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**The Perceptions and Expectations of Mothers of  
Children with Learning Disabilities Regarding  
Expressive and Creative Therapy**

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## **1. Introduction**

This doctoral dissertation joins the growing therapeutic discourse in recent years on the significance and understanding of parental involvement in the therapeutic processes of their children. In recent decades, expressive and creative therapists have begun to become integrated into special education schools. Expressive and creative therapy is one of the therapeutic tools through which it is possible to enhance the academic, emotional, and social adjustment of adolescents with learning disabilities. The purpose of the current study is to examine the perceptions and expectations of mothers of adolescents with learning disabilities studying at special education schools regarding expressive and creative therapy and therapists. The study takes a mixed methods approach and consists of three main studies: Study 1 – qualitative, explored the mothers’ expectations, perceptions and subjective experiences regarding the school-based therapy and therapist, with reference to a range of therapeutic issues and aspects; Study 2 – quantitative, explored whether the levels of parental efficacy and of parental stress affect mothers’ expectations of the school-based therapy and therapist; Study 3 – quantitative, explored whether the levels of parental efficacy and of parental stress affect satisfaction with therapy (two dimensions of maternal satisfaction with therapy were examined). In addition, the association of satisfaction with the duration of therapy and with the child’s age were also measured.

The results of the first study uncovered four main themes: mothers’ perceptions and expectations of emotional therapy in general, mothers’ perceptions and expectations of school-based expressive and creative therapy, mothers’ involvement in the therapeutic process, and satisfaction with the therapy. In Study 2 – a positive association was found between mothers’ expectations of the therapy and therapist and the levels of parental efficacy and of parental stress. Study 3 revealed that satisfaction with therapy in general - attitudes toward seeking help, was positively related to mothers' self-efficacy, and negatively related to level of stress, whereas progress evaluation of therapy was not related to the two psychological measures. Duration of therapy, on the other hand, was positively related to progress evaluation of therapy but not related to satisfaction with therapy in general (attitudes toward seeking help). The research findings have theoretical implications for understanding the phenomenon as related to mothers’ perceptions and expectations of the therapy and therapist. In addition, the study makes it possible to expand observation of two major

psychological dimensions: parental efficacy and parental stress, as affecting perceptions and expectations of therapy, as well as the association with mothers' satisfaction with therapy. Moreover, the study has a contribution to the field of expressive and creative therapy in general, and to providing expressive and creative therapy at schools, specifically. The processes detected in the current study might also have universal implications and might occur in a variety of psychological and paramedical therapies that utilize various therapeutic approaches as well as in a variety of difficulties and disabilities.

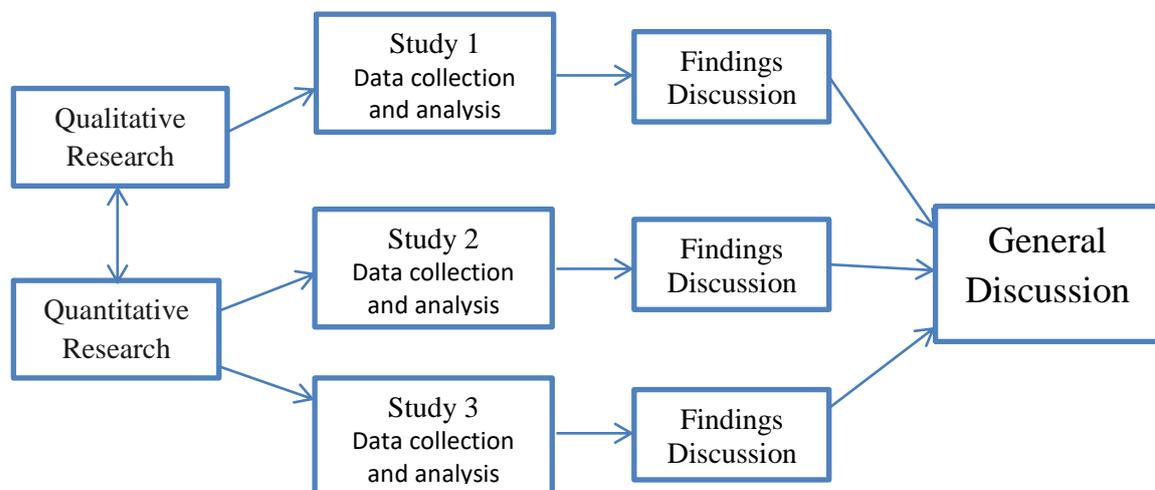
## **2. Research Design**

The current study has a mixed methods design. In this design the research questions refer to a combination of quantitative and qualitative research methods and therefore the collection of the data and their analysis was based on both quantitative and qualitative research. Creswell & Hirose (2019) stress that there is a constant need to combine and merge the data arising from the qualitative research, which have a direct effect on the quantitative research and vice versa. Combining the methods is a challenging part of such a research design. The rationale for combining qualitative and quantitative research methods derives from several reasons. One reason has to do with the fact that this combination of research methods facilitates an important point of encounter between the deductive reasoning raised by the quantitative research and the inductive reasoning raised by the qualitative research, enabling a wide two-sided perspective of the theory and data from the field (Coolican, 2014; Creswell, 2014; Creswell & Hirose, 2019).

## 2.1 Convergent Parallel Design

To receive a wide and thorough picture of mothers' perceptions and expectations of the school-based therapy and the expressive therapist, the study was conducted in the convergent parallel design. In the current type of research, the qualitative and the quantitative study are performed concurrently in order to best understand the research challenges and properly answer the research questions. Use of the present research method is aimed at bringing together the strengths and weaknesses of each of the research methods to take into account different but complementary data on the same topic. Data analysis was performed independently for each study: both for the qualitative study and for the quantitative studies. In the research process, independent research designs are produced, the combination of which answers the issue addressed by the overall study (Creswell & Clark, 2017). The research process is evident in the following illustration.

