FOUNDATIONS OF EDUCATION for Blind and Visually Handicapped Children and Youth:
THEORY AND PRACTICE

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Editor

AMERICAN FOUNDATION FOR THE BLIND, INC.
NEW YORK 1986
Working with Parents

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Parents of visually handicapped children play a major role in their education. Working with parents is no longer an ideal—it is a mandate. This chapter examines factors affecting attitudes of parents of visually handicapped children, levels of parent involvement in education, and common myths about parents. Strategies for increasing parent involvement and ensuring cooperation are explored.

Working with parents is no longer an ideal—it is a mandate. Teachers of blind and visually handicapped children will find their professional lives inexorably tied to those of the parents of their students as they work toward the best education possible for all visually handicapped children and youth. It is parents who can make or break a program; who can make the difference between a one-time exposure to a skill and its generalization to other areas of a student’s life; who can pressure the school administration for more materials and smaller caseloads; and who can either add to or subtract from a teacher’s successful career. Parents should be viewed as neither friends nor enemies; they are colleagues, and as such they deserve the same respect, training, patience, understanding, vacation, and sick leave given to any co-worker. The only difference is that their hours are longer, and their remuneration, if it comes at all, is usually intangible.

Too often, however, educators view parents from a distance and “surrender to an impulse to blame all family problems on parents” (Featherstone, 1980). It is not uncommon for teachers to report that over-correction procedures aimed at eliminating a child’s rocking or eyepoking do not work because “the parents don’t follow through at home;” that self-care skills are difficult to teach because “his parents do everything for him;” that parents fail to enforce good study habits or are negligent about the care of low vision aids. “His parents baby him.” “His parents refuse to send him to the store on his own.” Parents seem to be caught in a Catch-22, where they either do too much or too little for their children. Their actions seem to be under constant scrutiny by the very professionals that they depend on to help them help their children.

Such attitudes toward and judgments of parents are unacceptable, given today’s requirements in both federal and state law for parent involvement, training, participation, and counseling. Until the mid-1970s, parent involvement in education was marked by a laissez-faire attitude on the part of both parents and school personnel. In contrast to the roots of public education—where parents were both the administrators and supervisors of the local one-room schoolhouse—school officials had come to expect parents to give up their responsibilities for their children’s education at the point they entered the school system. Special education had become notorious for its failure to involve parents in the educational process:

Special education used to be a game played over the heads of parents. They were not allowed to see most records. They received few notices about their child’s program. These notices were usually incomprehensible and often came after the program had already begun or been changed. Their consent was engineered by telling them that if they wanted any service at all for their child they had to consent to the school’s recommendations. Parents were seldom invited to staff conferences about the child and evaluations of student progress were not shared with them. (Martin, 1979, p. 8)

To some extent, this attitude still prevails. The parent of a blind child recently wrote:

I was told by a pompous psychologist... and an overworked classroom teacher that it was unlikely that [my daughter] would ever achieve even the rudiments of academic skills, and, moreover, that she was an incorrigibly ill-behaved child. However, my own experience with [her] told me that the so-called experts were mistaken, that [my daughter’s] potential had not been tapped, and that her rambunctiousness stemmed from boredom. Unfortunately, any time I “rocked the boat,” I was patronized, or hit with veiled and not-so-veiled
threats that [my daughter] would be removed from the program, or that the program would be completely shut down to the detriment of other students. (Parent communication [name withheld], March 24, 1986)

A teacher who complains about the lack of follow-through in the home has an obligation to see that parents know how to follow through—whether it means training the parents themselves or finding someone who can. This places tremendous strain on the teacher-parent relationship, however, where expectations and demands can run high on both sides. It is incumbent on both parents and teachers to understand and respect the other's perspective.

FACTORS INFLUENCING PARENT ATTITUDES
All individuals bring their own values and experiences to a situation, and parenting is no exception. In addition, because the meaning of parenthood is so deeply involved with all aspects of personality (Ware, 1981), the birth of a handicapped infant can challenge an individual's basic system of values, beliefs, and trust, as well as his sense of control over his own life. How that individual responds to the situation will depend on his or her strengths and weaknesses, the help given by other family members (Wills, 1979) and by professionals, and the influence of many different factors.

