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A TRAINING PROGRAM FOR PARENTS OF LEARNING DISABLED CHILDREN: THE
EFFECTS ON PARENTAL ACCEPTANCE, PARENTAL EMPATHY, AND CHILD SELF
CONCEPT

THE UNIVERSITY OF ARIZONA

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SELF CONCEPT

by

Marion Linda Kranichfeld

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SCHOOL OF HOME ECONOMICS
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF SCIENCE
In the Graduate College
THE UNIVERSITY OF ARIZONA

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11/29/82

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ABSTRACT

The purpose of the present study was to evaluate the effectiveness of a modified Filial Therapy program for mothers of learning disabled children using a standard pre-test, post-test, control group design. 22 mothers completed the Porter Parental Acceptance Scale, and the Piers-Harris Self Concept Scale was administered to their children. Mother-child interaction was also videotaped and coded through use of the Acceptance of Other Scale. The 16-week experimental training program paralleled the Filial Therapy program with several modifications designed to adapt the model to address the specific needs of the learning disabled population. Results indicated that the experimental group subjects demonstrated a significant increase in parental empathy only. However, findings were in the expected direction for parent acceptance and child self concept, and one of the four parent acceptance subscales, which measures the parent's recognition of the child's feelings was found to be significant.

CHAPTER 1

Introduction

While no conclusive evidence concerning the etiology or even the exact nature of learning disabilities has yet been established, it has been estimated that 1% to 3% of the school population suffers from this disorder (Bryan, 1974a). That the disorder is so little understood is reflected in the definition of learning disabled (LD) children, developed by the National Advisory Committee on Handicapped Children, which focuses entirely on label clarification and descriptive information:

Children with special learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental asphasia, etc. They do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbance. (USPHS, 1969)

As this definition demonstrates, the set of characteristics or symptoms of the disorder which are common to all LD children, and serve to identify them, are educational in nature. Yet there is a growing body of evidence which suggests that these children experience, in addition to the learning disability, a range of social and emotional difficulties, including a high level of rejection by significant others and a low self concept; difficulties which demand attention but are

not addressed by the typically academic focus of most LD remedial programs. Therefore there exists a clear need for programs which are specifically designed to increase the LD child's social adjustment.

When the focus of the program becomes social adjustment rather than academic learning, parental involvement in the remediation process appears to offer several advantages. Parents of the LD children represent a manpower source which, if tapped, could greatly increase the leverage of LD professionals in providing services to the LD child; these parents retain a greater influence over the child's social adjustment than any other individual; and further, it appears that neglecting to involve these parents in the remediation process can actually result in the child's progress being inhibited.

A closer look at the parents of LD children reveals that they may play a significant role in the problematic pattern of the LD child's social adjustment. The family lives of LD children appear to be characterized by disorganization, emotional instability, communication problems, and alienation of the LD child from the other family members. The parents themselves appear to lack the parenting skills which are critical in raising any child, let alone an exceptional one. Involving parents in the remediation process therefore appears to be doubly advantageous in that it offers one possible way of intervening directly in the child's problematic social life.

Only a few studies have in fact been conducted which have evaluated the impact of involving parents in the LD remediation processes in various capacities. The results of these studies are encouraging, however, other models of parent-involvement programs need to be evaluated

before it is known how these parents can most effectively contribute to the remediation process.

Filial Therapy is one model of a parent training program which appears to be appropriate for use with parents of LD children. The main thrust of the program is to increase parental acceptance and parental empathy, both of which have been found to be positively associated with child self concept. It has been demonstrated that the LD child has a negative self concept, and increasing the child's experience of being accepted and understood should have a beneficial impact on the child's self concept. However, Filial Therapy has not been evaluated with parents of LD children, nor has it been evaluated with respect to increasing child self concept.

The present study evaluated the effectiveness of a modified Filial Therapy training program, adapted for use with mothers of LD children, in increasing parental empathy, parental acceptance and child self concept.

Review of Literature
Characteristics of the LD Child

It has been demonstrated that LD children have significantly lower comprehension of non-verbal communication (Bryan, 1977), and that LD boys, as opposed to LD girls or non LD children, fail to alter the complexity of their verbal communication when instructing younger children (Bryan, 1978). LD children have lower empathic ability (Bachara, 1976) and lower role taking ability than their nondisabled counterparts (Wong and Wong, 1980). The classroom behavior of these children is significantly different than that of non LD children. They spend less time attending to the task at hand (Bryan, 1974b; Bryan and Wheeler, 1972; Forness and Esveltdt, 1975), they attend to the teacher significantly less often, and in turn are ignored by both teachers and peers more often than are nondisabled children (Bryan, 1974b).

During the course of their verbal interactions they make more derogatory statements and more competitive statements, and receive more rejection statements and fewer statements of consideration from their peers (Bryan and Bryan, 1978; Bryan, Wheeler, Felcan and Henek, 1976). In addition, these children appear to play a submissive role when engaged in a small group, task-oriented situation, rather than assume a leadership role, or represent their own viewpoint (Bryan, Donahue, and Pearl, 1981).

These socially undesirable characteristics and behaviors

appear to account, at least in part, for the negative light in which LD children are viewed by others around them. Studies have repeatedly shown LD children to be less popular than their non LD peers (Bryan, 1974c; Bryan and Bryan, 1978; Bruininks, 1978; Garrett and Crump, 1980; Siperstein, Bopp and Bak, 1978). Furthermore, Bryan, (1976) has demonstrated that this unpopularity is not a short-term phenomenon, that LD children remain unpopular over long periods of time, regardless of changes in peer group composition. Scranton and Ryckman (1979) found that the low social status of LD children persists even in an 'open' school environment where the labeling effects of LD are theoretically minimized.

It has also been shown that teachers perceive LD students more negatively than other categories of students. Keogh, Tchir, and Windeguth (1974) found that teachers described educationally handicapped children in terms of behavior problems (hyperactive, aggressive, disruptive, lacking in responsibility, withdrawn, poor peer relations), while educable mentally retarded students were described in terms of learning problems. Garrett and Crump (1980) found that teachers preferred non LD students significantly more than LD students. In addition Bryan and Perlmutter (1979) showed evidence that complete strangers find female LD children significantly less desirable than either LD males or non LD children, after having viewed videotapes of these children interacting with others.

While handicaps which are specifically educational in nature may have a limited influence outside the academic environment,

the social and emotional problems which characterize many LD children are in operation not only in the classroom, but also in settings outside the classroom which involve social interaction. Thus the factors which combine to render the LD child unattractive and unpopular at school often appear to have a similar influence in the family arena as well. Kronick (1974) describes the manner in which LD children may be set apart, again in a negative light, in their own families:

The child who presents problems in language and memory may feel out of place in a verbal family, or a quiet, slow-moving family may find themselves with a dynamo in their midst; the highly productive family may realize that they must all adjust to a hypoactive offspring. A family that weighs and considers each decision and action may find that they have an impulsive child clashing with their *modus operandi*. Poor skill in choosing appropriate clothing to wear or insufficient motivation to dress neatly may make a child stand out in a stylish family, and clumsy table manners may be a source of irritation to the fastidious... The child who tends to do and say the wrong thing appears noticeably out of place in the politician's family. (p.145)

Learning disabilities can be a difficult disorder to identify and understand, and many times even after a diagnosis has been made, family members are uncertain which aspects of the child are disabled and which are intact (Kronick, 1974). The LD child possesses an average or above-average intelligence, is of normal physical appearance, and due to characteristically erratic behavior, appears to be capable of appropriate and competent performance at will. This 'invisible handicap' often leads the significant others in the LD child's life to believe that the child is lazy and contrary (Beers and Beers, 1975).

Owen, Adams, Stolz, and Fisher (1971) report that parents of LD children perceive their LD offspring as less acceptable and more

disturbed than their siblings. Strag (1972) found that parents view their LD children as lacking in consideration, quarrelsome, tending to show off, and generally negative. Further, in comparison to parents of severely mentally retarded children, these parents more often perceived their children as clingy, stubborn, and unable to receive attention. When compared to mothers of normal children, mothers of LD offspring perceive their children as having more behavior and adjustment problems (Doleys, Cartelli, and Doster, 1976). The LD child tends to be a less rewarding youngster than his or her siblings, and hence is more likely to become an abused child (Berman, 1979).

The picture that is drawn, then, in both the descriptive and the empirical literature, of the LD child's experience of his or her social world is a rather discouraging one. These children's relationships with the significant people in their lives are problem-ridden, and the LD children bear the brunt of the blame for this, both in the perceptions of others and in their own eyes. This description would tend to suggest that the self concepts of LD children would be lower than the self concepts of non LD children, reasoning which is supported by several studies.

Larsen, Parker and Jorjorian (1973) and Rosser (1974) have found significantly greater discrepancies between the real and ideal self concepts of LD children relative to those of normal children. Rosenthal (1973) compared the self esteem of 60 LD, non LD and asthmatic boys. Results obtained by Yauman (1980) indicate that mainstreamed elementary school LD children have a lower self concept than

either non LD children or special class LD children. Griffiths (1975) found that 131 dyslexic children, ranging in age from 6 to 14 years, perceived themselves as lacking in intelligence. Boersma, Chapman, and Maguire, (1978), studying children in grades three through six, found no difference between LD and non LD children on a measure of general self concept, but did find significant differences between these groups in self concept of ability (a component of self concept). Finally, Black (1974) compared retarded and normal readers within a sample of learning problem students. The results indicated that the retarded readers had a significantly lower self concept than the normal readers.

It becomes clear then, that many LD children experience a range of social and emotional problems, including a high level of rejection from the significant others around them and a low self concept. However, not all LD children appear to experience these difficulties (Kronick, 1978) and some learning disabilities specialists contend that these social and emotional problems are merely a function of the academic disability that, were the disability itself to be corrected, would cease to exist. To date, however, no empirical evidence exists which proves this to be the case. In addition, Bryan and Bryan (1975) argue that:

The major thrust of the remediation of the deficits in learning disabled children has been in the attempts to develop instructional techniques better suited to such children. Yet...it is just this factor which seems to be the most elusive in terms of development and the least potent in terms of effects. This is not to say that continued efforts should not be made to develop more refined instructional methods, but rather that to have a more effective impact on remediation of problems, it may be necessary to direct efforts to the study of other variables, such as teacher actions, rather than limiting the path of our efforts to development

of ever more instructional materials (p. 329).

While the social and emotional problems experienced by many LD children in and of themselves warrant treatment, it may be that their presence exacerbates the severity of the academic disability as well. Thus, until the enigmatic nature of learning disabilities has been penetrated and strategies for prevention secured, or until academic programs have been developed which demonstrate the capacity to effectively correct both the educational disability as well as the social and emotional problems which often accompany it, it would seem critical to apply intervention to increase the LD child's social adjustment as well.

Parent Involvement in LD Remediation

When the focus in the remediation of learning disabilities is shifted from academic concerns to the dimension of social and emotional adjustment, it becomes quickly evident that parental involvement in the remediation process may offer substantial advantages over intervention in the educational environment, or treatment of the child alone. Parents play a vital role in shaping the child's social and emotional experience, and as such could have a potentially powerful impact on the child's behavior and adjustment.

Parents who are not actively engaged as a member of the LD remediation team can have an inhibitive effect on the child's progress (Bryant, 1971). Chapman and Boersma (1979) obtained results

which suggest that unless parents receive specific information on how they can help with the remediation process, improvement may be hampered by negative interactions between parent and child. Bricklin (1970) describes parents' reactions at not being part of the remediation program: Guilty at believing they are to blame for the child's problems, and angry at the professional who occupies the enviable position of playing a helping role with the child.

