THE EFFECTS OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF MOTHERS OF CHILDREN WITH MODERATE MENTAL RETARDATION

BOONTHIWA CHOOCHUA

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Boonthiwa Choochua.
.....
Miss Boonthiwa Choochua
Candidate

Yajai Sitthimongkol
.....
Asst.Prof.Yajai Sitthimongkol, Ph.D.
Major-Advisor

Tassana Boontong
.....
Assoc.Prof.Tassana Boontong, Ed.D.
Co-Advisor

Wasana Chalamket.
.....
Asst.Prof.Wasana Chalamket, M.Ed.
Co-Advisor

.....
Prof.Liangchai Limlomwongse, Ph.D.
Dean
Faculty of Graduate Studies

Kobkul Phancharoenworakul
.....
Assoc.Prof.Kobkul Phancharoenworakul, Ph.D.
Chairperson
Master of Nursing Science
Faculty of Nursing

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January 31, 2000

Boonthiwa Choochua.
Miss Boonthiwa Choochua
Candidate

Yajai Sitthimongkol
Asst.Prof.Yajai Sitthimongkol, Ph.D.
Chairperson

Kobkul Phancharoenworakul
Assoc.Prof.Kobkul Phancharoenworakul, Ph.D.
Member

Tassana Boontong
Assoc.Prof.Tassana Boontong, Ed.D.
Member

Wajjanin Rohitsuk
Lect.Wajjanin Rohitsuk, Ph.D.
Member

Wasana Chalamket
Asst.Prof.Wasana Chalamket, M.Ed.
Member

Liangchai Limlomwongse
Prof.Liangchai Limlomwongse, Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University

Kobkul Phancharoenworakul
Assoc.Prof.Kobkul Phancharoenworakul, Ph.D.
Dean
Faculty of Nursing
Mahidol University

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4037089 NSPS/M : MAJOR: PSYCHIATRIC-MENTAL HEALTH NURSING; M.N.S. (PSYCHIATRIC-MENTAL HEALTH NURSING)
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BOONTHIWA CHOOCHUA: THE EFFECTS OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF MOTHERS OF CHILDREN WITH MODERATE MENTAL RETARDATION.THESIS ADVISORS: YAJAI SITTHIMONGKOL, Ph.D., TASSANA BOONTONG, Ed.D., WASANA CHALAMKET, M.Ed. 114 P. ISBN 974-663-558-1

The purpose of this study was to examine the effects of the supportive group therapy program on the stress and coping behaviors of mothers with moderate mentally retarded children. The subjects of the study were mothers who attended the Rajanukul Intervention Program, Rajanukul Hospital, during June and July 1999. The study employed a quasi-experimental design. The sixteen mothers who were selected were divided into two groups, a control and an experimental group. The experimental group participated in the supportive group therapy program. The program consisted of eight sessions of 60-90 minutes duration once a week. The subjects were assessed using stress and coping behavior questionnaires both pre-intervention and post-intervention. The information gathered was then used to provide descriptive analysis and t-test statistical analysis. The threshold of statistical significance was set at 0.05.

The findings of study revealed that after participating in the supportive group therapy program; 1) the subjects in the experimental group had lower level of stress than they did before, 2) the subjects in the experimental group had a higher mean score for coping behaviors than they did before, 3) the subjects in the experimental group had lower level of stress than those in the control group, and 4) the subjects in the experimental group had a higher mean score of coping behaviors than those in the control group.

The results of suggested that a supportive group therapy program can help the mothers to reduce stress and use more effective coping behavior. Nurses should be prepared with the knowledge and skills relating to conduct the supportive group therapy for the mothers. The supportive group therapy should be made available to the mothers of different ages.

4037089 NSPS/M : สาขาวิชา: สุขภาพจิตและการพยาบาลจิตเวชศาสตร์;
พย.ม. (สุขภาพจิตและการพยาบาลจิตเวชศาสตร์)

บุญทิวา ชูเชื้อ : ผลของการใช้กลุ่มบำบัดแบบประคับประคองต่อความเครียดและพฤติกรรมการเผชิญความเครียดในมารดาของเด็กที่มีภาวะปัญญาอ่อนระดับปานกลาง (THE EFFECTS OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF MOTHERS OF CHILDREN WITH MODERATE MENTAL RETARDATION) คณะกรรมการควบคุมวิทยานิพนธ์: ยาใจ สิทธิมงคล, Ph.D., ทัศนา บุญทอง, Ed.D., วาสนา แฉล้มเขตร, กศ.ม.114 หน้า
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การวิจัยนี้มีวัตถุประสงค์เพื่อ ศึกษาผลของการใช้กลุ่มบำบัดแบบประคับประคองต่อความเครียดและพฤติกรรมการเผชิญความเครียดในมารดาของเด็กที่มีภาวะปัญญาอ่อนระดับปานกลาง กลุ่มตัวอย่างคือมารดาที่พาบุตรมาเข้าร่วมโครงการส่งเสริมพัฒนาการเด็ก โรงพยาบาลราชานุกูล ระหว่างเดือนมิถุนายน ถึง เดือนกรกฎาคม 2542 รูปแบบของการวิจัยเป็นแบบกึ่งทดลอง โดยเลือกกลุ่มตัวอย่างแบบเจาะจงตามคุณสมบัติที่กำหนดจำนวน 16 คน เพื่อจัดเข้าสู่กลุ่มควบคุมและกลุ่มทดลอง ซึ่งกลุ่มทดลองได้เข้าร่วมโปรแกรมกลุ่มบำบัดแบบประคับประคอง 8 ครั้งต่อเนื่องกัน แต่ละครั้งใช้เวลาประมาณ 60-90 นาที โดยมีการเข้ากลุ่มสัปดาห์ละ 1 ครั้ง ทั้งนี้มารดาได้รับการประเมินความเครียด และพฤติกรรมการเผชิญความเครียด ในช่วงก่อนการทดลองและภายหลังการทดลอง ข้อมูลที่ได้จากแบบสอบถามนำมาวิเคราะห์โดยใช้สถิติเชิงพรรณนา และสถิติการทดสอบค่าที ค่านัยสำคัญทางสถิติกำหนดไว้ที่ระดับ 0.05

ผลการศึกษาพบว่า ภายหลังการเข้ากลุ่มบำบัดแบบประคับประคอง 1) มารดาในกลุ่มทดลองมีระดับความเครียดลดลง 2)มารดาในกลุ่มทดลองมีคะแนนเฉลี่ยของพฤติกรรมการเผชิญความเครียดเพิ่มขึ้น 3) มารดาในกลุ่มทดลองมีระดับความเครียดต่ำกว่ามารดาในกลุ่มควบคุม และ 4)มารดาในกลุ่มทดลองมีคะแนนเฉลี่ยของพฤติกรรมการเผชิญความเครียดสูงกว่ามารดาในกลุ่มควบคุม

ผลการศึกษามีข้อเสนอแนะว่ากลุ่มบำบัดแบบประคับประคองช่วยให้มารดามีความเครียดลดลง และมีพฤติกรรมการเผชิญความเครียดที่เหมาะสมมากขึ้น ดังนั้นพยาบาลควรเตรียมความรู้และทักษะในการจัดกลุ่มบำบัดแบบประคับประคองสำหรับมารดา ควรนำกลุ่มบำบัดแบบประคับประคองไปใช้กับมารดาของเด็กที่มีภาวะปัญญาอ่อนในช่วงอายุอื่นๆ

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

Mental retardation is an illness that profoundly affects both the mentally retarded person and their family. Mental retardation is estimated to affect 1% of the population of Thailand (Mental Health Department Newsletter, 1998: 12). Since the population of Thailand is about 60 million persons, the number of mentally retarded persons can be estimated to be around 600,000. Mentally retarded persons usually require treatment and care by both mental health professionals and their families. In Thailand although there are 49 institutions administered by the government or private sector that are able to provide such services, they are able to do so for only about 5,000 mentally retarded individuals each year (Kanokpongsakdi, R. & Sootabutara, K., In Tantiphalacheewa, K., Ed., 1993: 727). The vast majority of other mentally retarded persons remain the responsibility of their families, with their mother usually acting as the primary caregiver to the mentally retarded child (Scheiber, 1989: 42 - 44).

The birth of a child with mental retardation presents both a loss and a crisis for the family system (McCubbin & Patterson, In Figley & McCubbin, Eds., 1983: 21-36). Having a child with a developmental disability is an unanticipated event which most families are unprepared to cope with (Heaman, 1995: 311-320). Taking care of a mentally retarded child is burdensome which causes stress within the family, particularly to the mother who traditionally has greater child care responsibilities.

Generally, the mother expects to deliver a normal child. If the mother finds that her child has a developmental delay, she will feel disappointed (Kalman & Waughfield, 1993: 174). A child with mental retardation normally has sub-average intellectual functioning, existing concurrently with deficits in adaptive skills (Bregman & Harris, In Kaplan & Sadock, Eds., 1995: 2208). Mothers of children with disabilities are confronted with physical and psychological stresses. These physical stresses may show up as fatigue, higher blood pressure, increasing heart rate and peptic ulcer (Holroyd & Lazarus, 1982: 26). Psychological stresses may show up as guilt, denial, an inferiority complex, religious doubts, shame, infanticide confusion, a death-wish, anger, self-blame, loneliness, feelings of being unloved or helpless (Childs, 1985: 175-182), and anxiety about the child's future (Heaman, 1995: 315).

Furthermore these mothers may experience chronic stress from long-term care of their children, especially their child's daily life in the community (Srisulo, S., et al., 1998: 58). They may also have to face problematic behaviors of the child, such as limited self-care ability, speech and language problems, aggression, self-absorbtion, stubbornness, and irritability (Kanokpongsakdi, R. & Sootabutara, K., In Tantiphalacheewa, K., Ed., 1993: 708; Thienthanu, C. & Sootabutara, K., 1995: 1 and McGrath & Grant, 1993: 25-41). Such deficiencies in self-care or other problematic behaviors of the child are important factors in the development of chronic stress in the mother.

Having a mentally retarded child in the family usually affects not only the mother's mental health, but also the relationships among family members (Pongsaksri, A., 1995: 10-12). The mothers have to spend so much of their time and energy in taking care of the mentally retarded child that they have far less time for taking care of

other family members. Thus, other normal siblings may be ignored and become stressed (O' Donoghue, 1990: 640-672).

In summary, taking care of the mentally retarded child is time consuming and stressful to the mother. This stress is due to various parental factors, such as lack of knowledge about mental retardation (Srisulo, S., et al., 1998: 58), unfulfilled expectations about the development of their child, curtailed personal freedom, job problems, problematic behaviors of the child (Thamavasi, C., 1991: 62-64), the lack of a remedy for their child's condition, financial burden (Molony,1989: 270; Nakthongkaew, S., 1997: 28-31; Pongsaksri, A., 1995: 8-18), changes in social relationships due to negative attitudes of colleagues to the child (Huang, 1998: 311-320), or the lack of family and social support (Zimmerman, 1984: 105-118; Schilling, et al., 1984: 47-53; Heaman, 1995: 311-320).

When mothers discorer that they are stressed, they then try to overcome the stress by using coping strategies (Lazarus & Folkman, 1984: 150-153). Following Lazarus and Folkman's concept (1984), coping may be defined as the cognitive and behavioral efforts used to manage external and/or internal stressful demands that are appraised as exceeding the resources of the person concerned. Coping is a process that changes as the individual's appraisal of the situation changes. The two basic forms of coping behavior are problem-focused and emotional-focused coping. Typically, individuals use a combination of problem-focused and emotional-focused coping to handle stresses (Hainsworth, et al., 1994: 60). Typically, mothers with a mentally retarded child determine that the illness of the child is chronic with very little chance of change. This causes stress in the mother, to which she typically reacts with an emotional-focused coping strategy (Huang, 1998: 311-320 and Pongsaksri, A., 1993).

Mothers adopt various coping behaviors ways such as: social withdrawal because they are afraid that people will not accept their child (Wongsawan, S., 1994), abandoning the child due to the mothers' feelings of despair (Puwattananon, K., 1993: 21), trying to ignore the problem by spending more time asleep, denial of their child's condition (Tangudommongkol, U., 1997: 58-59), and by practicing meditation (Heaman, 1995: 317). Mothers who experience stress and use emotional-focused coping not only feel distress, but are also less able to themselves provide their child with quality care.

Alquilera and Messick (cited in Phasuk, N., 1985: 11) state that the three major factors related to coping behavior are situational factors, supporting factors, and adaptive coping skills. Similarly, Schilling (1984) state that personal coping and social supports are especially important resources for families with developmentally disabled children, Adams (1990 cite in Heaman, 1995: 312) states that social support is an important factor influencing mothers' coping strategies. Social support services include medical treatment, child developmental programs, home visits, consultation, and training (Thienthanu, C., 1992: 9-12; Nakthongkaew, S., 1997: 28-31 and Pongsaksri, A., 1995: 8-18). When mothers receive the social supports such as emotional, appraisal, information, and instrumental support (Kompayak, J., 1988: 100), their self-esteem, emotional stability, self-confidence, and problem-solving skills are increased (Intaravichai, J., 1990: 35).