The Changing Status of the Family
The American family is in a state of transition. Twenty years ago, the most predominant family unit in this country was composed of a working father, full-time mother, and two or more children. Recent statistics, however, reflect a quite different family composition (U.S. Department of Labor, 1985):

Six out of 10 women with children under 18 years old are in the labor force.
Almost 48% of women with children under age 3 work outside the home.
Almost half the children in two-parent families in 1984 had both an employed mother and father.
The number of families maintained by women grew more than 84% between 1970 and 1984. One-fifth of all current families with children are maintained by mothers. Over 16% of all families in the United States—10.3 million—had as their principal support women who were divorced, separated, widowed, or never married. Sixty percent of these woman-maintained families had children under the age of 18.
In 1981, 1 out of every 5 babies was born to a single mother.

Today's family is thus likely to consist of one or more working parents. This does not reflect a major change in family relationships: When women are employed, the majority of them are working because of economic need, not because of a desire to abandon their children or their household responsibilities. Nearly two-thirds of all women in the civilian labor force in 1984 were either single (26%), divorced (11%), widowed (5%), or had husbands whose incomes in 1983 were less than $15,000 (19%). When families are the sole responsibility of women, they are also more likely to live below the poverty line than other families.

Today's families are more mobile than they were in the 1960s and 1970s, both because it is easier to move and because seeking viable employment often necessitates a move. It is not uncommon for children to attend two or three different schools during their elementary years. But increased family mobility can lead to erosion of the family support network; no longer do children, parents, and grandparents live in close proximity to one another, and it has become increasingly difficult to rely on family members for guidance and support in times of trouble (Umansky, 1983). Extended families also served as the training ground for developing parenting and child-care skills. Children learned to care for their younger siblings in large families, and their parents and grandparents were models for nurturing, loving, and other support roles.

But statistics and changing mores do not mean that the American family is in trouble—it is simply in transition. At the same time that all these change were taking place, crime rates were decreasing, more children were completing high school and achieving better grades, and integration of both racial and other minorities into society was succeeding (Vincent, 1985).

Today's families are different, but they are just that—different. There is no typical family in the 1980s.

This does mean, however, that typical approaches
to parental involvement—those that were developed in the 1960s and early 1970s—are no longer valid. Many of the expectations professionals have for parent participation may be based on memories of their own family interactions, or on images of the ideal family popularized by television series. Understanding that parents may not be available during school hours, that they may not want to spend their limited time at home working with their children on therapy or homework, that they cannot adjust work and social schedules to accommodate IEP meetings, or that they may not be able to drive their children to numerous medical and educational appointments, may be difficult for a generation of professionals who grew up in a different economic, political, and social environment. “The greater disparity between a teacher’s background and a child’s lifestyle, the greater is the likelihood that the teacher may misinterpret the needs and behaviors of the child and family members” (Umansky, 1985).

Stages of Grief
Parents are frequently said to go through certain stages as they come to terms with a child’s handicap. The model most frequently referred to was originally developed to rationalize the actions of terminally ill patients (Kubler-Ross, 1969). While this theory is frequently used to describe parents’ emotional and coping status along an imaginary continuum of acceptance, there is little empirical evidence that parents of handicapped children actually go through these stages.

Certainly, all parents at one time or another experience these feelings, but whether they experience them in this sequence or to this degree is open to conjecture. Further, while the stages may very well apply to individuals who are dying, the underlying premise—that parents will or should one day achieve acceptance—may be suspect. In most cases, professionals try to force parents to accept their child’s blindness when they do not even know what acceptance is (Ferrell, 1984), or they offer platitudes and injunctions to accept the handicap that are embedded in Norman Rockwell family images (Featherstone, 1980).

As applied to parents of handicapped children, the model frequently includes the following stages:

1. Denial and isolation—This can be manifested as a denial that the handicap exists, or an effort to minimize the implications of the handicap. This stage can provide momentary escape for the parent, who is attempting to cope with feelings of guilt and shock while trying to carry out daily routines—including parenting the very child that is provoking the feelings to begin with. Many professionals attempt to move families out of this stage quickly, but as Ware (1981) warns, this can be “a serious mistake,” since this stage generally coincides with the newborn period and efforts should be directed toward enhancing attachment and encouraging confidence in parenting skills. Occasionally, this stage can occur throughout the child’s lifetime, such as when a parent dismisses a child’s reading difficulties with the comment, “I was the same way at that age. He’ll grow out of it.”

