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GRADUATE COLLEGE

EFFECTS OF FILIAL THERAPY ON MATERNAL PERCEPTIONS OF THEIR MENTALLY RETARDED CHILDREN'S SOCIAL BEHAVIOR

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

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EFFECTS OF FILIAL THERAPY ON MATERNAL PERCEPTIONS OF THEIR MENTALLY RETARDED CHILDREN'S SOCIAL BEHAVIOR

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CHAPTER I

NATURE OF THE PROBLEM

Introduction

There have been many group approaches under a wide variety of names employed to assist parents of mentally retarded children in understanding the psychological and social implications of the handicapping condition. Group counseling (Goodman and Rothman, 1961), group education (Ambrosino, 1960; Auerbach, 1961), group therapy (Coleman, 1953), and parent education (Dybwad and Goller, 1955; Green and Durocher, 1965) are only a few of the methods presently used to help parents of retarded children.

The stated purposes of these different programs have been variously defined, but it is quite evident that many of them have a therapeutic orientation for the parent, i.e., the gaining of insight, increasing realistic understanding or reducing neurotic non-acceptance of mental retardation. It is also evident that the goals have been somewhat vague

and poorly defined as exemplified by Beck (1959) in describing "group counseling." This author states:

> In group counseling we are not concerned with intensive group therapy, but with casework counseling in groups. Goals are: personality reintegration and adjustment to reality. Group processes and teaching methods are combined to afford the individual relief from tension, understanding of children's behavior, and techniques for handling specific problems (p. 228).

In addition to being vague, the above definition also discloses a certain contradiction. In view of the controversy over the similarities and differences between counseling and psychotherapy (Patterson, 1956; Tyler, 1969), the goal of "personality reintegration" for group counseling seems contradictory to the statement that this particular approach is "not concerned with intensive group therapy."

The matter of making a definition of a specific technique congruent with the established goals of that approach is complicated even further when one introduces the third major approach; i.e., parent and/or group education. Although Auerbach (1961) does not mention group counseling, she does make a distinction between "parent group education" and "group therapy," while shedding further light on the nature of group therapy. She explains:

> In parent group education, the goal of the leader is to help group members explore all aspects of the situation in which they find themselves with their children, to gain greater knowledge and understanding of their children's physical and emotional development, of their role as parents, and of the complexity of parent-child relationships. They do this through exchange of ideas and experiences within the group interplay, looking at both facts and feelings--

> their's and their children's. Sharing their reactions with others under skillful leadership seems to free parents to move on to new attitudes and new behavior, or to have greater confidence in what they are already doing.
>
> The goals and techniques of group education are different from those of group therapy. The group education leader does not focus on the pathology of the members, or probe into the unconscious. Although he must take into account the unconscious factors that influence behavior, he deliberately directs group thinking toward aspects of ego functioning in order to develop ego strengths (pp. 135-136).

One can conclude from the above discussion that many professionals have recognized that parents of mentally retarded children do need some type of assistance in coping with the myriad problems that the family experiences in relation to the handicapping condition. However, the primary question still remains: "What type of assistance do the parents need?"

In this regard, Dybwad (1964) has observed several changes in the focus of parent groups, with one being especially relevant to this particular study. That is, there has been a change in emphasis from asking "What happened?" to "What can I expect from him and what can I do for him?" The latter question reflects a more positive and hopeful attitude toward the mentally retarded individual and his capabilities.

Although mentally retarded children have been receiving increased attention from the professional specialties of medicine, psychology, and education, often the ultimate responsibility for the care and adjustment of the

mentally retarded rests with the family. It is axiomatic that parents play an important role in the social adjustment of their child, regardless of the child's intellectual ability. Whether or not the mentally retarded achieve maximum personal and social adjustment depends, to a great extent, on the attitudes of parents toward the handicapped child. As was succinctly stated by Willey and Waite (1964), "The attitude of parents toward their mentally retarded child determines the success or failure of family life and the life of the child (p. 193)."

The attitudes and behavior of parents toward their retarded children have been investigated (Condell, 1966; Grebler, 1952; Kanner, 1953; and Love, 1967-68); however, as Haring, Stein, and Cruickshank (1958) observed, research regarding the attitudes of parents and other individuals toward the physically and mentally handicapped person is grossly limited.

From these research studies just cited, it was generally concluded that parents of mentally retarded children need professional guidance in their efforts to accept and adjust to their child's handicap. Regardless of when the parents learn that they have a retarded child, at birth or several years later, the parents are always vulnerable to psychological trauma that often accompanies the professional diagnosis of mental retardation. Many parents of retarded children must cope with some or all of the following

feelings: "anxiety, hostility, guilt, shame, and feelings of rejection (Willey and Waite, 1964, p. 208)." How the parents ultimately adjust or fail to adjust to the perceived physical and psychological handicap of their child is an individual matter; there are no set patterns of parental reactions to knowledge of their child's mental retardation. However, Kanner (1953) has distinguished three principal types of reactions or attitudes: (1) mature acknowledgment of the actuality and acceptance of the child; (2) disguising of reality by blaming others for the child's handicap and/or failures or seeking magical cures; and (3) complete denial of the existence of mental retardation.

The implicit, if not explicit, purpose of parent counseling or parent education groups is to help the parent gain greater knowledge of the nature of mental retardation in general and more understanding of their own mentally retarded child in particular. With this increased knowledge and insight, it is assumed that parents will be able to display greater understanding and acceptance of their retarded child. While this assumption may be questioned, the fact that parents of mentally retarded children are not adequately informed regarding the nature of mental retardation was borne out in a study by Love (1967-68) in southwestern Louisiana. Although the study was somewhat limited in terms of geographical area, it was found that "parents not having mentally retarded children displayed greater knowledge of

mental retardation (p. 105)" than did parents who had mentally retarded children.

This situation may be due to the lack of adequately trained professionals being available, or it may be that the parents do not avail themselves of professional counseling services. Regardless of the cause, it seems apparent that parents of retarded children are inadequately informed as to what they can and should expect from their retarded child and how to deal with problem behaviors. Consequently, the parents of retarded children have needlessly had to suffer prolonged guilt and despair over the child's handicap. These attitudes and ego-deflating self-recriminations have forced the parents to deny or to engage in other defensive behaviors designed to cope with their negative feelings about themselves and their mentally retarded child.

Since many parents of retarded children are not adequately informed regarding the nature of mental retardation, there should be little surprise that they often vacillate between being too demanding on the one hand and too protective on the other. While the end result of either extreme is disastrous for the retarded child, his trying to adapt to an inconsistent relationship with parents poses adjustment problems also.

Levi (1943) and Willey and Waite (1964) have noted that maternal overprotectiveness is a rather typical relationship with deformed or defective children. Due to

already existing guilt feelings, parents of retarded children tend to err on the side of being too lenient. Speaking specifically of the parents of the mentally retarded child, Willey and Waite (1964) state:

> They are characterized by their intense resistance to any realistic recognition of the limitations of capacities of their children; by their withdrawal from social activities; and by their overprotection of children (p. 208).

Overprotection, in this sense, can be defined as the failure of parents to permit, if not encourage, their handicapped child to do the things which he is capable of doing. Thus, the retarded child is placed in future jeopardy by not being expected and required to accept responsibilities which he could negotiate with encouragement and support. In this regard, Jordan (1961) claims: "The retarded child is often led, as are many other handicapped individuals, away from, rather than toward, the development of traits necessary for social-vocational competence (p. 10)."

Since Alfred Binet developed his mental tests in 1905, Kirk and Johnson (1951) note that professional educators and others have had much interest in: " . . . knowing the abilities, disabilities, and personality structure of mentally handicapped children so that more adequate social and educational provisions can be made for them (p. 37)."

There is ample research evidence to indicate that the retarded can become productive members of our society.

Menolascino (1970) indicated that R. B. Edgerton's book entitled, The Cloak of Competency

> well illustrates the wide range of adjustive styles of the adult retardate and dispels the common professional stereotype of the passively compliant and socially-vocationally inept individual in our contemporary society (p. 717).

Unfortunately, too many teachers and parents believe that the numerical I.Q., as obtained on intelligence tests, limits a person in terms of his academic and social achievement. That is, it is assumed that the child who has an I.Q. below 80 is destined to fail in whatever he attempts. This writer is not criticizing the responsible use of psychological tests; however, it appears that too much emphasis has been placed on the quantitative results without considering the equally important social and emotional factors that affect intellectual performance. These important variables should cause one to question the literal use of the intelligence quotient of many standardized intelligence tests in use today.

The public schools have possibly contributed to this problem by stressing the importance of obtaining some "objective" score relating to the human intellect or achievement in order to categorize mentally retarded children. There have been several classification systems proposed to designate intellectual differences, with each system being based on different criteria. However, the various systems have been typically "devised around

(1) degree of mental deficiency, (2) etiology, (3) clinical types, or (4) educational or behavioral level (Hunt, 1969, p. 829)." For purposes of this discussion, attention will be limited to the classification systems dealing with the degree of mental deficiency, educational levels, and behavioral levels. Each of these approaches utilizes the numerical I.Q. as a basis for categorizing an individual into different levels of competency.

Table 1 describes the classification system which is commonly accepted in institutional and clinical settings.

TABLE 1

CLINICAL CLASSIFICATION SYSTEM OF MENTALLY RETARDED*

Clinical Labels	I.Q. Range (All I.Q. Tests)
Borderline Mental Retardation	68-85
Mild Mental Retardation	52-67
Moderate Mental Retardation	36-51
Severe Mental Retardation	20-35
Profound Mental Retardation	20

*Adapted from American Psychiatric Association (1968).

As indicated by the clinical labels, the different degrees or levels of mental deficiency are clearly denoted. This particular system is not to be confused with the one using

"clinical types." When using clinical types as a classification system, one is referring to certain physiological or organic disturbances which have unique physical characteristics, e.g., mongolism, cretinism, and hydrocephaly.

Table 2 presents a classification system of the mentally retarded which is quite common in the public schools;

TABLE 2

EDUCATIONAL CLASSIFICATION SYSTEM

Educational Labels	I.Q. Range (All I.Q. Tests)
Slow Learner	75-90
Educable Mentally Retarded	50-75
Trainable Mentally Retarded	25-50
Custodial Mentally Retarded	0-25

*Adapted from Love (1969).

however, these particular I.Q. levels are not necessarily accepted by all school systems. In some communities, there has been a trend toward raising the I.Q. levels, e.g., 55-80 for the educable mentally retarded (Hunt, 1969). In comparing the clinical classification system with that used in our public schools, one will notice that not only are the labels different, but the I.Q. ranges are considerably different.

The American Association of Mental Deficiency (AAMD) has proposed "a five-level classification system based upon the corresponding deviation scores on a reliable intelligence test (Hunt, 1969, p. 829)." Although this "Behavioral Classification" approach is slow to gain acceptance in the public schools (Hunt, 1969), Benton (1964) notes that this approach "describes mental retardation in terms of two positively correlated dimensions, measured intelligence and adaptive behavior (p. 26)." This is presented in Table 3.

TABLE 3

BEHAVIORAL CLASSIFICATION SYSTEM OF MENTALLY RETARDED*

Level	Behavioral Label	SD Range	I.Q. Range	
			WAIS or WISC	Stanford-Binet
V	Borderline	-1.01 to -2.00	70-84	68-83
IV	Mild	-2.01 to -3.00	55-69	52-67
III	Moderate	-3.01 to -4.00	40-54	36-51
II	Severe	-4.01 to -5.00	25-39	20-35
I	Profound	to -5.00	25	20

*Adapted from Heber (1959).