Supportive group therapy is widely accepted as an important social support intervention for helping mothers with a mentally retarded child to cope. A major goal of supportive group therapy is to help participants establish warm relationships and unconditionally positive self-regard. The group leader helps group members to express their feelings and opinions about their current situation. Participants'

responsibilities are to listen to these expressions, exchange experiences, recognize and pay attention to the problems of others, show empathy, encourage, and support each other. Participants gain self-esteem, self-confidence, self-awareness, and new or improved coping skills from participation in the supportive group therapy program. They learn to better accept and understand their real problems actual situations, and are able to effectively choose coping strategies (Kasornsamut, P., 1993: 7-11; Supmee, W., 1990: 37-58; Shives, 1998: 52 and Trotzer, 1977: 105-126). According to Rogers' concept of client-centered therapy (1970) human beings are good, valuable, and have the potential to solve problems by processing information to help them perceive situations realistically (Theeravekin, N., 1997: 170-178).

As a psychiatric nurse, this researcher had the responsibility of encouraging and helping patients and their families to cope with stress more effectively. Accordingly, this researcher utilized supportive group therapy in helping these mothers to cope more effectively. The supportive group therapy program educated these mothers about mental retardation and provided them with opportunities to share their experiences so that they could learn from each other and see their own problems more realistically.

Conceptual Framework of the Study

This section presents an overview of the stress and coping model of Lazarus and Folkman (1984) and supportive group therapy based on the client-centered therapy of Rogers (1970).

Mothers of the mentally retarded often find themselves in a situation that exceeds their resources and endangers their own well-being. Factors influencing the mother's stress may be divided into personal factors and environmental factors. Personal factors may include commitments and beliefs such as their attitude towards mental retardation or the expectation of giving birth to a healthy child. The mother may have no experience in caring for a mentally retarded child and therefore have difficulty in managing the situation, or find that the child's condition is very unpredictable. Often the mother may also lack knowledge about mental retardation (Pongsaksri, A., 1993), which increases their discouragement, fatigue, and low self-esteem. By contrast, the main environmental factors influencing the mother are the condition of their child, long-term caring, financial problems, social support, and social stigma (Srisulo, S., et al., 1998: 68-70).

When the mother realizes that she is stressed, she may then try to find ways to overcome the stress by using coping strategies which are problem-focused and/or emotional-focused coping (Lazarus & Folkman, 1984: 150-153). The goal of both these strategies is to relieve pressure resulting from the problem and to correct the mental balance mentality through the learning experience, after which the mother will be able to reappraise her situation. If she finds that such problems remain a threat, this coping process can be repeated until she finds effective coping behavior to use.

The researcher used the client-centered therapy of Rogers (1970) as the model for implementing the supportive group therapy program in this study. The significant elements of supportive group therapy in this study are reassurance, explanation, guidance, suggestion, encouragement, relief of stress, and environmental management. Group members were expected to develop increased self-awareness and self-esteem, and their ability to analyze problems and situations more realistically by using the power of group support. In the group support process, participants feel free to express their opinions or feelings and to exchange experiences in taking care of their children. Participation in taking and giving help among group members increases their self-esteem (Shives, 1998: 52) which encourages them to face their problems, ultimately reducing their stress and helping them to adopt more effective coping behavior.

As mentioned above, the conceptual framework of this study can be demonstrated in terms of factor relationships. These relationships are shown below in figure 1

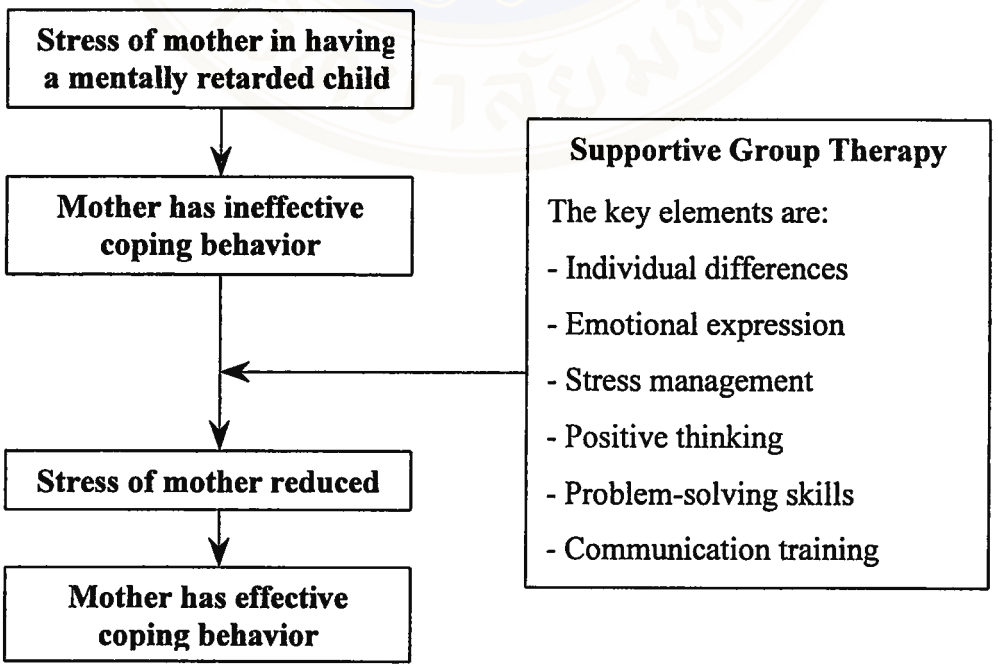

Figure 1: Conceptual framework of the study

Purpose of the Study

To study the effects of the supportive group therapy program on the stress and coping behavior of mothers of children with moderate mental retardation.

Hypotheses of the Study

1. After participating in the supportive group therapy program, the subjects will have lower level of stress than before.

2. After participating in the supportive group therapy program, the subjects will have a higher mean score of coping behaviors than they did before.

3. The subjects who participated in the supportive group therapy program will have lower level of stress than those who did not.

4. The subjects who participated in the supportive group therapy program will have a higher mean score of coping behaviors than those who did not.

Scope of the Study

This research was designed to study the effects of conducting a supportive group therapy program on the stress and coping behavior of mothers of pre-school aged children with moderate mental retardation. The sample group of participants consisted of mothers having a child with moderate mental retardation and attending the Early Intervention Program at Rajanukul Hospital, during June and July 1999.

Benefits of the Study

1. To encourage nurses to realize the importance and benefits of supportive group therapy in helping families who have a mentally retarded child.

2. To encourage administrative teams to implement supportive group therapy programs to help families who have a mentally retarded child.

3. To serve as a reference for other studies on the use of supportive group therapy for mothers with mentally retarded children of different ages.

Definition of Terms

1. **Supportive group therapy** consists of a regular program of expression and learning in a group setting facilitated by a group leader who is a professional health-care worker specially trained in this method. The program is based on the client-centered therapy of Rogers (1970). The contents of the program are as follows: orientation and forming group relationships, discovering individual differences, improving emotional expression, improving stress management, increasing positive thinking and self-esteem, improving problem-solving skills, communication training, and group evaluation. The participants were mothers of mentally retarded children and they took part in 60-90 minutes group session per weak for eight weeks.

2. **Stress** is recognition of feelings of discomfort, unhappiness, suffering, or sadness through the cognitive appraisal processes of mothers who are suffering because they are in a situation of having to care for a child with mental retardation, which exceeds their resources and endangers their own well-being. Stressors were assessed by a Stress Questionnaire, which was developed by the researcher, based on

the stress and coping models of Lazarus and Folkman, literature review, and further research on mothers with a mentally retarded child.

3. **Coping behavior** is the thought or action that the mother of the mentally retarded child chooses to use in order to manage the stress of taking care of her mentally retarded child. These strategies are classified as either problem-focused coping behavior and emotional-focused coping behavior. They were assessed using the Coping Behavior Questionnaire, which was developed by the researcher, based on the stress and coping model of Lazarus and Folkman, literature review, and further research on mothers with a mentally retarded child.

CHAPTER II

LITERATURE REVIEW

This study examined the effects of the supportive group therapy program on the stress level and coping behavior of mothers with a moderate mentally retarded child. The literature review covered the following topics:

- Mental retardation
- Stress and coping behavior of mothers of children with mental retardation

1. Concept of stress
2. Concept of coping behavior
3. Research on stress and coping behavior of mothers of children with mental retardation

- The relationship between supportive group therapy and the stress level and coping behavior of mothers of mentally retarded children.

1. Concept of supportive group therapy based on the client-centered therapy of Rogers
2. Effects of supportive group therapy on stress and coping behavior

Mental Retardation

Despite recognition of its existence since antiquity, there is little evidence of early medical interest in mental retardation before the end of the 18th century when there began to develop a rising respect for the individual (Bregman & Harris, 1995: 2207).

1. Definition

In the past, part of the difficulty in defining condition related to the central role of intelligence in mental retardation, where it was believed simply that the mentally retarded had a lower level of intelligence than was typical in the general population (Gelfand, et al., 1982: 339).

In 1959, the American Association on Mental Retardation (AAMR) added adaptive behavior as a criterion i.e. the person may have adapted successful to their environment although still being regarded as psycho-pathologically disturbed or abnormal (Wenar, 1994: 337 – 338).

The modern definition goes one step further. Adaptation itself is not seen as some kind of trait or absolute quality individuals possess, but as existing in relation to an environment. Therefore the environment must be scrutinized before one can correctly determine whether an individual is mentally retarded (Wenar, 1994: 339).

In summary, these days mental retardation refers to substantial limitations in present functioning. It is characterized by significant subaverage intellectual functioning within adaptive skill areas: communication, self-care, daily-living skills,

social skills, community interaction, self-determination, health, and safety. Age of onset is under 18 years.

2. Causation

The causes of mental retardation are many and varied, and in the majority of cases the cause is unknown. There are many studies that reported causes of mental retardation. However there are two known causes of mental retardation, genetic factors and environmental factors.

2.1 Genetic factors

Genetic factors are the single most common cause of mental retardation and can be partially implicated in up to 90% of cases. Syndromes of differing genetic origin are associated with distinct profiles of cognitive, emotional, and linguistic performance, as well as unique patterns of individual development (Dymek & Ratey, In Fogel & Schiffer, Eds.,1996).

2.2 Environmental factors

Environmental factors relate to three parts of the developmental cycle such as prenatal, perinatal and postnatal periods (Kaplan & Sadock, 1995: 2209-2210 and Dymek & Ratey, In Fogel & Schiffer, Eds.,1996: 553-554).

2.2.1 Prenatal factor that causes of mental retardation are usually attributed to diverse maternal factors such as age, improper diet, physical injury, disease or infection, toxic states, and blood incompatibility.

2.2.2 Perinatal causes are usually attributed to obstetric complications such as pro-longed and difficult delivery, birth injury, anoxia, and

maternal anesthesia. These can have a considerable effect on the neonate, and in fact this is a major cause of mental handicap.

2.2.3 Postnatal factors are implicated less often than prenatal and perinatal conditions in mental retardation, many conditions in the first several years of life can lead to mental handicaps. Factors such as head trauma and ingestion of toxic substances are often implicated in brain damage. Cerebral infection can have primary causes from specific infections such as bacterial meningitis or viral encephalitis, which causes of direct infection and inflammation of brain tissue. On the other hand, these problems can be secondary reactions of other infectious agents in the body, such as such as herpes simplex infection, diphtheria, and rubella.

3. Levels of mental retardation

Mental retardation is divided into four degrees of severity, reflecting the degree of intellectual impairment (Kaplan & Sadock, 1995: 2209-2210 and Ratey & Dymek, In Fogel & Schiffer, Eds., 1996: 550).

3.1 Mild mental retardation

Individuals with mild forms of mental retardation generally have IQ levels ranging from 55 to 70 points. This group accounts for about 80% of the mentally retarded. The mildly retarded are typically able to master essential school skills, and by adulthood can often achieve a satisfactory level of socially adaptive behavior. Many of these functionally retarded individuals are marked by impoverished and deprived backgrounds and generally have no physical problems associated with their disorder.

3.2 Moderate mental retardation

IQ levels in those diagnosed with moderate mental retardation range from 40-55 points. This group accounts for about 10-15% of retarded individuals. Moderate mental retardation is usually recognized early in life, when developmental milestones such as language are delayed. By adulthood, many of these individuals have reasonable verbal skills, although their rate of learning remains slow. In general, those with moderate intellectual impairments can acquire daily living and simple vocational skills and are able to function in society with guidance.

3.3 Severe mental retardation

IQ levels of severely retarded individuals range from 20-39 points. This group accounts for about 3-4% of retarded individuals. The deficits present in these individuals are apparent at a very young age and typically include severely defective speech. Severely retarded patients can sometimes develop limited levels of hygiene and self-help, but invariably they will basically remain dependent upon the care of others.

3.4 Profound mental retardation

The IQ level of profoundly retarded individual is measured at or under 20 points. This group accounts for about 1-2% of retarded individuals. Problems present in these individuals are often noticeable at birth, due to the presence of severe physical malformations and other obvious symptoms of abnormality. The profoundly retarded show multiple handicaps, severe deficits in adaptive skills, and are very resistant to learning.

4. Treatments

Various types of intervention have proven helpful in cases of mental retardation, particularly the identification of individual needs during the evaluation process. The process of selecting the appropriate intervention should begin during developmental and diagnostic evaluation (Pueschel, 1995: 197-209).

4.1 Medical intervention

The term medical intervention simply means that a physician takes care of the child's health problems. The specific treatment provided to a child may consist of frequent visits to the doctor or another health care provider such as a physical or occupational therapist, careful monitoring, or administering prescribed medication regularly.

4.2 Nutritional intervention

For children with feeding problems, food allergies, or food intolerance, a nutritional evaluation may be necessary in order for then to be able to eat and develop properly. Nutritional strategies may focus on what, how much, or how often a child eats.

