Parent Education: Its Impact on Parental Well-Being

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PARENT EDUCATION: ITS IMPACT
ON PARENTAL WELL-BEING

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ABSTRACT

This study undertook to determine the effect parent training programs have on parental mental well-being and whether the reason parents enter training affects their initial level of mental well-being or the outcome of the training.

A review of the research literature reveals that parents are the appropriate subjects to train to change children's behavior and personalities. The literature does not support the theory that parents cause children's behavior and personalities, but we can conclude that parents are a definite, important influence in these areas.

In the process of learning to impact their children, the parents participating in parent education programs often change their own attitudes and behavior. There is an abundance of research literature available about changing children, but little adequate data about changing parents. Some information is reported about attributes and changes of parents resulting from parent education training.

Although we have found that parent education programs positively influence the mental well-being of children, it is of interest to the authors of this paper if parents are thus affected by parent training. If this is indeed so, it would be
profitable for the psychological welfare of the nation to devote more public funds and energy into parent education.

In order to establish an empirical meaning for "mental well-being" or "mental health" it was necessary to search the literature for mental health indicators. Since the mental health concept is confounded by the personal values of the researchers, it was very difficult to create an adequate operational definition of positive mental health. In reviewing all the commonalities of the available material, we chose attitude toward oneself and attitude toward others as the most important indicators of mental health. Parents were tested on these two variables using a valid, standardized instrument.

To determine whether the reason parents enter training affects the outcome of training, we were able to test two types of parents, those who voluntarily enter training and those who were forced into training by actions of their children (runaway, truancy, drug involvement).

The background, experimental methods, results and conclusions of the study are reported on the following pages.
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CHAPTER I

INTRODUCTION

With nineteen (19) million citizens suffering from various forms of mental illness requiring professional intervention (Garmezy, 1971), attention is now being directed toward what can be done to help healthy people maintain and strengthen their mental well-being. This new direction has resulted in a general movement from the medical model with its focus on treatment to a public health model focusing on prevention and education. A large portion of this education and preventive effort is being directed toward parent-child interactions in the family. Rose (1955) feels, "The family is...the crucial group in the preventive way toward mental health. The happy family, united by ties of affection and companionship, is our greatest resource for mental health."

Parents have the primary influence during formative preschool years and are in the best position to help ensure the individual's successful adjustment. Moreover, people who wish to affect behavior must frequently be in the natural environment in which that behavior occurs. Patterson (1968) found parents to be the obvious choice for training, not only because of the great amount of time children spend with their parents in their first years of
life, but also due to the cultural role of parents as the main dispensers of reinforcers and punishers for their children.

Since parents are the appropriate subjects to impact their children, the question arises as to how effective they are in the role of teacher or trainer. Hall, Axelrod, Tyler, Grief, Jones and Robertson (1972) taught a group of parents to record and measure data, apply behavior analysis, use different research designs and understand learning theory principles. Using this new information, parents were successful in identifying, setting up and implementing many varying programs addressing a wide range of behaviors. The experimenters' use of reversal to baseline design strengthens the validity of their findings.

Studies by Allen and Harris (1966), Zeilberger, Sampens and Sloane (1968) and O'Leary, O'Leary and Becker (1967) dealt with excess behaviors in children. The studies had high parental involvement, methodological control, specificity, collected baseline data, employed observers to check reliability and used reversal-to-baseline procedures. However, there was no provision for adequate follow-up.

Patterson, Jones, Whittier and Wright (1965) and later, Salzinger, Feldman and Portnoy (1970) were able to demonstrate that parents can successfully alter the behaviors of the brain-damaged child. Gardner, Pearson, Bercovici and Bricker (1968) showed that parents could impact the schizophrenic behaviors of their children. However, because the child also went through training,
it is not clear which training was responsible for the subsequent change. McPherson and Samuels (1971) demonstrated that parents can successfully modify the behavior of acting out, aggressive or hyperkinetic children. However, since the data was obtained from self-reports of parents, it is highly suspect. Mira (1970) conducted an extensive behavior modification program involving the training of 113 parents over a 21-month period. Self-care skills, inappropriate social behaviors, completion of academic assignments and self-mutilation were some of the behaviors modified.

The following studies instituted complex therapy programs combining professional involvement in clinical settings with extensive parent-involved programs to modify serious multiple problem behaviors. Wahler (1969), in working with oppositional children using parental reinforcement, demonstrated through training mothers that oppositional behaviors could be decreased and cooperative behaviors increased. He had no follow-up procedure, but did have adequate procedures for checking reliability and validity and used reinstatement to baseline procedures. Hawkins, Peterson, Schweid, and Bijou (1966) trained parents with problem parent-child relations to modify their children's behaviors. This study had the benefit of follow-up (one month), training and evaluation in the home, had high inter-rater reliability and reversal to baseline conditions. While the results of this study showed significant change of behavior in the home setting, generalization of behavior outside the home was not in evidence. Bernal, Duryee, Pruett and
Burns (1968), in order to demonstrate the effectiveness of the parent as therapist, trained one parent to modify her own behavior in interaction with her child. There was a two-year follow-up and extensive use of video tape during training for feedback purposes.

Existing research thus has demonstrated in increasingly sophisticated studies that parents can be trained to effectuate change in their children in a wide variety of behavior areas, and there does not appear to be any class of overt child behaviors that parents cannot be trained to modify. Can these well-trained parents who substantially improve their children's behavior also improve their personalities? Can they become primary mental health agents to prevent their children from joining the ranks of the 19 million mentally ill citizens?

Pumroy (1966), using no objective measures to support his clinical impressions, states, "it seems obvious that the attitude parents have toward child-rearing is related to the way they interact with their children and this, in turn, should have an effect on the personality of their children."

Various studies indicate that parents can affect the personality and psychological health of the child. According to Reif and Stollak (1972) who reviewed the literature on the subject, the findings are not identical. They explain this by emphasizing the multiplicity of variables, differences in definitions and methodology, and the importance of intervening variables.
Liberman, Stollak and Denver (1971), in an investigation of playroom interactional behaviors of twenty (20) sets of parents and children, found that parental qualities of empathy, genuineness and non-possessive warmth were significantly related to indications of positive mental well-being in their children. A similar finding was reported by Bierman (1969) in his research review of effective parent-child interactions. His findings suggest the dimensions of attention, affection and activeness in parents have a profound influence on their children's level of functioning.