Hunt (1969) summarizes some of the problems that have been encountered in trying to develop a more descriptive method of classifying the mentally retarded which will meet with universal acceptance. He states:

> The once popular clinical classification by degree which used the terms "moron" (I.Q. 50-70), "imbecile" (I.Q. 25-49), and "idiot" (I.Q. 0-24) has generally been replaced by the classification using descriptive terms, such as "mild," "moderate," and "severe," and in educational settings particularly by terms such as "educable," "trainable," and "custodial." Unfortunately neither diagnosis nor prognosis is affected by a simple name substitution, and the limitations in such classifications have remained. Further, the same descriptive terms have been applied to different I.Q. levels, so "severe" may be used to designate I.Q. 50 and below in one system, I.Q. 25-49 in another, or I.Q. 25 and below in still another (p. 829).

As observed by Robinson and Robinson (1970):

> Mental retardation is not a disease entity like measles or pneumonia; a person is judged retarded only in the context of the community in which he lives, and in relation to the precise demands which are placed upon him (p. 618).

While psychometric and observational data are useful in terms of learning at what level and how a person operates under controlled and standardized conditions, "caution is vital in evaluating children in light of the work of other children. While not rejecting test data . . . we can see that I.Q.'s are not to be interpreted literally (Jordan, 1961, pp. 14-15)."

Realizing that it is impossible to build enough institutions to care for all of the retarded individuals in our society and considering the research findings that the retarded can learn to live a useful and productive life, "most experts now agree that the local community is the best place for treatment and training (Love, 1968, p. 1)." Covert (1965) attributes the increased possibility of the retarded individual to realize more of his potential if

cared for in modern community facilities to the "stimulus, care, and encouragement of family living (p. 67)."

In this regard, many communities have recognized their responsibility and have implemented programs to meet the needs of the mentally retarded and other handicapped individuals. However, it is readily admitted that much more needs to be done, particularly in the more sparsely populated areas of the United States (Isenberg, 1966). If we are to salvage the vast human resources of the mentally retarded, it is imperative that we attempt to help them before institutionalization becomes necessary. To this end, the retarded must be helped to acquire the basic skills of self-care in order to live as independently as possible in society.

Conceptual Frame of Reference for Study

In recent years, more and more attention has been drawn to the critical shortage of professional personnel to cope with the ever increasing mental and emotional problems of our society. Hobbs (1963) gives the following admonition:

> Much of the practice of clinical psychology as well as psychiatry is obsolete. A profession that is built on the fifty minute hour of a one-to-one relationship between therapist and client . . . is living on borrowed time. The only substantial justification for investing the time of a highly trained professional person in the practice of psychotherapy as we know it is the possibility of discovering new and more efficient ways of working with people who are in trouble (p. 3).

The above comments do not relate only to the treatment of adults. Continuing to quote Hobbs (1963), he states:

> Clinical psychology should now reclaim its birthright and devote itself primarily to problems of children. Fully one-half of our resources for the conduct of research and the provision of services should be invested in people under the age of twenty. Another one-fourth of our resources for research and service should be invested in adults who are identified primarily through their relationships with children (p. 3).

As originally conceived by Guerney (1964), filial psychotherapy "represents an attempt to develop a new method incorporating both of these goals (p. 304)." As defined by Guerney (1964):

> Filial therapy involves training parents, in groups of 6 to 8, to conduct play sessions with their emotionally disturbed young children, using an orientation and methodology modeled after client-centered play therapy. After training, the parents continue their weekly group sessions . . . with the therapist to discuss results, conclusions, and inferences about their children and themselves (p. 304).

For this study filial therapy was modified and extended in two important ways: (1) only the mothers were used in this study, as opposed to both parents, and (2) the target population of this study was educable mentally retarded children rather than emotionally disturbed children.

For the purpose of the present investigation, filial therapy was defined as the use of mothers of educable mentally retarded children as intervention agents in facilitating more adaptive social behavior in their educable mentally retarded children.

CHAPTER II

REVIEW OF THE LITERATURE

The research literature examining the use of parents as intervention agents to employ behavior modification techniques with their retarded child involves two major areas: (1) the training of lay or para professional persons as therapeutic (behavior change) agents, and (2) behavior modification with the mentally retarded. If one searches for studies evaluating the use of lay or para professionals with the mentally retarded, the available literature is substantially reduced. When restricting the topic to the use of parents (filial therapy) as intervention agents using behavior modification techniques with their own retarded child, the related literature is virtually nonexistent.

There is a voluminous amount of literature relating to both areas as separate entities. Also, there are several excellent comprehensive reviews of the available literature attesting to the efficacy of: (1) the use of para professionals to help meet the ever-growing need for social services (Carkhuff, 1966; Carkhuff, 1969a, 1969b; Gordon, 1965; Holzberg, 1963; and Reiff, 1966), and (2) the

application of behavior modification techniques to modify, change, or influence a wide variety of behavior disorders (Bachrach, 1962; Baer, Wolf, and Risley, 1968; Bandura, 1969; Biderman and Zimmer, 1961; Eysenck, 1960; Krasner and Ullmann, 1967; Ullmann and Krasner, 1965; Ullmann and Krasner, 1969; and Ulrich, Stachnik, and Mabry, 1966).

The majority of the above reported studies have been conducted in mental hospitals, out-patient clinics, public and private school classrooms, and research laboratories by both professionally and non-professionally trained therapists. However, there is growing evidence that parents can serve as effective behavior shaping agents in the home, if given appropriate information, as will be evidenced by the following studies.

This literature review will be concerned only with those studies which directly involve the use of parents to act as therapeutic agents for their child, regardless of the emotional, mental, or physical malady. The types of problems had to be extended due to the limited number of studies relating to the population of this study, the mentally retarded.

Filial therapy has been acknowledged as a "new psychotherapeutic method that extends specific Rogerian approaches to the training of parents . . . (Stover and Guerney, 1967, p. 110)." However, one can find precedent cases, prior to Rogers and Guerney, where parents were

employed as therapeutic technicians. Perhaps the first attempt of a professional therapist to actively employ a parent as a therapeutic agent was made by Freud. The initial report was published in German in 1909; however, an English translation of the detailed account of the "Analysis of a Phobia in a Five-Year-Old Boy" can be found in Freud's Collected Papers (1959). Speaking of this endeavor, although from a psychoanalytic vantage point, Freud states:

> . . . the treatment itself was carried out by the child's father . . . No one else, in my opinion, could possibly have prevailed on the child to make any such avowels; the special knowledge by means of which he was able to interpret the remarks made by his five-year-old son was indispensable, and without it the technical difficulties in the way of conducting a psychoanalysis upon so young a child would have been insuperable. It was only because the authority of a father and of a physician were united in a single person, and because in him both affectionate care and scientific interest were combined, that it was possible in this one instance to apply the method to a use to which it would not otherwise have lent itself (p. 149).

Bonnard (1950), also employing psychoanalytic principles, reported a case of a boy of four-and-a-half years who was suffering from a fairly severe, but limited "obsessional state." The mother was only seen "fortnightly," except during crisis phases of the treatment when she was seen on a weekly basis. In spite of the infrequency of the sessions, the author notes that it "must be remembered that when a parent acts as the therapist, the child receives a twenty-four hour service (p. 408)." At the time the article was written (1950), treatment was still continuing;

however, the child has shown progress and had not completely decompensated.

More recently but before the term "filial therapy" was coined, several studies were reported which are quite similar in rationale and technique to filial therapy. Natalie Rogers Fuchs (1957) described the play sessions with her one-and-a-half year old daughter which helped alleviate the child's phobia associated with her bowel movements. The mother described her daughter as being basically "normal"; nevertheless, this was one particular problem which was causing the family considerable concern. By reading about play therapy and corresponding by letter with her father (Carl Rogers) for assistance, Fuchs was able to apply Rogerian techniques in play therapy to overcome the daughter's fear of eliminating her bowels.

This same author also cited a case where she helped another mother, having a similar problem with her daughter, employ the same techniques and attitudes to effect some remission of the symptoms. Based on these two successful experiences, Fuchs concluded that "reasonably intelligent, sensitive parents can help their children over some of the rough spots of growing up by using the technique and attitudes of a play therapist (p. 89)."

Although many of the following studies do not explicitly label the technique as "filial therapy," there will be one basic underlying commonality, i.e., the parents

have been specifically guided to use certain procedures to achieve desired behavioral changes in their child.

Carkhuff and Bierman (1970) utilized the concept of "interpersonal skills" as the core of a treatment program to help sets of parents of emotionally disturbed children. The treatment group manifested significantly greater gains in communication and discrimination (empathy) skills; however, this did not generalize to play situations with their children. In fact, "none of the groups were successful in effecting constructive personality and adjustment changes of parents and children (p. 160)." The authors suggest that the failure to produce such changes was primarily due to "the experimental nature of the play situation . . . (p. 160)." In spite of the fact that the parents received training, no mention was made of the filial therapy.

Bernal (1969) reports two case studies in which the mothers of two male "brats" were instructed in the use of operant learning principles. The mothers received behavioral feedback via television of the intervention and instruction sessions in order to shape the mothers' management behaviors.

> According to daily notes kept by the mothers of the boys' problem behaviors at home, both children improved markedly within a period of 25 weeks from the first contact with the parents (p. 375).

Wolf, Risley, and Mees (1964) employed attendants and parents to extinguish chronic self-destructive behaviors of a hospitalized, pre-school boy who had been variously

diagnosed as mentally retarded, autistic, and brain-damaged. Severe tantrums were marked by head-banging, face-slapping, hair-pulling, and face-scratching. The application of laboratory-developed techniques in manipulating the consequences of the child's behavior, i.e., mild punishment, extinction, and the gradual shaping of appropriate (desired) behavior through reinforcement of successive approximations was successful in eliminating the various problem behaviors. The parents received instruction as to how to handle their child while he was still in the hospital as it was imperative that the parents continue the elaborate program when the child made home visits.

The study just mentioned by Wolf and his associates was concerned with concomitant tantrum and self-destructive behavior in one particular child. There are case studies available which attempt to alleviate problems which are not multiple and complex in nature, but more specific.

For example, Williams (1958) cites a case where "tyrant-like tantrum behavior" of a twenty-one month old child was eliminated through extinction procedures. The tantrum behavior was particularly pronounced at bedtime when the parents would leave his room after putting him to bed. The parents were encouraged to put the child to bed in a leisurely and relaxed fashion; however, they were to no longer reinforce the tantrum behavior by remaining in the room until the child went to sleep or to return to the

child's room while he was screaming and crying. By the tenth session, the tantrum behavior at bedtime was totally extinguished. It was noted by the author that aversive punishment was not employed and, "All that was done was to remove the reinforcement (p. 269)."

In a similar manner, Allen and Harris (1966) were successful in helping a mother eliminate pronounced self-scratching behavior of her five-year-old daughter through the application of operant conditioning techniques. In this case, the mother was "trained to withhold all reinforcement contingent upon the child's scratching herself but to reinforce other, desirable behavior (p. 79)." The mother reported during the third session, one week after the reinforcement procedures had begun, that the scratching had subsided somewhat. In the fourth session, two weeks after initiating the program, the sores which had previously developed were beginning to heal. After six weeks of continued application of the reinforcement procedures, every sore was healed completely.

Various phobic reactions have been successfully eliminated by parents employing techniques based on learning principles. Jersild and Holmes (1935) discuss various techniques that parents devised to overcome children's fears in a relatively short time.

Patterson (1965) wrote of a seven-year-old boy who suffered from "school phobia." After discussing in detail

the successful conditioning procedure, the author concluded:

> . . . we have been impressed with the general lack of awareness displayed by these parents as to what it is that they are reinforcing and the effect of this reinforcement upon the behavior of the child. The procedure described here should be appropriate for a variety of child behavior problems and for parents who do not show obvious signs of pathology. This latter statement assumes of course that the reinforcing contingencies adopted by any particular parents are not necessarily determined by the intensity or kind of emotional conflict in the parents. It is hypothesized here that many parents have been conditioned rather than 'driven' to adopt their idiosyncratic schedules of reinforcement (p. 284).

Earlier, Patterson had stated that the parents were instructed to selectively reinforce the child's behavior in the home, that is they were to reinforce the appropriate behaviors and ignore the "behaviors associated with reactions to separation anxiety (p. 280)." In this regard, the author claimed that "one of the crucial variables involved in this procedure is the reinforcement contingencies being used by social agents other than the experimenter (pp. 283-284)."

