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A COMPARISON OF THE EFFECTS OF THREE PARENT INTERVENTION PROGRAMMES ON CHILD'S AND MOTHER'S SELF-ESTEEM

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A dissertation submitted to the Faculty of Arts, University of the Witwatersrand, in partial fulfillment of the requirements for the degree of Master of Arts (Clinical Psychology).

Johannesburg, 1981

I hereby declare that this dissertation is my own work, and that it has not been submitted at another university.

K Rudick

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ABSTRACT

The aim of the present study was to evaluate the effectiveness of using parents as change agents for their children. This was based on the thesis that the early familial environment and the tone of the parent child relationship is crucial in influencing the development of personality and psychological adjustment. Self-esteem is viewed as the personality factor central to adjustment, and its development is traced in the family.

Parent education is viewed by community psychologists as an effective and primary technique in reducing psychopathology and promoting mental health. This approach focuses on changing the person within his environment. Within this approach, however, orientations differ and it is necessary to determine which is most effective.

This study evaluates three methods of parent education: the didactic, discussion and training approaches. A no-intervention control was included. Twenty-four mothers and their children were divided into four equal groups. The variable of self-esteem was used as a basis on which to compare the three approaches.

All mothers were assessed before and after the six-week programmes on the following measures: Self-esteem Inventory, Confidence in Parental Role, the

Relationship Change Scale and Satisfaction Change Scale, and the Incomplete Sentences Test. Children were rated by their mothers and teachers on the Behavior Rating Form and Semantic Differential.

Analysis of Variance demonstrated no significant findings. A trend analysis revealed an increase in both maternal and child esteem for the training group when compared with the other groups.

These results were then discussed and shortcomings and limitations in the research elaborated upon. Finally, suggestions and implications for further research were proposed.

CHAPTER 1

INTRODUCTION

1.1 The Nature of the Field

One of the more significant concerns of modern society is to produce more effective and competent members (Coopersmith, 1968). The acceleration of technological change has had a marked impact upon social structure, lifestyle, and upon the way that members of society perceive themselves in relation to significant others (Zurcher, 1977).

It is, in part, the task of the community psychologist to help society cope with its enormous social and technological change. The question is no longer how to avoid maladjustment and insecurity, but rather how to generate those capacities and qualities in the individual which enable him to functio. effectively in private, personal and public activities (Coopersmith, 1968). This emphasis on the constructive aspects of personality denotes a sharp departure from the more traditional theories on the aetiology of psychopathology (e.g. Davison and Neale, 1974; Hurley, 1969; Kolb, 1977; Ryan, 1971).

Whereas earlier theories focused on the diagnostic and curative aspects of psychopathology, current approaches are focusing on preventive aspects and the process by which healthy and effective individuals develop. Since stress is a major factor in our lives it is essential that the community psychologist focuses on socially learned capacities and skills to eliminate those stressful conditions that have destructive consequences (Dohrenwend, 1978).

According to Coopersmith (1968:219), the main requirements for the development of competent and effective behaviour and feelings of inner comfort and acceptance are fairly obvious:

> They include expectations of success (hope), motivation to achieve, initiative and the ability to deal with anxiety. Probably the most important requirement for effective behaviour, central to the whole problem, is self-esteem.

Although the importance of self-esteem in influencing behaviour is widely appreciated, there is considerable disagreement as to its nature and definition (Coopersmith, 1968; Wells and Marwell, 1976). Clinicians are well aware that many people receiving treatment from them are there because they feel themselves to be incompetent and socially rejected. It is universally recognised that self-confidence and an optimistic assessment of one's abilities contribute markedly to a well adjusted personality.

The common assumption that the early familial environment is the major contributor to emotional adjustment, has proved difficult to support (Coopersmith, 1967; Frank, 1965; Van der Veen and Novak, 1971). Research relating family interaction patterns to adjustment has yielded contradictory findings (Becker, 1964; Clausen, 1966; Fenichel, 1974; Hetherington and Martin, 1972).

Much research has pointed to the conclusion that persons with emotional and adjustment problems have experienced a troubled early family environment (Fischer, Boyd, Walker and Sheer, 1959; McKeown, 1950; Sperling, 1951;

Vogel and Bell, 1960). These environments have been termed 'pathogenic', and have been shown to be causative factors in adjustment problems (Frank, 1965; Graham, 1976).