In a study of pathological families, Singer and Wynne (1963), using a blind procedure in two phases, were able to distinguish between schizophrenic and neurotic children. Except for the absence of inter-rater reliability, their differentiations were valid and reached a statistically significant level of accuracy. As a result of their research they feel that it is the parent's thinking and relating to his child that are the crucial co-determinants of enhancing behavior in their children. Although they used a small sample, Lobitz and Johnson (1975) found from parent self-report confirmed by observation that both normal and deviant children responded to socially desirable changes in their parents' positiveness.

Foster (1971) demonstrated that individual children acquire specific behaviors to meet the needs of their parents, and parents using insufficient, defective communication patterns actually cause children to misbehave. Alexander (1973), in investigating the
communication patterns of twenty-two (22) normal and twenty (20) delinquent families supported Foster's findings. While families were involved in discussion and resolution, raters without knowledge of family status (delinquent or nondelinquent) checked the defensive and supportive communication patterns. Within problem families, the raters found destructive communication. In another study of family communication patterns, Alkire (1969) uncovered evidence that distortions in parent communications contribute strongly to disturbances in children. This replicates the findings of Foster and Alexander.

Numerous studies have attempted to identify characteristics in parents that may have resulted in abnormal behaviors in their children. Swift (1966) administered the P0I and PARI to forty (40) sets of parents with at least one child and found that parents' expression of control attitudes were significantly related to the level of psychological health of the parent. Specifically, the parent who expressed a lower need to control the behavior of his child appeared concurrently to feel that his own life was constructive, productive and enriched. The parent was successful in accepting his own behavior as well as the behavior of his child, while higher control parents were less secure, more uncertain and unfulfilled as individuals. The study featured accurate statistical procedures, reliable and valid instruments and a homogenous sample.

Murphy and Chandler (1972), in examining depressed mothers,
assumed that they bring up depressed children. In attempting to explain this relationship, they postulated that the children may be deprived because of the mother's withdrawal or preoccupation, or the children may become emotionally depressed in empathy with the mother. Also,

"the passive or tired mother in a meager home not only fails to provide information and personal stimulus, she may prevent activity, including activity such as asking questions which feed the spontaneous interest of the child."

Gassner and Murray (1969), in an investigation of parents of neurotic children and a control group of parents of normal children, showed that parents of disturbed children gave a higher priority to their own wishes and preferences than those of their children. Spinetta and Rigler (1972), in their review of literature on the child-abusing parent, found a preponderance of literature supporting Gassner and Murray's study. Sherman and Farina (1974), investigating other parental characteristics, demonstrated that poorly adjusted children are inclined to have parents who lack social skills. The design of their study makes one question their conclusions, however. Using groups of college men rated by their peers as to social skills, they compared these students to their mothers who had self-rated themselves as to social skills. Not only does this study fail to point out causality, but it fails to control for variables possibly influencing the outcome.
The preceding research provides some evidence to show that parental practices and influence do affect their children's behavior and personality development, but do they cause it? Macfarlane (1964) did an intensive study of 200 children from infancy to adolescence, then saw them again at age 30. He predicted that the children from troubled homes would be troubled adults and the children with happy childhoods would be happy adults. The results proved wrong in two-thirds of their predictions. However, it is not clear what the effect of time (adolescence to age 30) or other significant events might have had on the resulting adults' attitudes. Macfarlane's results concur with Frank's conclusions following his review of the literature (Frank, 1965). He could find no factors in the parent-child relations of disturbed families to distinguish them from other families. He further affirms that the assumption of the family as the factor in the development of personality has not been validated. From his review he offers an optional hypothesis:

"Perhaps the child's perception of family members rather than what they really are, or maybe what the child brings to the family, such as his nervous and metabolic systems and his cognitive capacity to integrate stimuli into meaningful perceptual and conceptual schema may also influence his personality."

His ideas are not based upon research findings, but rather the lack of conclusive data from studies of the family's role in
personality development. Zuckerman (1966) takes issue with Frank's findings in the literature. While acknowledging that the role of familial factors is not simple, Zuckerman sees it as an important one. He reports that Frank made an error in interpreting the PARI in the Zuckerman, Oltean and Monashkin (1958) study for not one item, but one scale distinguished mothers of schizophrenics from mothers of normals. Another factor to note is that the PARI requires parents to describe the ideal and not themselves.

To thoroughly investigate the controversy of the cause-effect model in parent-child relations is beyond the scope of this paper, but from the research literature reviewed, we feel justified in concluding that parents do indeed influence the mental well-being of their children. This conclusion leads us to theorize that properly trained parents may possibly become effective mental health agents in their homes and communities.

Currently, there are many types of parent education programs available to train parents to be more effective in dealing with their children. This paper will not review the types of programs, but will consider the attributes of parents who participate successfully in these programs. Little research is available at this time, but studies do present opinions and occasionally data suggesting relationships between certain measures and successful parent training outcomes.

Patterson, Cobb and Ray (1972) found that training some uneducated, lower socio-economic parents to be difficult and often
unsuccessful because of their lack of even the most rudimentary child management skills. However, Mira (1970) found no relationship between parents' education, intelligence or socio-economic level and training success. There was no follow-up on her extensive behavior modification program though. Salzinger, et al. (1970) found educational level, intelligence and reading ability of the parent, motivation and cooperation to be positively related with successful outcomes, and the higher these particular measures were, the more likely was a positive outcome. Zuckerman, Barrett-Ribback, Monashkin and Norton (1958) tested 413 mothers in a factor analysis of parent attitude scales. They found that the single most significant variable was the education of the mother. Schaefer (1959) tested 100 mothers in a factor analysis of parent behavior ratings with similar results.

Wagner (1968), reporting only one behavior modification case study as representative of his may clinical cases, demonstrated how to train a mother to modify her 11-year old girl's eating and social behaviors. He emphasized that the successful training outcome depended on the parental attributes of motivation and cooperation. Bernal, et al. (1968) and Bernal, Williams, Miller, and Reagor (1972) concur with this emphasis. Wahler (1969), Hawkins, et al. (1966) and other parent-child behavior modification studies also contribute their successful outcomes to the parents' interest, consistency and cooperation.

In summary of the few studies available, we find that the
most common attributes of parents successfully participating in programs were cooperation, motivation and education. Research does not reveal whether parents enter training with these attributes, or if they acquire them during training. However, research has shown that parent education programs designed to change parent attitudes toward their children often change parents' attitudes toward themselves and others.