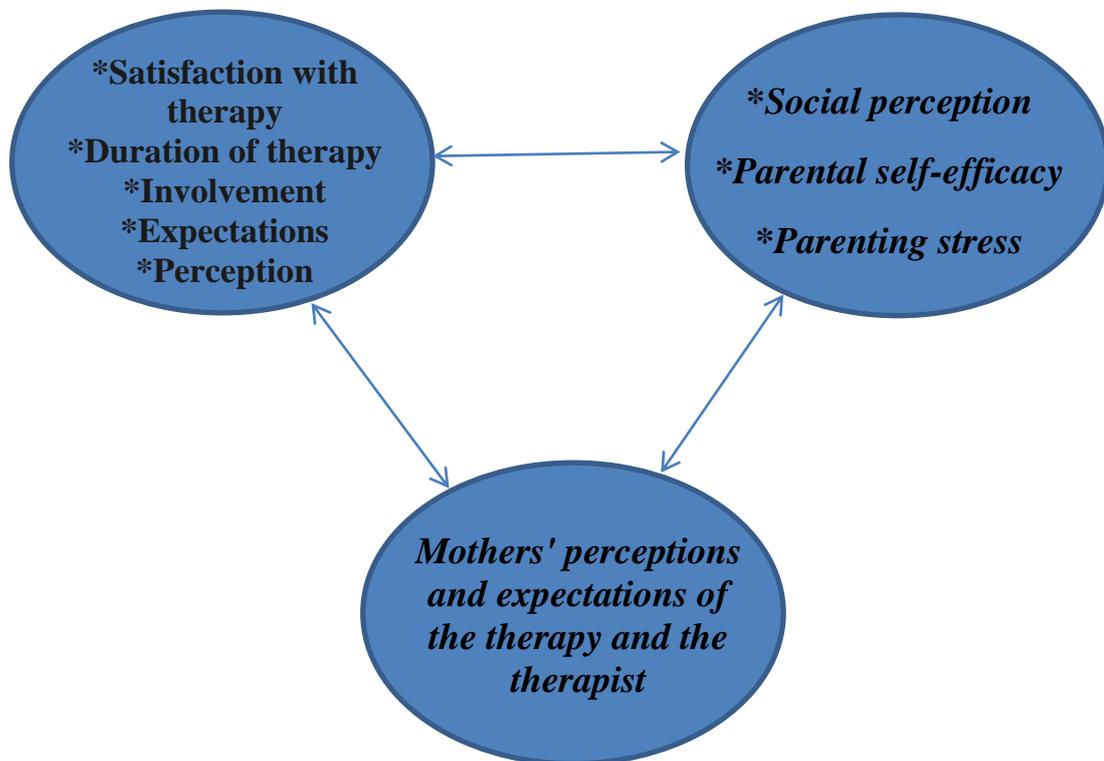
**Figure 1** The convergent parallel design



## 2.2 Conceptual framework

-The current study dealt with mothers' perceptions and expectations of expressive and creative therapy and therapists at special education schools for children with learning disabilities. The study refers to three psychological theories (social perception, parental stress, and parental efficacy) and to several key concepts related to the therapeutic field (satisfaction with therapy, expectations, perceptions, duration of therapy, and involvement in therapy). All these define the general research setting. The following illustration shows the conceptual framework of the study.

**Figure 2** The conceptual framework of the study



### **3. Study 1 - perceptions and expectations regarding therapy**

Study 1 examined the perceptions and expectations of mothers of children with learning disabilities, regarding expressive and creative therapy and their children's therapist.

#### **Research Method**

In the first study we focused on the qualitative dimension that addresses the issue of one's subjective experience. The qualitative study included an attempt to understand the research subject from the perspective of the participants. The purpose was to understand their world views and thoughts. The premises of qualitative research lead to a study that implements techniques of active listening, discourse and presence in the natural environment studied (Denzin & Lincoln, 2011; Shkedi, 2003).

The main purpose of this study was to understand and recognise the expectations and perceptions of mothers with regard to expressive and creative therapy provided to their children at school. The desire to understand and to become familiar with the personal experience of the mothers within the unique context of the encounter between education and therapy led to selection of the qualitative paradigm. This study used a grounded theory aimed at facilitating the process of identifying and integrating themes and categories from the data gathered, and the latter in turn helped understand the meaning of the data and develop new theories (Sabar Ben-Yehoshua, 2016). Grounded theories help conceptualise social patterns that arise from the research and that can be affiliated with a time, place and population (Denzin, 1983).

The purpose of using grounded theory is to facilitate its everyday implementation. Practical implementation of the theory encompasses four main features. The first feature of the therapy focuses on its need to closely match the area utilised. The second feature focuses on the need for the theory to be easily understood by lay persons engaged in the field studied. The third feature emphasises implementation of the theory in many varied everyday situations rather than only in a specific situation. The final feature relates to the flexibility that must afford users partial control of the process and the structure in an array of everyday situations, while changing over time (Glaser & Strauss, 2017).

## **Participants**

Eighteen Hebrew speaking mothers of children aged 14-18 (grades 9-12) whose children have learning disabilities, were studying in a special education setting at a large school in central northern Israel and had been receiving expressive therapy for at least one year.

## **Research Method**

This study utilised semi-structured in-depth interviews: The in-depth interview is the study's major source of knowledge (Glaser & Strauss, 2017). The purpose of the interview is to understand people's experience and the meaning they attribute to this experience (Shkedi, 2003). The interview provides access to the cultural context of human behaviour and provides a way of understanding the meaning of this behaviour (Knox & Burkard, 2009). Semi-structured in-depth interviews are characterised by a flexible and dynamic structure, where the course of the interview and its nature depend on the trust and contact formed between the interviewer and the interviewee as well as on the interaction formed throughout the interview (Schwartz & Jacobs, 1979). The interview guide focused on topics related to parental functioning and to the perception and expectations of parents of adolescents who receive expressive therapy at a special education school. Major topics on which the semi-structured interview focused are: perceptions, prejudices, involvement, relationship with the therapist, parameters determining the success of the therapy, setting therapeutic goals, guidance and more. The interview guide was constructed based on a literature review regarding parent perceptions and expectations of expressive and creative therapy and therapists.

### **3.2 Data Analysis**

The interviews were analysed based on the principles of grounded theory to identify and define main ideas, themes and categories (Carmaz, 2006). The data analysis process was based on the three stages defined by Strauss and Corbin (1990).

### **3.3 Findings**

The findings refer to four main themes. The first theme relates to factors that influence mothers' perceptions of the therapy. The second theme focuses on the uniqueness of expressive and creative therapy at school. The third theme presents mothers' perceptions of their involvement in the therapy, while the fourth theme discusses perceptions of satisfaction with therapy provided at the school.

#### **3.3.1 Factors influencing mothers' perceptions of the therapy**

Mothers' perceptions of the therapy have many aspects related both to their perception of their own difficulties and to their perception of their children's difficulties. These are accompanied by factors that affect acceptance and recognition of their child's disability and the transfer to special education. The factors influencing mothers' perceptions of the therapy are enhanced by the mothers' personal experience from past experiences with their child's emotional therapy and by their knowledge of the nature of therapy. Finally, the impact of the mother's encounter with the figure of the school-based therapist was explored.

#### **3.3.2 The unique role of expressive and creative therapy in the school setting**

The second theme describes the unique role of expressive and creative therapy in the setting of the special education school, as reflected in the interviews. The first part of the theme deals with mothers' expectations of the therapy and therapist at the school. The second part focuses on the unique role of referrals for therapy within the school as well as the parent's perception of the location and significance of the therapy and the therapist within the school setting. Finally, mothers' perceptions of the differences between emotional therapy at school and private emotional therapy in the community.

#### **3.3.3 Mothers' perceptions of their involvement in therapy**

This theme presents mothers' perceptions about their involvement in their child's therapy from a range of aspects, i.e., the first encounter with the therapist, setting the goals of the therapy, and the significance of parent support and guidance. Also presented are aspects related to perceptions of mothers' involvement in the context of conflicts with the therapist as well as mothers' perceptions when their children show resistance to therapy. Finally, mothers' perceptions and involvement will be portrayed through three styles of involvement.