Similarly, Tahmisian and McReynolds (1971) were able to help the parents of a thirteen-year-old school-phobic girl use instrumental, behavior-shaping procedures to eliminate the avoidance behavior. In addition to the usual procedure of rewarding appropriate behavior and withholding any reward following inappropriate behavior, these authors established a "series of behavior-shaping, school-approach hierarchies (p. 266)" which ranged from a brief school visit to all day attendance. The total time of treatment was three weeks and consumed only two hours of the therapist's time. Ninety

minutes of this time was devoted to the training of the parents and three subsequent follow-up telephone calls accounted for the other thirty minutes.

In a study relating specifically to filial therapy, Stover and Guerney (1967) report that mothers who learned the "desired reflective, empathic role in conducting weekly one-hour play sessions (p. 110)" with their own "emotionally maladjusted" children, were more effective in being reflective and less directive in the parent-child relationship. It was also observed that the children of the mothers in the "filial therapy" group became more aggressive. It was concluded that mothers "can learn to modify their pattern of interaction with their own emotionally disturbed children in the direction of the role behavior of a "client-centered therapist" and that "in some significant aspects of their behavior in the play situation, children respond quickly to this change in mother's behavior (p. 115)."

Other problem areas in which parents have been instrumental in bringing about desired behavior changes are as follows: water phobia (Bentler, 1962); toilet training (Madsen, 1965); eliminative disturbances (Peterson and London, 1965; Tomlinson, 1970); stuttering (Rickard and Mundy, 1965); deviant or problem behaviors (Wahler, Winkle, Peterson and Morrison, 1965; Zeilberger, Sampen, Sloane, 1968); and encopresis (Edelman, 1971).

It is apparent from the above reported studies that parents can and do serve as influential and effective social reinforcers. It is also evident that parents can learn to relate in a more positive manner which facilitates the acquisition of more appropriate behavior by their child.

As noted by Guerney and associates (1966), the traditional professional helper has attempted "to separate distinctly the child's own therapy sessions from the counseling or psychotherapy offered to the parent (p. 6)." Continuing to speak of the traditional approach, they state:

> The treatment procedures, regardless of any verbal reassurances to the contrary, have tended to suggest to the parent that his potential as an ally for ameliorating the child's problems was not taken seriously; and that the role he played in the development and continuation of the problem was the important factor (p. 6).

In almost direct contrast to the traditional treatment procedures "filial therapy" regards the parents as an important ally and the actual agent for effecting behavior change. In addition to the benefits of utilizing the parents mentioned earlier, Stover and Guerney (1967) note the following:

> Further, in filial therapy one can hope for a more parsimonious utilization of the professional therapist's time by extending portions of his role to a nonprofessional with the further advantages of: (a) avoidance of fears and rivalry that develop in the parent as the child decreases dependency and develops affection for the therapist; (b) reduction of guilt feelings of helplessness that often arise when the parent is obliged to abandon the problem to the expert for resolution, and (c) avoidance of the problems that otherwise could be aroused when the parent does develop appropriate new responses to new behavior patterns of the child (p. 110).

In his article which provided the description and rationale of filial therapy, Guerney (1964) noted that Dorothy Baruch presented illustrative material which supported her conclusion that "play sessions at home offer a way of fostering good parent-child relationships (p. 305)." Moustakes (1959) has also suggested that "play therapy" sessions conducted in the home by parents of relatively normal children can provide very positive experiences for the parent and the child who are involved in this "relationship therapy."

The basic rationale for the use of filial therapy (play therapy) with normal and emotionally disturbed children is deemed equally applicable for the justification to use parents as intervention agents with other populations; namely, mentally retarded children. Guerney, Guerney, and Andronico (1966), speaking of the parents as therapeutic agents in play therapy, state that parents could possibly be more effective than a professional "in enhancing the child's sense of belonging and worthiness, and make him feel somewhat less negative and more 'giving' toward the parents (p. 8)." The reasons for this assumption are as follows:

> . . . (a) the parent has more emotional significance to the child, (b) anxieties learned in the presence of, or by the influence of, parental attitude could most effectively be unlearned, or extinguished, under similar conditions, and (c) interpersonal misexpectations should be efficiently corrected if appropriate delineations were made clear to the child by the parent himself as to what is, and what is not, appropriate behavior according to time, place and circumstances (p. 8).

The present study was designed to determine: (1) the efficacy of using mothers as intervention agents in facilitating more socially adaptive behavior, as perceived by the mothers, in their educable mentally retarded children, and (2) the change in maternal attitudes, after participating in the experimental treatments, toward their educable mentally retarded children. Two different filial therapy approaches and a no-treatment control group were used to evaluate the effectiveness of working through parents to achieve the above goals. In both filial therapy groups, the mothers were used as intervention agents to facilitate more socially adaptive behavior in their educable mentally retarded children. However, the format of the two groups differed.

In one of the filial therapy groups, an expert presented the mothers with concepts and techniques of specific reinforcement and extinction procedures (see Appendix G) by which to achieve desired behavioral goals. In the second filial therapy group, the expert was present; however, the mothers were encouraged to and supported in finding solutions to their own problems of concern through peer interaction.

Definition of the Terms

Educable Mentally Retarded (EMR). Kirk (1962) has defined the educable mentally retarded child as:

> . . . one who, because of slow mental development, is unable to profit to any great degree from the [normal] programs of the regular schools, but who has three potentialities for development: (1) minimum educability in reading, writing, spelling, arithmetic, and

> so forth; (2) capacity for social adjustment to a point where he can get along independently in the community; and (3) minimum occupational adequacy such that he can later support himself partially or totally at a marginal level (p. 86).

To be classified as educable mentally retarded, a child's valid, numerical I.Q., as obtained on the 1960 Stanford-Binet L-M Intelligence Scale (S-B) or Wechsler Intelligence Scale for Children (WISC), must fall within the range of 48 to 85. The obtained numerical I.Q. was considered valid if the above mentioned tests had been administered by a competent examiner; e.g., a psychologist or counselor with specialized training in the use of that test.

Socially Adaptive Behavior. In this study, the terms "adjustive" and "adaptive" behavior will be used interchangeably. Willey and Waite (1964) suggest that adjustment suggests an element of harmony with the world (p. 34). They continue by saying that:

> It is a state of feeling, an ideal probably never reached but possessing various degrees of attainment. It is continuous, and the individual may derive some satisfaction from the struggle toward rather than the attainment of this adjustment . . . Teachers and parents can aid the adjustment process either by helping to change the environment or by helping to change the pupil's relationship with his environment . . .
>
> The element of social adjustment requires that personal needs and satisfactions are integrated with the needs and satisfactions of other people in the social milieu. This implies, of course, an acceptance of certain responsibilities (p. 34).

Socially adaptive behavior refers to that behavior which indicates responsibility and independence of action as measured by the Vineland Social Maturity Scale (VSMS).

Maladaptive Behavior. As with adaptive behavior, "maladaptive" and "maladjustive" behavior will be used synonomously. According to Ullmann and Krasner (1967), "Maladjustive behavior may be defined in terms of the behavior that important people in the individual's environment (his social reinforcers) wish to increase, decrease, or change (p. 7)."

Filial Therapy-Training Group (FT-T). As previously defined, filial therapy involved an expert introducing mothers of EMR children to concepts and methodologies of specific reinforcement and extinction procedures (see Appendix G) to facilitate more adaptive social behavior in their children.

Filial Therapy-Discussion Group (FT-D). This approach was quite similar to the non-directive or client-centered approach which is most often associated with the name of Carl Rogers. However, for this study the label of filial therapy-discussion group was deemed more descriptive of the second experimental technique used in this study. Succinctly stated, in this approach the experimenter stressed and encouraged verbal communication; however, the leader made no attempt to direct or structure the topics of discussion or to provide solutions to problems being presented by the group

members. It was left to the various group members to offer encouragement and support to each other to try new approaches to achieve desired goals.

Rationale for Inquiry

Love (1968) notes that mental retardation ranks nationally as a major social, economic, and health problem. He continues by saying, "There are twice as many mentally retarded as there are cases of blindness, polio, cerebral palsy and rheumatic heart disease (p. 1)."

In spite of the above pronouncement, many authors note that it is almost impossible to accurately estimate the incidence of mental retardation (Robinson and Robinson, 1970). Based upon the report of the President's Panel on Mental Retardation published in 1962, entitled A Proposed Program for National Action to Combat Mental Retardation, the most frequently quoted estimate of the number of mentally retarded people in the United States is six million (Kolstoe, 1970). In terms of percentage, the most frequently reported estimate of mentally retarded persons is roughly three percent of the population in this country (Robinson and Robinson, 1970).

While special programs and facilities for the physically and mentally handicapped are presently expanding rapidly (compared to only two decades ago), the estimations of the number of persons in special education programs and institutions vary. Mackie (1969) noted that approximately

> 540,000 children were enrolled in special education programs for the mentally retarded in 1966. This figure is less than half of the number of such children estimated to need some form of special education (p. 22).

In an earlier publication, Mackie and Robbins (1960) estimated that 250,000 additional retardates were in institutions or workshops.

These figures by Mackie and Robbins (1960) suggest that the large majority of the mentally retarded are not confined to institutions (Wallin, 1969). Love (1968) estimates that ninety-five percent of the mentally retarded individuals in the United States live in their local communities, where treatment may or may not be available.

In spite of the above statements, there is ample evidence to indicate that it has only been relatively recent that emphasis on institutional custody of the retarded has waned (Garton, 1968). "Even as late as 1930, many retarded children were still being kept hidden in back rooms because of shame or ignorance on the part of parents (Love, 1968, p. 70)."

Because of this lack of concern in the past, Kolstoe (1970) notes that "many retarded individuals were unable to learn to care for themselves in a community setting and were committed to institutions for lifetime care (p. 24)." He continues by saying that since:

> . . . only about one-sixth of the groups are currently being trained to care for themselves, waiting lists for institutional placement are growing, and budgetary

> appropriations to build more institutions continue to soar (pp. 24-25).

In view of the shortage of trained professionals and institutional facilities to care for the large number of mentally retarded children, there appears to be a great need for methods of treatment involving parents of retarded children. This research investigation attempted to provide mothers of educable mentally retarded children (I.Q.'s ranging from approximately 50 to 85 as measured by the Wechsler Intelligence Scale for Children or the Stanford-Binet) with a learning experience which would foster more realistic aspirations and goals for their retarded children. It was hoped that the mothers of retarded children would learn to accept the idea that their child, except for their limited intellectual ability, is more like than unlike other children who are considered "normal."

This point was made by Baker (1944) when he reminds us that:

> All children crave recognition, praise, and security. The very factors which make for success in normal children are the same for which handicapped children must strive but in greater degree. All children want to play, have need for proper food and shelter, may weep over the same things, suffer the same disappointments, and rejoice over the same successes. They develop from infants into children and then into adults, possibly at different rates, yet all seek to attain the same general goal of maturity. They have fears, worries, suffer from the same shock, ask the same questions about their origins, and in countless ways live similar patterns.
>
> In any study of exceptional children the norm of the average child should constantly be kept in mind . . . Most children grow up to accept the duties of

> citizenship, so that whatever preparation is merited by nonhandicapped children should also be provided for the handicapped in sufficient measure to help them achieve the same results (p. 8).

Robinson and Robinson (1970) expressed the same basic idea in more succinct terms by saying that:

> We cannot, however, expect to find pervasive traits or dimensions common to all retardates but not to normal children, other than their relative deficit in gereral mental ability and its direct consequences (p. 620).

The primary goals of education, regardless of intellectual ability, are to promote "self-realization, human relationships, economic security, and civic responsibility (Willey and Waite, 1964, pp. 76-77)." The ultimate goal of education, even for the mentally retarded, is to help each individual become "as productive and useful a person as his innate ability permits (Love, 1968, p. 24)."

