need help not only with management (McMichael, 1971) but also in understanding and clarifying their ideas, attitudes and emotions (Webster, 1977). Furthermore, parents of handicapped children do not routinely seek psychotherapy but initially seek help for themselves from those who serve their children. (Heisler, 1972).

Treatment approaches are following a trend away from seeing the parents of handicapped children as a unitary phenomenon to be approached in one standard way (Blatt, 1957; Hale, 1979; Tavormina, 1976; Tymchuck, 1975). Beginning research indicates that a combined or eclectic approach, that is, an approach that combines both experiential therapy and educational concepts to parent education will be better accepted and more effective (Hale, 1979; Tavormina, 1976; Tymchuck, 1975). Furthermore, it is suggested that attachment of parent interventions to the child's educational format can avoid the parental resistance associated with a therapy format (Adams, 1977; Hale, 1979).

Tymchuck (1975) articulated an effective parent education model that includes a combination of the dynamic and educational strategies. Two

reports (Tavormina et al., 1976; Tavormina, 1975) examined the effectiveness of groups for parents, in which the emphasis was upon: (1) training parents to manage or train the child; (2) reflective groups in which group discussion was the modaltiy; and (3) combination groups. The author's conclusions were that the combination groups were most effective. Tymchuck pointed out that a uniquely educational approach is not effective, due to the fact that parents all come with an experiential history of failures, complex emotional feelings, and social pressures that may have led them to reject their child. "To train parents to be trainers of these children might curtail the chances for success for such training." (p. 19) Tymchuck points out the fallacy behind the uniquely emotional approach stating that: "Reconciliation of the parents' feelings does not translate into their being more accepting or better able to handle their child's behavior."

Hale (1976) supports Tymchuck's model of parent education. However, Hale (1979) found that more effective change was achieved in parents participating in an experiential humanistic process of encountering feelings in a here-and-now approach. He concluded that more learning and change took place as the result of parents working with their own attitudes, feelings, and behavior within a laboratory process. He goes on to say that discussion groups may be about feelings but tend to be past or future tense. Thomas (1977) also demonstrated that "experience-based" groups showed a greater amount of change in increased openness than did case study or control (nonexperience) groups. Thomas hypothesized that engaging in a here-and-now experience helps people overcome their reluctance to share undesirable aspects of themselves that may cause

rejection by others. He believes that if these feelings are not shared, they become deeply imbedded in individuals and will eventually be manifested into problems of low self-concept and feelings of unworthiness.

Articles by Wolgenburger and Kurtz (1969), Kaplan and Williams (1972), and Beck (1973) advocate group process with parents. The case studies presented confirmed what was expected: That group work techniques and strategies with parents were not only time saving, but were the treatment of choice (Huber, 1979). Rose (1969) thought that the value of the group in a behavioral model comes from the abundance of models present for the client to imitate. Although the parents were being treated for the absence of behaviors necessary to deal adequately with their children, he thought that almost all parents would have adaptive behaviors in their repertoire that they could teach other parents.

Loeb (1977),using a humanistic Gestalt approach to parents,reported that parents were able to express feelings in the group that they had never been able to verbalize previously; "...new members act as if a heavy burden had been relieved from their shoulders." (p.7)

Humanistic Psychology and Parent Education. Buscaglia (1975) has written about parent's need and the needs of the handicapped individual from a humanist's point of view. Loeb (1977) articulated the use of techniques borrowed from Perls, Ellis, and Rogers which are definitely humanistic but the theoretical framework from humanistic psychology was not attempted. A review of the literature revealed only one articulated model of humanistic parent education (Hale, 1979). In Hale's study of 102 parents of young mentally retarded children, he assessed the effects of an experiential humanistic therapeutic-parent education model.

He first tested the parents using The Personal Orientation Inventory (POI), a test developed by Shostrom that purports to measure levels of actualization in twelve subcategories. Hale found the parents to be lower than the norm on the POI profile. These findings support the conclusion that there is a difference between parents of retarded children and the general population in terms of growth in actualization. The POI scores of the parents in the study offered evidence of low self-esteem and deferred actualization.

Hale divided the parents into two groups. Group One received an experiential humanistic therapy and Group Two received discussion groups. Both groups participated in education that included concepts of child development, information sharing by professionals, and behavior management. All parents improved their POI scores at the conclusion of parent education in the subcategories of: Inner directedness, Existentiality, Feeling Reactivity, Acceptance of Aggression and the Ability to Form Close Relationships.

Parents that participated in the experiential groups (Group One) improved significantly while parents who participated in the discussion groups (Group Two) did not make the same significant gains. The implications from this study indicate that the experiential process of encountering feelings in a here-and-now approach coupled with educational concepts designed to increase parental knowledge induced more change towards actualization in parents of retarded children than did discussion groups with education.

Family as a System

Family theorists and therapists view the family as a system although

they conceptualize the family system in different ways. They also differ on the basic rule in operation when they say that a change in one family member involves a change in each other family member.

Those therapists of the psychoanalytic approach consider the family as a close relationship system in which the family members are influenced by each other's psychological make-up (Framo, 1972). Change in one individual's behavior as a response to another individual's behavior happens because two or more persons in a close relationship carry out psychic functions for one another (Bozormenyi-Nagy, 1973; Framo, 1972). An important aspect in this formulation is that the referent point of feeling or behavior is always an "other" who will have some predictable reactions.

The interactional approach is based upon the cybernetics model and the unit of analysis for therapy is "behavioral-communication" or "interactional phenomena" between and among family members (Haley, 1963, 1976; Jackson, 1965; Satir, 1967, 1975; Watzlawick, 1967). Homeostasis is that concept used to explain the aspect of system whereby change in one family member is related to change in another family member (Jackson, 1968). Family homeostasis describes the family as a unit with internal, ongoing interactional processes that maintain an internal balance for family functioning.

Therapists who subscribe to the behavioral approach deny the existence of internal motivating forces and consider the family as a system of interlocking behaviors (Ballentine, 1972; Patterson, 1975). This aspect of the system i.e., interlocking behaviors, is explained from the standpoint of learning theory. Each individual "learns" how to respond to each other individual. "Meaning" of behavior is irrelevant since a person can learn to respond to either adaptive or maladaptive behavior

in the same manner.

The above descriptions show that each approach stems from a different conceptualization of how the family as a system brings about change in individual family members. Such divergent views are unified, however, in the belief that motivations or behaviors of one family member are considered to influence the motivations or behaviors of each other family member. That is, changes in one family member's behavior and/or inner psychic processes will bring about changes in other members behavior or inner psychic process of the family system.

Conceptual Framework

A review of the literature reveals that parents of handicapped children suffer stresses that place them at risk for having their growth towards actualization impeded. It is suggested that using Maslow's model of psychological functioning, based on healthy individuals, is a better method to view individuals experiencing extreme life stresses than a model based on troubled individuals. It has also been found that parents level of actualization can be enhanced with an experiential humanistic therapeutic group-parent education model. Thus, as a basis for developing potential methods of intervention, Maslows' Humanistic Theory of the self-actualizing person and the combination approach to parent education will be used. Furthermore, using a system's theory of family dynamics, it can be hypothesized that a change in one family member will create a change in other family members. That is, if growth in self-actualization occured for one family member a corresponding change in functioning can occur in other family members.

Maslow (1954, 1962) viewed a self-actualizing person as one who

is more fully functioning and living a more enriched life than the average person. The fundamental thesis of Maslows' theory includes the concepts of self-actualization, growth, and a hierarchy of basic needs. In the hierarchy of basic needs, lower level needs must be experienced before actualization can be experienced. For Maslow, growth is the progressive satisfaction of higher and higher needs. In most of his writing, this growth is teleological; that is, the end product, actualization, is implicit in the beginning, embryonic human. Growth, then, is the natural unfolding toward those ends. In spite of this drive to grow, some people do not. Parents of handicapped children are one group that is at risk for having their growth towards actualization impeded.

Being a parent of a handicapped child is a demanding and stressful experience for parents. Their energies and resources are utilized in attempting to meet their lower level needs. Their inability to satisfy lower level needs impedes growth towards actualization. The failure to meet lower level needs can exert an antigrowth influence. These needs must be met in order to create the daring and risking involved in creativity and growth towards actualization.

A treatment approach that provides both dynamic and educational aspects provides a setting whereby parents are able to satisfy some of their lower level needs. Providing information of the parents choice allows them to increase their knowledge and confidence as persons and parents. They can then begin to look to themselves for answers rather than look to others for total direction.

Parents also need a supportive atmosphere with a here-and-now approach in which they can encounter and express their feelings.

Conducting this in a group context allows parents the opportunity to know that others share the same feelings. With this knowledge parents can become more self-accepting, thereby increasing their self-esteem and capacity to interact in a meaningful way with other people.

This treatment approach encourages parents to learn new coping skills, and results in a reduction in stress, which encourages a reorganization at a higher level of functioning and actualization.

Research Questions

The specific research questions that will be explored are: (1) What are the levels of actualization of parents of preschool handicapped children and how do they compare with The Personal Orientation Inventory scores for self-actualized people? (2) How do the levels of actualization of parents of preschool handicapped children compare with parents of nonhandicapped children? (3) What association exists between parents POI scores and their demographic variables? and (4) What effect does exposure to an experiential therapeutic group-parent education program have on parents levels of actualization?

Definition of Terms

Parents of Handicapped Children

A parent of a child or youth from 0 to 21 years of age that is "...mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired, or children with specific learning disabilities who by reason thereof require special education and related services." (PL 94-142 (20USC 1401 et seq. (89 Stat. 773))

Parent of Preschool Handicapped Children

A parent of a child from 2½ to 6 years of age that is certified handicapped under Oregon Law #ORS 343.055 and in need of special education and services. A complete minimum eligibility criteria can be found in Appendix A.

Self-Actualization

Self-actualization is an ongoing process whereby individuals make more complete use of their unique capacilities and potentialities. Shostrom (1963) suggests that this is a person who lives a more enriched life than the average person, one freer of inhibitions and emotional turmoil. Self-actualized individuals seem to be fullfilling themselves by doing the best they are capable of doing.

Self-Actualized Person

For the purpose of this study, a self-actualized individual will be defined as one who scores between 50 and 60 on The Personal Orientation Inventory.

CHAPTER III

METHODS AND PROCEDURE

In this chapter, the design, sample, and treatment procedure are described. In addition, the instrumentation and handling of the data are discussed.

Design of Study

This research was a quasi-experimental study utilizing a pretest posttest static group design. The study sample consisted of twenty-one parent volunteers whose pretest scores were compared with The Personal Orientation Inventory (POI) self-actualized scores and scores of parents with nonhandicapped children. Seven parents volunteered to participate in an experimental group. The remaining fourteen parents served as a control group.

The Sample

The sample for the study consisted of 21 parent volunteers, from a preschool in Corvallis, Oregon, whose children were certified handicapped under Oregon Law (PL 94-142). There were eight males and thirteen females with a mean age of 31. The parents had completed an average of sixteen years of education with a range from six to eighteen years.

Treatment Procedure

The author's approach to parent education is based upon Hale's (1979) model. This four faceted approach includes humanistic experiential therapy, information sharing of the parents choice, child development, and behavior management training.

This therapeutic group-educative program for parents of preschool handicapped children combines behaviorally based education as well as an appreciation of feelings. The objective of the model is to provide information, a place where feelings may be shared, and an experience where cohesiveness as a group may be utilized for support.

The first two weeks of the model consisted of assessment of parents present knowledge of child development (Appendix E), level of self-actualization as measured by The Personal Orientation Inventory (POI) (Appendix F), and parent selection of topic areas for discussion (Appendix D). The assessment provided the author with information on the parents' present level of functioning and knowledge so that information could be presented at the appropriate level. The author used the selected topic areas as a basis for planning the coming weeks activities. During the second week the results of the assessment were synthesized, professionals were contacted, the schedule arranged, and a report made back to the parent group.

The remainder of the program consisted of six 3 hour sessions. The first 90 minutes was devoted to a didactic presentation with group discussion of the major topic areas the parents selected. The second 90 minutes was devoted to a humanistic experiential therapeutic group experience, designed to enable parents to express feelings.

Didactic Presentation. In addition to the opportunity to relate and deal with their feelings toward the handicapped child, parents need factual information which relates to child development, child management, and topics with which they are concerned (Hale, 1979). The parents for the first group selected stress reduction management and communication techniques to complete their week's group experience.

The focus for week three was child development, which included a group discussion during which parents identified the major developmental landmarks of the prenatal period, infancy, toddler, and preschool periods. They were also assisted in ascertaining their own child's present level of development. A lecture on the complex steps and cycles in development, intended to make parents aware of the tremendous range of individual expression, was included.

The fourth and fifth week focused on stress-reduction management. Parents were given handouts and listened to lectures, to enable them to identify the different levels of stress and its effects upon the body's systems. They were also assisted in assessing their present level of stress and methods of coping. They were taught new methods of dealing with stress that included becoming aware of areas that cause stress for them, physical exercise, relaxation exercises, and change of attitude towards themselves and others.

The sixth week focused on child-behavior management. Parents were given a lecture and handouts that identified different child temperments and their effects on the parent and on the parent child interaction. They were assisted to identify their present level of behavior management and introduced to different means of coping with child behavior problems. The parents were first taught the "Child's Game" which is designed to identify behaviors that will increase positive interactions with their child. The second component of learning behavior management consisted of the "Adult's Game" where parents were taught step by step ways of teaching their child to mind and follow directions. Parents practiced and integrated these "Games" with each other in dyads with the help of the group leader.

The seventh week focused upon communication techniques. Parents were given a lecture, group discussion and experiences to increase their awareness of means they use to communicate verbally and nonverbally. The objective was to provide them with new tools to enable them to increase their abilities to send clear messages.

The eighth week was utilized for retesting with the POI and an evaluation of the group experience. Parents were also guided through an exercise to increase their cohesiveness as a group without the author as the designated leader. This activity is congruent with the objective for the group to be a support for each other without professional help.

Humanistic Experiential Therapy. A critical aspect of parent education is the establishment of a milieu which enables parents to talk about feelings. This author's stance in parent education not only gives permission to the parents to feel and communicate deeper feelings, but encourages feelings and communication from the beginning. This was facilitated via awareness techniques (Hale, 1979; Johnson, 1972) for enabling parents to relieve and express feelings centered around their handicapped child and themselves. The awareness techniques effectively shortcut the process of establishing meaningful group interaction (Beck, 1974; Hale, 1979).

The awareness technique began with a guided relaxation exercise that included visualization using all of the sensory modalities. i.e., seeing, hearing, smelling, touching. The parents were then gently led to experience feelings by the use of a structured dialog conducted by the group leader. While parents were experiencing this phase they were asked to make a hand gesture that described the feelings that they were

having at the moment. This movement enabled the group leader a means back into the parent feelings if they became blocked during discussion. The group leader then proceeded to "anchor" this experience in three ways: (1) Auditory, a shift in voice tone and telling them that she was going to touch them on the left shoulder; (2) Visual, their own internal visualization; and (3) Tactile, moving around the group and placing a hand on the left shoulder of each group member.

The parents were then brought fairly quickly from this "experiencing state" to one of awareness to enable them to discuss and share the experience. From the research of Hale (1979) and the author's experience this has proved an effective techniuqe. Parents often have experienced long repressed pain, and eagerly share this with the group, thus gaining support, clarification, and an enhancement of the individual members and group interaction.

The parents were then gently led back to a relaxed state where they encountered a time in which they were in control, experiencing strength, calmness and confidence. This feeling was anchored in the above manner on the right shoulder. This feeling of strength was then merged with the original painful feelings by asking the parents to take the feelings of strength and control back to the time when they felt distressed. The group leader proceeded to touch both shoulders of each group member thus providing an auditory, internal visual, and tactile merging of feelings. The parents were then gently brought back to awareness of their surroundings where they shared their experience.

The first therapy group consisted of the parents' original feelings surrounding the birth or diagnosis of a handicapping condition in their child. The subsequent weeks included topic areas of: (1) stresses

involved in having a handicapped child; (2) awareness of internalized roles, (3) changes in family and marital dyad relationships; and (4) implications for externalizing power.

A long term goal of therapy is to help parents in owning and taking responsibility for any feelings they may have. The basic outline of the therapy process is as follows:

1. Guided relaxation
2. Guided structured experience of contact with distressing situation.
3. Anchor experience
4. Discussion
5. Relaxation-shorter version
6. Guided structured experience where parents feel calm, strong, and in control.
7. Anchor experience
8. Merge the two experiences with visualization, words and tactile experience
9. Discussion

Data Collection Instruments

The Personal Orientation Inventory (POI). The POI was developed by Everett L. Shostrom and was first published in 1963. The test purports to measure levels of actualization and was based on the theories of Maslow, Rogers, Shostrom, and others.