### **3.3.4 Perceptions of satisfaction with therapy at the school**

The fourth and last theme deals with issues of evaluation/measurement as well as satisfaction with the expressive and creative therapy within the school setting. In the assumption that therapy in the school setting has unique features, attempts should be made to assess mothers' perceptions of satisfaction with therapy provided at the school.

### **3.5 Discussion - - Main Points**

The mothers' difficulty with accepting their child's disability can be attributed to several factors: the mother's prior life perceptions, perceptions of those who are different in society, perceptions regarding acceptance of others and their perception regarding acceptance of their child's disability (Yedidya & Reiter, 2002). Another psychological point of view stresses an additional element – the unique personality structure of each parent and its significance. The personality structure, which differs from parent to parent, is based on the relationship with their own parents, childhood memories and experiences.

Since perceptions and attitudes are based on experiences of success, i.e., on the life stories and experiences of the parents themselves, all these are projected on their children and shape the parent's expectations of the child and of the therapeutic process (White et al., 2017). Notably, very few studies have focused on parental distress, presuming that the source of the difficulty is contained in the parent and as such affects the child and the extended family (Lawrence et al., 2015).

Lack of knowledge regarding the essence of expressive and creative therapy might stem from mothers' reaction on two psychological dimensions: parental self-efficacy and the parent's level of stress. With regard to parental self-efficacy (Bandura, 1989; Bandura et al., 2011), it may be hypothesised that a parent with a low level of parental self-efficacy might disengage from the treatment and be uninvolved. Furthermore, parents of this type will take a passive stand and observe the process from the outside. Such parents will seek little information about their child's therapy, will not express interest in the process and in the progress of the therapy and its outcomes. Consequently, they may expect the therapist to "fix" the child with minimal parental involvement. In contrast, parents with high parental self-efficacy

will be curious about the therapy, check what types of therapy the school offers, and inquire who are the therapists who work at the school. Parents of this type will thoroughly investigate the therapeutic domain on all its levels and be more inquisitive and eager for knowledge and for deeper understanding of the foundations that underlie emotional therapy. As a result, these parents will be more involved in their child's therapy.

The combination of emotional, pedagogic and educational work is foreign to most parents. There seems to be some confusion in parents' understanding of the role of therapy and of the therapist's role in the school. Most of the professional literature deals with understanding the parent's difficulties, mainly in their encounter with educational elements (Ishai-Karin, 2004). The professional literature describes the complexity of school-based therapists, who conduct themselves in the space between the teen, the educational system and the parents (Snir & Regev, 2018; Plotnik, 2013). Therefore, the school system, and the therapist in particular, must mediate for parents the complexity that exists within the context of the therapeutic-educational relationship and grant more meaning to the therapeutic process provided to their child. This, so that the parents will be more involved in their child's therapy.

Referral for treatment by a third party is associated with parents' complex internal dialogue when their child's distress is reflected to them. Parenting is a human developmental stage. This stage requires people to undergo significant processes within themselves. An encounter with the homeroom teacher or with the element referring for treatment may "throw back" the parent to an experience of primary narcissistic wounds. Nonetheless, when parents are aware of their child's difficulty and initiate referral for treatment, they display involvement in the process and as a result are capable of cooperating better with the therapist.

Another psychological aspect relates to the issue of whether the parents' consent to the school's initiative to refer the child for therapy in the "educational garage" or disregard this initiative. Therapy within the educational system lets the parent send the child for therapy, but a frequent source of difficulty is parental blocking. It is to be assumed that this occurs by means of a defence mechanism operated by the parents in order to avoid meeting their own painful parts, thus leaving the job to the therapist. The fact that the therapy is provided at school, with no

parental involvement on different levels, prevents the parents from directly encountering painful experiences from their own childhood. Furthermore, the lack of parental involvement prevents them from encountering life events in which they felt abusive, abused, disappointed or disappointing. The therapeutic focus at the school affects the child and relates to the child's difficulties, with no reference to parental blocking, which might at times have an impact on the child's behaviour.

The advantage of working within a school system is manifested in the capacity to facilitate systemic multi-professional work that combines all the educational and therapeutic elements. School-based parental guidance often reduces the parent's sense of guilt feelings with regard to the issue of his or her parenting ability and quality (sensations that sometimes arise more strongly in individual guidance settings). Support and guidance within the school setting raise the chance of parental cooperation. Another advantage evident in the research findings relates to the school-home relationship. When providing guidance and support at the school the parents can receive a wider picture of the child and his or her functioning and raise questions and issues if there are functional emotional gaps that are manifested at home or at school. The parents can also update the school about occurrences at home.

Children's resistance to therapy is often related to a former and primary parental inability to handle conflicts and confrontations, which is often manifested in difficulties between the parent and the child (Berman & Caspi-Yavin, 1991). This is related to the parent's persistence in situations of discomfort, vagueness and frustration. In such situations the question is to what degree the parent can contend with anger, conflicted opinions, aggression and so on. The parent's ability to handle therapy-related conflicts and resistance is associated with the parent's exposure to the child's therapy. A parent who is less knowledgeable of the advantages and significance of the therapy may take part in the process and thus join the child's resistance..

The research findings indicated three involvement styles of mothers in therapy. The first style is **observing and enabling involvement**. The involvement of these mothers is characterised by two major attachment styles (Holmes, 2014). The first is secure attachment: Parents with a secure attachment style, who have trust in the world, express less concerns and fears, feel safe in their relationship with their child

as well as with the therapist's relationship with the child. Parents with a secure attachment style will feel safe letting their child receive therapy, with no concern that emotional contents that will arise in therapy might hurt their parental basis and thus threaten their existence. The second attachment style through which it is possible to discern observing and enabling involvement is insecure attachment, with an emphasis on parental avoidance. This can be viewed in parents' avoidance of encountering their own pain and difficulties when the child requires emotional therapy. In order to avoid encountering these difficulties and for parents to not encounter their own pain and difficulties they might take many actions, both conscious and unconscious, to avoid meeting negative and disappointing feelings. Therefore, the therapist's role is very significant in these stages of the therapy with the aim of keeping the parents in the picture and letting them constantly feel a range of parental sensations, both positive and negative (Winnicott, 1977).

Regarding the second style, mothers with **initiating involvement**, two main attachment patterns can be noted: The first is the secure attachment pattern, where the mother maintains continuous contact with the therapist. She believes in the therapy and in the therapist, initiates and is involved in the therapy, so that the therapy will succeed. The second attachment pattern is the anxious/resistant insecure pattern of attachment. In this attachment pattern the parent makes contact and communicates with the therapist but from a position of needing constant updates about the therapy. This might make it hard for the parent to send the child for therapy and to release him to form a relationship with another significant figure. The parent finds it difficult to handle feelings of vagueness and difficulty as well as not knowing what is happening in the child's therapy and in the child's relationship with the therapist. The parent finds it hard to accept a personal and close relationship between the child and another figure; this can often be threatening for the parent, leading to the conclusion that initiating involvement with an insecure/anxious attachment style can be harmful for the therapeutic relationship.