Many educators and psychologists agree that the family background and environment play a significant role in the total development of all persons (Love, 1968). Although parents must learn to cope with their feelings of guilt, shame, and anger after their child is diagnosed as mentally retarded, the primary focus of this study was to help parents (mothers) improve and increase their retarded child's repertoire of social behavior.

Objectives of the Study

The purposes of this study are to evaluate the comparative effects of three treatment groups in facilitating socially adaptive behavior in EMR children and fostering more

positive maternal attitudes toward EMR children as both are perceived and reported by the mothers. One group involved an expert informing mothers of EMR children about concepts and techniques of specific reinforcement and extinction procedures through an extension of filial therapy (FT-T). The second group of mothers of EMR children were treated with a nondirective, discussion-oriented (FT-D) approach which focused on peer-generated solutions to behavioral problems and/or goals. The third group of mothers of EMR children were placed in a no-treatment (CONTROL) group. The specific questions considered for investigation were as follows:

1. Is there any difference in the effectiveness of the modified filial therapy (FT-T) approach, the non-directive, discussion-oriented (FT-D) approach, and no-treatment (CONTROL) in facilitating more adaptive social behavior, as perceived by the mothers, in their EMR children?
2. Is there any difference in the effectiveness of the modified filial therapy (FT-T) approach, the non-directive, discussion-oriented (FT-D) approach, and no-treatment (CONTROL) in fostering more positive attitudes in the mothers toward their EMR children?

CHAPTER III

EXPERIMENTAL DESIGN AND STATISTICAL METHODOLOGY

Subjects

The subjects for this study were drawn from the mothers and foster mothers who have an Educable Mentally Retarded (EMR) child enrolled at the Holy Family Center. The Holy Family Center, in conjunction with the Kansas Elks Association, provides comprehensive educational experiences for educable mentally retarded children. The Holy Family Center charges a $50.00 registration fee and tuition is currently $125.00 per month; however, it is nonsectarian and eligibility is based on careful psychological and educational evaluation procedures.

Holy Family Center is a day school and serves eligible children from the age of six through eighteen. The program is designed to permit flexibility of methods and curriculum in order to cope with individual differences. While this program serves primarily the Wichita area, there are no resident restrictions. Since it is not a residential facility and the parents are responsible for the transportation of their child to and from the school, the distance

factor may prohibit some children from participating in the program. Also the registration and tuition fees are prohibitive for some families.

The school itself is located in suburban west Wichita on an eighteen acre tract of land. The school contains 47,300 square feet of floor space which permits large classrooms, numerous rooms for special services, and/or activities, and a gymnasium-auditorium complex.

The teaching staff includes Sisters, representing two communities of Sisters, who are assisted by lay teachers. Other staff members include the Principal-Director, a speech therapist, a physical education director, and a consulting psychologist.

Initially, a letter (see Appendix A) was sent to thirty of the forty-three mothers (including foster mothers) who have EMR children enrolled at the Holy Family Center as of February 1, 1972. Thirteen mothers were excluded from consideration as ten of the families were already involved in some training and/or psychotherapy program. Two of the students had recently been assigned to new foster parents and it was doubted that they had much knowledge about their foster child's level of social functioning. In one other case, the mother represented a Spanish-American family and she could neither speak nor understand English.

The letters were addressed to only the mothers because it was assumed that there would be less conflict in

scheduling the meetings to meet different work schedules. Also, if only the mother was involved, many potential baby-sitting problems could be eliminated because the father could remain home to care for the children. It was also assumed that the mothers would be more cooperative and assume more responsibility in attending the weekly meetings on a regular basis.

As noted above, the subjects for this study were drawn from the thirty mothers and foster mothers who were considered eligible for this study. To be considered eligible, the mother must have had an Educable Mentally Retarded child whose I.Q. fell within the range of 48 to 85, living in her home and attending the Holy Family Center (see Table 4). It was also required that the mother express an

TABLE 4

COMPARATIVE DATA OF EMR CHILDREN

Group	$\bar{X}$ Chronological Age	Sex		$\bar{X}$ Numerical I.Q.	$\bar{X}$ AAMD Rank
		Male	Female		
FT-T	12-11	3	4	62.14	2.00
FT-D	14- 4	3	4	66.29	1.57
Control	15- 7	4	3	67.57	1.43

interest in and willingness to participate in the study. The fact that the various instruments mailed them were

completed and returned to the experimenter was one test of their desire to participate.

Of the thirty mothers who were sent the above mentioned letters, sixteen (53.3%) mothers responded by attending the briefing session (see Appendix B). The remaining fourteen (46.7%) mothers were contacted by telephone and queried as to their interest in participating in the study. If the mothers expressed interest in learning more about the study at that time, they were given the same explanation as were the mothers who attended the original sessions.

All of the mothers, those who came to the initial meeting and those who were later contacted by telephone, were asked to indicate whether they were or were not interested in participating in the study. The mothers who decided not to participate in the study were not pressured in any way to change their minds. Only those mothers who were willing to participate, either initially or after the follow-up discussion, were included in the experimental or control groups.

Each of the sixteen mothers who attended one of the briefing sessions agreed to participate in the study. Of the fourteen mothers who were contacted by telephone, all but four (approximately 28.5%) agreed to participate in the study. Two of these mothers were unable and/or unwilling to provide reasons for their resistance to participation in the

study; however, one mother indicated that her seventeen-year-old daughter had "learned all that she was ever going to learn." In the other case, the child had died between the time the initial letter was sent and the briefing session.

The twenty-six mothers who had agreed to participate in the study were then mailed the instruments and asked to return them in an enclosed, self-addressed and stamped envelope. The two families (one natural mother and one foster mother) in which there were two EMR children, the mother was asked to fill out the instruments for the oldest child.

Thirteen (50%) of the twenty-six sets of instruments were returned within a period of one week. Follow-up telephone calls were made to twelve of the thirteen mothers who had failed to send back the completed instruments. (One family did not have a telephone and four mothers had decided not to participate in the study; consequently, a total of five instrument sets were never returned.) Within the next week, twenty-one (approximately 81%) of the original twenty-six sets of instruments had been received and constituted the subject pool. The twenty-one participating subjects were randomly assigned to three equal treatment groups (N = 7).

Treatments

Filial Therapy-Training Group (FT-T). Those subjects assigned to this experimental condition were seen for eight weekly sessions by this researcher for a period of

approximately two hours. The first hour was devoted to a structured didactic presentation by the experimenter. The format of these didactic lectures (see Appendix G) was adapted from Valett's (1969) book entitled Modifying Children's Behavior: A Guide for Parents and Professionals. The last hour of each session was devoted to group discussion of the lesson presented during that session and demonstration of the techniques through role-playing when appropriate.

The purpose of this particular approach was to have an expert aquaint the mothers with specific information in the use of reinforcement and extinction procedures to help their retarded children acquire more adaptive social behavior as measured by the Vineland Social Maturity Scale.

Filial Therapy-Discussion Group (FT-D). The subjects assigned to this group were also seen concurrently with the FT-T group, for eight weekly sessions by this researcher for a period of approximately two hours. The experimenter served as a facilitator of discussion and did not make any attempt to select or direct the content of the discussions. Likewise the experimenter did not provide any suggestions as to how a parent should handle a specific situation that presents a problem for the family. When the mothers attempted to place the experimenter in the teacher or expert role, the experimenter dealt with this by offering "restructuring,

reassurance, and reflection of feelings (Perkins and Wicas, 1971, p. 275)."

The purpose of this approach was to provide an atmosphere of warmth, acceptance, and empathic understanding in which the mothers could explore and express their feelings and concerns regarding their retarded children. It was assumed that each mother would experience support and encouragement to try new ways of relating to their retarded child and facilitate more adaptive behavior as measured by the Vineland Social Maturity Scale.

No-Treatment Group (CONTROL). Those subjects placed in this group were asked only to complete the instruments both prior to and after the experiment. They were not asked to meet as a formal group in any way during the experiment. They were treated just as those subjects who volunteered for the experiment but were not assigned to either of the other two experimental groups.

Instrumentation

After the list of cooperating mothers was compiled, a second letter (see Appendix C) and the various instruments used in this study were mailed. Two primary measures were employed in this study to evaluate the effectiveness of the three treatment groups. The instruments, administered prior to and after the treatments, were the Vineland Social Maturity Scale, Form B, which was developed by Doll (1936) and the Parent Attitudes Toward Mentally Retarded Children

by Love (1968). This title was changed to Parent Questionnaire (see Appendix D) to avoid possible defensiveness of the mothers' responses. The Personal Data Sheet (see Appendix F) was a secondary instrument and was provided in the initial mailing only.

Vineland Social Maturity Scale (VSMS). The VSMS was developed by Edgar A. Doll in 1936. The expressed purpose of this scale was to provide a device for the quantitative estimation of social maturation and competence (Doll, 1958). The Scale consists of 117 items which are arranged in order of average age norms. Eight different areas of socially independent behavior are evaluated (Doll, 1936).

This instrument was standardized on data from a total of 620 normal subjects. Ten white subjects of each sex at each year from birth to thirty years of age comprised the normative group (Doll, 1958). In discussing the standardization process, Doll (1936) states:

> This is not a sufficient number of subjects for final standardization, but it may be noted that the calibration of such a scale is not determined by the number of subjects at each age alone, but rather by the succession of ages over a range of years. The stability of such a standardization is therefore determined in a large measure by the internal consistency of the Scale as a whole (pp. 2 and 6).

In a group of 123 feeble-minded subjects, the correlation of reliability between first and second Social Age (SA) scores on the VSMS was .92 (Doll, 1958). In terms of validity, a coefficient of correlation of .85 between obtained and estimated SA scores resulted from the analysis

of 250 re-examinations of feeble-minded subjects (Doll, 1958).

Although the VSMS was mailed to all mothers for completion prior to the group meetings, it was necessary for this investigator to re-administer this instrument to all subjects. Most of the items were quite precise in nature; however, some of the items were rather vague without additional information. Consequently, for the mothers in the two experimental groups, each of the items was explained as to what types of social skills were needed for credit. Each mother recorded her own responses. This was done for both experimental groups during the first part of the initial meeting. Those mothers who were absent from the first group session and the mothers in the CONTROL group were telephoned and given the same additional information, and this researcher recorded their positive or negative response to each item. All testing was completed during the week in which the group meetings commenced.

The same basic procedure was followed during the posttest phase of the study. At the close of the final group session, all of the items of the VSMS were again explained, and each mother recorded her own responses. Those mothers who were not at the final session were telephoned the next day and administered the VSMS in the same fashion as described for the pretest. The mothers in the CONTROL group were telephoned during the final week of the

group sessions and re-administered the VSMS as outlined previously.

Parent Questionnaire (PQ). This scale was developed by Love (1967-68) after he was unable to find an appropriate instrument to measure parental attitudes toward their mentally retarded children. The instrument consists of thirty statements and requires the subject to place a check mark under one of five columns for each statement (see Appendix D) as to whether they strongly agree, agree, disagree, strongly disagree, or are undecided. While an "undecided" response to any item receives a value of 3, some "strongly agree" responses receive a value of 5 and other responses under the same heading receive a value of 1 (see Appendix E). The higher assigned value represents a more positive attitude toward mentally retarded children.

In terms of reliability, the "split-half" method of determining the coefficient of reliability was used with two different groups of parents. In a study of 62 parents in Greeley, Colorado, the computed coefficient of reliability was +.91, while in southern Louisiana, the scores of 200 parents yielded a coefficient of reliability of +.93.

As noted previously, this instrument was mailed to and returned by all research subjects prior to the first group meeting. For the mothers in the two experimental groups, this scale was administered to those present at the final meeting after the VSMS was completed. Those mothers

who were not present at the final group meeting and the mothers in the CONTROL group were mailed this instrument the day after the last group session and asked to return it by the end of the next week. All research subjects who were mailed this scale complied with the request.