Alternatively, Farina (1976:383) has suggested that

> the etiology of severe maladjustment is not necessarily traced to the parents who are emotionally upsetting their children. Rather, several lines of information suggest that inadequate preparation of the child to deal with his social environment may be the cause.

This suggests that parents, although tending to cope adequately, are themselves not equipped with the interpersonal skills necessary for good adjustment in their children (Solomon, 1978).

Farina and Holzberg (1970) view the parental role as a crucial contributory factor in adjustment, but state that inconsistent and inadequate parental behaviour does not create maladjusted children. Rather, as parents become less socially aware and less competent, their children will increasingly tend to be maladjusted.

These findings have serious implications in the light of Coopersmith's (1967) research. In his investigation of factors leading to the development of high self-esteem, which is crucial to good adjustment, Coopersmith found that the parent-child relationship was the most critical variable. He found that in each case of high self-esteem the child came from a family where there was a close relationship between the parents and the child. The expression of caring in these families

was qualitative, rather than quantitative, and each child regarded himself as a significant person worthy of his parents' regard. Basking in this appraisal, the child came to regard himself in a similar, favourable light. By deduction, therefore, a poor parent-child relationship may be a causative factor in the child's maladjustment.

If we accept that the family does play an important role in the child's development of personality and psychopathology, it becomes important that the parents be trained as parents, and that they be given skills which facilitate adaptive behaviour in their children. It is important that the most effective method of transmitting these skills be found.

Over the past decade, parent education has become a field of increasing interest among education and mental health professionals. Historically, the phenomenon is an old one, and since 1800 there have been many individuals, private and government institutions involved with educating large numbers of parents (Croake and Glover, 1977; Shapiro, 1956).

Operationally defined, parent education is "the purposive learning activity of parents who are attempting to change their methods of interaction with their children for the purpose of encouraging positive behaviour in their children" (Croake and Glover, 1977: 151). Underlying such a strategy is the assumption that the most important category of variables responsible for the child's personality develop-

ment is that within the family and the parent-child relationship (Farina, 1976; Hallowitz, 1964). The parents are a 'vital force' in the lives of their children, and their attitudes towards themselves and their children are of importance in childrearing (Armentrout, 1971; Burchinel, Hawkes and Gardner, 1957; Chazan, 1959; Coopersmith, 1967; Faure, 1970; Peterson, Becker, Hellmer, Shoemaker and Quay, 1959; Peterson, Becker, Shoemaker, Luria and Hellmer, 1961; Wetter, 1971).

In order to provide a worthwhile service to society, the effectiveness of parent education programmes must be determined. It is also essential that the efficacy of different types of parent education be assessed relative to each other. Croake and Glover (1977) and Tavormina (1974) have noted the need for comparative research and for better-designed and controlled studies in order to determine empirically the efficacy of parent training techniques.

Research on the effectiveness of parent training has tended to be inadequate, both in terms of quality and quantity (Croake and Glover, 1977; Rinn and Markle, 1977). Conclusions regarding the psychotherapeutic outcome of such studies have tended to be vague and loosely defined (Frank, 1979). In an attempt to overcome some of these difficulties, the present study compared the outcome results of three parent education techniques with one another, and to a control group, specifying the variables measured and the methods and techniques that were used.

By participating in a parent education programme a parent becomes both a recipient and an agent of therapeutic intervention (Reisinger, Ora and Frangia, 1976). However, the focus of any parent training technique is the child and his behaviour (Croake and Glover, 1977). This is an aspect of parent education which has been largely ignored in research, in that the effects of such intervention on the child have not been evaluated at times (Reisinger, Ora and Frangia, 1976; Rinn and Markle 1977; Tavormina, 1974). The present study hopes to overcome this by evaluating the effects of the interventive strategies on both parents and children.

A problem arises when selecting variables on which to evaluate the outcome of the techniques. Results have tended to support the hypotheses of the researchers, yet hypotheses and crucial variables differ with each approach (Rinn and Markle, 1977). While a behaviourally oriented approach will focus on observed behaviour, a discussion-encounter approach will focus on feelings. Evaluation of each approach would take place in terms of these two very different criteria. It becomes necessary, therefore, to find a variable which would be applicable to each different technique. Since the manner in which a person perceives and values himself is seen as crucial in determining his behaviour and adjustment, it was decided that self-esteem should be the variable on which the techniques would be evaluated (Rogers, 1959).