The POI consists of "...150 two-choice comparative value and behavior judgments. The items are scored twice: First, for two basic scales of personal orientation, inner directed support (127 items), and time competence (23 items); and secondly, for 10 subscales, each of which measures conceptually important elements of self-actualizing." (Shostrom, 1966, p.4)

The person scoring low on the inner directedness scale is an other directed person who has:

> ...been motivated to develop a radar system to receive signals from a far wider circle than just parents...approval by others becomes the highest goal. Thus all power is invested in the actual, or imaginary, approving group. Manipulation, in the form of pleasing others and insuring constant acceptance, becomes the primary method of relating. (POI Manual, 1966, p.4)

Time competency on the POI has to do with how much a person is able to be in the present as compared with living in the past or the future. A higher time competency score indicates greater present-centeredness.

The 10 other subscales of the POI are described in the POI Handbook (Knapp, 1976), as follows:

> Self-Actualizing Value (SAV) measures the affirmation of primary values of self-actualizing people. A high score indicates that the individual holds and lives by values characteristic of self-actualizing people, while a low score suggests the rejection of such values.
>
> Existentiality (Ex) measures the ability to situationally or existentially react without rigid adherence to principles. Existentiality measures one's flexibility in applying values or principles to one's life. It is a measure of one's ability to use good judgment in applying these general principles. Higher scores reflect flexibility in application of values, while low scores may suggest a tendency to hold to values so rigidly that they become compulsive or dogmatic.
>
> Feeling Reactivity (FR) measures sensitivity or responsiveness to one's needs and feelings. A high score indicates the presence of such sensitivity, while a low score suggests insensitivity to these needs and feelings.
>
> Spontaneity (S) measures freedom to react spontaneously, or to be oneself. A high score measures the ability to express feelings in spontaneous action. A low score suggests that one is fearful of expressing feelings behaviorally.
>
> Self-Regard (SR) measures affirmation of self because of

worth or strength. A high score measures the ability to like oneself because of one's strength as a person. A low score suggests feelings of low self-worth.

Self-Acceptance (SA) measures the affirmation or acceptance of one's self in spite of one's weaknesses or deficiencies. A high score suggests acceptance of self and weaknesses, and a low score suggests inability to accept one's weakness.

Nature of Man—Constructive (NC) measures the degree of one's constructive view of the nature of man. A high score suggests that one sees man as essentially good and can resolve the good-evil, masculine-feminine, selfish-unselfish, and spiritual-sensual dichotomies in the nature of man. A high score, therefore measures the self-actualizing ability to be synergic in one's understanding of human nature. A low score suggests that one sees man as essentially bad or evil.

Synergy (SY) measures the ability to be synergistic-transcend dichotomies. A high score is a measure of the ability to see opposites of life as meaningfully related. When one is synergistic, one sees that work and play are not different, that lust and love, selfishness and selflessness, and other dichotomies are not really opposites at all.

Acceptance of Aggression (A) measures the ability to accept one's natural aggressiveness—as opposed to defensiveness, denial, and repression of aggression. A high score indicates the ability to accept anger or aggression within one's self as natural. A low score suggests the denial of such feelings.

Capacity for Intimate Contact (C) measures the ability to develop contactful intimate relationships with other human beings, unencumbered by expectations and obligations. A high score indicates the ability to develop meaningful, contactful, relationships with other human beings, while a low score suggests that one has difficulty with warm interpersonal relationships.

(p. 5-7)

Shostrom's development of The Personal Orientation Inventory has provided researchers with a comprehensive measure of values and behaviors seen to be important in the development of self-actualization. Knapp (1971) points to the diversity of the research stimulated by the POI as an indication of both its initial need and complete acceptance.

What follows is a review of empirical research which aids in verifying the POI as a measurement tool.

Construct Validity. During the early development of the POI Shostrom (1964) demonstrated that POI scores significantly differentiated a sample of clinically nominated, self-actualizing (n=29) individuals from a sample nominated as nonactualizing (n=34). The inventory was shown to discriminate between individuals who had been observed in their life behavior as having attained a relatively high degree of actualizing, and those individuals who did not evidence such development. Both groups were selected and identified by eighteen prominent, practicing, certified clinical psychologists.

In reports by Fox (1965) and Fox, Knapp, and Michael (1968), a sample of 100 hospitalized psychiatric patients were found to be significantly lower on all POI scales than the nominated self-actualizing (n=29) and normal (n=160) adult samples reported by Shostrom (1964). The major scales of Time Competence and Inner-Direction gave more significant differentiation then scores on the subscales. However, all POI scales significantly differentiated the hospitalized population from normal and self-actualizing samples.

Shostrom and Knapp (1966) showed significant differentiation in a sample of outpatients tested with the POI. Outpatients in advanced psychotherapeutic progress (n=39) were significantly differentiated from beginning patients (n=37). The relationships that were shown indicated that the POI scales were tapping areas of "emotional morale," or "psychological well-being". McClain's (1970) study found that nine of the POI scales were significantly correlated with staff-evaluation

of school counselors based on Maslow's criteria of self-actualization.

A number of studies have been undertaken to examine the relationship of POI variables to other personality constructs and scales. Although developed from a very different theoretical and technical viewpoint the POI shows an interesting relationship to the major factorial trait personality inventories of Cattell, Comrey, Eysenck and Guilford.

The POI and the Eysenck Personality Inventory or EPI (Eysenck and Eysenck, 1963) were administered by Knapp (1965) to a college sample to examine relationships between these conceptually different theories of personality. Results indicated, that though developed from different theoretical viewpoints, both instruments were related to a common core of mental health.

In a study relating POI variables to the Guilford-Zimmerman Temperment Survey or G-Z (Guilford and Zimmerman, 1949) and to the Sixteen Personality Factor Questionnaire or 16PF (Cattell and Eber, 1957), Meredith (1967) reported correlations ranging in magnitude up to .48. Correlations with the 16PF ranged in magnitude up to .44 when considering the major POI scale of Inner-Directed. Significant correlations between the other major POI scale, Time Competence, and G-Z and 16PF temperment scales, suggests that those whose primary orientation is in the present would be described (from the 16PF) as assertive, happy-go-lucky, venturesome, trusting, and self-assured; and (from the G-Z) as relaxed, active, ascendant, sociable, emotionally stable, objective, and tolerant. The relatively low magnitude of correlations between these instruments and the POI indicate that they are measuring somewhat different aspects of personality.

To examine the relationship of self-actualizing to the major personality constructs defined through factor analysis, Knapp and Comrey (1973) administered the POI and The Comrey Personality Scales or CPS to a sample of eighty-four volunteer undergraduate students (Comrey, 1970). Previous findings that actualizing is related to emotional stability were reconfirmed, and certain theoretical concepts of the actualizing model as measured by the POI were shown to be meaningfully related to factorial dimensions defined in Comrey's taxonomy of personality.

While these relationships will probably be of greatest usefulness to individuals familiar with one or more of the earlier instruments, in obtaining a landmark for exploration of the POI a few generalizations might be in order. Regarding conceptual overlap between the POI and the factorial instruments, the Self-Regard subscale most clearly represents the traditional emotional-stability dimension. While POI subscales for which little overlapping variance appeared, with no correlation over .40, were Feeling Reactivity, Spontaneity, Self-Acceptance, Synergy, and Capacity for Intimate Contact. These perhaps most clearly represent complex new concepts garnered from humanistic theories of personality.

Tosi and Hoffman (1972) conducted a factor analysis of the POI using a sample of 132 students (30 males, 102 females) with an average age of 19.3 years. A factor analysis attempts to make a large number of correlations more manageable by reducing the interrelations among many variables to interrelations among few factors. According to the authors, the objective of the study was to determine those subscale groupings of the POI that have optimum combination of internal consistancy and differentiation between groups. It was found that three

factors accounted for 72% of the total variance of the POI. They labeled these factors as follows:

I.	Extroversion:	describing an extroverted, self-assumed person who does not hesitate to act on his or her feelings.
II.	Open Mindedness:	describing a person who is present oriented and one with an optimistic and constructive approach to life.
III.	Existential-non-conformity:	describing a personality which acts fully on its own rules, demonstrates value independence, and establishes meaningful contacts with other people.

In discussing these findings, Tosi and Hoffman noted that the POI did, in essence measure the construct of the healthy personality. However, they urged that further research be conducted that would perhaps reduce the number of subscales without weakening the theoretical framework of the instrument.

More recently, Tosi and Landamood (1975) have critically reviewed the entire framework of the POI, citing item overlap in its subscales and its lack of parsimony as its most salient deficiencies. They concluded with the statement that the POI is a very adequate research instrument with somewhat more limited use in individual counseling and psychotherapy.

Reliability. The POI is based on concepts of dynamic traits of personality. The POI is sensitive to rhythmical changes in personality during the intervals between administrations. The Acceptance of Aggression and Feeling Reactivity scales measure variables that are affect related, and as such may be measuring fluctuation in mood states

from test to retest. With this knowledge in mind the following is an examination of available studies of the stability of POI scores.

Klavetter and Mogar (1967) administered the POI twice, with a one week interval, to a sample of forty-eight college students. The major POI scales of Time Competence and Inner-Direction displayed high reliability coefficients of .71 and .77 respectively. The other subscale correlations ranged from .52 to .82. Wise and Davis (1975) reported a test-retest coefficient of .75 and .88 for Time Competence and Inner-Directed scales respectively.

Illardi and May (1968) examined the stability of POI scores among a sample of forty-six student nurses over a one year period. They reported coefficients ranging from .32 to .74 which they stated were in the ranges of somewhat comparable MMPI and Edwards Personal Preference Survey test-retest reliability studies.

Warheim and Foulds (1971) administered the POI to 95 subjects, first under normal conditions and then following instructions whereby each subject was to picture himself applying for a job he very much wanted. Results indicated that "fake-good" responses did not increase self-actualization profiles. In fact, lower scores were reported on 10 of 12 scales. Ecker and Watkins (1975) duplicated these findings using three groups of subjects, one of which were psychology majors with a knowledge of personality theory. It was concluded that a response set of appearing self-actualized is not a factor in the administration of the POI, even with subjects who have a background in psychology.

In summary, two characteristic "lie profiles" are built into the POI that are easily detected by those trained in evaluation of the

instrument. One results in a representitive profile in the case of deliberate attempts to present a favorable impression without specific knowledge of concepts of actualizing. Particularly characteristic of such profiles are extremely elevated Self-Regard scores coupled with depressed Self-Acceptance and Existentiality scores. The other is a uniformly hyperelevated profile.

The preceding research has established that Shostrom's POI is a capable research instrument. Knapp (1971) notes that Maslow himself acknowledged, "There is today a standardized test of self-actualization (the POI). Self-actualization can now be defined quite operationally, as intelligence used to be defined, i.e., self-actualization is what the test (POI) tests".

Personal Information Data Form. The personal information data form (Appendix C) was administered to all subjects at the time they were initially tested with the POI. Information collected included age, sex, number of years of education, total family income, religion, and marital status.

Evaluation of the Group Questionnaire. At the completion of the experimental group and after taking the POI the second time the seven parents in the experimental group were asked to complete a questionnaire (Appendix H). This open ended questionnaire was developed by the investigator and allowed the parents to express their perceptions of the group and to relate any stressful occurances that may have occured to them or their family during the process of the group. A content analysis was completed on the parents responses.

Data Collection Procedure

Permission to conduct the study was obtained from the Directors of the preschool. During the first regularly scheduled parent group meeting of September, 1980, 32 parents of preschool handicapped children were invited to participate in the author's research study. A general outline of the purpose of the study, the treatment program, procedures for confidentiality, and an estimate of the time involved for parents was presented. All parents volunteering to be participants in the study were presented with a consent form (Appendix B) required by the University of Oregon Health Sciences Center, Human Subjects Committee. On this form the rights of subject participants in this study were fully outlined.

The investigator administered The Personality Orientation Inventory and the Personal Information Data Form to all 21 parent volunteers. Code numbers were assigned to the respondents in order to preserve anonymity. Two hours were allowed for the completion of the POI.

Before administering the instruments, the examiner stressed that there were no right or wrong answers. The subjects were given written and verbal instructions of the following: If the first statement of the pair was true or mostly true, as applied to them, to blacken between the lines in the column headed "a". If the second statement of the pair is true or mostly true, as applied to them, then blacken between the lines in the column headed "b".

They were instructed that if neither statement applied to them, or if it referred to something they didn't know about, they were to make no answer on the answer sheet. They were encouraged to give their own opinion of themselves and not to leave any blank spaces if they

could avoid it.

All subjects were again tested by the same examiner during the final week of the experimental group. Again they were provided two hours to complete all of the questions.

The subjects in the experimental group were tested as a group. Individual appointments were made with the control group and the POI was completed in their home with the author present.

Data Analysis

The Personal Orientation Inventory answer sheets from the pre and posttest were scored, recorded and changed to standard scores (POI Manual). Mean subscale scores were obtained in order to compute a composite POI profile of the 21 parents. Comparisons were made between the parent's subscore means, the POI scores of self-actualized individuals, and parents of nonhandicapped children using Student's t-test with the significance level set at .05. Means of the experimental groups subscores were compared with the means of the control groups pre and posttest using a Student's t-test at .05 significance level. An analysis of covariance was completed on the experimental and control groups mean postest subscores using the pretest scores as the covariant. Significance level set at .05. A correlation between POI scores and demographic data was made using chi-square at .05 significance level.

Summary

This chapter included a discussion of methods and procedures used in this study. A humanistic experiential therapeutic group-parent education program developed by the researcher was implemented with the experimental group. The Personal Orientation Inventory

served as the research instrument. Discussion of the instrumentation, data collection and data analysis were provided.

CHAPTER IV

RESULTS OF THE STUDY

This chapter presents a discussion of the results of this study which investigated the effects of a humanistic experiential therapeutic group-parent education program on the self-actualization levels of parents of preschool handicapped children.

Group Composition

Of the 21 parents tested with The Personal Orientation Inventory, 62% (n=13) were female, and 38% (n=8) were male. One hundred per cent of the population was white. In terms of marital status, 90% (n=19) were married and 10% (n=2) were divorced. The religious breakdown of the group included 71% (n=15) Protestants and 29% (n=6) Catholics. The age of participants in this study ranged from 21 years to 41 years, with a mean age of 31. Figure 1 illustrates the distribution of the age of the parents. Education levels of parents is illustrated in Figure 2. The range of education was from six to eighteen years, with a mean of sixteen years.

The parents in the experimental group consisted of 86% (n=6) females and 14% (n=1) male. Five subjects were married and two were divorced. Their age ranged from 25 years to 36 years, with a mean of 30 years. All subjects had obtained a high school diploma, with a mean of 14 years of education.

The parents in the control group consisted of 50% (n=7) females and 50% (n=7) males. The subjects were all married. Their age ranged from 23 to 41 years, with a mean of 31 years. They had completed

Figure 1. Age Distribution of 21 Parents of Preschool Handicapped Children Tested with The Personal Orientation Inventory September, 1980

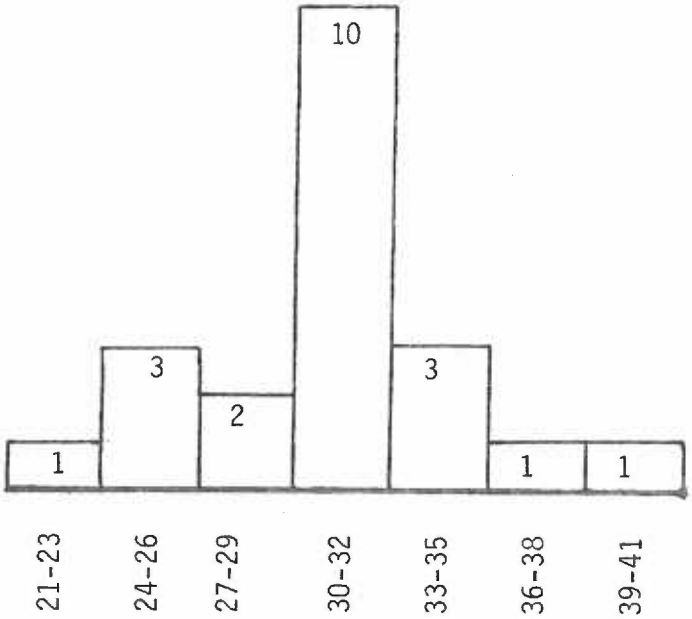


Figure 2. Distribution of Education Levels of 21 Parents of Preschool Handicapped Children Tested with The Personal Orientation Inventory, September, 1980

an average of 14 years of education, with a range from 6 to 18 years.