Personal Data Sheet. This questionnaire (see Appendix F) was developed by this researcher to obtain demographic data about the research subjects. It was hoped that this information would permit simple *a posteriori* comparisons of the mothers who participated in this study.

Statement of Research Hypotheses

The following hypotheses were tested:

1. The filial therapy-training group will be more effective in facilitating socially adaptive behavior, as perceived by the mothers, of educable mentally retarded children than will the filial therapy-discussion group as measured by the Vineland Social Maturity Scale.
2. The filial therapy-training group will be more effective in facilitating socially adaptive behavior, as perceived by the mothers, of educable mentally retarded children than will no-treatment as measured by the Vineland Social Maturity Scale.
3. The filial therapy-discussion group will be more effective in facilitating socially adaptive

behavior, as perceived by the mothers, in educable mentally retarded children than will no-treatment as measured by the Vineland Social Maturity Scale.

4. The filial therapy-training group will be more effective in fostering more positive maternal attitudes toward their retarded children than will the filial therapy-discussion group as measured by the Parent Questionnaire.
5. The filial therapy-training group will be more effective in fostering more positive maternal attitudes toward their retarded children than will no-treatment as measured by the Parent Questionnaire.
6. The filial therapy-discussion group will be more effective in fostering more positive maternal attitudes toward their retarded children than will no-treatment as measured by the Parent Questionnaire.

Statistics

Prior to the testing of treatment differences, the pretest raw scores on the Vineland Social Maturity Scale (VSMS) and the Parent Questionnaire (PQ) were subjected to a one-way analysis of variance (Ferguson, 1966) to determine whether there were differences between the treatment groups at the start of the experiment. In addition, the pre- and

posttest scores for the CONTROL group on the VSMS and the PQ were evaluated by means of the Pearson product-moment correlation coefficient (Ferguson, 1966) to ascertain the degree of relation between the two dependent variables, the VSMS and PQ, prior to and after the experiment.

The statistical test used to evaluate treatment differences was a one-way analysis of variance (Ferguson, 1966) on the change scores of the VSMS and PQ. Where the results were significant, Scheffé's method (Ferguson, 1966) of comparing means two at a time was used. As noted by Ferguson (1966), the Scheffé method reduces the Type I error or Alpha risk more than other multiple comparison methods, e.g., individual t-tests. Also this particular method "is not seriously affected by violations of the assumptions of normality and homogeneity of variance, unless these are gross (Ferguson, 1966, p. 297)." The .05 level was adopted as the criterion for significance for all statistical tests.

The Personal Data Sheet permitted simple a posteriori comparisons of the demographic variables when meaningful and appropriate.

CHAPTER IV

RESULTS

Before analyzing and interpreting the data which relates to the specific hypotheses of this study, the preliminary statistical methodologies will be described and reported first. Presenting the results in this manner should aid the reader in understanding the main effects of this study.

Table 5 presents the pre- and posttest scores, as well as the means and standard deviations, for all treatment conditions on the two dependent variables used in this study, the Vineland Social Maturity Scale (VSMS) and the Parent Questionnaire (PQ). The VSMS scores represent equivalent social age values and the PQ scores reflect the actual raw scores.

The pretest scores of the VSMS and the PQ for all three treatment groups were analyzed by the one-way analysis of variance (Ferguson, 1966) to determine whether there were any initial differences among the groups. As shown in Tables 6 and 7, the three experimental groups did not differ significantly ($p > .05$) from each other during the pretest

TABLE 5

INDIVIDUAL PRE- AND POSTTEST SCORES ON VINELAND SOCIAL MATURITY SCALE AND PARENT QUESTIONNAIRE FOR THREE EXPERIMENTAL GROUPS

Group	Subject	VSMS		PQ	
		Pre	Post	Pre	Post
FT-T	A	10.8	11.0	117	110
	B	4.5	5.0	139	134
	C	6.3	7.0	106	101
	D	8.5	8.8	117	116
	E	5.6	5.8	122	116
	F	10.5	10.5	124	125
	G	10.5	10.8	121	117
	$\bar{X}$	8.10	8.41	120.86	117
	SD	2.63	2.51	9.88	10.57
FT-D	H	7.8	8.3	127	119
	I	9.7	10.0	95	104
	J	10.5	10.8	116	110
	K	8.8	9.3	115	121
	L	11.0	11.7	132	132
	M	9.7	10.3	137	130
	N	8.8	9.3	125	116
	$\bar{X}$	9.47	9.96	121	118.86
	SD	1.07	1.09	13.94	10.03
Control	O	11.0	11.0	126	135
	P	7.8	7.8	124	119
	Q	8.0	8.3	120	118
	R	11.3	11.3	109	115
	S	11.3	11.3	109	103
	T	10.3	10.3	103	105
	U	11.0	11.3	107	101
	$\bar{X}$	10.14	10.16	114	113.71
	SD	1.59	1.47	9.13	11.97
Total	$\bar{X}$	9.24	9.52	118.62	116.52
	SD	2.98	1.88	11.08	10.57

Note:

VSMS stands for Social Age Equivalents; PQ stands for Raw Scores.

TABLE 6

ANALYSIS OF VARIANCE: PRETEST SCORES
ON VINELAND SOCIAL MATURITY SCALE

Source of Variation	df	SS	MS	F	p
Between Groups	2	15.18	7.59	2.15	NS
Within Groups	18	63.47	3.53		
Total	20	78.65			

Note:
An F value of 3.55 was needed for significance at .05 level.

TABLE 7

ANALYSIS OF VARIANCE: PRETEST SCORES
ON PARENT QUESTIONNAIRE

Source of Variation	df	SS	MS	F	p
Between Groups	2	224.09	112.05	.89	NS
Within Groups	18	2256.86	125.38		
Total	20	2480.95			

Note:
An F value of 3.55 was needed for significance at .05 level.

Pearson product-moment correlation coefficient between the VSMS and the PQ were computed for the CONTROL group under pre- and posttest conditions and yielded nonsignificant ($p > .05$) negative correlations of -.54 and -.09

respectively. From these results, it was evident that the VSMS and the PQ are measures of two independent variables.

Tables 8 and 9 provide the summary of the analysis of variance (Ferguson, 1966) for change scores on the VSMS and

TABLE 8

ANALYSIS OF VARIANCE: GROUP DIFFERENCE CHANGE SCORES ON VINELAND SOCIAL MATURITY SCALE

Source of Variation	df	SS	MS	F	p
Between Groups	2	.56	.28	8.75	<.01
Within Groups	18	.57	.032		
Total	20	1.13			

TABLE 9

ANALYSIS OF VARIANCE: GROUP DIFFERENCE CHANGE SCORES ON PARENT QUESTIONNAIRE

Source of Variation	df	SS	MS	F	p
Between Groups	2	44.13	22.07	.678	NS
Within Groups	18	585.68	32.54		
Total	20	629.81			

Note:
An F value of 3.55 was needed for significance at .05 level.

PQ respectively. These results indicate a significant difference between the pre- and posttest scores on the VSMS

(see Table 8); however, the treatments failed to produce any significant difference in pre- and posttest scores on the PQ (see Table 9).

To identify the location(s) of significance on the pre- and posttest scores of the VSMS and ultimately to test the specific hypotheses for this study, Scheffé's method of comparing means two at a time was used (Ferguson, 1966). The results of Scheffé's test are presented in Table 10.

TABLE 10

SCHEFFE'S TEST FOR PAIRWISE COMPARISONS OF GROUP MEANS ON VINELAND SOCIAL MATURITY SCALE CHANGE SCORES

Group	Group	
	FT-D	Control
FT-T	F = 3.28	F = 5.77
FT-D		F = 17.77*

Note:
An F value of 7.10 was needed for significance at .05 level.
*p < .01

While the FT-T group approached the criterion level of significance (p = .05) in comparison to the CONTROL group, the only significant difference between means on the VSMS was between the FT-D group and the CONTROL group. Thus, in terms of the first three hypotheses relating to the VSMS, only the third hypothesis can be accepted, i.e.,

mothers in the FT-D group would perceive a greater increase in socially adaptive behavior, as measured by the VSMS, in their mentally retarded children than would mothers of mentally retarded children in the CONTROL group. It was this pairwise comparison which contributed to the over-all significance of F.

Since the one-way analysis of variance of the pre- and posttest scores on the PQ yielded no significant results, Scheffé's method was not used to make pairwise comparisons of means. There was no improvement in maternal attitudes toward their mentally retarded children as measured by the PQ and each of the last three hypotheses was clearly not supported.

The demographic information gathered by the Personal Data Sheet by which post hoc comparisons of the groups were made will be presented, when appropriate, in Chapter V. Chapter V deals with this investigator's comments and conclusions regarding this research project.

CHAPTER V

DISCUSSION AND CONCLUSIONS

There were two main purposes of this research study: (1) to determine the effectiveness of mothers as intervention agents in facilitating socially adaptive behavior in their EMR children, and (2) to evaluate the change in maternal attitudes toward their EMR children after the mothers participated in the research project. As outlined in Chapter III, there were six hypotheses generated to test the aforementioned goals of this study. These hypotheses and subsequent findings will be presented below.

Hypothesis 1: The first hypothesis stated that mothers in the FT-T group would perceive a greater increase in socially adaptive behavior, as measured by the VSMS, in their mentally retarded child than would mothers in the FT-D group. This hypothesis was not supported by the data and was rejected. In fact, although not significant ($p > .05$), there was a reversal in directions with the mothers of mentally retarded children in the FT-D group perceiving somewhat greater growth in socially adaptive behavior, as

measured by the VSMS, than the mothers of retarded children in the FT-T group.

The above results may be accounted for by sporadic attendance of some of the FT-T group members. While the FT-D group members were present approximately three-fourths (76.8%) of the time, the FT-T group members were present only approximately two-thirds (66.1%) of the time. One of the critical factors relating to field research is the inability of the investigator to tightly control the behavior of the research subjects. In this regard, it is axiomatic that in order for a person to gain something from a "new" learning experience, his physical presence is the basic requirement for learning to take place. The problem of enforcing attendance at meetings, which comprised a significant part of the experimental treatments, was dealt with by calling the absent members after the missed meeting and before the next scheduled meeting.

In the subjective opinion of this experimenter, a greater sense of esprit de corps seemed to be generated among the FT-D group members. This manifested itself in their obvious eagerness to continue the experimental treatment. On several occasions, the various group members resumed their discussion of important topics in the parking lot after the formal session had terminated.

Conversely, the members of the FT-T group never seemed to develop the feeling of closeness and unity which

developed in the FT-D group. Perhaps one explanation for this was that an "expert" was expounding knowledge, information, and facts which the mothers in the FT-T group were not quite ready and/or able to accept and assimilate. It will be recalled that in the FT-T group, the first hour of each session was devoted to a didactic lecture of principles and practices related to reinforcement and extinction procedures, and the last hour was devoted to the discussion of topics which the mothers deemed important to them. Thus, the development of group cohesion in the FT-T group may also have been thwarted by not providing the group members ample opportunity to become more personally acquainted through the sharing of mutual and unique concerns about their mentally retarded children. This last supposition is supported somewhat by Hereford (1963) when he states, "The main problem lies in those parental difficulties which stem not from ignorance but from attitudes, feelings, and emotions (p. 4)."

Hypothesis 2: The second hypothesis stated that mothers in the FT-T group would perceive a greater increase in socially adaptive behavior, as measured by the VSMS, in their mentally retarded child than would mothers in the CONTROL group. Although a perceived increase of socially adaptive behavior resulted in the predicted direction for the mentally retarded children of the mothers in the FT-T group and approached the criterion level of significance

($p. = .05$), the difference between the FT-T and the CONTROL group was clearly not significant.

As noted above, some mothers in the FT-T group were not too regular in their attendance at the group sessions. Even more important, some of the members of the FT-T group were not always willing to cooperate by completing the homework assignments. These assignments involved the selecting and counting of target behaviors and charting the observed progress of their retarded child. Due to the problem just cited, this researcher was disappointed, in spite of his maximum effort, that the full potential benefits of this group experience was not realized by all members. However, it must be noted again that the investigator in field research has minimal control over the research subjects' attendance and degree of participation.

