GUIDANCE NEEDS OF MIDDLE SCHOOL EDUCABLE MENTALLY RETARDED AND GIFTED CHILDREN

BY

JOHN DEANS SCOULLER III

A DISSERTATION PRESENTED TO THE GRADUATE COUNCIL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF EDUCATION

UNIVERSITY OF FLORIDA

1975
Dedicated to

Christel Waltraud Scouller
ACKNOWLEDGEMENTS

I wish to express my most sincere thanks and appreciation to my committee chairman, Dr. Robert Myrick, who provided the needed balance of positive feedback and constructive criticism. He also gave tirelessly of his time when it was most needed. Thank you.

Sincere appreciation is extended to each of the other committee members: to Drs. Cary Reichard and Joseph Wittmer.

A special thank you goes to Mrs. Carol Sheppard whose skills in typing this study were greatly appreciated.

To Christel, my dear wife, is extended my deepest gratitude. Her love, patience, and understanding have made this study possible, and to her it is dedicated.
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GUIDANCE NEEDS OF MIDDLE SCHOOL EDUCABLE MENTALLY RETARDED AND GIFTED CHILDREN

By

John Deans Scouller III

August, 1975

Chairman: Robert D. Myrick
Major Department: Counselor Education

The purpose of this study was to investigate the guidance needs of middle school educable mentally retarded (EMR) and gifted (GIF) children, their self-concept, the number of counselor contacts, problems viewed as appropriate for discussion with a counselor, and perceived counselor attributes.

The study was conducted in five middle schools of Alachua County, Florida. The subjects were 236 EMR and 257 GIF students in exceptional classes. Placement criterion for EMR students was an IQ of 75 or less on the WISC or Binet. Placement criterion for GIF students was an IQ of 130 or more on the Slosson.

Three criteria instruments were administered to examine the above mentioned areas. The Mooney Problem Check List, Form J (MPCL) was modified by using only the even-numbered items. The modified form was referred to as the Modified
Mooney Problem Check List (MMPCL). This instrument gives scores in seven problem areas as well as a total score and was used to assess guidance needs. The Piers-Harris Children's Self-Concept Scale (CSCS) was used to measure self-concept. The Counseling Service Questionnaire (CSQ) was developed and administered to ascertain the number of counselor contacts, problems viewed as appropriate for discussion with a counselor, and perceived counselor attributes. Questions pertaining to problems viewed as appropriate for discussion were adapted from the MPCL.

The instruments were administered during May, 1975, and read to the students. Three hypotheses were tested using multivariate analysis of variance, a t test, and chi square. The level of significance for all tests was set at the .05 level of confidence.

The students were classified as EMR or GIF (status), male or female (sex), and low or high perceived problems (problem perception). Low problem students had MMPCL total scores one standard deviation or more below the mean while high problem students had total MMPCL scores one standard deviation or more above the mean.

The analysis of the data showed that EMR students reported significantly more problems on the MMPCL than did
GIF students and significantly more problems on each of the seven subtests. GIF students reported a higher self-concept than did EMR students. However, high problem EMR and GIF students reported nearly identical self-concepts with no significant difference. There was no significant difference between students due to status, sex, or problem perception on their views of the counselor. All groups of students perceived the counselor as having more positive than negative attributes. EMR students felt all problem areas were appropriate for discussion while GIF students felt only three of the seven areas were appropriate. EMR students had almost three times as many counselor contacts as did GIF students. Both EMR and GIF students reported the highest number of problems in the area of Self-Centered Concerns. The area of Relations to People in General ranked high in the concerns of these students.

The guidance needs reported by EMR and GIF students differed in frequency rather than kind. EMR students reported more problems than GIF students and appeared to need more guidance services than GIF students.

The self-concept of those students who reported many problems was significantly less positive than students who reported few problems. The reciprocal effect between self-concept and perceived problems suggests that specific
counselor interventions directed toward perceived guidance needs would enhance the self-concept.

Both EMR and GIF students reported many problems concerned with interpersonal relationships. Interventions such as peer facilitating, teacher discussion groups, and group counseling could be used to increase students' skills in the area of effective communication.
CHAPTER I

INTRODUCTION

The middle school years, generally between ages 10 to 14, are marked by rapid changes in an individual's physical and psychological characteristics. The relatively peaceful years of elementary school give way to the sometimes tumultuous periods of pubescence and puberty. The latency years are over.

Concomitant with physical changes that markedly alter the body image come equally marked changes in emotions. The occasional confusion originating within an individual is frequently compounded by expected changes in behavior by parents and teachers.

The storm and stress of this period, the ups and downs of energy level, the sudden awkwardness of the body, and the onrush of new emotions all function to mold an individual into unaccustomed shapes. The developing person in these years is at the same time both hammer and anvil as the growing personality begins the crystallization process that will continue long into adulthood.
Unexpected and previously unexperienced emotions can develop almost overnight and create guidance needs. Adaptive behaviors learned during the latency stage can become maladaptive as new needs and desires develop and external demands change. These transitional years from childhood to adulthood are times when counselors and teachers need to provide services to enhance the positive growth of students.

There are an estimated 1,760,000 (World Almanac, 1975) educable mentally retarded (EMR) and gifted (GIF) students in the United States. The guidance needs and problems of these students during the middle school years have not been clearly identified. Moreover, school counseling services are often limited to identification and placement of these students in exceptional programs without regard to their guidance needs.

**Purpose of the Study**

This study investigated the perceived problems of EMR and GIF middle school students. In addition, the study examined the relationship between self-concept and perceived problems, the number of counselor contacts, and the perceptions EMR and GIF students have about counselors. Also investigated were the types of problems that these students felt were appropriate for discussion with counselors. More specifically, this study attempted to answer the following questions:
1. What kinds of problems (guidance needs) do EMR and GIF students have?

2. What is the relationship between perceived problems and self-concept?

3. Is there a difference in the self-concept of children who report many problems and those who report less?

4. Is there a difference in the self-concept of EMR and GIF students?

Children who have many problems may or may not be receiving adequate counseling services. This study also attempted to answer these questions:

1. Do EMR and GIF students with many problems have more or less counselor contacts than students with fewer problems?

2. Do EMR and GIF students have similar numbers and types of perceived problems?

There are few concrete data on the types of problems EMR and GIF students feel are appropriate for discussion with counselors and other guidance assistants.

1. What types of problems are viewed as appropriate for discussion with a counselor by EMR and GIF students?

2. Are there any similarities and differences between EMR and GIF students' problems viewed as appropriate for discussion with counselors?
Need for the Study

A review of the literature (Chapter II) reveals that very little has been reported about the problems of EMR and GIF students at the middle school level. While the literature tends to emphasize the educational and curricular needs of these students, research related to guidance needs has been sadly neglected (Mann, Beaber, Jacobson, 1969; Gowan, 1971). Some studies have investigated the relationship between intelligence, self-concept, and academic achievement. Other studies have shown the effects of counseling on social behavior and self-concept.

Students often discuss problems with a counselor based on their perceptions of the counselor as a helping person. If students view the counselor positively they are more likely to seek out the counselor or be receptive to counselor help. If they have little regard for the counselor then guidance needs may not be met even if the counseling services are available. Counselors need to know how EMR and GIF students perceive them and their work if they are to be effective. There are, however, remarkably few studies indicating how EMR and GIF students view counselors.

The need for counselors in the schools appears to be continuing at a rate greater than the supply. As part of the
developmental counseling paradigm, an approach that would direct services at perceived needs, preventive counselor intervention would be a viable function (Shaw, 1973). Assessment of problems are a vital part of this type of program. All students have problems, but what special kinds of problems do EMR and GIF students experience? If teachers and counselors have a greater understanding about these problems perhaps they can be more effective in planning guidance strategies. Are guidance needs of EMR and GIF students so different that special programs need to be introduced or are their problems similar enough that similar strategies might be used? There is a need to know more about the personal problems and needs as perceived by EMR and GIF students.

Little is known as to what areas of concern students view as appropriate for discussion with counselors. There may be areas in which students are experiencing difficulties and yet would not be willing to discuss them. This would have implications for guidance services. The study investigated this area.

Guidelines for counselor intervention in EMR and GIF programs are also needed. Counselors work with all students and with teachers to develop classroom units in areas of perceived problems. The perceptions of counselors by EMR and GIF students should be valuable for counselors. The
data acquired in this study provide baselines for comparison with further evaluations and effectiveness studies.

**Definition of Terms**

In this study the following definitions were used:

**Educable Mentally Retarded (EMR)**

Educable mentally retarded (EMR) refers to a student in a class for educable mentally retarded individuals, whose scores on standardized, individual intelligence tests (Binet or WISC) will range between 55 and 75.

**Gifted (GIF)**

Gifted (GIF) refers to a student in an "enrichment class," whose scores on a standardized, individual intelligence test (Slosson) must be above 130.

**Perceived Problems**

Perceived problems refers to those self-identified areas of concern as reported on the Modified Mooney Problem Check List. This term is also used synonymously with guidance needs.

**Self-Concept**

Self-concept in this study refers to a conception of self, as measured by the Pier-Harris Children's Self-Concept Scale.
Low Perceived Problems

Low perceived problems refers to a level of response on the Modified Mooney Problem Check List one standard deviation or more below the mean.

High Perceived Problems

High perceived problems refers to a level of response on the Modified Mooney Problem Check List one standard deviation or more above the mean.

Organization of the Study

The rest of the study is organized into four more chapters. Chapter II contains a review of the relevant literature. The populations, data collection, criterion instruments, null hypotheses, and statistical procedures are presented in Chapter III. Chapter IV contains the results of the study. A summary of the study, limitations, and implications are reported in Chapter V.
CHAPTER II

REVIEW OF THE LITERATURE

As children develop from infancy to adulthood they have many experiences through which they progress. Some children pass through these with little personal difficulty. Others find certain tasks and problems more difficult and experience enough distress to interrupt their development. This course of development has many tasks to be accomplished, many stages through which to progress, and many needs which must be met. These tasks have been delineated by Havighurst (1953), the stages outlined by Erikson (1950), and the psychological needs identified by Maslow (1970).

Needs for security, trust, belongingness, and love are common to children and necessary for the development of self-esteem and a positive self-concept. School personnel should provide services to facilitate the positive growth and development of these factors to the extent that they are knowledgeable about them.

School counselors can intervene along the developmental continuum at two broadly defined points: (1) at developmental
hurdles, and (2) in psychosocial crises (Zaccaria, 1965). Developmental hurdles, or tasks, are those predictable events that occur with relative consistency in the life of all children. Counseling interventions of an ongoing nature can be implemented and utilized for these events. Psychosocial crises, however, are those situations which, while occurring in somewhat predictable patterns, have the potential for greater positive or negative effects on the individual. Counselors can be psychologically prepared for these crises and provide services to avoid what Couchman (1974) refers to as "the pain of serious emotional and social disorders" (p. 457). He feels these occur more frequently and with greater severity than is usually recognized.

At the middle school level the life stage of the pre-adolescent and early adolescent is marked by rapid and radical physical and psychological change (Wickes, 1966). McCandless (1970) described adolescence as "a time of drastic change and a part of the continuous stream of human development" (p. 35). Regarding puberty, Anna Freud wrote

The physiological process which marks the attainment of physical sexual maturity is accompanied by a stimulation of the instinctual processes, which is carried over into the psychic sphere in the form of an influx of libido. The relation established between the forces of the ego and the id is destroyed, the painfully achieved psychic
balance is upset, with the result that the inner conflicts between the two institutions blaze up afresh. (1946, p. 158)

Counseling services at the middle school level can facilitate the progression through this transitional period. There would seem to be a middle ground between the two positions suggested by Zaccaria (1965). May (1963) felt that there is a period, a pause, between a stimulus and its response during which the person can consider alternatives and choose the one most viable for the situation. The middle school years are comprised of many stimulus, pause and response situations that permit student and counselor interactions for examination of alternatives.

Guidance and counseling services have been recognized as important parts of the school program during the middle school years. Conant (1960) wrote that guidance specialists could provide junior high students with help in personal, social, and academic areas. A general goal of guidance as described by Humphreys and Traxler (1954) was to assist the individual to live a well balanced physical, mental, emotional, and social life. Johnson, Busacker, and Bowman (1961) indicated that counseling at the junior high level was a process to help students identify and accept problems and to develop action plans to deal with them. Dinkmeyer and Owens (1969)
felt that a nonspecific goal of counseling to be the facilitation of the total development of the individual.

The above statements make no distinctions between regular, gifted, or retarded students. Guidance services should be available to all students regardless of intellectual capacity. Davis (1958) wrote that gifted, normal, and handicapped children have similar guidance needs and the counselor has a responsibility to all students. However, counseling services for gifted and retarded students are often restricted to identification and placement. Wilson (1973) wrote that counselors are inadequately prepared to meet the needs of exceptional children and feel unequipped to counsel them.

Stoumbis and Howard (1969) discussed the various school programs during the middle school years but gave minimal attention to guidance and counseling services. Exceptional children were completely ignored. With the extensive interest, special program funding, and national organizations for both EMR and GIF children, it might have been expected that specific guidance needs of these children would be thoroughly investigated. Dunn (1973) in his lengthily review of EMR children and Martinson (1973) in her review of cognitively superior children discussed the educational needs of these populations but included nothing about counseling services. Other writers (Wiest, 1955; Fine, 1969; Mann, Beaber, Jacobson, 1969; Gowan,
1971) indicate that the literature in counseling with EMR and GIF students at the middle school level is sparse.