1.2 Aims

The present study aimed at comparing the outcome of three parent education programmes with one another, and with a control group. More specifically, the study aimed at improving the quality of the parent-child interaction. This was based on the theories of Rogers (1959) and Coopersmith (1967). It was hoped that participation in a parent education programme would improve cognitively-held attitudes toward the self on the part of the parent. Furthermore, it was hoped that these changes in parental attitudes would effect similar changes in the child's attitude toward himself. The rationale for this lies in Coopersmith's (1967) work, and the theory of identification with a parent as being crucial for the child's definition of himself.

In order for parent education to be a valid method of intervention both these objectives would have to be met. The technique would then become important, both as an interventive therapeutic strategy, and also in the context of primary prevention.

The aims of this study were implemented in the following manner: Four groups of volunteer mothers were obtained from a primary school. All had children in grades one and two. Three groups received three different parent education programmes. Pre and post testing took place one week prior to, and one week after the programmes. The fourth group, serving as a control group, received no intervention, but was psychometrically assessed.

The criteria used to assess the outcome of the programmes included parental ratings of self-esteem, parental and teacher ratings of child's self-esteem, maternal rating of confidence in the parental role, and a relationship evaluation questionnaire.

Difference scores were obtained from the pre-and post-test data, and a comparison of the means between groups was made on all measures. The effects of parent education on both the mother and the child were determined. Following this, the most effective technique for eliciting change in the parent-child relationship was identified.

1.3 Hypotheses

The following hypotheses are related to the aims stated above:

1. Participation in a parent education programme will significantly raise the mother's level of self-esteem.
2. Parental participation in an education programme will significantly increase the child's level of self-esteem.
3. A change in the level of parental self-esteem will have a corresponding change in the child's level of self-esteem.
4. Discussion and training approaches to parent education will be more effective in facilitating change in the parent-child interaction than a didactic approach and no intervention.

CHAPTER II

RATIONALE FOR PARENT EDUCATION

This chapter presents a rationale for parent education within the framework of community psychology. The role of parents as agents of change is discussed. Finally, parent education as a technique is considered.

2.1 The Nature of Community Psychology

Allen, Chinsky, Larcen, Lochman and Selinger (1976) note that the past decade has witnessed changes in the field of mental health services. There has been a reconceptualisation of clinical practice, tending towards the implementation of a variety of innovative service approaches, and away from traditional treatment procedures. This reconceptualisation views man and his actions in a social setting and directs therapeutic intervention accordingly. It stresses individualised goals, and a maximisation of human effectiveness, (Skuy, 1975; Solomon, 1978).

This reconceptualisation of clinical practice has its roots in practicality. It is well known that the demand for mental health services far outweighs the supply (Albee, 1959, 1968; Alley and Blanton, 1976; Arnhoff, 1968; Baldwin, 1975; Bender, 1976; Cook, 1970; Curtis and Miller, 1976; Sobey, 1970; Zax and Spectre, 1974). Gillis (1976) has noted the inability of psychiatric services in South Africa to cope with the demand, despite excellent utilisation of existing

services. In addition, the demand for treatment is not synonymous with the need for treatment, (Cowen, Gardner ard Zax, 1967). Epidemiological studies have shown the need for mental care to be even greater than that reflected by demand (Husaini, Neff and Stone, 1979; Leighton, Leighton and Armstrong, 1964; Shepherd, 1976).

A demand of this nature places a great burden on existing psychiatric services, and particularly on man-power resources (Brownlee, 1980). One-to-one therapeutic intervention therefore becomes limited in its use and efficacy (Donofrio, 1970).

The answer to this problem, however, does not lie only in increasing existing services (Cone and Sloop,1974). Many services have been criticised for their inability to prevent emotional disturbance and promote mental health. Dunham (1967) has noted that forty years after the inception of child guidance clinics which were used extensively, delinquency remained a problem, and adult psychoses rates remained approximately constant. Attempts have been made at streamlining existing psychiatric services with limited success (Fenichel, 1974; Graham, 1976; Korchin, 1976). In fact, Chu and Trotter (1974) note that while the number of state mental hospitals in the USA and the number of in-patients has increased, the demand for services has not decreased. Cone and Sloop (1974) argue that traditional one-to-one approaches are not sufficiently effective, and that increasing services as they are will

not fulfill the demand. Rather, alternative forms of intervention need to be utilised.