2. Anger—During this stage anger can be directed toward the professionals who did either too much or not enough; toward the family genes; toward fate; or simply toward anyone and anything. “Early on, it seems that the anger is so intense that it touches almost everyone, because it is triggered by feelings of grief and inexplicable loss that one does not know how to explain, nor how to deal with” (Smith, 1984, p. 1). Anger in itself is not bad; it can be helpful. If anger is not allowed to be expressed, however, it can eventually be directed toward the child (Ware, 1981).

3. Bargaining—This stage may be characterized by a search for a cure, another doctor, or a different educational program. While it is difficult to distinguish this stage from the recommended practice of seeking a second or third opinion, it reflects the anguish parents can experience in finding answers to questions about their child’s health, handicapping condition, or educational potential.

4. Depression—The handicapping condition has begun to have its full impact on the family during this stage, and depression seems to permeate all aspects of the family’s relationships. It is during this period that parents may measure their expectations for their child before learning of the handicap against what appears to be a limited potential for growth and development. Depression can also be expressed as feelings of inferiority—“I’m not a good parent. I can’t help. It’s hopeless”—or as pessimism about the future: “Maybe it’s worse than they’re letting on. What if it keeps getting worse? What can I expect from the future?”

5. Acceptance—Parents are at peace with themselves as people and as parents, and see their child as an individual with his own strengths and weaknesses. Lairy & Harrison-Covello (1973) suggest that parents who have reached this stage are more likely to have further pregnancies, which may imply that the parents no longer see blindness as an overwhelming handicap or fear that other children will be born with the same condition. Reaching a point of acceptance, however, does not necessarily imply competent parenting. Parents can be at peace with a child’s handicap, yet not change the manner in which they relate to their child or enforce behavior. By the same token, parents who never accept their child’s handicapping condition can be highly successful and intuitive parents who
seem to know how to obtain optimal performance from their child. Ortiz (1973) found that mothers of children with rubella syndrome tended to be neither overly accepting nor rejecting, nor were they martyrs, but they still were able to carry out their child's educational program.

As Ware (1981) stated:

Acceptance does not mean liking the handicap. It does not mean that the anguish and lost dreams will be forgotten. They will always be remembered but relieved with less frequency and with lessening intensity. Acceptance does not mean enjoying the necessity for special programs and agencies. Instead, you learn to appreciate the existence of good programs and agencies and develop confidence in your ability to make the judgments which are best for your child. It does not mean never wishing your child can see. Of course, you would like for him to have sight! You simply abandon this as an ever-present wish, because you know it is a fact that he cannot see and you know you love him dearly even though he cannot see. It does not mean never crying or feeling angry and depressed. These feelings will periodically return. Their recurrence does not mean that you have not adjusted or that you are losing your ability to cope. It means you are human. (Ware, 1981, p. 46)

Severity of the Handicap

Schell (1981) and Marion (1981) have stated that the severity of the child's handicap often influences the attitudes and feelings of parents. The more obvious the handicap, the less socially acceptable it is. Parents of blind and visually handicapped children may be particularly vulnerable to such social pressures, since many eye disorders are accompanied by obvious physical manifestations, such as cataracts, deviated eyes, and nystagmus.

Different children affect parent-child interactions in different ways and require different parenting techniques. The more severe the handicap, the greater influence certain factors will have on parents' self-concept and sense of control over the situation. Some of the factors that influence parents' responses to handicapped children include: (a) the reward that parents derive from parenting; (b) how difficult and time-consuming routine caregiving tasks (dressing, feeding, etc.) are or become; (c) how frequently the child needs to be hospitalized, and how life-threatening and stressful those hospitalizations are; (d) the additional financial resources that are required to support the child's medical needs; (e) parents' expectations for the child's future, which may be pessimistic, even if unfounded; (f) the isolation of parents from family and friends because of the time and financial commitments, as well as the social stigma associated with the handicap; and (h) less time for sleeping, recreational activities, and performing routine household chores (Moroney, 1981; Ramey, Beckman-Bell, & Gowan, 1980). The impact of these factors increases geometrically with the severity of the handicap. Parents of blind and visually handicapped children may feel the impact even more, because blindness is often perceived to be one of the most limiting of handicaps.