**Educable Mentally Retarded Students**

**Characteristics of EMR Children**

The general characteristics of EMR students are in some ways similar and in other ways different from regular and gifted students. Sarason wrote

> Perhaps the most satisfactory point of view is to regard the mentally retarded group as consisting largely of essentially normal people whose output of mental ability places them at the lower end of a distribution of normal traits. (1955, p. 441)

This opinion is reiterated by Goldstein and Seigle (1971) who wrote that EMR students learn the same way, through experience, and using imitation, reasoning, and generalization as other students do. The differences come in terms of rate and degree which are slower and less for EMR students. Due to a lower level of abstraction ability and general comprehension EMR students have a shorter attention span and a consequent proclivity for a lower tolerance of ambiguity and frustration.

The farther removed an example is from the concrete situation the more difficulty EMR students have in learning
that example. The more abstract the learning is the greater is the chance of misunderstanding and the longer the example takes to be learned (Kirk, 1972).

The rate at which the EMR student learns has a much closer relationship with mental age than with chronological age (Kirk, 1972). School work is learned slower and with greater difficulty for the EMR student. The potential ceiling of learning is significantly lower than with regular students. Because learning and academic expectations in the school setting are usually geared to chronological age the EMR student becomes increasingly frustrated if academic potential is not recognized and realistic expectations developed. Inability to progress at an expected, normal rate contributes to his frustration (Kirk, 1972).

Weber (1963) indicated that the mentally retarded may have less physical stamina, more speech defects, and be more subject to physical illness than normal children. There can be as much variation, however, in the mentally retarded as in the normal population. The sensory modalities of vision and hearing of EMR students are usually within the normal range. Kirk (1972) and Goldstein and Seigle (1971) also indicate that physical characteristics of EMR students are usually within the normal range. Physical differences that do exist may result from cultural characteristics as much as from the
level of mental ability. Intelligence may play a role in physique through indirect means such as lack of information and understanding about nutrition and less attention to minor illness which may have a mildly cumulative effect. There does not appear to be a genetic relationship between physical and mental development unless there is a definite physical syndrome such as Down's, Klinefelter's, or Turner's.

Charles (1963), in a follow-up of the original Baller study with 206 mental defectives (Binet IQ less than 70), found that the death rate of this population, at age 42, was 15 percent, only slightly higher than the national average. However, by age 56 over one third of the original population was dead (Baller, Charles, and Miller, 1967).

Excluding the subjects who had been institutionalized, the marriage rate for the population in Baller's study was 84 percent with a divorce rate of 21 percent. In comparison, Terman's study of genius indicated a marriage rate of 84 percent and a divorce rate of 15 percent for that population.

Charles, in his 1963 follow-up, reported that Wechsler Adult Intelligence Scale scores were obtained from a representative sample (n = 24) defectives. The full quotient was 81 with verbal and performance quotients of 72 and 88 respectively. Charles located 73 children of the defectives and found their average IQ to be 95, with a range of 50 to 138.
Davis (1958) wrote that EMR children have the same guidance needs of normal children. He stated that EMR students have the same emotional needs as do normal students. They need to feel loved, to have the security provided by acceptance, and to experience warm and trusting relationships.

Freedman, Kaplan, and Sadock (1972) suggested that even severely retarded persons can develop normal personalities given an accepting and stimulating family and educational environment. However, their self-concept often develops unfavorably due to frequent frustrations, failures, and mistakes.

Play interests and activities closely parallel the mental rather than chronological development of EMR children. This may result in some social ostracism because they may choose younger age mates because of feeling more comfort. Activities with younger children provide EMR students with more positive feedback than activities with age mates where they are unable to participate at an appropriate maturity level. The social maturity of the EMR individual may be more age appropriate as to preferred clothing and hair styles, music likes, and the use of current verbal expressions.

The EMR student, then, may present a complex totality of physical and mental modalities characterized by various levels of development in different areas. These differences are more extreme than in normal children and consequently create
confusion not only in the parents, teachers, and peers, but also within the retarded person. This confusion can lead to increased vulnerability, sensitiveness, and defensive actions with an increase of seemingly inappropriate behavior.

What are the guidance needs of EMR students? Since they are developing at slower rates in emotional and educational areas what types of problems are they experiencing? Will they perceive themselves as having different problems than their age mates? What types of guidance programs can be utilized with this group?

**Guidance Needs of EMR Children**

Much of the research that has been done on the guidance of mentally retarded individuals has been done in institutional settings rather than in public schools. Fine wrote

> The literature and theory related to counseling with retardates is rather sparse and most of the reported studies deal with moderately retarded, institutionalized children. The literature also reflects a bias against psychotherapy with the mentally retarded. The basic arguments are: (1) the client needs to have the capacity for insight or self-awareness, and the lower the IQ the less evident is this capacity, (2) the client needs to have a fairly high capacity for verbalization and the mentally retarded are frequently limited in verbal skills, and (3) after all of the time and effort one spends with a retardate he is still a retardate; hence time may be more productively spent with a nonretarded child who presumably has more potential as a human being. (1969, p. 257)
The guidance needs of the EMR are as serious as for any other group. Berman (1967) found that over 30 percent of retardates referred to a psychiatrist expressed suicidal ideation. After ventilation of initial anger, they expressed feelings of depression, helplessness, hopelessness, low self-esteem, and rejection by authority figures. Shelton (1968), while indicating that the retarded need psychological help as much as anyone else, wrote "Many psychiatrists tend to shun mental retardation as hopeless or unproductive for their therapeutic talents" (p. 30).

Davis wrote

The educable mentally retarded student must be identified as early as possible, must be trained in emotional control, must be helped to formulate a more realistic self-concept, and must be aided in choosing appropriate educational and vocational goals. (1958, p. 184)

Davis indicated that EMR students are similar to other students in emotional development and have similar needs, but deviate intellectually. Davis called for training in social behavior and character development more than for academic achievement. Davis felt

The counselor should encourage parents and teachers to give lessons and training which are within the abilities of the intellectually subnormal so that he may achieve up to capacity.
Social training and character development are more significant than academic attainment for these children. They will be accepted by society if they are cheerful, willing, and obedient. However, if they lack these qualities of adjustment, they will be shunned and disliked. (1958, p. 185)

Adjustment problems of the EMR appear to be the greatest handicap to a successful, fulfilling life, secondary to retardation, of the mentally retarded. DiMichael and Terwilliger (1953) asked rehabilitation counselors about the characteristics of the retarded that stood in the way of successful adaptation to independent living. Personal and interpersonal problems were the most frequently mentioned. These problems consisted of undesirable personal attitudes, exaggerated opinions about ability and deserved wages, sexual problems, and lack of interest in work.

Roos (1968) wrote that mentally retarded individuals are frequently institutionalized because of social behavior which does not meet the norm of the dominant culture from which they come. He suggested, for the mildly retarded, that learning experiences directed at improving socialization skills would be worthwhile goals for teachers and counselors in public schools.

Rosen and Rosen (1969) emphasized the importance of social skill training for mildly mentally retarded youth
and young adults. They felt that social isolation, often imposed on the retarded, resulted in "ineptness in appropriate social skills, accompanied by emotional difficulties arising from feelings of rejection and deprivation" (p. 52).

Mann, Beaber, and Jacobson (1969) wrote that "in many schools counseling is limited to the normal students, while the special education teacher must do his own counseling" (p. 359). Wiest wrote that

Perusal of the literature reveals that therapy with the retardate has been one of the most thoroughly neglected areas of investigation within the legitimate realm of clinical psychology. There is a paucity of research and little more theoretical material. (1955, p. 640)

In a study to determine differences in personality patterns between average and below average (IQ 50-80) students, Porter, Collins, and McIver (1965) found some very distinctive features of the retarded group. The EMR group was "emotionally immature, depressed, reserved, critical, aloof, undependable, socially bold, venturesome, impulsive, and obstructive" (p. 462). They also found that these negative patterns increased as intelligence decreased. The personality patterns manifested by this group of retarded subjects were those which society has considered less desirable. Certainly implied by these results is the need for counseling in social skills and personal behavior.
Thorne (1960) felt that mental defectives (IQ up to 75) could learn by rote memory many problem solutions that would be effective in everyday life. He cited an example of a ward matron who acted as a model for an institutionalized woman. The woman eventually became quite competent with ward duties and became a paid staff member of the institution. Thorne felt that environmental characteristics in which EMR students could optimally learn were "friendly, accepting, tolerant, and supportive" (p. 207). These are similar to relationship factors in counseling considered important by some writers (Halkides, 1958).

There are few studies of counseling with EMR students in school settings reported in the literature. Articles, such as the one by Woody and Herr (1965), seem to be common. They wrote about the guidance needs of EMR students in public schools. Four of these needs focused on teachers, parents, other students, and the community. They suggested a direct approach with EMR students to help them accept their capacities.

Fine (1969) attempted to conduct group counseling with five EMR (IQ 50-80) students at the middle school level. He used a client-centered approach. After eight sessions he terminated the group due to the school staffs' reaction to the group's unruliness. He suggested that play therapy or
activity therapy might be appropriate for this population.

Cheney and Van Lydegraf (1963) reported the guidance needs, as measured by the MPCL, of 220 seventh grade students matched on intelligence, age, and achievement. The average number of problems checked was 26.6. Girls had more self-centered concerns than boys, and boys had more concerns about school than girls. The authors indicated that the students with the highest number of checked concerns also desired counseling. Would these same concerns differentiate the EMR females from males?

The lack of counseling services extended to EMR students may be due to the factors mentioned by Fine (1969) as well as the self-contained nature of the special class which often places it away from the mainstream of school activities. Another factor might be that EMR teachers have special training and supposedly can facilitate both cognitive and affective aspects of the schooling process.

Self-Concept of EMR Children

The construct of the self as a phenomenological aspect of the individual has received considerable research attention in the past 30 years (Wylie, 1961; Purkey, 1970; Ziller, 1973). Many correlational studies have been conducted and the reciprocal effects of self-concept and achievement have been demonstrated (Purkey, 1970). Experimental studies
(Hardy, 1966; Wink, 1963) illustrated that self-concept was basic to achievement. Studies to change the self-concept (Culbertson, 1972) have been reported with no emphasis on problems or needs of the students. How is self-concept related to perceived problems? What effects would counseling have on self-concept if specific problems were the focus of the counselor intervention?

Snyder (1966) correlated the self-attitudes, personality adjustment, and anxiety in a group of 170 mentally retarded (IQ 50-79) children of junior and senior high school age (14-11 - 18-11). He found that there was a significant difference between high and low achieving students on personality adjustment as measured by the California Test of Personality. Anxiety and self-concept were also differentiating factors between high and low achieving students. The total group of 170 students had lower personality adjustment scores on the California Test of Personality than did students with average IQ's.

Gill and Messina (1973) investigated the self-concept of three groups: (1) students with specific learning disabilities (no IQ stated) with a mean age of 9.7; (2) students with a mean IQ of 143 and a mean age of 10.8; and (3) educable mentally retarded students (IQ 50-75) with a mean age of 14.4. Coopersmith's Self-Esteem Inventory and Waetjen's
Self-Concept Test were used to measure self-esteem. The EMR students had the lowest self-concepts of the three groups. Jones (1972) reported at length on the stigma of being in special classes. His studies indicated that a significant majority of high school students will lie about their special class placement. His subjects identified themselves as being in regular classes and doing regular work. Many felt social pressures against special class placement because of the attitudes of regular students. Students in special classes were regarded as "dumb, dumb bunny, dum-dum, retard, Z, eddie, and dodo" (p. 562). The positive effect on the self-concept under these conditions is questionable.

Meyerowitz (1962) reported the increase in self-derogatory statements which occurred upon placement in a special class for educable mentally handicapped (IQ 60-85). His experimental and control groups came from children entering first grade. Half the group was placed in special education classes (experimental group), while the other half was placed in regular classes. At the end of the year there was a significant difference in the derogatory statements between the two groups with the special class students receiving the most derogatory scores.

Warner, Thrapp, and Walsh (1973) interviewed 369 EMR students in the age range of eight to seventeen. Sixty-one
percent said that they liked being in special classes.

Goldman and May (1972) reported a study with 200 subjects. The sample consisted of 100 educable mentally retarded and 100 regular students. The groups were matched on age and socio-economic variables. The group of students in EMR classes were found to have lower self-concepts than the students in regular classes. Another finding of interest had to do with the length of time spent in EMR classes. The authors found that children who were new to EMR classes as well as those who had been in EMR classes for three years had the lower self-concepts of the two groups. Students who had been in EMR classes for one or two years had a higher self-concept than students just entering EMR classes or who had been there for three years. This variability was not found in the regular class group.

Ensher (1973) reported distressing observations in an article on structured observations (rating scales) of educable special class students and teachers. Over half the teachers

...variously manifested behaviors of over-protection, overwhelming assistance, excessive control, impatience, incessant dwelling on weaknesses rather than strengths, and conspicuously absent expectations for positive change with children in their classes. (1973, p. 40)
While Ensher did not comment on the effect of these attitudes and behaviors on the students' self-concept, it seems clear that these are less than facilitative conditions for developing or maintaining positive self-regard. She did comment on the behavior of the students in regard to "levels of hyperactivity and distractibility and evidence of frustration and anxiety" (p. 40). She suggested that isolation and self-contained settings tended to maintain the status quo of these situations. In addition, Ensher wrote that

At present, a large portion of the literature on mental retardation has been directed toward determinations of ways in which children thus classified differ from groups of nonretarded children. An increasing focus of research and educational practice on wide dimensions of their behavior, performance, and development may begin to reveal that the majority of children with learning and emotional difficulties share more commonalities with, than differences from, children who are conceived to learn normally. (1973, p. 41)

That retarded students (IQ 50-80) in both institutional and public school settings are aware of and sensitive to other people's feelings toward them was shown in a study by Guthrie, Butler, and Gorlow (1961). Their study revealed four factors which were characteristic of a retarded group's personal feelings regarding their social behavior. These factors were "I act hatefully, I am shy and weak, I am
useless, and nobody likes me" (p. 228). Three positive values seemed characteristic of another group of retardates in their study: "there's nothing wrong with me, I do as well as others do, I don't give trouble" (p. 227). The results indicated that the acceptance of negative attitudes was independent of the acceptance of positive attitudes. They suggested that counseling with retardates should take into consideration these basic differences in positive and negative perceptions. They felt that the effects of counseling could be enhanced by having subjects with similar perceptions in the same counseling groups. Different approaches would be used with the different groups.