The community psychology approach acknowledges that traditional methods of therapeutic intervention have been unsuccessful, or at least inefficient, and that new ways of meeting human needs must be found (Solomon, 1978). In order to do this an interdisciplinary approach which appreciates the complexity of the interrelationship between the person and his environment must be used. Many traditional approaches overlook or underestimate the complexity of this interrelationship, and this is postulated as one of the reasons that these methods fail to yield positive long-term results (Allen, Chinsky, Larcen, Lochman and Selinger, 1976; Cowen, 1967; Goodman, 1967; Zax and Cowen, 1972).

Tizard (1970) and Vernon (1964) question the efficacy of traditional psychotherapeutic practices, and note that the superiority of one-to-one approaches has not been demonstrated.

The current shortage of professional manpower in the mental health field is well documented (for example, Allen, Chinsky, Larcen, Lochman and Selinger, 1976; Cook, 1970; Curtis and Miller, 1976; D'Augelli and Danish, 1976; Donofrio, 1976; Guerney, 1969, 1977; Kugler, 1975; Lorion, Cowen and Caldwell, 1974; Meyerstein, 1977).

However, even if these shortages were alleviated to some extent, there would still be many population groups

in need of mental health services who would not be reached (Solomon, 1978). Awareness of this must force the mental health professional to redefine his role and find some solution to real and pressing social problems (Cowen, Zax and Laird, 1966; Zax and Cowen, 1972). Hobbs (1964) states that the mental health specialist be trained in ways to multiply his effectiveness by working through other less extensively trained people.

There is much disagreement as to the efficacy of using non-professionals in a therapeutic capacity. Reif (1967) views the non-professional in a 'bridging' role between the professional and his target population. Furthermore, since non-professionals are unlikely to be identified with the professional in his defined role, they are more likely to gain access to certain groups. Another 'bridging' function the non-professional has is his ability to deal with issues on a much broader level, in that he is able to combine house, school and social activities. In this way, a problem may be taken out of its specific context and placed within the individual's milieu (Skuy, 1975; Solomon, 1978).

Fiedler (1950) maintains that a good therapeutic relationship is not much different from any interpersonal relationship. Rogers (1957, 1967) similarly asserts that meaningful changes in therapy arise out of the nature of the relationship between client and therapist, rather than out of any skills the professional may have. Rogers (1957) identifies three characteristics which are necessary for

change: congruence (the therapist must be at one with himself), unconditional positive regard (an acceptance of the client and his experience), and empathy (sensing the client's world as if it were his own). Frank (1973) supports Rogers and emphasises the therapist's personal attributes rather than his training.

However, there is some disagreement with these contentions. Steisel (1972) questions whether intimate involvement of the indigenous population in solving problems is useful. He maintains that such people may be suffering from similar problems, and will therefore be unable to objectively assess the difficulties, and provide therapeutic intervention. Steisel (1972) further maintains that non-professionals are unable to direct mental health programmes.

Kirk, commenting on the study by Persons, Clark, Persons, Kadish and Patterson (1973:181) echoes these doubts. She asks

> Do we believe that therapy, or counselling, is an enterprise whose successful engagements are the result of learning a few principles and a few superficial techniques? If we believe that the depth of understanding of personality structure and functioning and of traits is basic, can they be by-passed for a quickie learning mode of interaction?

Despite disagreement in this area, the trend today is to utilise more and more non-professionals in the mental health field. Traditional approaches have not worked. Smith and Hobbs (1966) with reference to child guidance

clinics have commented on their limited effectiveness. They feel that much of the practice of clinical psychology and psychiatry is obsolete. A profession which revolves around a fifty-minute hour spent in a one-to-one relationship between therapist and client is, they say, 'living on borrowed time'. Guerney (1969), in response to this, states that new methods should be developed which allow each hour of professional time to help more individuals in a way that is more effective than traditional approaches have been. Thus, new facilities, skills, orientations and greater utilisation of manpower resources are required (Solomon, 1978).