Age At Onset

According to Mori (1983), the older a child is when the handicap is diagnosed, the more difficult it is for the parents. Parents of children with congenital blindness have never known their child any other way. When the visual handicap occurs later, either due to an accident or because a diagnosis was not possible earlier, parents must adjust to a new concept of their child. The process parents of older children go through may be no different from that of parents of newborns, but the family has already developed dreams and goals for the child which may need to be fundamentally altered because of the diagnosis of impairment. Even if the child has been diagnosed as handicapped previously, a subsequent but new diagnosis of blindness on top of the other handicapping conditions may be particularly difficult for parents because of the myth and stigma usually attached to visually handicapping conditions (see Chapter 2).

Socioeconomic Status

Schell (1981) and Marion (1981) state that the higher the socioeconomic status of the family, the more adverse the reaction to the birth of a handicapped child. Certainly, parents of all socioeconomic levels share similar feelings about the birth of a handicapped child, but some feelings may relate directly to the value placed by adults on childhood and on the development of children into responsible adults (Umansky, 1983). In pre-industrial society, children were important to the family to help generate family income or as extra hands to maintain the family farm. The more children a family had, the more prosperity it enjoyed.

In today's society, however, parents have children primarily for emotional satisfaction, not for financial security. Higher socioeconomic families may also see children as a means of continuing the family name and fortune, while lower socioeconomic parents may wish for a better life for their children. In either case, the birth of a handicapped child can raise difficult questions about the child's ability to reproduce and to hold gainful employment. Higher educational levels in parents do not necessarily guarantee enlightened attitudes toward persons with handicaps, either; college graduates are just as likely to have been exposed to and to sustain common myths about blindness.

How Information Was Received

The manner in which parents are first told about their child's handicap can also influence parent attitudes
Financial Hardships
Financial matters are of concern to all families and range from providing food, shelter, and warmth, to planning for college education for the children. As life expectancy rises, parents are also concerned about their own retirement. The stress is particularly hard on one-parent families, many of whom are women, and the majority of whom are in low paying or less skilled jobs (U.S. Department of Labor, 1985). Families maintained by women are also more likely to live in poverty. The United States Department of Labor reports that, in 1983, more than 1 out of 3 families maintained by a woman was poor, compared with 1 out of 13 other families.

The financial stress on already overburdened families rises concomitantly with the birth of a handicapped child (Moroney, 1981). The average monthly medical bill for a severely handicapped child, for example, has been estimated at $650.00, while the average monthly medical bill for a nonhandicapped child is estimated at approximately $25.00 (Shankaran, 1985). The additional costs of special day care programs, transportation to and from therapy services, and special equipment have not been estimated. It is understandable that parents may not want or be able to purchase toys, consult another physician, or even to attend a parent group, given their limited financial resources and the necessities that must be provided for all their children. Educators must be sensitive to the financial implications of the recommendations and requests they make to parents and should make those recommendations and requests only when they can also refer the family to financial aid.

Time
The lack of time frequently contributes to stress, which can be manifested as anger, impatience, or tension among family members. Families with handicapped children report that time is a rare commodity in their daily lives. Parents frequently state that they have less sleeping time, particularly during the infant and preschool years, and that basic caregiving chores (dressing, bathing, eating) take longer to accomplish. They also feel that a great deal of time is spent in transit to various therapies, educational programs, and recreational opportunities (Moroney, 1981; Ramey, Beckman-Bell, & Gowan, 1980). Parents rely on professional guidance as to which programs their children could benefit from, but sometimes those recommendations are made without an awareness of where the programs are located or when they are offered. Efforts should be made to refer parents to comprehensive center-based services as much as possible, and to locate alternate transportation sources, such as other parents or community vans, to relieve some of the time pressure parents often experience.

The emphasis that educators often place on parents as teachers can place an added burden on parents to perform at home, when they are asked to set aside a special instructional period during which the parent and child work together. Many parents—of both nonhandicapped and handicapped children—do devote daily time to working with their children on homework. The difference is that a special instructional period is an assignment, while working on homework is only a suggestion; the first is mandatory, while the second is voluntary. The first case also carries with it an implication that the parent will be judged by his child’s progress. In such cases, the time that is given by the parent is likely to be resented and loaded with anxiety. Teachers do not teach all day long; parents should not be expected to do so either.