The third style that arose relates to mothers with **passive aggressive involvement**. This attachment pattern is based mainly on ambivalent/resistant insecure attachment. It is clear that in this style of involvement the mother recreates attachment patterns from her early childhood. This attachment pattern is manifested on one hand by the parent's passive response, feeling that he or she is not part of the

process, leading to narcissistic wounds in the parent and fortification of the victim's position, and as a result the parent is not part of the therapy or in contact with the therapist. Another response on the other end of the scale is the aggressive response - the parent grasps the therapist as excluding him or her from the child's therapy, generating anger and aggression towards the therapist.

When the therapist encounters the passive aggressive involvement pattern, this might affect the therapist and the therapy in two main ways. First, it might arouse contents that will harm the therapist's ego, self-efficacy and independence of the therapist in therapy. In this state, the therapist will develop antagonism towards the parent and, unconsciously, towards the client. Hence, the interventions might be very superficial and will not advance the therapy. A second attitude that can arise in the therapist is identification with the client. In this state, the therapist will take the parent's place and act out "rescue fantasy". Of course, these two responses by the therapist are ultimately damaging to the fabric of the relationship between the client, the therapist and the parent.

The research findings facilitate observation of measures assessing mothers' satisfaction with school-based therapy in two spheres: The first relates to satisfaction and the change in the client (the adolescent), and the second sphere relates to satisfaction with regard to the parent and his or her inner world.

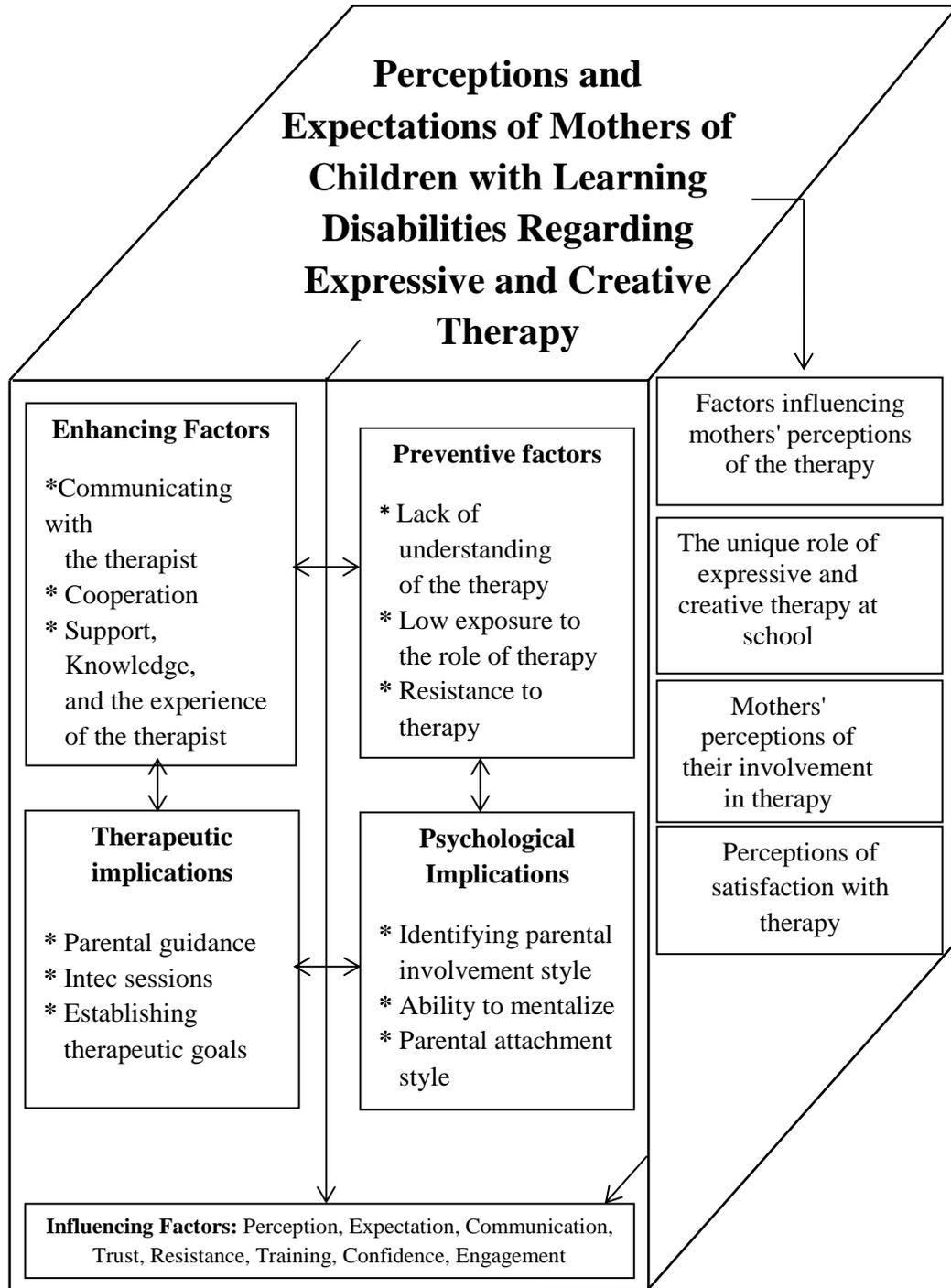
The research findings related to satisfaction measures that focus on changes in the child. This means positive or negative changes that occur in the child's inner world (change in the child's self-confidence, decrease/increase in levels of anxiety and so on). The mothers also expressed satisfaction with regard to measures of environmental, behavioural and pedagogic dimensions, availability for learning, reduced number of absences, decrease in the quantity of confrontations, improvement in social difficulties.

Another dimension of mothers' satisfaction with the therapy relates to satisfaction concerning a change in their maternal experience following their child's therapy. The child's therapy creates a change in the mother's inner world and in her perception of the child. The mother has less intrinsic criticism and as a result her personal and emotional well-being increase. In addition, it is notable that the existence of emotional therapy within the school makes it easier for the mother from a physical

organizational perspective (not having to take the child for therapy after school) as well as from a financial perspective, facilitating financial well-being for her and her family.

Another psychological aspect that led to higher maternal satisfaction with therapy is the nature of the therapy provided at the school, which is less connected to deep contents related to the parent's internal world. Due to the very existence of the therapy in a public setting and various difficulties and limitations (intake sessions, successive encounters, regular parent guidance) the therapy is less connected to deep levels that are directly related to the parent. Moreover, the therapy deals less with intra-family conflicts. Parent and family contents are not the declared goal of the therapy. The declared goal of therapy at the school is to enable the pupil to be available for learning by treating his or her emotional difficulties. The mother's satisfaction with the therapy is related to the lower engagement of therapy at the school with issues involving the parent-child relationship, thus excluding the parent from meeting him or herself, as could have happened if the parent would have met the child's therapist in a private clinic.