In a study of retarded students (IQ 62-78) Snyder, Jefferson, and Strauss (1965) found that reading level was significantly correlated to self-concept as measured by the California Test of Personality. The authors felt that achievement was "heavily dependent upon the possession of a relatively good self-concept with its concomitant adaptive defenses" (p. 17). Snyder (1966) postulated these defenses, which reduce self-concept and reading level, to be "withdrawal, avoidant and not trying maneuvers which serve to aid the retardate with a poor self-concept to avoid immediate failure" (p. 38).
Humes, Adamczyk, and Myco (1969) used a group counseling approach to investigate counseling effectiveness in raising self-concept as measured by The Way I Feel About Myself Scale and the Self-Concept Scale and in improved class adjustment by a teacher rating scale. The California Test of Personality was also used. The subjects were special class students (IQ 53-77). Counseling was for one hour per week for 12 weeks. The evaluation showed no significant change in self-concept but did show significant changes in a positive direction on the behavior rating scale and the personality inventory.

**Self-Concept and Achievement of EMR Children**

Purkey commented on research with the self-concept and achievement of nonretarded children. He wrote

> Although the data do not provide clearcut evidence about which comes first - a positive self-concept or scholastic success, a negative self-concept or scholastic failure - it does stress a strong reciprocal relationship and gives us reason to assume that enhancing the self-concept is a vital influence in improving academic performance. (1970, p. 27)

Wink (1963) and Hardy (1966) conducted experimental rather than descriptive studies to determine the effects of self-concept on learning. Wink (1963) used retarded females (IQ 45-80) in an institutional setting to determine the
effects of self-concept on learning and the effects of positive and negative reinforcement on learning. He divided the subjects into two groups of high self-concept and low self-concept. Self-concept was measured by the Laurelton Self-Attitude Scale. He reported that the high self-concept subjects learned significantly better (faster and with fewer errors) than did the low self-concept subjects. Learning was measured by a researcher developed instrument. Positive reinforcement facilitated learning to a significant degree.

Hardy (1966) also used the Laurelton Self-Attitude Scale and a researcher developed learning task with retardates (IQ 50-80). He found that self-concept "was significantly related to achievement of a controlled learning task" (p. 1657). Subjects with high positive self-concepts learned faster than subjects with low positive self-concepts. Hardy found this difference to be independent of IQ and chronological age.

Gorlow, Butler, and Guthrie (1963) investigated the relationship between self-attitudes of retardates (IQ 50-80) and their "motivation for and acceptance of the learning experience to which they are exposed" (p. 549). They found that the reading and arithmetic scores were higher in the group with a higher self-concept as measured by the Laurelton Self-Attitude Scale. This finding held true even when the
effects of intelligence were partialled out. Self-concept was the critical variable for achievement.

McCowan (1968) reported on brief contact counseling with low achieving (defined as repeating a grade) and low ability students (IQ 80-95). He matched the students on grade level and IQ and assigned them randomly to experimental and control groups. He met individually with each student in the experimental group for a ten-minute period twice a week. These brief contact sessions were structured, directive, and relatively pragmatic with emphasis on monitoring the subjects' academic progress. He reported significant results in three areas: (1) achievement level increased over the school year, (2) attendance at school improved, and (3) students in the experimental group participated to a greater degree in other counseling sessions.

In a study to examine the influence on achievement of group and individual counseling on children with personal and academic problems, Lodato, Sokoloff, and Schwartz (1964) worked with slow learners (defined as students with school related problems). One group of 11 students was in a special, seventh - eighth grade class and participated in group counseling for an unspecified period of time. The authors used teacher ratings on behavior and attitude scales to evaluate progress. Positive changes were reported in academic
achievement, school attendance, integration into regular classrooms, and improved self-concept. Karen Machover participated in the study and evaluated the self-concept through pre- and post-treatment figure drawings.

Mann, Beaber, and Jacobson (1969) did a study with 36 EMR students (IQ 56-80) divided into control and experimental groups, 18 students to each group. Subgroups of six students in the experimental group met for semi-structured sessions over a 12-week period in which a specific topic was discussed each week. Changed significantly in positive directions were reduction of anxiety and improvement in deportment, reading, and arithmetic. Results indicated that self-concept could be raised significantly through group counseling with these subjects. Self-concept was measured by Lipsitt's Self-Concept Scale and The Way I Feel About Myself Scale.

The question of academic achievement in special class environments was approached indirectly by Schurr, Towne, and Joiner (1972). They felt that students showing a decrease in self-concept accompanying placement in special classes was not an important variable. The important consideration, they felt, was how the self-concept of academic ability (SCA) would be effected by special class placement. They showed that the SCA of educable mentally retarded students actually improved, over time, after EMR class placement. Other
findings indicated that EMR students who returned to regular classes showed a drop in SCA. The authors did not measure the actual relationship between academic achievement and the self-concept of academic ability.

**EMR Children's Perceptions of Guidance Services**

The works of Rogers (1951), Whitehorn and Betz (1954), Heine (1950), and Fiedler (1951) along with Carkhuff and Berenson (1967) have identified counselor attributes and therapeutic conditions that relate to positive counselor and client interactions. Perceived attributes of facilitative counselors include trust and confidence in the counselor who views the problems of the individual in the perceptual context of that individual. Clients feel the counselor understands. Problems are clarified, but clients make their own decisions. The counselor takes an active part in the process but does not become overly or ego involved.

Counselors create perceptions by the functions they perform and the manner in which they perform them (Rippee, Hanvey, Parker, 1965). Students can form attitudes about counselors and assign attributes to them without personal contacts. The role in which counselors are seen may determine the type of interactions they have with students (Dahlem, 1969).
Strowig and Sheets (1967) investigated the change in student perceptions of high school deans as their role was changed to one of counseling. As deans, the staff members had disciplinary and administrative authority. This role was dropped as they became counselors. The students reported more positive attitudes toward the deans than they did about the counselors. The authors felt this might have been the result of the confusion that accompanied the role change. They also wondered if the loss of status and power which was part of the dean image lessened the opinions held by the students. The students did report satisfaction with the personal-social, vocational, and educational counseling they received.

Gibson (1962) reported that high school students viewed counselors as disciplinarians, administrators, and part-time librarians. The students in his study preferred to be counseled by fellow students.

Student perceptions of high school counselor roles were reported by Grant (1954) to be, in order of decreasing importance, educational planning, vocational planning, and personal-emotional counseling. This same ranking was reported by Winslow (1955) in his study with 146 high school students.
The opinions and attitudes of EMR students toward counselors have not been investigated. The studies available in the literature were conducted with regular students, usually in high school. What are the attitudes of middle school EMR students about counselors? What type of concerns, if any, would they view as appropriate for discussion with a school counselor? The lack of research data in this area suggests a need for this study.

Gifted Children

Characteristics of GIF Children

The characteristics of gifted children and adults have been thoroughly described by Terman and Oden (1959) in the study of about 1500 children identified in 1920 and 1921. Seventy percent of the subjects in this study had IQ's of over 140 on the Binet. Thirty percent of this group was identified by the Terman Group Test and had IQ's of 135 or above. The mean IQ's of the two groups were 151 and 142.6 respectively. This longitudinal study is considered by Freehill (1961) and Kirk (1972) to be the magnus opus of studies with the gifted.

Freehill (1961) wrote about the views of the gifted or genuises described in past literature. The views that genuises were abnormal, pathological, imbalanced intellectually, degenerate, unstable, maladjusted, and characterized
by emaciation, brain lesions, stammering, and sterility have been fairly well extinguished. The work of Terman and Oden (1959) quite explicitly demonstrated the dangers of making generalizations from small and biased samples.

The physical characteristics of GIF children tend generally to be superior to normal children. At birth the weight of the gifted population averages three-fourths of a pound heavier, they sleep more, and they walk and talk one month and three-and-a-half months earlier, respectively, than normals (Terman and Oden, 1947).

As school children the GIF students had about the same incidence of childhood diseases and visual defects as did normal children. Academically the gifted were ahead of their age mates by one to three years (Terman and Oden, 1947).

Mental characteristics are beyond those of age mates between gifted and normals, but physical skills are closer to those students with similar chronological ages. The ability to adapt to new situations is apparent in the gifted and they are more comfortable in a variety of situations than same age students. This is one of the reasons GIF students can successfully interact in classes for older children.

Terman and Oden (1947) wrote that the GIF are characterized by:
...quick understanding, insatiable curiosity, extensive information, retentive memory, large vocabulary, and unusual interests in such things as number relations, atlases, and encyclopedias. (1947, p. 25)

Educational characteristics of GIF students include the ability to read before going to school in almost half the population, 43 percent. GIF children learn at rates much quicker than normals although they are not free of learning handicaps. The abilities to abstract, to generalize, and to synthesize generally develop earlier and at a faster rate in GIF than in normals. Repetition and concreteness are not as necessary in learning for the GIF as compared to normals or EMR. Memory functions are more highly developed and useable in regard to short and long term associations. The vocabulary level and reasoning abilities are well beyond those of age mates of normal intelligence.

As would be expected, the majority of GIF students graduated from college (70 percent). Over 60 percent of these graduates returned to graduate school. Occupational GIF students were eight times as frequent in professional positions as the normal population.

The marriage rate for the gifted population was 84 percent and the divorce rate 14 percent for men and 16 percent for women. The fertility rate of the gifted in 1945 was
1.52. The fertility of the EMR group reported by Charles (1963) was 2.03. The national rate was 2.62.

The children of the gifted population who had been administered IQ tests, 384 in 1945, achieved a mean IQ of 127.7. In 1955 about 1500 children had been tested and the mean IQ was found to be 132.7.

The emotional development of GIF students is dependent upon factors similar to other groups. The need for love, trust, security, and belongingness does not decrease as intelligence increases. A stable self-concept is an important factor in the emotional adjustment of GIF students as well as other children (Strang, 1955).

Children with superior intelligence are often sought out by other children and not regarded as oddballs. Miller (1956) and Gallagher (1958) reported that GIF students were as popular if not more popular than their age mates.

As the subjects in Terman and Oden's (1959) longitudinal study reached middle age the level of mental health was approaching that of the general population. Eighty percent of the subjects were reported to have made satisfactory adjustments; 15 percent showed some maladjustment; and five percent were seriously maladjusted and required hospitalization. Freehill (1961) raised the question as to whether these figures are artifacts of GIF individuals' greater awareness
of the signs of mental illness, their willingness to seek professional help, and their ability to pay for services. The majority of admissions was voluntary and to private mental hospitals.

The gifted population appears to have most everything working in its favor. Highly intelligent, socially accepted and flexible, physically able, and academically advanced, these students would appear to need few guidance services. However, their general advancement in major areas brings them earlier, in relation to their chronological age mates, to developmental tasks and psychosocial stages. Do gifted students have different types of guidance needs at the middle school level than other students? What kinds of guidance services, programs, and units could school counselors and teachers implement for this group? This study will attempt to answer these and related questions.

Guidance Needs of GIF Children

Studies of guidance services for GIF students other than identification are sparse. Gowan (1971) wrote that "Relatively little has been written, and even less research has been done, concerning the specific guidance needs of the gifted" (p. 33). Rothney and Sanborn (1966) said that "a great deal of basic knowledge is still lacking in this area" (p. 698).
Identification of specific areas for counselor intervention with gifted students remains meager. Groth and Holbert (1969) conducted a study to discover unresolved needs in gifted students (IQ 130 and up, ages 10-14) which might have implications for guidance services. They felt that more positive gains could be made in counseling if the counselor knew "which step in the hierarchial needs was the unresolved one" (p. 129). They concluded that even though boys and girls of average and gifted intelligence in the 10-14 year span were essentially at similar levels in hierarchial needs, the gifted were functioning at slightly higher levels but were not problem free. They studied 281 gifted children and did not identify any specific guidance needs in personal, educational, or vocational areas.

Gowan (1968) suggested some rather vague guidelines for counseling the creative person. After discussing the influence of Erikson's eight stages of man (Erikson, 1950) and postulating that depression will follow periods of creativity, Gowan wrote

The creative individual should know that a pause and rest after a creative effort is natural and normal. It need not be a depressive pause; as a part of the natural rhythm it can be as refreshing as sleep after physical love.

Secondly, a child needs to value himself and to have his ideas valued before he can
value others or their ideas. Counselors should therefore help the child build a consistent value system—the child's, not the counselor's. The values a creative child builds may flow from his divergent thinking, and he may not wish to emulate grown-up models. (1968, p. 159)

Gowan continued by saying "guidance for the creative involves the realization that counseling is not just the solving of problems, but a positive process promoting mental health" (p. 161). Gowan (1971) also wrote "The gifted have particular learning needs for information, for understanding, for beauty, truth, and full self-realization" (p. 34). He did not compare this to the needs of educable mentally retarded students.

Torrance (1961) wrote that gifted children have guidance needs of a supportive nature. He reported that in a study of approximately 5,000 children in grades three through six, three characteristics showed up as distinguishing the highly creative from the less creative (the students were matched for sex and intelligence; no criteria were given for differentiating the highly from the less highly creative). Teachers and peers tended to regard the highly creative as having wild or silly ideas which were off the beaten track. Torrance grouped these characteristics under the heading "estrangement" and suggested that these children could profitably utilize a counselor, teacher, or other significant adult from whom they could receive encouragement and understanding.
Garrison and Cunningham (1952), in a study of the personal problems of 294 ninth grade students, reported no significant differences on the total responses on the MPCL between girls and boys. The mean number of responses in this study was 33.4. The greatest number of concerns were reported in the area of School. The second highest area was Relations to People in General for girls and Money, Work, the Future for boys. Boys checked the lowest number of items in Home and Family while girls checked the lowest number in Health and Physical Development.