4.3 Educational intervention

The educational options for children with developmental disabilities are numerous. Early intervention is a form of educational programming for infants, toddlers, and preschoolers. In addition, it offers families with a mentally retarded child a means of coordinating a range of services designed to help meet the needs of both the child and the family concerned. An educationally based program of social, communication, vocational, and adaptive skill development can often lead to a reduction of maladaptive behavior (Kaplan & Sadock, 1995: 2227).

4.4 Therapeutic intervention

Pueschel (1995: 203-206) viewed that many children with mental retardation require at least one form of special therapy at some point during their lives.

4.4.1 Physical therapy

Physical therapy (PT) involves attempts to help children develop their gross motor abilities such as improving head control, crawling, sitting, walking, jumping, and running.

4.4.2 Occupational therapy

The term occupational therapy (OT) originally referred to various forms of treatment for adults with disabilities, which made them unable to participate in normal activities of daily living, through which they were helped to improve their occupational skills. Occupational therapy, particularly for young children, refers to a form of treatment designed to enhance their fine motor skill and control of the smaller muscles of the body such as those in the face, arms, and hands. Occupational therapy aims at improving the way different muscles work together, such as in eye-hand coordination.

4.4.3 Speech-language therapy

Speech-language therapy is used to help children who show a significant language delay or hearing loss. It often involves alternative forms of communication such as sign language or communication boards. In order to use a communication board with pictures or words, the child has to learn to recognize names of objects, understand that pictures are representations of objects, and comprehend that written words refer to specific things.

4.4.4 Psychological services

Psychological services commonly available these days include individual therapy for the child; counseling or therapy for the parents, and family therapy and consultations on specific problems such as discipline, behavior problems, learning disabilities, and emotional disorders. Many parents including those with retarded children seek help because they are having difficulty coping with the stresses of everyday life. Treatment commonly involves play therapy, behavior management training, group therapy, and family therapy.

The main objective of assisting development in the mentally retarded is to help them live normal or more normal lives. Because the child's ability and the family's cooperation are important factors in this process, they should have access to psychological services.

Stress and Coping Behavior of Mothers of Children with Mental Retardation

This section reviews research related to stress and coping behavior found in mothers of children with mental retardation. This review is grounded in the theoretical model of stress and coping of Lazarus & Folkman (1984), including the concepts of stress and coping.

1. Concept of stress

1.1 Definition

Selye (1976) defined stress as the rate of wear and tear on the body. A stressor can be physical, chemical, developmental, or emotional. Stress can be objectively measured by the structural and chemical changes that stress produces in the body. A general response to stress is manifested in diseases, such as hypertension, peptic ulcer, and autoimmune illnesses.

Lazarus and Folkman (1984) defined stress as a manifestation of the relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.

In summary, stress is sorrow, suffering, or worry in response to a factor that is appraised by the person as harmful, threatening or disturbing. These negative effects of stress usually produce illness in the sufferer.

1.2 Cognitive appraisal

A person evaluates incidents through a cognitive appraisal process, which focuses on the significance and continuity of the person's life (Lazarus & Folkman, 1984). Three types of appraisal commonly used to evaluate stressful events are outlined below.

1.2.1 Primary appraisal consists of the cognitive determination of the degree of the threat to the individual. It consists of the judgment that an encounter is irrelevant, benign-positive, or stressful. Stressful appraisals can take three forms: harm/loss, threat, and disturbing.

1.2.2 Secondary appraisal consists of evaluation of the individual, and what might and can be done to achieve an effective outcome. This evaluation requires cognitive and behavioral appraisal in order to determine the most appropriate type of stress management assistance.

1.2.3 Reappraisal refers to the development of a new appraisal based on new information from the environment or the person's own reactions. A reappraisal is simply an appraisal that follows an earlier appraisal in the same encounter and modifies it.

In summary, all stress responses are influenced by the personal meaning or cognitive appraisal of the situation.

1.3 Factors influencing appraisal

The cognitive appraisal process is influenced by two factors: personal and situational factors (Lazarus & Folkman, 1984).

1.3.1 Personal factors

Two personal characteristics that are important determinants of appraisal are commitments and beliefs.

1.3.1.1 Commitments are an expression of what is important to people. Commitments affect appraisal by guiding people into or away from situations that threaten, harm, or benefit them.

1.3.1.2 Beliefs are an evaluation of what is happening and an appraisal that an outcome can be controlled.

1.3.2 Situational factors

1.3.2.1 Novelty encourages appraisal inferences based on previous experience or general knowledge.

1.3.2.2 Predictability implies that there are predictable environmental characteristics that can be learned.

1.3.2.3 Event uncertainty introduces the notion of probability. Event uncertainty in real life is usually stressful.

1.3.2.4 Temporal factors include imminence, duration and uncertainty.

1.3.2.4.1 Imminence refers to how much time there is before an event occurs. Generally, the more imminent an event is, the more intense its appraisal becomes.

1.3.2.4.2 Duration refers to how long a stressful event persists.

1.3.2.4.3 Temporal uncertainty refers to not knowing when an event is going to happen.

1.3.2.5 Ambiguity refers to lack of situational clarity. A person resolves the ambiguity by choosing an interpretation and acting upon it, refusing to acknowledge or attend to the lack of clarity in the information provided.

2. Concept of coping behavior

Lazarus and Folkman (1984: 141) define coping as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding personal resources.

According to Lazarus and Folkman (1984), coping is a process through which the person manages the demands and emotions generated by the appraised stress. Positive coping leads to successful adaptation, which is characterized by achieving a better mental balance.

2.1 Forms of coping behavior.

Coping behavior consists of various actions and thoughts used to deal with a stressor. They have two forms: problem-focused behavior and emotional-focused coping behaviors (Lazarus & Folkman, 1984: 150-153).

2.1.1 Problem-focused forms of coping

Problem-focused coping strategies are similar to strategies typically used in problem solving such as: defining the problem, generating alternative solutions, weighing the alternatives in terms of their costs and benefits, choosing among them, and taking action. Strategies directed at achieving motivational or cognitive changes include shifting the level of aspiration, reducing ego involvement, finding alternative channels of gratification, developing new standards of behavior, or teaching new skills and procedures.

2.1.2 Emotion-focused forms of coping

Emotion-focused coping strategies are directed at changing the meaning of the situation without changing the actual person-environment relationship. Typically this consists of cognitive processes directed at lessening emotional distress, which includes strategies such as avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from a negative event.

Other cognitive strategies are directed at reducing emotional distress and include strategies such as reducing self-blame and reducing self-punishment.

In summary, coping behavior serves two functions: managing the problem or altering the perception of the problem within the existing environment that is causing the stress. This requires problem-focused coping and regulation of the emotional response to the problem that calls for emotion-focused coping. There is no one best coping strategy for a particular situation: each strategy can assist or impede the other in the coping process.

2.2 Coping resources

Lazarus and Folkman (1984) identified major categories of resources. Their purpose was not to be exhaustive, but to illustrate the multidimensionality of coping resources and the various levels of abstraction at which several of these dimensions can be considered.

2.2.1 Health and energy

A person who is frail, sick, tired, or otherwise debilitated has less energy to expend on coping than a healthy.

2.2.2 Positive beliefs

Oneself positively can also be regarded as a very important psychological resource for coping. Positive beliefs include in two category, general and specific beliefs that serve as a basis for hope and that sustain coping efforts in the face of the most adverse conditions.

2.2.3 Problem-solving

Problem-solving skills include the ability to search for information, analyze situations for the purpose of identifying the problem in order to generate alternative courses of action, weigh alternative courses of action, weigh alternatives with respect to desired or anticipated outcomes, and select and implement an appropriate plan of action. They are also important resources for coping.

2.2.4 Social skills

Social skills refer to the ability to communicate and behave with others in ways that are socially appropriate and effective. Social skills facilitate problem-solving in conjunction with other people, increase the likelihood of being able to enlist their cooperation or support, and in general give the individual greater control over social interactions.

2.2.5 Social support

The individual gains sustenance and support from social relationships has been know intuitively for a long time, and should be, in a sense, obvious. Schaefer (1982 cite in Lazarus & Folkman, 1984: 250) distinguished three types of functions of social support.

2.2.5.1 Emotional support includes attachment, reassurance, being able to rely on and confide in a person, which contributes to the feeling that one is loved or cared about.

2.2.5.2 Tangible support involves direct aid such as loans or gifts, and services such as taking care of someone who is ill, doing a job or chore.

2.2.5.3 Informational support providing information or advice, and giving feedback about how a person is doing.

2.2.5 Material Resources

Material resource refers to money and the goods and services that money can buy. This obvious resource is rarely mentioned in discussions of coping, although its importance is implied in discussions of the strong relationships that are found among economic status, stress, and adaptation.

2.3 Adaptation outcome

Adaptive outcome requires cognitive appraisal and coping behavior. This involves the following three areas.

2.3.1 Social function ways in which the individual fulfills their various roles and interpersonal relationship.

2.3.2 Morale: this is concerned with how people feel about themselves. This type of evaluation is based on affects or emotion such as satisfaction/dissatisfaction, happiness/unhappiness, or hope/fear.

2.3.3 Somatic health: stress and coping are causal factors in illness. During a stressful period, any or all of these areas may be compromised. Successful coping results in an improvement in social functioning, psychological well-being, and health.

3. Research on stress and coping behavior of mothers of children with mental retardation

This section consists of two parts. The first covers research, which describes the kinds of stresses which mothers and families report experiencing in caring for a mentally retarded child. The second measures the individual well-being of mothers

involved in this process and describes both effective and ineffective coping behaviors which these mothers can take.

3.1 Research on stress of mothers and families of children with mental retardation

Cumming et al. (1966) compared stress in the mothers of mentally retarded, chronically ill and neurotic children. They found that having a child with a health deficit of any of these type was a psychologically stressful experience for the mother, and that the mothers of the mentally retarded children appeared to experience greater stress than mothers of children with other types of health deficit.

McCubbin and Patterson (1983) summarized the sources of stress experienced by families who have chronically ill children as follows: strained family relationships, modifications in family activities and goals, the burden of increased tasks and time commitment, increased financial burden, need for housing adaptation, and social isolation.

Thamavasri, C. (1991) studied stress in the parents of young mentally retarded children with different degrees of severity. The sample consisted of parents of 149 children with mental retardation. A short Questionnaire on Resources and Stress short form (QRS-SF) was used to collect data. The study found that degrees of severity influenced parental stress, but that the sex of the mentally retarded child did not. Three stressors identified in parents were problems of the child (mild stress = 73.8%), attitudes of the parents (moderate stress = 79.2%), and problems of the family (mild stress = 57.7%).

A brief overview of the typical situation in which these mothers find themselves is outlined in the following process. The mothers of a chronically ill child grieve for the loss. This is accompanied by disbelief, anger, guilt and stress. Sources of stress typically include lack of knowledge, the burden of care, the financial burden, and lack of family and social support. However, once they accept their child's condition, the mother can start to develop strategies to better manage their life and the caring of their child.

3.2 Research on coping behavior of mothers of children with mental retardation

Childs (1985) interviewed 50 mothers of children with mental retardation about their negative feelings. These were grouped into 13 categories: guilt, denial, inferiority, questioning of religious beliefs, shame, confusion, death wish, anger, need to blame others, loneliness, feelings of being unloved, infanticide, and helplessness. The response categories were then listed in order of frequency of occurrence.

Sloper (1991) investigated five factors derived from the Ways of Coping Checklist related to physical and mental health and satisfaction with life. In the univariate analysis on mothers, all five factors were found to be significantly associated with at least one outcome measure. Multiple regression analysis was used to explore the relationships between their predictor variables (stressors, resources and coping behaviors) and outcome measures (satisfaction with life, mental and physical health). It was found that practical coping significantly predicted mothers' perceived satisfaction with life, where as wishful thinking was a significant predictor of poor

mental and physical health. This result suggests that different coping behavior affects different aspects of maternal adjustment.

Pongsuksri, A. (1993) studied maternal coping with a mentally retarded child in 60 mothers. The study found that the mothers considered problem-focused coping behavior more helpful than emotional-focused coping behavior and that problem-focused coping behavior was associated with lower emotional distress.

Puwattananon, K. (1993) studied the attitudes and relationships of 200 mothers who took their children to attend treatment and follow up sessions at Rajanukul Hospital. The study found a significant positive relationship between mother and child. Recommendations of the study included that nurses involved should foster a positive attitude in the mother and her relationship to the mentally retarded child by such means as providing counseling and information to the child's family as well as the mother.

In summary, the mother of a mentally retarded child typically faces multiple demands in caring for the child, and that accepting the child's condition can facilitate improvement and development of maternal coping behavior. Coping strategies utilized by the mothers of the child should include both problem-focused and emotional-focused coping behavior, however social support is also needed so that mothers can continue their family life as much as possible in the way that they were used to.

The Relationship between Supportive Group Therapy and the Stress Level and Coping Behavior of Mothers of Children with Mental Retardation.

1. Concept of supportive group therapy based on the client-centered therapy of Rogers

The main research strategy of the study was to apply the concept of client-centered therapy developed by Rogers (1970) in a group setting aimed at reducing stress and enhancing coping behavior in mothers caring for not more than one mentally retarded child.