Historically, the educational system has not been geared toward parent involvement, and relationships between LD parents and professionals have traditionally been problematic. Parents have experienced great difficulty in acting effectively to obtain remedial services for their children, and have often been frustrated by the posture which professionals have adopted toward them (Gorham, 1975). Nonetheless, professionals are increasingly acknowledging the importance of parental involvement in the remediation process, as well as changes which they must initiate in order to forge better relations with parents (McLoughlin, Edge, and Strenecky, 1975; McLoughlin, McLoughlin, and Steward, 1979).

To the extent that parents have had the opportunity to respond to these overtures by professionals, they have indicated a strong interest in becoming part of the remediation team. Two surveys found parents of the learning disabled feeling dissatisfied with their level of information regarding the disorder, frustrated in their attempts to obtain help for their child, ineffective in their contact with professionals, and in need of immediate and practical help for dealing directly with their children (Becker, Bender, and Kawabe, 1980; Dembinski and Mauser, 1977). In order

to foster parent involvement in LD intervention, a profile is needed which would detail the particular characteristics and needs of the parent-child relationships and home environments of LD children.

Parents of LD Children

Over the last ten years there has been a limited but apparently growing interest in the nature of the parent-child relationships and general home environments of LD children. Reports on this area of concern have been both clinical-descriptive and empirical in nature, and, taken as a whole, seem to suggest that a relationship exists between the quality of these familial variables and the existence of a learning disability. It should be noted, however, that no study has as yet established the existence of a causal relationship between these variables. It cannot be assumed, therefore, that the quality of the family environment is responsible for the development and/or maintenance of learning disabilities, or that the existence of a child's learning disability adversely or otherwise effects the home environment.

Friedman (1978) emphasizes that the family is the child's first school, where values regarding learning are first set, and where the child's receptivity to the learning process is determined. Here the child receives his or her earliest models for relationships with 'learning authorities,' as well as the basic skills which are fundamental to classroom learning, such as the ability to listen and follow directions. "The family is the primal group in which learning how to learn begins. The child is taught how to learn before anybody is aware of teaching..."

(Brodey, 1968, p. 101). Klein, Altman, Dreizen, Freidman, and Powers, (1981a, 1981b) describe the dysfunctional attitudes of parents which seem to be associated with the child's learning problems. These are attitudes toward authority, which are based on the assumption that the educational system is to blame for the child's problems, and that educational professionals are incompetent; attitudes toward the child, which carry the message that the child is incapable and convey a vote of no confidence in his or her capacities; and attitudes towards responsibility for learning, which communicates that the child is not responsible for adequate performance, and give the child permission to fail without trying. The authors "consider unrealistic the separation of educational remediation from the restructuring of parental attitudes that are interfering with the learning process" (Klein et al. 1981a, p. 16).

A number of studies have obtained findings specifically concerning the quality of the parent-child relationship as it relates to the incidence of learning disabilities. Chapman and Boersma (1979) administered questionnaires to mothers of 81 LD and non LD children in grades three through six. Mothers of LD children reported significantly fewer positive reactions to their child's school performance, and significantly more negative interactions with their child. Freund and Elardo (1978) studied 17 LD children and their mothers. Using a structured interview measure, the Home Environment Process Interview, the authors found that two variables contributed significantly to the prediction of social competence in the LD child. Parental encouragement techniques, the first variable, focused on maternal encouragement behaviors relative to the

child's socially responsible conduct. Child-oriented sensitivity, the second variable, assessed the parent's communication to the child of the parent's awareness of the way the child felt in a given situation. This finding is of particular significance to the present study, in that it suggests that parental empathy may be associated with decreased social and emotional problems in the LD child. However, because the sample size of this study was small, the authors indicate that the findings must be viewed tentatively.

Doleys, Cartelli, and Doster (1976) observed 27 mother-child pairs interacting in structured and nonstructured play situations. The sample included mothers of LD, normal and behavior deviant children. Mothers of the LD children asked significantly more questions than other mothers and dispensed more rewards to their children than the mothers of normal children. Based on this quantitative data it would appear that mothers of LD children were actively engaged in effectively managing the behavior of their children. However, the study did not control for the quality of these parental behaviors. The authors state that the majority of the mothers' questions were tutorial or instructive in nature, and at times bordered on the excessive. In addition, the authors questioned the appropriateness of the rewards which were dispensed, both in terms of the timing and nature of the reward. That these mothers were in fact not effectively managing their children's behavior is demonstrated by the findings that mothers of LD children elicited a significantly lower percentage of compliance relative to mothers of normal children.

Wulbert, Inglis, Kriegsman, and Mills (1975) compared the home environment

of language disabled preschoolers with the home environments of normal and Down's Syndrome children, and found that mothers of language disabled children were significantly less responsive to and involved with their child than were the other two groups of mothers.

The studies cited above suggest the existence of a negative, though not causal, relationship between the quality of the parent-child relationship and learning disabilities, and the social and emotional problems which often accompany the disability. In contrast, Humphries and Bauman (1980) obtained results which do not support this relationship. Using the Parental Attitude Research Instrument, these researchers compared 42 mothers of LD children with 42 mothers of non LD children, matched for age, SES, and education. Mothers of LD children were found to be significantly more authoritative and controlling, but significantly less hostile and rejecting than the control mothers.

Several investigators have searched for associations between learning disabilities and the overall home environment, including family behavior dynamics. Owen et al. (1971) conducted at-school interviews with parents of 76 educationally handicapped and 76 normal elementary and high school children. It was found that families of educationally handicapped children are generally less well organized and less emotionally stable. Peck and Stackhouse (1973) observed the verbal interactions of 15 families with learning problem children and 15 normal families. Using a laboratory experiment involving a revealed difference technique, they found that reading problem families took longer to reach decisions, spent greater amounts of time in silence, exchanged less explicit

relevant information, and engaged in more irrelevant exchanges. These two categories of families did not differ in their initial level of agreement between family members. Therefore the authors conclude that normal families are more effective decision makers, not because of higher agreement, but because they have evolved a more efficient decision-making process. Peck and Stackhouse (1973) speculate that reading problem families have taught the reading problem child not to learn, and that the child, in turn, has developed the 'art of being stupid.'

Two studies have employed the Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell and Bradley, 1979) to investigate the home environments of LD children. This inventory taps such dimensions of the home as emotional and verbal responsivity of the mother, avoidance of restriction and punishment, languages stimulation, and provision of appropriate play materials. One of the major functions of the HOME Inventory is to identify homes which are likely to impede or foster cognitive development. Van Doornick, Caldwell, Wright, and Frankenburg (1975) conducted an 11-year follow-up of 286 children who had participated in an early education project. In this study, scores obtained on the HOME Inventory at 12 months of age correctly identified 62% of the children who displayed school competency problems at 12 years of age. Wulbert, Inglis, Kriegsman, and Mills (1975) found that the total HOME Inventory scores of language disabled preschool children were significantly lower than the HOME scores of either normal or Down's Syndrome children. Freund, Bradley, and Caldwell (1979) suggest that home environmental assessment measures may well be superior to child-focused measures in the early prediction of learning disabilities.

Kronick (1976a) conducted an in-depth naturalistic observation of three families with LD children. She describes some of the pathological patterns of interaction that were in evident operation in these families. Distortion and breakdown in communication; disorganization in management of instrumental resources (because of the LD child's need for consistency and structure to counteract a tendency toward erratic and unpredictable behavior, this disorganization is considered an especially debilitating phenomenon); difficulty in dealing with conflict, suppression of anger and hostility; and most importantly, alientation of the LD child from the other family members, either in the role of the 'problem child', or as the scapegoat on whom the family vents its hostilities and frustrations. This isolation of the LD child is often compounded by the parents' unwillingness to talk about, face directly, understand or accept the child's disability. The message received by the child is that he or she is not understood or accepted.

The majority of the studies which have been reviewed here have supported the notion that there indeed exists an association between the quality of the home environment, including the parent-child relationship and learning disabilities. No evidence concerning the nature of this relationship has yet been produced which might illuminate the question of causality, or the direction of causality in this association. However, it seems plausible that an interaction may exist which is bidirectional. Freund, Bradley, and Caldwell (1979) state:

We are not here making the naive assumption that the home environment is always the causative agent in learning disabilities. The uneven performance on the part of the LD mother who rewards her child awkwardly and with a poor sense of timing may be due, in large part, to the fact that her child is impulsive, inconsistent and unpredictable and responds sporadically to her carefully planned

reinforcements... To some extent, what we observe in the home environments of learning disabled children is a reaction to, as well as a determinant of, the child's behavior... It is possible the LD children do not hold up their end of parent-child interaction, that they disappoint parental expectations, and thereby, contribute to the distortion and disorganization of home environmental processes. The dynamics of this reciprocal interaction require further investigation (p. 48).

Regardless of origin, it is probable that the troubled conditions which characterize the family lives of LD children play a major role in maintaining the social and emotional difficulties which these children experience. It is evident from profile presented above that parents of LD children contribute to these problematic home conditions. Therefore, one possible route to improvement in the social adjustment of LD children is to apply treatment to their parents, rather than directly to the children themselves.

Previous Studies of Parent Involvement

Only a small number of studies have been conducted which have evaluated treatment programs for parents of LD children, and the thrust of treatment content has varied considerably within these studies. Ryback and Staats (1970) trained four mothers to use a token system in tutoring their dyslexic children. These mothers were able to achieve significant increases in their children's reading ability. Hetrick (1979) conducted six two-hour training sessions to teach parents communication skills to use with their children. Relative to a control group, these parents significantly improved the quality of their communication with their children; however, this improvement did not generalize to the number of problems in the over-all parent-child relationship, or to the child's academic performance.

Baker (1970) compared the relative effectiveness of several different LD treatment methods. These methods consisted of various combinations of academic tutoring for the child, Rogerian counseling for the mother, and Play Therapy for the child. It was found that either therapy for the child or counseling for the mother, or both, in combination with tutoring, significantly improved the parent's attitude toward the child and the child's academic achievement. These improvements were significantly greater than those achieved with tutoring alone. Baker infers from these results that the parent-child relationship seems to be at least one of the most important factors in the maintenance of academic problems in children with learning disabilities. Gilmore (1971) in his review of Baker's study, states that;

The research findings and the additional observations in Baker's study raise some very important questions as far as the treatment of perceptual difficulties is concerned. His research suggests that the current methods of teaching the so-called perceptually handicapped child which are employed by the schools with either the group or the tutoring approach are not successfully treating the child's difficulty. These methods are based on an unfounded assumption that all perceptual difficulties have a neurological cause. It would appear that except in a medical case of a thoroughly diagnosed neurological impairment, the current treatment method is dealing with symptoms and not with causes. Research in experimental psychology has found repeatedly that emotional conflicts can interfere with the visual process. Any improvement secured in the child under current teaching methods will be of doubtful permanency since it is not eliminating the conflict caused by an emptiness and an emotional deficit that these children apparently experience (p. 81).

Runyan (1973) conducted Adlerian parent education groups with families of reading problem children. Significant improvements were found in the children's home and school behavior as reported by parents. Rosenthal (1973) compared two groups of dyslexic boys on a general measure of self esteem six months after one of the groups of boys, and

their families, had been given information about the nature and causes of dyslexia. It was found that the informed group of boys had significantly higher self esteem than the uninformed group, implying that level of knowledge regarding the disability may be one important factor in determining the degree to which emotional problems develop in combination with the educational disability.