Larson (1972), in a three-year project testing the effectiveness of small group approaches in bringing about improved family communications, found that improved self-concept resulted in two of the three groups of parents studied. However, he only collected data during the last year of the study and did not use the same measures for assessment. He did try to control for the expectations of the members by assigning them to groups for which they volunteered and used waiting lists as control groups. Collins (1954) demonstrated that mothers' attitudes in child management showed "real" changes during a two-week training program for parents of hearing handicapped youth. Although her study consisted of only 17 mothers, she used self-reports, observation by the staff, situational checklists and a parent attitude survey to confirm her results. Similar results were found by Schmitz (1975) as he replicated previous studies of Parent Effectiveness Training courses. He found that this training changed the participants' attitudes significantly in the areas of causation and trust (as measured by the Parent Attitude Survey Scales) and authorianism,
dogmatism and close-mindedness (as measured by the Dogmatism Scale, Form F). Stearn (1971), also using Parent Effectiveness Training courses, demonstrated that not only did parent attitudes toward democratic control change in a more democratic direction, but the children of parents who become more democratic showed gains in self-esteem. Spoon and Southwick (1972), in studying parent education programs observed that:

"The participants seemed to be saying that they had gained a greater objectivity about their lives along with the necessary flexibility, motivation and openness to try to improve themselves."

Since parent education programs may affect parents' attitudes about themselves as well as their children, this paper proposed to investigate and measure some of these attitudes, particularly attitudes related to positive mental well-being. To do this we will attempt to establish some meaning for the term "mental well-being" for empirical use in this study.

Mental illness can be identified by symptoms, but how does one identify mental health? Is it the opposite of mental illness? There are many opinions available. Kahoe (1975) views mental health and mental illness as separate dimensions and not just the opposite or absence of one another. He feels that mental health involves a defensive ego orientation and a growth-related task orientation.

Clausen (1956) defines it as the individual's ability to
resist mental illness under stress. Kubie (1954) finds a pre-dominance of conscious over unconscious urges in the normal population. Martin (1970) feels we may never be able to define it, but it may be determined by evidences of emotional well-being. However, Branch (1975) says there is more to it than emotional elements, namely the effect of the social environment. Caplan and Grunebaum (1967) think it depends on an adequate provision of psychosocial resources. Hofling (1975) sees it as successful adjustment which includes a realistic appraisal of life situations, an effective conscience, ability to love others and the ability to find outlets for needs. Menninger (1953) outlines similar characteristics of a mentally healthy person. (See Appendix A.)

Shoeben's (1957) five criteria of positive mental health include consciousness or insight, self-control, personal responsibility, social responsibility and democratic social interest ideals.

The only model of positive mental health researched and described in the literature is the self-actualized person discussed by Abraham Maslow (1954) and Carl Rogers (1951). The characteristics of this mentally healthy model include a realistic orientation, acceptance, spontaneity, independence and other characteristics listed in Appendix B. Carl Rogers believes that when self-actualization is attained, there is little discrepancy between the perceived self and the ideal self.

There are many and varied opinions and views of mental well-
being as expressed by the above mostly derived from clinical observation and theorization. Some actual research has been done in this area, and two important large-scale attempts to assess the mental health of a population are reported below.

The Midtown Manhattan study (Srole and others, 1962) established by Thomas Rennie in 1950 was an attempt to rate the mental health of 2000 adult residents of Manhattan by securing a single, lengthy interview with each. A structured interview was outlined by a carefully prepared questionnaire emphasizing intra-psychic functioning, interpersonal relationships and inquiry about physical health problems with a psychosomatic basis. Each interview questionnaire was evaluated according to personality strengths and weaknesses by two psychiatrists. Over 26% of the group interviewed were rated impaired or incapacitated. Their final definition of mental health was freedom from psychiatric symptomatology and optimal functioning of the individual in his social setting. This definition is representative of the early influence of the medical model.

The validity of the study was affected by the lack of personnel with the same level of training to conduct the interviews. Many types of mental health workers participated which affected the uniformity of the information gathered. Also, the raters did not have a perspective on long-term functioning in order to differentiate major adjustment problems from situational stress problems. Some symptoms would not be revealed in a single interview.
and were not obtained.

A similar study by Alexander Leighton (1959) and his associates of Cornell University (1963) in 1948-50 was the Stirling County study done in rural Canada. A much smaller population of 1150 was sampled, but the small community atmosphere made it possible to have access to additional information and records. Participants consisted of people who were psychiatric cases, people who probably would become psychiatric cases and those who may not become psychiatric patients. Classification was done by psychiatrists and extended to the whole lifetime. About 31% of the population fell into the impaired category. Rigorous study of the inter-rater reliability of the ratings of the psychiatrists suggested correlations of 0.90, but many questioned whether the method of using a potential psychiatric population is a meaningful way to assess mental health. People with similar symptoms had different reactions to these symptoms, some being able to function in the community and others who were unable to fit in and cope. Golfarb, Moses and Downey (1965) found that the high agreement reached by the psychiatrists on overall ratings dropped substantially when looking at specific symptom patterns.

Both of the studies purported to assess strengths but actually ended up evaluating impairment. Also, they could not determine whether impairment resulted from physical illness, mental illness or circumstances. Another weakness of the studies is the use of the technique of the interview. Kendall (1954) points out
that there is no established reliability for interview data, and it may be influenced by moods, sequence of questioning, response to the interviewer and other subtle factors.

Smith (1966) conducted an interesting study exploring the competence of Peace Corps teachers in Ghana. He did detailed tape-recorded interviews near the end of the first and second years of service which were screened by judges for descriptive ideas characterizing the personalities of the volunteers. He intercorrelated the resulting personal profiles of item ratings and factored the matrix of correlations to obtain personality patterns. Patterns of self-confidence, high self-esteem, energy, responsibility, autonomy, trust in others, persistence with flexibility and hopeful realism were found. These correlated with measures taken while the volunteers were still in training. Except for the possibility of the halo effect due to the type of persons being rated, the study appears to be valid and reveals some possible mental health indicators.

Some of the best and most comprehensive research on the meaning of positive mental health has been done by Marie Jahoda (1958). She concluded from her studies that mental health is a function of behavior patterns and environment, and "all ideas on positive mental health examined can be assigned to one of these six categories" as follows:

1. Indicators of positive mental health should be sought in the attitudes of an individual toward his own self.
2. Another group of criteria designates the individual's style and degree of growth, development of self-actualization as expressions of mental health. This is not self-perception but concerns what a person does with his self over a period of time.