Perrone, Weiking, and Nagel (1965) reported a study concerned with the counseling needs of various types of bogus students as viewed by seventh and eighth grade pupils (mean IQ was one standard deviation above the national mean on group IQ tests). The pupils were grouped as to high or low number of problems as reported on the MPCL (high number, mean was 53.1; low number, mean was 6.5). The students with high numbers of problems recommended the greatest amount of counseling for female students who were not good looking and were social isolates outside of school. The students with low numbers of problems recommended more counseling for male students who seemed nervous, easily upset, loners, and were teased.
Peer group validation is often difficult for gifted students to attain. According to Gowan (1971) the gifted have their own inner feelings, standards, and expectations, but frequently must compromise these to norms of other groups.

Self-Concept of GIF Children

In a study of the self-concept of elementary school children Trowbridge (1974) used the Self-Esteem Inventory with 3,789 third through sixth grade students. Her findings indicated a significant difference in self-concept, in a negative direction, in those students above the 80th and below the 20th percentile on group tests of intelligence, specifically, the Otis Lennon Mental Ability Test and the Lorge Thorndike Intelligence Test. She felt that the results for the high scorers (above the 80th percentile) might be explained by their perceptions that adults (both parents and teachers) expect too much from them. Approximately ten percent of the Self-Esteem Inventory items relate to adult expectations which may have been internalized by the high scoring students. She did not postulate any explanations for the negative correlation between the low scorers (below 20th percentile) and the significantly lower self-esteem of these students.

That the self-concept may become less important to the individual in favor of the social self and identification
with a group is suggested by Torrance (1971). In a study with high achieving third, fourth, and fifth grade students (n = 250) Torrance found that while 35 percent of third grade students asked for adult help in solving a problem, only 16 percent of the fifth graders sought adult help. Twenty-one percent of the third graders looked to their peers for help while 67 percent of the fifth graders asked peers. Torrance interpreted this to indicate an increase in the need for students to seek consensual validation from peers rather than from adults as they progress through elementary school. Adults were teachers and parents; counselors were not included.

A study showing a decrease in self-concept as students progressed through school was reported by Morse (1964). Using the Self-Esteem Inventory he found that there was a significant drop in self-esteem from the third to the eleventh grade. The social self, however, improved after the third grade, and Morse felt that schools were "more effective in socializing youngsters than in making them secure within themselves" (p. 197).

Jacobs (1971) feels that the tendency of gifted children to reduce their dependence on adults begins in the kindergarten year of school. He analyzed the Rorschach protocols of 20 gifted (IQ 125-144) and 20 control (IQ 97-119) students. He found significant differences on the production of popular
responses between the gifted and regular students. He considered the decrease in production of popular responses in the gifted children reflective of their developing reliance on self rather than others.

Doughty (1969) studied the self-concepts of students identified as gifted (IQ 120 and up), identified as gifted but actually not (IQ 119 and below), and those students not identified as gifted but gifted. The students not identified as gifted had lower self-concepts than the other two groups on the Spaulding Self-Concept Inventory.

Culbertson (1972) studied the effects of counseling on self-concept. He reported a study with 90 fourth, fifth, and sixth grade students in enrichment programs for mentally gifted minors. A control group and two experimental groups were randomly selected. One experimental group received group counseling; members of the other experimental group received individual counseling; and the control group received no treatment. The Piers-Harris Children's Self-Concept Scale was administered pre- and post-treatment. At the end of the eight-week experimental period there was no significant difference on self-concept between any of the groups. Culbertson identified no particular counseling needs for any of the groups.
Self-Concept and Achievement of GIF Children

In a study to investigate the relationships of ability level, achievement, and self-esteem, Kunce, Getsinger, and Miller (1972) examined the results from a modified form of the Self-Esteem Inventory, the Differential Aptitude Test, and the academic grades of 247 ninth grade students. The students comprised the entire ninth grade class in a small midwestern city. They found a small but significant positive correlation between the three criteria variables. However, due to the low correlations (.16 to .20) they drew no conclusions that raising the self-concept would have any effect on any of the other two variables.

In a partial review of the literature of the effects of counseling with underachieving gifted students, Wyne and Skjei (1970) reported conflicting results on achievement. They felt that counseling outcomes should be broadened to include "improved self-concept, reduced level of anxiety, and improved classroom behavior" (p. 833).

Ralph, Goldberg, and Passow (1966) believe that it is essential to reverse the trend of gifted underachievers before they reach high school. They indicated that behavior patterns leading to underachievement begin to crystallize long before high school and attempts to change these patterns at the high school level have been unsuccessful.
In a study to determine the effects of counseling on the grade point average of underachieving gifted high school students, Finney and Van Dalsem (1969) conducted a two-year study. Group counseling on a weekly basis was carried out for the two year period. The results showed that counseling had no significant effect on grade point average. However, on the California Personality Inventory and teacher rating scales, significant changes in positive directions were found on personality factors between the experimental and control groups.

**GIF Children's Perceptions of Guidance Services**

This writer could find only one study even indirectly connected to perceptions held by gifted students of guidance services. Beals and Simmons (1962) conducted a study to determine the guidance needs of gifted high school students. They studied 247 high school students with minimum IQ's of 140 on the California Test of Mental Maturity (either verbal or nonverbal score). They found that for educational planning, both present and future, 64 percent of the students received the most help from their parents, 17 percent from counselors, and 11 percent from teachers. The parents, often highly trained themselves, felt "counselors and teachers should give more guidance in aiding young people to develop a life
philosophy and in establishing the values needed in a democ­
ocratic society" (p. 715). The students were willing to
discuss educational and vocational plans with counselors, but
they were unsure if they would discuss personal problems with
them.

It appears that there is little known about how gifted
students perceive the guidance services they have received
or how they perceive school counselors.

Summary

Studies of the guidance needs and the self-concepts of
educable mentally retarded students has been a relatively
recent development in education. The EMR student has been
regarded as an inappropriate candidate for counseling.
Studies that have been done, however, tend to show that
counseling is effective in dealing with problems faced by
EMR students. These problems are basically the same as faced
by other students.

The effect of special class placement on the overall
functioning of EMR students remains controversial. Inclusion
programs, "mainstreaming" (Lord, 1974), and resource rooms
may eventually provide adequate services which will eliminate
the need for special class placement.

Counselors can provide counseling services to EMR stu-
dents with confidence that their efforts will be helpful to
the students. Research is needed, however, to explore ways in which counseling services can be utilized by this group.

The literature on the guidance needs of gifted students appears to be of a general nature with little specificity as to actual areas where counselor interventions would be most effective. Reported studies tend to concentrate on the relationship of self-concept to underachievement and self-concept differences between gifted and nongifted students. Perceptions of guidance services received by gifted students are almost unknown. Exploratory research is needed to evaluate the feasibility of providing guidance services to this group.
CHAPTER III

DESIGN OF THE STUDY

This study deals with the perceived problems of EMR and GIF middle school students. The study investigated the relationship between self-concept and perceived problems, the number of counselor contacts by the subjects, and the perceptions EMR and GIF students have about counselors. It also investigated the types of problems students view as appropriate for discussion with a counselor.

Populations

The EMR and GIF populations for this study were drawn from six middle schools in Alachua County, Florida. Alachua County is in the north central part of Florida and has an estimated population of 124,129. Gainesville, the county seat, is the location of the University of Florida.

Four of the middle schools are in an urban area and two are in rural areas, with 4895 students in sixth, seventh, and eighth grades. The EMR students in these six schools total 236. GIF students total 257. These two populations total 493 and were the subjects used in this study. The
number of students in EMR and GIF classes listed by school can be found in Table 1.

Criterion Instruments

**Modified Mooney Problem Check List**

The Mooney Problem Check List (MPCL), junior high school form (Mooney and Gordon, 1950), is a 210 item instrument. Students respond by checking those items about which they are concerned or feel are problems. The 210 items are divided into seven areas of 30 items each. The seven areas are:

1. Health and Physical Development
2. School
3. Home and Family
4. Money, Work, the Future
5. Boy and Girl Relations
6. Relations to People in General
7. Self-Centered Concerns

Reliability studies with the MPCL have yielded correlations in the .90 to .98 range. Gordon (1950) reported a study in which a test-retest reliability of .93 was found. He administered the check list to 116 college students on two occasions nine days apart. Mooney and Gordon (1950) reported a college study with follow-ups from one to ten
Table 1
Student Populations at Middle Schools
by EMR and GIF Classification

<table>
<thead>
<tr>
<th>School</th>
<th>Total Subjects in School</th>
<th>EMR</th>
<th>GIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Clark</td>
<td>176</td>
<td>39</td>
<td>137</td>
</tr>
<tr>
<td>Howard Bishop</td>
<td>99</td>
<td>45</td>
<td>54</td>
</tr>
<tr>
<td>Lincoln</td>
<td>58</td>
<td>58</td>
<td>*</td>
</tr>
<tr>
<td>Mebane</td>
<td>31</td>
<td>31</td>
<td>*</td>
</tr>
<tr>
<td>Spring Hill</td>
<td>19</td>
<td>19</td>
<td>*</td>
</tr>
<tr>
<td>Westwood</td>
<td>110</td>
<td>44</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>493</td>
<td>236</td>
<td>257</td>
</tr>
</tbody>
</table>

*No program
weeks after the initial administration. Rank order correlations ranged from .90 to .98.

McIntyre (1953) reported a validity study using seven problem areas from the high school form. He predicted, from the responses in these areas, seven types of problems the students would be experiencing and could be verified from school records. Six of the seven predictions from the MPCL to the school records were accurate at the .05 level of significance.

The modified form of the Mooney Problem Check List (MMPCL) consists of the 105 even numbered items from the junior high school form. The same seven areas are represented with 15 items drawn from each area. A copy of this instrument is in Appendix A. Permission to reproduce the even numbered items was obtained from the Psychological Corporation.

Scouller (1975) reported a study of the split-half reliability of the MPCL. The subjects were 18 sixth, 17 seventh, and 15 eighth grade students at an urban middle school in Gainesville, Florida. Three teachers administered the MPCL to their classroom groups. The students were instructed not to sign their names.

The results were split on an even/odd basis and analyzed using the Pearson product-moment coefficient of correlation. The even/odd reliability of the total score from the MPCL was
.93 (n = 50). Because the reliability of the total score does not reflect the reliability of the seven areas, reliabilities were calculated for each area. These reliabilities are reported in Table 2.

Best (1970) indicated reliabilities of .60 to .80 are substantial or marked and that reliabilities from .81 to 1.00 are high to very high. For survey purposes 15 items from each of the seven areas would appear to be an adequate sample of the self-perceived guidance needs of middle school students.

**Piers-Harris Children's Self-Concept Scale (CSCS)**

The CSCS (Piers, 1969) consists of 80 declarative sentences to which the subjects respond yes or no. There are 36 positively worded and 44 negatively worded sentences. The use of "don't" statements is avoided because of a tendency for double negatives to confuse young children (Piers and Harris, 1964). The 80 item questionnaire was developed from an original pool of 164 statements. Subsequent refinements have reduced this to the present length scale.

Wing (1969), in a study with 244 fifth grade students, established a test-retest reliability of .77 over a four month period. Piers and Harris (1964) reported Kuder-Richardson Formula 21 coefficients ranging from .78 for tenth grade girls to .93 for third grade boys. Spearman-Brown
Table 2
Split-Half Reliability of Area Scores of the Mooney Problem Check List

<table>
<thead>
<tr>
<th>Area</th>
<th>Split-Half Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Physical Development</td>
<td>.66</td>
</tr>
<tr>
<td>School</td>
<td>.80</td>
</tr>
<tr>
<td>Home and Family</td>
<td>.81</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>.78</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>.66</td>
</tr>
<tr>
<td>Relations to People in General</td>
<td>.85</td>
</tr>
<tr>
<td>Self-Centered Concerns</td>
<td>.75</td>
</tr>
</tbody>
</table>

Pearson r., n = 50
coefficients were listed at .87 for tenth grade students and .90 for sixth grade students.

Using 98 special education students, ages 12 to 16 (IQ not given), Mayer (1966) compared the CSCS with the Lipsitt Children's Self-Concept Scale. He found a Pearson r of .68 between the two instruments.

Counseling Service Questionnaire (CSQ)

The CSQ is an instrument developed by the researcher which has three areas of inquiry. These are:

1. The number of student and counselor contacts.
2. Problem areas perceived as appropriate for counseling.
3. The attributes of counselors as perceived by students.

The number of student and counselor contacts is indicated on a number line from 0 to 10. Students check the number that corresponds to the number of contacts they have had with the counselor during the present school year.

The areas perceived as appropriate for counseling are the seven areas from the MPCL. The student is instructed to check those areas felt to be appropriate for discussion with a counselor.
The perceived attributes of counselors as perceived by students are measured by an adjective check list comprised of six positive and six negative indicators. The student is instructed to check those attributes felt to describe a counselor. A copy of the instrument is in Appendix B.

Data Collection

The data were collected in the Spring of 1975. All instruments were administered in classroom groups within a one-week period. The time required for the students to complete the instruments was about one hour. Administrative procedures were as follows:

1. A packet containing the criterion instruments (Modified Mooney Problem Check List, Piers-Harris Children's Self-Concept Scale, Counseling Service Questionnaire) was distributed to the 15 EMR and GIF teachers in each school on May 6, 1975.