As is readily discernable, this population is a special group, not necessarily a representation of a cross-section of parents of preschool handicapped children. The group is white, mostly married females with some college education. Those parents who did not volunteer to participate (n=11) stated that they had previous family commitments or were already involved in a therapy program. A few parents thought that the time commitment for the program was an extra burden on their already strained schedules.

Statistical Analysis

Each research question is stated below followed by the analysis of the data obtained from the research instruments.

Research Question One

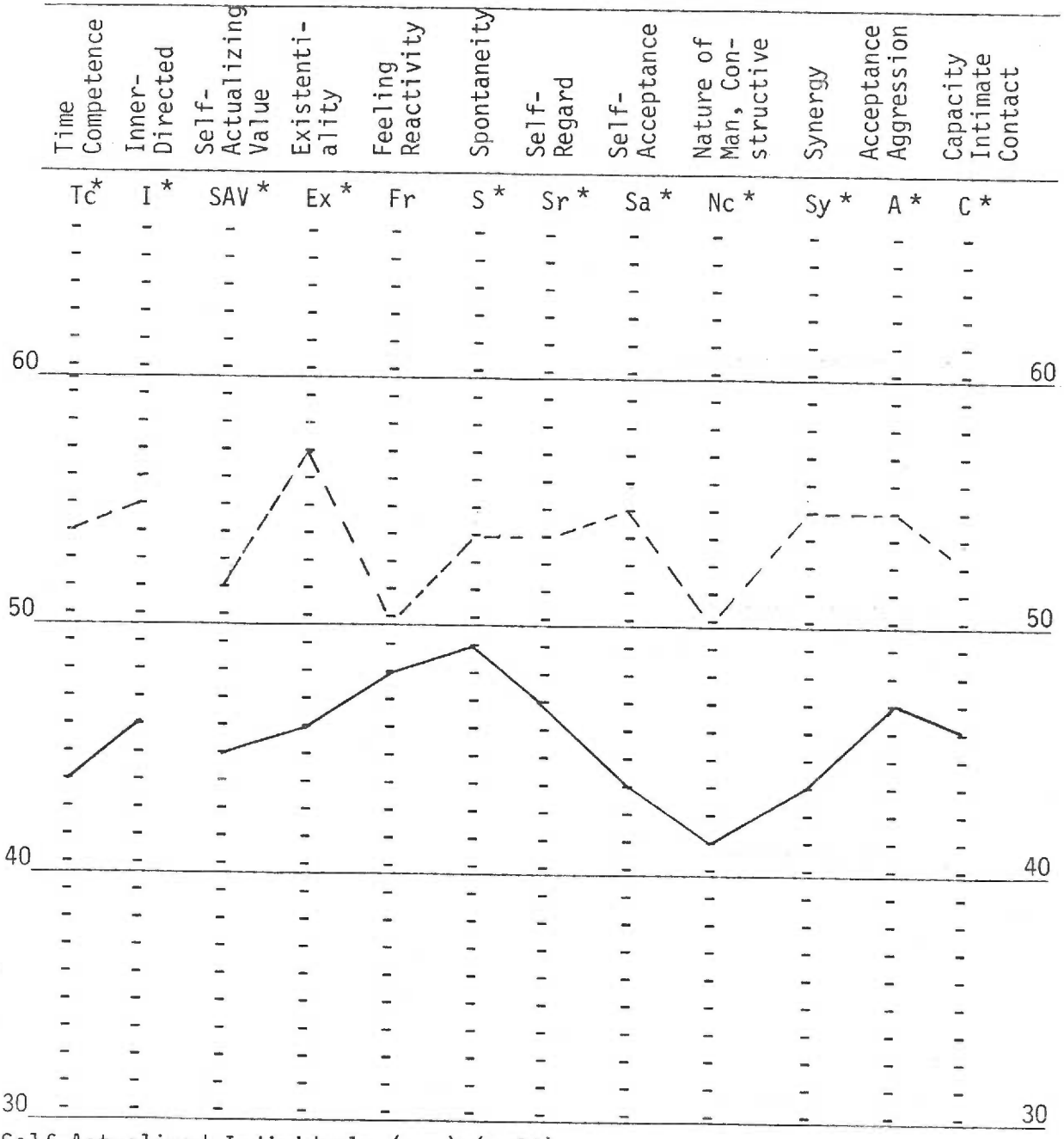
> What are the levels of actualization of parents of preschool handicapped children and how do they compare with The Personal Orientation Inventory scores for self-actualized individuals?

The Personal Orientation Inventory (POI) pretest mean scores of parents of preschool handicapped children in the current study were compared with the mean POI scores developed by Shostrom (1964) for self-actualized individuals. A two-tailed t-test at .05 level of confidence was used to test statistical significance between the groups subscores.

Figure 3 gives the mean and standard deviation of pretest POI scores for parents of preschool handicapped children and self-actualized individuals. Parents in this study scored below the self-actualized group in all areas except Feeling Reactivity. A low score

Pretest

Figure 3. POI Profiles for Parents of Preschool Handicapped Children and Self-Actualized Individuals



	Tc*	I*	SAV*	Ex*	Fr	S*	Sr*	Sa*	Nc*	Sy*	A*	C*
Self-Actualized Individuals (---) (n=24)												
M	54	55	52	57	51	54	54	55	50	55	55	53
SD	2.5	11.5	3.6	3.5	2.8	1.9	1.9	3.5	2.2	1.2	3.1	3.4
Parents of Handicapped Children (——) (n=21)												
M	44	46	45	46	48	49	47	44	42	44	47	46
SD	9.5	9.8	9.8	9.2	9.2	10.8	12.6	8.1	11.7	8.4	11.3	9.7

* Significant at .05 level

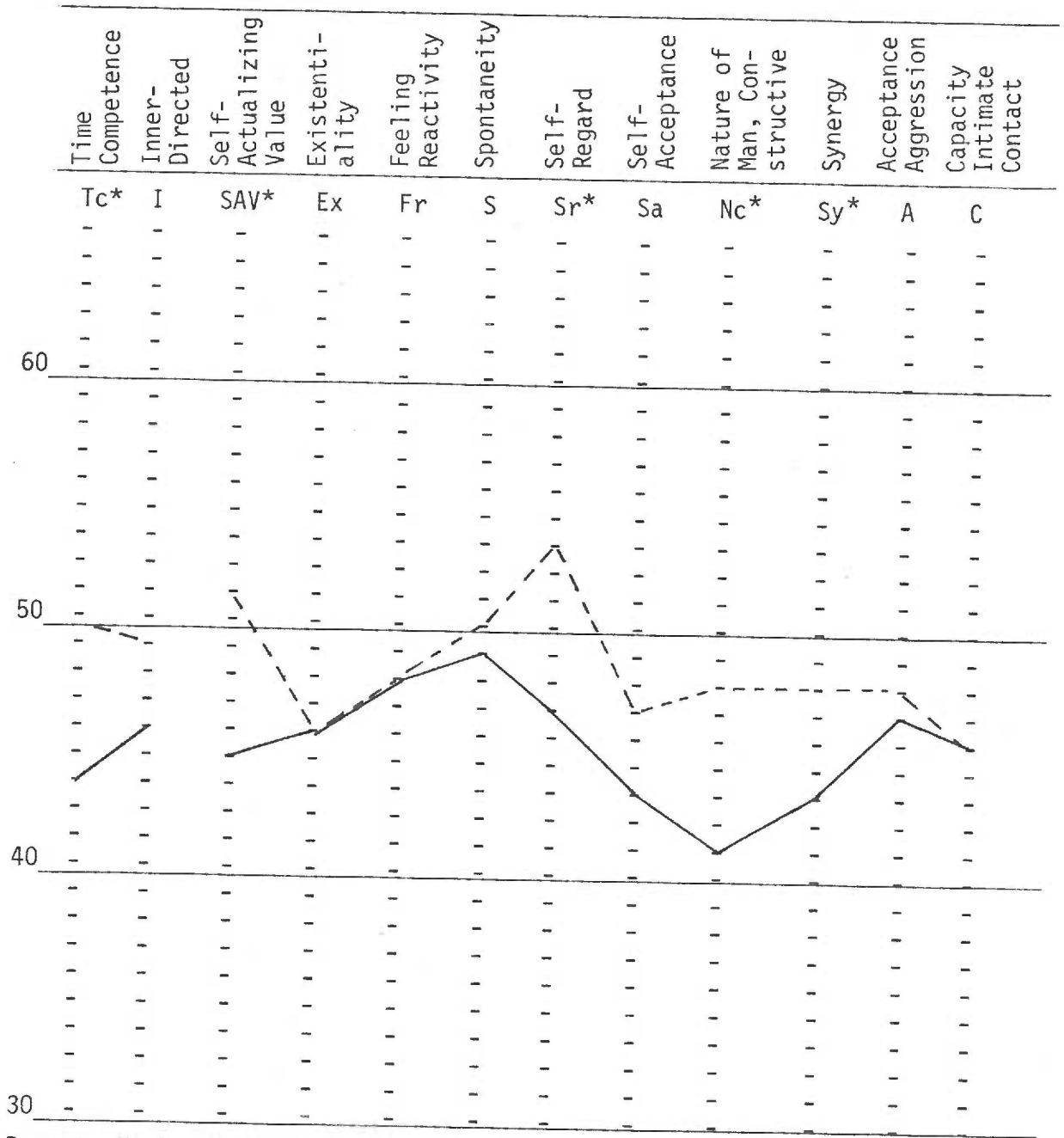
Comparison with the studies of Hersch (1973) is made in Figure 4 which illustrates POI comparisons of couples with nonhandicapped children and the parents of this study. Parents of preschool handicapped children scored not only below the self-actualized group but also lower than parents of nonhandicapped children tested by Hersch (1973).

The group subscores of parents of nonhandicapped children and parents of handicapped children tend to parallel each other except in five areas. Significant differences were found at the .05 level of confidence for: Time Competence ($t(40)= 2.742$, $p < .005$), parents of handicapped children tend to be more past or future oriented; Self-Actualizing Values ($t(40)= 3.020$, $p < .005$), parents of nonhandicapped children are in the self-actualized range while parents in this study scored well below the mean; Self-Regard ($t(40)= 2.622$, $p < .01$), parents of handicapped children are unable to accept themselves with weakness; Nature of Man ($t(40)= 2.170$, $p < .025$), while both sets of parents are below the norm level, parents of handicapped children tend to be closer to viewing man as essentially evil; and Synergy ($t(40)= 2.001$, $p < .05$), parents of handicapped tend to see opposites of life as antagonistic.

Although parents of preschool handicapped children tended to score lower than parents with nonhandicapped children in many areas there were no significant differences in the areas of: Inner-Direction, Existentiality, Feeling Reactivity, Spontaneity, Self-Acceptance, Acceptance of Aggression and the Capacity for Intimate Contact.

In summary, the scores on the POI of parents of preschool handicapped children are lower than the POI scores for self-actualized individuals, and except for Existentialtiy and Feeling Reactivity

Figure 4. POI Profiles for Parents of Preschool Handicapped Children and Parents with Nonhandicapped Children



Parents Nonhandicapped Children (---) (n=24)

	Tc*	I	SAV*	Ex	Fr	S	Sr*	Sa	Nc*	Sy*	A	C
M	50	49	52	46	48	51	54	47	48	48	48	46
SD	3.2	11.2	2.7	4.1	3.1	2.7	2.0	3.4	1.7	1.1	3.3	3.5

Parents Handicapped Children (——) (n=21)

	Tc*	I	SAV*	Ex	Fr	S	Sr*	Sa	Nc*	Sy*	A	C
M	44	46	45	46	48	49	47	44	42	44	47	46
SD	9.5	9.8	9.8	9.6	9.2	10.8	12.6	8.1	11.7	8.4	11.3	9.7

* Significant at .05 level

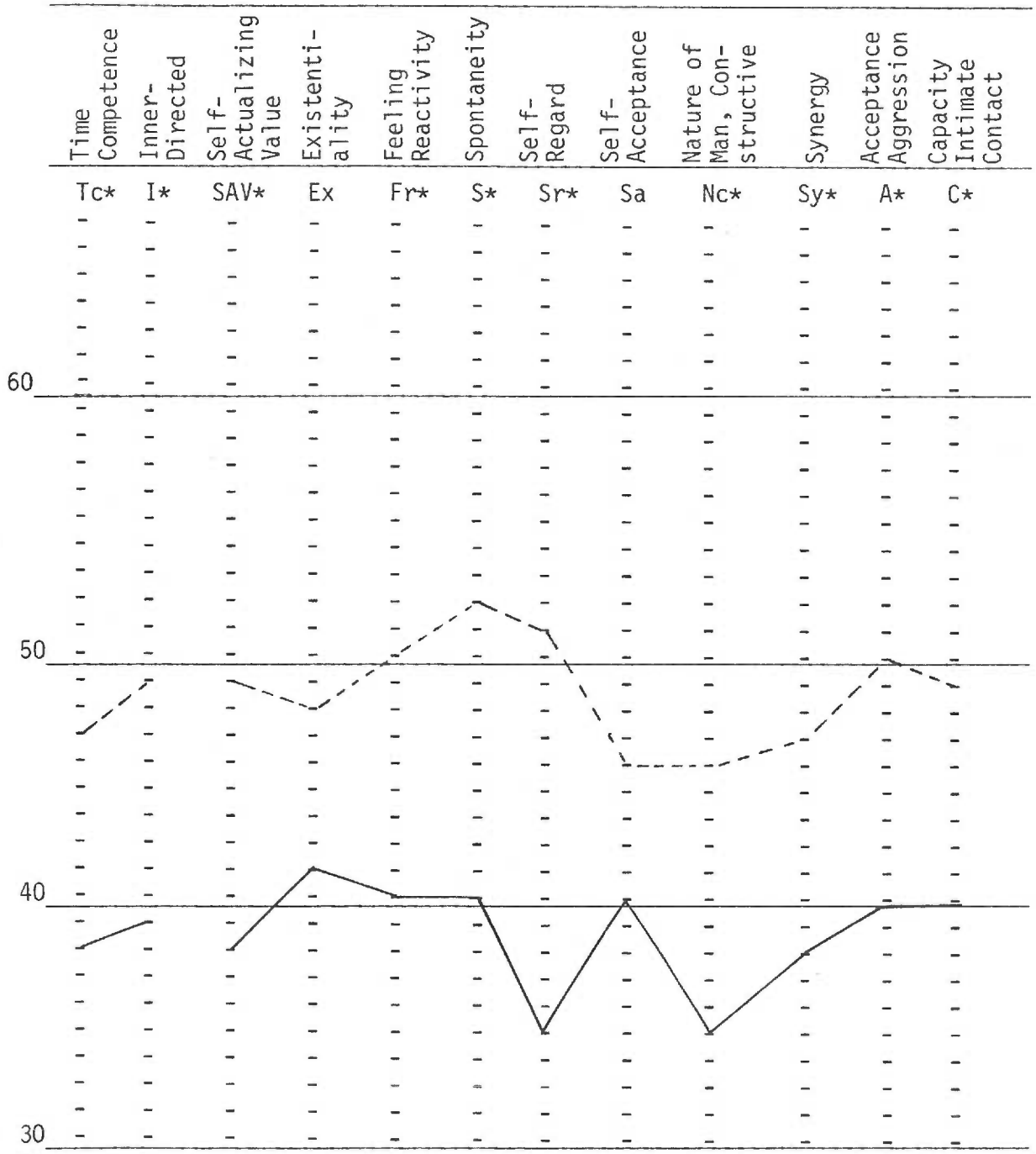
subscores, below the POI scores of parents of nonhandicapped children.

Pretreatment scores of parents participating in the experiential therapeutic group-parent education program (experimental group) and parents who did not participate (control group) are shown in Figure 5. The experimental groups prescores were below the POI mean of 50 in all areas. The control groups scores were in the actualizing range in the subscores of Feeling Reactivity, Spontaneity and Self-Regard.