Spector (1975) compared the effectiveness of three short-term parent counseling approaches: Traditional psychodynamic, behavior modification, and one approach which merely involved an increase in parent-child involvement in mutually satisfying activities (parent attention group). All three groups achieved improvement in child's behavior, mother attitude toward child, and child attitude toward mother. While no treatment approach was statistically superior to the others in achieving these improvements, the parent attention group made the strongest gains overall. Spector considers this finding to be dramatic in the sense that no professional 'interfered' with the dynamics of the parent-child relationship. He concludes that, in view of the apparent improvement in the children in all of the treatment approaches, it would appear that training mothers of LD children to be counselors for their own children may be more effective than treating the children themselves.

Filial Therapy

It is precisely this reasoning which constitutes the rationale of a treatment program, called Filial Therapy, in which parents are trained to function as play therapists by learning to communicate empathic understanding and a warm acceptance of their children. Filial Therapy (B. Guerney,

1964; L. Guerney, 1976) is based on the argument that, as the parent has an ongoing and extremely significant relationship with the child, these attitudes should have more impact coming from the parent than coming from a professional. While Filial Therapy has been previously conducted with parents of some LD children, its effectiveness in remediating the particular problems of that population has not yet been substantiated. However, the general efficacy of the Filial model has been evaluated in a series of studies conducted with children four to ten years of age who were experiencing serious emotional difficulties.

Shortly after its conception, Stover and B. Guerney (1967) tested the effectiveness of the Filial model by assessing changes in mother-child communication after participation in four play sessions. Compared to waiting-list mothers who served as controls, the 28 experimental mothers demonstrated an increase in empathic communication and a decrease in directive communication. In a three-year study undertaken to obtain a more comprehensive understanding of the efficacy of Filial Therapy B. Guerney and Stover (1971) found a 66% reduction in child problems as reported by parents, a decrease in parent dissatisfaction, and improvement in both parent and therapist ratings of child adjustment. Mother-child behavior changes during play sessions included a decrease in child aggression and dependency, as well as increases in maternal involvement and acceptance of child self-direction.

Oxman (1971) provided a control group for the experimental subjects in the B. Guerney and Stover (1971) study. Subjects were matched for parent and child age, family size, and SES. Significant changes in experimental subjects included improvement in symptomatology

and maternal dissatisfaction. Horner (1974) also obtained a 59% decrease in symptomatology for 60 children after six months in Filial Therapy.

Sywulak (1977) used a four-month waiting period to implement a subject-as-own-control design to study 32 parents and 19 children participating in the Filial program. Clients typically participate in the program for an average of 12 months, and Sywulak was interested in examining changes which occur by the second and fourth months of treatment. Significant gains were demonstrated in parental acceptance and symptomatology. Seventy percent of the parental acceptance gain occurred during the first two months of treatment.

Filial Therapy may be a particularly appropriate mode of treatment for use with parents of LD children in one important respect. The main thrust of the Filial program is toward increasing parental acceptance, and it appears that there may be a positive relationship parental acceptance and child self concept. Porter (1954) has defined parental acceptance as;

feelings and behavior on the part of the parents which are characterized by unconditional love for the child, a recognition of the child as a person with feelings who has a right and a need to express those feelings, a value for the unique makeup of the child and a recognition of the child's need to differentiate and separate himself from his parents in order that he may become an autonomous individual. (p.177).

Therefore, the message which is communicated by the accepting parent is that the child is loved, recognized, respected and valued. Self concept, in turn, can be thought of as "a complex and dynamic system of beliefs which an individual holds true about himself (Purkey, 1970 p. 7). Most self concept theorists agree that a main factor in the development of this belief system is the accumulated experience of 'the evaluation of self by others' (Rogers, 1951, p. 499), particularly the

evaluation by significant others. Thus, the child whose parents communicate a realistic, warm acceptance of him/her should perceive him/herself as being more valuable, and have a higher self concept than the child whose parents communicate, through rejection, that the child has no value.

Parental Acceptance and Self Concept

Coopersmith (1967) found that high self esteem is associated with total or near-total acceptance of the child by parents who clearly define and enforce limits for the child, and who demonstrate respect for individual action within those limits. Peppin (1962) administered behavior rating scales to parents of sixth graders, with which they were asked to rate their child. The sixth graders used these same measures to rate themselves. Favorability of self assessment was related to positive perception of the child by the parent. Miller (1971) studied the verbal and non-verbal dimensions of mother-child communication. The mother's ability to be reflective as opposed to judgemental in her communication, as well as her level of empathy, genuineness, and positive regard for the child were all significantly and positively associated with high self esteem in the child. Sears (1970) found that parental warmth at five years of age was associated with self esteem when the child was twelve.

The above studies attempted to assess parental acceptance by directly tapping parents' attitudes and behaviors toward their children. Other studies have examined the relationship between parental acceptance

as perceived by the child, and self concept, arguing that the child's perception of the parent's behavior and attitudes will be more powerful determinants of the child's experience than the parent's actual perceptions of behaviors. A positive significant relationship has been found between perceived parental acceptance and self concept among college students (Lanza, 1970; Medinnus, 1965), high school students (Rosenberg, 1963), and school age children (Swanson, 1969).

Two studies have found that this relationship appears to hold cross-culturally. Lefley, (1974) obtained a significant association between perceived parental acceptance and selfesteem among boys in two American Indian tribes. Rohner (1975) conducted a survey of 101 societies worldwide and also found evidence to corroborate the existence of this relationship.

In contrast to the studies cited above, Mote (1966) obtained findings which do not support the existence of the relationship between parental acceptance and self concept. As indexed by a questionnaire for mothers, parental warmth, satisfaction with child behavior, and punitiveness were not found to be associated with self concept. Parental satisfaction with child learning was the only variable found to be related to self concept.

Most of the studies reported in this section present some methodological difficulties that influence the interpretation of their findings. Operational definitions of parental acceptance have varied greatly, and often the measures used to assess this construct have been subscales or adaptations of instruments designed for other, more general purposes. No replication studies have been conducted, and researchers

often work theoretically independent from the previous studies. Longitudinal data is lacking, and most of the studies have employed only a single measure of parental acceptance.

Nonetheless, parental acceptance has been repeatedly found to be positively associated with child self concept, and it is possible that if LD children experience an increase in parental acceptance, they will also demonstrate an increase in self concept. It is in this sense, then, that there may be a high degree of fit between the needs of parents of LD children and the particular strengths of the Filial Therapy program. However, it has not yet been demonstrated that Filial Therapy techniques would be effective in increasing the parental acceptance of parents of LD children. In addition, child self concept has never been studied as an outcome variable of the Filial Therapy program.

Summary: Statement of the Problem

To summarize the main points which have been made in the foregoing discussion, it has been demonstrated that many LD children experience certain social and emotional problems, including low self concept, in addition to their educational disability. It appears that parents of LD children contribute to the continued existence of these adjustment problems through what might be called a skill deficit. Therefore, it seems plausible that intervening with the parents of LD children, rather than with the children themselves, may have a positive impact on the adjustment of these children. Very few studies have been reported which have implemented such intervention programs, however, the results which have been generated by these studies are

very encouraging.

Filial Therapy is one program which appears to be of particular relevance to the needs of parents of LD children. Its focus is directed toward increasing parental acceptance, and tentative results from a variety of studies indicate that there may be a positive relationship between parental acceptance and child self concept.

While there is a clear need for programs which increase the social and emotional adjustment of LD children, few such programs exist. Further, little has been done to evaluate the potential contributions of parents of LD children to such programs. Research is needed to evaluate various programs which involve parents in different capacities in the remediation process. In addition, studies are needed which evaluate parent outcomes (i.e. increased parent skills) as well as child outcomes (behavior change, increased adjustment, academic progress).

The purpose of the present study is to evaluate the effectiveness of a modified Filial Therapy program in increasing the parental acceptance and empathy of mothers of LD children, and in increasing the self concepts of the LD children themselves.

Hypotheses

It is hypothesized that mothers in the experimental group will, relative to the control group mothers:

- 1) demonstrate a significantly greater increase in parental acceptance, and
- 2) demonstrate a significantly greater increase in parental empathy

It is also hypothesized that children in the experimental group will, relative to the control group children:

- 1) demonstrate a significantly greater increase in self concept.

CHAPTER 2

Methods

This chapter describes sampling procedures, relevant characteristics of the sample, research design, intake and experimental treatment procedures, and the measures which were implemented to assess the dependent variables.

Sample

Twenty-five mothers were recruited throughout Pima County, Arizona, to participate in the study, each having a child between seven and ten years of age who had been diagnosed by the schools as having a learning disability. Recruitment was accomplished by sending letters to prospective parents from the Tucson Chapter of the Association for Children with Learning Disabilities, and by placing an article in both the university newspaper and a major county newspaper. In addition, the Amphitheatre Public Schools provided support by sending a recruitment letter home to parents of all children between the ages of seven and ten who were enrolled in LD classes.

Twenty-eight mothers initially made contact with the researchers regarding participation in the program. Of these 28, three were ineligible due to child age, had misunderstood the format of the program, or were unable to participate due to scheduling difficulties. Thus, 25 mother-child pairs of the initial 28 completed the pre-test interview schedule. Of these 25, two pairs withdrew from the program after completing the

pre-test interview. One pair moved from the city and one pair was unwilling to return after the video equipment had malfunctioned during the original interview. In addition, one mother who had been assigned to the treatment group underwent oral surgery after completing four weeks of training, was forced to miss three sessions, and subsequently withdrew from the program. Therefore, pre- and post-test data were available on the 22 mother-child pairs who completed the program.

Children in the sample were predominantly male (86%), and ranged in age from seven to ten years, with a mean of nine years. Grade placement of these children ranged from first to fifth grade, and the mean was grade three. Subjects' scores on the Peabody Individual Achievement Test indicated that 35½% were performing approximately at grade level; 30½% and 28½% were performing one year below and above grade level respectively; and 22% were performing two or more years below grade level, while 4½% were performing two or more years above grade level. Table 1 presents the results of t-tests performed on all ordinal level demographic data. These results indicate that there were no significant differences between experimental (E) and control (C) groups on child age, grade level, grade/achievement performance discrepancy, mother's age and education, and family income. Table 2 presents comparisons of nominal level demographic data by treatment and control groups.

Table 1: Means, Standard Deviations, and Results of t-tests of Ordinal Level Demographic Variables.

<u>Variable</u>	<u>E</u> N = 11		<u>C</u> N = 11	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Child age	9.27	.905	8.82	.982
Child grade	3.36	1.12	3.27	.786
Grade/Achievmt. Discrepancy	-1.11	1.32	-.76	1.34
Mother's age	38.91	7.15	34.27	5.72
Mother's educ. (highest grade)	13.55	1.57	12.00	2.41
Income	\$16,545	\$7,518	\$14,954	\$9,001

	<u>t</u>	<u>df</u>	<u>p</u>
Child age	1.13	20	.272
Child grade	.22	20	.878
Grade/Achvmt. Discrepancy	-.61	20	.550
Mother's Age	1.68	20	1.09
Mother's Education	1.78	20	.090
Income	.45	20	.658

Table 2: Comparisons of Nominal Level Demographic Data by Treatment and Control Groups.