**Figure 2:** The figure presents the summary of the findings chapter and the implications of the discussion chapter



## 4. Study 2 - Expectations from Therapy

Study 2 examined the relationship between parental self-efficacy and stress levels and expectations of therapy and of the therapist among mothers of children with learning disabilities who receive expressive and creative therapy.

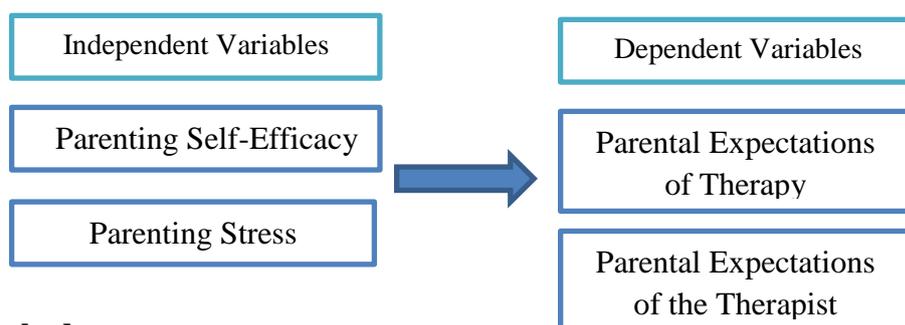
### Research Questions

1. What is the relationship between the self-efficacy of mothers of children with learning disabilities who receive expressive and creative therapy, and their expectations of therapy and of the therapist?
2. What is the relationship between the stress levels of mothers of children with learning disabilities who are undergoing expressive and creative therapy and their expectations of therapy and of the therapist?

### Research hypotheses

1. Participants' self-efficacy levels will be positively related to their expectations of the therapy and therapist, such that higher levels of self-efficacy will be associated with higher levels of expectations.
2. Participants' stress levels will be negatively related to their expectations of the therapy and therapist, such that higher levels of stress will be associated with lower levels of expectations.

### Research Variables



### Research Method

The quantitative research method is a correlational method, and it was used to try and examine the parent-therapist relationship, parents' expectations of the therapy and the therapist, and parents' perceived self-efficacy, which also has a considerable weight in the parent-therapist relationship. Also examined was the association between parental stress levels and expectations of the therapy and of the therapist.

## Participants

Fifty-four Hebrew speaking mothers of children aged 14-18 (grades 9-12) whose children have learning disabilities and have been receiving expressive therapy for at least one year. The study was conducted at two large special education schools, one in central northern Israel and the second in northern Israel.

## Research Instruments

- Sociodemographic background questionnaire
- Parenting Stress Index/Short Form - SF/PSI (Abidin, 1995)
- Early Intervention Parenting Self-Efficacy Scale (Guimond, Wilcox & Lamorey, 2008)
- Expectations About Counselling Brief (Tinsley, 1982)
- Expectations questionnaire (Ingber&Dromi, 2009, 2010)

### 4.1 Hypothesis Testing

**The first hypothesis**, postulating that participants' self-efficacy levels would be positively related to their expectations of the therapy and the therapist, such that higher levels of self-efficacy would be associated with higher levels of expectations, was confirmed. Self-efficacy was moderately and positively correlated with 'general expectations' ( $r_{(52)} = .54, p < .01$ ), 'expectations of therapy' ( $r_{(52)} = .55, p < .01$ ), 'expectations of the therapist' ( $r_{(52)} = .48, p < .01$ ) and 'expectations of relations with the therapist' ( $r_{(52)} = .50, p < .01$ ). The higher the self-efficacy exhibited by the participants the higher their expectations in general, expectations of the therapy, expectations of the therapist and expectations of the relationship with the therapist.

**The second hypothesis**, postulating that participants' stress levels would be negatively related to their expectations of the therapy and the therapist, such that **higher** levels of stress would be associated with lower levels of expectations, was confirmed. General stress levels were moderately and negatively correlated with 'general expectations' ( $r_{(52)} = -.54, p < .01$ ), 'expectations of the therapy' ( $r_{(52)} = -.50, p < .01$ ), 'expectations of the therapist' ( $r_{(52)} = -.53, p < .01$ ) and 'expectations of relations with the therapist' ( $r_{(52)} = -.48, p < .01$ ). The higher the general stress levels exhibited by the participants the lower their expectations in general, expectations of

the therapy, expectations of the therapist and expectations of the relationship with the therapist. Similar results were obtained for each of the three dimensions of stress levels ('parental distress', 'child dysfunctional interaction', and 'difficult child';)

#### **4.2 Discussion - Main Points**

The experience of parental efficacy is enhanced by the parent's encounter with the therapist at the school. The parent's experiences and past experience have a considerable impact on parental efficacy. Positive past experiences related to many successes increase both the parent's self-efficacy and future expectations of therapy and of the therapist (Sutton & Hughes, 2005; Hoffman, 1984). For this reason, in the encounter of the therapist with the parent it is very significant to give the parent room and to empower the parent following coping with a child who has learning disabilities and difficulties at home. It is easier for the educational system and the expressive and creative therapist in particular to cooperate with parents with high parental efficacy. Notably, it is possible to promote parental efficacy in order to raise mothers' expectations of the therapy and thus enlist them in the therapeutic process.

The current study indicated a paradox. Precisely those mothers who need treatment, assistance or support in coping with their child had the lowest expectations of therapy and of contact with the therapist. Mothers with high stress levels often feel paralysed and take an avoidance attitude to the distress. In practice, those who need help and assistance the most are prevented from receiving it. This can be perceived through the psychological state of acquired helplessness (Maier & Seligman, 1976). Mothers who cope for a lengthy period of their life with their child's severe disability (behavioural, emotional, academic etc.) find it hard to believe in their ability to improve the situation. As a result, symptoms of depression, passivity and so on emerge. The acquired helplessness is also projected on the therapy and the therapist and the mother is unable to motivate herself to take part in the therapeutic process.

With regard to the long term coping of parents who have high levels of stress, the research literature defines the parent as being in a "state of attrition". Parents who cope for years with high levels of stress were found to consequently have reduced physiological and psychological resources. As a result, their levels of depression and

anxiety rise, leading to a drop in the ability to cope with the situation (Kaufman, 2007; Overholser & Fisher, 2009; Selye, 1946). Hence, it may be hypothesised that mothers' expectations of the therapy provided to their child or expectations of the therapist are significantly reduced.