Paired Student t's were used to compare the two groups on the 12 POI subscores prior to the beginning of the treatment program. The experimental groups subscores were significantly lower than the control group in all areas except Existentiality ($t(19)= 1.394$, $p < .10$) and Self-Acceptance ($t(19)= 1.560$, $p < .10$). The subscores for the other areas were significant at .05 in the following areas: Time Competence ($t(19)= 1.8$, $p < .05$), Inner Direction ($t(19)= 2.72$, $p < .01$), Self-Actualizing Value ($t(19)= 3.313$, $p < .005$), Feeling Reactivity ($t(19)= 2.41$, $p < .025$), Spontaneity ($t(19)= 2.98$, $p < .005$), Self-Regard ($t(19)= 2.940$, $p < .005$), Nature of Man ($t(19)= 2.18$, $p < .025$), Synergy ($t(19)= 2.472$, $p < .025$), Acceptance of Aggression ($t(19)= 2.28$, $p < .025$), and Ability to Form Warm Close Relationships ($t(19)= 2.290$, $p < .025$).

In comparison to the 14 parents in the control group the 7 parents who volunteered to participate in the experimental group were less sensitive to their own needs and feelings, had a lower capacity for spontaneity, lower self-regard, see man as basically evil, have a reduced capacity for intimate contact and acceptance of anger and aggression, and have problems seeing opposites of life as having meaning.

Figure 5. Pretest POI Profiles for Experimental and Control Group Parents of Preschool Handicapped Children



	Tc*	I*	SAV*	Ex	Fr*	S*	Sr*	Sa	Nc*	Sy*	A*	C*
Control (---) (n=14)												
M	47	49	49	48	51	53	52	46	46	47	50	49
SD	7.3	9.4	9.4	10.1	7.6	10.0	6.7	9.2	10.0	6.0	10.7	10.1
Experimental (——) (n=7)												
M	38	39	38	42	41	41	35	41	35	38	40	40
SD	11.3	7.1	6.7	8.0	9.1	7.8	14.4	4.5	11.8	9.1	9.7	6.2

* Significant at .05 level

Research Question Three

What association exists between parents POI scores and their demographic variables?

Although the parents in the experimental group volunteered and scored significantly lower than the control group on the POI subscores, there were no statistically significant differences found between parents POI scores and their demographic variables. Chi-square was performed at .05 level of significance. Variable and level of significance are presented in Table 1.

Table 1. Chi-square Analysis of Variance of Demographic Variables and POI scores of parents of preschool handicapped children.

Source	Chi-square	df	Significance
Age	8.25	8	.4094
Education	9.60	7	.2124
Income	8.00	4	.0916
Sex	2.52	1	.1121

Research Question Four

The main problem explored in this study was concerned with the effects of the treatment program on the parents level of self-actualization.

What effect does exposure to a humanistic experiential therapeutic group-parent education program have on parents of preschool handicapped childrens level of actualization?

Paired Student t's were used to compare the post treatment mean

scores between experimental and control groups. Figure 6 gives the mean and standard deviation of each of the 12 POI post subscores for the experimental and control groups.

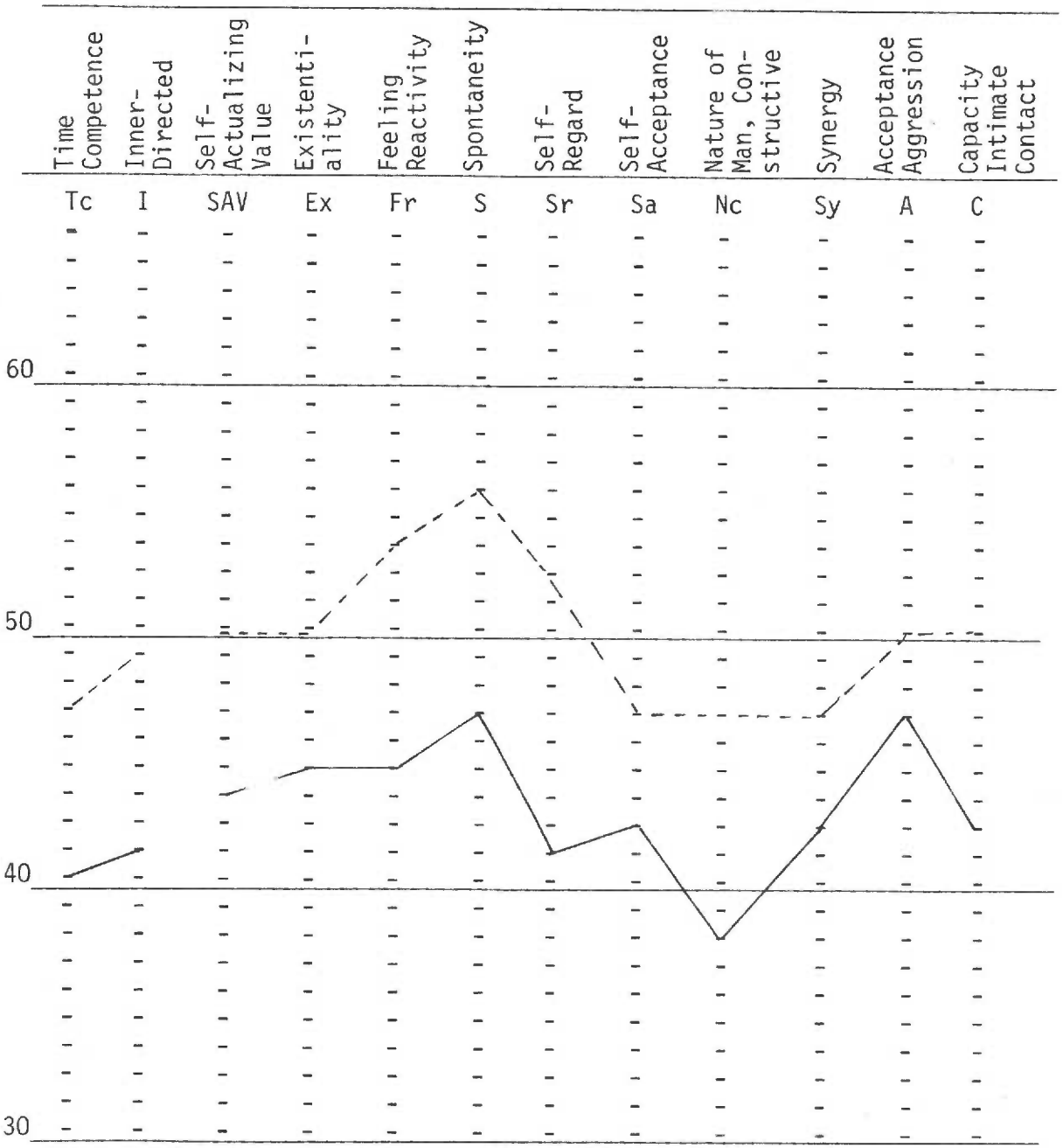
Differences between the groups at pretest were reduced in several subscore areas at posttest; Time Competence ($t(19)= 1.403$), $p < .10$), Inner-Direction ($t(19)= 1.601$, $p < .10$), Self-Actualizing Values ($t(19)= 1.379$, $p < .10$), Existentiality ($t(19)= 1.324$, $p < .10$), Self-Acceptance ($t(19)= 1.147$, $p < .10$), Nature of Man ($t(19)= 1.3$, $p < .10$), Synergy ($t(19)= 1.636$, $p < .10$), and the Acceptance of Aggression ($t(19)= .842$, $p < .10$).

Four subscores at posttest between the two groups remained statistically significant at the .05 level for: Feeling Reactivity ($t(19)= 1.909$, $p < .05$), Spontaneity ($t(19)= 2.4$, $p < .025$), Self-Regard ($t(19)= 1.87$, $p < .05$), and Capacity for Intimate Contact ($t(19)= 2.161$, $p < .025$).

Because the groups were of unequal size, equal variance within the subgroups could not be assumed. One-way ANOVAS were performed to determine if there were significant differences in the adjusted post treatment scores of the subjects.

Table 2 presents an analysis of the significance of the data between the experimental and control groups on each of the adjusted post mean subscores of the POI. The analysis of covariance resulted in an F ratio which was lower than the critical value of F at the .05 level of significance. No significant difference was found between the subjects exposed to the treatment program and the control subjects at posttest with adjustments made for initial differences.

Figure 6. Posttest POI Profiles for Experimental and Control Groups of Parents of Preschool Handicapped Children



	Tc	I	SAV	Ex	Fr	S	Sr	Sa	Nc	Sy	A	C
Control (---) (n=14)												
M	47	49	50	50	54	56	53	47	47	47	50	51
SD	8.1	9.3	11.1	10.3	7.2	10.1	5.8	10.3	10.6	6.8	10.9	9.5
Experimental (——) (n=7)												
M	41	42	44	45	45	47	42	43	38	43	47	43
SD	9.6	9.4	8.2	8.8	10.1	7.2	15.0	6.1	14.3	10.5	8.7	6.9

Table 2. One-way Analysis of Covariance of Experimental versus Control Subjects Posttest Performance on The Personal Orientation Inventory Using Pretest Scores as Covariate

SOURCE	SS	MEANS (ADJ) EXPERIMENTAL	CONTROL	F	SIG. OF F
Tc	8.298	46.09	44.60	.384	.543
I	7.588	47.79	46.32	.211	.651
SAV	5.194	48.92	47.69	.070	.794
Ex	.863	48.68	48.23	.037	.851
Fr	6.630	49.98	51.36	.175	.680
S	5.781	52.31	53.63	.114	.739
Sr	4.816	49.99	48.66	.107	.747
Sa	1.591	45.89	45.28	.079	.781
Nc	34.268	45.99	42.93	1.103	.308
Sy	14.970	46.10	48.24	.268	.611
A	76.637	52.93	48.39	1.758	.201
C	5.977	47.93	46.69	.300	.591

When the treatment condition is introduced the mean subscores for the experimental group raises in several areas, revealing that exposure to the treatment program does change subjects scores and is consistent enough within the group to be statistically significant. The difference between experimental and control groups at pretest becomes smaller at posttest. The effect indicated in Figure 6 shows the experimental group with a gain in mean score at posttest over the control group in all areas.

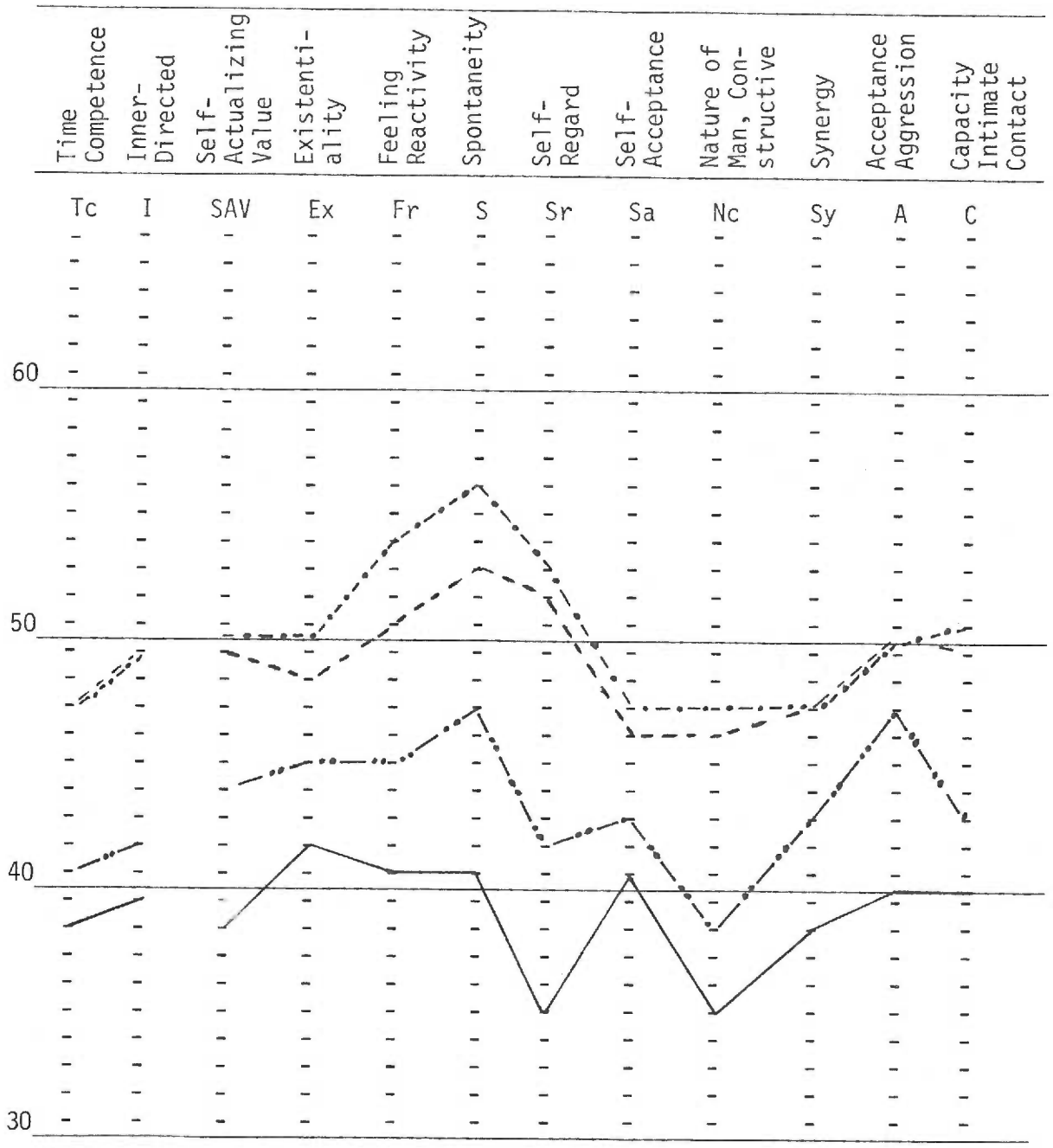
When the group pre and posttest means are graphed (Figure 7) it becomes readily apparent that the experimental group had considerable increase in subscores in the areas of Existentiality, Feeling Reactivity, Acceptance of Aggression, Spontaneity, Self-Regard, Self-Acceptance and Self-Actualizing Values. They also became more inner directed and time competent.

Parents in the control group had a small increase in scores in the areas of Existentiality, Spontaneity, Self-Acceptance and the Nature of Man.

An interesting observation is made when looking at the gains made by the control group scores from pre to posttest. If subscores of individuals who have a spouse in the experimental group (n=5) are removed from the control group mean, the control groups scores change very little; five scores remain the same (Time Competence, Existentiality, Nature of Man, Synergy, Acceptance of Aggression), two scores slightly increase (Feeling Reactivity, Spontaneity), and five scores slightly decrease (Inner-Directed, Self-Actualizing Values, Self-Regard, Self-Acceptance and the Capacity for Intimate Contact).

At posttest the subscore means of individuals with spouses in the experimental group increase in eleven of the twelve POI subscores. All of their scores were in the actualized range at posttest except for Acceptance of Aggression. Although their pretest scores were higher than their spouses attending the group, significant increases in scores at posttest were made in the areas of: Inner Direction ($t(4)= 3.64$, $p < .025$), Self-Actualizing Values ($t(4)= 5.92$, $p < .005$), Existentiality ($t(4)= 3.64$, $p < .01$), Spontaneity ($t(4)= 3.189$, $p < .025$), Self-Acceptance ($t(4)= 3.189$, $p < .025$), and Synergy ($t(4)= 6.37$, $p < .005$).

Figure 7. Pre and Posttest POI Profiles for Experimental and Control Groups of Parents of Preschool Handicapped Children



Summary of Evaluations

The seven participants in the experimental group completed a brief questionnaire, following posttesting with the POI, at the end of the last session. The questions and responses are summarized below.

1. What meaning has the group had for you?

One major theme emerged in response to this question. Parents felt an overwhelming positive response in being able to get in touch with feelings deep inside of them that had been buried for a long period of time. Bringing these feelings out for discussion was found by the parents to be very beneficial in helping them resolve painful issues.

2. If any particular aspect of your experience during the group stands out more than other aspects, would you please describe it?

The most frequently stated response to this question was related to the subjects' experiences in tuning into their emotions which gave them new feelings of confidence and assertion. This new confidence enabled many of them to begin long delayed dialogs with their spouses. Having a clear notion of what their feelings were along with the communication techniques learned in the group enabled them to begin clarification of postponed issues in their lives.

3. How do you plan to use the skills learned in the group on a daily basis?

The majority of responses to this question focused on plans to use their newly learned skills in monitoring their levels of stress and in taking steps to reduce it when it is high, e.g., "I have alredy set aside time for daily relaxation procedures." "When I find myself getting upset, I will analyze it and decide if its worth it." "I have begun swimming daily, which really reduces my tension."