3. Integration of the above two categories.

The following groups of criteria concentrate on the person's reality concepts:

4. Autonomy in his degree of independence from social influence.

5. Adequacy of a person's perception of reality.

6. Environmental mastery--adequacy in love, work and play. (p. 23)

Jahoda also says:

"By and large, empirical indicators are not well developed in the mental health literature. As a consequence, the assessment of an individual in this respect is often left to the intuitive insight of an observer. The vast research literature on human behavior, on the other hand, presents many empirical indicators and ingenious devices for observation, but it rarely deals with the complex problem of what constitutes mental health." (p. 82)

The recent research of Gavin (1975) concurs with Jahoda's criteria for he cites environmental mastery along with satisfying
relationships as important. Wertheim (1975) also operationally defines four components of mental health which include emotional capital or investment, autonomy, self-regulation and competence.

White (1973) and Buss (1966) agree with the extensive study of Dr. William Soskin for the Joint Commission on Mental Illness and Health (1966) which concluded that there is no completely acceptable, all inclusive concept in existence for mental health. It is an individual personal matter that may vary with the time, place, culture and expectations of the social group. Also, Dr. Soskin reported that mental health research procedures, settings and objectives are so varied they defy classification. Also, many studies are relevant to mental health, but are not labeled so.

This very reason makes it difficult to even review the literature on mental health. However, Scott (1958) did do a review of research definitions of mental health and concluded that more research is needed into the relationships among the criteria and into the conditions under which these intercorrelations vary.

In scientific research it is important to separate values from concepts and measures, so we must try to define mental health in nonevaluative variables. Smith (1961) criticizes the lists of mental health criteria prevalent in the literature, even those of Jahoda and Maslow, saying they have little scientific merit. He recommends a systems theory approach coming from observable data and noncontradictory to accepted theories of personality, yet coming from the larger social field of which they are a part.
However, the values problem encountered in giving the concepts empirical meaning that is relevant to research and practice is generally frustrating. According to French (1968) the major variables are:

1. The person including self-identity and personality along with demographic characteristics.
2. The objective environment including organizations, groups and interpersonal relations.
3. The psychological environment including organizations, groups and interpersonal relations.
4. Responses including affective, physiological and behavioral.
5. Mental and physical health and illness.
6. Interpersonal relations including liking, power and trust.

French believes:

"...it is important to include measures of mental health variables which sensitively reflect the major influences of the environment on mental health, so such data will eventually lead to knowledge useful in preventing poor mental health and in promoting good mental health by means of improvements in the social environment." (p. 159)

His research tends to be inclusive and eclectic selecting important variables amenable to reliable quantification. So the variables
may have nothing in common, but may apply in different realms. For example, adjustment refers to a relationship between the person and the objective or psychological environment. This has direct implications for data collection for it must be obtained from sources other than the person. So mental health is multidimensional involving many concepts and many types of data.

French feels the Self-Identity Theory which includes the variables of self-esteem, self-actualization and adjustment are good mental health indicators.

In a six-year study done at the University of Illinois under the direction of Wilbur Schramm and Dr. Charles Osgood (Nunnally, 1961) dealing with what people feel and think about mental health phenomena, some personality variables chosen as basic were the self-concept and perception of others.

In reviewing the commonalities of all the previous research and information, we also have decided to use the following two elements as determinants of mental well-being for the purposes of this study:

1. Attitude toward oneself - Self-awareness, the ability to respond to one's own needs and feelings, to feel secure and confident about oneself, to perceive reality correctly, and to have a positive self-concept and self-esteem.

2. Attitude toward others - Empathy, the ability to relate well with others, to understand their needs and feelings,
to communicate adequately and to function successfully in society.
STATEMENT OF THE PROBLEM

Historically, as Brim (1965) found, parent education programs have tried to judge their effectiveness by evaluating the resulting behavior of the child with almost no reference to the contributions of a parent's personal characteristics. Little research exists on the effects of parent training programs on parental mental well-being despite findings demonstrating that changes in parent attitudes significantly affect the child's well-being (Liberman, et al., 1971; Bierman, 1969; Medinnus and Curtis, 1963; Lobitz and Johnson, 1975; Stearn, 1971).

By means of a standardized instrument this study will attempt to measure the selected variables of mental well-being in parents entering parent training classes and again after completing training. This leads us to the first question this study will attempt to investigate:

Do parents involved in parent training education demonstrate more significant gains in mental well-being than parents not involved in any parent education training?

Our research has shown that parent attitudes and motivation significantly affect the outcome of training. Of importance also to this study is whether or not the circumstances under which
parents enter training is a determining factor in the mental well-being of the parents. To investigate this, two types of parent groups entering training for varying reasons were evaluated. One group consisted of parents who voluntarily chose training for self-improvement purposes, and the other consisted of parents who were forced into training by actions of their children. Within these groups of parents the following questions were considered:

Do parents who voluntarily choose parent training demonstrate a higher level of mental well-being prior to entering training than parents who are involuntary participants?

Do voluntary parents demonstrate more significant gains in their mental well-being as a result of parent training than do involuntary parents?

From the above questions, we have generated the following hypotheses:

1. Parent training significantly improves parental mental well-being.

2. Parents who voluntarily enter parent training show a higher level of mental well-being prior to training than parents who involuntarily enter training.

3. Parents who voluntarily enter parent training show more significant gains in their mental well-being following training than do parents who involuntarily enter training.
CHAPTER II

METHOD

This chapter describes the experimental design in regard to subjects, apparatus and procedures.

Subjects

The subjects for this study were composed of five groups of parents categorized as follows:

1. Voluntary Experimental Parent Group - Voluntary parents were those parents who have identified themselves (enrolled without external pressure) as in need of or desiring a type of parental instruction. Specifically, this group is composed of parents who were already participating in some parent-child cooperatives under the direction of the Parent Resource Center of Orlando, Florida. The participating parent-child cooperatives were located at the Asbury United Methodist Church, 220 West Horatio Avenue, Maitland, Florida and the St. Mark's Lutheran Church, 1121 Fairbanks Avenue, Orlando, Florida.

2. Voluntary Control Parent Group - Again, voluntary parents were defined as those parents who have identified themselves as in need of or desiring parental instruction. This group was created by parents on a waiting list for prenatal training at
Winter Park Memorial Hospital, 200 North Lakemont Avenue, Winter Park, Florida.

3. Involuntary Experimental Parent Group - Involuntary parents were those parents who have entered parental instruction as a result of external factors. Specifically, involuntary parents refers to those parents who have entered training as the result of actions of their children, i.e. runaway, truancy, drug involvement. This group was composed of parents attending a Communication Workshop for Parents of Adolescents at Great Oaks Village, 1718 East Michigan Avenue, Orlando, Florida.