In the educational and therapeutic work at school, in moments of crisis and in routine, it is possible to identify mothers who have high levels of stress, who are coping with experiences of helplessness, paralysis, frustration and disappointment that affect them and their child (the pupil) as well as the fabric of life and the family system in general. Mothers who experience such a state might often be the element that overburdens the educational system. In addition, mothers with high levels of stress have a very high level of despair, have a drained attitude and avoid seeking assistance and help. Nonetheless, the studies indicate that cooperation with therapeutic elements and social support affect the parent's levels of stress (Esdaile & Greenwood, 2003; Scorgie, Wilgosh & McDonald, 1998) and help reduce them. The research literature also shows that in the right conditions mothers usually seek the support and counselling of professionals to cope with stress levels (Ingber & Dormi, 2009).

## **5. Study 3 - Satisfaction with Therapy**

Study 3 examined the relationship between parental self-efficacy, stress levels, therapy duration and child age, and satisfaction with therapy in mothers of children with learning disabilities who receive expressive and creative therapy.

### **Research Questions**

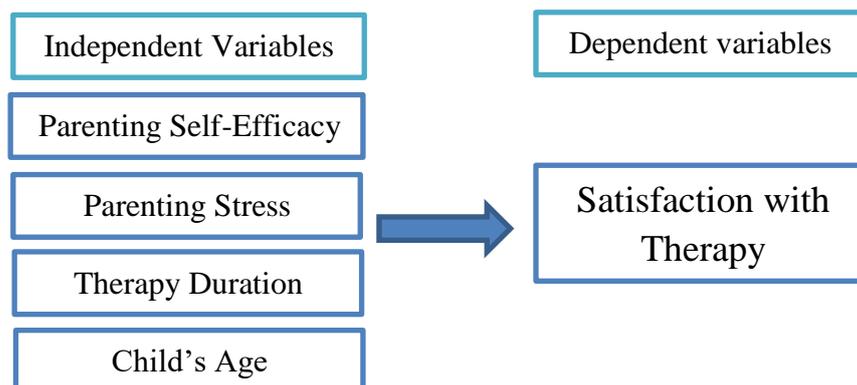
1. What is the relationship between the self-efficacy of mothers of children with learning disabilities who receive expressive and creative therapy, and their satisfaction with therapy?
2. What is the relationship between the stress levels of mothers of children with learning disabilities who are undergoing expressive and creative therapy, and their satisfaction with therapy?
3. What is the relationship between therapy duration and satisfaction with therapy?
4. What is the relationship between child age and satisfaction with therapy?

### **Research hypotheses**

1. Participants' self-efficacy levels will be positively related to their satisfaction with therapy, such that: (1a) higher levels of self-efficacy will be associated with higher levels of 'Progress evaluation' (Satisfaction 1) and (1b) higher levels of self-efficacy will be associated with higher levels of 'Attitudes towards seeking help' (Satisfaction 2).
2. Participants' stress levels will be negatively related to their satisfaction with therapy, such that (2a) higher levels of stress will be associated with lower levels of 'Progress evaluation' (Satisfaction 1) and (2b) higher levels of stress will be associated with lower levels of 'Attitudes towards seeking help' (Satisfaction 2).
3. Satisfaction with therapy will be positively related to the duration of therapy, such that (3a) a longer duration of therapy will be associated with higher levels of 'Progress evaluation' (Satisfaction 1) and (3b) a longer duration of therapy will be associated with higher levels of 'Attitudes towards seeking help' (Satisfaction 2).

4. Satisfaction with therapy will be negatively related to the child's age, such that (4a) older children will be associated with lower levels of parents' 'Progress evaluation' (Satisfaction 1) and (4b) a longer duration of therapy will be associated with higher levels of 'Attitudes towards seeking help' (Satisfaction 2).

### Research Variables



### Research Instruments

- Sociodemographic background questionnaire.
- Parenting Stress Index/Short Form - SF/PSI (Abidin, 1995)
- Early Intervention Parenting Self-Efficacy Scale (Guimond, Wilcox & Lamorey, 2008).
- Satisfaction and Estimation of Progress Questionnaire (Kopelman-Rubin et al., 2011, 2012).
- Attitudes toward Seeking Professional Psychological Help (Fischer & Farina, 1995).

### Research Method

The research was conducted in a quantitative design using a correlational approach, which examines phenomena as they appear in nature with no interference by the researcher. The study examined the association between parental efficacy levels, parental stress levels, and satisfaction with therapy on two main satisfaction measures. In addition, the quantitative tool explored whether there is an association between satisfaction and the duration of therapy and the child's age.

### Participants

Fifty-four Hebrew speaking mothers of children aged 14-18 (grades 9-12) whose children have learning disabilities and had been receiving expressive therapy

for at least one year. The study was conducted at two large special education schools, one in central northern Israel and the second in northern Israel.

### 5.1 Hypothesis testing

**The first hypothesis**, which postulated that participants' higher levels of self-efficacy would be associated with higher levels of satisfaction (as measured by 'Satisfaction 1' & 'Satisfaction 2') with therapy was only partially supported by the findings. A medium-high positive correlation was found between self-efficacy and attitudes towards seeking help ('Satisfaction 2';  $r_{(52)} = .60$ ,  $p < .01$ ), whereas no significant correlation was found between self-efficacy and progress evaluation ('Satisfaction 1';  $r_{(52)} = .25$ ,  $p > .05$ ).

**The second hypothesis**, postulating that participants' higher levels of stress would be associated with lower levels of satisfaction (as measured by 'Satisfaction 1' & 'Satisfaction 2') with therapy, was partially supported by the findings. A medium-high negative correlation was found between PSI General and attitudes towards seeking help ('Satisfaction 2';  $r_{(52)} = -.51$ ,  $p < .01$ ), whereas no significant correlation was found between PSI General and progress evaluation ('Satisfaction 1';  $r_{(52)} = -.22$ ,  $p > .05$ ).

**The third hypothesis**, which postulated that participants' satisfaction with therapy (as measured by 'Satisfaction 1' & 'Satisfaction 2') would be positively related to therapy duration, was partially supported. Duration of therapy was positively related to progress evaluation ('Satisfaction 1';  $r_{(52)} = .33$ ,  $p < .05$ ), interpersonal progress ( $r_{(52)} = .41$ ,  $p < .05$ ) and emotional progress (both dimensions of 'Satisfaction 1').

**The fourth hypothesis**, which postulated that participants' satisfaction with the therapy (as measured by 'Satisfaction 1' & 'Satisfaction 2') would be positively related to the child's age, was not confirmed. Child's age was not found related to attitudes towards seeking help ('Satisfaction 2') or to 'general progress evaluation ('Satisfaction 1') and its dimensions. Table 49 presents all the correlations between the child's age and 'Satisfaction 1' and its dimensions and 'Satisfaction 2' from therapy indices.