		E group (N)	C group (N)
Sex	Male	90.9% (10)	81.8% (9)
	Female	9.1% (1)	18.2% (2)
		100% (11)	100% (11)
Marital Status	Married	63.6% (7)	54.5% (6)
	Divorced	18.2% (2)	27.3% (3)
	Remarried	18.2% (2)	18.2% (2)
		100% (11)	100% (11)
Occupation	Homemaker	63.6% (7)	54.5% (6)
	Employed	27.3% (3)	45.5% (5)
	Student	9.1% (1)	0 (0)
		100% (11)	100% (11)

Mothers in the sample ranged in age from 24 to 52 years, with a mean age of 37 years. Fifty-nine percent of the mothers were full-time homemakers, 37% were employed, and 4% were students. Educational background of the mothers included 50% who had a high school education or below; 40% who had some college education; and 10% who had a college degree or higher. Fifty-nine percent of the mothers were married for the first time, 23% were divorced, and 18% were re-married. Family income levels ranged from below \$5,000 to \$30,000, and the mean income was approximately \$15,750. There were no significant differences between treatment and control group mothers on age, educational background, or family income.

Referral sources for the subjects included recruitment letters (36½%), pediatricians (19%), teachers (13%), school counselors (13%), friends (4½%), and newsmedia (4½%). Mothers were asked to report problems which their children experienced at school, when interacting with peers, and at home. Problems at school most frequently mentioned were reading (reported by 64% of the sample), memory (41%), math (27%), behavior problems (27%), spelling (27%), and motor coordination (23½%). Problems with peers included being picked on (32%), aggression (32%), and being left out (23%). Children's problems at home which were most frequently cited were non-complicance (32%), lacking self confidence (23%), and unpredictability (23%) and aggression (18%). Forty-one percent of the children in the sample were on some form of medication. Table 3 presents comparisons of treatment and control groups subjects on school, peer, and home difficulties.

Table 3: Comparisons of Child Difficulties by Treatment and Control Groups

Variable	E-Group	C-Group
<u>Difficulties in school</u>		
Reading	45.5% (5)	81.8% (9)
Behavior Problems	36.4% (4)	18.2% (2)
Motor Coordination	36.4% (4)	9.1% (1)
Memory	54.6% (6)	27.3% (3)
Spelling	18.2% (2)	36.4% (4)
Math	27.3% (3)	27.3% (3)
Peer Difficulty	27.3% (3)	9.1% (1)
<u>Difficulties with Peers</u>		
Picked on	54.6% (6)	9.1% (1)
Aggressive	27.3% (3)	36.4% (4)
Left Out	45.5% (5)	0% (0)
<u>Difficulties at Home</u>		
Non-compliance	36.4% (4)	27.3% (3)
Lacks self Confidence	18.2% (2)	27.3% (3)
Unpredictable	27.3% (3)	18.2% (2)
Aggressive	27.3% (3)	9.1% (1)

A pretest-posttest control group design (Campbell and Stanley 1963) was employed in the present study. The 22 mother-child-pairs were randomly assigned to either experimental (E) or control (C) group conditions, and the C group subjects were offered the treatment program at the end of a four-month waiting period. This design controls for such potential threats to validity as history and maturation which are of particular relevance to a research project involving children. Testing effects, subject expectancies and/or awareness of program focus, as well as experimenter attention, are not controlled within this design.

Intake Procedure

After initial telephone contact had been made to ascertain that subjects were willing and eligible to participate, a one and one-half hour interview was scheduled with mother and child at the university. Parent intake packets were mailed to the mother, which included a map of the campus with the appointment location circled, the paper/pencil parent acceptance measure, and forms regarding general demographic information.

When the parent and child arrived for the interview, the child went with the graduate research assistant (a doctoral student in educational psychology) to one room and the parent went with the investigator to another room. For the first hour, the investigator talked with the parent, securing child background information, explaining the nature of the service-research program, answering questions, determining the parent's goals and willingness to commit herself to four months

of classes. In addition, the investigator assessed the degree of fit between the parent's goals and the program services. Lack of fit was not a problem and apparently was taken care of through the recruitment letter and the initial telephone interview. Finally, the parent was asked to sign a permission form giving permission to collect and use data for research purposes.

While the investigator gathered information from the parent, the graduate assistant talked with the child to establish rapport and then administered verbally the Piers-Harris Self Concept Scale (Piers and Harris, 1969). Following these procedures, the parent and child were asked to play together for 15 minutes, just as they might do at home. The parent was told that their interaction would be videotaped.

Following the taping, the child played with the graduate assistant and the parent met with the investigator. The investigator made a recommendation for the parent to participate in the research program and discussed any remaining parent questions. The parent was told that she would be assigned to a group when space became available, and that this might take from two weeks to four months. Each parent was told that some parents may have to wait longer than others because groups were being formed according to a random selection process and time and space limitations would permit conducting only a few groups at a time. They were told that they would be notified if they were going to have a long wait and that they would be requested to complete some additional research forms at the end of four months. Parents were told that the anticipated expense for the program would be for a few inexpensive special toys which they would keep. Parents were requested to make a deposit of

\$40, payable at the first session, which would be refunded in full upon completion of the program. This deposit was waived in the case of participants who were unable to afford it.

Experimental Treatment

The basic format of the treatment program employed in the present study parallels that of Filial Therapy, with several modifications designed to adapt the model to address the specific needs of the LD population. These modifications were the inclusion of technical knowledge regarding learning disabilities, strategies for dealing with schools, and a behavior management skill training component. The main thrust of the program, however, as in Filial Therapy, focused on training parents in the specific skills of Play Therapy (Axline, 1947).

The underlying principles of Play Therapy hold that every individual has a basic drive toward self-actualization or ongoing growth and enhancement. Within an atmosphere of respect and acceptance, the individual is capable of conflict resolution, growth, and integration. The therapist establishes this atmosphere of acceptance and respect by endeavoring to "assume as far as he is able, the internal frame of reference of his client, to perceive the world as the client sees it, to perceive the client as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of that understanding to the client" (Rogers, 1951, p. 29).

As play is seen as the natural medium through which a child communicates his/her feelings and perceptions, the therapy sessions

are focused around the child's play activities. The physical environment is structured to provide as much freedom to the child as possible, i.e. there is a minimum of furniture, breakable items etc. Toys are chosen to allow for various forms of expression, such as fantasy, aggression, and competition. The child is the sole judge of the activities that are engaged in, and the tone and content of the sessions. The therapist follows the child's lead by responding empathically to the emotional material which the child brings to the session, and communicates an attitude of warmth and understanding acceptance to the child.

Infinite acceptance of the child's behavior, however, is not a realistic goal. It is crucial, therefore, that the play session be 'structured' through the imposition of certain common-sense limits. While no restrictions are placed on the child's verbal expressions, limits are placed on acting out in a destructive manner, and on the time length of the session. Limits are communicated to the child at the start of the session, and are consistently enforced so that the child may be able to accurately predict the consequences to various actions, and regulate his or her behavior accordingly. Thus, the play session is structured to allow the child to experience the security of acceptance by clearly delineating the limits of that acceptance.

The experimental training program consisted of 16 weekly sessions two hours in length. Mothers met in small groups (5 to 7 subjects) in a conference room in the psychology building at the university. Two mothers each week brought their child to the training sessions to participate in play sessions. When not so engaged, the children were supervised in

a nearby room by a babysitter. Training sessions were conducted by the project Director and a graduate research assistant. The project Director was a Ph.D. psychologist with five years of clinical practice in child and family therapy, and four years experience teaching child and family therapy at the graduate level in university settings. The graduate research assistant was a doctoral student in educational psychology.

Brief lectures and discussion sessions were used to present basic concepts (for example, parent acceptance) and information regarding learning disabilities, including strategies for improving parent effectiveness in home-school relationships. In addition, parents were given reading materials (Patterson, 1979), handouts, and homework exercises. Skills training procedures (modelling, role-play, etc.) were employed to teach the behavior skills of empathic responding and limit setting. Parents then practiced these skills and received individual feedback. Throughout the early weeks of the program, leaders demonstrated how play sessions were to be conducted, while mothers observed through a one-way mirror. As each mother felt sufficient mastery of the skills and confidence in her ability, at approximately week six, she began to conduct play sessions with her own child while leaders and other group members observed.

In their attempt to accept new ideas and adopt new behaviors toward their children, mothers often experienced frustration and resistance. Particularly when these feelings are imbedded in the context of a parent-child relationship that is already problematic, parental change is best facilitated by the exploration, understanding, and acceptance

of these stressful emotions. This calls for close attention and sensitivity on the part of the leaders to subtle cues from parents that they are experiencing conflict. Parents were encouraged to recognize the feelings which they were experiencing, and support was provided for the parents in their struggle to change.

In order to increase generalization of the play session skills to life outside the training environment, subjects began to conduct play sessions at home during the last month of the program. In addition, considerable attention was given to identifying home situations where the new skills could be applied. Finally, later sessions were also devoted to teaching parents to develop and implement home behavior management programs. An overview of the treatment sessions follows:

- Week 1: Getting acquainted
 - Discussion of difficulties children and parents face
 - Overview of program
 - Parent's goals for program
 - Self concept
- Week 2: Working with the schools: The parent/child/school interface
 - Role of self concept in school achievement
 - Importance of parental acceptance of child
 - How to communicate acceptance of child
- Week 3: Demonstration of adult acceptance of child: Two 15-minute play sessions
 - Discussion of leader's behavior with child
 - Understanding acceptance and rejection
 - School and home examples of child acceptance and rejection
- Week 4: Demonstration play sessions
 - Discussion of leader's behavior with child
 - How to set limits and enforce them
 - Practice communicating acceptance

- Week 5: Demonstration play sessions
 Discussion of leader's behavior with child
 Description of some teaching strategies adaptive education teacher's use with LD children
 Techniques to complement your child's teacher
 Skills to elicit teacher's cooperation
 Practice communicating with teachers
- Week 6: Demonstration play sessions
 Discussion of leader's behavior
 Structuring home environments to support learning and reduce conflict
 Practice communicating acceptance
- Weeks 7,
 8, 9, 10: Two parents conduct a play session with own child
 Discussion of parent learning
 Discussion of home situations where learning support skills could be applied
- Week 11: Parent play sessions with own child
 Discussion of parent learning
 Principles of reinforcement and behavior change
- Week 12: Two parent play sessions with own child
 Discussion of parent learning
 Review principles of behavior change
 Discuss home play sessions
 Parents collect baseline data on target behavior for one week
- Week 13: Two parent play sessions with own child
 Discussion of parent learning
 Discussion of parent collected baseline data
 Parents develop plan to modify one target behavior
 Parents conduct one play session at home per week
- Week 14: Two parent play sessions with own child
 Discussion of parent learning
 Discussion of home play sessions
 Parents implement behavior modification plan and collect frequency counts
 Parents conduct play sessions at home
- Week 15: Two parent play sessions with own child
 Discussion of play sessions
 Evaluation of behavior modification program - make necessary changes
 Discussion of home play sessions
 Parents implement behavior modification program and collect frequency counts - cont'd.
 Parents conduct play sessions at home

Week 16: Parents conduct play sessions
Discussion of plans to continue play sessions
and behavior management programs

Measures

Self-reported parental acceptance was measured by the Porter Parental Acceptance Scale (PPAS) (Porter, 1954). The PPAS (see Appendix B) is a 40-item questionnaire where each item describes a situation in which children express overt behaviors or verbalizations. Each item is repeated twice in the questionnaire, first to see what the parent feels in the situation, and second, to see what the parent does in the situation.