1.1 Definition

Groups are interdependent associations of two or more persons with related goals (McMahon & Presswalla, In Haber, et al., Eds., 1996: 179). The goals of group members may be influenced by many factors, including interpersonal relationships, individual needs, the physical environment, and the unique interaction of the group (Johnson, 1996: 212). Groups often used as laboratories for the study and improvement of human relationships, or in leadership training, education, or counseling workshops (Rogers, 1970). Support groups are formed to provide support and problem-solving opportunities for members who share a common problem or who are distressed about a particular issue (McMahon & Presswalla, In Haber, et al., Eds., 1997: 182). Although such groups take various forms, the major emphasis of most is on the importance of the "here and now" experience (Yalom, 1975).

Two of the main objectives of supportive group therapy are to develop interpersonal relationships between participants and to help identify and establish similar personal goals for them as a way of reducing emotional stress. In this process, group members gain support from knowing they are not alone in their experiences and can share solutions to their common problems. As a result, the members begin to perceive themselves and their problems in new ways. Other objectives of caregiver support group therapy include the promotion and maintenance of the caregiver's health, enhancement of their coping skills, acquisition of knowledge about available community resources, and socialization with others having similar responsibilities.

1.2 Basic theory of group therapy

1.2.1 Psychoanalytic group therapy

In this process the group leader is prominent. The leader focuses the group on interpretation of dreams and free association. The leader helps members to re-experience early family relationships and uncover buried feeling associated with past events that carry over into current behaviors (Johnson, 1996: 222).

1.2.2 Interpersonal group therapy

Stress relief is the goal of this group activity, which focuses on differences in emotion and behaviors in relationships between individuals. This process is based on the concept that stress arises from interpersonal relationships and can therefore be reduced or relieved through interpersonal support. The leader helps to make participants comfortable with others in the group, which helps to reduce stress, improves self-esteem. These benefits can then be applied to other relationships in order to realize similar gains.

1.2.3 Gestalt group therapy

This process emphasizes self-expression, self-exploration, and self-awareness here and now. The main goal is to help members discover and use freedom of choice and to assume responsibility for their own choices by focusing on everyday problems and trying to solve them.

1.2.4 Rogerian group therapy (Person-centered therapy)

The main goal of this process is for participants in the group to express their feelings and by doing so become increasingly open to new experiences and develop greater confidence in themselves and their own judgment. The leader's role is to encourage this expression of feelings, clarify these feeling with members, and accept them with empathy and unconditional positive regard.

For this study, the researcher chose the Rogerian group therapy as the research intervention tool used to encourage participants to express their feelings about taking care of their mentally retarded child. This group process would facilitate the development of closer relationships between participants and in turn produce the biggest improvement in their self-esteem.

1.3 Components of supportive group therapy

The components of the supportive group therapy program were not considered in any particular order, any of them may be applied at any time and in varying combinations (Bloch, 1996: 302 - 308). These components are briefly described below.

1.3.1 Reassurance: The group leader provides reassurance to group members in at least two ways: by removing their doubts and misconceptions, and by

pointing out to them and others their assets. This is important because participants often tend to omit from their self-appraisal any assets and abilities and the leader can bolster their esteem by pointing these out. Similarly, reassurance can also be used to good effect to relieve fears.

1.3.2 Explanation: The group leader's aim in using this strategy is to enhance the participants' ability to cope by clarifying the nature of their problems. Participants are helped to face their problems and to decide how they can best deal with them. The group leader's explanations should be in straightforward everyday language.

1.3.3 Guidance: Supportive group therapy usually entails guiding the participants through a range of situations, mainly by giving direct advice. The goal is not merely to assist the members to deal with a particular issue but also to teach them the skills necessary for coping with other similar problems.

1.3.4 Suggestion: The participants are offered a few choices in considering whether to comply. The leader aims to induce change by influencing them implicitly.

1.3.5 Encouragement: The purpose of encouragement is to combat feelings of inferiority, to promote self-esteem, and to urge participants to adopt courses of action about which they are anxious. However the encouragement given may not only be futile but also counter-therapeutic if given in an inappropriate way.

1.3.6 Effecting changes in the patient's environment: Stressful environmental factors need to be carefully assessed by the group leader so that any modifications to the participants' environment are suitably positive. Environmental

changes can be as important as the removal of stress because they can encourage healthy participation in social activities.

1.3.7 Permission for catharsis: The therapeutic relationship established by the group leader permits the participants to share with a sense of relief their pent-up feelings such as fear, grief, sorrow, worry, and frustration.

1.4 Stages of group development (Johnson, 1996: 224-225 and Haber, et al., Eds., 1997: 190-194) The development of the group may be considered to consist of four stages which together form a full-life cycle as explained below.

1.4.1 Pre-group stage

The formation or pre-group phase of group development occurs before group meetings begin. This phase involves the selection of participants and the making of such administrative arrangements as establishing space and time for meetings and deciding the length and frequency of group meetings. It is a time for goal setting by the leader.

1.4.2 Initial stage

The initial stage of group development is the beginning of communication and trust, it is where participants first become acquainted with each other. As participants may be unclear about the purpose of the group, group norms, and roles, the leader should explain these important aspects of the group to participants.

1.4.3 Working stage

As the group moves into this stage, greater concern for others' personal involvement and a sense of trust and commitment develop among the

participants. They are free to broach their problems and to make attempts to solve them. Participants initiate behavioral changes and support and encourage one another as new behaviors are tested. Empathy and co-operation become increasingly evident as the group's energy is directed toward accomplishing the therapeutic goals of the group.

1.4.4 Termination stage

The group leader must take the initiative in the termination stage and introduce reminiscing and reflection to stimulate a review of group themes and facilitate discussion of group accomplishments. Members begin to focus on relationships and tasks that will occur "when the group is over."

1.5 Process patterns of the group.

Rogers (1970: 15-37) described the process of group patterns in sequential order in 15 simple terms as detailed below.

1.5.1 Milling around: The group leader makes clear at the outset that the group has unusual freedom and that this activity not one for which the leader will take directional responsibility. There tends to develop a period of initial confusion, awkward silence, polite surface interaction, "cocktail-party talk," frustration, and there is usually a significant lack of continuity.

1.5.2 Resistance to personal expression or exploration: It is the public self that members tend to show each other, and only gradually, fearfully, and ambivalently do they take steps to reveal something of their private self. At this stage members still repress many or all of their emotions,

1.5.3 Description of past feelings: In spite of ambivalence about the trustworthiness of the group and the risk of exposing oneself, expression of feelings begins to assume a larger role in the discussion. In this stage participants will begin to refer to the present as being outside the group in time and place.

1.5.4 Expression of negative feelings: In this stage members begin to test the freedom and trustworthiness of the group environment.

1.5.5 Expression and exploration of personally meaningful material: Participants have now experienced for themselves how negative feelings can be expressed and accepted without catastrophic results. They begin to take more chances and risks letting the group know some deeper aspects of themselves and as a result they can find themselves.

1.5.6 The expression of immediate interpersonal feeling: Entering into the process at this stage is the explicit bringing into the open of feelings experienced in the immediate moment by one member toward another. These feelings are sometimes positive, sometimes negative. Each of these feelings or attitudes can be, and usually is, explored in the increasing climate of trust, which is being established.

1.5.7 The development of healing capacity in the group: In this stage a number of participants will begin to show a natural and spontaneous capacity for dealing in a helpful, facilitating, and therapeutic fashion with the pain and suffering of others.

1.5.8 Self-acceptance and the beginning of change: Participants begin to experience a combination of self-acceptance and self-exploration. They begin

to work on the problem of accepting themselves and on the façade they usually exhibit.

1.5.9 The cracking of facades: At this stage the group begins to demand that the individuals show their true selves, that there current feelings not be hidden. Demands and responses may become particularly assertive or aggressive.

1.5.10 The individual receives feedback: In this stage of freely expressive interaction, the individual rapidly acquires a great deal of data as to how he or she appears to others. This can be decidedly upsetting, but so long as these various bits of information provide feedback in the context of caring which is developing in the group, they are generally highly constructive.

1.5.11 Confrontation: There are times when the term feedback is too mild to describe the interactions that take place, when it is better said that one individual confronts another-which is what happens in this stage.

1.5.12 The helping relationship outside the group sessions: No account of the group process would be adequate, without observing that it involves times when participants offer to give help outside the session to other participants who are struggling to express themselves, or wrestling with a personal problem.

1.5.13 The basic interaction that occurs in the group is that individuals come into much closer and more direct contact with each other than is customary in ordinary life. However it can be said that at this stage individual participants begin to speak of commitment to participation in the group.

1.5.14 Expression of positive feeling and closeness: As indicated in above, an inevitable part of the group process seems to be that when feelings are expressed and can be accepted in a relationship, then a great deal of closeness and

positive feeling results. Thus as the sessions proceed, an increasing feeling of warmth and group spirit and trust is built up.

1.5.15 Behavioral changes: Many changes in the behavior of group participants occur. Gestures change and tone of voice changes. These are usually spontaneous and reveal more about their true feelings and emotions. Individuals may show an astonishing amount of thoughtfulness and helpfulness toward each other.

1.6 Group Leader

The group leader is the person around whom the group form, the person who begins the group, provides continuity, and facilitates development of its cohesiveness (Haber, et. al., eds., 1997: 189). The leader participates in the group basically as a facilitator. Rogers (1970: 47-59) identified several tasks which the leader performs in order to group progress:

- Make the climate safe for participants: listen carefully, accurately, and sensitively

- Accept the group exactly where it is. If the group wishes to intellectualize, or have a superficial discussion, the leader does not attempt to push the group to a deeper level

- Accept statements on face value or unconditionally

- Clarify the message (feelings, thoughts, and ideas) for the speaker and help other participants to understand it

- Provide feedback and confrontation

The facilitator can develop, in a group which meets intensively, a psychological climate of safety in which freedom of expression and reduction of

defensiveness gradually occur. It is essential that the leader demonstrates empathy, unconditional positive regard, and sincerity.

1.7 Group members

In order to receive gratification from group membership, participants must express their feelings, help others, and contribute to the maintenance of the group.

1.8 Group Size

Normally, groups are composed of about six people and the therapist. This number has been arrived at empirically, and research is yet to be done to establish whether there is an optimum number of participants (Rogers, 1951: 293-294). However, Brammer and Shostrom (1960: 301) have suggested that the group be limited to a minimum of six and maximum number of ten participants plus the group leader.

2. Effects of supportive group therapy on stress and coping behavior

This section will reviewed the effects of supportive group therapy.

Bualert, A. (1993) studied the effects of Rogerian group counseling on reducing the stress of schizophrenic patients' relatives at Somdetchaophraya Hospital. Seven caregivers participated in Rogerian group counseling for three hours each week for the eight consecutive weeks that were assigned to the experimental group while eight other caregivers participated in a control group. After the intervention, she found that stress in the experimental group was significantly lower than that of the control group, as indicated by $p < 0.05$.

Mannion (1996) conducted comparative analysis between support group participants and non-participants among family members of the mentally ill. The above researcher interviewed 225 families using a structured interview process that included measurement of grief, burden, coping generally strategies, self-efficacy, mastery and social support. The support group participants were found to have smaller burdens, smaller social networks, and better utilization of adaptive coping strategies than non-participants.

Tiemdao, P. (1997) studied the effects of group counseling on stress reduction in 16 caregivers of dementia patients who were attending the Elderly Clinic at Pramongkutklao Hospital, Bangkok. Group counseling of one session per week over eight weeks were arranged, which included teaching participants about dementia, stress, and stress management. After the group counseling, the caregivers in the experimental group were found to have lower levels of stress than the caregivers in the control group.

Srisuro, S. (1998) studied the effect of group counseling on the knowledge and attitudes of parents of mentally retarded children aged from 18 months to three years old. The study sample consisted of 16 parents who had a mentally retarded child in the early intervention program at Rajanukul Hospital. The participants attended counseling two times a week for 75 minutes over a period of five weeks. The results showed increasingly of knowledge about mental retardation, adaptive behaviors, and attitude towards the Early Intervention Program and staff of the hospital.

Goodkin (1999) conducted a randomized controlled intervention clinical trial on a bereavement support group of HIV-1-seropositive and -seronegative homosexual men. The bereavement support group intervention focused on grief, life stressors,

social support, and coping style. The intervention consisted of ten 90-minute weekly sessions, after which the researchers were able to conclude that the brief group intervention can significantly reduce overall distress and accelerate grief reduction.

In summary, this chapter reviewed stress and coping behavior, the supportive group therapy as well as the relationship between the stress and coping behavior of mothers of children with mental retardation. It can be concluded that the mothers of children with mental retardation have severe stress and used ineffective coping behaviors. The supportive group therapy is an essential intervention that used to reduce stress and help the mothers to cope more effectively.

CHAPTER III

METHODOLOGY

This chapter presents the research design, the population and sample used, the research instruments employed, the research procedures, and the analysis of the data acquired.

Research Design

This research consisted of a nonequivalent control group pre-test and post-test design of a quasi-experimental type (Polit & Hungler, 1991: 163-164) as shown in Figure 2 below.

	Pre-test		Post-test
Experimental group	O_1	←——— X ———→	O_2
Control group	O_3		O_4

Figure 2: Research design

O_1, O_3 refer to the scores for stress level, and coping behavior of the experimental group and control group sample prior to participation in the supportive group therapy.

X refers to the supportive group therapy which was conducted in the experimental group.

O_2, O_4 refer to the scores for stress level and coping behavior of the same sample after participation in the supportive group therapy.

Population and Sample

In this study, the population consisted of mothers with a mentally retarded child who had been receiving help at Rajanukul Hospital.