2. On May 7, 1975, the teachers distributed the three instruments to each student in their classrooms.

3. The students recorded their age, sex, and grade on all answer sheets but did not sign their names.

4. The teachers read the instructions and each of the items. They proceeded in this order:
   a. Modified Mooney Problem Check List,
   b. Piers-Harris Children's Self-Concept Scale,
c. Counseling Service Questionnaire.

5. The students responded to the instruments per instructions.

6. The teachers collected the three instruments.

7. The teachers marked an "X" on the instruments completed by those students who were in class but did not meet the criterion for EMR or GIF class placement and the population criteria for this study.

8. All instruments were then returned to the original packets.

9. The investigator collected the packets on May 8, 1975.

10. The investigator excluded from the study all instruments completed by students who did not meet EMR or GIF class placement criterion.

11. The data were analyzed and hypotheses tested.

Null Hypotheses

There were three null hypotheses tested in this study.

I. There is no significant difference between middle school EMR and GIF students, middle school female and male EMR and GIF students, and middle school low and high perceived problem EMR and GIF students on
   a. guidance needs from the MMPCL,
b. self-concept from the CSCS,
c. the number of counselor contacts from the CSQ,
d. perceived counselor attributes from the CSQ.

II. There is no significant difference between middle school EMR and GIF students on guidance needs based on the total number of responses to the MMPCL.

III. There is no significant difference on problems viewed as appropriate for discussion with a counselor as measured by the CSQ between
a. EMR and GIF students,
b. female and male students,
c. low and high problem students.

Analysis of the Data

The responses obtained from the Modified Mooney Problem Check List, the Piers-Harris Children's Self-Concept Scale, and the Counseling Service Questionnaire were analyzed by multivariate analysis of variance (Anderson, 1958). The appropriate multivariate computer program from the Statistical Analysis System (Barr and Goodnight, 1972) was utilized to perform the analysis. The level of significance was set at the .05 level of confidence. Where significant differences existed an analysis of variance procedure was used to
determine the differences.

The means of the EMR and GIF groups on the total number of responses on the MMPCL were analyzed using a t test (Mendenhall, 1975). The level of significance was set at the .05 level of confidence.

A chi square test (Mendenhall, 1975) was used to test the responses to the seven problem areas from the CSQ. The level of significance was set at the .05 level of confidence.
CHAPTER IV

RESULTS OF THE STUDY

Chapter IV reports the results of the study and is divided into main areas by Null Hypotheses I, II, and III. Hypothesis I deals with similarities and differences between EMR and GIF children on perceived problems, self-concept, the number of counselor contacts, and perceived attributes of the counselor. Hypothesis II examines the difference in the total number of guidance needs between EMR and GIF children. Hypothesis III examines the relationship between the reported problems of EMR and GIF children and their willingness to discuss these problems.

A multivariate analysis of variance (MANOVA) was used to test the first hypothesis. MANOVA uses a multiple regression format to simultaneously test all independent and dependent variables. The independent variables were status, sex, and low/high problem perception while the dependent variables were perceived problem areas, self-concept, counselor contacts, and counselor attributes. Each variable contributed a certain amount of variance which was computed conjointly with the variances from all other variables.
Separate MANOVA's were computed for each independent variable and for each possible two and three way interaction.

Also reported in Chapter IV is a correlational analysis concerned with the interrelationships between the total number of perceived problems, self-concept, counselor contacts, and counselor attributes.

**Null Hypothesis I**

The first null hypothesis was

There is no significant difference between middle school EMR and GIF students, middle school female and male EMR and GIF students, and middle school low and high perceived problem EMR and GIF students on

a. guidance needs from the MMPCL,
b. self-concept from the CSCS,
c. the number of counselor contacts from the CSQ,
d. perceived counselor attributes from the CSQ.

This hypothesis was concerned with the differences between the three independent variables of EMR/GIF (status), female/male (sex), and low/high perceived problems (problem perception) on the seven problem areas from the MMPCL, the self-concept from the CSCS, and the number of counselor contacts and perceived counselor attributes from the CSQ (ten dependent variables). A MANOVA (Barr and Goodnight,
1972) was performed on each of the independent variables with the ten dependent variables. The results are summarized in Table 3, and reported below.

Analysis of Independent Variables

**Status.** The first independent variable, status, was analyzed by MANOVA. The F value (38.95) was significant at the .0001 level (Table 3) and the hypothesis of no significant differences between EMR/GIF students was rejected. There were significant differences on the responses to the ten dependent variables by EMR and GIF students.

**Sex.** The MANOVA procedure used to analyze the independent variable sex and the ten dependent variables yielded an F value of 3.58 which was significant at the .0003 level (Table 3). The null hypothesis was rejected. There was a significant difference between male/female students due to the dependent variables.

**Problem Perception.** The third independent variable of problem perception, whether a student had low or high perceived problems, was analyzed by MANOVA. The F value was 19.30 (Table 3) which was significant at the .0001 level. There were significant differences between low/high students on the ten dependent variables and the null hypothesis was rejected.
Table 3
Multivariate Analysis of Variance for Status, Sex, and Problem Perception

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>F Value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR and GIF students</td>
<td>38.95</td>
<td>0.0001</td>
</tr>
<tr>
<td>Male and Female students</td>
<td>3.58</td>
<td>0.0003</td>
</tr>
<tr>
<td>Low and High Problem students</td>
<td>19.30</td>
<td>0.0001</td>
</tr>
</tbody>
</table>
Analysis of Interactions

Because there were significant differences on each of the independent variables, a further MANOVA was run to test for all possible interactions between those variables.

Status with Sex. This interaction was tested by MANOVA and the resultant F value of 1.81 was not significant at the .05 level (Table 4). There was no significant interaction between status and sex on the ten dependent variables.

Status with Problem Perception. The MANOVA test for the interaction of status with perception on the ten dependent variables yielded an F value of 3.84 (Table 4) which was significant at the .0001 level. There was a significant interaction between status and perception on the ten dependent variables.

Sex with Problem Perception. An F value of 2.07 (Table 4) was obtained from the MANOVA technique and was significant at the .0044 level for the interaction of sex with perception on the ten dependent variables.

Status with Sex with Problem Perception. This three-way interaction was analyzed by a MANOVA procedure and the results are summarized in Table 4. The F value was 1.40 which was not significant at the .05 level. There was no significant interaction between status, sex, and perception due to the ten dependent variables.
Table 4

Multivariate Analysis of Variance for Interaction Effects Between Status, Sex, and Problem Perception

<table>
<thead>
<tr>
<th>Interactions</th>
<th>F Value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR/GIF x Male/Female</td>
<td>1.81</td>
<td>0.0581</td>
</tr>
<tr>
<td>EMR/GIF x Low/High Problems</td>
<td>3.84</td>
<td>0.0001</td>
</tr>
<tr>
<td>Male/Female x Low/High Problems</td>
<td>2.07</td>
<td>0.0044</td>
</tr>
<tr>
<td>EMR/GIF x Male/Female x Low/High Problems</td>
<td>1.40</td>
<td>0.1164</td>
</tr>
</tbody>
</table>
### Table 5
Summary of Analysis of Variance for EMR and GIF Vs. Low and High Numbers of Perceived Problems

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Family</td>
<td>1</td>
<td>12.847</td>
<td>8.75</td>
<td>.0004</td>
</tr>
<tr>
<td>Self-Centered Concerns</td>
<td>1</td>
<td>13.138</td>
<td>12.94</td>
<td>.0001</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>1</td>
<td>9.267</td>
<td>5.51</td>
<td>.0048</td>
</tr>
<tr>
<td>School</td>
<td>1</td>
<td>8.386</td>
<td>8.82</td>
<td>.0004</td>
</tr>
<tr>
<td>Health and Phys. Develop.</td>
<td>1</td>
<td>8.405</td>
<td>8.11</td>
<td>.0006</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>1</td>
<td>9.265</td>
<td>7.75</td>
<td>.0008</td>
</tr>
<tr>
<td>Relations to People</td>
<td>1</td>
<td>9.266</td>
<td>4.54</td>
<td>.0113</td>
</tr>
<tr>
<td>Piers-Harris Self-Concept</td>
<td>1</td>
<td>197.698</td>
<td>4.38</td>
<td>.0132</td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>1</td>
<td>15.818</td>
<td>0.77</td>
<td>.5328</td>
</tr>
<tr>
<td>Counselor Attributes</td>
<td>1</td>
<td>12.737</td>
<td>0.01</td>
<td>.9906</td>
</tr>
</tbody>
</table>
Additional Analysis

Due to the significant interaction of the independent variables of status with problem perception and sex with problem perception, an ANOVA (SAS: Barr and Goodnight, 1972) was used to identify dependent variables upon which the significant differences occurred. Significant dependent variables identified through ANOVA were then analyzed by the least significant differences test (LSD: Arkin and Colton, 1970) to identify significant student groups. The findings of the ANOVA and LSD are reported below.

The MMPCL is subdivided into seven areas. There are total scores for responses to all the seven areas. A combined total score for the MMPCL is available and was analyzed separately from the MANOVA and ANOVA procedures and is reported later in this chapter.

The results of the ANOVA and LSD from the interaction of status with problem perception is reported below by the seven areas, with each considered as a separate dependent variable.

Status and Problem Perception

Home and Family. The results of the ANOVA for this variable are reported in Table 5. The F value of 8.75 indicated a significant difference between status and problem perception. GIF/High and EMR/High students reported
significantly more perceived Home and Family problems than did GIF/Low and EMR/Low students (Table 6).

**Self-Centered Concerns.** The results of the ANOVA for this variable are reported in Table 5. The F value of 12.94 was significant at the .0001 level and pointed to a significant difference between status and problem perception. GIF/High and EMR/High students reported significantly more perceived Self-Centered Concerns than did GIF/Low and EMR/Low students (Table 6).

**Boy and Girl Relations.** The results of the ANOVA for this variable are reported in Table 5. The F value of 5.51 was significant at the .0048 level. There was a significant difference between status and perception interactions. EMR/Low and GIF/Low students reported significantly fewer perceived Boy and Girl problems than did EMR/High and GIF/High students (Table 6).

**School.** The results of the ANOVA for this variable are reported in Table 5. The F value of 8.82 was significant at the .0004 level and showed a significant difference between status and problem perception. GIF/Low and EMR/Low students reported significantly fewer perceived problems in this area than did EMR/High and GIF/High students (Table 6).

**Health and Physical Development.** The results of the ANOVA for this variable are reported in Table 5. The F
Table 6

Means From Criteria Instruments for Status, Sex, and Status with Problem Perception

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>EMR</th>
<th>GIF</th>
<th>Male</th>
<th>Female</th>
<th>Means Low EMR</th>
<th>High EMR</th>
<th>Low GIF</th>
<th>High GIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Family</td>
<td>5.15</td>
<td>2.40</td>
<td>3.87</td>
<td>3.39</td>
<td>1.79</td>
<td>10.68</td>
<td>0.04</td>
<td>6.30</td>
</tr>
<tr>
<td>Self-Concerns</td>
<td>7.60</td>
<td>3.31</td>
<td>5.47</td>
<td>4.99</td>
<td>2.58</td>
<td>13.53</td>
<td>0.29</td>
<td>7.79</td>
</tr>
<tr>
<td>Boy and Girl</td>
<td>4.65</td>
<td>2.14</td>
<td>3.52</td>
<td>3.01</td>
<td>0.92</td>
<td>9.42</td>
<td>0.17</td>
<td>4.52</td>
</tr>
<tr>
<td>School</td>
<td>6.19</td>
<td>1.76</td>
<td>4.29</td>
<td>3.20</td>
<td>2.46</td>
<td>9.42</td>
<td>0.13</td>
<td>4.33</td>
</tr>
<tr>
<td>Health</td>
<td>5.41</td>
<td>2.28</td>
<td>3.84</td>
<td>3.53</td>
<td>1.86</td>
<td>9.00</td>
<td>0.71</td>
<td>5.27</td>
</tr>
<tr>
<td>Money, Work, Future</td>
<td>6.65</td>
<td>2.49</td>
<td>4.92</td>
<td>3.78</td>
<td>2.36</td>
<td>10.95</td>
<td>0.33</td>
<td>5.00</td>
</tr>
<tr>
<td>People in General</td>
<td>6.33</td>
<td>2.95</td>
<td>4.66</td>
<td>4.27</td>
<td>2.21</td>
<td>11.21</td>
<td>0.29</td>
<td>6.76</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>50.41</td>
<td>58.31</td>
<td>53.96</td>
<td>55.59</td>
<td>57.33</td>
<td>47.84</td>
<td>69.13</td>
<td>47.76</td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>2.94</td>
<td>1.09</td>
<td>2.24</td>
<td>1.60</td>
<td>1.91</td>
<td>4.42</td>
<td>0.75</td>
<td>1.45</td>
</tr>
</tbody>
</table>
value of 8.11 was significant at the .0006 level. There was a significant difference between EMR/Low and GIF/Low problem students who reported fewer problems than EMR/High and GIF/High students (Table 6).

Money, Work, the Future. The results of the ANOVA for this variable are reported in Table 5. The F value of 7.75 was significant at the .0008 level. There was a significant difference between status and problem perception. GIF/Low and EMR/Low reported significantly fewer perceived problems in this area than did EMR/High and GIF/High students (Table 6).

Relations to People in General. The results of the ANOVA for this variable are reported in Table 5. The F value of 4.54 was significant at the .0113 level. There was a significant difference between status and problem perception. GIF/Low and EMR/Low students reported significantly fewer perceived problems in this area than did EMR/High and GIF/High students (Table 6).