4. Please identify the component(s) of the group which were:

(a) Most useful to you:

Several participants commented on the benefits they felt in having new and useful information on child management and development. Many parents valued the discussion of these issues and were pleased that they were not alone in their struggles. They stated that it was comforting to know other parents in the group had similar problems.

(b) Provided new information:

Most parents found the visulization techniques to reduce stress and contact feelings was entirely new information.

(c) Least useful to you:

All seven parents found nothing in the group as "least useful". One parent commented that she would like more indepth information on communication and relaxation techniques.

(d) Provided no new information:

One participant responded to this question. The concepts regarding child development were not new to this parent.

5. Please identify any major stresses that have come up in your life since the beginning of this group.

All seven parents had suffered a major financial or emotional stress during the period of time they were attending the group. There were job losses, emergency surgeries, automobile accidents along with the upcoming stresses of family visits for the holidays and final exams for the student parents.

Summary

In this chapter, the results of the data were presented and discussed

in relation to each of the research questions. A summary of the participants evaluation of the treatment program concluded the chapter.

CHAPTER V

DISCUSSION

Four research questions were formulated and tested at the .05 level of significance. The summary of results is presented in relation to each research question and includes a discussion of the findings as well as the theoretical implications of the results. Implications for nursing practice and suggestions for further research conclude the chapter.

Discussion of Findings for Research Question One

Research question 1 concerned the comparison of pretest mean Personal Orientation Inventory (POI) subscores of parents of preschool handicapped children with POI mean subscores of self-actualized individuals. Parents of handicapped children scored significantly below the self-actualized group in all areas except Feeling Reactivity.

Maslow postulated a hierarchy of needs. Lower level needs in this hierarchy must be experienced before actualization can be experienced. A handicapping condition in their child has been found to be a strain on parents lower level needs of economic and physical status, family harmony, social contacts and self-esteem (Kew, 1975; McMichael, 1971; Younghusband, 1971). The low POI subscore results would suggest that the stresses that parents of preschool handicapped children encounter have impeded their growth towards actualization. These findings are consistent with the constructs of humanistic psychology attributed to Maslow.

The POI subscores of Self-Regard and Self-Acceptance which measure

a persons self-esteem along with the other 9 subscores were significantly lower than the self-actualized group. This would tend to support the conclusion in the literature that having a handicapped child is likely to have a negative effect on parents self-esteem and the increased stresses decrease parents opportunity for actualization.

Further POI results indicate that the parents of this study were more outer (believe their lives are determined by others) than inner (feel in control of their lives) directed. This indicates a dependence on the support and views of others, be they family or professional. One explanation for this outer-directedness was given by many parents who expressed a feeling of confusion which existed at the time of diagnosis and continues to this day. Hospital procedures, medical terms of diagnostic assessment results, and busy health care professionals were stated as being reasons for the continued lack of understanding of their child's condition. This dependence on information and support from others appears to continue longer than the initial crisis that surrounds the time of diagnosis. Without timely adequate information, the parent's dependency appears to continue indefinitely with the resultant feeling that their lives are being determined by others.

In regarding interpersonal sensitivity, the POI results indicate that parents of handicapped children in this study tended to have difficulty forming or maintaining warm interpersonal contacts. If the major contacts parents are making are with the professionals caring for their child (Kew, 1975; Reports to Carnegie Trust, 1964; Tizard & Grad, 1964) there is little opportunity to seek a peer group for support and growth. The restriction of the families activities and finances reported by Kew

(1975) and McMichael (1971) also reduces the opportunity for contact. Many parents in this study were unable to attend the group due to lack of finances or trained babysitters to care for their child while they were gone. There were no couples in the group due to the necessity for one parent to be at home with the handicapped child.

In summary the parent's POI scores offer evidence of low self-esteem, dependency upon others for information and affirmation and a general trend of deferred actualization.

Similar POI profiles were reported by Hale (1979) in his study of parents of mentally retarded children. Parenthood has been postulated to be a time of developmental crisis for parents (LeMaster, 1965). It maybe that the lower scores for parents of physically and mentally handicapped children demonstrates that more than the normal expected crisis of parenthood is occuring. The findings of this study tend to support the conclusion that there is a difference between parents of handicapped children and the general population in terms of growth in actualization. This difference suggests that the presence of a handicapped child in the home impedes parental growth towards self-actualization.

Discussion of Findings for Research Question Two

Probing for other dimensions that might account for the low POI scores of parents of preschool handicapped children the researcher compared POI subscores of parents in this study with POI subscores of parents of nonhandicapped children. Parents of preschool handicapped children obtained scores that would indicate that they were less self-actualized than couples who had nonhandicapped children. Significant differences were found in the areas of Time Competence, Self-Actualizing

Values, Self-Regard, Nature of Man, and Synergy.

The results of this study indicate that the parent of the preschool handicapped child is more likely to live in the past or the future than other parents. The birth or diagnosis of a handicapping condition in their child occurred from 2½ to 5 years ago for these parents. Thus, it may be that they are preoccupied with the past in terms of causation and with the future in terms of planning for their child. Avoidance of the unpleasant, demanding present would also be reflected in the Time Orientation scores of the POI.

The POI results also indicate that parents of preschool handicapped children reject values of self-actualized individuals. The parental feeling of helplessness reported by Kew (1975) and McMichael (1971) is supported by the POI testing indicating that parents may have problems being autonomous and independent, and have an increased sensitivity to social pressures and expectations. This trend toward decreased actualization may stem from the dependency on others for information and care for their handicapped child, resulting in an inability to be spontaneous in thinking, emotions and behavior. Furthermore, the increased care taking needs, economic drain, and parental concern for the handicapped child does not allow for periods of privacy necessary for intense concentration that Shostrom (1964) stated led to a realistic orientation in the self-actualized individual.

Parents in this study are also more skeptical of man's goodness than parents of nonhandicapped children. They have difficulties viewing their fellow humans with trust and tolerance. In many of the group interactions, the parents expressed guilt over having possibly caused their child's handicapping condition. As the group progressed, parents began

to express anger toward various social institutions in our society. For example, one father was exposed to toxic chemicals while in the military and wonders if this caused his child's condition. The parents continue to be angry with the United States Government for putting people in the position of possibly being damaged. In another case, one couple's child was born at the change of shifts at a hospital during a time of much confusion, secrecy, and lack of support for the parents during the delivery. In the post partum period the parents received information that was confusing and difficult to understand. The medical terms used and the conflicting reports received from physicians began the feelings of helplessness which were exacerbated by the general avoidance they felt from the nursing staff. The mother was placed in a private room to "protect" her from viewing other mothers interacting with their babies. She also was unable to see her baby for three days. She stated, "I felt alone, abandoned, confused and helpless." Regarding health care professionals, all parents expressed a need for nurses and physicians to be more responsive to the emotional needs of parents. As one mother stated, "Don't give me the news in you fancy language, say you're sorry and walk away with a sad face. Sit down! Be with me! Explain things as many times as I need it until I can understand. Let me know you care."

The POI subscore results also indicate that parents in this study have difficulties in transcending dichotomies, to see opposites of life as meaningfully related. The presence of a handicapped child requires parents to make constant changes and learn new coping abilities. Fear of ridicule or rejection and the realistic difficulty of finding persons qualified to care for a child with many needs reduces the parents

ability to have some independence from the child and continue other adult relationships. This lack of stress relieving activities and resources for sharing their feelings may lead parents to have difficulty in realistically viewing stresses inherent in their family.

Discussion of Findings for Research Question Three

Searching for characteristics that might account for the low POI scores of parents of preschool handicapped children this study examined the demographic variables of sex, age, income, and educational levels of the parents. No significant associations were found between the parent's demographic variables and their pretest POI score results.

Because human development occurs over time and is a learning process strongly influenced both by exposure to changing life conditions and, as Eysenck (1975) maintains, by certain prevaling genetic predispositions, it seems logical, then, that increased exposure to adjustments encountered in educational and job related situations might increase awareness, broaden knowledge, and strengthen the innate creativity in the growing individual thus leading to increased levels of actualization. That the POI did not detect this tendency among respondents of this study again confirms the theoretical implication that the presence of a handicapped child leads to decreased levels of actualization for some parents. Furthermore, these changes appear unrelated to the sex, age, economic or educational levels of the parents in this study.

The above findings do not support Cummings (1966) and Fabrega and Haka (1967) studies which showed that fathers were detached and aloof and mothers were better able to work through feelings. Both parents

of the handicapped child in this study may be reacting differently, yet show equal evidence of lower levels of actualization, although the subscore of Feeling Reactivity was not significantly lower than Shostroms self-actualized group. This would indicate that parents may be aware of their own needs and feelings but may be placing perceived needs of her/his partner, family, and affected child first. This suggests that knowledge of one's needs and feelings does not necessarily translate into their being acted upon.

Discussion of Findings for Research Question Four

Research question 4 was concerned with the effects of a humanistic experiential therapeutic group-parent education program on parents of preschool handicapped childrens Personal Orientation Inventory scores. One-way ANOVAS were used to compare the posttest scores on the experimental and control groups. The non-significant F ratio obtained on the analysis of covariance established that no significant differences existed between experimental and control groups at posttest. The experimental group showed considerable positive movement in all 12 of the POI subscores compared with the control group which showed small positive increases in 4 of the 12 areas and negative changes in 2 of the areas.

An interesting phenomenon occurs when the POI subscores of spouses of parents who did not participate in the experiential group are removed from the control group scores. The changes noted in the control groups scores are primarily due to the increase in actualization obtained by parents who had a spouse in the experimental group. Although spouses who did not participate started with a higher premean score than their spouse who did participate, the majority of their posttest scores were

in the self-actualized range showing an increase in mean scores. These findings are consistent with the Systems Theory of family dynamics and support the conclusion that change in one family member results in changes in another family member. Parents in the group reported sharing the groups activities with their spouses. The communication techniques enabled many of the couples to discuss family issues that had previously resulted in marital discord. Parents also utilized group feedback to enable them to learn new approaches in interacting with their spouses. As one mother reported, "I don't know if it's this group or what, but we have not got along this well since J. (their handicapped child) was born. We are together more and discussing things I've been complaining about for years."

Parents in the experimental group were able to increase their inner directedness which is the major POI subscore that is an overall estimator of actualizing (Shostrom, 1964). The increase appears to be related to the new/renewed confidence in their abilities that parents reported. The parents confirmed repeatedly that exposure to other parents confirmed that they held similar feelings which they may have considered bad, harmful, or at least unusual. They also felt more competent as parents, which is substantiated by subscore results which show a shift from being dependant upon others to being more in control of their lives. This shift suggests that there is less need to look for external verification of the self and of parenting skills when inner confidence and self-esteem are present.

Parents in the experimental group were able to increase their capacity to form warm close relationships. They made movement that

could be accounted for by two factors. One element may be the fact that close relationships were developed between the parents in the experiential group. These feelings of closeness started at the onset of the groups when they shared the full range of emotion they felt with the birth and/or diagnosis of a handicapping condition in their child. This sharing enhanced the development of trust and relationships through open honest communication. Another element may be that parents were also taught communication skills to use with family and friends to encourage the open communication about feelings aroused in people by the presence of the handicapped child. Parents stated that this helped reduce the feelings of helplessness and embarassment that they felt whenever friends or relatives were around. The active listening taught could also be associated in improved scores for the Capacity for Intimate Contact.

The parents in the experimental group also learned to become more flexible in their application of values. It would be expected that parents in a state of prolonged confusion and an unresolved feeling state would hold more carefully to values until new, flexible ways of coping were comfortable.

When parents are feeling insecure about their approach to the child, they may be filling the vacuum created with external values and knowledge or opinions about child rearing. Many mothers in this study continue to have very close ties with their own mothers. Frequent contact is made for advice and comfort. It is hypothesized that as real acceptance of the self and child appears, the value of the parents own skills as a parent are confirmed. Thus, the outside expert will be less desperately clung to and the parents can begin to relax as they become more secure in their own skills.

The parents reported that confidence in parenting skills was restored or established with resultant enhancement of self-esteem. This confidence would tend to allow the parent the freedom to be flexible in values rather than adhere to rigid guidelines for fear of doing something wrong. This process of confidence and growth would show flexibility in the application of values (Existentiality) as was verified by the POI.

The parents were also able to increase their already relatively high level of feeling reactivity during the group. The group offered them a chance to focus on the self separate from the handicapped child which may increase sensitivity to personal needs, attitudes and feelings. In short, a greater awareness of self would be the result of participation in a group designed with a "feeling orientation." And, as humanistic theory purports, with greater self-awareness, the energy previously used to keep the self out of awareness is freed for coping with other problems and needs. The parents made movement from feeling helpless in the face of problems to being in control of their lives. The parents in this study are now in a better position to assume control over the development of their own selfhood.

The strong movement in the positive direction, towards increased actualization, for parents and their spouses, gives support for the use of this model in increasing levels of actualization for parents of preschool handicapped children. Given parents of handicapped children relatively high pretest mean scores of Feeling Reactivity (sensitive to personal needs and feelings) and Spontaneity in expressing feelings, it

logically follows that a here-and-now approach presented with a "feeling oriented" framework is an appropriate consideration.

Conclusions

In terms of Maslows humanistic theory, the results of the study suggest that parents of preschool handicapped children, although lower than the norm in levels of actualization, can be encouraged to grow again. Perhaps parent education enhances their sensitivity to their own feelings by providing an opportunity to become in contact with deeply buried emotions and a place where warm interpersonal relations may be developed through the sharing of feelings and issues, thereby leading to increased self-esteem. Parents need no longer rely upon outside contacts for direction. With a renewed sense of confidence in their abilities, parents are able to reorganize themselves at a higher level of functioning and actualization. Furthermore, positive change in one parent impacts on the other parent. Such a process when viewed as part of the psychological "chain reaction" described by Family Systems theory gives theoretical credence to the application of the actualizing model in the treatment of parents with handicapped children.

Implications for Nursing Practice

In traditional health care delivery settings which tend to function from pathology-oriented frameworks in relation to mental health problems, little if any provision is made for individuals who may not have severe mental health problems, yet need to develop a relevant repertoire of skills to strengthen and maintain mental health. This model of therapy and education in the treatment program emphasizes the individual's capacity for developing personal resourcefulness in her/his own mental health maintenance and wellness promotion.

On the basis of the findings, the treatment program developed for this study has the potential to serve as a model for psychiatric/ mental health nurse specialists to use in promoting self-actualization of parents with handicapped children. A mental health nurse specialist has not only the background in dynamic theory and techniques but the essential components of being able to understand and interpret to parents the health care related items.

Suggestions for Further Research

The suggestions which follow emerged from the investigator's retrospective reflection on this study. They represent a continuing commitment to the development and evaluation of mental health programs to address the deficits which exist for many families in acute and chronic stress situations.

The Population. Although the sample was obtained from a preschool that serves 90% of the identified preschool handicapped children in Benton County, the researcher cannot generalize to all parents of preschool handicapped children from the self-selecting group of parents in this study. Replication of this research is needed to determine if the same treatment model applied to other groups of parents would yield the same results.

In light of the experimental groups lower levels of actualization research is needed to determine if there is a difference in variables, other than the ones studied, between parents who volunteered for the group and parents who chose not to participate. Correlations between parent POI scores, the degree of the child's handicapping condition, the degree of bonding at birth and the presence of supportive relatives and friends may lead to significant variables.

A study of the place of residence of the parents might reveal what type of community can best meet the actualizing needs of a family with a handicapped child. Is a more rural or urban area with closer contacts and emotional support of neighbors and community or areas with increased facilities for evaluation, health care, and education better able to meet the needs of the family with a handicapped child?

In view of the typical discovery by individuals who participated in the treatment program that painful feelings had been buried and went back any number of years, introducing therapeutic/educative interventions earlier is recommended as a means of mental health prevention. Comparison studies of groups receiving interventions early could be made with groups of parents that received delayed or no interventions.

The Treatment Program. The researcher also served as the parent educator for the experiential group. The same model of parent education should be tested with a different educator. If the same positive results are found, it could be concluded that the model resulted in the parental changes and not the author's desire for positive results.

Some of the participants in the evaluation of the group suggested that more indepth presentations in communication skills and stress reduction techniques be included in the model. Several participants suggested that an advanced therapeutic group program be developed as a continuation of the treatment program. It may be that the parents were reluctant to have the program come to an end. Another possibility is that increasing skills necessary for further self-actualization requires additional refinement beyond an eight week program. Further treatment could either be in the form of a higher level program or

periodic follow-up meetings for the purpose of continued support and reinforcement of new learning.