The sample used consisted of mothers having a pre-school aged child with mental retardation and attending the Early Intervention Program at Rajanukul Hospital. The sample was selected by the following criteria:

1. the person must have been a primary caregiver of a mentally retarded child for at least last 6 months.

2. the person must have mot previously participated in any supportive group therapy.

3. the person must have consented willingly to participate in this study.

Thirty mothers were selected according to the above criteria. The researcher then asked these mothers to complete the general information, stress assessment, and coping behavior questionnaires in order to determine their levels of stress and coping behavior scores. These 30 mothers were selected to form the sample of this study based on the following criteria:

1. a moderate to severe stress score.

2. a moderately effective or ineffective coping behavior score.

Twenty subjects were found to meet the above criteria. Those twenty subjects were randomly divided into two groups, an experimental group and a control group:

1. The ten subjects of the experimental group were then assigned to participate in the supportive group therapy for an eight-week period.

2. The ten subjects of the control group were then assigned to receive only regular hospital services.

Two subjects in the experimental group dropped out after participating in session number 2 of the program. Therefore, at the end of the study the sample size of the experimental group was eight.

Instruments

This study was of a quasi-experimental nature. The research instrument used in this study consisted of the supportive group therapy program and the two data collection instruments used to assess the effects of the program.

1. Research instrument: Supportive group therapy program

The supportive group therapy program developed was based on the Stress-Coping Model of Lazarus and Folkman (1984) and client-centered therapy (Rogers, 1970). The goal of the program was to reduce stress in and to utilize the effective coping behavior of the participants. The participants were given the opportunity to share knowledge about their individual differences, express their emotions, learn new ways of managing their stress, use positive thinking, and to receive training in problem-solving and communication skills.

Once program development reached this point, four experts in group therapy were asked to review the content validity. These experts consisted of two nursing instructors teaching psychiatric-mental health nursing, one psychologist who was working in group therapy, and one physician who was working with mentally retarded children and caregivers.

Subjects in the experimental group participated in the program for eight close-group sessions once a week. Each session was between 60-90 minutes, long, running

from approximately 8.30-10.00 am. Sessions included a warm-up for 20 minutes and then proceeded to work through the major themes of the sessions for the remaining 60-70 minutes. The objectives and activities of each session were as follows:

Session 1: Orientation and relationship building

The objectives of the first session were 1) to inform the group members about the program objectives, the role of the group members, group leader and co-leader, the times of the sessions and the length of the program, and 2) to build relationships among the group members. The group leader used the game " buddy " as one of the ways to achieve the above objectives. Before the end of the first session, the group leader gave group members the chance to share their feelings and to express any questions or doubts about the information that the group leader had provided.

Session 2: Understanding of individual differences

The objectives of the second session were 1) to enhance the group members understanding and acceptance of individual differences, and 2) to encourage the group members to perceive themselves realistically. The group members were asked to play the game " my preferred picture " which involved them in choosing a picture and then reflecting on their feelings about it. The group leader then provided an opportunity for the group members to share their thoughts about caring for a mentally retarded family member, after which the group members concluded that each person is different.

Session 3: Emotion and emotional expression

The objective of third session was to increase group members understanding and expression of the character of emotions. The group leader introduced an " emotional doll " model for the group members to analyze and discuss the emotional expressions of. The group leader then encouraged the group members to share their own

experiences about emotional expression and the effect of those expressions on themselves and others.

Session 4: Stress and stress management

The objectives of the fourth session were 1) to teach group members about the nature of stress, and 2) to train participants in relaxation techniques. Role play of stressful events was introduced as a way of getting the group members to share their experiences of stress and stress reduction. The group leader then provided the group members with an opportunity to reflect on their own experiences with stress and their methods of relaxation. Next the group leader introduced muscle relaxation the group members as an effective way of reducing their stress. Finally, the group leader provided the group members with an opportunity to reflect on their thoughts and feeling about muscle relaxation as a stress relief technique.

Session 5: Positive thinking training

The objectives of the fifth session were 1) to teach group members about positive thinking, and 2) to increase the self-esteem of the group members. The group leader introduced " my gift " which involved the group members in thinking of beneficial uses for a cloth with holes. This activity helped to train the group members in positive thinking. The group leader then encouraged the group members to try and discover the strengths of each other, of themselves and of their families.

Session 6: Problem-solving training

The objective of the sixth session was to improve the problem-solving skills of group members. The group leader encouraged the group members to tell the group about situations, which were worrying them or in which then felt in need of help. The group members were then asked to choose one problem that they wanted to solve and

to share their experiences about situations, causes, results and strategies which would be of help in solving the problem. Next, the group members received specific suggestions on how to solve the problem from other group members. Finally, the group leader encouraged the group members to summarize the problem-solving process.

Session 7: Communication training

The objective of the seventh session was to train group members in effective request-communication for stress reduction. The group leader introduced the group members to role-play activities that involved them in asking one another for help. Then, the group members were asked to share their experiences in request-communication outside the group. Next, the group leader trained the group members in request-communication techniques before providing participants with the opportunity to express any doubts, thoughts, or feelings about participation in the sessions. Finally, the group leader informed the group members that the last session of the supportive group therapy program would be the following week.

Session 8: Summary and evaluation

The objective of the last session was to allow group members to review the sessions in which they had participated and to evaluate what they had gained from them. The group leader asked them to complete an evaluation questionnaire on their thoughts and feelings about participation. The group leader then encouraged the group members to make use of the knowledge and skills they had learned in the sessions in their daily lives. Finally, the group leader thanked for their participation in the group.

2. Data collection instruments

2.1 Demographic data is contained 13 items about the demographics of the subjects and their mentally retarded children.

2.1.1 Demographic data sought about the subjects consisted of age, place of living, marital status, level of education, occupation, family income, number of mentally retarded children in the family, and previous experiences in caring for a mentally retarded child.

2.1.2 Demographic data sought about the mentally retarded child consisted of sex and sequence of birth in family.

2.2 Stress Questionnaire

The stress questionnaire was developed by the researcher, based on the theoretical model of stress and coping behavior of Lazarus and Folkman (1984), literature review and research on mothers who had a mentally retarded child. Altogether there were 43 items listed and these are described briefly below:

2.2.1 Personal factors influencing stress included:

- Information needs 7 items (items 1, 2, 3, 4, 5, 7, 9)
- Ability in home care management 2 items (items 6, 8)
- Expectation of maternal role 9 items (items 10, 11, 12, 13, 14, 15, 16, 18, 20)
- Expectation of the child's ability 2 items (items 17, 19)

2.2.2 Environmental factors influencing stress included:

- Problem behavior of the child 10 items (items 21-30)
- Social support needs 13 items (items 31-43)

The subjects were asked to rate their stress level in relation to each item on a four-point scale as follows:

Level of stress	Score
No stress	0
Mild stress	1
Moderate stress	2
Severe stress	3

Score for stress level were then classified into 4 categories:

0.00	indicated	zero stress level.
0.01-1.00	indicated	mild stress level.
1.01-2.00	indicated	moderate stress level.
2.01-3.00	indicated	severe stress level.

After the instrument was constructed and prepared for content review, four experts were asked to review the content validity. Thirty mothers who were using the services of the Queen Sirikit National Institute of Child Health were included in this evaluation of reliability, and Cronbach's alpha reliability was 0.85.

2.3 Coping Behavior Questionnaire

The coping behavior scale was developed by the researcher based on the theoretical model of stress and coping behavior of Lazarus and Folkman (1984), literature review, and research on mothers who had a mentally retarded child. Altogether there were 24 items listed and these are described briefly below.

2.3.1 Problem-focused coping behavior: 12 items; (items 1-12)

2.3.2 Emotional-focused coping behavior: 12 items; (item 13-24)

The coping behavior of subjects was measured by rating 30 statements on a four-point scale as follows:

Rating	Score
Never	0
Seldom	1
Often	2
Always	3

These scores were then used to determine the effectiveness of coping behavior. Ineffective coping behaviors was determined by ratings provided on a reversed scale as shown below.

Rating	Score
Never	3
Seldom	2
Often	1
Always	0

Scores for coping behavior were then classified as follows:

0.01-1.00	indicated	ineffective coping behavior.
1.01-2.00	indicated	rather ineffective coping behavior.
2.01-3.00	indicated	effective coping behavior.

Four experts were then invited to comment on the questionnaire. Thirty mothers who were using the services of the Queen Sirikit National Institute of Child Health were included in the evaluation of reliability, which produced a Cronbach alpha reliability of 0.72.

Content Validity and Reliability

1. Content validity

The content validity of the stress assessment tool and the coping behavior scale has been proven many times. The content validity of the questionnaires were assessed by four experts in this field: two were nursing instructors in the Mental Health and Psychiatric Nursing Department of Mahidol University, one was an instructor in the Surgical Nursing Department of Mahidol University also an expert in the field of stress and coping behavior, and the remaining one was a physician at Rajanukul Hospital, the main hospital in Bangkok caring for the mentally retarded children. Many of their suggestions were subsequently incorporated in these instruments.

2. Reliability

Responses from thirty mothers conforming to the same research criteria as those in the study sample were used to assess the reliability of the stress assessment tool and the coping behavior scale. These 30 mothers all had a child with mental retardation and were using the services of the clinic at the Queen Sirikit National Institute of Child Health. Reliability of stress assessment and coping behavior were tested by Cronbach's Alpha Coefficient. The reliability of stress assessment and coping behavior were 0.85 and 0.72, respectively.

Data Collection Procedures

1. Preparation of the researcher and the assistant

The researcher was a nurse with clinical experience in caring for psychiatric patients and their families. Moreover, the researcher had received training in group therapy under the supervision of Mr.Phipat Kuntayanuwong (Chief of the Adolescent Psychiatric Unit) and Mrs.Amphan Jarutassnangkoon (a professional nurse in Rossukon Unit) of the Somdet Choaphraya Psychiatric Hospital, Bangkok. These clinical experiences provided the researcher with a confident basis on which to conduct the group therapy program.

2. Data collection

The data collection procedures were conducted in the following sequence:

2.1 A request to conduct the study was submitted by the Graduate Studies office of Mahidol University to the director of Rajanukul Hospital.

2.2 The sample were identified according to the inclusion criteria and responses provided by mothers of pre-school aged children with moderate mental retardation.

2.3 Subjects were informed about the purpose of the study and explanations about the nature and procedures of the study were provided. Mothers were asked to participate as subjects in the study and to sign a consent form agreeing to do so.

2.4 The subjects were asked to complete the general information, stress assessment, and coping behavior questionnaires as a pre-test.

2.5 The researcher selected 20 of the subjects as group participants and divided them by simple random sampling into two groups: an experimental group and a control group.

2.6 Appointments were made with subjects for the following purposes:

2.6.1 Subjects in the control group were asked to answer both questionnaires again eight weeks later.

2.6.2 Subjects in the experimental group were asked to participate in the supportive group therapy program consisting of one 60-90 minute session every week for eight weeks.

2.7 After the eighth and final session of the supportive group therapy program, subjects in the experimental group and control group were asked to answer both questionnaires a second time (post-test).

2.8 The researcher collected and processed the data ready for further analysis.

Data Analysis

The data collected from 20 subjects were analyzed using the Statistical Package for the Social Sciences for Windows (SPSS/FW).

1. Descriptive statistics including frequency, percentage, and chi-square were performed to describe the demographic characteristics of the sample.

2. Descriptive statistics were derived for the mean and standard deviation of both the stress level and coping behavior mean scores of the sample population.

3. A t-test was conducted in order to determine the difference in both the stress level and a mean score of coping behaviors for the experimental group before and after the intervention.

4. A t-test was conducted in order to determine the difference in both the stress level and a mean score of coping behaviors for the control group before and after the intervention.

5. A t-test was conducted in order to determine the difference in both the stress level and a mean score of coping behaviors between the experimental group and the control group after the intervention.

CHAPTER IV

RESULTS

In this chapter the results of the study were presented and discussed in relation to the research hypotheses used. The data collected from the subjects were analyzed using the Statistical Package for the Social Sciences for Windows (SPSS/FW) and the findings were presented in the tables and descriptions that follow.

Table 1 Number, percentage and Chi-square test of characteristics in both the experimental group and control group.

Characteristics	Control		Experimental		X^2
	N	%	N	%	
	(N = 8)		(N = 8)		
Age (years old)					
21 – 30	2	25	1	12.5	
31 – 40	2	25	6	75	
41 – 50	4	50	1	12.5	0.127 ^{ns}
Place of living					
Bangkok	6	75	6	75	
Provincial	2	25	2	25	1.000 ^{ns}
Marital status					
Married	7	87.5	8	100	
Widow	1	12.5	0	0	0.302 ^{ns}
Level of Education					
Primary school	2	25	3	37.5	
Secondary school	4	50	3	37.5	
Diploma	1	12.5	1	12.5	
Bachelor's degree	1	12.5	1	12.5	0.952 ^{ns}

Table 1 (continued)

Characteristics	Control N (N = 8)	Control %	Experimental N (N = 8)	Experimental %	X^2
Occupation					
Housewife	2	25	6	75	
Employee	4	50	1	12.5	
Merchant	2	50	1	12.5	0.187 ns
Family income / month					
< 8,000	4	50	3	37.5	
8,001 - 16,000	2	25	2	25	
16,001 - 24,000	1	12.5	2	25	
24,000 - 32,000	1	12.5	0	0	
> 32,000	0	0	1	12.5	0.649 ns
Number of mentally retarded children in family					
1	8	100	6	75	
2	0	0	2	25	0.131 ns
Previous experience in caring for a mentally retarded child					
No	8	100	6	75	
Yes	0	0	2	25	0.131 ns

ns = non significant

Table 1 shows that there are no statistically significant differences in every category between these two groups. Most subjects were aged 31 - 40 years old, were living in Bangkok, were married housewives, had completed secondary school, had a family income of less than 8,000 baht / month, has only one mentally retarded child, and had no previous experience in caring for a child with mental retardation.