Five responses are presented which describe different parental feelings and reactions in response to the situation. These responses are weighted to represent different levels of acceptance, from low to high. The respondent is asked to choose the response that is most characteristic of his/her own style of reaction. In accordance with Porter's definition of parental acceptance, there are four subscales underlying the total scale, each representing one of the four dimensions of parental acceptance: Parent recognition of the child's feelings and right to express them; parent recognition of child's uniqueness; parent recognition of child's need for autonomy; and parent's unconditional love for the child. Each subscale is represented by 10 items in the scale, half of which address parental feelings while the other half are concerned with parental behavior. In order to reduce the influence of social desirability on respondent's choices, responses are stated in a positive form so that respondents can comfortably choose several answers to each item.

Porter (1954) reports a split-half reliability correlation of .766 raised by the Spearman Brown Prophecy formula to .865. Sywulak (1977) found a four-month test-retest reliability coefficient of .88 ($p = .001$) for the PPAS. Face validity, as reported by Porter (1954) was established by a panel of five judges. The judges were asked to rank the responses according to level of acceptance and at least three out of the five judges agreed on every item.

Parental empathy was measured through use of the Acceptance of Other Scale (AOS) (see Appendix B) developed by Guerney (1977). According to the authors, the scale was:

designed to measure the understanding and acceptance conveyed by one person (the responder) in his verbal responses to a communication from another (the other). The scale gives primary weight to empathy as a form of acceptance and to those responses that encourage the other to follow his own line of thought. It assesses the responder's sensitivity to the other's phenomenological field; his willingness to stay within the boundaries defined by the other's phenomenological field; and his sensitivity to the feelings, needs, and motivations of the other as these have been expressed both by the other's words and manner (p. 364)

The AOS is an eight-point scale where the lower levels of responses are accusative, openly rejecting, abusive, and argumentative; where the middle levels are characterized by ordinary social conversation, or taking the lead; and where the highest levels of response are those that reflect the deepest feelings of the other and convey a completely empathic acceptance of the other.

The scale was used to evaluate videotaped segments of parent-child interaction. The unit of analysis to which the scale was applied in this study was defined as "a statement of the responder which is made between two statements by another" (Guerney, 1977, p. 365). The

responder's statement is evaluated primarily in light of the other's statement that immediately preceded it. All rater judgements are made before the other's reaction to the response, on the basis that otherwise accuracy and reliability would be contaminated by characteristics of the other (i.e., assertiveness, agreeableness, etc.) Therefore, the ratings reflect the rater's judgement of the interpersonal effect of the responder's statement.

Two graduate students received 35 hours of training in the use of the AOS on non-data videotapes of parent-child interaction. When inter-rater reliability (number of agreements divided by total number of responses rated) reached 90%, raters independently and blindly rated 16 two-minute segments which had been selected from the total sample of data tapes. Inter-rater reliability on these two-minute segments was 81%. Each rater then independently and blindly rated half of the data tapes, selected to ensure an equal representation of pre, post and treatment and control conditions. In order to assess rater drift, two tapes were rated by both raters (unbeknown to one another), one at the mid-point of the rating process (87% inter-rater reliability), and one at the end of the rating process (83% inter-rater reliability).

Self concept was measured using the Piers-Harris Self Concept Scale (Piers, 1969). This scale consists of 80 simple, declarative sentences, worded at the third grade reading level. Each item was read aloud to the subjects, who answered yes or no to each question depending on the way they generally felt about themselves. Possible scores on this measure range from one to eighty. The items were taken from a collection of

children's statements about what they liked and disliked about themselves and an approximately equal number of positive and negative statements were included to control for acquiescence-response set.

One internal factor analysis (Piers and Harris, 1964) indicated that ten factors accounted for 42% of the variance, and six were "large enough to be interpretable": Behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and happiness and satisfaction. Two and four-month test-retest correlations for fifth graders have been reported at .77 (Piers, 1969). The Piers-Harris Self Concept Scale has received generally favorable reviews when compared to other available measures of children's self concept (Buros, 1971; Franklin, 1978; Shavelson, Hubner and Stanton, 1976; Wylie, 1974). These judgements are made primarily in light of the greater availability of information on the Piers-Harris regarding scale construction, internal factor analysis, etc; to the satisfactory reliability and validity ratings which have been reported for the Piers-Harris; and to the commendably simple format of the measure which allows it to be administered quickly, and with a minimum amount of confusion.

Hypotheses

It is hypothesized that experimental (E) parent subjects will, relative to the control (C) group subjects:

- 1) Demonstrate a significantly greater increase in parental empathy as measured by the Acceptance of Other Scale (AOS), and
- 2) Demonstrate a significantly greater increase in parental acceptance as measured by the Porter Parental Acceptance Scale (PPAS).

It is further hypothesized that experimental (E) child subjects will, relative to the control (C) group subjects:

- 1) Demonstrate a significantly greater increase in self concept, as measured by the Piers-Harris Self Concept scale (PH).

CHAPTER 3

Results

An analysis of covariance was performed on the mean scores of the dependent measures at posttest to determine the effect of treatment; i.e., whether the E group had changed significantly in relation to the C group. Pretest scores were treated as the covariate.

The number of subjects varies for the analyses reported for several reasons. First, in the case of the behavioral data, the video equipment malfunctioned and it was not possible to secure uncontaminated data for two subjects after this was discovered. At posttest, four of the control group parents no longer wanted to participate in the treatment program; Three were unwilling to come to the university for the videotaping; however, all four willingly returned the posttest questionnaires. Second, the Porter Parental Acceptance Scale (PPAS) was inadvertently omitted from the pretest questionnaire packet. Parents in the treatment group were given the measure and asked to complete it prior to the first session, however only six parents complied. Two of the control group parents were discovered to be marginally literate and reported being unable to complete the measure. Finally, one child in the experimental group refused to cooperate in taking the Piers Harris (PH) self concept test at posttest, though attempts were made on three separate occasions to accomplish this.

Main Statistical Analysis

Table 4 presents the means for the E and C groups at pretest and posttest, while Table 5 presents the results of the analysis of covariance which was used to determine the effects of treatment from pretest to posttest. The pretest score of each measure was designated as a covariate in the analysis to statistically equate any variation on the dependent variables among groups prior to treatment. Results indicated that the E group relative to the C group demonstrated a significant increase in parental empathy (AOS), $F(1,16) = 30.695$, $p = .001$. However results were not significant for parental acceptance PPAS, $F(1,12) = 3.801$, $p = .075$; or for child self concept. (PH), $F(1,18) = .080$, $p = .780$.

Subsequent Analyses

The results obtained on the Porter Parental Acceptance Scale (PPAS), while not statistically significant, nonetheless approached significance, and indicated that some parental acceptance change had occurred in the E group subjects relative to the C group subjects. Therefore, an analysis of covariance was performed on each of the four subscales of the PPAS to determine if any of these was more responsive to treatment effects than the other subscales, or more responsive than the scale as a whole. Table 6 presents the mean scores and standard deviations of the E and C groups on the PPAS subscales, and Table 7 presents the results of the analysis of covariance of the subscale scores. This analysis indicated that the subscale Parent Recognition of Child's Feelings (PRCF) reflected a significantly greater increase in

Table 4. Means and Standard Deviations for the Acceptance of Other Scale (AOS), Porter Parental Acceptance Scale (PPAS), and the Piers-Harris Self Concept Scale (PH).

Variable	Pre-treatment		E-Group Post-treatment		C-Group Pre-treatment		Post-treatment	
	M	SD	M	SD	M	SD	M	SD
AOS	3.62 (N = 9)	.2402	5.36	.7422	3.65 (N = 8)	.2948	3.77	.2563
PPAS	122.67 (N = 6)	13.02	142.33	5.57	118.77 (N = 9)	16.73	126.22	22.34
PH	50.80 (N = 10)	14.91	56.20	14.26	55.18 (N = 11)	15.35	57.27	18.29

Table 5. Summary of the Analyses of Covariance---Applied to the Mean Experimental and Control Group Scores for the Acceptance of Other Scale (AOS), Porter Parental Acceptance Scale (PPAS), and the Piers-Harris Self Concept Scale (PH) With Pretest Scores as Covariates.

Variable	SS	df	MS	F	p
<u>AOS</u>					
Source of Variation					
Pretest	.027	1	.027	.078	.784
Treatment	10.601	1	10.601	30.695	.001
<u>PPAS</u>					
Source of Variation					
Pretest	2702.366	1	2702.36	17.933	.001
Treatment	572.703	1	572.703	3.801	.075
<u>PH</u>					
Source of Variation					
Pretest	1762.290	1	1762.290	9.318	.007
Treatment	15.156	1	15.156	.080	.780

Table 6.Means and Standard Deviations of the Porter Parental Acceptance Scale (PPAS) Subscales--- Parent Recognition of Child Feelings (PRCF), Parent Recognition of Child Uniqueness (PRCU), Parent Recognition of Child Need for Autonomy (PRCA), Parent Unconditional Love (PUL).

Subscale	E-Group				C-Group			
	Pre-treatment M	SD	Post-treatment M	SD	Pre-treatment M	SD	Post-treatment M	SD
PRCF	33.167	6.765	40.667	7.884	31.444	6.327	32.222	7.173
PRCU	35.667	3.559	37.500	4.550	32.667	4.388	34.667	4.555
PRCA	39.833	4.167	42.667	2.503	37.889	4.676	39.556	4.610
PUL	14.000	7.266	21.500	8.385	16.778	8.408	19.778	10.426

Table 7. A Summary of the Analysis of Covariance as Applied to the Porter Parental Acceptance Scale (PPAS) Subscales--- Parent Recognition of Child Feelings (PRCF), Parent Recognition of Child Uniqueness (PRCU), Parent Recognition of Child Need for Autonomy (PRCA), Parent Unconditional Love(PUL).

Variable	SS	df	MS	F	p
<u>PRCF</u>					
Source of Variation					
Pretest	138.869	1	138.869	3.826	.074
Treatment	211.234	1	211.234	5.820	.033
<u>PRCU</u>					
Source of Variation					
Pretest	143.946	1	143.946	11.277	.006
Treatment	1.277	1	1.277	.100	.757
<u>PRCA</u>					
Source of Variation					
Pretest	79.554	1	79.554	6.691	.024
Treatment	16.164	1	16.164	1.359	.266
<u>PUL</u>					
Source of Variation					
Pretest	20.426	1	20.426	.205	.659
Treatment	17.214	1	17.214	.173	.685

parental acceptance among E group relative to C group subjects, $F(1,12) = 5.820$, $p = .03$. The Parent Recognitions of Child Uniqueness (PRCU $F(1,12) = .100$, $p = .757$, Parent Recognition of Child's need for Autonomy (PRCA) $F(1,12) = 1.359$, $p = .266$, and the Parent Unconditional Love (PUL) $F(1,12) = .173$, $p = .685$ subscales demonstrated no such significant increases.

Conclusions

It was hypothesized that the experimental parent subjects would relative to the control group subjects:

- 1) Demonstrate a significantly greater increase in parental empathy as measured by the AOS. Significant results were found on the AOS ($p = .001$), and the hypothesis was upheld.