Summary

The purpose of this study was to investigate the effects of a humanistic experiential therapeutic group-parent education program on parents of preschool handicapped children.

The sample for the study included 21 parent volunteers ranging in age from 21 years to 41 years of age. The mean age of the seven parents in the experimental group was 30 years while the control group was 31 years. The sample consisted of 1 male and 6 females in the experimental group and 7 males and 7 females in the control groups.

The research instrument was The Personal Orientation Inventory (POI) developed by Everett L. Shostrom to measure levels of self-actualization. Actualization is defined by the tests subtests: time competency, inner values, existentiality, holding the same values as self-actualized individuals, sensitivity to one's own needs, spontaneity, high self-worth, seeing opposites of life as related, seeing man as basically good, and having the capacity for intimate contact.

Twenty-one parent volunteers of preschool certified handicapped children were tested with the POI in September 1980. The mean score of the parents was compared with the POI subscores for self-actualized individuals and parents of nonhandicapped children.

Seven parents volunteered to take part in the experimental treatment program which was developed and presented by the researcher and consisted of eight sessions three hours in length over a three month

period. The remaining 14 parents served as a control group. Major treatment components of the program included stress reduction techniques, communication techniques, child development, behavior management and a humanistic experiential therapeutic group.

Parents in the experimental group and their nonparticipating spouses increased their level of self-actualization from pre to posttest. This strong positive movement gives support for the use of this treatment model, by psychiatric/mental health nurse specialists, in increasing parents of preschool handicapped children's level of self-actulization.

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APPENDICES

APPENDIX A

MINIMUM ELIGIBILITY CRITERIA FOR HANDICAPPED CHILDREN

(PL 94-142)

MINIMUM ELIGIBILITY CRITERIA FOR HANDICAPPED CHILDREN

The school staff shall use the following minimum criteria in determining a child's eligibility to receive special education and related services:

A. Visually Handicapped
The child shall be examined by an ophthamologists or optometrist licensed by a state board to verify:

1. That the child's residual acuity is 20/70 or less in the better eye with correction; or

2. That the child's visual field is restricted to twenty degrees; or

3. That the child has an eye condition which would adversely affect educational performance; and

4. That the child has received or is receiving medical treatment for an eye condition.

B. Hearing Impaired

1. Adequate information shall be obtained to document a deficit in auditory function sufficient to impair educational performance, based upon:

   a. Audiologic findings;

   b. Tests to determine speech and language deficits; and any or all of the following:

      (1) Standardized tests of achievement or intelligence;
      (2) Informal tests and inventories of academic performance (commercial or teacher made);
      (3) Data from systematic observation

2. The child shall be evaluated by an audiologist licensed in the State of Oregon or a physician licensed by a state board of medical examiners utilizing standard auditory diagnostic procedures to confirm hearing levels and determine any amplification needs.

3. The child shall be examined by a physician licensed by a state board of medical examiners to determine the need for medical treatment.

C. Speech Impaired

1. The child shall be evaluated by a qualified examiner using diagnostic procedures and tests appropriate for determining that:

a. The child has difficulty in one or a combination of the four areas of speech: articulation, phonation, rhythm, and symbolization;

b. The child's speech or language deviates from the accepted general developmental age norms;

c. The speech or language difficulties interfere with communication; or

d. The speech or language difficulties cause emotional stress.

2. The school staff shall have the child referred for a medical examination when:

a. There is an indication that a supportive diagnosis is needed;

b. The child fails to make satisfactory progress in the remedial speech program; or

c. There is evidence that the speech problem may be associated with pathology that requires medical treatment prior to or in addition to the remedial instructional activities.

D. Orthopedically Impaired or Other Health Impaired

1. The child shall be examined by a physician licensed by the Board of medical examiners for the State of Oregon to verify:

a. That the child's condition is either permanent or is expected to exist for more than a two-month period;

b. Whether the child required home or hospital instruction, supplemental classroom instruction, or related services.

E. Specific Learning Disabilities

1. A multidisciplinary evaluation team may determine that a child has a specific learning disability if:

a. The child does not achieve commensurate with his or her age and ability levels in one or more of the areas listed in subpart b below, when provided with learning experiences appropriate for the child's age and ability levels; and

b. The team finds that a child has a severe discrepancy between achievement and intellectual ability in one or more of the following areas:

(1) Oral expression;
(2) Listening comprehension;
(3) Written expression;
(4) Basic reading skills

(5) Reading comprehension;
(6) Mathematics calculation; or
(7) Mathematics reasoning.

2. The team may also determine that a child has a specific learning disability if it obtains evidence of a deficit in perception, conceptualization, language, memory, motor skills, or control of attention such as to prevent the child from profiting adequately from the regular class methods and materials with special education help.

3. The medical examination generally required in determining eligibility of handicapped children for special education may be waived by school staff, but medical examination will be recommended when learning problems may be associated with neurological, vision, or hearing problems, or when after a period of special education help, the child has failed to make reasonable progress.

4. The team may not identify a child as having specific learning disability if the severe discrepancy between ability and achievement is primarily the result of:

   a. A visual, hearing, or motor handicap;
   b. Mental retardation;
   c. Emotional disturbance; or
   d. Environmental, cultural, or economic disadvantage.

F. Seriously Emotionally Disturbed

1. The school staff shall obtain an evaluation of the child conducted by qualified educational authorities, with psychological evaluation when appropriate.

2. The emotional problems shall have existed over an extended period of time and to such a degree as to significantly interfere with the child's educational progress. The nature of the emotional problems may include:

   a. An inability to learn at a rate commensurate with the child's intellectual, sensory-motor, and physical development;

   b. An inability to establish or maintain satisfactory interpersonal relationships with peers, parents, or teachers;

   c. Inappropriate types of behavior or feelings under normal circumstances;

   d. A variety of excessive behavior ranging from hyperactive, impulsive responses to depression and withdrawal; or

   e. A tendency to develop physical symptoms, pains, or fears associated with personal, social, or school problems.

3. The child shall be examined by a physician licensed by a State Board of Medical Examiners to verify:

   a. Whether there are physical factors contributing to the child's educational problems;

   b. Whether medical treatment is needed prior to placing the child in a special education service; or

   c. Whether any other type of examination is needed.

4. Needed medical or psychological services should be provided concurrently with the special education services through the use of available ancillary resources.

G. Mentally Retarded

1. The school staff shall provide an individual intellectual assessment using one of the following standardized intelligence tests:

   a. Stanford-Binet
   b. WISC-R
   c. WPPSI
   d. The examiner in consultation with the parents may use an alternative individual performance test if deemed appropriate. Such test, however, shall be appropriate to the child's spoken language, and shall take into account the cultural background and other factors which could invalidate a child's test performance.

2. Intelligence tests shall be administered by a qualified examiner.

3. Intelligence test results shall not be more than one year old at the time the child's eligibility is established.

4. Intelligence test scores shall be two or more standard deviations below the mean.

5. The school staff shall substantiate that the child's academic achievement is below age and grade norms.

6. The school staff shall conduct an assessment of the child's adaptive behavior ro document whether there is consistent impairment of adaptive behavior in one or more of the following areas.

   During infancy and early childhood in:

   a. Sensory-motor skills development;
   b. Communication skills;
   c. Self-help skills;
   d. Socialization.

7. Adaptive behavior may be assessed by using a specific scale such as the American Association on Mental Deficiency Adaptive Behavior Scale--Public School Version; System of Multicultural Pluralistic Assessment; Gesell Developmental Schedules; or the Vineland Social Maturity Scale.

8. When a specific scale is not used, the project staff shall insure that nonspecific tests and the interpretation of test results relate to the standards expected of the child's age level and to the cultural norms of the child's home, community, and environment.

9. The child shall be examined by a physician licensed by a State Board of Medical Examiners to verify:

   a. Whether there are any physical factors contributing to the child's educational problems;

   b. Whether medical treatment is needed prior to placing the child in a special education service; or

   c. Whether any other type of examination is needed.

10. The school staff shall prepare a documented history of retarded overall functioning which summarizes all relevant, factual information obtained from family, developmental and school history to further support the child's need for special education.

APPENDIX B

INFORMED CONSENT

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER

INFORMED CONSENT

I, _____, herewith agree to serve
(First Name) (Middle Name) (Last Name)
as a subject in the investigation named, "The Effects of a Humanistic Experiential Therapeutic Group-Parent Education Program on the Self-Actualization Levels of Parents of Preschool Handicapped Children," conducted by Annabelle O'Neal-Saegaert, R.N., B.S.N., under the supervision of Susan Will, R.N., M.S.N., as part of the Masters Program of the University of Oregon Health Sciences Center, School of Nursing, Portland Oregon.

The investigation aims at discovering the levels of actualization of parents of handicapped children and to determine if exposure to a therapeutic-parent education class will change these levels of actualization. The procedures to which I will be subjected are: completion of questionnaires which will require approximately 30 minutes at the beginning and end of the class sessions, and participation in class sessions three hours in length which includes information of my selection and carefully selected guided experiences designed to put me in contact with feelings regarding myself and child.

The information obtained by the investigator will be kept confidential. My name will not appear on the records and the information I provide will be identified by a three digit code necessary for analyzing the data. Annabelle O'Neal-Saegaert has offered to answer any questions that I might have about my participation in this study. I understand I am free to refuse to participate or to withdraw from participation in the study at any time without effect on my relationship with Linn-Benton Community College, The Old Mill School, or the investigator.

_____ _____
(Date) (Subjects Signature)

_____
(Witness's Signature)

APPENDIX C

PERSONAL INFORMATION DATA FORM

PERSONAL INFORMATION DATA

Directions: Please answer all questions in the space provided to the right of the vertical line. Do not make any response in the margin. All responses are confidential and should be as accurate as possible.

Reference Number_____

1. _____	1. Sex: Female_____ Male _____
2. _____	2. Age: Years _____ months_____
3. _____	3. Marital Status: (Please Circle) 1. Single 2. Married 3. Divorced 4. Separated 5. Living with a male partner 6. Living with a female partner
4. _____	4. Personal Religious Preference (Please Circle) 1. No Preference 2. Protestant 3. Catholic 4. Jewish 5. Mormon 6. Other Religious Denominations: Please list _____
5. _____	5. 5. Approximate yearly income, after taxes, earned by all members of your home. (Please Circle) 1. $5,000 or less 2. $5,001 to $10,000 3. $10,000 to $15,000 4. $15,001 to $20,000 5. $20,001 to $25,000 6. $25,001 and above
6. _____	6. Formal education Completed (Please circle the last year of formal schooling you completed) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - 11 - 12 13 - 14 - 15 - 16 - 17 - 18 - 19 - 20 - 21 - 22 - 23

APPENDIX D

TOPIC AREAS FOR THERAPEUTIC-PARENT EDUCATION CLASSES

TOPIC AREAS FOR THERAPEUTIC PARENT EDUCATION CLASSES

Please select five areas that you would like discussed in the following weeks. Place a one (1) by the topic you would like most to discuss, a two (2) by the next, etc., until you have selected five.

____Techniques for Stress Reduction

____Principles of Child Development

____Current Research Regarding Minimal Brain Damage: Causes and Treatment

____Development of the Self-Concept

____Speech and Language Development

____Behavior Management Skills

____Child Motor Development

____Community Resources

____Genetics

____Dental Care

____Communication Skills

____Anatomy and Physiology of the Nervous System for Parents

____Nutrition

____Differences in Right and Left Brain Function

____Other Topics You Would Like to Discuss (Please List)

_____

_____

_____

_____

_____

APPENDIX E

CHILD DEVELOPMENT QUIZ

CHILD DEVELOPMENT QUIZ

PLEASE CIRCLE THE LETTER (S) THAT CORRESPOND TO YOUR CHOSEN ANSWER

1. The prenatal period is extremely vital because

   a. this is the period during which all brain development occurs
   b. allthe ground work is laid for everything that follows
   c. at this time maturation will either occur or not occur

2. Which of the following is not a disease which passes through the placental barrier?

   a. heart disease
   b. syphilis
   c. diptheria
   d. rubella

3. Most drugs affect an unborn child in the same way and to the same extent regardless of when the pregnant mother takes the drug.

   a. true
   b. false

4. Between 6 and 8 months the child is likely to develop

   a. a hairy covering on their body
   b. a strong single attachment
   c. increased aggression toward peers
   d. all of the above

5. The average child is able to take a step by

   a. 8 months
   b. 12 months
   c. 18 months
   d. 24 months

6. The development of motor coordination is affected by:

   a. the child's genetic heritage
   b. what a child is rewarded for
   c. what the child is encouraged to do
   d. all of the above

7. The main factor responsible for the development of muscular and motor skills is

   a. practice
   b. experience
   c. mental age
   d. maturation

8. Which of the following is correct about the way preschoolers reason?

   a. They often reason from the general rules they have figured out to specific cases.
   b. They reason on the basis of what they want to happen.
   c. They reason from specific cases and from general rules about what they expect to happen.
   d. none of the above.

9. Carolyn, at five, gets the letters "d" and "b" confused. This shows that:

   a. she is not unlike other five-year-olds.
   b. she may have a learning problem.
   c. she may have a visual problem.
   d. she has not had an academically oriented kindergarten experience.

10. Which is considered "normal" for the age range during which a child usually produces her first word?

    a. 10 to 12 months
    b. 12 to 18 months
    c. 8 to 18 months
    d. 10 to 20 months

11. The gap between what the toddler understands and what the toddler can say:

    a. is large
    b. will be closed by the time he is six
    c. is small
    d. none of the above

12. The most rapid vocabulary growth occurs during the periods of

    a. 6 to 12 months and 18 to 24 months
    b. 18 to 24 months and 30 to 36 months
    c. 1 to 2 years and 4 to 5 years
    d. 12 to 18 months and 30 to 36 months

13. A two year old commonly uses:

    a. one word utterances
    b. two word sentences
    c. multi-word sentences
    d. none of the above

14. During the toddler period, children generally preface most conversations with:

    a. "why"
    b. "no"
    c. "me"
    d. "I"

15. The child begins to use language to help solve problems during the stage from:

    a. 2 months to 13 months
    b. 18 months to 6 years
    c. 6 years to 12 years
    d. 12 years on up

16. From 18 months to 6 years the child advances in the areas of:

    a. physical growth and perceptual development
    b. language, cognition and interpersonal relationships
    c. self-concept and morality
    d. all of the above

17. Between 18 months and 2 years a child will probably show great advances in the areas of:

    a. cognition and language
    b. fine motor skills
    c. cooperative and associative play
    d. all of the above

18. Parents may have difficulty handling a two year old because at this age children are likely to show:

    a. the appearance of being less attached to their parents
    b. new cognitive and language skills
    c. more demands for independence and increased aggression
    d. all of the above

19. A four-year-old child could be expected to:

    a. button clothes and tie her shoes
    b. tell time and count to ten
    c. use a spoon and fork when eating
    d. pretend in her play and put away her toys

20. Which of the following statements describes a child at 5 years of age?

    a. enjoys parallel play
    b. enjoys dramatic play
    c. asks questions about birth and death
    d. has a vocabulary of over 2000 words
    e. can name basic colors
    f. needs help in dressing himself

21. Girls learning to be girls and boys learning to be boys grows out of imitation of adults of the same sex around the age of 5 or 6.

    a. true
    b. false

22. Even though a parent may expect one type of child (temperamentally) but get another type, this won't affect the parent's responses to the child.

    a. true
    b. false

23. Which factor(s) influences the strength of attachment between the infant and mother?

    a. time spent interacting with the child
    b. the mother's treatment of the child
    c. the child's temperamental qualities
    d. all of the above influence the strength of attachment

24. The child's first reference point for self identification probably is:

    a. his newly acquired language skills
    b. his own name
    c. his environment
    d. his parents

25. Which of the following might be the cause of a toddler's temper tantrum?

    a. loss of attention
    b. over stimulation
    c. strict behavior expectations
    d. all of the above

26. During the toddler years, aggressive behavior is usually expressed in the form of:

    a. verbal abuse
    b. spitting
    c. bed wetting
    d. temper tantrums
    e. all of the above

27. Which of the following are basically anxiety-producing situations for a young child?

    a. fear of being abandoned by a caring adult
    b. fear of losing significant other (caring adult) love
    c. fear of being punished
    d. A and B

28. The ability to control behavior develops with age and is related to a child's cognitive development.

    a. true
    b. false

29. The earliest time at which one can tell whether a child has a positive or negative self-concept is:

    a. 18 months, because the toddler with a positive self-concept, will be more outgoing.
    b. 5 or 6 years, because the child begins to verbalize feelings about self at this age.
    c. 3 years, because the nursery school teacher can readily identify the child with a negative self-concept.
    d. 12 years, because the young adolescent is just beginning to see the emerging adult self.