Self-Concept (Children's Self-Concept Scale). The results of the ANOVA for this variable are reported in Table 5. The F value of 4.38 was significant at the .0132 level. There was a significant difference between status and problem perception. GIF/High and EMR/High had significantly lower self-concepts than EMR/Low and GIF/Low students (Table 6).
Counselor Contacts and Counselor Attributes (Counseling Service Questionnaire). The results of the ANOVA for these two variables are reported in Table 5. The F values of 0.77 and 0.01 are not significant at the .05 level. There were no significant differences on these variables (Tables 6, 7, 8).

Sex and Problem Perception

The second significant interaction of sex and problem perception was analyzed by ANOVA. The results of that analysis are reported below by the seven areas of the MMPCL, with each area considered a separate dependent variable.

Home and Family. The results of the ANOVA for this variable are reported in Table 9. The F value of 5.92 was significant at the .0034 level. There was a significant difference between students by sex and problem perception. Female/High and Male/High students reported significantly more perceived problems in this area than did Female/Low and Male/Low students (Table 7).

Self-Centered Concerns. The results of the ANOVA for this variable are reported in Table 9. The F value of 7.25 was significant at the .0012 level. There was a significant difference between students by sex and problem perception. Male/High and Female/High reported significantly more problems in this area than did Female/Low and Male/Low students (Table 7).
### Table 7

Means From Criteria Instruments for Sex with Problem Perception

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Low Problem</th>
<th></th>
<th>High Problem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Home and Family</td>
<td>0.93</td>
<td>0.90</td>
<td>7.94</td>
<td>7.85</td>
</tr>
<tr>
<td>Self-Concerns</td>
<td>1.37</td>
<td>1.52</td>
<td>10.00</td>
<td>9.70</td>
</tr>
<tr>
<td>Boy and Girl</td>
<td>0.67</td>
<td>0.38</td>
<td>7.47</td>
<td>4.45</td>
</tr>
<tr>
<td>School</td>
<td>1.60</td>
<td>0.90</td>
<td>6.72</td>
<td>5.35</td>
</tr>
<tr>
<td>Health</td>
<td>1.22</td>
<td>1.38</td>
<td>6.78</td>
<td>6.40</td>
</tr>
<tr>
<td>Money, Work, Future</td>
<td>1.48</td>
<td>1.19</td>
<td>8.47</td>
<td>5.10</td>
</tr>
<tr>
<td>People in General</td>
<td>1.15</td>
<td>1.38</td>
<td>8.97</td>
<td>7.45</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>63.15</td>
<td>63.33</td>
<td>47.69</td>
<td>47.95</td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>1.59</td>
<td>1.00</td>
<td>3.19</td>
<td>1.50</td>
</tr>
<tr>
<td>Counselor Attributes</td>
<td>9.41</td>
<td>10.67</td>
<td>9.28</td>
<td>10.35</td>
</tr>
</tbody>
</table>
Table 8

Means From Criteria Instruments for Status with Sex with Problem Perception

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Low EMR Male</th>
<th>Low EMR Female</th>
<th>High EMR Male</th>
<th>High EMR Female</th>
<th>Low GIF Male</th>
<th>Low GIF Female</th>
<th>High GIF Male</th>
<th>High GIF Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Family</td>
<td>1.85</td>
<td>1.73</td>
<td>9.69</td>
<td>9.75</td>
<td>0.07</td>
<td>0.00</td>
<td>6.19</td>
<td>6.41</td>
</tr>
<tr>
<td>Self-Concerns</td>
<td>2.77</td>
<td>2.36</td>
<td>12.38</td>
<td>11.00</td>
<td>0.07</td>
<td>0.60</td>
<td>7.63</td>
<td>7.94</td>
</tr>
<tr>
<td>Boy and Girl</td>
<td>1.15</td>
<td>0.64</td>
<td>10.00</td>
<td>8.40</td>
<td>0.21</td>
<td>0.10</td>
<td>4.94</td>
<td>4.12</td>
</tr>
<tr>
<td>School</td>
<td>3.08</td>
<td>1.73</td>
<td>9.38</td>
<td>11.20</td>
<td>0.21</td>
<td>0.00</td>
<td>4.06</td>
<td>4.59</td>
</tr>
<tr>
<td>Health</td>
<td>1.92</td>
<td>1.82</td>
<td>9.00</td>
<td>10.20</td>
<td>0.57</td>
<td>0.90</td>
<td>4.56</td>
<td>5.94</td>
</tr>
<tr>
<td>Money, Work, Future</td>
<td>2.69</td>
<td>2.00</td>
<td>11.25</td>
<td>10.40</td>
<td>0.36</td>
<td>0.30</td>
<td>5.69</td>
<td>4.35</td>
</tr>
<tr>
<td>People in General</td>
<td>2.08</td>
<td>2.36</td>
<td>11.38</td>
<td>11.40</td>
<td>0.29</td>
<td>0.30</td>
<td>6.56</td>
<td>6.94</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>58.54</td>
<td>55.91</td>
<td>47.56</td>
<td>49.33</td>
<td>67.43</td>
<td>71.50</td>
<td>47.81</td>
<td>47.71</td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>2.30</td>
<td>1.45</td>
<td>4.50</td>
<td>4.00</td>
<td>0.93</td>
<td>0.50</td>
<td>1.88</td>
<td>1.06</td>
</tr>
</tbody>
</table>
Table 9
Summary of Analysis of Variance for
Sex Vs. Problem Perception

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Family</td>
<td>1</td>
<td>12.847</td>
<td>5.92</td>
<td>.0034</td>
</tr>
<tr>
<td>Self-Centered Concerns</td>
<td>1</td>
<td>13.138</td>
<td>7.25</td>
<td>.0012</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>1</td>
<td>9.267</td>
<td>5.16</td>
<td>.0064</td>
</tr>
<tr>
<td>School</td>
<td>1</td>
<td>8.386</td>
<td>0.89</td>
<td>.5845</td>
</tr>
<tr>
<td>Health and Phys. Develop.</td>
<td>1</td>
<td>8.405</td>
<td>0.23</td>
<td>.7942</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>1</td>
<td>9.265</td>
<td>1.31</td>
<td>.2715</td>
</tr>
<tr>
<td>Relations to People</td>
<td>1</td>
<td>9.266</td>
<td>0.30</td>
<td>.7484</td>
</tr>
<tr>
<td>Piers-Harris Self-Concept</td>
<td>1</td>
<td>197.698</td>
<td>0.006</td>
<td>.9942</td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>1</td>
<td>15.818</td>
<td>0.15</td>
<td>.8571</td>
</tr>
<tr>
<td>Counselor Attributes</td>
<td>1</td>
<td>12.737</td>
<td>1.01</td>
<td>.3663</td>
</tr>
</tbody>
</table>
Boy and Girl Relations. The results of the ANOVA for this variable are reported in Table 9. The F value of 5.16 was significant at the .0064 level and indicated a significant difference between students by sex and problem perception. Female/Low and Male/Low students reported significantly fewer problems in this area than did Male/High and Female/High students (Table 7).

The remaining seven dependent variables were not significant at the .05 level (Table 9). There was no significant interaction effect between sex and problem perception on the dependent variables of School, Health and Physical Development, Money, Work, the Future, Relations to People in General, Self-Concept, Counselor Contacts, and Counselor Attributes.

**Null Hypothesis II**

The second null hypothesis was

There is no significant difference between middle school EMR and GIF students on guidance needs based on the total number of responses to the MMPCL.

This hypothesis examined the difference between the total number of responses to the MMPCL by EMR and GIF students. The results of the t test for significance between the means is summarized in Table 10. The difference in the means was
Table 10

Test of Significance of Means of Total Number of Responses on the Modified Mooney Problem Check List of EMR and GIF Students

<table>
<thead>
<tr>
<th>Students</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR</td>
<td>41.98</td>
<td>20.07</td>
<td>13.32*</td>
</tr>
<tr>
<td>GIF</td>
<td>17.81</td>
<td>15.98</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05
significant \( (t = 13.36, p < .05) \) and the hypothesis was rejected. EMR students reported significantly more total problems on the MMPCL than did GIF students.

**Null Hypothesis III**

The third null hypothesis was

There is no significant difference on problems viewed as appropriate for discussion with a counselor as measured by the CSQ between

a. EMR and GIF students,
b. female and male students,
c. low and high problem students.

This hypothesis dealt with the responses to the seven problem areas from the CSQ. The areas were adapted from the seven problem areas on the MPCL. Which problem areas would students view as appropriate for discussion with a counselor? Would there be any differences between GIF/EMR, male/female, and low/high problem students as to the areas they thought were appropriate for discussion? Each problem area is reported independently of the others and in terms of the three independent variables of status, sex, and problem perception. The test of significance was chi square. A summary of the results are reported in Table 11.
Table 11
Summary of Chi Squares
(Status, Sex, and Problem Perception from CSQ)

<table>
<thead>
<tr>
<th>Students and Problem Areas</th>
<th>$x^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMR/GIF</strong></td>
<td></td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>34.67*</td>
</tr>
<tr>
<td>School</td>
<td>12.65*</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>21.43*</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>0.72</td>
</tr>
<tr>
<td>Home and Family</td>
<td>6.99*</td>
</tr>
<tr>
<td>Problems in General</td>
<td>5.36*</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>15.44*</td>
</tr>
<tr>
<td><strong>Female/Male</strong></td>
<td></td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>2.23</td>
</tr>
<tr>
<td>School</td>
<td>1.31</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>0.72</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>8.94*</td>
</tr>
<tr>
<td>Home and Family</td>
<td>3.78</td>
</tr>
<tr>
<td>Problems in General</td>
<td>0.33</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>0.15</td>
</tr>
</tbody>
</table>
Table 11 - Continued

<table>
<thead>
<tr>
<th>Students and Problem Areas</th>
<th>$X^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low/High</td>
<td></td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>2.26</td>
</tr>
<tr>
<td>School</td>
<td>1.29</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>4.13*</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>7.79*</td>
</tr>
<tr>
<td>Home and Family</td>
<td>4.60*</td>
</tr>
<tr>
<td>Problems in General</td>
<td>5.81*</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>5.84*</td>
</tr>
</tbody>
</table>

*p < .05
Problem Areas

Health and Physical Development. There was a significant difference between EMR/GIF students in this area. A chi square of 34.67 (Table 11) was significant beyond the .05 level. Significantly more EMR than GIF students felt problems in this area were appropriate for discussion.

There was no significant difference between male/female students in this area. The chi square of 2.23 (Table 11) was not significant at the .05 level. Just as many females as males thought this was an appropriate area for discussion.

There was also no significant difference between low/high problem students in this area. The chi square of 2.26 (Table 11) was not significant at the .05 level. Just as many low problem students as high problem students felt this was an appropriate area for discussion.

School. There was a significant difference between EMR/GIF students on the variable of School. A chi square of 12.65 (Table 11) was significant at the .05 level. Significantly more GIF students than EMR students felt this was not appropriate for discussion.

There was no significant difference between male/female students in this area. The chi square of 1.31 (Table 11) was not significant at the .05 level. Just as many males as females felt this area was appropriate for discussion.
There was no significant difference between low/high problem students. The chi square of 1.29 (Table 11) was not significant at the .05 level. Just as many low problem as high problem students felt this area was appropriate for discussion.

Money, Work, the Future. There was a significant difference between EMR/GIF students in this area. The chi square of 21.43 (Table 11) was significant at the .05 level. Significantly more GIF students thought this area was not appropriate for discussion.

There was no significant difference between male/female students. The chi square of 0.72 (Table 11) was not significant at the .05 level. Just as many males as females felt this was an appropriate area for discussion.

There was, however, a significant difference between low/high problem students in this area. The chi square of 4.13 (Table 11) was significant at the .05 level. Significantly more high problem students felt that this was an appropriate area for discussion than low problem students.

Boy and Girl Relations. There was no significant difference between EMR/GIF students in the area of boy/girl relations. The chi square of 0.72 (Table 11) was not significant at the .05 level. Just as many EMR as GIF students felt this was an appropriate area for discussion.
There was a significant difference between male/female students. The chi square of 8.94 (Table 11) was significant at the .05 level, with more males thinking this was not an appropriate area for discussion with a counselor.

There was a significant difference in this area between low/high problem students. The chi square of 7.79 (Table 11) was significant at the .05 level. More high problem than low problem students felt this was an appropriate area for discussion.

Home and Family. There was a significant difference between EMR/GIF students in this area. The chi square of 6.99 (Table 11) was significant at the .05 level. More EMR than GIF students felt this was an appropriate area for discussion.

There was no significant difference in this area between male/female students. The chi square of 3.78 (Table 11) was not significant at the .05 level. Just as many females as males felt this was an appropriate area for discussion.

There was, however, a significant difference in this area between low/high problem students. The chi square of 4.60 (Table 11) was significant at the .05 level. More high than low problem students felt this was an appropriate area for discussion.
Problems in General. There was a significant difference between EMR/GIF students for general problems. The chi square of 5.36 (Table 11) was significant at the .05 level. More GIF than EMR students felt this was not an appropriate area for discussion with a counselor.

There was no significant difference between female/male students. The chi square of 0.33 (Table 11) was not significant at the .05 level. Just as many females felt this was an appropriate area for discussion as males.

There was a significant difference between low/high problem students in this area. The chi square of 5.81 (Table 11) was significant at the .05 level. More high than low problem students felt this was an appropriate area for discussion.

Personal Problems. There was a significant difference in this area between EMR/GIF students. The chi square of 15.44 (Table 11) was significant at the .05 level. More GIF students than EMR students felt personal problems were not appropriate for discussion with a counselor.

There was no significant difference in this area between female/male students. The chi square of 0.15 was not significant at the .05 level (Table 11). Just as many males as females felt this was an appropriate area for discussion.

There was a significant difference in this area between low/high problem students. The chi square of 5.84 (Table 11)
was significant at the .05 level. More high problem than low problem students felt this was an appropriate area for discussion.

A summary of responses by status, sex, and problem perception is presented in Table 12.