- 2) Demonstrate a significantly greater increase in parental acceptance as measured by the PPAS. Results were obtained which do not support this hypothesis; however, these results were in the expected direction and showed a trend toward significance ($p = .075$). Further analyses were performed on the PPAS in the form of subsampling. One of the four PPAS subscales, Parent's Recognition of Child Feelings (PRCF), proved to be significant ($p = .03$). However, the main hypothesis was not upheld.

Additionally, it was hypothesized that child subjects in the experimental group, relative to control group subjects, would:

1) Demonstrate a significantly greater increase in self concept as measured by the Piers-Harris self concept scale (PH). Significant results were not obtained for this variable ($p = .780$), and this hypothesis was not upheld.

CHAPTER 4

Discussion

The results of this study support the effectiveness of the treatment program in increasing parental empathy among mothers of LD children, and, to a lesser extent, in increasing parental acceptance among these same mothers. The results of the AOS were significant at the .001 level; those of the PPAS subscale (PRCF) were significant at the .03 level. However, significant results were not obtained on the remaining PPAS subscales, on the total PPAS scores, or on the PH self concept measures.

The highly significant results obtained on the Acceptance of Other scale indicate that the treatment program effectively trained the E subjects in the use of the empathic responding skills. At pretest, the mean score for both E and C groups on the AOS was in the mid 3-level range. Level 3 statements reflect a lack of interest in what the other thinks and feels. Level 3 statements which are typical of parents include such directive responses as, "Well that's nice dear. Now why don't you go over and play with the darts for awhile." Other typical parental 3-level statements include teaching or instructing-type responses. For example, if mother and child are playing darts, the mother might begin to ask the child, pointing to the dart board, "What does eight plus eleven equal?" It is quite understandable that the sample as a whole scored at level 3 prior to the beginning of treatment.

At posttest, however, E group subjects obtained a mean score of 5.36, while C group subjects remained at level 3 (3.77). E group subjects

were reflecting, at the minimum, an effort to 'stay with' their child, to put aside their own concerns, and to follow the child's line of thought. Not immediately evident in the posttest mean are the many parents who were demonstrating a highly empathic ability and obtaining consistent scores at levels 6 and 7; these levels reflect an ability to accurately focus on and accept the child's thoughts and feelings and reflect a recognition of the legitimacy and importance of the child's feelings. Considering that LD children are often extremely active, angry, frustrated, and frustrating, and therefore can be difficult to accept, it is clear that the E group mothers were struggling to move toward their children, to put aside habitual behaviors and often the role of 'opponent,' in order to gain a deeper understanding of their children.

By her very struggle to change, by her attempts to experience and communicate a deeper, more empathic understanding of her child, each mother was demonstrating an increased acceptance of that child. The ability to accept the child as an autonomous individual with his or her right to her own feelings is a prerequisite to respond empathically to the child. The results obtained in the (total) Porter Parental Acceptance Scale, which were substantial, in the expected direction, and approached significance, support the belief that E mothers experienced an increase in parental acceptance.

In addition, the results from the Piers-Harris self concept scale, while again not significant, were in the expected direction. The E group children, as a whole, appeared to be experiencing a more positive evaluation of themselves, and it is possible that this is a result of the mother's increasing empathy and acceptance of their children.

Several possible explanations exist which can be brought forth to help account for the lack of significant improvement in overall parental acceptance and child self concept. The main thrust of the treatment program lay in training mothers in the behavioral skills of play therapy, and the results obtained on the AOS certainly indicate that this training was effective. While an increase in the attitudinal dimension of parental acceptance would be a logical extension of these behavioral changes, it is the author's opinion that this would represent a generalization of the training skills. Changes in attitude imply a much greater shift in the individual's orientation toward others than do acquisition of new behaviors; behavioral skills are specific, observable, and, to some degree concrete dimensions of performance; it seems logical to conclude that it would be much easier, much less time consuming, to train a mother to exhibit accurately, on cue, and within a specified and conducive environment certain behaviors toward her child, than to effect changes in her attitudes toward, or beliefs about her child. This is not to say that attitudinal changes are impossible to bring about, rather that they may well require longer periods or greater effort on the part of the trainer to be accomplished. This viewpoint was expressed by many of the E group mothers at posttest who indicated that they felt they were just beginning to experience a sense of competence with their skills. They reported regret that the training program was terminating, and expressed a desire for some kind of support group to continue after the training was complete.

The assertions that attitudinal change, as measured by the PPAS would represent a generalization of the training skills, is to some extent

supported by the results obtained on the PPAS subscales. The only subscale for which significant results were achieved is organized around the concept that the parent recognizes the child as a person with feelings, who has a right and a need to express those feelings. Certainly this recognition is very much in accordance with the underlying principles of the empathic mode of responding, and much more closely aligned with the thrust of the training program than the other subscales, which measure the parent's recognition of the child as unique, and having a need for autonomy and unconditional love. It appears that parental attitudes of acceptance were changing in conjunction with the newly acquired skills only insofar as the attitudes were closely related to the principles underlying the skills.

It can also be argued that significant results on child self-concept would represent an even greater generalization of training skills. If parental acceptance and child self concept are closely related, as has been found in a number of studies (e.g., Rohner, 1975; Miller, 1971), it may well be that significant and consistent movement in parental acceptance is necessary before the child begins to receive (or allow him/herself to receive) the message that he/she is valuable. Weiner (1978) has made some observations about LD children and their self concepts which are particularly germane to this point. A summer remedial camp for LD children, designed specifically to increase interpersonal skills, self concept, and behavior, was evaluated according to these three variables. The LD children's behavior, as reported by teachers, improved significantly while self concept did not. Weiner (1978) speculates that the LD child's evaluation of self appears to be particularly resistant to intervention,

more so than the evaluation which others make of the child. It may be that the training program reported here was of sufficient duration to ensure that parents actually learned the behavioral skills, but not long enough to guarantee generalization outside the training environment to actually begin to change the tone of the mother-child relationship in such a way as to increase child self concept.

A further possibility is that the mother-child relationship is somewhat resistant to change, rather than the individuals themselves. The findings of Doleys, Cartelli, and Doster (1979), or Chapman and Boersma (1979), or Wulbert, Inglis, Kriegman and Mills (1975) infer that there may be a higher level of entrenched negative interactions in the relationships between mothers and learning disabled children than among mothers and non-LD children. In this event, one possible way to bypass this particular problem might be to have mothers practice the play therapy skills with children other than their own, giving them time to develop a sense of confidence in their own abilities, and in the effectiveness of the skills themselves, before tackling a relationship with an already extensively negative history.

In fact, this may be a factor of some importance in the process of change. The present researcher has observed situations in which a mother participating in the training group did master, at a minimum level, the new behaviors being taught; however, when involved in interactions with her child, her use of the skills was such as to incorporate them into the same negative context within which the relationship had always existed. The end effect was to transform the

skills of empathic responding, limit-setting, etc., into new tools with which to wage the same old struggle with the child.

For example, while playing the card game of Go Fish with her child, the mother won several hands in a row, and the child was obviously becoming discouraged, upset, and even angry at his mother. Finally after the mother had guessed another card correctly, the child said, "I hate you when you win all the time." The mother, continuing to reach for a card from the child's hand, said in a mocking, taunting tone of voice, "You don't like it when I take your pretty cards away from you."

One non-assessed component which appeared to be particularly valuable to these parents was the didactic component which presented information regarding LD children, strategies for dealing with LD professionals, schools, etc. This information appeared to require less of the parents in the way of changes, and yet it appeared to address some confusions and skill problems which were causing significant trouble for parents in understanding their LD child, or in acting as an advocate for their child.

Limitations

A non-random sampling procedure was employed to engage potential participants in the program. This procedure, while attempting to contact a broadly based sample, is admittedly influenced by the factor of self selection of participants. Parents who would not willingly involve themselves in a training program of this nature may differ in some significant ways from the subjects in the present study; for example,

in being less motivated to change their own or their child's behavior, and as such, being less responsive to treatment. Another limitation to the study was that one of the main researchers also led the treatment groups, and confounding effects of experimenter bias must be considered possibly active in this research.

A small number of subjects were available for inclusion in the study ($n = 25$), and the attrition rate of the control group, in addition to logistical difficulties, reduced this number still further. The generalizability of the data is also questionable with regard to the small, and possibly unrepresentative sample. Several different factors account for this small sample size. The long waiting period for control group subjects (four months) ensured that individuals would encounter many opportunities to be busily engaged, or removed from the area altogether, at posttesting and when control group training procedures began.

However, the question still remains as to why such a small number of prospective participants were attracted to the program to begin with. Possible speculations as to the cause of this are numerous. Parents of LD children have been characterized as a 'neglected population.' They are coping with the stress of raising an exceptional and often difficult child, many times without knowledge of parenting skills. They are a population in need, it seems, and yet one without organized, readily available, and effective channels to sources of support, information, etc. (Becker, Bender and Kawabe, 1980; Dembinski and Mauser, 1977). It may be that many parents of LD children are unaware of their own needs for support in raising their child, and are not actively seeking

help; or that they are aware of their needs but not aware of existing resources to meet them. The trend toward advocacy for parents of the LD child appears to be only beginning to gain momentum. (McLoughlin, Edge, and Strenecky, 1975; McLoughlin, McLoughlin, and Steward, 1979), and many of these parents remain isolated from the organizations which have been formed to meet their needs. It is interesting to note, though, that those parents who did respond were from a variety of SES groups---two marginally literate, three on public assistance, as well as two families from more affluent professions.

Suggestions for future research include extending the length of treatment time and conducting a contact control group simultaneously with the treatment group, preferably one which receives a 'best alternative' method of treatment, rather than a placebo condition. This would also make possible a follow-up testing with control group subjects, a very desirable procedure, but one not ethically or logistically possible under the present study design. Other suggestions include gathering educational data on the LD child, such as achievement test scores or grade point averages, over the course of the program, or even better at several points in time, including after the program ends. Finally, a behavioral assessment of empathy which was administered in a natural setting, such as the subject's homes, would reveal a more accurate picture of the extent of skills generalization.

Major Findings of the Study

The present study substantiated the effectiveness of the treatment program under consideration in increasing parental empathy, and to a lesser

extent, parental acceptance of mothers of LD children. While child self concept did not demonstrate significant increases, results were obtained in the expected direction, and it remains unclear whether increases in parental acceptance and empathy, sustained over a long period of time, would result in increased child self concept.

APPENDIX A

Porter Parental Acceptance Scale B.M. Porter (1954)	Degree of Feeling of Affection
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Directions: Please check one column for each item below as it best describes your feelings about your child		A		A	
	Much	little	The	little	Much
	more	more	same	less	less
	than	than		than	than
	usual	usual		usual	usual

1. When he is obedient

2. When he is with me

3. When he misbehaves in front of special guests

4. When he expresses unsolicited affection.
"You're the nicest mommy (daddy)
in the whole world."

5. When he is away from me

6. When he shows off in public

7. When he behaves according to my
highest expectations

8. When he expresses angry and hateful
things to me

9. When he does things I have hoped he would
not do

10. When we are doing things together

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

Read each statement carefully and then place a circle around the letter in front of the one which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things.

It is possible that you may find a few statements which describe a type of behavior which you have not yet experienced with your child. In such cases, mark the response which most nearly describes how you think you would feel or what you think you would do.

Be sure that you answer every statement and mark only one response for each statement.