2.2 Parents as Change Agents

According to Korchin (1976), the broadest aim of community psychology is to reduce the amount of psychopathology in the population. It is commonly assumed by adherents of this model that psycho-social stress arises out of the interactional process between the individual and his social environment (Bloom, 1973; Kelly, 1966). This implies that any programme which aims at either primary or secondary prevention must focus on both individual psychological characteristics and the social system, or rather, the person within his environment (Cowen, 1973; Nietzel, Winnett, MacDonald and Davidson, 1977; Zax and Specter, 1974).

Parent education is an approach which meets this need. Although it is an interventive strategy born out of individual and group psychotherapy techniques, it

has the potential for wide application. Parent education is based on the thesis that the parent-child relationship is a crucial variable in the psychological adjustment of the child (Farina, 1976; Mussen, Conger and Kagan, 1974; Wolman, 1975). Not only is this interaction important during childhood, but it is also considered an important influence on the person's ability to cope in adult life. In view of this, any technique which changes the parent-child interaction positively may be a valuable means of helping disturbed children, and also of preventing future disturbance. This means that parent education as an interventive strategy would have both a primary and secondary preventive function.

Parent education may be viewed as an alternative to traditional one-to-one approaches as it differs in three fundamental ways (Brownlee, 1980). First, the effectiveness of the professional may be increased since intervention is conducted in a group situation over a brief period of time. Second, it is possible to achieve change at the source of the problem, that is, a destructive parent-child interaction might emerge as a constructive relationship. Third, by focussing on the primary preventive aspects of parent education, programmes need not be viewed as treatment measures, and may thus become more acceptable to population groups that would normally avoid mental health care. Furthermore, by using non-professionals (in this case, parents) in a helping role, many people who would not

normally have access to professional help would receive mental health care in the form of parent education.

Parent education has a number of advantages over traditional psychotherapeutic approaches (Donofrio, 1976; Zacker, 1978). Most important is the fact that the parent is with the child continually, rather than for one hour a week in the course of therapy, and is therefore able to influence the child long after intervention has ceased. Zacker (1978) notes several additional factors testifying to the superiority of parent education. First, parents are likely to view the professional as an ally rather than a threat, and consequently will be less suspicious of or opposed to therapeutic effects. Second, the treatment occurs within the parent-child interaction in a natural setting (the home) and generalisation is greatly enhanced. Third, the parent exerts greater control over more and powerful reinforcers for the child than does the professional. Clement (1974) notes that a child will identify more strongly with his parents than with a professional, making the parent a more effective model for behaviour change.

It is evident that there is a need for greater implementation of programmes, including both professionals and non-professionals, ranging from the traditional mental health team to increased utilisation of manpower resources such as parents and teachers. In South Africa, women constitute a vast source of untapped non-professional

manpower. The unique racial situation increases their potential effectiveness as agents of change. The large force of domestic servants allows many housewives the time and opportunity to develop the skills they require in a helping relationship, and to provide services to various population groups. Careful planning of men health programmes is essential in view of the diffe. ng needs of various population groups, and in order to facilitate optimal service delivery.

2.3 Parent Education

Parent education programmes are educational services designed to enhance relationships between parents and their children. The purpose of the programmes is to increase the psychological and emotional well-being of parent and child, and to promote a relationship between the two that is satisfying.

Parent education programmes involve the sort of learning generally associated with educational programmes; that is, they include intellectual explanation and discussion, and deal on a cognitive level with concepts and ideas. However, expansion and change of ideas and attitudes is only the beginning. The major goal of parent training programmes today is the modification of behaviour within the parent-child interaction.

The participants are given the rationale and the skills that enable them to meet communications from their children with empathic acceptance; to recognise and

accept their own feelings and those of others; and to help their children understand and formulate their own motivations more clearly, and thus to develop their personalities more fully (Guerney, 1977). Within the parent child interaction, it becomes necessary for the parent to regulate the activity and intensity of child behaviour (Bell, 1971). Parent education programmes aim at providing participants with these skills.

The goals of parent education are not curative only, they are preventive also. Guerney (1977:5) suggests that in aiding people to achieve lives more satisfying to themselves and others, mental health professionals "..... should offer new educational and re-educational services that reshape behaviour and life-styles". This does not imply that the goals of such new educational services should be different from or conflict with traditional psychotherapy. In fact, professionals should not hesitate to recommend both where necessary.