Critical Events
At different periods in the life of a family, parent-child and parent-professional relationships may be particularly difficult to maintain because of the stress of certain events. Hammer (1972) has identified six critical events in the life of the family with a handicapped child:

- The child is born or the handicap is suspected.
- The diagnosis is being made and the handicap is being treated.
- The child is ready to enter a school program.
- The child reaches puberty.
- The child reaches the age of vocational planning.
- The parents grow old and worry that the child will outlive them.

At least three of these critical events are key periods
in the lives of all families, whether the children are handicapped or not. They take on more significance, however, when the child is impaired, because the standard resolutions are not available. When the nonhandicapped child is ready to enter school, reaches puberty, or begins vocational planning, parents generally know what to expect because they have had similar experiences themselves. When these same events occur with a handicapped child, it is a new experience entirely for the parents, and the same concerns and fears are raised all over again. Educators need to be aware of these critical periods in the life of a family and be able to respond appropriately; information and assistance in locating resources will help parents combat their fear of the unknown.

Lack of Control
Feeling in control of one's life is a natural desire. Parents of children with handicaps, however, frequently feel powerless to change what is happening around them. Mori (1983) suggested that one of the most critical and debilitating aspects of having a handicapped child is the uncertainty. Parents do not know what to expect from the future—will the child be able to attend school, will she ever learn, go to college, or raise a family? What effect will the child with a handicap have on the other children? What will happen after the parents die? Parents may believe that the child's condition is the worst it could possibly be. Or they may fear that society will reject the child. Few of these questions or fears are ever answered immediately. The uncertainty and questioning lasts for many years and continuously contributes to feelings that one is not in control of one's own life.

Most people approach parenthood with the certainty that they are responsible for their children, that they will make the best possible choices for them, and that their rights as parents are grounded in common law and cannot be removed unless they do something horrible to their children. Yet parents of handicapped children suddenly find themselves forced to rely on the judgments, opinions, and recommendations of experts. "Compounding the problem is that these others are often strangers with whom no bond of trust has yet been established" (Smith, 1984, p. 2), and that attention is focused on the abnormality of the child and the situation simply because specialists have to be consulted in the first place (Ware, 1981).

A sense of control is not fostered if parents feel that they are under constant scrutiny. One mother wrote,

A sense of the feeling of lack of control has been expressed by parents as they discuss the difference between professionals who choose to work with handicapped children, and parents who have no choice:

People who are in this profession of working with the handicapped have chosen it, and it is a profession that gives you a lot of self-esteem and a lot of good feelings. Everybody likes people and admires people who work with handicapped children. ... It's such an enabling profession. ... This is something that if they get into and they pursue, they have chosen and it makes them feel good. The parents have not chosen this. No parent would choose to have a child that is anything less than normal and whole. And so while we both want the best for our child, the best program, we also have to realize that we're coming from different places. You're coming from a place that gives you a lot of self-esteem. A parent of a handicapped child does not have that self-esteem. (Kupfer, 1985, pp. 24-25)

A parent's sense of being out of control can affect the parent-child relationship. It can also place unrealistic expectations that professionals have all the answers. Professionals working with parents of handicapped children need to examine how their actions, language, and judgments contribute to this insecurity while at the same time develop strategies to help parents gain control over their lives.

Parents as an In-group
To a certain extent, parent attitudes toward professionals are formed from bonding with other parents, by sharing experiences and feelings about their children and about the professionals they have encountered. Parents cannot share these feelings with most professionals, simply because most professionals simply do not know what it is like to have a handicapped child (Kupfer, 1985). As long as professionals withhold information or attempt to make decisions for parents, there will be cause for parents to discuss insensitive, uncaring professionals and to dismiss their recommendations.

The dichotomy between "those who know" and "those who cannot even imagine" will grow. Extreme examples of this dichotomy can be debilitating to parent-professional relationships, because it may lead to an unwillingness to listen—"No one is going to tell me about my child!"—and an inability to take advantage of the professional's training and expertise.