30. A child who has a poor self-concept is likely to

    a. do poorly in school
    b. be anxious
    c. be ineffective in groups
    d. have all of the above characteristics

31. Fantasy in children's play:

    a. is usually a withdrawal from real events
    b. is usually a reaction to real events
    c. is usually a time-wasting childish pastime
    d. is usually copied from TV

32. As the child grows from two to five years which of the following changes in aggressive behavior can usually be noted?

    a. older children are more likely to retaliate against injustice
    b. there is less aggressive behavior
    c. the younger child usually experiences the after effects of aggression
    d. all of the above can usually be noted

33. How does imitation (watching parents and family) affect aggression?

    a. it increases overall aggression
    b. it teaches new aggressive techniques
    c. it has little effect unless the consequences of the aggressive act are perceived as positive by the child
    d. none of the above

34. Whether or not a child follows rules may be influenced by the following factors:

    a. home discipline and parental behavior
    b. cognitive skills and physical characteristics such as brain damage
    c. the specific situation and the likelihood of getting caught
    d. all of the above

35. Parents who wish to encourage their children to follow rules and resist temtation regardless of the likelihood of getting caught

    a. withhold affection
    b. use reasoning techniques related to feelings and people
    c. use punishment to enforce strict rules
    d. insit upon instant, automatic obedience

36. For discipline to be successful, parents must be:

    a. consistent in their behavior and demands
    b. always willing to change rules
    c. willing to spank
    d. none of the abve
    e. all of the above

37. Which of the following is not true about punishment?

    a. punishment is a very common means of training children to behave acceptable
    b. punishment is less effective in training a child than showing the child an alternative way of behaving
    c. punishment may positively reinforce a child if gaining attention is his primary goal
    d. punishment is never necessary in child rearing

38. Picking up an infant when she starts to cry will actually decrease the baby's overall crying because:

    a. the baby will always be in the parents arms
    b. the baby is not able to learn what crying means
    c. the child develops a sense of trust in her environment
    d. none of the above

39. If a mother picks up an infant immediately after the infant begins crying, the baby will probably be spoiled and cry more.

    a. true
    b. false

40. Ideally, a child's teeth and gums should be appraised periodically beginning:

    a. just before he starts school
    b. as soon as he is sent to first grade
    c. shortly after completion of his baby teeth, usually between two and three years of age
    d. following completion of his baby teeth, usually between four and five years of age

41. A child should be suspected of a hearing problem if he presents one or more of the following conditions, except

    a. failure to respond to conversation when head is turned away

b. frequent requests for repetition of word or sound
c. faulty pronunciation of rarely used words
d. unusual dependence on visual cues

42. Signs of problems seeing include the following, except

a. frequent or continuous frowning
b. irritability when doing close work
c. inattention during reading periods, chart or map work
d. vomiting just before going to school

43. By the end of the first year, which immunizations should a baby receive?

a. Diptheria, tetanus, pertussis (whooping cough), (DPT)
b. Trivalent oral polio virus vaccine
c. measles-rubella vaccine
d. all of the above

44. As growth gradually slows doen in toddlerhood, the baby needs:

a. more snack foods to encourage his appetite
b. less food than he did earlier
c. parents who will make sure he gets a completely balanced diet each meal

45. During the first months after birth, the effect of malnutrition is most strongly felt in the area of

a. development of lifelong dietary habits
b. development of fine muscle coordination
c. development of eye coordination
d. development of the nervous system

46. The rate of development remains largely the same from child to child

a. true
b. false

47. The sequence of development remains largely the same from child to child

a. true
b. false

48. Mainstreaming involves

a. a therapist who goes along with the mainstream of scientific thought when deciding upon therapy for a retarded child
b. a retarded child who still lives at home in her natural environment
c. an atypical child who is put in a regular classroom with "normal" children
d. none of the above

APPENDIX F

THE PERSONAL ORIENTATION INVENTORY

July 5, 1980

Everett L. Shostrum PhD
205 W. 20th Street
Santa Ana, California 92706

Dear Dr Shostrum:

I am a graduate nursing student at the University of Oregon Health Sciences Center, Portland, Oregon. I am presently beginning a research project with parents of preschool handicapped children.

I would appreciate your permission to use the "Personal Orientation Inventory" in my research.

Please send your reply to: Annabelle Saegaert
2930 N.W. Princess
Corvallis, Oregon 97330

Thankyou very much for your time and assistance in this matter.

Sincerely yours,

[redacted]

Annabelle Saegaert R.N. B.S.N.

Permission Granted,

[redacted]

7/28/80

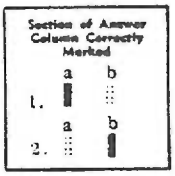
PERSONAL ORIENTATION INVENTORY

EVERETT L. SHOSTROM, Ph.D.

DIRECTIONS

This inventory consists of pairs of numbered statements. Read each statement and decide which of the two paired statements most consistently applies to you.

You are to mark your answers on the answer sheet you have. Look at the example of the answer sheet shown at the right. If the first statement of the pair is TRUE or MOSTLY TRUE as applied to you, blacken between the lines in the column headed "a". (See Example Item 1 at right.) If the second statement of the pair is TRUE or MOSTLY TRUE as applied to you, blacken between the lines in the column headed "b". (See Example Item 2 at right.) If neither statement applies to you, or if they refer to something you don't know about, make no answer on the answer sheet. Remember to give YOUR OWN opinion of yourself and do not leave any blank spaces if you can avoid it.



In marking your answers on the answer sheet, be sure that the number of the statement agrees with the number on the answer sheet. Make your marks heavy and black. Erase completely any answer you wish to change. Do not make any marks in this booklet.

Remember, try to make some answer to every statement.

Before you begin the inventory, be sure you put your name, your sex, your age, and the other information called for in the space provided on the answer sheet.

NOW OPEN THE BOOKLET AND START WITH QUESTION 1.

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SAN DIEGO, CALIFORNIA 92107

1. a. I am bound by the principle of fairness.
   b. I am not absolutely bound by the principle of fairness.

2. a. When a friend does me a favor, I feel that I must return it.
   b. When a friend does me a favor, I do not feel that I must return it.

3. a. I feel I must always tell the truth.
   b. I do not always tell the truth.

4. a. No matter how hard I try, my feelings are often hurt.
   b. If I manage the situation right, I can avoid being hurt.

5. a. I feel that I must strive for perfection in everything that I undertake.
   b. I do not feel that I must strive for perfection in everything that I undertake.

6. a. I often make my decisions spontaneously.
   b. I seldom make my decisions spontaneously.

7. a. I am afraid to be myself.
   b. I am not afraid to be myself.

8. a. I feel obligated when a stranger does me a favor.
   b. I do not feel obligated when a stranger does me a favor.

9. a. I feel that I have a right to expect others to do what I want of them.
   b. I do not feel that I have a right to expect others to do what I want of them.

10. a. I live by values which are in agreement with others.
    b. I live by values which are primarily based on my own feelings.

11. a. I am concerned with self-improvement at all times.
    b. I am not concerned with self-improvement at all times.

12. a. I feel guilty when I am selfish.
    b. I don't feel guilty when I am selfish.

13. a. I have no objection to getting angry.
    b. Anger is something I try to avoid.

14. a. For me, anything is possible if I believe in myself.
    b. I have a lot of natural limitations even though I believe in myself.

15. a. I put others' interests before my own.
    b. I do not put others' interests before my own.

16. a. I sometimes feel embarrassed by compliments.
    b. I am not embarrassed by compliments.

17. a. I believe it is important to accept others as they are.
    b. I believe it is important to understand why others are as they are.

18. a. I can put off until tomorrow what I ought to do today.
    b. I don't put off until tomorrow what I ought to do today.

19. a. I can give without requiring the other person to appreciate what I give.
    b. I have a right to expect the other person to appreciate what I give.

20. a. My moral values are dictated by society.
    b. My moral values are self-determined.

21. a. I do what others expect of me.
    b. I feel free to not do what others expect of me.

22. a. I accept my weaknesses.
    b. I don't accept my weaknesses.

23. a. In order to grow emotionally, it is necessary to know why I act as I do.
    b. In order to grow emotionally, it is not necessary to know why I act as I do.

24. a. Sometimes I am cross when I am not feeling well.
    b. I am hardly ever cross.

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25. a. It is necessary that others approve of what I do.

    b. It is not always necessary that others approve of what I do.

26. a. I am afraid of making mistakes.

    b. I am not afraid of making mistakes.

27. a. I trust the decisions I make spontaneously.

    b. I do not trust the decisions I make spontaneously.

28. a. My feelings of self-worth depend on how much I accomplish.

    b. My feelings of self-worth do not depend on how much I accomplish.

29. a. I fear failure.

    b. I don't fear failure.

30. a. My moral values are determined, for the most part, by the thoughts, feelings and decisions of others.

    b. My moral values are not determined, for the most part, by the thoughts, feelings and decisions of others.

31. a. It is possible to live life in terms of what I want to do.

    b. It is not possible to live life in terms of what I want to do.

32. a. I can cope with the ups and downs of life.

    b. I cannot cope with the ups and downs of life.

33. a. I believe in saying what I feel in dealing with others.

    b. I do not believe in saying what I feel in dealing with others.

34. a. Children should realize that they do not have the same rights and privileges as adults.

    b. It is not important to make an issue of rights and privileges.

35. a. I can "stick my neck out" in my relations with others.

    b. I avoid "sticking my neck out" in my relations with others.

36. a. I believe the pursuit of self-interest is opposed to interest in others.

    b. I believe the pursuit of self-interest is not opposed to interest in others.

37. a. I find that I have rejected many of the moral values I was taught.

    b. I have not rejected any of the moral values I was taught.

38. a. I live in terms of my wants, likes, dislikes and values.

    b. I do not live in terms of my wants, likes, dislikes and values.

39. a. I trust my ability to size up a situation.

    b. I do not trust my ability to size up a situation.

40. a. I believe I have an innate capacity to cope with life.

    b. I do not believe I have an innate capacity to cope with life.

41. a. I must justify my actions in the pursuit of my own interests.

    b. I need not justify my actions in the pursuit of my own interests.

42. a. I am bothered by fears of being inadequate.

    b. I am not bothered by fears of being inadequate.

43. a. I believe that man is essentially good and can be trusted.

    b. I believe that man is essentially evil and cannot be trusted.

44. a. I live by the rules and standards of society.

    b. I do not always need to live by the rules and standards of society.

45. a. I am bound by my duties and obligations to others.

    b. I am not bound by my duties and obligations to others.

46. a. Reasons are needed to justify my feelings.

    b. Reasons are not needed to justify my feelings.

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47. a. There are times when just being silent is the best way I can express my feelings.
    b. I find it difficult to express my feelings by just being silent.

48. a. I often feel it necessary to defend my past actions.
    b. I do not feel it necessary to defend my past actions.

49. a. I like everyone I know.
    b. I do not like everyone I know.

50. a. Criticism threatens my self-esteem.
    b. Criticism does not threaten my self-esteem.

51. a. I believe that knowledge of what is right makes people act right.
    b. I do not believe that knowledge of what is right necessarily makes people act right.

52. a. I am afraid to be angry at those I love.
    b. I feel free to be angry at those I love.

53. a. My basic responsibility is to be aware of my own needs.
    b. My basic responsibility is to be aware of others' needs.

54. a. Impressing others is most important.
    b. Expressing myself is most important.

55. a. To feel right, I need always to please others.
    b. I can feel right without always having to please others.

56. a. I will risk a friendship in order to say or do what I believe is right.
    b. I will not risk a friendship just to say or do what is right.

57. a. I feel bound to keep the promises I make.
    b. I do not always feel bound to keep the promises I make.

58. a. I must avoid sorrow at all costs.
    b. It is not necessary for me to avoid sorrow.

59. a. I strive always to predict what will happen in the future.
    b. I do not feel it necessary always to predict what will happen in the future.

60. a. It is important that others accept my point of view.
    b. It is not necessary for others to accept my point of view.

61. a. I only feel free to express warm feelings to my friends.
    b. I feel free to express both warm and hostile feelings to my friends.

62. a. There are many times when it is more important to express feelings than to carefully evaluate the situation.
    b. There are very few times when it is more important to express feelings than to carefully evaluate the situation.

63. a. I welcome criticism as an opportunity for growth.
    b. I do not welcome criticism as an opportunity for growth.

64. a. Appearances are all-important.
    b. Appearances are not terribly important.

65. a. I hardly ever gossip.
    b. I gossip a little at times.

66. a. I feel free to reveal my weaknesses among friends.
    b. I do not feel free to reveal my weaknesses among friends.

67. a. I should always assume responsibility for other people's feelings.
    b. I need not always assume responsibility for other people's feelings.

68. a. I feel free to be myself and bear the consequences.
    b. I do not feel free to be myself and bear the consequences.

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69. a. I already know all I need to know about my feelings.

    b. As life goes on, I continue to know more and more about my feelings.

70. a. I hesitate to show my weaknesses among strangers.

    b. I do not hesitate to show my weaknesses among strangers.

71. a. I will continue to grow only by setting my sights on a high-level, socially approved goal.

    b. I will continue to grow best by being myself.

72. a. I accept inconsistencies within myself.

    b. I cannot accept inconsistencies within myself.

73. a. Man is naturally cooperative.

    b. Man is naturally antagonistic.

74. a. I don't mind laughing at a dirty joke.

    b. I hardly ever laugh at a dirty joke.

75. a. Happiness is a by-product in human relationships.

    b. Happiness is an end in human relationships.

76. a. I only feel free to show friendly feelings to strangers.

    b. I feel free to show both friendly and unfriendly feelings to strangers.

77. a. I try to be sincere but I sometimes fail.

    b. I try to be sincere and I am sincere.

78. a. Self-interest is natural.

    b. Self-interest is unnatural.

79. a. A neutral party can measure a happy relationship by observation.

    b. A neutral party cannot measure a happy relationship by observation.

80. a. For me, work and play are the same.

    b. For me, work and play are opposites.

81. a. Two people will get along best if each concentrates on pleasing the other.

    b. Two people can get along best if each person feels free to express himself.

82. a. I have feelings of resentment about things that are past.

    b. I do not have feelings of resentment about things that are past.

83. a. I like only masculine men and feminine women.

    b. I like men and women who show masculinity as well as femininity.

84. a. I actively attempt to avoid embarrassment whenever I can.

    b. I do not actively attempt to avoid embarrassment.

85. a. I blame my parents for a lot of my troubles.

    b. I do not blame my parents for my troubles.

86. a. I feel that a person should be silly only at the right time and place.

    b. I can be silly when I feel like it.

87. a. People should always repent their wrongdoings.

    b. People need not always repent their wrongdoings.

88. a. I worry about the future.

    b. I do not worry about the future.

89. a. Kindness and ruthlessness must be opposites.

    b. Kindness and ruthlessness need not be opposites.

90. a. I prefer to save good things for future use.

    b. I prefer to use good things now.

91. a. People should always control their anger.

    b. People should express honestly-felt anger.

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92. a. The truly spiritual man is sometimes sensual.
    b. The truly spiritual man is never sensual.

93. a. I am able to express my feelings even when they sometimes result in undesirable consequences.
    b. I am unable to express my feelings if they are likely to result in undesirable consequences.

94. a. I am often ashamed of some of the emotions that I feel bubbling up within me.
    b. I do not feel ashamed of my emotions.

95. a. I have had mysterious or ecstatic experiences.
    b. I have never had mysterious or ecstatic experiences.

96. a. I am orthodoxly religious.
    b. I am not orthodoxly religious.

97. a. I am completely free of guilt.
    b. I am not free of guilt.

98. a. I have a problem in fusing sex and love.
    b. I have no problem in fusing sex and love.

99. a. I enjoy detachment and privacy.
    b. I do not enjoy detachment and privacy.

100. a. I feel dedicated to my work.
     b. I do not feel dedicated to my work.

101. a. I can express affection regardless of whether it is returned.
     b. I cannot express affection unless I am sure it will be returned.

102. a. Living for the future is as important as living for the moment.
     b. Only living for the moment is important.

103. a. It is better to be yourself.
     b. It is better to be popular.

104. a. Wishing and imagining can be bad.
     b. Wishing and imagining are always good.

105. a. I spend more time preparing to live.
     b. I spend more time actually living.

106. a. I am loved because I give love.
     b. I am loved because I am lovable.