Table 2 Number, percentage and Chi-square test of child characteristics in the experimental group and the control group.

Characteristics	Control		Experimental		X^2
	N	%	N	%	
	(N = 8)		(N = 8)		
Sex					
Male	6	75	4	50	
Female	2	25	4	50	0.302 ns
Sequence of birth					
1	5	62.5	3	37.5	
2	2	25	3	37.5	
3	1	12.5	1	12.5	0.637 ns
4	0	0	1	12.5	

ns = non significant

Table 2 shows that there are no statistically significant differences in both categories as indicated by the two Chi-square scores of > 0.05. It also shows that most of them were the first male-born child of the families concerned.

Table 3 Comparing the difference in mean stress score for the experimental group before and after the intervention using the t-test. (n = 8)

Experimental group	Stress score		t
	$\bar{X}$	S.D.	
Pre-test	1.37	0.34	
Post-test	1.07	0.23	- 4.86 *

* $p < 0.05$

Table 3 shows that after participating in the supportive group therapy, the level of stress of the subjects in the experimental group was significantly decreased, as indicated by a statistical significance of $p < 0.05$.

Table 4 Comparing the difference in mean score of coping behaviors in the experimental group before and after the intervention using the t-test. (n = 8)

Experimental group	Coping behavior score		T
	$\bar{X}$	S.D.	
Pre-test	1.79	0.12	
Post-test	2.18	0.20	- 4.051 *

* $p < 0.05$

Table 4 shows that after participating in the supportive group therapy program, the mean score of coping behaviors of the subjects in the experimental group was significantly increased, as indicated by a statistical significance of $p < 0.05$.

Table 5 Comparing the difference in mean stress score of the control group before and after the intervention using the t-test. (n = 8)

Control group	Stress score		t
	$\bar{X}$	S.D.	
Pre-test	1.39	0.35	
Post-test	1.50	0.50	1.397 ^{ns}

ns = non significant

Table 5 shows that after participating in the supportive group therapy program, the level of stress of the subjects in the control group was not significantly different, as indicated by a statistical significance of $p > 0.05$.

Table 6 Comparing the difference in the mean score of coping behaviors of the control group before and after the intervention using the t-test. (n = 8)

Control group	Coping behavior score		t
	$\bar{X}$	S.D.	
Pre-test	1.73	0.19	
Post-test	1.74	0.21	- 0.683 ^{ns}

ns = non significant

Table 6 shows that after participating in the supportive group therapy program, the mean score of coping behaviors of the subjects in the control group was not significantly different, as indicated by a statistical significance of $p > 0.05$.

Table 7 Comparing the difference in mean stress score of the experimental and control group after the intervention using the t-test (independent sample). (n = 16)

Mothers	Stress score		t
	$\bar{X}$	S.D.	
Control group	1.50	0.50	
Experimental group	1.07	0.23	- 2.178 *

* $p < 0.05$

Table 7 shows that after participating in the supportive group therapy, the level of stress of the subjects in the experimental group was significantly lower than those in the control group, as indicated by a statistical significance of $p < 0.05$.

Table 8 Comparing the difference in mean score of coping behaviors of the experimental and control group after the intervention using the t-test (independent sample). (n = 16)

Mothers	Coping behavior score		t
	$\bar{X}$	S.D.	
Control group	1.74	0.21	
Experimental group	2.18	0.20	4.303 *

* $p < 0.05$

Table 8 shows that after participating in the supportive group therapy, the mean score of coping behaviors of the subjects in the experimental group was significantly higher than those in the control group, as indicated by a statistical significance of $p < 0.05$.

CHAPTER V

DISCUSSION

The purpose of this study was to examine the effects of supportive group therapy on stress and coping behavior of mothers of children with moderate mental retardation. This section discussed the validity of the four hypotheses on which this study was based in relation to the research findings obtained.

Hypothesis 1: After participating in the supportive group therapy program, the subjects will have lower level of stress than before.

Research Finding: After participating in the supportive group therapy program, the average stress level of the experimental group significantly decreased, as indicated by $p < 0.05$, (Table 3), thus validating the first hypothesis. The best explanation for this positive finding is that participation in the therapy program lowers the abnormally high stress levels in the group members to a more normal level. This research finding is consistent with the Stress-Coping Model of Lazarus and Folkman (1984), which suggests that one of the main determinants of the adoption of more effective coping behavior was the provision of informational and emotional support. Mothers who participated in the supportive group therapy were provided with the opportunity to share their opinions, feelings, and experiences in taking care of their child. Thus they were more able to realize and acknowledge that other mothers had the same or similar problems in caring for their mentally retarded child. In this study, the group process

began by building a warm and trusting relationship with each member (Rogers, 1970: 46). As a result the group members felt free to express their unpleasant feelings about past events, and through this process were able to perceive the problems of the others with empathy and sincerity, and to suggest ways to reduce stress in themselves and others. In addition, the group members came to realize that each of them had to take responsibility for their own stress management by applied what they learned in the supportive group therapy program. One group member made the following comments about the benefits of being a group member:

" Participating in the group provided me with an opportunity to express my feelings and I feel happy with this. "

" Sharing the same problems. "

" Learning many things from other group members. "

" I have better concentration, and I am mentally calm and happy after practicing the relaxation technique. "

The research results from the supportive group therapy program were similar to Rogers's conclusion. Rogers (1970) concludes that a group process can reduce personal stress because the process helps the group members to feel free and to accept the reality of themselves and others. Similarly, Srisuro, S. (1998) who also conducted group counseling found that providing information and improving about mental retardation and adaptation to problematic behavior of the child produced a more positive attitude in their mothers. Chareinkul, K. (1996) found that after participating in the supportive group, caregivers of psychiatric patients had higher level of knowledge about the disease and more positive feelings about hospital services. While, Beulert, A. (1993) concluded that schizophrenic patient's caregivers who

participated in a Rogerian group counseling had reduced levels of tension because they had learned more about the patients' illness and more effective ways to cope with living with the patient which helped establish a better relationship between patient and caregiver.

Hypothesis 2: After participating in the supportive group therapy, the subjects will have a higher mean score of coping behaviors than they did before.

Research Finding: After participating in the supportive group therapy program, the mean score of coping behaviors of the experimental group significantly increased, as indicated by $p < 0.05$. (Table 4), thus validating the second hypothesis. The best explanation for this positive finding is that the mothers who participated in the supportive group therapy program were encouraged to share their experiences in taking care of a mentally retarded child. The group members learn how to manage problems, improve their attitude, develop positive ways of thinking, improve their problem solving and communication skills and apply suggestions from the group to their daily life. In addition, they provided encouragement and advice to each other from their own positive experiences, thus increasing their self-esteem and their effective coping behavior as can be seen in the following quotes:

" I try to smile at others who look down upon me and my child."

" I remain calmer when I quarrel with my husband."

" I try to practice relaxation techniques when I feel stressful."

" Sometimes, I find good things about my child, for example her lovable traits or her attempts to please."

" I learned new ways of solving problems from participation in this group."

This research finding was consistent with the conclusion of Kiatgungwalgri's study. Kiatgungwalgri, N. (1997) found that uterocervical cancer patients undergoing radiotherapy had developed more effective coping behavior after participating in a self-help group because they had learned better strategies for coping with tension and more effective problem solving skills. The self-help group provided them with more social support, which increased their self-esteem.

Hypothesis 3: The subjects who participated in the supportive group therapy program will have lower level of stress than those who did not.

Research Finding: After participating in the supportive group therapy, the subjects in the experimental group had lower level of stress than those who had not participated in the supportive group therapy program, as indicated by $p < 0.05$ (Table 7). This finding supports the third hypothesis. The research finding is consistent with the conclusions of Tiemdao, P. (1997) who conducted a study of group counseling in the caregivers of dementia patients. She found that caregivers who had received counseling had lower stress level than caregivers who had not.

The best explanation for this positive finding is that mothers who participated in the supportive group therapy program had an opportunity to share their opinions, feeling and experiences about caring for a mentally retarded child. The group members realized and acknowledged that they were not the only people faced with such a burden, but that other persons were also faced with similar situations. Furthermore, their participation fostered mutual trust within the group which helped them to more freely express their unhappy feelings as can be seen in the following quotes:

" Sometimes, my son is a stubborn child. I feel very angry and hit him, but I feel guilty later. "

" I was angry with my husband when he would not help me in taking care of our child because he said that he was tried from his job and that I should be caring for the child by myself. "

" I felt very resentful when people looked down upon me and my child. "

" I was criticized by relatives for how I take care of my child."

Once group member expressed their feelings, they would receive feedback or advice from other group members that encouraged them to accept their problems and try to solve them before they worsened. Thus, these factors all helped to reduce the stress level of the mothers who participated in the supportive group therapy program.

Hypothesis 4: The subjects who participated in the supportive group therapy program will have a higher mean score of coping behaviors than those who did not.

Research Finding: After participating in the supportive group therapy, the experimental group had a higher mean score of coping behaviors than the control group which had not participated in the supportive group therapy program, as indicated by $p < 0.05$ (Table 8). This finding supports the fourth hypothesis and is consistent with the conclusions of Mannion (1996) who studied 225 families with a psychiatrically disabled relative, and found that the families who had participated in support groups were better able to cope with the situation than the families who had not. The best explanation for this positive finding is that mothers who participated in the supportive group therapy program had an opportunity to learn more about mental retardation and to share their direct experiences in caring for a mentally retarded child

with other group members. Furthermore they received useful information about how to care for their mentally retarded child, and learned new skills to manage the stress of taking care of their child, such as relaxation techniques, problem-solving methods, and direct communication skills. These skills provided a foundation for more effective coping behaviors (Lazarus & Folkman, 1984). In addition, the group process provided one of the social supports that helped the group members to increase their self-esteem, which in turn helped them to share their experiences in caring for a mentally retarded child, and to give and receive advice about how to handle their situation. Thus this finding indicated that mothers who participated in the supportive group therapy program had more effective coping behaviors than those who did not.

CHAPTER VI

CONCLUSION

Conclusion

This study employed a quasi-experimental research approach to examine the effect of supportive group therapy on stress and coping behavior of mothers of children with moderate mental retardation. The conceptual framework was adapted from the Stress-Coping model of Lazarus & Folkman (1984) and the client-centered therapy of Rogers (1970). The study population comprised of mothers of mentally retarded children attending the Early Intervention Program at Rajanukul Hospital, Bangkok. Sample were selected by purposive sampling, with the sample consisting of 16 subjects who were divided into two groups by simple random sampling into an experiment group and a control group.

The research instruments used in this study included 1) a structured supportive group therapy program, and 2) three data collection instruments as follows:

- Demographic Data: The data collection instrument was divided into two parts consisting of 1) the mothers of children with mental retardation, and 2) their mentally retarded children. The data collected about the mothers consisted of their age, place of living, marital status, level of education, occupation, family income, number of mentally retarded children in the family, and previous experience in caring for a mentally retarded child. The data collected about their mentally retarded children consisted of their sex, age, and sequence of birth in the family.

- Stress Questionnaire: The data collection instrument was divided into two factors influencing stress: personal and environmental factors (43 items).

- Coping Behavior Questionnaire: The data collection instrument was consisted problem-focused coping behavior 12 items and emotional-focused coping behavior 12 items.

Four experts were then asked to comment on the stress questionnaire and the coping behavior questionnaire and these comments were considered during revision of the questionnaires. Reliability of these two questionnaires was tried out on thirty mothers of mentally retarded children who had similar demographic characteristics to the subjects of the study Cronbach alpha reliabilities for the stress questionnaire and the coping behavior questionnaire were calculated at 0.85 and 0.72 respectively.

Data collection proceeded by the researcher asking the subjects to complete the general information, stress assessment, and coping behavior questionnaires. Following this, the control group received only regular hospital services such as information or individual counseling, while the experimental group participated in the eight-week supportive group therapy program consisting of one session per week of 60-90 minutes duration. In these sessions, the group members were encouraged to share their caring experiences to express their feelings and thoughts, and received training in problem solving and communication skills. After the eighth and final session, the subjects were asked to complete the same questionnaires again. Once this was completed, the data collected were analyzed by computer using the Statistical Package for the Social Sciences for Windows (SPSS/FW).

General analysis was used to determine frequency, percentage, and chi-square values. A t-test was used to determine the average difference in stress level and coping behavior score between the experimental group and the control group.

The results of this study validated all four hypotheses:

1. After participating in the supportive group therapy program, the level of stress of the subjects in the experimental group was significantly decreased ($p < 0.05$).

2. After participating in the supportive group therapy program, the mean score of coping behaviors of the subjects in the experimental group was significantly increased ($p < 0.05$).

3. After participating in the supportive group therapy program, the average level of stress of the subjects in the experimental group was significantly lower than that of the control group ($p < 0.05$).

4. After participating in the supportive group therapy program, the average mean score of coping behaviors of the subjects in the experimental group was significantly higher than that of the control group ($p < 0.05$).