The Myth of Cure
Another factor that influences the parent-professional relationship is the belief that the child can be made better through medical or educational intervention. In most other phases of life, this does occur. Individuals visit a doctor to cure an illness and attend school to obtain an education and a chance at a better life.
When dealing with issues of disability, this does not happen. Nevertheless, the expectation for cure, for making things better, is still there. Kupfer (1985) stated it best:

There is a certain animosity that is just there between parents and professionals that will always be there because you have these intervention programs, you can do this diagnosis, but you can't make our kids better. The bottom line is, he can't be fixed. And that always makes a parent sad. And as a professional that's something you have to understand. (p. 22-23)

THE CONTINUUM OF FAMILY INVOLVEMENT

Federal laws mandating parent involvement are based on three major assumptions: (a) parents should make decisions about their child's education; (b) parent participation ensures the rights of the child under Public Laws 94-142 and 98-199; and (c) parents are capable of teaching and already function as their children's teachers (Turnbull, Turnbull, & Wheat, 1982). Mori (1983) views family involvement in the education of children with handicaps as developmental in nature. Families are composed of individuals with differing backgrounds who will respond to an educator's efforts to involve them in the educational process along a continuum of options. Different members of the same family may function at different places along this continuum at any one time, and the needs of both the family member and the educational system may change periodically and cause shifts along the continuum. Mori suggests the following levels of family involvement:

1. **Passive receptivity to the child's participation in the program.** Parents allow the child to participate in the educational program and may or may not attend conferences.

2. **Minimal involvement in the child's program.** The parents have more personal contact with the professionals involved in the program, including discussions about the program itself. Parents may participate in parent groups and training sessions.

3. **Involvement as a trainee in intervention strategies.** The parents receive instruction in working with their child.

4. **Involvement as a fully participating member of an interdisciplinary team.** Parents participate in the educational process by exchanging meaningful information with professionals, selecting goals for the child, teaching, measuring, and evaluating the child's progress.

5. **Involvement as a counselor of other families with handicapped children.** Parents are willing not only to share their own feelings, but to provide emotional support and encouragement to other parents.

6. **Involvement as both advocate and policy maker.** Parents have become thoroughly integrated into the agency or educational program, and a high level of mutual trust and respect exists. Parents help to formulate policy and can interpret that policy to the larger community.

7. **Involvement as program initiator and developer.** Parents take on the responsibility of starting new programs, either for their own children or for others.

It is critical for professionals to understand that an individual parent's involvement at any given point in time is dependent on a great many factors. But parents can and do involve themselves in the educational programs of children, and a sensitive professional will not only recognize and accept the level of participation desired at that point, but will also strive to help parents along to the next level.

Stile, Cole, and Garner (1979) have identified several factors associated with parent attrition:

- **Meetings are held at inconvenient times and/or locations.** Financial pressures may necessitate parents' working double or split shifts, and distant locations may be difficult—or too expensive—to reach. Try to schedule parent group meetings at different times of the day, or on weekends. When possible, plan the parent meeting around a meal, and include all children; all families have to eat, and including siblings reduces the need for babysitters.

- **Parents are not asked for their input.** Everyone likes to be asked for input. It increases self-concept and helps parents to feel more in control of the situation. Research has shown, moreover, that parents really do know their children best. Parent and teacher assessments of the same child do not differ significantly regarding the child's level of performance (Vincent, 1985).

- **Professionals make unwarranted assumptions regarding parents' prerequisite skills.** Teachers may assume either too much or too little
about what a parent brings into the educational environment. Frequently this is expressed as “parents do not follow through at home,” when in fact the parents may not be aware of what they are supposed to be doing at home, or the strategies they can utilize to provide follow-up. When too little is assumed, professionals may adopt a condescending attitude toward parents. Both approaches discourage parent involvement.

Parents are not given consistent and ongoing feedback on their efforts or the child’s progress. Reinforcement is a critical feature of all educational programs and working with parents is no exception. Adults respond to positive reinforcement as well as children, and both parents and teachers need feedback on how well they are doing.

Parents feel threatened. It is easy, too, for parents to feel intimidated when they are forced to turn to highly-trained individuals who use educational jargon and seem totally competent, particularly at a time when parents feel incompetent and insecure. One parent has stated that during her child’s earliest years, all the successes belonged to professionals; “only the failures were mine” (Oster, 1985).

Parents have unrealistic expectations for results within the program. Parents turn to an educational program for help with their child. Education has become a cure-all in our society, and parents hope that the situation will improve with educational intervention. When that does not occur, disappointment prevails. Both program and child goals need to be continually reviewed with parents so that realistic expectations can evolve.