Extended Analysis

**MMPCL and CSQ.** This study also investigated the relationship between the responses to the seven areas of the MMPCL and the seven problem areas from the CSQ. Would students who had many perceived problems on various areas of the MMPCL indicate a willingness to discuss these problems with a counselor? A correlational technique was used to analyze the relationship between similar pairs of problem areas from the MMPCL and the CSQ. The results of that procedure are reported in Table 13.

The correlations between similar pairs of problem areas were positive and significant (Table 13). As a student reported increasing numbers of problems in various areas he also reported a willingness to discuss these problems. Students who report high numbers of problems would be amenable to counseling.

**MMPCL and Self-Concept (Children's Self-Concept Scale).** This study also investigated the relationship between the total number of responses on the MMPCL and the self-concept
Table 12

Summary of Responses in Percents to the Counseling Service Questionnaire

<table>
<thead>
<tr>
<th>Students and Problems</th>
<th>EMR/GIF</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>66</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>School</td>
<td>83</td>
<td>17</td>
<td>67</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>82</td>
<td>18</td>
<td>61</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>50</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Home and Family</td>
<td>57</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td>Problems in General</td>
<td>72</td>
<td>28</td>
<td>61</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>68</td>
<td>32</td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female/Male</th>
<th>Female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>54</td>
<td>46</td>
<td>47</td>
</tr>
<tr>
<td>School</td>
<td>77</td>
<td>23</td>
<td>72</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>71</td>
<td>29</td>
<td>70</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>55</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>Home and Family</td>
<td>55</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Problems in General</td>
<td>67</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>57</td>
<td>43</td>
<td>58</td>
</tr>
</tbody>
</table>
Table 12 - Continued

<table>
<thead>
<tr>
<th>Problem Areas</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low/High</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Physical Development</td>
<td>47</td>
<td>53</td>
<td>60</td>
<td>40</td>
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<tr>
<td>School</td>
<td>69</td>
<td>31</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>59</td>
<td>41</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>31</td>
<td>69</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>Home and Family</td>
<td>42</td>
<td>58</td>
<td>61</td>
<td>39</td>
</tr>
<tr>
<td>Problems in General</td>
<td>53</td>
<td>47</td>
<td>73</td>
<td>27</td>
</tr>
<tr>
<td>Personal Problems</td>
<td>46</td>
<td>54</td>
<td>67</td>
<td>33</td>
</tr>
</tbody>
</table>
Table 13

Correlation Coefficients Between Similar Areas
From the Modified Mooney Problem Check List
and the Counseling Service Questionnaire

<table>
<thead>
<tr>
<th>Areas from MMPCL</th>
<th>Areas from the Counseling Service Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Home Self Boy/Girl School Health Money People</td>
</tr>
<tr>
<td>Self</td>
<td>.24</td>
</tr>
<tr>
<td>Boy/Girl</td>
<td>.26</td>
</tr>
<tr>
<td>School</td>
<td>.10</td>
</tr>
<tr>
<td>Health</td>
<td>.28</td>
</tr>
<tr>
<td>Money</td>
<td>.30</td>
</tr>
<tr>
<td>People</td>
<td>.22</td>
</tr>
</tbody>
</table>

p for all correlations < .05
from the CSCS. Did students with few perceived problems have a high or low self-concept? The correlation between problems and self-concept was negative and significant at the .05 level (Table 14). The fewer perceived problems a student reported the higher was that student's self-concept.

**MMPCL and Counselor Contacts (Counseling Service Questionnaire).** Do students who report many perceived problems have more counselor contacts than students who reported few perceived problems? A correlation was computed between problems and contacts to answer this question. The correlation was positive and significant at the .05 level (Table 14). Students who reported many problems also reported more counselor contacts than students who reported few problems.

**MMPCL and Counselor Attributes (Counseling Service Questionnaire).** How do students who report many perceived problems view the counselor? To answer this question a correlation was computed between the total number of problems and the student's perception of counselor attributes. The correlation was negative and significant at the .05 level (Table 14). As a student reported more problems about himself his attitude toward the counselor became less positive.

**Self-Concept and Counselor Contacts.** What was the relationship between the self-concept and the number of counselor contacts? Would a student with a high self-concept see the
Table 14

Intercorrelations Between the Total Number of Responses on the Modified Mooney Problem Check List, the Piers-Harris Children's Self-Concept Scale, the Number of Counselor Contacts, and Counselor Attributes From the Counseling Service Questionnaire

<table>
<thead>
<tr>
<th>Areas</th>
<th>Total MMPCL</th>
<th>Self-Concept</th>
<th>Counselor Contacts</th>
<th>Counselor Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MMPCL</td>
<td>1.00</td>
<td>-.57*</td>
<td>.22*</td>
<td>-.14*</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>1.00</td>
<td>.01</td>
<td>.26*</td>
<td></td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>1.00</td>
<td>-.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Attributes</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05
counselor more frequently than a student with a low self-concept? The correlation between these two variables was not significant at the .05 level (Table 14). The number of counselor contacts (CSQ) appeared to be independent of self-concept (CSCS).

**Self-Concept and Counselor Attributes.** Would a student who has a high self-concept report more positive or more negative attributes of a counselor? The correlation between self-concept (CSCS) and counselor attributes (CSQ) was positive and significant at the .05 level (Table 14). As a student reported a higher self-concept he also reported more positive attributes about the counselor.

**Counselor Contacts and Counselor Attributes.** Do students who have many counselor contacts view the counselor as having many positive attributes? The correlation between these variables was not significant at the .05 level (Table 13). It appeared that perceived attributes of counselors was independent from the number of counselor contacts.

The majority of EMR and GIF students view the counselor as having more positive attributes than negative ones. As can be seen in Table 15, 298 of the 343 students who responded to the Counselor Attributes section of the CSQ, viewed the counselor as positive.
Table 15
Attitudes Toward Counselors by EMR and GIF Students

<table>
<thead>
<tr>
<th>Attitude</th>
<th>EMR</th>
<th>GIF</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>162</td>
<td>136</td>
<td>298*</td>
</tr>
<tr>
<td>Neutral</td>
<td>11</td>
<td>8</td>
<td>19**</td>
</tr>
<tr>
<td>Negative</td>
<td>20</td>
<td>6</td>
<td>26***</td>
</tr>
</tbody>
</table>

* Includes 106 students who had no counselor contacts during the year.
** Includes 7 students who had no counselor contacts during the year.
*** Includes 17 students who had no counselor contacts during the year.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Little information has been reported regarding the guidance needs of EMR and GIF students. Even less information is available as to how these students view counselors and if they will discuss their problems with counselors. What is the relationship between guidance needs and the self-concept of EMR and GIF students? Do students with many problems have a lower self-concept than students with few problems?

The purpose of this study was to answer the above questions by investigating the guidance needs, self-concepts, perceived counselor attributes, the number of counselor contacts by EMR and GIF students, and problems viewed as appropriate for discussion with a counselor.

The subjects for the study were the 236 EMR and 257 GIF students in the middle schools of Alachua County, Florida. Students with IQ's less than 75 and more than 129 on individually administered tests are eligible for placement in exceptional classes.
All subjects were administered a modified form of the Mooney Problem Check List, Form J (105 items rather than 210), the Piers-Harris Children's Self-Concept Scale, and the Counseling Service Questionnaire. The latter was developed to ascertain the number of counselor contacts, problems viewed as appropriate for discussion, and student perceptions of the counselor.

The instruments were administered during May, 1975. All instruments were read to the students by their teachers. Students marked their responses on the instruments to avoid the use of separate answer sheets and the possibility of mismatching responses to questions.

Three null hypotheses were tested using multivariate analysis of variance, a t test, and chi square. The level of significance for all tests was set at the .05 level of confidence.

**Hypothesis I**

The first hypothesis looked at differences between EMR/GIF, female/male, and low/high perceived problem middle school students on the variables of guidance needs, self-concept, number of counselor contacts, and counselor attributes. Guidance needs were the seven problem areas from the MMPCL.

**Perceived Problems.** The interaction of EMR/GIF with low/high problem perception resulted in significant differences
in several areas. EMR and GIF students with many perceived problems consistently reported more problems in all seven problem areas from the MMPCL than did EMR and GIF students with few perceived problems.

The interaction of sex with low/high problem perception resulted in significant differences in three of the seven problem areas from the MMPCL. On the variables of Home and Family, Self-Centered Concerns, and Boy and Girl Relations female and male low problem students reported significantly fewer problems than did high problem male and female students. It might logically be expected that low problem students would report fewer problems than high problem students, but this was not the case with the remaining four problem areas from the MMPCL.

**Self-Concept.** The self-concepts of EMR and GIF students with many perceived problems were almost identical. Both groups reported equal numbers of positive self-statements that were lower than all other groups. GIF students with high perceived problems had lower self-concepts than all the EMR students combined. GIF students had a higher self-concept than EMR students, and female GIF students with low perceived problems had the highest self-concept of all. There was not a significant difference, however, between the self-concept of GIF females and males.
Counselor Contacts. The number of counselor contacts as measured by the CSQ showed no significant differences in the two interactions of status with problem perception and sex with problem perception. However, students who reported many problems also reported more counselor contacts than did students with few problems. Of EMR students with high problems 73 percent had one or more counselor contacts while only 52 percent of high problem GIF students had one or more counselor contacts. Of EMR students with high problems four of 24 had no counselor contacts, and 24 of 39 high problem GIF students had no counselor contacts. One high problem GIF student reported ten contacts while six high problem EMR students reported ten contacts.

Counselor Attributes. There were no differences between EMR/GIF, female/male, and low/high perceived problem students in the number of positive attributes they assigned to counselors. Low problem female EMR students viewed counselors as slightly more positive than did other students. The EMR male students with low problems saw counselors as slightly less positive than did other students. As mentioned above, however, the differences in perceived counselor attributes were not significant.
Hypothesis II

This hypothesis examined the differences in the total number of guidance needs from the MMPCL of EMR and GIF students. The statistical analysis, a t test, showed that there was a significant difference with the EMR students reporting over twice as many perceived problems as GIF students.

Hypothesis III

The significance between EMR/GIF, female/male, and low/high perceived problem students as to the appropriateness of problems for discussion with a counselor was dealt with by this hypothesis. The problems were the seven problem areas from the CSQ which had been adapted from the MPCL. The statistical procedure used chi square to test the differences. The results indicated that more EMR students were willing to discuss problems with a counselor than were GIF students. However, high problem GIF students were willing to discuss problems in all seven areas while high problem EMR students did not feel problems in Boy and Girl Relations and Home and Family were appropriate for discussion. The only significant differences between female/male students was in the area of Boy and Girl Relations. More females thought this was an appropriate area for discussion than did males. Except in the areas of Health and Physical Development and School
problems, significantly more high than low problem students felt that the areas were appropriate for discussion.

Extended Analyses

The relationship between the responses on the MMPCL and the CSQ were correlated to see if students who reported many problems would be willing to discuss those problems. All correlations between similar pairs of problem areas were positive and significant. As students reported more problems they also reported a willingness to discuss those problems.

The relationship between the total number of MMPCL responses, the self-concept, the number of counselor contacts, and perceived counselor attributes were also examined. As students reported more guidance needs (MMPCL) they reported a lower self-concept. Also, as they reported more guidance needs they reported fewer positive attributes about the counselor. As they reported a higher self-concept they reported more positive counselor attributes.

The number of counselor contacts increased as students reported more guidance needs. However, neither the relationship between the number of counselor contacts and counselor attributes was significant nor was the relationship between self-concept and counselor contacts.
Limitations

The subjects in this study were EMR and GIF students in the middle schools of Alachua County, Florida. A racial division between the EMR and GIF classrooms showed a preponderant number of blacks in EMR classes and the converse in GIF classes (Appendix C).

All the instruments were of a self-report nature. The accuracy of the results was dependent upon the conscientious reporting by the subjects. A teacher from one of the EMR classes reported that some students may have lost interest in the MMPCL and marked responses indiscriminately. There were 13 students in this teacher's class. The students were included in the results.

Conclusions and Implications

The guidance needs reported by EMR and GIF students differed in frequency rather than kind. EMR students reported at least twice as many perceived problems in all areas and more than twice as many total problems. There were, however, both EMR and GIF students who reported no problems.

EMR students generally had a lower self-concept than GIF students as well as reporting more problems.
findings suggest that intelligence is only one of several factors which differentiate the two groups. There appears to be a reciprocal effect between numbers of problems and self-concept. As the self-concept goes down the number of reported problems increases. Counselors and teachers should be mindful of these factors in their dealings with EMR children. Behaviors that cause school personnel concern may be underlined by a low self-concept and the awareness of many personal problems. Programs directed toward alleviating or ameliorating these personal concerns may be more effective in helping students profit from the school experience than punitive actions directed toward overt behaviors.

Major differences existed between EMR and GIF students in problem areas viewed as appropriate for discussion. With the exception of Boy and Girl Relations more EMR than GIF students felt that all problem areas were appropriate for discussion. This finding does not mean that GIF students were not willing to discuss problems. The majority of GIF students were willing to discuss problems in the areas of School, Money, Work, the Future, and Problems in General. Also, high problem GIF students were willing to discuss concerns in all seven problem areas. It appeared that those who reported the most problems, EMR students, were willing to discuss those problems. Direct counselor involvement
with EMR students would seem to be a service that would meet with minimal student opposition. Meeting the guidance needs of GIF and EMR students might also be accomplished through indirect means such as teacher consultation, guidance units within the classroom, and counselor participation in curriculum meetings.

The attitudes EMR and GIF students have about counselors were of a strongly positive nature. Implications are difficult to draw from this finding, but it appears that counselors are viewed as positive influences within the school milieu.