## 5.2 Discussion - Main Points

A possible way of interpreting the findings is through the understanding that high parental efficacy is associated with high expectations of therapy. Mothers with high parental efficacy develop high expectations of therapy. This creates a dynamic that fundamentally motivates experiences of success and of satisfaction with therapy. When parents have high parental efficacy, their subjective experience facilitates the therapy's success and increases satisfaction with the process and with the outcomes of their child's therapy. It is possible to observe the finding brought in the context of the Pygmalion effect (Jussim, 1986), where high parental efficacy is associated with high expectations of therapy and predicts the actual success of the therapy. High parental efficacy, in addition to perceiving therapy as beneficial, positive and enabling mutual communication between the therapist and the parent, often shapes the parent's satisfaction with the therapy (Hart et al., 2007). With regard to the mother's therapeutic relationship with the therapist, it may be hypothesised that high parental efficacy is unconsciously projected on the therapist and thus ascribes to the therapist a higher potential ability to succeed than among mothers with low parental efficacy.

The lack of a correlation in the study between parental efficacy and the measures of satisfaction with the child's progress in therapy can be explained by the mother's internal and external reality (Casement, 2013). In the mother's subjective experience and in her inner world, when she had prior experience with therapy and it was positive, this contributes to the level of satisfaction. In addition, when the perception is that emotional therapy can succeed and help the mothers, this gives them the ability to influence and control the success of the therapy. In contrast, in an external reality where the mother must evaluate the child's progress, she has very little influence. The mother is unable to directly influence the child's responses or beliefs and, as a result, the therapeutic process. Parental efficacy can have a direct and personal impact on the parent but not necessarily on the child. The child's realistic difficulties with the learning disability significantly reduce the mother's satisfaction with the therapy, which is not under her control. Another aspect of the lack of correlation between satisfaction (Satisfaction 1) and self-efficacy is related to the parent's communication and relationship with the child's therapist.

With regard to the research findings concerning the Satisfaction 2 questionnaire, a medium-high negative correlation was found between PSI general and attitudes towards seeking help. The research literature indicates hardships that stem from the difficulty of being a parent, including the consequences and demands that lead to many changes in the balance within the family system (Anthony et al., 2005). The higher the levels of stress, the lower the faith in therapy. Stress weakens all the physical systems and does not allow the individual to utilise internal resources. Stress reduces the parent and makes him or her more vulnerable. High levels of stress lead to a continuous state of failure experiences. The ability to hold optimistic views diminishes considerably, leading to and shaping negative thinking. When these various difficulties are joined by the child's disability and the child's functional decline in a range of aspects, the stress level rises and as a result satisfaction with therapy might also drop considerably.

This, whereas no significant correlation was found between PSI general and progress evaluation (Satisfaction 1) Since the mother has no direct ability to influence the therapy's progress or the child's responses, the levels of stress are not related to levels of progress in therapy and consequently to satisfactory outcomes of therapy. The different results on the satisfaction measures can be explained by the concept of "locus of control". Locus of control denotes the degree to which people feel that they have influence/control over the results of their behaviour (Phares, 1976). The research findings concerning the Satisfaction 2 questionnaire indicate that in the association between stress levels and faith in therapy and its outcomes an internal locus of control is in action. The mother feels and acts in the understanding and belief that she has control over her inner world and that she has access to a variety of emotional, cognitive and behavioural tools. As a result, her satisfaction with the therapy is higher. In contrast, with regard to the findings of the Satisfaction 1 questionnaire on measuring satisfaction with progress in the child's therapy, the mother's ability to influence the child's various behavioural, emotional and intra-psycho functions is lower. The mother's limited ability to affect the therapy's progress represents an external locus of control.

This finding is innovative because, to date, the correlation between the duration of therapy and mothers' satisfaction with the outcomes of expressive and creative therapy in the educational system and specifically in special education schools has not been explored. Israel's Ministry of Education defines therapy in special education schools as short-term therapy for one year (Ministry of Education, 2003). In practice, expressive and creative therapy at special education schools can continue for many years based on the considerations of the school or considerations arising from the therapy and of course the pupil's desire to remain in therapy. As a result, adolescents are given the option of long-term therapy over many years. No reference was found in the research literature to mothers' satisfaction with short- or long-term therapy. With regard to the literature's reference to differences between short- and long-term therapy, long-term therapy was indeed found to be more efficient than short-term therapy. Nonetheless, compared to short-term therapy most measures indicate that the influence and differences between the two types of therapy are relatively small (Horn et al., 2015; Lorentzen, Strauss & Altmann, 2018).

With regard to the findings of the Satisfaction 2 questionnaire that were partially supported, it may be hypothesised that the maternal attitude towards satisfaction with therapy and seeking therapy is related to the fact that mothers' internal attitude to therapy did not change. Belief in therapy and in its outcomes is part of the mother's set of beliefs. Mothers' perceptions of therapy were forged over many years. It may be concluded that these stable conceptions did not change as a result of the child's disability or of their prior experiences. Hence, the child's duration of therapy did not change their attitude and conceptions regarding satisfaction with their child's therapy.

The research findings, indicating mothers' satisfaction with lengthy treatment of their child, can be observed through the ecological model (Bronfenbrenner, 1979). According to this model the client develops and grows in an environment consisting of interrelated systems. Improvement in the child's inner world will affect his or her external world and functioning, which will affect the emotional climate of the parents and family. Of course, in wider circles there will also be an effect on the educational and environmental system. Hence, with regard to the Satisfaction 1 questionnaire, the child's duration of therapy, namely lengthy exposure to therapy, creates a change in

the child's inner world, which leads to an external change (behavioural, academic, social) that is projected on and affects the parent's well-being and inner world. All these affect the child's home, school and environmental systems, and as a result raise mothers' satisfaction.

The research findings indicate no correlation between the child's age and mothers' satisfaction with therapy. It may be hypothesised that age per se does not influence and is not related to the quality of therapy or satisfaction with it as perceived by the mothers. Since the clients are adolescents who are undergoing individual psychological change, two teens of the same age might have different degrees of maturity and readiness to enter a therapeutic process and apply themselves to it. It is evident that the factor affecting parent satisfaction is not chronological age; instead, the child's emotional maturity might affect success of therapy and consequently increase mothers' satisfaction with therapy. This finding has encouraging meanings, as the chance that therapy will succeed, and as a result mothers' satisfaction, do not depend on the child's age. Hence, it may be concluded that even when the therapy begins at a later age the client can benefit from it and the parent will be able to discern a change. Namely, there is no critical age for beginning treatment. Within all agencies affecting referral and mapping, this finding should be brought to the attention of educational-therapeutic staff working at schools when placing school children in therapy.

## **6. General Discussion**

Expressive and creative therapy is one of the therapeutic tools that can be used to help adolescents with learning disabilities reach better academic and social adjustment at school. The success of the therapy is affected by a range of factors. One of these is mothers' attitudes towards the therapy and the therapist. To date, very little research knowledge has been gathered on these attitudes. Accordingly, the purpose of the current study was to examine the perceptions and expectations of mothers towards the therapy and the therapist, as well as their parental efficacy, level of parental stress and satisfaction with the therapy.