Parents are burned out from previous efforts. For various reasons, past involvement in educational programs may have been unsuccessful and discouraging for parents, or it may have required so much of their energy that they need a vacation. Parents do have a right not to be involved; in many cases, they may seek involvement at a later time after they have had a chance to rest, to spend some time alone, and to evaluate the current program.

The program neglects the social needs of parents. Parent involvement is more than meeting the child’s needs; it also means meeting the parent’s needs for time off, activities with other adults, and respite care.

Reluctance of parents of mildly involved children to associate with parents of severely impaired children. Parents of mildly handicapped children may understandably feel that they have little in common with parents of children who are severely impaired. This is sometimes observed in groups of parents of visually handicapped children, some of whom may have children who are “just blind,” while others have multiply impaired visually handicapped children who require different degrees of care and who have varying educational potentials. The emphasis in parent groups may be better placed on the parents’ needs for sharing and support on common issues and concerns, rather than on those with which only limited numbers of parents can identify.

GUIDELINES FOR PROFESSIONALS IN DEALING WITH PARENTS
Professionals hold the power in the parent-professional relationship; they affect parents’ self-concept, confidence, and level of involvement in the educational program by what information they choose to share and how they share it. But educators have just as much responsibility under special education law to educate and be responsive to the parent as they do to the child, and they will find that employing strategies to share their power will enhance parent participation in and support of the educational program, while strengthening the parent-professional relationship.

Beckett (1985), Featherstone (1980), Gorham (1975), Mori (1983), and Oster (1985) have suggested the following guidelines for professionals to employ when dealing with parents:

1. Involve parents in every step.
2. Talk face-to-face, and eliminate any physical barriers (such as a desk or telephone) when communicating with parents. Maintain eye contact.
3. Ask parents what their needs are.
4. Be attentive and use active listening skills as necessary. Show respect and concern for both the parent and the child. Learning to listen better conveys respect and demonstrates to parents that you think they can contribute valuable information. Good
listeners discover strengths as well as weaknesses.

5. Share any and all information. Make no assumptions about what families want or need, and do not try to judge when parents are ready for new information and when they are not. They are adults.

6. Be specific and objective about presenting information. Give how-to advice, including helping to devise a realistic management plan with suggestions for living on a daily basis.

7. Help parents understand the child's abilities and assets. What the child can do is much more important to both the child and the parent than what he cannot do. Help parents to think positively by reiterating that there is no such thing as a final diagnosis.

8. Use everyday language, and minimize use of jargon or acronyms. Give parents a glossary of educational and medical terms to help them interpret the language of other professionals.

9. Answer all questions honestly, but sensitively. Admit that you don't have answers to all questions.


11. Clarify and summarize the results of any meeting or conference before concluding, and follow up with a written summary.

12. Give copies of all reports to parents (they must stay informed to stay involved). Remember that any written materials should be in the parents' native language and in an accessible mode of communication if the parent is sensorily handicapped.

13. Create opportunities for parents to talk with other parents. "The most realistic way to decrease families' isolation is by providing them with access to their peers" (Oster, 1985, p. 31). Parents offer parents respect with empathy and without the burden of clinical assessment.

14. Warn the family of any gaps in service or inadequacies in the community.

Umansky (1983), in a position paper developed for the Association for Childhood Education International, has given a three-pronged charge to educators:
(a) Children must be given a sense of heritage—pride in the uniqueness of each population group, with continual support for the similarities among people who live and work together.

(b) The curriculum must reflect children's current and future needs in family and society.

(c) Educators and parents must become more familiar with each other. Children do things at home they don't do at school and vice versa.

The charge is really no different for teachers of blind and visually handicapped children. They, too, must convey a sense of pride of self to blind and visually handicapped children, and they must employ a curriculum based on a lifelong perspective. Just as im-

Study questions
1. What differences can you identify between your present family unit and your parents' family units?
2. Discuss acceptance of a child's handicap from both a professional's and a parent's point of view.
3. How does the child's age affect a parent's response to a diagnosis of visual impairment?
4. How could physicians be better prepared for dealing with parents?
5. Are parents their child's best teacher? Discuss why or why not.
6. How would a teacher of visually handicapped children counter a parent's question that, "My child will always be blind. What can you do to make a difference?"
7. Plan the time, place, and agenda for a series of meetings for parents of visually handicapped children.