Recommendations

1. Application of research findings

This study clearly confirmed that taking care of a mentally retarded child was burdensome and placed severe stress on the child mother. It also showed that most of these mothers used ineffective coping behavior. The applications of these findings are the followings:

1.1 Nurses need to be highly alert for stress symptoms of the mothers of mentally retarded child and be ready to provide these mothers with a supportive group therapy. This intervention will provide the opportunity to express their feelings related to their care for the child. It also helps them to reduce their stress level and to use more effective coping behavior, resulting in more positive attitudes towards taking care of their mentally retarded child and increased self-esteem.

1.2 Institutions that provide services for mentally retarded children and their families should provide support to nurses in developing their knowledge and skills about individual and group counseling for family members. In particular, these institutions should provide nurses with more time to develop and implement activities aimed at improving the mental health of mothers caring for a mentally retarded child.

2. Application to future research

2.1 In this study, the level of stress and coping behavior of mothers with mentally retarded children were assessed by the questionnaire immediately at the end of the supportive group therapy program. In order to test the long-term effect of the supportive group therapy program, it is recommended that the assessment of their stress and coping behavior be carried out three months and six months later.

2.2 A supportive group therapy should be made available to mothers with mentally retarded children of different ages, such as school-aged children or adolescents.

Limitations of the Study

The sample of this research consisted of 16 mothers of mentally retarded children who took their children to receive the treatment at Rajanukul Hospital. The subjects were selected by purposive sampling according to inclusion criteria which identified mothers of pre-school aged children with moderate mental retardation who were the primary caregiver, who had no previous experience in participating in supportive group therapy, and who consented to participate in the study. Therefore, the samples obtained were not necessarily representative of the entire population of mothers of mentally retarded children. In order to test for external validity, further studies should be conducted on another group of mothers of mentally retarded children who are receiving health care services at a different organization, or who are living in the community.

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APPENDIX

APPENDIX A

List of Experts

To help finalize the conceptual definition and method of measurement, the validity of the intervention program and the questionnaires was assessed by four consulting experts:

1. Associate Professor Pongsri Srimoragot, D.N.S.
   Department of Surgical Nursing
   Faculty of Nursing, Mahidol University

2. Assistant Professor Payoa Pooncharean, M.Ed.
   Department of Mental Health and Psychiatric Nursing
   School of Nursing, Faculty of Medicine, Ramathibodi Hospital,
   Mahidol University

3. Atirat Wattanapailin, Ed.D.
   Department of Mental Health and Psychiatric Nursing
   Faculty of Nursing, Mahidol University

4. Raunkaew Kanokpongsakdi, M.D.
   Deputy Director of Rajanukul Hospital

APPENDIX B

Consent Form

(Experimental group)

Dear Mother:

I am Boonthiwa Choochua, a graduate nursing student at the Faculty of Nursing, Mahidol University. I am interested in studying stress and coping behavior of mothers having a mentally retarded child. This research will be useful in promoting mental health and improving the quality of nursing care. There are no risks from participating in this study, however your participation will be voluntary. Whether you participate or not will not affect the service you have been receiving in any way. If you agree to participate, you will be asked to complete three questionnaires which will take you about 20 minutes. After that we will make an appointment with you to attend group supporting therapy, each session took 60-90 minutes once a week for eight weeks. After the final session of the program you will be asked to complete the same questionnaires once again. If you agree to participate, please sign this form. Thanks for your cooperation.

Boonthiwa Choochua

Researcher

I am willing to participate in this study.

Signature .....

Consent Form

(Control group)

Dear Mother:

I am Boonthiwa Choochua, a graduate nursing student at the Faculty of Nursing, Mahidol University. I am interested in studying stress and coping behavior of mothers having a mentally retarded child. This research will be useful in promoting mental health and improving the quality of nursing care. There are no risks from participating in this study, however your participation will be voluntary. Whether you participate or not will not affect the service you have been receiving in any way. If you agree to participate, you will be asked to complete three questionnaires which will take you about 20 minutes. Eight weeks later that, you will be asked to complete the same questionnaires once again. If you agree to participate, please sign this form. Thanks for your cooperation.

Boonthiwa Choochua

Researcher

I am willing to participate in this study.

Signature .....

APPENDIX C

RESEARCH INSTRUMENT

The Supportive Group Therapy Program

Session I

Orientation and relationship building

Objectives

1. To establish the relationship between the group leader and the group members and between the group members themselves toward group therapy program.

2. To inform about the group, such as its character, objectives, agreement, and the role of its members.

Resources

None

Activities: these proceeded by the following steps.

1. The group leader introduced herself to the group members, then showed the appreciation for their participating in the group therapy program.

2. The group leader informed the group members about their right as members in the group activities and asked their permission for tape recording during each session.

3. Each member introduced herself to the group.

4. The group leader informed about the group as follows

4.1 The objectives of the group therapy program were:

4.1.1 To provide an opportunity for the group members to exchange their opinions, feelings, and experiences with each other.

4.1.2 To improve the self-awareness, self-understanding and self-acceptance of the group members.

4.1.3 To increase self-esteem of the group members.

4.1.4 To increase the willpower and feel competence in managing problems of the group members.

4.1.5 To encourage the group members to apply the acquired knowledge and experiences into their daily living.

4.2 The supportive group therapy sessions met for 60-90 minutes each week for eight consecutive weeks.

4.3 Role of the group leader

4.3.1 To assist the group members in achieving the goal of the group therapy program.

4.3.2 To clarify issues and give information to the group members.

4.4 Role of the co-leader

To assist the group leader in facilitation group activities during the process of the group therapy program.

4.5 Role of the group members

4.5.1 To be an active listener.

4.5.2 To ask the question when you suspect.

4.5.3 To exchange experiences and opinions.

4.5.4 To share comments and suggestions.

4.5.5 To keep confidential.

5. The group leader asked for questions or suggestions from the group members.

6. The group leader then started with "Buddy Game" for forming the good relationship among the group members as follows:

6.1 Each member made a pair voluntarily.

6.2 Each pair was asked to interchange their personal information such as age, occupation, address, favorite things, etc.

6.3 After knowing each other, each member introduced her partner to the group.

6.4 The group leader provided the group members with the opportunity to ask about personal data of each member.

6.5 The group leader summarized the characteristic of each member.

7. The group leader provided the group members with an opportunity to express their feelings about the initial session.

8. The group leader summarized the session and informed the topic that would be discussed in the next session. The group members were encouraged to share their opinions and comments about what they learned from this session.

9. The group leader allowed the group members to ask any questions related to the session.

10. The group leader thanked the group members for their cooperation and confirmed the date and the time for next session.

Session II

Understanding of individual differences

Objectives

1. To understand self and other in the realistic way.
2. To accept the concept of individual differences.

Resources

Ten pictures (including pictures of animals, sea, park, skyline buildings, working people, etc.)

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.
2. The group leader explained the activities for this session.
3. The group leader asked each member to look at ten pictures and chosen one that they liked the most.
4. Then the group members were asked to talk about the pictures and their feelings towards the pictures one by one.
5. The group leader showed each picture to the group and then asked them that "Who chose this picture?" The group leader gave that picture to those who chose that picture. (If more than one member chose the same picture, the group leader asked them to sit side by side.)
6. Each member was encouraged to show her picture individually to the group and express her opinions with regard to the following questions:
   - 6.1 What did you see on that picture?
   - 6.2 Why did you choose that picture?

6.3 How did you feel about that picture?

6.4 Why did you feel like that?

7. The rest of group members were encouraged to express their opinions about that picture being shown with regard to the following questions:

7.1 What did you see on that picture?

7.2 How did you feel about that picture?

7.3 Why did you feel like that?

8. The group leader then repeated the steps number 6-7 for other pictures.

9. The group leader summarized that: "For this session, we had learned that each individual could have different thoughts or feeling about the same picture. Each person had his own perception toward the situation which related to his own leaning by using five senses (sight, hearing, smell, touch, taste), age, sex, attitudes, experiences, and emotion. You always found the individual difference in daily life which each person would have their own perspective point of view. For example, when you had a new dress that you thought it was good for you, but someone said that it did not fit for you or someone said that you looked smart when you dressed your new dress. If we could understand and accepted to individual differences such as these, we could live happily with others"

10. The group leader allowed the group members to ask any questions about the session.

11. The group leader thanked the group members and confirmed the date and the time for next session.

Session III

Emotion and emotional expression

Objectives

1. To understand her own emotions.
2. To discuss about the emotional and how is affect on her.
3. To be aware of individual differences of emotional expression.
4. To learn more appropriate ways how to express their emotions.

Resources

Ten cards of cartoon-pictures demonstrating various feelings.

Activities: these proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.
2. The group leader explained the activities for this session: "Each member will be given one card. Then we would talk about the cards."
3. The group leader gave each member an envelope containing a card of different emotional doll.
4. Each member was encouraged to show her card to the group and expressed her opinions by the following questions:
   - 4.1 How did the doll feel?
   - 4.2 Why did you think that?
5. The other members were encouraged to express their opinions about that card being shown by following step 4.1 and 4.2 above.
6. The group members take turn talking by following steps number 4-5.

7. The group leader provided a correct answer of the emotion displayed by each doll.

8. The group leader provided the following summary: "An emotion was an experience that was felt with some intensity as happening to the self, was generated in part by a cognitive appraisal of a situation, and was accompanied by both learned and reflexive response. There were two basic types of emotion: one was a positive state such as happiness, joy, satisfaction, on being pleased; the other one was a negative state such as anger, fear, sadness, guilt/shame, or disgust. Individual responses and expressions depended on individual differences as persons, which were a product of individual learning, experience, reasoning, and understanding. Emotional expression could be verbal and nonverbal. Verbal expression was a way of clearly communication to other people how one felt so that one could understand his/her feeling. On the other hand, sometimes people misunderstood nonverbal ways of expressing emotions because of individual differences in their perception of being expressed."

9. The group leader collected the cards and shuffled them and gave each member a new card.

10. The group members were allowed to consider their new cards for three minutes.

11. The group leader asked the group members to close their eyes and think about their experience, which related to the emotions expressed on their new cards.

12. Each member was encouraged to show her new card individually to the group and express her opinions by the following questions:

12.1 Had you have any experiences which made you feel like the doll in your new card? Could you tell us about them?

12.2 How that emotion effected you both physical and mental?

13. The other members were encouraged to express their opinions about that card being shown by step 12.1 and 12.2.

14. The group members repeated steps number 12-13.

15. The group leader summarized that emotion that would effect a person both physical and mental as follow:

15.1 Emotional responses commonly stimulated physical changes such as alteration of blood pressure, heart rate, pulse, respiratory rate, muscle contraction, circulatory systems, and intestinal movement.

15.2 Emotional responses commonly stimulated psychological changes such as anger, aggression, anxiety, despair, impaired judgement, problem-solving ability and creative thinking, and alteration of sleep and eating patterns.

16. The group leader introduced new activities to the group members as follow "The positive and negative state of emotions were a part of our life. We would have many problems when we expressed our negative state emotional. So that, we would discuss about this issue."

17. The group members chose one negative state of emotion which they would like to discuss with the group.

18. The group members were encouraged to express their opinions by the following questions:

18.1 How would you express your emotions related to that situation?

18.2 How other persons expressed their emotion related to the same situation?

18.3 How did you feel when others people expressed their emotion to you?

19. The group leader summarized that "Emotion was a part of our life. It was good for us to accept the emotions that we had had. However, it was very important for us to be aware that. How did I feel right now? How did I express an appropriate way which would not give a negative impact to myself and others?"

20. The group leader allowed the group members to ask any questions about the session that they might have.

21. The group leader thanked the group members and confirmed the date and the time for next session.

Session IV

Stress and stress management

Objectives

1. To learn about the nature of stress.
2. To learn how to use the various relaxation techniques.

Resources

1. Two role-plays involving stress situations
2. Stress management pamphlets
3. Whiteboard
4. Whiteboard marker

Activities: These proceeded by the following steps.

1. The group leader greeted the group member and reviewed the main idea of the previous session.

2. The group leader explained the activity for this session: "I would like you play the role in a situation that I would give you. Each group could create their own scenario and did the role-play, after that we would discuss about it."

3. Each member was divided into two groups.

4. The group leader gave each group an envelope containing the information of a different role-play card.

5. Each group prepared themselves for the scenario.

6. Members of each group played the role they have been assigned.

7. The group members were encouraged to express their opinions, by toward each role play situation the following questions:

7.1 "How did you feel about your role?"

7.2 "How did you think others feel about the role-play situation which you were involved?"

7.3 "Had you ever been faced that kind of situation in your daily life? How did you feel about it?"

8. The group leader summarized the role play activity as follows:

8.1 Stress could provide a mental warning that the demands of your present situation exceed your available resources that you appraised as for coping with it by making you felt unhappy or sad. If you did not find ways to relax, this stress would eventually cause you problems in doing your job or in your life.

8.2 Causes of stress were divided into the following three categories:

8.2.1 Mental factors-such as fear, disappointment, or anxiety.

8.2.2 Life-event changes-such as starting a new job, the loss of a favorite thing, the onset of a major change in life.

8.2.3 Physical illness-from mild to severe in degree.

9. The group leader encouraged the group members to share their responses to the following questions: "What physical and mental changed to you when you had stress?"

10. The group leader summed up stress-responses as follows:

10.1 Short-term stresses caused headaches, sleep disturbances, fatigue, constipation, diarrhea, over-excitement, anxiety, bad dreams, menoschesis, reduced sexual satisfaction, and other irritations.