4. Involuntary Control Parent Group - Involuntary parents were again defined as those parents identified by their children's behaviors as needing parental instruction. This group was composed of parents awaiting parental instruction at the Remedial Behavior Center of Great Oaks Village, the Youth Development Center of Thee Door of Central Florida, Inc., or the Green House Family Counseling Center, Inc. These parents will at a future date be involved in parental training as were those parents making up the Involuntary Experimental Parent Group.

5. General Parent Control Group - General parents were those parents not involved in any parental skills training either as voluntary or involuntary participants. This group was composed of parents attending APPLE (Adventist Parents Play-Learning Experience), a parent-child play group meeting bimonthly at Forest Lake Elementary Educational Center, Sand Lake Road, Maitland,
Apparatus

A way of evaluating parent education programs can be accomplished by determining how successful a particular program is in accomplishing a predetermined set of objectives. From the objectives of the programs participating in this study (see Appendix C and Appendix D) and from the preceding research review, the two variables of self-awareness and empathy (attitude toward oneself and attitude toward others) have been selected as important mental health indicators and common objectives of the two programs.

Subjects were administered the Personal Orientation Inventory (POI) as a pre and post test measure, and a background information form. (See Appendix E.) The Personal Orientation Inventory is a 150 item forced-choice instrument purporting to estimate mental well-being. The background information form was an eighteen-item questionnaire to determine appropriate demographic data.

We have selected the Personal Orientation Inventory as an effective research instrument to use in this experiment although Medinnus (1967) reports that interrogation of the mother by interview or inventory is the classical research technique. Other techniques used are reports on the behavior of mother and child by observers, or grown children may be asked to recollect practices of parents. Medinnus feels that interview responses are descriptions by highly ego-involved reporters and this gives studies a selective and distorted quality. Observations also may be invalid.
if the observer misinterprets, misses or destroys information. However, the Personal Orientation Inventory is a standardized, well-researched, well-accepted measure of mental health to assess in parents the variables of attitude toward oneself and others. Shostrom and Knapp (1966) state:

"Instruments like the MMPI have effectively measured a patient's state of illness, but have given very little aid for assessing a patient's more positive mental health attributes. The Personal Orientation Inventory was recently developed in an effort to meet this need. Research on the POI suggests that this instrument actually does measure a patient's state of positive mental health and that it could be effectively used alone or in conjunction with the MMPI to evaluate progress in therapy."

Foulds (1969a) concurs with this by expressing the following opinion: "Research findings indicate that this inventory is a reasonably valid and reliable measure of positive mental health."

In other studies by Foulds (1969b), he found:

"The rating of ability to communicate empathic understanding were significantly and positively related to six of the 12 POI scales (p<.05), ratings of the ability to communicate facilitative genuineness were significantly and positively related to a total of the conditions offered. The highest correlations (ranging
up to \( r = .55 \) were against POI scales of SAV, Fr and I. These findings suggest that the ability to sensitively and accurately perceive the inner 'being' or experiencing of another human being and to communicate this understanding to him is related to psychological well-being or self-actualization as measured by the POI."

He also stated that the Inner Direction and Feeling Reactivity scales appeared to be the most adequate for differentiating between two groups of subjects (those able to provide empathy, respect and genuineness and those who were not able to provide these in counseling).

The items on the POI were derived from research and from the theories of Horney, Maslow, Reisman, May, Perls, Ellis, Fromm, Rogers and Buhler and from value judgment problems seen by therapists at the Institute of Therapeutic Psychology. Shostrom (1965) demonstrated its effectiveness in differentiating between two groups nominated by qualified Ph.D. level therapists from the Los Angeles and Orange County Societies of Clinical Psychologists—one composed of individuals defined as fully functioning and another group defined as less fully functioning. All scales significantly differentiated the two groups thus giving a positive indication of validity. Knapp (1968) used the POI to effectively differentiate between groups scoring high and low on the neuroticism scale of the Eysenck Personality Inventory thereby
demonstrating concurrent validity.

A more intricate description of the instrument is given by LeMay and Damm (1969) as follows:

"The POI consists of 150 paired items, each pair defining an opposition. The subject is asked to select the one of a pair that is true of himself. The responses are scored along two major scales and ten subsidiary scales. The Time Competence (TC) scale assesses the effective use of time in the present. The Inner Directed (I) scale defines relative autonomy by assessing a balance between other directedness (dependence) and inner directedness (self-willed). A self-actualized individual transcends and integrates both orientations. The subsidiary scales purport to tap: Values on Self-Actualization (SAV), Existentiality (Ex), Feeling Reactivity (Fr), Spontaneity (S), Self-Regard (Sr), Self Acceptance (Sa), Synergy or the ability to transcend dichotomies (Sy), Acceptance of Aggression (A) and the Capacity for Intimate Contact (C). Scales TC and I have no overlapping items, but between them they contain all the items on the ten remaining scales. The item overlap averages 94%.

McClain (1970) found that POI scores were significantly related to ratings of counselor self-actualization. It has been

Procedures

Prior to their participation in this study, subjects signed an informed consent blank (See Appendix E.) specifying the use of the data to be collected. Following the signing of this form, the subjects were given the background data form, a test booklet for the Personal Orientation Inventory (POI) and a pencil. The permission form was read aloud along with instructions for completing the test. The groups were allowed to ask questions regarding procedure, then proceeded with signing the permission form, filling out the demographic form and taking the test. The testing took approximately thirty to forty minutes and was not timed. The examiners endeavored to create a relaxed, warm atmosphere by informing the participants that there are no right or wrong answers and to answer all questions as truthfully as possible.

Testing occurred in a pre and post test design. The test was administered in the first class meeting, no later than the beginning of the second class, and upon the completion of the last class six weeks later. Control groups were also tested with a six-week interval elapsing between the pre and post tests. The dates for testing of each group were as follows:

Voluntary Experimental - January 18
Voluntary Control - March 11
Involuntary Experimental - February 2 and March 27
Involuntary Control - March 30
General Control - March 5

All groups were tested at the locations detailed above except for the control groups who were tested in their home settings.

Although more than fifteen (15) subjects were tested in several of the groups, only fifteen (15) composed each final group with the exception of the Voluntary Control Group of fourteen (14) and the Involuntary Experimental Group. Due to a lack of cooperation on the part of some of the members of the latter group, we were able to obtain only ten (10) pre and post tests.