Hypothesis 3: The third hypothesis, and the only one which was accepted, stated that the mothers in the FT-D group would perceive a greater increase in socially adaptive behavior, as measured by the VSMS, in their mentally retarded children than mothers in the CONTROL group. There are several reasons which could account for this significant difference: (1) as previously stated, the members of the FT-D group were very active and involved in the group meetings; (2) the educational level of the mothers in the FT-D group ($\bar{X}$ = 13.4 years) was significantly higher than that of the CONTROL group ($\bar{X}$ = 10.7 years). The educational

level of the mothers in the FT-T group ($\bar{X}$ = 11.9 years) was not significantly different from the FT-D or CONTROL groups. In spite of the educational differences noted, a combined total of fifteen (71%) mothers for all three groups listed their occupation as "housewife": FT-D group, 4; FT-T group, 6; and CONTROL, 5; and (3) the nature of the mother-child relationship may have been an influential factor. There were six natural or adoptive mothers in the FT-D group, five natural or adoptive mothers in the FT-T group, and three natural or adoptive mothers in the CONTROL group. All of the remaining mothers included in this study were foster mothers. On the negative side, one might question the quality of the relationship between a child and the foster mother; however, on the positive side, the foster child does have a family to live with, to relate to, and to help him with his adjustment problems.

Perhaps the most influential factor which led to the acceptance of the third hypothesis was the manner in which the FT-D group members used the time made available to them. Although there were brief periods of levity, most of the time was devoted to the sharing of individual and universal concerns relating to their mentally retarded children. However, the group did not stop with the mere ventilation of their problems; they sought to find appropriate and realistic solutions to their problems through group discussion. At times the group members would urge an individual to raise

or to lower the unrealistic goals set up for that person's retarded child. In some cases, the group members would offer specific solutions to problems, with it being emphasized at all times that each person had the right to accept or to reject the group's suggestions.

The experimental treatments failed to produce any significant effects ($p > .05$) in terms of fostering more positive maternal attitudes toward their mentally retarded children. Consequently, hypotheses 4, 5, and 6, relating to the improvement of maternal attitudes toward their mentally retarded children, as measured by the PQ, were all rejected. Since there was no significant improvement in maternal attitudes toward their mentally retarded children in any of the groups, no attempt will be made to discuss each hypothesis separately. Instead, the discussion pertaining to this set of hypotheses will concern itself with the general assumption which led to their initial formulation and the possible factors which led to their subsequent rejection.

It was believed that many parents of mentally retarded children, in addition to the feelings of guilt, remorse, and anger, also suffer from feelings of shame and embarrassment. As observed by Willey and Waite (1964), parents often severely restrict their own as well as their retarded children's public or social interactions. For fear of others in society staring at the gross physical abnormalities or judging the retarded child's behavior as being

"crazy" or "peculiar," the parents isolate the retarded child and themselves from the sneers of others by withdrawing with him into their own little world, their home. When the parents do venture out, they leave the retarded child at home with a relative or an equally protective baby-sitter. Thus, it was assumed that if a retarded child could learn to behave in more independent and socially acceptable ways, the parents would feel less embarrassment and feel more positive towards their mentally retarded children. However, in spite of the improvement of the mentally retarded children's social functioning, even in the FT-D group, there was not a corresponding improvement of maternal attitudes.

Several explanations can be offered to account for the failure of the treatments provided for the experimental groups to improve maternal attitudes towards their mentally retarded children. In the first place, it was found that there was no significant relationship between the two instruments, the VSMS and the PQ, used in this study. Secondly, one might raise the question as to whether the PQ is actually measuring parental attitudes towards their mentally retarded children. From the rather high raw scores obtained on the PQ, it is quite possible that the "ceiling effect" was operating. The ceiling effect phenomenon is defined by English and English (1958) as:

> . . . a limitation upon scores as a testee approaches the possible maximum score. By chance, one may fail

> a few items within one's ability range and pass a few above it. As ability begins to coincide with maximum difficulty of the test, it is still possible to fail items by chance but there are no compensating chance successes. Thus, at its upper end, any test becomes less discriminating.

Thus, the PQ may not have been sensitive enough to detect the small degree of attitude change which occurred at the upper end of the scale. A third explanation might be that no specific attempt was made to alter the maternal attitudes. Although the mothers were permitted to talk about their negative feelings and attitudes, neither of the experimental treatments was specifically designed to change these attitudes. Also, one might suspect that an eight week period of time is too short for any real attitudinal changes to take place without specific efforts directed towards this goal. Considering the length of time the mothers have lived with their feelings and attitudes, positive as well as negative, perhaps it is unrealistic to assume that attitudes can be changed in any appreciable way in this period of time. And finally, the amount of actual growth in their mentally retarded children's socially adaptive functioning may have seemed very minimal and insignificant to the mothers.

While it is possible to conclude from this study that mothers who experienced filial therapy perceived positive changes toward more socially adaptive behavior in their mentally retarded children than did mothers in the CONTROL group, it is impossible to conclude that this perceived improvement of socially adaptive behavior fosters more

positive maternal attitudes toward their mentally retarded children. In view of the present results, the practical and functional utility of filial therapy, as used in this study, is still in question but should not be taken as evidence that the use of parents to provide a meaningful relationship with their mentally retarded children has no merit and should not be considered. However, one is still confronted by the same question, "What type of help can parents use?"

Contrary to expectations and predictions, mothers in the FT-D group perceived greater growth in socially adaptive behavior in their mentally retarded children than did mothers in the FT-T group. There are two observations which seem pertinent to this finding. First, mothers, if given an opportunity to discuss their concerns and goals for their mentally retarded children with mothers in similar situations, can provide support and serve as influential resource persons in finding appropriate and meaningful solutions to behavior problems. In this regard, a mother can function as an important intervention agent and ally to the therapist who is often given or takes the total responsibility for "curing" behavioral and/or emotional problems. Second, similarly and somewhat surprisingly, many principles of behavior modification were discussed by the mothers in the FT-D group although they did not label these principles and concepts in sophisticated, technical terminology. For example, one mother related that she had

problems with her daughter having temper-tantrums at the slightest frustration of her desires. Another mother offered a solution that had worked for her when her child displayed the same behavior--to simply ignore it. In a way, one might assume that by describing what was done, some of the mystery was taken out of the more esoteric term of "extinction." Several mothers in the FT-D group were helped by other mothers to see how they were being manipulated by their mentally retarded children, therefore, creating more dependence upon them by their children.

The results of this study provide several implications which should be evaluated through further research efforts. The main problem encountered, at least with the present sample in the FT-T group, was the rather poor attendance. As with other evaluative research projects of action programs in natural settings, the control of subjects is much more difficult than in laboratory or even clinic settings (Hereford, 1963). This was certainly true in this study. Would parents of mentally retarded children be more cooperative in attending the group meetings if some type of remunerative inducements were offered? If the mothers were paid to attend the meetings, would the results be considered as valid as those results where mothers were not paid? In this particular study, only those mothers who expressed an interest in participating in the sessions were involved. What would be the effect of requiring parents, as a

condition for their mentally retarded child to be enrolled in a special education class, to participate in some type of parent-education program? Does the nature of the mother-child relationship, i.e., natural versus adoptive and/or foster, make a difference? Would the treatment effects be enhanced by having both parents participate in the group meetings? Would the expert's efforts receive greater acceptance if the parents of mentally retarded children were first given an opportunity to become more personally acquainted through discussion sessions? For example, a third group of parents could have been included in the present study which combined elements of each of the other two experimental groups, i.e., discussion the first four sessions followed by four sessions of didactic lectures on and demonstration of learning principles related to behavior management. Even a fourth group might be added with the sole intent being to change parental attitudes to see how this effects social behavior of their mentally retarded children.

Another important question concerns the matter of how many sessions should be provided for the parents? A well designed program might be able to produce positive results in four weeks while a poorly designed program might not result in any significant change in four months. No perfect time period appears evident from this or similar studies. Hopefully the researcher can adapt his program to give an

optimum amount of time to permit adequate learning to take place and yet not so long that sessions become just another meeting to attend.

Still another possible variable exists in terms of the length of time the mentally retarded child has lived in the home. For example, one might assume that parents who have had a mentally retarded child in the home for fifteen years might be less flexible and less willing and/or able to change their attitudes and behavior management techniques than parents who have had a mentally retarded child in the home for only five years. Thus, it may be that parents with younger mentally retarded children are more receptive to new ideas regarding behavior management from an expert or their peers.

And finally, the matter of the educational level of the parent should be investigated as it relates to different types of programs. It might be that parents who have completed more years of formal education can profit more from a certain approach while parents with less education might find a different approach more beneficial. Although it might be difficult, if not impossible, to predict the direction of the interaction effects, the educational level of the parents may be an important factor to consider.

As with most research efforts, the results raise many more questions that must be answered before many conclusions can be drawn from the original research study. It is hoped

that this present study will stimulate more interest and concern in finding ways to help mentally retarded children truly realize their potential in all aspects of human functioning.

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APPENDICES

APPENDIX A

INITIAL LETTER TO PARENTS

Dear Mother:

I have received permission from the Principle-Director, Sister M. Veronice, to invite you to participate in a research study which will be conducted at the Holy Family Center. The research project is scheduled to begin in March; however, the exact date is not yet known. This will be decided after our initial meeting.

Briefly stated, the study will attempt to evaluate the effectiveness of a new approach in helping the retarded child become more independent in and responsible for his own behavior. In order to accomplish this, we will need approximately sixteen hours of your time.

I would like an opportunity to visit with you about this at your convenience. I have set aside two days, March 1 and 2, to be at the Holy Family Center to visit with interested mothers. On these two days I will be available from 9:00- 12:00 and from 1:00- 4:00. During these hours, I have scheduled four, one-and-a-half hour sessions to discuss the study and to answer questions. If you would like to know more about the proposed study, please feel free to stop by the school on these two days.

The schedule of the meetings is as follows:

March 1, 1972	9:00 - 10:30 a.m.	1:00 - 2:30 p.m.
	10:30 - 12:00 a.m.	2:30 - 4:00 p.m.
March 2, 1972	9:00 - 10:30 a.m.	1:00 - 2:30 p.m.
	10:30 - 12:00 a.m.	2:30 - 4:00 p.m.

Although you may enter or leave the discussion at any time, I would urge that you try to be present at the beginning of any session. The first part of each session will be devoted to a description of the study and what will be expected of you. The last forty-five minutes or so will be

devoted to a question and answer period.

It is important that we discuss the benefits of this study as I am as concerned about retarded children as you are. I feel that these discussion sessions on March 1 and 2 will help to alleviate some of your concerns and fears about being involved in a research study. If you are unable to be present on these dates but are interested in learning more about the study, please call me at 268-8251 (office) or 685-5509 (home.) If I am not available at the time you call, please leave your name and number, and I will return the call as soon as possible.

Thank you for your time and consideration of this request to participate in this study.