The middle school years seem marked by a high level of concern by both EMR and GIF students about problems relating to self. The problem area of Self-Centered Concerns had the most responses by both EMR and GIF students. The intellectual, physical, and emotional changes taking place within students during this period are reflected in their awareness of and the willingness to discuss these problems. Guidance needs in the area of relating to other people were frequently mentioned. Teachers and counselors can and should develop more programs to help students develop interpersonal skills.

One hundred and thirty EMR and GIF students reported no counselor contacts during the school year. Twenty eight of these students reported many guidance needs. That counselors do not see all students in the school does not in itself carry
a negative implication. However, this finding might sound a note of warning that there are some EMR and GIF students who could benefit from counselor intervention but are not being seen. This does not necessarily mean that the guidance needs of these students are being ignored. School personnel other than the counselor or someone from an outside agency may be seeing these students.

Profiles of the typical or representative EMR and GIF student and the high problem EMR and GIF student are presented in Appendices D and E. These profiles were compiled from data collected in this study and are presented in such a way that a direct comparison can be made between the various factors investigated in this study.

**Recommendations**

Almost half the GIF and a third of the EMR students had not seen a counselor during the school year. Counselors should continue to develop more viable roles within the school in order to decrease the counselor/pupil ratio and be available for more student contact. A consultant role is certainly one of great value. Personal contacts can also do much to facilitate the affective as well as cognitive objectives of the school.
This study found that those students who reported many problems were willing to discuss them. Counselors should be readily available to these students and seek new avenues where students have an opportunity to explore problems (e.g., peer facilitating, teacher discussion groups, group counseling, and so forth). EMR students reported the greatest number of problems and the lowest self-concepts. Counselors need to develop ways to meet the guidance needs of these students.

Problems relating to self and others were frequently reported by both EMR and GIF students. It appears that much more involvement might be accomplished to help students develop the interpersonal skills necessary for effective communication. The concomitant development of self-confidence that would occur would be of personal value and might serve to increase positive self-concept.

Teachers, counselors, parents, and administrators are aware of many students who need guidance services. There will be some students, though, who will go unnoticed and yet have many problems. Some type of identification program, such as a problem check list, might be developed to help identify more of these students. Counselors with available time and expertise should be provided for those students who have many and/or serious problems but not the resources for assistance outside the school setting.
School districts approve the use of academic achievement and career maturity testing. Under certain circumstances the use of psychological tests are permitted. There would be many sociological difficulties inherent in psychological maturity testing; but, as more and more social importance is placed upon interpersonal relationships and self-responsibility, measurements in this area may be refined and implemented. Counselors could play an important role in a program of this nature. Tests that differentiate between students on the basis of factors other than race should be developed for use in admitting students to special programs.

Several questions for further research have been suggested by this study. A more extensive investigation into the concerns and needs of high problem students is needed. Can the problems these students experience be effectively resolved within the school setting through more intensive counseling or should these students be referred for help outside the school? A very realistic limitation for some of these students is a lack of environmental support to seek assistance outside of the school setting. What can counselors do to meet the needs of these students?

What kinds of guidance programs could be developed for those high problem EMR and GIF students who have the lowest self-concept of all groups? Would it be feasible to include
students from both groups in counseling sessions? Would specific interventions based on identified problems help these students with interpersonal and personal problems? Would a decrease in problems result in an increase in self-concept? The reciprocal nature of these two factors suggests that this might occur.

Are the problems reported by EMR and GIF students of a developmental or chronic nature? Would different methods of counseling produce similar or different results with the different groups? EMR and GIF students may respond differently to various counseling approaches. They may require different types of learning experiences to derive the maximum benefit from guidance services. More research needs to be conducted in this area.

How does self-concept relate to behavior? What type of behavioral differences are there between low and high self-concept EMR or GIF students? This is a question that needs further investigation.
APPENDICES
APPENDIX A

MODIFIED MOONEY PROBLEM CHECK LIST
MIDDLE SCHOOL FORM
Modified Mooney Problem Check List
Middle School Form

This is not a test. There are no right or wrong answers. This is a check list of problems that girls and boys your age might have. Please check the problems that bother you.

Please do not sign your name.

Grade _____, Girl _____, Boy _____, Age _____

DIRECTIONS: Read the list slowly. As you read a problem which troubles you, make an X on the line.

1. Don't get enough sleep __
2. Not as healthy as I should be __
3. Getting low grades in school __
4. Being a grade behind in school __
5. Not interested in books __

6. Not living with my parents __
7. Parents working too hard __
8. Spending money foolishly __
9. Having no regular allowance __
10. Having no car in the family __

11. Not allowed to go around with the kids I like __
12. Not enough time for play and fun __
13. Slow in making friends __
14. Being left out of things __
15. Wishing people liked me better __

16. Taking things too seriously __
17. Being afraid of making mistakes __
18. Too short for my age __
19. Too tall for my age __
20. Not good looking __

21. Trouble with arithmetic __
22. Slow in reading __
23. Sickness at home __
24. Mother or Father not living  
25. Parents not understanding me  

26. Wanting to earn some of my own money  
27. Not knowing how to buy things wisely  
28. Girls don't seem to like me  
29. Boys don't seem to like me  
30. Not knowing how to make a date  

31. Being talked about  
32. Too easily led by other people  
33. Getting into trouble  
34. Sometimes not being as honest as I should be  
35. Lacking self-control  

36. Often not hungry for my meals  
37. Underweight  
38. Overweight  
39. Can't keep my mind on my studies  
40. Not smart enough  

41. Parents favoring a brother or sister  
42. Parents expecting too much of me  
43. Restless to get out of school and into a job  
44. Needing to find a part-time job now  
45. Having to work too hard for the money I get  

46. So often not allowed to go out at night  
47. Wanting to know more about girls  
48. Wanting to know more about boys  
49. Being picked on  
50. People finding fault with me  

51. Worrying  
52. Lacking self-confidence  
53. Often have a sore throat  
54. Often get sick  
55. Afraid I may need an operation  

56. School is too strict  
57. Not getting along with a teacher  
58. Being criticized by my parents  
59. Parents not trusting me  
60. Unable to discuss certain problems at home  

61. Deciding what to take in high school  
62. Wanting to know more about college
63. No place to entertain friends __
64. Trouble in keeping a conversation going __
65. Not sure about proper sex behavior __

66. Wanting to be more like other people __
67. Missing someone very much __
68. Being careless __
69. Forgetting things __
70. Not taking some things seriously enough __

71. Can't talk plainly __
72. Smoking __
73. Textbooks hard to understand __
74. Trouble with reports __
75. Afraid to speak up in class __

76. Not getting along with a brother or sister __
77. Wanting more freedom at home __
78. Needing a job during vacations __
79. Needing to decide on an occupation __
80. Wondering if I've chosen the right vocation __

81. Girl friend __
82. Boy friend __
83. Getting into arguments __
84. Losing my temper __
85. Hurting people's feelings __

86. Being punished for something I didn't do __
87. Thinking about heaven and hell __
88. Nose or sinus trouble __
89. Not being as strong as some other kids __
90. Bothered by a physical handicap __

91. Too little freedom in classes __
92. Not interested in certain subjects __
93. Clash of opinions between me and my parents __
94. Mother __
95. Father __

96. Not knowing what I really want __
97. Wondering if I'll ever get married __
98. Learning how to dance __
99. Thinking too much about the opposite sex __
100. Embarrassed by talk about sex __
101. Disliking someone __
102. Keeping away from kids I don't like __
103. Sometimes lying without meaning to __
104. Can't make up my mind about things __
105. Finding it hard to talk about my troubles __
APPENDIX B

COUNSELING SERVICE QUESTIONNAIRE
Counseling Service Questionnaire

INSTRUCTIONS: Please do not sign your name.

Grade _____, Girl _____, Boy _____, Age _____

How many times have you talked with a counselor this year? Check one of the numbers.

0 1 2 3 4 5 6 7 8 9 10

Here are some problems students your age have. Check the ones you would talk about to a counselor.

Health and Physical Development Yes___Maybe___No___
School Yes___Maybe___No___
Money, Work, the Future Yes___Maybe___No___
Boy and Girl Relations Yes___Maybe___No___
Home and Family Yes___Maybe___No___
Problems in General Yes___Maybe___No___
Personal Problems Yes___Maybe___No___

Here are some ways to describe a counselor. Check the ones which you feel would describe a counselor.

____ caring
____ understanding
____ does not understand me
____ strict
____ a person I can talk with
____ bossy
____ a good listener
____ too busy to see me
____ helpful
____ interested in me
____ unfriendly
____ bugs me
APPENDIX C

NUMBER OF STUDENTS BY RACES IN EMR AND GIF CLASSES
Number of Students by Races in EMR and GIF Classes

<table>
<thead>
<tr>
<th>School</th>
<th>EMR</th>
<th></th>
<th>GIF</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>White</td>
<td>Black</td>
<td>White</td>
</tr>
<tr>
<td>Port Clark</td>
<td>41</td>
<td>4</td>
<td>5</td>
<td>131</td>
</tr>
<tr>
<td>Howard Bishop</td>
<td>39</td>
<td>8</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Lincoln</td>
<td>40</td>
<td>18</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Mebane</td>
<td>31</td>
<td>4</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Westwood</td>
<td>44</td>
<td>0</td>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>34</td>
<td>10</td>
<td>235</td>
</tr>
</tbody>
</table>

*No program
APPENDIX D

PROFILE: REPRESENTATIVE EMR AND GIF STUDENT
Profile: Representative EMR and GIF Student

<table>
<thead>
<tr>
<th>Area</th>
<th>EMR</th>
<th>Means</th>
<th>GIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Perceived Problems</td>
<td>41.98</td>
<td></td>
<td>17.81</td>
</tr>
<tr>
<td>Home and Family</td>
<td>5.15</td>
<td>2.38</td>
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</tr>
<tr>
<td>Self-Centered Concerns</td>
<td>7.60</td>
<td>3.31</td>
<td></td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>4.65</td>
<td>2.14</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>6.19</td>
<td>1.76</td>
<td></td>
</tr>
<tr>
<td>Health and Phys. Develop.</td>
<td>5.41</td>
<td>2.28</td>
<td></td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>6.65</td>
<td>2.49</td>
<td></td>
</tr>
<tr>
<td>Relations to People in General</td>
<td>6.33</td>
<td>2.95</td>
<td></td>
</tr>
<tr>
<td>Piers-Harris Self-Concept</td>
<td>50.41</td>
<td>58.31</td>
<td></td>
</tr>
<tr>
<td>Counselor Contacts</td>
<td>2.94</td>
<td>1.09</td>
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<tr>
<td>Counselor Attributes</td>
<td>9.54</td>
<td>9.97</td>
<td></td>
</tr>
</tbody>
</table>

Problem Areas Appropriate for Discussion

<table>
<thead>
<tr>
<th>Area</th>
<th>EMR</th>
<th>Means</th>
<th>GIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Phys. Develop.</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>yes</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>yes</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Boy and Girl Relations</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Home and Family</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Problems in General</td>
<td>yes</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Personal Problems</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E

PROFILE: REPRESENTATIVE HIGH PROBLEM EMR AND GIF STUDENT
Profile: Representative High Problem EMR and GIF Student

<table>
<thead>
<tr>
<th>Area</th>
<th>EMR</th>
<th>Means</th>
<th>GIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Perceived Problems</td>
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<tr>
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<td>Self-Centered Concerns</td>
<td>13.53</td>
<td>7.79</td>
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<tr>
<td>Boy and Girl Relations</td>
<td>9.42</td>
<td>4.52</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>9.42</td>
<td>4.33</td>
<td></td>
</tr>
<tr>
<td>Health and Phys. Develop.</td>
<td>9.00</td>
<td>5.27</td>
<td></td>
</tr>
<tr>
<td>Money, Work, the Future</td>
<td>10.95</td>
<td>5.00</td>
<td></td>
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<tr>
<td>Relations to People in General</td>
<td>11.21</td>
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<td>Piers-Harris Self-Concept</td>
<td>47.84</td>
<td>47.76</td>
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<td>Counselor Contacts</td>
<td>5.69</td>
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<tr>
<td>Counselor Attributes</td>
<td>9.42</td>
<td>9.85</td>
<td></td>
</tr>
</tbody>
</table>

**Problem Areas Appropriate for Discussion**

- Health and Phys. Develop. yes yes
- School yes yes
- Money, Work, the Future yes yes
- Boy and Girl Relations no yes
- Home and Family no yes
- Problems in General yes yes
- Personal Problems yes yes
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John Deans Scouller III was born in Pontiac, Illinois, in 1939. In 1946, he moved to Bloomington, Illinois. He attended University High School, which was the laboratory school for Illinois State University, and graduated in 1957. He joined the U. S. Army in 1959 and spent two years stationed in Friedberg, Germany. The two years in Germany were of great benefit to John. His life was further enhanced by his marriage to Christel W. Diehl. The last eight months of army service was spent in San Francisco.

John returned to Bloomington and entered Illinois State University. He majored in Industrial Arts and minored in Psychology. His student teaching experience was with mentally retarded junior high school students. He received his B. S. in 1965, and immediately entered the graduate program at I.S.U. in School Psychology. He received his M.S. in School Psychology in 1966, and moved to Tacoma, Washington, with his wife and daughter. He worked for the public school system as a School Psychologist for seven years.

In 1973, John moved to Gainesville, Florida, with his wife, daughter, and son, and entered the Counselor Education
program at the University of Florida. He completed his counseling practica and internships at Shands Teaching Hospital, Adult Outpatient Psychiatric Clinic, in 1975. He completed the work for the Doctor of Education and graduated from the University of Florida in August, 1975.
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

Robert D. Myrick, Chairman
Professor of Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

Cary L. Reichard
Associate Professor of Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

Joseph P. Wittmer
Professor of Education
This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Education.

August, 1975

________________________________________
Dean, College of Education

________________________________________
Dean, Graduate School