107. a. When I really love myself, everybody will love me.
     b. When I really love myself, there will still be those who won't love me.

108. a. I can let other people control me.
     b. I can let other people control me if I am sure they will not continue to control me.

109. a. As they are, people sometimes annoy me.
     b. As they are, people do not annoy me.

110. a. Living for the future gives my life its primary meaning.
     b. Only when living for the future ties into living for the present does my life have meaning.

111. a. I follow diligently the motto, "Don't waste your time."
     b. I do not feel bound by the motto, "Don't waste your time."

112. a. What I have been in the past dictates the kind of person I will be.
     b. What I have been in the past does not necessarily dictate the kind of person I will be.

113. a. It is important to me how I live in the here and now.
     b. It is of little importance to me how I live in the here and now.

114. a. I have had an experience where life seemed just perfect.
     b. I have never had an experience where life seemed just perfect.

115. a. Evil is the result of frustration in trying to be good.
     b. Evil is an intrinsic part of human nature which fights good.

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116. a. A person can completely change his essential nature.

b. A person can never change his essential nature.

117. a. I am afraid to be tender.

b. I am not afraid to be tender.

118. a. I am assertive and affirming.

b. I am not assertive and affirming.

119. a. Women should be trusting and yielding.

b. Women should not be trusting and yielding.

120. a. I see myself as others see me.

b. I do not see myself as others see me.

121. a. It is a good idea to think about your greatest potential.

b. A person who thinks about his greatest potential gets conceited.

122. a. Men should be assertive and affirming.

b. Men should not be assertive and affirming.

123. a. I am able to risk being myself.

b. I am not able to risk being myself.

124. a. I feel the need to be doing something significant all of the time.

b. I do not feel the need to be doing something significant all of the time.

125. a. I suffer from memories.

b. I do not suffer from memories.

126. a. Men and women must be both yielding and assertive.

b. Men and women must not be both yielding and assertive.

127. a. I like to participate actively in intense discussions.

b. I do not like to participate actively in intense discussions.

128. a. I am self-sufficient.

b. I am not self-sufficient.

129. a. I like to withdraw from others for extended periods of time.

b. I do not like to withdraw from others for extended periods of time.

130. a. I always play fair.

b. Sometimes I cheat a little.

131. a. Sometimes I feel so angry I want to destroy or hurt others.

b. I never feel so angry that I want to destroy or hurt others.

132. a. I feel certain and secure in my relationships with others.

b. I feel uncertain and insecure in my relationships with others.

133. a. I like to withdraw temporarily from others.

b. I do not like to withdraw temporarily from others.

134. a. I can accept my mistakes.

b. I cannot accept my mistakes.

135. a. I find some people who are stupid and uninteresting.

b. I never find any people who are stupid and uninteresting.

136. a. I regret my past.

b. I do not regret my past.

137. a. Being myself is helpful to others.

b. Just being myself is not helpful to others.

138. a. I have had moments of intense happiness when I felt like I was experiencing a kind of ecstasy or bliss.

b. I have not had moments of intense happiness when I felt like I was experiencing a kind of bliss.

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139. a. People have an instinct for evil.

b. People do not have an instinct for evil.

140. a. For me, the future usually seems hopeful.

b. For me, the future often seems hopeless.

141. a. People are both good and evil.

b. People are not both good and evil.

142. a. My past is a stepping stone for the future.

b. My past is a handicap to my future.

143. a. "Killing time" is a problem for me.

b. "Killing time" is not a problem for me.

144. a. For me, past, present and future is in meaningful continuity.

b. For me, the present is an island, unrelated to the past and future.

145. a. My hope for the future depends on having friends.

b. My hope for the future does not depend on having friends.

146. a. I can like people without having to approve of them.

b. I cannot like people unless I also approve of them.

147. a. People are basically good.

b. People are not basically good.

148. a. Honesty is always the best policy.

b. There are times when honesty is not the best policy.

149. a. I can feel comfortable with less than a perfect performance.

b. I feel uncomfortable with anything less than a perfect performance.

150. a. I can overcome any obstacles as long as I believe in myself.

b. I cannot overcome every obstacle even if I believe in myself.

APPENDIX G

CURRICULUM FOR PARENT EDUCATION CLASSES

THERAPEUTIC GROUP-PARENT EDUCATION OUTLINE

Week 1:
- Introduction and Overview
- Warm-up exercise. Get acquainted and build cohesion
- Child Development Evaluation
- Discussion

Week 2:
- Warm-up exercise. Get acquainted and build cohesion
- Introduction and explanation of Personal Orientation Inventory
- Personal Orientation Inventory Evaluation of Parents

Week 3:
- Child Development: lecture and discussion
- Therapeutic group: First encounter with knowledge that something was different about their child

Week 4: 5
- Warm-up exercise. Build cohesion and experience mild stress
- Stress management lecture, discussion and dyad interaction
- Therapeutic group: Encounter stressful times involved in having a handicapped child

Week 6:
- Behavior Management lecture
- Teach "Child's Game" and "Adult's Game"
- Role playing in dyads topics covered
- Therapeutic group: Changes in marital dyad relationships surrounding management of handicapped child

Week 7:
- Communication: lecture, experiential, discussion
- verbal and nonverbal communication
- misunderstandings
- Therapeutic Group: Awareness of internalized roles and implications for externalizing power

Week 8:
- Warm-up: Preparation for separation and closure of group
- Retest with Personal Orientation Inventory
- Closing exercise
- Therapeutic group: Encountering strength from within

Week Three
CHILD DEVELOPMENT CURRICULUM

Instructional Objective	Content	Method	Material
Given a group discussion parents will be able to identify their individual needs for further child development knowledge.	Growth and Development: A. Prenatal Period B. Infancy C. Toddler D. Preschool	Review revised pretests that were completed in October, 80. (Appendix A)	Revised pre tests.
Given a brainstorming session parents will list some major developmental landmarks.	I. Principles of development-change through lifespan. A. Development is complex. 1. Tremendous range of individual expression. 2. Difficulty in predicting outcomes. B. Development is similar for all persons; steps we go through similar but exact sequence, rate, etc., all very different. (Brazelton, 1969, pp. XIV, XV) 1. Head to toe Middle to extremities (e.g. shoulders before fingers) Simple to complex.	Brainstorming	Brazelton, T.B. Infants and Mothers, A Delta Book: New York 1969.
	2. Developmental landmarks (Have parents use magic markers to write developmental landmarks on newsprint on wall)	Discussion	Newsprint sheets with titles: 1 year 2 year 3 year 4 year 5 year magic markers

Instructional Objective	Content	Method	Materials
Given a lecturette, the parents will be able to state two principles of development.	C. Development is a two-way street: the child affects his environment as much as it affects him. 1. Homuncules vs. tabula rosa. nature vs nuture 2. Development is interaction of child's temperment and abilities with environmental experiences and demands which the child encounters. (Thomas and Chess, 1977) D. Development goes through stages (e.g. Erickson) Trust/mistrust-infancy Autonomus/shame-preschoolers E. Development proceeds in vicious or benign cycles; there are rarely clearcut causes. e.g. Mother's reaction to two-year old negativity. (White and Watts, 1973)	Lecturette	Thomas, A.S., Chess, S. Temperment and Development, Brunner/Mazel: New York, 1977.

Weeks Four and Five
STRESS MANAGEMENT CURRICULUM

Instructional Objective	Content	Method	Materials
Given a handout "Instant Autobiography" parents will be able to interact with each other to increase awareness of differences and likeness.	Appendix B	Fill out form silent movement around the room reading other peoples. Break into dyads and share.	Handouts watch pencils tape
Given a lecturette parents will be able to define stress and its stages.	Definition: Any input stimulus interpreted as demanding adaptation or requiring the individual to do or be anything different than he is at this moment.	Lecturette	
Given verbalized story parents will be able to identify primitive origins of stress and the fight/flight response.	Stages of Stress: I. Alarm II. Resistance-Tension III.Exhaustion	Verbalized story of primitive man.	
Given a lecturette parents will be able to identify how stress manifests itself.	Memory Rings A. Word Memory B. Emotional C. Muscle D. Chemical-Cellular	Lecturette	
Given a handout parents will be able to identify areas that cause stress for them.	Roles, Values, People, and things: Parents will identify three of each. Take away any one of these and they will feel stress. Loss may occur by words, the system, death, etc.,	Completion of handout and discussion	Handouts: Appendix C,D,E, Pencils

Instructional Objective	Content	Method	Material
Given a diagram parents will be able to identify what happens to people when loss occurs.	The stages of grief: 1. Protest 2. Despair 3. Detachment	Discussion	Handout "Stages of Grief"
Given a lecturette parents will be able to increase their awareness of their ability to change stress producing situations	How to manage stress? 1. Increase awareness 2. Learn techniques to reduce.	Lecturette	
Given a handout parents will be able to identify their present methods of reducing stress.		Complete handout and discuss in dyads	Handout: "Stress Reduction Analysis
Given a handout parents will learn by discussion new ways of coping with stress.		Discussion	Handouts: "What the Doctor Says" and "Burn Out: Causes and Cures."

Week Six
BEHAVIOR MANAGEMENT CURRICULUM

Instructional Objective	Content	Method	Material
Given a lecturette parents will be able to state the influence of temperment on development.	Influence of temperment on development. A. Definition: temperment-the "How" of behavior abilities the "What" motivations the "Why". Nocorrelation between temperment and intelligence.	Lecturette	
Given a lecturette parents will be able to list several temperment characteristics.	B. Thomas & Chess-New York Longitudinal Study (NYLS) 1. Reasons for pursuing: belief in indiviuality of children, combating mal-de-mere syndrome. 2. Method NYLS-141 children-studied them from 1956 to present. Also studied rubella exposed, MR, and premature children and parents. 3. Nine categories of temperment. wide range of behavioral styles exhibited by normal children.	Lecturette	Brazelton, T.G., Infants and Mother 1969. Brazelton. T.G., Toddlers and Parents, A Delta Book: New York, 1976.
Given a handout, parents will be able to describe the differences between the temperments of the "easy child", the "difficult child", and the "slow -to-warm-up child."	Three tempermental constellations: a. easy-40% b. difficult-10% c. slow-to-warm up-15% There are other constellations	Discussion	Handout: "Nine Categories of Temperment"

Instructional Objective	Content	Method	Material
Given a group discussion, parents will be able to describe a situation in which an "easy", "difficult", and "slow-to-warm up might have difficulty adapting.	Discuss: 1. situations in which each "child" adapts easily. 2. situations in which each"child" has difficulty adapting. 3. Parental practices which are will matched with the child's temperment. 4. Parental practices which are not well matched with the child's temperment and could be detrimental to development.		News print sheets for: Easy Child Difficult Child Slow-to-warm up Child.
Given a group discussion, the parent will be able to explain the importance of matching expectations and demands to the temperment and abilities of the child.			
Given a handout parents will be able to identify behaviors that will increase positive interactions with their child.		Handout with discussion	Handout: "Child's Game"
Given a dyad interaction parents will be able to integrate and practice the concepts of the "Child's Game."		Break into two's take turns being child and parent.	Toys

Instructional Objective	Content	Method	Materials
Given a lecturette parents will be able to explain the concepts of teaching their child to mind and follow directions.	Teach adult how to avoid common problems parents have: 1. Not always being sure what they want the child to do; 2. Using too many words and explanations; 3. Giving more than one command at a time; 4. Failing to praise the child when he minds; and 5. Gicing up when the child is consistent in his refusal to mind. Procedure: Tell: Select one thing they want the child to do. Warn: Select a consequence if the child refuses to mind. Time Out: Carry out consequences Praise: Praise in a descriptive manner if child obeys.	Lecturette	3-5 cards "Adults Game"
Given a dyad interaction parents will be able to integrate and practice the concepts of the "Adults Game".			

WEEK SEVEN
COMMUNICATION CURRICULUM

Instructional Objective	Content	Method	Material
Given a group discussion parents will identify different ways people communicate.	I. Ways people communicate A. Verbal; 7% of message B. Nonverbal 80% of message. 1. 13% conveyed by voice qualities. i.e. pitch, volume, emphasis.	Discussion	None
Given a circle activity parents will be able to identify different perceptions people have of nonverbal communication.	I. Non verbal messages given and received by individuals varies.	Seated in a circle parents will volunteer to think of an experience and then take a pose to illustrate his/her feeling in that situation. The rest of the group will respond with one word descriptions of their perceptions of the nonverbal message.	
Given a small (4-5) group discussion parents will identify "roadblocks" to their communication.	I. People present different verbal and nonverbal means of communicating that prevents a clear message from being sent.	Discussion and retrival of ideas.	chalk board and chalk.
Given a lecturette parents will identify the major components of listening to the message of others.	Listening the other half of communicating: 1. Putting yourself in other persons shoes. 2. Rarely add content to the others message. 3. Give clues that you are listening.i.e. eye contact, head nod. 4. clarify in an unobtrusive way.	Lecturette	None

Instructional Objective	Content	Method	Materials
Given a lecturette parents will identify the major components of paraphasing.	When message sent is message received. Check out by: 1. Stating intention to share 2. Report what you understood partner to say; in your own words. 3. Partner confirms or clarify's original message by resending parts left out or misunderstood.	Lecturette	None
Given triads, parents will practice paraphasing anothers statement.		Seated in a triangle the first person will make a brief statement and the second person will paraphrase; incuding non-verbal or feeling messages included in the statement. It is the first person's responsibility to accept or reject the paraphase. In case of rejection the first person restates the original statement and paraphrazing is tried again. Continue until the first person feel he has been understood. The third person acts as observer and gives feedback to both. Roles change until all have had a turn in each role.	

Miller, S., Nunnally, E.W., and Wackman, D.B., Couple Communication:Talking Together. Interpersonal Communications Program, Inc.: Minneapolis, Minnesota, 1979.

APPENDIX H

EVALUATION OF GROUP QUESTIONNAIRE

EVALUATION OF GROUP

1. What meaning has the group had for you?

2. If any particular aspect of your experience during the group stands out more than other aspects, would you please describe it?

3. How do you plan to use the skills learned in the group on a daily basis?

4. Please identify the component(s) of the group which were:

   a. Most useful to you

   b. Provided new information

   c. least useful to you

   d. Provided no new information

5. Please identify any major stresses that have come up in your life since the beginning of the group seven weeks ago.

AN ABSTRACT OF THE THESIS OF

ANNABELLE O'NEAL-SAEGAERT

for the Master of Nursing

Date of receiving this degree: June, 1981

Title: The Effects of a Humanistic Experiential Therapeutic Group Parent Education Program on the Self-Actualization Levels of Parents of Preschool Handicapped Children

Approved: _____
(Susan J. Will, R.N., M.S.N., Advisor)

A humanistic experiential therapeutic group-parent education program was developed and tested for its effects on self-actualization levels of parents of preschool handicapped children. The Personal Orientation Inventory developed by Everett L. Shostrom, was used to determine parents level of self-actualization.

The sample consisted of 21 parent volunteers between the ages of 21 and 41 whose children were certified handicapped and enrolled in a mainstreamed preschool, in Corvallis, Oregon.

The quasi-experimental study utilized a pretest posttest static group design. The experimental group (n=7) received the treatment program taught by the investigator. The remaining parents (n=14) served as a control group.

The treatment program consisted of eight three-hour sessions based upon John Hale's (1979) model. Major treatment approaches included humanistic experiential therapy, information sharing of the parents choice, child development, and behavior management training.

Two-tailed t-test revealed significant differences at the .05 level between parents of preschool handicapped children and self-actualized individuals in 11 of the 12 POI subscore areas. Significant differences at the .05 level were also found in five of the 12 areas between parents of preschool handicapped children and parents of nonhandicapped children.

The experimental group volunteered to take part in the treatment program and scored significantly below the control group on 10 of the 12 pretest subscores of the POI, using a two-tailed t-test at .05 level of significance.

Paired student t's revealed no significant differences in eight of the posttest POI, subscore areas for the experimental and control groups.

A one-way ANOVA was used to take into account the pretest differences between the groups. The results indicate no significant differences in posttest adjusted scores between the two groups.

The humanistic experiential therapeutic group-parent education program produced statistically significant changes in self-actualization levels of parents of preschool handicapped children. The difference between experimental and control groups at pretest became smaller at posttest with the experimental group showing a gain at posttest over the control group.

It was concluded on the basis of this study that the therapeutic group-parent education program does effect some favorable changes in parents of preschool handicapped childrens level of self-actualization and has the potential to serve as a model for mental health nurse specialists in working with parents of preschool handicapped children.