All group subjects were matched for having completed pre and post tests while those failing to complete the post test were eliminated. In the Voluntary Experimental Group where there were many more than fifteen subjects with pre and post tests, all parents with over one-year previous parent training experience were also eliminated, and those parents with the least parent training were included until the total of fifteen (15) was reached.

Although the Personal Orientation Inventory provides for ten (10) separate scales, two of these scales were selected specifically because they compared favorably with the two mental health variables of attitude toward oneself and attitude toward others. These are subtest Fr on the Feeling Scale and subtest C on the Interpersonal Sensitivity Scale. They are defined as follows:
Fr - Feeling Reactivity - Measures sensitivity of responsiveness to one's own needs and feelings.

C - Capacity for Intimate Contact - Ability to develop contactful intimate relationships with other human beings unencumbered by expectations and obligations.
CHAPTER III

RESULTS

DEMOGRAPHIC MAKE-UP

Total Subjects

The total study was composed of sixty-nine (69) subjects responding to both the pre and post tests. These subjects ranged in age from twenty (20) to fifty-nine (59) with an average age of thirty-two (32). The subjects in this study were predominantly white females—69.6% females compared to 30.4% males and 98.6% white compared to 1.4% Oriental.

The greatest majority (95.7%) of the subjects were married with 83.8% of those married presently involved in their first marriage. The average length of the marriages in this study was 9.5 years. Each family represented had an average of 1.96 children ranging from three (3) months to twenty-seven (27) years of age.

The occupations of the subjects broke down into fifteen (15) separate categories. When combined into similar categories, the largest groups of subjects were observed to be housewives (37.3%), professional (33%) and clerical (11.9%). Income-wise, the subjects were from the middle class with an average income of $18,820.00
annually. The incomes ranged from a low of $6,000 to a high of $30,000 annually.

Of this population, 83.1% were of the Protestant persuasion while 15.4% were Catholic and 1.5% were Jewish. No religious preference was reported by 5.8% of the subjects. There was no significant difference in religious activity level as 50% considered themselves religiously active (attended services in the last thirty days), and 50% did not consider themselves active. While there was no difference in religious activity, there was significant difference in previous training experiences. Of all the subjects reporting, 85.5% had no previous training while 14.5% reported previous parent training.

In summary, this study was composed of primarily young white females in their first marriage with about two children. A typical subject may be either a housewife or professional with a family income averaging $18,820.00. She is probably Protestant, but may or may not be religiously active. She also has had no previous parent training.

Subjects By Group

Group 1: Voluntary Experimental Parents was the most uniform of all the groups. It was composed of all married females with 86.7% of them in their first marriage. They had 1.4 children, and the average length of the marriages was 6.8 years. They were primarily housewives (92.9%), of the Protestant preference (73.3%), active in their religious preference (66.7%), 73.3% had no previous
parent training, and their average income was $19,133.00.

Group 2: Involuntary Experimental Parents showed more diversification than Group 1. Females outnumbered males 60% to 40%. Of all the subjects in the group, 80% were in their first marriage with an average marriage length of 18.3 years and 3.7 children. Half of this group were professionally employed while 30% were clerical. This group was also primarily Protestant (66.7%), but evenly divided on religious activity level. This group also had the majority of subjects (80%) with no previous parent training. Their average income level was $18,500.00.

Group 3: Voluntary Control Parents was composed almost evenly of males (53.3%) and females (46.7%). All of the subjects in this group were married with 86.7% of them in their first marriage with an average marriage length of two years with .25 children. Over half of this group (53.3%) were professionally employed with the rest evenly divided among the other occupations. Like the other two groups, this group was predominantly Protestant (78.6%). However, 73.3% did not consider themselves active. Also, all of the parents in this group had no previous parent training. Their average income level was $21,625.00.

Group 4: Involuntary Control Parents was almost evenly divided between males (42.9%) and females (57.1%). The greater majority of these subjects (92.9%) were married and in their first marriage (76.9%) with an average marriage length of 15.7 years and 2.8 children. Professional employment made up 61.5% of the
group, and 91.7% of the group had a religious preference for Protestantism. They were not religiously active (85.7%) nor did they have previous parent training (92.9%). Their average income level was $18,062.00.

Group 5: General Control Parents was predominantly composed of white females (80%) who were all married with 86.7% in their first marriage and an average marriage length of 9.8 years with 2.1 children. Occupationaly, the group was made up of over half housewives (53.3%). They were all of the Protestant persuasion and active in religious affairs (86.7%). This group, just as the others, had 80% of its subjects without previous parent training experience. Their average income level was $17,250.00.

Analysis of Variance was computed between groups in relation to the categories of sex, marital status, first marriage, length of marriage, number of children, occupation, religion, religious activity level, previous parent training and income level. Statistical significance was noted in the categories of sex ($p=.0140$), occupation ($p=.0092$), religious activity ($p=.0004$), number of children ($p=.0000$) and length of marriage ($p=.0000$).
TEST RESULTS - PRE TEST

A One-Way Analysis of Variance was computed between the five groups on two dependent variables, pre test scores on Scale 7, Fr: Feeling Reactivity and Scale 14, C: Capacity for Intimate Contact of the Personal Orientation Inventory. (See Tables 1 and 2 for Frequency Distributions.)

No significant differences were noted between groups on pre test measures of Scale 7 ($F=1.085$, d.f.=4, $p=0.3714$) and Scale 14 ($F=1.443$, d.f.=4, $p=0.2301$). On the basis of these findings, simple One-Way Analyses of Variance were then computed on post test scores without using difference scores or Analyses of Covariance procedures.
TABLE 1

PRE 7 FREQUENCY DISTRIBUTION
FR: FEELING REACTIVITY

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# TABLE 2

**PRE 14 FREQUENCY DISTRIBUTION**

C: CAPACITY FOR INTIMATE CONTACT

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|       | 69        | 100.0            |
TEST RESULTS - POST TEST

One-Way Analyses of Variance were computed between all groups on two dependent variables, post test scores on Scale 7, Fr: Feeling Reactivity and Scale 14, C: Capacity for Intimate Contact of the Personal Orientation Inventory. (See Tables 3 and 4 for Frequency Distributions.) Significant differences were noted between groups on the post measure Scale 7 ($F=3.426, \text{d.f.}=4, p=0.0134$). No significant differences were noted between groups on the post measure Scale 14 ($F=2.288, \text{d.f.}=4, p=0.0695$).