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, it:
 - a. Makes me feel annoyed
 - b. Makes me want to know more about what excites him
 - c. Makes me feel like punishing him
 - d. Makes me feel that I will be glad when he is past this stage
 - e. Makes me feel like telling him to stop
12. When my child misbehaves while others in the group he is with are behaving well I:
 - a. See to it that he behaves as the others
 - b. Tell him it is important he behaves well when he is in a group
 - c. Let him alone if he isn't disturbing the others too much
 - d. Ask him to tell me what he would like to do
 - e. Help him find some activity that he can enjoy and at the same time not disturb the group
13. When my child is unable to do something which I think is important for him it:
 - a. Makes me want to help him find success in the things he can do
 - b. Makes me feel disappointed in him
 - c. Makes me wish he could do it

- d. Makes me realize that he can't do everything
 - e. Makes me want to know more about the things he can do
14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:
- a. Makes me realize he is growing up
 - b. Pleases me to see his interest widening to other people
 - c. Makes me feel resentful
 - d. Makes me feel that he doesn't appreciate what I have done for him
 - e. Makes me wish he liked me more
15. When my child is faced with two or more choices and has to choose only one, I:
- a. Tell him which choice to make and why
 - b. Think it through with him
 - c. Point out the advantages and disadvantages of each, but let him decide for himself
 - d. Tell him that I am sure he can make a wise choice and help him foresee the consequences
 - e. Make the decision for him
16. When my child makes decisions without consulting me. I:
- a. punish him for not consulting me
 - b. Encourage him to make his own decisions if he can foresee the consequences
 - c. Allow him to make many of his own decisions
 - d. Suggest that we talk it over before he makes his own decision
 - e. Tell him he must consult me first before making a decision
17. When my child kicks, hits or knocks his things about it:
- a. Makes me feel like telling him to stop
 - b. Makes me feel like punishing him
 - c. Pleases me that he feels free to express himself
 - d. Suggest that we talk it over before he makes his decision
 - e. Tell him that he must consult me first before making a decision
18. When my child is not interested in some of the activities of his age group it:
- a. Makes me realize that each child is different
 - b. Makes me wish he were interested in the same activities
 - c. Makes me feel disappointed in him
 - d. Makes me want to help him find ways to make the most of his interests
 - c. Makes me want to know about the activities in which he is interested.

19. When my child acts silly and giggly, I:
- a. Tell him I know how he feels
 - b. Pay no attention to him
 - c. Tell him he shouldn't act that way
 - d. Make him quit
 - e. Tell him it is alright to feel that way, but help him find other ways of expressing himself
20. When my child prefers to do things with friends rather than with his family, I:
- a. Encourage him to do things with his friends
 - b. Accept this as part of growing up
 - c. Plan special activities so that he will want to be with his family
 - d. Try to minimize his association with his friends
 - e. Make him stay with his family
21. When my child disagrees with me about something which I think is important, it:
- a. Makes me feel like punishing him
 - b. Pleases me that he feels free to express himself
 - c. Makes me feel like persuading him that I am right
 - d. Makes me realize he has ideas of his own
 - e. Makes me feel annoyed
22. When my child misbehaves while others in the group he is with are behaving well, it:
- a. Makes me realize that he does not always behave as others in his group
 - b. Makes me feel embarrassed
 - c. Makes me want to help him find the best ways to express his feelings
 - d. Makes me wish he would behave like the others
 - e. Makes me want to know more about his feelings
23. When my child is shouting and dancing with excitement at a time I want peace and quiet, I:
- a. Give him something quiet to do
 - b. Tell him that I wish he would stop
 - c. Make him be quiet
 - d. Let him tell me about what excites him
 - e. Send him somewhere else
24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- a. Try to minimize his association with that person

- b. Let him have such associations when I think he is ready for them
 - c. Do some special things for him to remind him of how nice I am
 - d. Point out the weaknesses and faults of that other person
 - e. Encourage him to create and maintain such association
25. When my child says angry and hateful things to my face, it:
- a. Makes me feel annoyed
 - b. Makes me feel that I will be glad when he is past this stage
 - c. Pleases me that he feels free to express himself
 - d. Makes me feel like punishing him
 - e. Makes me feel like telling him not to talk to me that way
26. When my child shows a deep interest in something I don't think is important it:
- a. Makes me realize he has interests of his own
 - b. Makes me want to help him find ways to make the most of this interest.
 - c. Makes me feel disappointed in him
 - d. Makes me want to know more about his interests
 - e. Makes me wish he were more interested in the things I think are important for him
27. When my child is unable to do some things as well as others in his group, I:
- a. Tell him he must try to do as well as the others
 - b. Encourage him to keep trying
 - c. Tell him that no one can do everything well
 - d. Call his attention to the things he does well
 - e. Help him make the most of the activities which he can do
28. When my child wants to do something which I am sure will lead to disappointment for him, I:
- a. Occasionally let him carry such an activity to its conclusion
 - b. Don't let him do it
 - c. Advise him not to do it
 - d. Help him with it in order to ease the disappointment
 - e. Point out what is likely to happen
29. When my child acts silly and giggly it:
- a. Makes me feel that I will be glad when he is past this age
 - b. Pleases me that he feels free to express himself
 - c. Makes me feel like punishing him
 - d. Makes me feel like telling him to stop
 - e. Makes me feel annoyed

30. When my child is faced with two or more choices and has to choose only one it:
- a. Makes me feel I should tell him which choice to make and why
 - b. Makes me feel that I should point out the advantages and disadvantages
 - c. Makes me hope that I have prepared him to choose wisely
 - d. Makes me want to encourage him to make his own choice
 - e. Makes me want to make the decision for him
31. When my child is unable to do something which I think is important for him I:
- a. Tell him he must do better
 - b. Help him make the most of the things which he can do
 - c. Ask him to tell me more about the things which he can do
 - d. Tell him that no one can do everything
 - e. Encourage him to keep trying
32. When my child disagrees with me about something which I think is important I:
- a. Tell him that he shouldn't disagree with me
 - b. Make him be quiet
 - c. Listen to his side of the problem and change my mind if I am wrong
 - d. Tell him maybe we can do it his way another time
 - e. Explain that I am doing what is best for him
33. When my child is unable to do some things as well as others in his group it:
- a. Makes me realize that he can't be best in everything
 - b. Makes me wish he could do as well
 - c. Makes me feel embarrassed
 - d. Makes me want to help him find success in the things he can do
 - e. Makes me want to know more about the things he can do well
34. When my child makes decisions without consulting me it:
- a. Makes me hope that I have prepared him adequately to make his own decisions
 - b. Makes me wish he would consult me
 - c. Makes me feel disturbed
 - d. Makes me want to restrict his freedom
 - e. Pleases me to see that as he grows he needs me less
35. When my child says angry and hateful things about me to my face I:
- a. Tell him it's alright to feel that way, but help him find other ways of expressing himself

- b. Tell him I know how he feels
 - c. Pay no attention to him
 - d. Tell him he shouldn't say such things to me
 - e. Make him quit
37. When my child prefers to do things with his friends rather than with his family, it:
- a. Makes me wish he would spend more time with us
 - b. Makes me feel resentful
 - c. Pleases me to see his interests widening to other people
 - d. Makes me feel he doesn't appreciate us
 - e. Makes me realize that he is growing up
38. When my child wants to do something which I am sure will lead to disappointment for him, it:
- a. Makes me hope that I have prepared him to meet disappointment
 - b. Makes me wish he didn't have to meet unpleasant experiences
 - c. Makes me want to keep him from doing it
 - d. Makes me realize that occasionally such an experience will be good for him
 - e. Makes me want to postpone these experiences
39. When my child is not interested in some of the usual activities of his age group, I:
- a. Try to help him realize that it is important to be interested in the same things as his group
 - b. Call his attention to the activities in which he is interested
 - c. Tell him it is alright if he isn't interested in the same things
 - d. See to it that he does the same things as others in his group
 - e. Help him find ways of making the most of his interests
40. When my child shows a deep interest in something I don't think is important, I:
- a. Let him go ahead with his interest
 - b. Ask him to tell me more about this interest
 - c. Help him find ways to make the most of this interest
 - d. Do everything I can to discourage his interest in it
 - e. Try to interest him in more worthwhile things

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX B

ACCEPTANCE OF OTHER SCALE

<u>Rating</u>	<u>Meaning of rating</u>
8	Verbally reflects (states) the deepest feelings expressed by the other. Also, content, if any, accurately reflects the main thrust of the other's meaning. A highly empathic response.
7	Recognizing feelings with full attention to mood, but not conveying sensitivity to level of intensity, or not responding fully to the significant feelings. Also, content, if any, is in accord with main thrust of the other's.
6	A paraphrasing of content that is in accord with the main thrust of other's meaning. Accepting, accurate, but not stating any feelings of the other.
5	The attempt to "stay with" the other is clear, but the response goes astray in some way. The following are examples of ways in which the response may stray from one that focuses fully on the other's own thoughts and momentum: a) questioning in an attempt to get an elaboration about the other's intent that has not been implied by the other; b) a response that has the effect of infusing ideas different from the other's.
4	Nonaccusative social conversation. Responding with one's own ideas after the fashion of typical social discourse. (A half minute of total silence is scored here. Under certain circumstances, "yes" or "uhm uhm" and responses of this nature are

also scored here).

- 3 Directing. Moderately critical in tone, but not abusive.
Taking the lead, giving suggestions. Although statements are not presented as being in direct opposition, the statement has the effect of interjecting thoughts that are in opposition to those expressed by the other. Questioning in order to defend one's own point of view.
- 2 Open disagreement with content expressed by the other. Contrary statement. Statements suggestive of boredom, incredulity, rejection, disgust, disbelief, and so on.
- 1 Strongly argumentative. Accusative. Openly rejecting the other person or that person's right to have the feelings he has expressed. Abusive. Demanding. Angry.

BIBLIOGRAPHY

- Axline, V.M. Play Therapy. Boston: Houghton-Mifflin, 1947
- Bachara, G. Empathy in learning disabled children. Perceptual and Motor skills, 1976, 43, 541-542.
- Baker, B.E. The effectiveness of parent counseling with other modalities in the treatment of children with learning disabilities. (Doctoral dissertation, Boston University, 1970). Dissertation Abstracts, 1970, 31, 5-A, 2166-2167.
- Becker, L.D., Bender, N.W. and Kawabe, K.K. Exceptional parents: A survey of programs, services and needs. Academic Therapy, 1980, 15, 523-538.
- Beers, K. and Beers, J. Parents, professionals and public policy. In S. Kirk and J. McCarthy (Eds.) Learning disabilities: Selected ACLD papers. Boston: Houghton-Mifflin, 1975.
- Berman, A. Parenting learning disabled children. Journal of Clinical Child Psychology, 1979, 8, 245-249.
- Boersma, F.J. and Chapman, J.W. Self-perception of ability, expectations and locus of control in elementary learning disabled children. University of Alberta, 1978.
- Bricklin P. Counseling parents of children with learning disabilities. The Reading Teacher, 1970, 23, 331-338.
- Brodey, W.M. Changing the Family. New York: Clarkson Potter, 1968.
- Bruininks, V. Actual and perceived peer status of learning disabled students in mainstream programs. Journal of Special Education, 1978, 12, 51-58.
- Bryan, T. Learning disabilities: A new stereotype. Journal of Learning Disabilities. 1974a, 7, 304-309.
- Bryan, T. An observational analysis of classroom behaviors of children with learning disabilities. Journal of Learning Disabilities, 1974b, 7, 26-34.
- Bryan, T. Peer popularity of learning disabled children. Journal of Learning Disabilities, 1974c, 7 621-625.
- Bryan, T. Peer popularity of learning disabled children: A Replication. Journal of Learning Disabilities, 1976, 9, 307-311.