### **Theoretical contribution**

The theoretical contribution of the study is evident in its illumination of three main processes that occur for the mothers with regard to therapy provided to adolescents with learning disabilities. The first process is related to mothers' perceptions and expectations of their involvement in their children's therapy (Bachar et al., 1990) at school as well as to their relationship and communication with the therapist (Siklos & Kerns, 2006). The second process is related to the cognitive dimension – perceived parental efficacy (Bandura, 1989), enabling expanded generalisation from the findings of previous studies that proved the significance of self-efficacy as a cause of the therapy's success. The innovation of the current study in this issue is by showing that the influencing process of parental efficacy occurs among mothers of adolescents as well. The third process is related to a psychological variable – mothers' level of stress (Lazarus, 1990). The study uncovered an interesting finding showing that high levels of stress reduce expectations of therapy and of the therapist. In light of the fact that high levels of stress are prevalent among mothers of adolescents with learning disabilities, this finding has special significance both in theory and in practice, as will be presented below in the applied recommendations of the research. The third process illuminated the significance of the mothers' satisfaction with the therapy in general and with the specific therapeutic process undergone by their children, where these two dimensions were explored in the context of stress and of efficacy.

### **Contribution to the field of expressive and creative therapy**

The contribution to the field of expressive and creative therapy is significant and it is evident on several dimensions. The study presents mothers' perceptions and expectations in various aspects related to the field of expressive and creative therapy. Then, the study explores the impact of psychological components related to mothers' perceptions of expressive and creative therapy. And, on a third dimension, mothers' satisfaction with expressive and creative therapy was measured for the first time from several aspects of the therapy.

### **Contribution to the therapeutic field within the school**

Expressive and creative therapists have been and are still being integrated in schools, during the past several decades. The current study is the first to focus on mothers' point of view regarding their attitude to and perception of the therapy and the therapist as well as the connection between the language of therapy and the educational language. The current study provides first of all to schools that provide expressive and creative therapy and secondly to the management level in the Ministry of Education, a wide picture of mothers' perception of school-based therapy, which will enable them to perform the necessary adaptations and changes, as presented below in the applied recommendations of the study.

### **Universal contribution**

The current study may have universal implications related to mothers' involvement in the therapy provided to their adolescent children. The processes detected in the current study and described above might also occur in a range of psychological and paramedical therapies that utilise various therapeutic approaches, as well as in a range of difficulties and disabilities. The option of generalising the findings to additional therapeutic methods as well as to additional difficulties, is possible because the maternal experience has a universal nature and the dimensions of parental efficacy and parental stress too have human implications common to a variety of situations. Therefore, the findings of the current study might help any professional element who works with parents understand the complexity of the situation and find appropriate ways of coping.

### **Research limitations**

The research population consisted of mothers with adolescents who have learning disabilities, and not fathers. It is to be assumed that differences would be found in the attitudes, intentions, expectations and perceptions of mothers and fathers towards the therapy and therapists. There is evidently a difference between mothers and fathers in various psychological processes, i.e., levels of efficacy, stress and others. The research population included mothers from the majority population group. Mothers from other common sociocultural groups in Israeli society, such as the ultra-Orthodox, Arabs and new immigrants, were not examined. The research population focused on the perceptions and expectations of mothers with adolescents who have difficulties and are studying in a special education setting. The perceptions and expectations of mothers with adolescents studying in special education who have other difficulties, such as emotional difficulties, cognitive difficulties, communication difficulties and so on, were not examined. The data were gathered from mothers only. The voice of the adolescents or of the therapists was not heard with regard to their satisfaction with the therapy and with the therapist-parent relationship. The expectations and perceptions of mothers with regard to therapy and the therapist was not explored among mothers whose child was not receiving therapy at the school. No data were gathered for mothers of clients in their first year of therapy.

### **Suggestions for further research**

It would be advisable to examine the research questions among a range of schools serving special education populations such as behavioural difficulties, emotional-mental difficulties, communication difficulties and more. Furthermore, the study can be expanded to younger clients. It would be advisable to examine the perceptions and attitudes of parents whose child was diagnosed but does not take part in therapy offered by the school. It is necessary to examine whether parents' expectations and perceptions develop and change throughout their children's development, beginning from infancy, through the latency period, to adolescence. A comparison should be held between mothers and fathers with regard to parental efficacy and stress levels as affecting attitude to therapy and to the therapist. It is suggested that the research questions be examined among parents belonging to additional sociocultural sectors, such as Arabs, ultra-Orthodox, new immigrants. It is important to compare between parents' perceptions of the outcomes of therapy

provided at the school and in other public settings (hospitals, welfare, etc.). Furthermore, it is necessary to compare the outcomes of therapy provided at schools with the outcomes of therapy provided in private practice. It is recommended to compare the expectations of therapists working at a school with regard to the relationship and communication with parents in the school, with therapy provided in other settings. It is recommended to compare the differences and impacts (symptoms, satisfaction) of short- and long-term therapy held at the school. It is necessary to examine the satisfaction of clients with therapy and with the therapist. This should be examined both among adolescents and among young children. It is desirable to develop a research tool that will measure satisfaction with expressive and creative therapy among adolescents receiving therapy at school.

### **Applied recommendations**

With the pupil's transfer to junior high school, parent meetings with therapists should be held in order to detect parent difficulties and expectations of the therapy and the therapist. In addition, the educational/therapeutic system must offer to follow the transition and to utilise the parent as a mediator in the child's absorption experience. The parents must be given an extensive frontal/written explanation of expressive and creative therapy and its contribution to them and to their child. In addition, as much as possible, parents must be given an explanation about the therapists' training and prior experience. Regular parent guidance sessions at the school should be made possible (beyond intake encounters and annual update meetings) not at the expense of time allocated for the child's therapy, at first as a pilot and then by offering parents who are interested regular guidance at a high frequency. In addition, if necessary the therapist must be given the possibility of offering to hold intake sessions/parent guidance in the evenings (for a fee). When setting the therapeutic goals, at first in the presence of the therapist, ultimately an educator should be included in order to form an overall picture of the various educational and emotional goals from all points of view. In this way, the ILP will be granted a wider and more valid view.

With the help of the educational staff, it is necessary to try and encourage parents to be involved in their children's therapy process and in the relationship with the therapist.

Continue enhancing the understanding of parents' expectations and perceptions of school-based therapy (expectations, satisfaction, connection and communication) .Enhancing cooperation in the work-triangle consisting of the parent, homeroom teacher and therapist. Collaborations should be advanced in on-site training for headmasters In the process of training therapists, it is necessary to enable more exposure and understanding of the educational system. The school should organize and initiate parent workshops in order to improve and enhance the conditions necessary for successful treatment. The purpose of the workshops is to coordinate parent expectations, enhance parental efficacy and reduce stress levels this, in order to promote internal self-encouragement resources and trust in the therapy and in the therapist's role. It is necessary to receive feedback from the adolescents (clients) concerning the therapy and the relationship with the therapist. This type of feedback will allow the therapeutic organs at the school to align themselves differently when necessary and to use a range of different therapeutic interventions.

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