Sincerely,

Larry A. Boll
Psychology Intern

APPENDIX B

INITIAL BRIEFING SESSION

I. Introduction of experimenter
   A. Academic-training background
   B. Experiencial background
      1. School psychologist
      2. Staff psychologist
         a. Child, adult, family psychotherapy
         b. Psychological testing
         c. Community education
         d. Director, day care center for retarded children
   C. Present academic-occupational status

II. General comments
   A. Statistical information concerning the retarded
      1. Over 126,000 children born in the United States each year
      2. Number one health problem afflicts an estimated six million Americans, and affects some thirty million others, namely, the family
      3. Institutional cost for one person in the course of a lifetime—$100,000 to $300,000
   B. Quotation of John F. Kennedy: "Although children may be the victims of Fate, they will not be the victims of our neglect."
   C. Current status of the retarded
      1. More special education classes being established in public, private, and parochial schools
      2. More sheltered workshop and job-training facilities are being developed
      3. The retarded are finding more occupational opportunities due to greater understanding and acceptance of the retarded

D. Future status of the retarded depends on efforts of
   1. Community
      a. Schools
      b. Employers
   2. Parents
      a. Help educate the community
      b. Help your own retarded child

III. Basis for this study
   A. Need for parent groups
   B. Types of parent groups
      1. Parent education
      2. Parent group counseling
      3. Parent group psychotherapy

IV. Design of present study
   A. Types of groups
      1. Training group
      2. Discussion group
      3. No-treatment control group
   B. Group placement--random
   C. Group sessions
      1. Eight weekly sessions
      2. Two hours per session
   D. Instrumentation
      1. Personal Data Sheet
      2. Vineland Social Maturity Scale
      3. Parent Questionnaire

APPENDIX C

FOLLOW-UP LETTER TO PARENTS

Dear Mother:

Thank you again for your interest and willingness to participate in this study. It is designed to increase your understanding of your retarded child and to help him become more responsible for his own behavior. Your cooperation in this study is vital if these goals are to be realized.

As indicated to you in the first session, the study requires certain instruments to be completed prior to and again after the study has been conducted. Please answer each item as you honestly feel and not as you believe you should feel. After you have completed the instruments, please place them in the self-addressed, stamped envelope and drop them in the mail. I would like them returned, if at all possible, by March 23, 1972.

In the very near future, you will be contacted as to which group you have been assigned. You will recall that the group assignments would be made on a random basis and not according to how you responded to any of the instruments.

I would appreciate your prompt return of these instruments so that we will be able to start having our group meetings the first week in April, 1972. You will be informed approximately one week in advance of the date and time of the first scheduled meeting.

Again, I thank you for your time and consideration of these requests.

Sincerely,

Larry A. Boll
Psychology Intern

APPENDIX D

PARENT QUESTIONNAIRE*

Directions

This instrument which you have consists of a list of thirty statements about mentally retarded children. To the right of each statement are five columns: Column I -- Strongly Agree; Column 2 — Agree; Column 3 — Undecided; Column 4 -- Disagree; and Column 5 -- Strongly Disagree. After reading each statement you should indicate with a check mark ( ) whether you strongly agree, agree, disagree, or strongly disagree with that statement. If you are not sure as to whether you agree or disagree with a particular statement, you should then place a check mark ( ) in the "undecided" column.

As far as the scoring of this instrument is concerned, be assured that there is no "right or wrong" answer to any of these statements. However, please keep in mind the great importance of checking only those columns that truly reflect YOUR feelings concerning a particular statement. Don't let your judgment be swayed by what you think others believe. REMEMBER, the results of this instrument will be held completely confidential.

. . . . . .Please respond to every statement.

*Title was changed from "Parent Attitudes Toward Mentally Retarded Children Scale" as originally named by Love (1967-68).

Item No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	Mentally retarded children are usually better off in mental institutions.					
2	I would not mind if my child sat beside a mentally retarded child in the classroom.					
3	If I were an employer, I would hire a mentally retarded person.					
4	There is a high relationship between immorality and mental retardation.					
5	Mentally retarded adults tend to lower the standards of living of their neighbors.					
6	"Feeble-minded" is a more descriptive and appropriate term than "mentally retarded."					
7	Mentally retarded children have the same basic needs as any other child.					
8	I generally feel rather uncomfortable around mentally retarded children.					

Item No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
9	On many occasions, the average-ability youngster is distracted -- and prevented from learning -- by his mentally retarded classmates.					
10	Mentally retarded children are inclined to be behavior problems.					
11	I would not mind paying extra taxes to establish a special education class in our community.					
12	Mentally retarded children can be identified by a decidedly different look in their eyes.					
13	Mentally retarded children usually grow up to be good citizens.					
14	Mentally retarded children are deserving of much consideration from the rest of the world.					
15	It does not "hurt" normal children to mingle with mentally retarded children.					

Item No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
16	Mentally retarded children are, oftentimes, quite considerate of other people.					
17	I would not mind going to a social affair with a mentally retarded person.					
18	It is an unhealthy situation for average-ability children and mentally retarded children to have daily contacts with each other.					
19	I would not mind if my child invited a mentally retarded child to his birthday party.					
20	I would prefer that my own child did not play with a neighborhood child who is mentally retarded.					
21	It is a fact that mentally retarded people do not contribute anything to a community.					
22	Mentally retarded children are usually quite stingy.					

Item No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
23	It would be better to take the money spent on educating the mentally retarded and spend it on the gifted child.					
24	Mentally retarded children usually end up in jail or a retention home.					
25	The army should turn down all mentally retarded people.					
26	I would rather see mentally retarded children enrolled in public school special education classes than see them enrolled in state institutions.					
27	There is very little, if any, relationship between mental retardation and low morals.					
28	If I had a mentally retarded child I think I could love him as deeply as I would love my normal children.					
29	Mentally retarded people contribute as much to a community as does the average person.					

Item No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
30	On the whole, mentally retarded children are as affectionate as normal children.					

APPENDIX E

PARENT QUESTIONNAIRE

SCORING SHEET

Item No.	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	1	2	3	4	5
2	5	4	3	2	1
3	5	4	3	2	1
4	1	2	3	4	1
5	1	2	3	4	5
6	1	2	3	4	5
7	5	4	3	2	1
8	1	2	3	4	5
9	1	2	3	4	5
10	1	2	3	4	5
11	5	4	3	2	1
12	1	2	3	4	5
13	5	4	3	2	1
14	5	4	3	2	1
15	5	4	3	2	1
16	5	4	3	2	1

Item No.	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
17	5	4	3	2	1
18	1	2	3	4	5
19	5	4	3	2	1
20	1	2	3	4	5
21	1	2	3	4	5
22	1	2	3	4	5
23	1	2	3	4	5
24	1	2	3	4	5
25	1	2	3	4	5
26	1	2	3	4	5
27	5	4	3	2	1
28	1	2	3	4	5
29	5	4	3	2	1
30	5	4	3	2	1

Note:

Title was changed from "Parent Attitudes Toward Mentally Retarded Children Scale" as originally named by Love (1967-68).

APPENDIX F

PERSONAL DATA SHEET

Name: _____ Home Phone: _____

Address: _____ Business Phone: _____

Occupation: _____

Education:

Circle Last Year Completed: Elementary: 1, 2, 3, 4, 5, 6, 7, 8

High School: 9, 10, 11, 12

College: 1, 2, 3, 4

Graduate School: 1, 2, 3, 4

Total Number of Children in Family: _____

Date of Birth of Retarded Child: _____

Age of Retarded Child (present): _____

Birth Order of Retarded Child: 1st, 2nd, 3rd, etc. _____

Have You Had Opportunity to Talk With A Professionally Trained Person About Your Retarded Child? _____ Yes _____ No

If yes, were you satisfied with the results?

_____ Yes _____ No _____ Partially

When Did You First Find Out That Your Child Was Retarded? (Check one below)

_____ At Birth _____ 1-2 Years After Birth _____ 2-4 Years After Birth

_____ At the Time of Starting School _____ During or After 1st Grade

How Would You Rate Your Over-All Understanding of Your Child's Mental Retardation: (Check one below)

Satisfactory _____ 5, _____ 4, _____ 3, _____ 2, _____ 1, Unsatisfactory

APPENDIX G

WHAT IS BEHAVIOR AND HOW IS IT LEARNED?
Lesson 1

I. Definition of behavior

II. Variables influencing behaviors
- A. Physical
  - 1. Heredity
  - 2. Age
- B. Emotional or mental
  - 1. Abilities
  - 2. Interests
  - 3. Values
- C. Environmental
  - 1. Home
  - 2. School
  - 3. Neighborhood

III. How behavior is acquired
- A. Experiencing and observing
- B. Training or teaching

IV. Evaluating behavior (Vineland Social Maturity Scale)
- A. Appropriate - desirable - adaptive
  - 1. Paying attention
  - 2. Eating
  - 3. Dressing
  - 4. Getting along with others
  - 5. Helping at home
- B. Inappropriate - undesirable - maladaptive

V. Exercise

Step I: I would like each of you to think of some of the desirable behaviors in your child. (List them on the chalkboard.)

Step II: Now, let's try to think of some of the undesirable behaviors you observe in your child. (List them on the chalkboard.)

Step lII: **Now, let's try to determine how these behaviors were learned through experience, observation, training and/or teaching.**

APPROPRIATE VERSUS INAPPROPRIATE BEHAVIOR
Lesson 2

I. BRIEF review of Lesson 1 "What is Behavior and How is it learned?"
   - A. Definition of behavior
   - B. Variables influencing behavior
   - C. How behavior is acquired
   - D. Evaluating behavior (appropriate vs. inappropriate)

II. Parents as teachers
   - A. Children spend most time with parents until entering school
   - B. Read: "Children Learn What They Live"
   - C. Positive as well as negative behaviors
   - D. Parents needs and demands

III. Ways of teaching children
   - A. Most effective means
     1. Modeling
     2. Showing
     3. Helping
   - B. Least effective
     1. Bribing
     2. Telling

IV. Effective family interactions
   - A. Understanding of child's feelings
   - B. Compromising of family rules and expectations

V. Exercise

Step I: I would like to briefly explain the P-A-C paradigm. We each have a "parent," an "adult," and a "child" within us. The "parent" part of us tells us what we should or should not do. The "child" part of us consists of our feelings and our wants. The "adult" part of us is the thinking part of us that acts as a computer.

Step II: Try to determine what part of a person is saying the following:

- A. "You don't love me. You never let me do what I want to do."
- B. "You should eat your dinner, Johnny. If you don't, you won't grow up and be big and strong like your daddy."
- C. "Johnny, I would appreciate it if you would help me by cleaning your room."

Step III: For homework during the next week, try to determine which part of you is making various comments, suggestions, or demands.

ESTABLISHING BEHAVIORAL OBJECTIVES
Lesson 3

I. BRIEF review of Lesson 2 "Appropriate Versus Inappropriate Behavior"
   - A. Parents as teachers
   - B. Ways of teaching children
   - C. Effective family interactions

II. Parental concerns
   - A. "How can I be both fair and firm?"
   - B. "How strict should we be in establishing limits of behavior?"
   - C. "How can I talk to my spouse about my concerns?"
   - D. "How does a single parent deal with family concerns?"
   - E. "How do I know if I am a good parent?"

III. Family goals and selecting priority behaviors
   - A. Priority behaviors reflect family goals
     1. Mealtime routines
     2. Proper manners
     3. Living arrangements
     4. Work responsibilities and chores
     5. Vacation and holiday plans
   - B. Priority behavior must not be too vague or general
     1. Target behaviors should be specific
     2. One target behavior should be selected at a time

IV. Exercise

Step I: What are some family goals which might be appropriate for discussion? (List them on the chalkboard.)

Step II: What are some examples of behaviors that cause problems or tension in the family? (List them on the chalkboard.)

Step III: As homework for next week, I would like for you to keep a list of behaviors that cause problems. Please bring them in next week so we might compile a list of actual target behaviors that might need to be dealt with directly.