10.2 Chronic stresses caused hypertension, heart disease, peptic ulcer, or mental illness.

11. The group leader encouraged the group members to share their opinions on the following question: "What did you react when you felt stress?" The group leader then wrote the group members' answers on the whiteboard.

12. The group leader provided a summary of the following of stress management methods:

12.1 Health improvement

12.2 Environmental improvement (i.e. house, office, or workplace)

12.3 Positive thinking (better humor or more forgiving attitude0

12.4 Relaxation training (i.e. muscle relaxation, controlled breathing, meditation training, or listening to music

The group leader concluded that anyone could suffer from unhealthy levels of stress, but the most important thing was to be aware when it occured on you so you could manage them effectively.

13. The group leader demonstrated the following muscle relaxation technique.

13.1 Finding a comfortable seating position.

13.2 Contraction of the following muscle for about ten seconds and then relaxing it for a few seconds before repeating the activities ten times.

13.3 Clenching the hands and tensing the arms.

13.4 Raising the eyebrows.

13.5 Narrowing the eyes and puckering the nose.

13.6 Clamping the jaws closed, compressing the lips, and pushing up with the tongue on the roof of the mouth.

13.7 Raising the chin from the neck to the highest point and then holding that position.

13.8 Deep breathing and lifting of the shoulders.

13.9 Contracting the abdomen and the anus during and after exhalation from the lungs.

13.10 Bending the toes, straightening the ankles and tensing the leg muscles.

14. The group leader asked the group members to demonstrate these muscle relaxation techniques themselves.

15. The group leader then provided the group members with the opportunity to share their thoughts and feelings about the muscle relaxation techniques demonstrated.

16. The group leader allowed the group members to ask any questions about the session that they might have.

17. The group leader thanked the group members and confirmed the date and the time for next session.

Session V

Positive thinking training

Objectives

1. To learn about positive thinking.
2. To increase the group members' self-esteem.

Resource

1. Ten gifts, each contained a piece of cloth with holes.
2. Ten papers
3. Ten pens

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader introduced the concept of positive thinking by using the activity "The gift that I received".

3. The group leader explained the activity as follows: "Each member would receive a gift, then we would discuss about the gift that you received."

4. The group leader asked each member to select a gift and open it.

5. The group leader encouraged the group members to discuss on the following questions:

    5.1 How did you feel when you received a gift?

    5.2 Why did you choose?

    5.3 How did you feel when you knew what your gift were?

6. The group leader asked each member to find three positive things from the gifts, then wrote them down on the paper.

7. The group leader asked each member to write three useful things from the gift.

8. The group leader asked the group members to express their opinion on steps number 6 and 7.

9. The group leader explained the group members as follows: "In our life, we had to faces the various situations, some of which you could not be denial. Usually, we want all the good things would be happen to us and we always chosen the best choices for ourselves. Unfortunately, very often it would not meet our expectation, which created the feeling of disappointment and misery. Since there was inevitable, so we should unhappy find the way to live with them. By looked for the positive point from that situation."

10. The group leader encouraged members to learn how to appreciate themselves by asking them to close their eyes and listen to the group leader's voice: "During the past three weeks that we spent time together, you must have notice and recognized the good qualities to each others. Today, you have an opportunity to tell them about your feeling and thought. You could let them know."

11. The group leader gave nine pieces of papers to each member, and asked them to write down the good qualities of each member by using a separate sheet of paper.

12. Each member had an opportunity to talk to that person and tell them what were the good points of other members, and then handed it to those members.

13. The group leader gave member the opportunity to express their responses and what they had learned from the group.

14. The group leader sum up the session as follows: " You had learned from the other that how they were appreciate on you. Some quality, you never know that will exist have on you. So, you learn the new thing and would feel better about yourself and made you feel more confident. To help you to do this, you should look for good things around you or found ways to express the goodness within yourselves in order to boost your self-esteem, which would give you the confidence to succeed.

15. The group leader asked the group members for questions or commented about this session.

16. The group leader thanked the group members and confirmed the date and the time for next session.

Session VI

Problem-solving training

Objectives

1. To provide an opportunity to express feeling of unhappy situation.
2. To improve the problem-solving skills.

Resources

1. Fifty pieces of paper.
2. Ten pens.

Activities: these proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activity for this session "I would like you to close your eyes and think about any situations during the last two weeks which made you feel worried, upset or unhappy. You need someone to help you. Then I want you to write it down on separate pieces of paper. After that we would discuss these experiences that you had. Then we would help each other to find the alternative solutions."

3. The group leader asked the group members to close their eyes and think about their situations.

4. Each member wrote it down on separate pieces of paper.

5. Each member selected one of her own situations and shared to the group.

6. The group leader posted them on the whiteboard.

7. Repeat steps number 5-6 until every member shared all of their experience.

8. The group leader asked all members to group the topic into categories.

9. The group members selected one of these categories.

10. The group members were encouraged to express their opinion by the following questions:

10.1 What was your experiences of unhappy situation?

10.2 How did you feel? What was the effect on you?

10.3 How did you act to those situations? What was the effect on you?

11. The group leader summarized and suggested the alternative procedure to deal with problem by using the 6-steps of problem-solving skills as following:

11.1 Analyzing the situation, clarifying and presenting them in hierarchy order.

11.2 Gathering the necessary information from family members, friends, or the others which related to the situation.

11.3 Setting short-term goals and long-term goals.

11.4 Thinking about all of possibility strategies to deal with the problem.

11.5 Choosing the one which appropriated to that situation.

11.6 Evaluating the results. If the problem was still alive, repeating steps 11.1-11.5 if necessary.

12. The group leader allowed the group members to ask any questions about the session that they might have.

13. The group leader thanked the group members and confirmed the date and the time for next session.

Session VII

Communication training

Objectives

1. To increase the effectively communication, how to ask for help, and how to express their feelings and needs.

2. To develop self-confidence in communicating with other.

Resource

1. Two role-play situations

2. The pamphlets about "asking for help"

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activity as follows: "I would like you to play the role in a situation that I would give to you. Each group could create their own scenario. After both role play we would discuss about it."

3. The group members were divided into two groups.

4. The group leader gave each group an envelope containing the role-play situation-card.

5. Each group was given five minutes to prepare for the scenario.

6. The first group played their assigned roles.

7. The group members were encouraged to express their opinions on the following questions:

7.1 "How did you feel when you were in this role?"

7.2 "How the other felt when they were in the other role?"

7.3 "Have you ever had the same experience in your daily life? How did you feel about it?"

7.4 "How did you react or deal with this situation?"

8. The second group played their assigned roles.

9. Follow procedure in steps number 7.

10. The group leader summarized that: "Sometimes, you could not solve all the problems that you had by yourself, so it was possible to seek help from the others. However in order to ask for help, you must realize that you need help, then you must be able to express your need to the others. This procedure asking for help presented as following:

10.1 You must accept that sometimes you could not solve your problem alone.

10.2 You must find somebody who could help you.

10.3 You must evaluate her willingness to help you.

10.4 You must be able to express your feelings, your expectations and your needs to her.

10.5 In asking for help, it was necessary to communicate, which involved the following processes:

10.5.1 Communication was a process of transmitting information, thoughts, beliefs, feelings and attitudes between at least two persons.

10.5.2 Two types of communication

10.5.2.1 Verbal communication referred to written and spoken messages exchanged in the form of words the elements of language.

10.5.2.2 Nonverbal communication referred to messages that were conveyed by facial expressions, body movement, touch or eyes movement etc.

10.5.3 There were different way of asking for help.

10.5.3.1 Expressing your feelings by using "I message", e.g.: "I am concerned about the care of our child and would like you to come with me to see the doctor."

10.5.3.2 Using criticism, e.g.: "You are the causes of the problem and you never help me take care our child. So, you must to see the doctor with me."

10.5.3.3 Expressing your feeling by using "Citing a third person", e.g.: "The doctor would like you and I to see him tomorrow about our child."

11. The group leader asked each group member to choose a partner and practice the procedure how to asking for help.

12. The group members provided the members an opportunity to express their feelings and ask for help from others while acting out the situation they thought of.

13. The group leader encouraged the group members to use these ways of communicating with others effectively in their daily lives.

14. The group leader allowed the group members to ask any questions about the session that they might have.

15. The group leader informed all group members that the next session would be the last, and would review all the concepts that we had learned.

16. The group leader thanked the group members and confirmed the date and the time for next session.

Session VIII

Summary and evaluation

Objectives

1. To review the acquired experiences in the supportive group therapy program.
2. To do self-evaluation and evaluate the supportive group therapy program.
3. To extend help outside after the program.

Resource

None

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader asked the group members to review the important content in the previous sessions. Each member was written down his or her opinion that was received during the program. By answered all the following questions:

2.1 What were the topics of each session?

2.2 What the new ideas you had gained from the group?

2.3 Which problems had you tried to tackle? How it affected on you?

2.4 Did you have changed? How? How did you feel about it?

2.5 What were you impressions from your participating in this group therapy program?

2.6 If the next group therapy were organized, what topic would you like to have?

2.7 Did you have any other suggestions or comments?

3. The group leader gave the group members an opportunity to take turn talking during the group therapy session.

4. The group leader summarized the content of eight session as follow: "During the past eight weeks, you had learned that people had differences in their thoughts, feelings or emotional responses which result in their behavior and the way to react differently. By awareness and understanding of these individual differences, you can accept the differences among yourselves and others. Besides, you had also learned that stress produced feelings of unhappiness, which could happen to anyone. Then, you should deal with stress in appropriately ways. Sometime you met unexpected situation, you should learned how to cope with it by adjust the way of thinking. Bring all the positive things around us, it would make you feel better about yourselves and others which improved good relationship among the family member and skills in dealing with your problems. By following the six steps you had learned about asking others for help, which would allow you to find the best way to minimize or solve the problem."

5. The group leader thanked all the group members for their cooperation, understanding and consideration to each other in solving their problems and dealing with unpleasant circumstances.

6. The group leader concluded the final session with the following remarks: "During the past eight weeks, you had shared your feelings, opinions and experiences. Each group member should have benefited from group therapy program. I hoped that you would be able to apply this to your daily life and in dealing your problems. Although the supportive group therapy was now in the last session, please try to keep in touch with other members so that you could help one another in the future."

APPENDIX D

DATA COLLECTION INSTRUMENTS

Demographic Data

Questionnaire No. _____.

Demographic data about the subject Date _____.

1. Age _____ years old

2. Address _____

3. Marital status ( ) married ( ) separated
( ) widowed ( ) divorced

4. Level of education ( ) Primary school ( ) Secondary school
( ) Diploma ( ) Bachelor degree / above

5. Occupation ( ) employee ( ) Government official
( ) Merchant ( ) Housewife
( ) State enterprise employee
( ) Farmer ( ) Other _____

6. Family income _____ Baht / month

7. Number of mentally retarded children in the family _____

8. Previous experience in caring for a child with mental retardation
( ) Yes ( ) No

Demographic data about the mentally retarded child

1. Sex _____

2. Age _____ years old

3. Sequence of birth _____

Stress Questionnaire

This questionnaire seeks to discover your opinions and feelings about when incidents which occur while caring for your mentally retarded child.

Please mark a (/) in the box below the most accurate description of your stress level. Choose only one response to each situation. The following scale indicates level of stress.

No stress	indicates	you had no feelings of discontent
Mild stress	indicates	you had mild feeling of discontent
Moderate stress	indicates	you had high feelings of discontent
Severe stress	indicates	you had extremely high feelings of discontent

Example

Situation	What you felt?			
	No stress	Mild stress	Moderate stress	Severe stress
1. When you realized the extent of your child's Illness.				/

Explanation

When you realized the extent of your child's illness, you had extremely high feelings of discontent.

Situation	What you felt?			
	No stress	Mild stress	Moderate stress	Severe stress
1. When you know about your child's illness.				
2. You lack understanding of the cause of the illness.				
3. You lack knowledge about caring for your child.				
. . .				
41. You have contact with health officers.				
42. You receive different information from different health officers.				
43. There are insufficient government services available for your child.				

Coping Behavior Questionnaire

This questionnaire seeks to discover how often you think or act stressfully while caring fore your child. Please make a (/) in the box below the most accurate response. Choose only one answer to each question.

Example

Ways of coping	Never	Seldom	Often	Always
1. You seek information about how to take care of your child by reading books, or magazines.				/

Explanation

You seek information all the time by reading books, or magazines about how to take care of you child.

Ways of coping	Never	Seldom	Often	Always
1. You seek information about how to take care of your child by reading books, or magazines.				
2. You ask doctors or nurses about caring for your child.				
3. You share your feelings and opinions with other mothers who face similar problems.				
. . .				
22. You try to forget that you have a child suffering from this condition.				
23. You eat more than usual when you feel unhappy about your caring abilities.				
24. You think that your child will be normal in the future.				

BIOGRAPHY

NAME	Miss Boonthiwa Choochua
DATE OF BIRTH	9 November 1973
PLACE OF BIRTH	Lopburi, Thailand
INSTITUTIONS ATTENDED	Boromarajonani College of Nursing, Bangkok, 1991-1995: Diploma in Nursing Science Equivalent to Bachelor of Science in Nursing Mahidol University, 1997-1999: Master of Nursing Science (Psychiatric-Mental Health Nursing)
POSITION & OFFICE	1995-Present, Boromarajonani College of Nursing, Bangkok, Thailand. Position: Registered Nurse 4