- Bryan, T. Learning disabled children's comprehension of non-verbal communication. Journal of Learning Disabilities.
- Bryan, T. Social relationships and verbal interactions of learning disabled children. Journal of Learning Disabilities, 1978, 11, 107-115.
- Bryan, T. and Bryan J. Understanding learning disabilities. Port Washington, N.Y.: Alfred Publishing Co. Inc., 1975.
- Bryan, T., Donahue, M., and Pearl, R. Learning disabled children's peer interaction during a small group problem-solving task. Learning Disability Quarterly, 1981, 4, 13-22.
- Bryan, T. and Pearl R. Self concepts and locus of control of learning disabled children. Journal of Clinical Child Psychology. 1979, 2, 80-88.
- Bryan, T. and Wheeler, R. Perception of learning disabled children: The eye of the observer. Journal of Learning Disabilities, 1972, 5, 484-488.
- Bryan, T., Wheeler, R., Felcan, J., and Henek, T. "Come on Dummy:" An observational study of children's communications. Journal of Learning Disabilities, 1976, 9, 661-669.
- Bryan, J. and Perlmutter, B. Immediate impressions of learning disabled children by female adults. Learning Disability Quarterly, 1979, 2, 80-88.
- Bryant J.E. Parent-child relationships: Their effect on rehabilitation. Journal of Learning Disabilities, 1971, 4, 325-329.
- Buros, K. Seventh mental measurements yearbook. Highland Park, N.J.: Gryphon Press, 1971.
- Caldwell, B.M. and Bradley, R.H. Home Observations for Measurement of the Environment. Little Rock: University of Arkansas at Little Rock, Center for Child Development and Education, 1979.
- Campbell, D.T. and Stanley, J.C. Experimental and quasi-experimental designs for research. Chicago: Rand-McNally, 1963.
- Chapman, J.W. and Boersma, R.J. Learning disabilities, locus of control, and mother attitudes. Journal of Educational Psychology, 1979, 71, 250-258.

- Dembinski, R.J. and Mauser, A.J. What parents of the learning disabled really want from professionals. Journal of Learning Disabilities, 1977, 10, 578-584.
- Doleys, D., Cartelli, L., and Doster, J. Comparison of patterns of mother-child interaction. Journal of Learning Disabilities, 1976, 9, 371-375.
- Forness, S.R. and Esveldt, K.D. Classroom observation of children with learning and behavior problems. Journal of Learning Disabilities, 1975, 8, 382-383.
- Franklin, M.R. Self concept and its relationship to academic achievement and other selected variables. Unpublished Doctoral Dissertation, University of Arizona, 1978.
- Freund, J.H., Bradley, R.H., and Caldwell, B.M. The home environment in the assessment of learning disabilities. Learning Disability Quarterly, 1978, 1, 80-86.
- Freund, J.H., Bradley, R.H. and Caldwell, B.M. The home environment in the assessment of learning disabilities. Learning Disability Quarterly, 1978, 1, 80-86.
- Friedman, R. Using the family school in the treatment of learning disabilities. Journal of Learning Disabilities, 1978, 11, 378-382.
- Garrett, M.K. and Crump, W.D. Peer acceptance, teacher preference, and self-appraisal of social status among learning disabled students. Learning Disability Quarterly, 1980, 3, 42-48.
- Gilmore, J.V. Review of "The effectiveness of parent counseling with other modalities in the treatment of children with learning disabilities," Unpublished Doctoral Dissertation by B. Baker. Journal of Education, October, 1971, 154, #1, 74-89.
- Gorham, K. A lost generation of parents. Exceptional Children, 1975, 41, 521-525.
- Griffiths, A.N. Self concepts of dyslexic children. Academic Therapy, 1975, 11, 83-90.
- Guerney, B.G. Jr. Filial Therapy: Description and rationale. Journal of Consulting Psychology, 1964, 28, 304-310.
- Guerney, B.G. Jr. (Ed.) Relationship enhancement. San Francisco: Jossey-Bass, 1977.
- Guerney, B.G. Jr. and Stover, L. Final report on filial therapy for grant MH18264-01, National Institute on Mental Health, 1971.

- Guerney, L.F. Filial Therapy Program. In D.H. Olsen (Ed.), Treating Relationships. Take Mills, Iowa: Graphic Publishing Co., 1976.
- Guerney, L.F. Play therapy with learning disabled children. Journal of Clinical Child Psychology, 1979, 8, 242-244.
- Hetrick E. Training parents of learning disabled children in facilitative communication skills. Journal of Learning Disabilities, 1979, 12, 275-277.
- Humphries, T.W. and Bauman, E. Maternal child rearing attitudes associated with learning disabilities. Journal of Learning Disabilities, 1980, 13, 54-57.
- Keogh, B., Tchir, C., and Windeguth-Behn, A. Teacher's perceptions of educationally high risk children. Journal of Learning Disabilities, 1974, 7, 367-374.
- Klein, R., Altman S., Dreizen, K., Freidman, R., and Powers, L. Restructuring dysfunctional parental attitudes toward children's learning and behavior in school: Family-oriented psychoeducational therapy, Part 1. Journal of Learning Disabilities, 1981, 14, 15-19.
- Klein, R., Altman S., Dreizen, K., Freidman, R., and Powers, L. Restructuring dysfunctional parental attitudes toward children's learning and behavior in school: Family-oriented psychoeducational therapy, Part 2: Journal of Learning Disabilities, 1981, 14, 99-101.
- Kronick, D. Some thoughts on group identification: social needs. Journal of Learning Disabilities, 1974, 7, 144-148.
- Kronick, D. Three families. San Rafael, Cal.: Academic Therapy Publications, 1976.
- Kronick, D. An examination of psychosocial aspects of learning disability adolescents. Learning Disability Quarterly, 1978, 1, 86-93.
- Lanza, E.R. Investigation of various antecedents of self esteem as related to race and sex. (Doctoral Dissertation, Ball State University, 1969). Dissertation Abstracts International, 1970, 31, 1077A.
- Larsen, S.C., Parker, R., and Jorjorian, S. Differences in self concept of normal and learning disabled children. Perceptual and Motor Skills, 1973, 37, 510.
- Lefley, H.P. Social and familial correlates of self esteem among American Indian children. Child Development, 1974, 45, 829-833.
- McLoughlin, J., Edge, D., and Strenecky, B. Parental involvement in the diagnosis and treatment of learning disabilities. Journal of Learning Disabilities, 1978, 11, 32-37.

- McLoughlin, J.A., McLoughlin, P., and Stewart, N. Advocacy for parents of the handicapped: A professional responsibility and challenge. Learning Disability Quarterly, 1979, 2, 51-57.
- Medinnus, G.R. Adolescents' self acceptance and perceptions of their parents. Journal of Consulting Psychology, 1965, 29, 150-154.
- Miller, T.W. Communicative dimensions of mother-child interactions as they effect the self esteem of the child. Proceedings of the Annual Convention of the American Psychological Association, 1971, 6, 241-242.
- Owen, R., Adams, P., Forrest I., Stolz, L., and Fisher, S. Learning disorders in children: Sibling studies. Monographs of the Society for Research in Child Development, 1971, 36, #144.
- Patterson, G.R. and Gullion, E. Living with children. Champaign, Illinois: Research Press, 1968.
- Peck B., and Stackhous, T. Reading problems and family dynamics. Journal of Learning Disabilities, 1973, 6, 506-511.
- Peppin, B.H. Parental understanding, parental acceptance, and the self concept of children as a function of academic over and under achievement. (Doctoral dissertation, The Claremont Graduate School, 1962). Dissertation Abstracts.
- Piers, E.V., and Harris, D.B. Age and other correlates of self concept in children. Journal of Educational Psychology, 1964, 55, 91-95.
- Piers, E.V. and Harris, D.B. The Piers-Harris self concept scale. Nashville: Counselor for Recordings and Tests, 1969.
- Porter, B.M. Measurement of parental acceptance of children. Journal of Home Economics, 1954, 46, 176-182.
- Rogers, C.R. Client-centered therapy. Boston: Houghton-Mifflin, 1951.
- Rohner, R.P. They love me, they love me not: A world-wide study of the effects of parental acceptance and rejection. New Haven: HRAF Press, 1975.
- Rosenberg, M. Parental interest and children's self conceptions. Sociometry, 1963, 26, 35-49.
- Rosenthal, J.H. Self esteem in dyslexic children. Academic Therapy, 1973, 9, 27-39.
- Rosser, G.J. A comparative analysis of the real-ideal self concept of nondisabled and language or learning disabled children. (Doctoral dissertation, Baylor University, 1973). Dissertation Abstracts International, 1974, 35, 270A.

- Runyan, A.J. Parent education with families of children with extreme reading problems. (Doctoral dissertation, University of Oregon, 1972). Dissertation Abstracts International, 1973, 33, 5499A-5500A.
- Ryback, D. and Staats, A.W. Parents as behavior therapy technicians in treating reading deficits (dyslexia). Journal of Behavior Therapy and Experimental Psychology, 1970, 1, 109-119.
- Scranton, T.R. and Ryckman, D.B. Sociometric status of learning disabled children in an integrative program. Journal of Learning Disabilities, 1979, 12, 402-407.
- Sears, R.R. Relation of early socialization to self concepts and gender role in middle childhood. Child Development, 1970, 41, 267-289.
- Shavelson, R.J., Hubner, J.J., and Stanton G.G. Self concept: Validation of construct interpretation. Review of Educational Research, 1976, 46, 407-441.
- Siperstein, G.N., Bopp, M.J., and Bak, J.J. Special status of learning disabled children. Journal of Learning Disabilities, 1978, 11, 98-102.
- Smith, M.D. Prediction of self concept among learning disabled children. Journal of Learning Disabilities, 1972, 1979, 12, 664-669.
- Spector, R.A. Comparative effectiveness on learning disabled children of three short-term parent counseling approaches. (Doctoral dissertation, University of Southern California, 1975). Dissertation Abstracts International, 1975, 36, 138A.
- Strag, G.A. Comparative behavioral ratings of parents with severely mentally retarded, special learning disability, and normal children. Journal of Learning Disabilities, 1972, 5, 631-635.
- Swanson, B.M. Parent-child relations: A child's acceptance by others, of others, and of self. (Doctoral dissertation, University of Oklahoma, 1969). Dissertation Abstracts, 1969, 30, 1890A.
- Sywulak, A.E. The effect of filial therapy on parental acceptance and child adjustment. Unpublished Doctoral Dissertation, Pennsylvania State University, 1977.
- U.S. Public Health Service. Minimal brain dysfunction in children. Phase 2, Government Printing Office, 1969.
- Wong, B. and Wong, R. Role taking skills in normal and learning disabled children. Learning Disability Quarterly, 1980, 3 11-18.
- Wulbert, M., Inglis, S., Kriegsman, E., and Mills, B. Language delay and associated mother-child interactions. Developmental Psychology, 1975, 11, 61-70.

Wylie, R.C. The self concept (Vol. 1): A review of methodological considerations and measuring instruments. Lincoln, Nebraska: University of Nebraska Press, 1974.

Yauman. B.E. Special education placement and the self concept of elementary school children. Learning Disability Quarterly, 1980. 3, 30-35.