TRAINING PARENTS TO TEACH DESIRABLE BEHAVIOR
Lesson 4

I. BRIEF review of Lesson 3 "Establishing Behavioral Objectives"
   A. Parental concerns
   B. Family goals and selecting appropriate behaviors
   C. List on chalkboard some problem behaviors obtained from homework assignment

II. Reinforcing or rewarding behavior
   A. Types of reinforcement
      1. Positive - pleasant consequences
      2. Negative - unpleasant consequences
   B. Effects of reinforcement
   C. Neither are totally "good" or "bad"

III. Procedures developed in animal laboratories to effect behavioral change
   A. Positive reinforcement
      1. Pay for work
      2. Praise for achievement
      3. Return a favor for a favor
   B. Negative reinforcement
   C. Extinction
      1. Do not pay for work
      2. Do not praise for achievement
      3. Do not return a favor for a favor
   D. Reinforcement of alternative behaviors or selective reinforcement
      1. Extinguish or ignore undesirable behavior
      2. Reinforce or reward desirable behavior
   E. Shaping
      1. Reinforce successive approximations to the final desired behavior
      2. Steps must be spaced appropriately, i.e., not too small nor too large of steps in terms of preciseness or complexity
   F. Modeling or demonstrating

IV. When to reinforce behavior
   A. Immediately after child behaves in desired manner
   B. At the first sign of even the slightest effort and/or success in achieving some behavioral goal

V. How to reinforce
   A. Determine what child values highly
   B. Make it contingent upon producing certain kinds of behaviors

C. Steps to reinforcing behavior
   1. Initially, provide immediate and consistent reinforcement
   2. Gradually, replace tangible rewards with social reinforcers, i.e., praise, encouragement, etc.
   3. Finally, reinforce only intermittently so that child does not always need an immediate "pay off"

VI. Use of negative reinforcement (punishment)
   A. To reduce or stop undesirable behavior
      1. Physical punishment
         a. Spanking
         b. Slapping
         c. Hitting
      2. Psychological or behavioral punishment
         a. Nagging
         b. Screaming
         c. Social isolation
         d. Loss of privileges
   B. Reduces or weakens the tendency to repeat undesirable behavior, but not teach child what is desirable behavior
   C. Wisely used may stop undesirable behavior long enough for more desirable behavior to be taught and reinforced

VII. Exercise
   Step I: What are some of the reinforcers, both negative and positive, used with your children? (List them on the chalkboard.)
   Step II: Try to recall incidences when the various reinforcers used were effective and when they were not.
   Step III: Are there alternate ways, based on our discussion of this lesson, to develop more desirable behaviors and eliminate undesirable behavior?
   Step IV: For homework this coming week, try to determine what undesirable behaviors would serve as good target behaviors to be eliminated. Also, try to think of some ways you can use the reinforcement principles discussed tonight.

CHANGING BEHAVIOR
Lesson 5

I. BRIEF review of Lesson 4 "Training Parents to Teach Desirable Behavior"
   - A. Reinforcement
     1. Positive
     2. Negative
   - B. Techniques
     1. Positive reinforcement
     2. Negative reinforcement
     3. Extinction
     4. Selective reinforcement
     5. Shaping
     6. Modeling or demonstrating
   - C. When and how to reinforce
   - D. List on chalkboard the target behaviors selected as part of the homework and try to determine how they were learned

II. Causes of undesirable behavior
   - A. Inappropriate reinforcements
     1. Tantrum behavior
     2. Not abiding by limits
   - B. Direct imitation
     1. Sex roles
        - a. Females - quiet, reserved, submissive
        - b. Males - loud, aggressive, boistrous
     2. Fears and prejudices
     3. Review "Children Learn What They Live"
   - C. Parental inconsistency - child decides for himself
     1. "Not to pay attention to adults and authority figures"
     2. "Not to follow through on agreements or responsibilities"
     3. "Not to abide by rules or limits"
     4. "How to play adults off against one another"
     5. "How to manipulate people and situations"
     6. "How to have an unhappy marriage"
   - D. Children teach parents
     1. Rewards for parental attention
     2. Punishes for parental inattention

III. Exercise

Step I: What are some general areas of agreements, between you and your spouse, in terms of expectations for your child?

Step II: What are some general areas of disagreements, between you and your spouse, in terms of expectations for your child?

Step III: For homework, select one specific target behavior and keep an accurate count of every time you observe that particular behavior. Do this for three days, starting tomorrow. On the morning of the fourth day, start initiating your reinforcement and/or extinction program to develop more adaptive social behavior. Continue to keep a record of the times you observe that selected target behavior.

Step IV: Encourage spouse to participate in the selection of the target behavior and to implement the same reinforcement and/or extinction program to develop more adaptive social behavior.

Step V: Discuss possible ways in which to record behavioral occurrences.

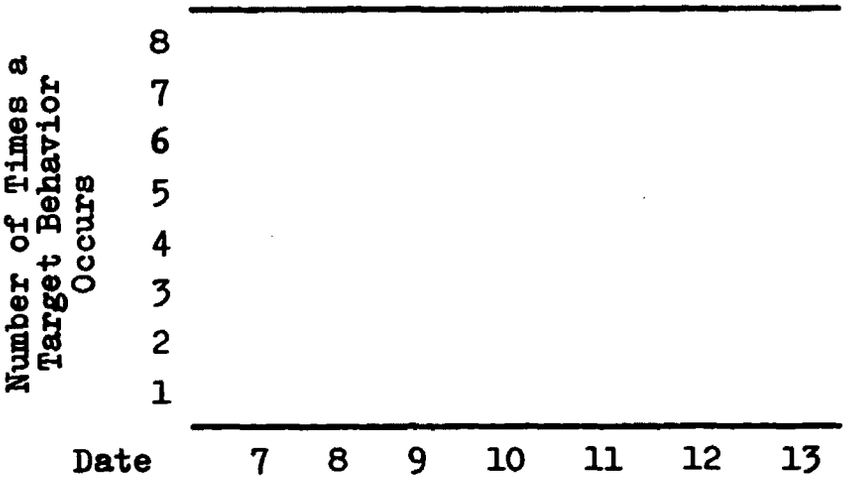
REFINEMENT OF BEHAVIOR CHANGE SKILLS
Lesson 6

I. BRIEF review of Lesson 5 "Changing Behavior"
   A. Causes of undesirable behavior
      1. Inappropriate reinforcements
      2. Direct imitation
      3. Parental inconsistency

II. Discuss homework results in detail
   A. Types of target behavior - selected
   B. Spouse's reaction
   C. What were results of recording target behavior?
      1. First three days
      2. Second three days
   D. Successful experiences
   E. Problem areas

III. Prerequisite for changing undesirable behavior
   A. Select undesirable behavior to be changed, and
   B. Select desirable behavior to replace the undesirable behavior
   C. Observe and keep record of times undesirable behavior occurs
   D. Design reinforcement program
   E. Implement reinforcement program
   F. Continue to keep record of times undesirable behavior occurs

IV. Types of behavior recording charts
   A.



B.

Target Behavior:*		Tantrum Behavior		Date	
1	6	11	16	21	26
2	7	12	17	22	27
3	8	13	18	23	28
4	9	14	19	24	29
5	10	15	20	25	30

*Each time target behavior occurs, cross out the next highest number.

C.

	Date	Desirable Behavior	Undesirable Behavior	Parental Response
Father's Observation				
Mother's Observation				

V. Design to meet specific needs
   A. Rating of performance
      1. Poor
      2. Fair
      3. Average
      4. Good
      5. Very good
   B. Assigning of points or tokens to different levels of performance
      1. Poor = 1 point or 1 token
      2. Fair = 2 points or 2 tokens
      3. Average = 3 points or 3 tokens
      4. Good = 4 points or 4 tokens
      5. Very good = 5 points or 5 tokens

VI. Exercise

Step I: As a group project, let's design several behavior recording charts and reinforcement programs. (To be placed on the chalkboard.)

Step II: Also, as a group, let's discuss and try to use these recording charts and reinforcement programs with actual target behaviors which are considered undesirable. (To be placed on the chalkboard.)

Step III: For homework, continue to keep record of the target behavior you selected to eliminate. If necessary, you may redefine the undesirable behavior you selected. Do not forget to reinforce more appropriate and/or socially adaptive behavior while extinguishing the undesirable behavior.

SPECIAL REINFORCEMENT SYSTEMS
Lesson 7

I. BRIEF review of Lesson 6 "Refinement of Behavior Change Skills"
   - A. Discuss homework of previous week
   - B. Discuss prerequisites for changing undesirable behavior
   - C. Discuss and design several types of behavior recording charts

II. Special reinforcement systems
   - A. Individual reinforcement systems
     1. Child must understand what is expected of him
     2. Child must understand how and when he will be rewarded
   - B. Use of tangible rewards for privileges and/or material goods
     1. Bus tokens
     2. Poker chips
     3. Money
     4. Points
   - C. Can exchange for privilege and/or material goods when child wants, provided he has the required amount
   - D. Better to use "token" or "point" system rather than to reward each desirable behavior with food or candy
   - E. Also, don't fail to provide verbal praise for desirable behavior so that these more tangible reinforcers can be withdrawn
     1. Need to behave properly, not for tangible rewards, but for more positive feedback from others and more positive feelings about himself
     2. Must learn to accept a postponement of reward or reinforcement, e.g., paycheck

III. Family reinforcement system
   - A. Entire family participates as a unit
     1. Each member has certain responsibilities or chores
     2. Each member receives certain tokens or points for privileges or other rewards important to that individual
   - B. May combine token or point system with allowance system
   - C. May need to be discussed frequently and revised when necessary

IV. Home-school reinforcement system
   A. School and home must often cooperate to effect positive behavioral change
   B. Home may adopt and extend token and recording system used in the school
   C. If school is not using a token system, perhaps some token system may be instituted

V. Exercise
   Step I: Discuss problems encountered in trying to effect socially adaptive behavior in the home. Encourage group participation to offer possible alternative solutions.
   Step II: Discuss problems encountered in trying to use the behavior recording charts. If necessary, put the parent designed chart on the chalkboard and elicit group suggestions to revise and make easier to use.

MANAGING BEHAVIOR PROBLEMS
Lesson 8

I. BRIEF review of Lesson 7 "Special Reinforcement Systems"
   A. Special reinforcement systems
      1. Individual reinforcement system
      2. Use of tangible rewards
      3. Home-school reinforcement system

II. Personal inadequacies
   A. Fear of failure or loss of parental respect
      1. Turn to parents for comfort and support
      2. Providing direct assistance by parents may encourage and teach overdependency
   B. Insecurity
      1. Often results from extremely unpleasant associations and experiences
         a. School
         b. Certain people
         c. Learning
         d. Certain places
         e. Foods
      2. Fears and inadequacies may be modified by the following methods
         a. "Do not force the child into frightening situations. Instead, gradually expose him to what he is afraid of while giving him support and encouragement."
         b. "Pair the unpleasant situation with a pleasant one. For example, have the child view a frightening (to him) animal from a distance while eating ice cream."
         c. "Recognize the child's fears and talk with him about it, but be careful not to reinforce it by your own anxieties and responses."
         d. "Strongly reward progress in dealing with the inadequacy or problem; e.g., as the child gradually moves to the point of petting the frightening animal, praise and reward him every step of the way."

III. Self-care problems; e.g., eating, dressing, toileting, or washing
   A. Break each self-help skill down into several very basic or simple tasks gradually increasing the level of difficulty

B. With each successful accomplishment, reward with praise and/or single M&M candy; gradually reduce use of M&M candy and use only praise. After skill has been learned, use tokens, stamps, or points and integrate it into chart containing his responsibilities and chores
C. Helpful to set up a highly consistent daily routine in order to help him predict what is to happen next which will help stabilize his behavior

IV. Social problems
A. Cooperating and sharing with peers are usually more desirable behaviors than are oral and physical aggression
B. Wide variety of group experiences may expose child to many good models and provide him with opportunities to receive important positive reinforcement for displaying desirable social skills
C. Controlled environment may help child avoid potentially problem-producing situations
D. Do not reinforce negative behaviors; e.g., tantrums, hyperactivity, or aggressiveness by attending to it
E. On the positive side, strongly reward socially desirable behavior by giving extra attention, praise, and tangible rewards
F. If punishment is necessary to suppress undesirable social behavior, social isolation or "time out" should be employed by placing child in corner or equally undesirable place for a specific period of time

V. Exercise
Step I: As the final assignment, the mothers will be given the Vineland Social Maturity Scale and the Parent Questionnaire to complete before leaving. For those mothers who are absent, the Parent Questionnaire will be mailed to them the next day with a stamped, self-addressed envelope so they may be returned without delay. Also, the mothers will be telephoned the next day for purposes of administering the Vineland Social Maturity Scale.