In order to determine which pairs of group comparisons accounted for the overall significant difference, post-hoc contrast t-tests were computed. Various combinations of groups were contrasted (See Table 5 for results.), and significance was noted in Group 3: Voluntary Control Group versus Group 5: General Control Group ($t=2.583, \text{d.f.}=64, p=0.012$), Group 4: Involuntary Control Group versus Group 5: General Control Group ($t=2.563, \text{d.f.}=64, p=0.012$), Group 1: Voluntary Experimental Group versus Group 5: General Control Group ($t=2.511, \text{d.f.}=64, p=0.015$) and Group 1: Voluntary Experimental Group versus Group 2: Involuntary Experimental Group ($t=2.182, \text{d.f.}=64, p=0.033$). No statistical difference was noted when Group 2: Involuntary Experimental Group was contrasted with Group 5: General Control Group ($t=0.064$,}
In order to determine whether parents entering parent training voluntarily showed more significant gains than do parents who involuntarily enter training, two-tailed t-tests were computed comparing Scale 7 pre scores with Scale 7 post scores and Scale 14 pre scores with Scale 14 post scores for Group 1: Voluntary Experimental Group and Group 2: Involuntary Experimental Group. Group 1: Voluntary Experimental Group was computed as demonstrating significant change on Scale 7 ($t=2.74$, d.f.=14, $p=0.016$) and on Scale 14 ($t=3.54$, d.f.=14, $p=0.003$). Group 2: Involuntary Experimental Group was computed as not demonstrating significant change on Scale 7 ($t=0.10$, d.f.=9, $p=0.923$) and on Scale 14 ($t=0.10$, d.f.=9, $p=0.920$).
TABLE 3

POST 7 FREQUENCY DISTRIBUTION
FR: FEELING REACTIVITY

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### TABLE 4

**POST 14 FREQUENCY DISTRIBUTION**

**C: CAPACITY FOR INTIMATE CONTACT**

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<td>Voluntary Experimental vs. Involuntary Experimental</td>
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* Significant

D.F. = 64
### TABLE 6

**SCALE 7: FEELING REACTIVITY**

**MEAN SCORES BY GROUP**

**PRE AND POST MEASURES**

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<td>General Control</td>
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1. There appears to be no overall significant gains in mental well-being for groups of parents participating in parent education training as compared to groups of parents not participating in parent education training.

The main thrust of this paper was to investigate the question of whether parents involved in parent education programs demonstrate significant improvement in mental well-being as measured by two scales of the Personal Orientation Inventory than do parents not involved in parent education training. According to test results, significant gains in the mental well-being variables of attitude toward oneself (Fr: Scale 7) were observed in three groups--Group 1: Voluntary Experimental Group, Group 3: Voluntary Control Group, and Group 4: Involuntary Control Group. However, no significant changes were found in any of the five groups in attitude toward others (C: Scale 14). These results suggest the following possibilities:

a. It would appear that parents involved in the Parent
Resource Center classes (Group 1: Voluntary Experimental Group) benefited from their training as demonstrated by their significant improvement on Fr: Scale 7. This group obtained the highest mean gain on Fr: Scale 7 (See Table 6.) of the three groups demonstrating improvement. From these facts it is logical to assume that parent education training for this particular group was the significant factor.

b. Anticipation of training appears to significantly improve parents' mental well-being. A surprising element in this study was the fact that the two specific control groups, Group 3: Voluntary Control Group and Group 4: Involuntary Control Group, also made significant gains on Fr: Scale 7, however, not to the extent of Group 1: Voluntary Experimental Group. Both groups were composed of parents on waiting lists to enter training programs. As such, the purpose of these groups was to control for motivation. Looking at each group closer, we observe that Group 3: Voluntary Control Group was a prenatal waiting list group who were anticipating many positive changes in their lives. Group 4: Involuntary Control Group was composed of parents who had already had a troublesome child removed from their household and were anticipating professional training in how to deal with this child. Both groups thus had high anticipatory factors influencing this unpredictable change.

Possible alternate explanations of the change demonstrated by the control groups are the historical factor and test reactivity.
In the former, although all experimental and control groups were tested before and after a six-week period, these periods did not occur simultaneously. However, the authors know of no definite historical influences during the time span of January through May, 1978, that may have affected parents' mental well-being. In the case of the latter, the effect of taking the pre test upon the post test must be considered. However, if this factor did increase the responsiveness to the experimental variables, one would also expect to see Group 2: Involuntary Experimental Group and Group 5: General Control Group demonstrating similar improvement, which they did not.

c. Parents required to participate in parent education programs at the Remedial Behavior Center do not show significant improvement in their mental well-being. It is interesting to note that Group 2: Involuntary Experimental Group was the only group of the five that demonstrated a decrease in mean score for both Fr: Scale 7 and C: Scale 14 (See Table 6.). The parent training class these parents were involved in was a strict behavioral approach to teaching communication skills. This class spent minimal time on participants' self-awareness. This factor, coupled with the resistiveness of these subjects as encountered by the examiners, quite possibly accounts for their lack of improvement on the variables. This in no way addresses whether or not these parents improved their communication skills or whether or not their child's behavior improved.
2. Parents who voluntarily enter parent education training classes do not have a higher level of mental well-being than parents who involuntarily enter training prior to the beginning of training.

Of secondary importance in this study was whether the motivational level of parents, as reflected by their voluntary or involuntary nature, affected their level of mental well-being prior to entering training. No significant differences were noted on the pretests of Scales Fr and C between the involuntary and voluntary groups, or any other groups. Therefore, we can conclude that parents voluntarily entering parent education training classes do not have a higher level of mental well-being than parents involuntarily entering training as demonstrated by the absence of significant differences at pretest level.

3. Parents who voluntarily enter parent education training classes demonstrate more significant improvement in mental well-being than do parents who involuntarily enter training.

In analyzing the test results, it was found that parents who voluntarily entered parent education training classes demonstrated more significant improvement in the scales related to mental well-being than did parents who involuntarily entered training. Parents who involuntarily entered training showed a slight decrease in these scales. Again, it is worth noting the difference of emphasis these two training programs presented. The voluntary parent class was tested during a six-week segment with the main focus on self-growth. The involuntary parent class was strictly a behavioral approach to
communication improvement emphasizing self-growth minimally. This difference quite possibly explains the differences noted in the scale scores of the two groups.
STRENGTHS AND WEAKNESSES

In reviewing the strengths and weaknesses of this study, some of its strengths are in the rather large total population of 69 that participated, the specificity of the control groups which includes the use of subjects who were on actual waiting lists, and the provision of a general control group which enhanced the design of the study. The accurate statistical procedures to determine significance verified the results of the study, and the use of a proven instrument reduced the possibility of error instrumentation.

It is obvious that this study has its share of weaknesses as well as strengths. Of particular note is the composition of the population which was predominantly white, female and middle class. The experimental groups and their matched specific control groups were quite dissimilar in many areas of demography. It would have been more appropriate to use a waiting list from the Parent Resource Center as a voluntary control group (which was not available at the time of this study). The disadvantage of using the prenatal waiting list is that they only had .25 children each along with other differences. If the experiment had been based on matched samples, it would have been more appropriate to compare the Voluntary Experimental Group with the General Control Group although there would be no control for motivation.
Additionally, it would have been more valid if subjects had been randomly selected on both the pre and post test measures rather than using only those who responded on both measures. The manner in which subjects were eventually included in the study resulted in a testing of predominantly "modified volunteers" (involved in training classes but volunteering to participate thus possibly having higher motivation).

Finally, while testing occurred in overlapping time frames, it would have been more desirable to have the time frames exactly corresponding.

It appears that investigating parenting programs with identical objectives, methodology, instructors and locations would provide more uniform and valid results.
SUMMARY

In summary, this study undertook to determine the effect parent training education programs have on parental mental well-being and whether the reason for entering training affects the initial level of mental well-being or the outcome of training.

As was demonstrated in the review of the literature, this study along with those presented do not support the idea that parent education programs significantly improves parental mental well-being, nor does it disprove it.

It was determined that no significant difference existed in the mental well-being of parents whether voluntary or involuntary participants prior to training.

Finally, this study does indicate that parents participating in the program directed by the Parent Resource Center benefited from their training. It further indicated that parents required to participate in parent training classes at the Remedial Behavior Center do not show significant improvement in their mental well-being.
IMPLICATIONS FOR FURTHER RESEARCH

Upon completion of this study, it appears to the authors that the following areas could provide additional insights into parent training and mental well-being:

1. Studies including both parental partners participating in training compared with only one parent participating.

2. Studies in which similar training programs (those with similar objectives, methodology and instructors) are compared.


4. Studies with a more even distribution of males and females, race, income and religious activity level.
Menninger describes a mentally healthy person as follows:

1. Can deal constructively with reality.
2. Can maintain a sense of security most of the time.
3. Finds satisfaction in giving.
4. Is relatively free from tensions and anxieties.
5. Relates consistently to others.
6. Can accept present frustration for future gains.
7. Profits from experience.
8. Directs hostile feelings into creative and constructive areas.
9. Has a capacity to love.
10. Is able to manage aggressiveness.
Characteristics of the self-actualized person are as follows:

1. Realistically oriented.
2. Accept themselves, others and the natural world.
3. Have a great deal of spontaneity.
5. Have an air of detachment and a need for privacy.
6. Are autonomous and independent.
7. Fresh rather than stereotyped appreciation of people and things.
8. A profound mystical or spiritual experience.
9. Identify with mankind.
10. Profound and deeply emotional intimate relationships with a few specifically loved people.
11. Have democratic values and attitudes.
12. Do not confuse means with ends.
13. Philosophical, rather than hostile, sense of humor.
14. Possess a great fund of creativeness.
15. Resist conformity to culture.
16. Transcend the environment rather than just coping with it.
Valencia Community College Parent Education Project

General Goals:

1. Help parents deal with their emotions about being parents.
2. Teach skills for successful parent-child relationships.
3. Teach skills for successful parent participation in the child's intellectual growth.
4. Help parents raise children who are healthy, constructive and successful members of their family, school and community.
5. Provide in-service training for individuals in helping professions serving parents.
6. Develop a model program for Parent Education services applicable to community colleges and university continuing education departments.

Specific Objectives (selected):

9. (Affective Objective) Students will value sharing the discovery of their own feelings, accepting ownership and developing expression for feelings.

6. (Cognitive Objective) Students will understand basic concepts of interpersonal relations usable within the relations of families.
APPENDIX D

Communication Workshop for Parents of Adolescents

The following is a proposal concerning a workshop for parents of adolescents stressing the development of effective communication skills. This proposal in no way is designed as a total treatment program, but rather, is just one necessary step in assisting families to solve their problems. It is specifically designed to address those parents whose adolescents are experiencing behavior problems (i.e. runaway, truancy, delinquency) and referred through the Juvenile Justice System. The work presented in such a workshop is a modified version of the work of Jane E. Brownstone, Ph.D. and Carol J. Dye, Ph.D. published by Research Press.

Goals:

1. To give parents specific information on how to communicate more effectively.
2. To help parents begin analyzing their families' communication patterns.
3. To help parents identify their own style of communication with their children.
4. To start parents in practicing alternative methods where it seems warranted.
APPENDIX E

RESEARCH QUESTIONNAIRE

NAME_________________________________________AGE____SEX____

CURRENT MARITAL STATUS________________________________________

IS THIS YOUR FIRST MARRIAGE?_____HOW LONG HAVE YOU BEEN MARRIED?___

ARE YOU A SINGLE PARENT?_____________________

NUMBER OF CHILDREN_________AGES________________________________

OCCUPATION____________________________________________________

RACE____________________RELIGIOUS PREFERENCE____________________

DO YOU CONSIDER YOURSELF ACTIVE IN RELIGIOUS ACTIVITIES (ATTENDED
IN THE LAST 30 DAYS)?___________________________________________

HAVE YOU BEEN INVOLVED IN ANY PREVIOUS PARENT TRAINING PROGRAMS?

________________________________________________________________

HOW LONG HAVE YOU BEEN IN THIS PROGRAM? _________________________

DO YOU BELIEVE THIS CLASS WILL BE HELPFUL?_______________________

WHY DID YOU ENROLL IN THIS PARENT TRAINING CLASS?_______________

________________________________________________________________

APPROXIMATE FAMILY INCOME_________________________
I, __________________, hereby give my consent to participate in a research study to be conducted by Jean Anderson and Dick Jacobs. By agreeing to participate, I understand that:

1. Participation or nonparticipation in this study does not affect my right to participate in this parent training class.
2. That my identity and identifying characteristics will be kept confidential.
3. The final results of this study (this does not include the identity of the subjects) will be released to the sponsoring organization of this parent training class.
4. The information obtained will be used to investigate the effectiveness of this training class and parental attitudes.
5. I am being asked to complete two Personal Orientation Inventories and a background information form.
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