Guerney (1977) points out that parent education programmes differ from traditional approaches not as much in goals as in philosophy, conception, organisation and efficiency. Viewing psychotherapy as a type of education makes it easier, in concept and practice, to develop primary prevention programmes that really work. It is important to note that in any parent education programme, we are dealing with the implementation of values and not only with treatment. We are not so

much doing things to people that changes them, as giving them a skill that may be used to change themselves and their ways of interacting with others. In the course of traditional methods of psychotherapy, the recipient is dependant on the skill of the professional for solutions to a problem. This means that clients, with his help, have solved one set of problems rather than acquired problem-solving skills, and are likely to be dependent on a professional to help them solve future problems. They have not necessarily learned how to prevent conflicts and problems from arising again, or how to solve the same problems should they re-occur. One of the greatest advantages of a parent education programme is that it imparts a skill to the parent that he can continue to use for a lifetime. Thus, a skill-orientated programme may be considered simultaneously a remedial programme, and a programme of primary, secondary or tertiary prevention. For individuals with problems it has a secondary or tertiary prevention function, and for parents who do not have any problems it has a primary prevention function.

Another significant advantage of parent education programmes is the cost-benefit ratio which is significantly better in education programmes than in traditional psychotherapeutic approaches (Reisinger, Ora and Frangia, 1976; Zacker, 1978). The reasons for this are fourfold: a) parents are used as change agents for their children (see Chapter III), b) there is more efficient use of

professional manpower, and the method lends itself to using non-professionals (e.g. successful clients who then receive training) as group leaders, thereby reaching more people, c) pr m resolution will be more stable and durable since education programmes emphasise continued use of problem-resolution and problem-prevention skills in the natural environment, and d) education programmes deal with problems in living, and the programmes focus on learning to use skills in the home.

Thus it can be seen that the purpose of any education programme is to add a set of skills to the parent's behavioural repertoire which will improve the parent-child interaction.

Despite this basis, the efficacy of parent education as a treatment or preventive measure has not been proved. The development and utilisation of parent education techniques without a sound basis for their application may lead to ineffective intervention. Most of the thrust of the community psychology approach has been towards programme development and description with little emphasis on systematic evaluation of effectiveness. More recently, these issues have been focussed on. It is essential that if community approaches are to correct past failures, research evaluation must become an integral part of programme development. To this end, an investigation of the outcome of parent education techniques was considered, in the present study, a necessary preliminary to the use of parent education as a primary or secondary preventive measure for emotional disturbance.

CHAPTER III

PARENT EDUCATION GROUPS

This chapter presents an overview of the general principles of parent education in a group setting. Evidence regarding the validity of such an approach is presented. Renz and Cohen (1977) have differentiated three basic groups: didactic, group discussion and training. These are discussed with reference to the present study.

3.1 Overview of the Field

One of the basic tenets of developmental psychology is the thesis that the early familial environment of the child, and the tone of the parent-child relationship is a crucial factor influencing the development of personality and psychological adjustment (Frank, 1965; Serot and Teevan, 1961). According to Dinkmeyer and Muro (1971:284):

> ..... one of our major societal problems involves the fact that parents almost never have adequate experience, training and actual background to enable them to function effectively in child training. As a result, many parents are generally largely unequipped to play the most significant role in the development of society.

The skills which the majority of parents utilise in rearing their children and dealing with family problems are those used by their own parents, by their parents' parents. and by their grandparents' parents (Durrett and Kelly, 1974; Gordon, 1970). However, psychology and the other behavioural sciences have amassed considerable

knowledge about effective child rearing practices, (Durrett and Kelly, 1974; Hawkins, 1972). With the advent of the community psychologist in mental health services, parents have increasingly been used as change agents for their children, singly, and in group settings (Reisinger, Ora and Frangia, 1976; Tavormina, 1974). The focus traditionally has been on effective child rearing and child management issues, but current trends are towards primary prevention, which Hereford (1963) terms "educating the parent for parenthood".

Professionals such as Carkhuff (1969) and Gordon (1970) have made an attempt to pass on to parents skills used by professional counsellors in helping children with problems. Accordingly, effective means of teaching and transferring these skills are needed before the profession is able to offer the required assistance to parents of emotionally disturbed children (Durrett and Kelly, 1974).

Unfortunately, all too often an emotional problem is presented to the professional only once it is well established. This means that its remediation may be slow and expensive. It therefore becomes imperative that parents of "normal" children be educated as a primary measure (Benson, Berger and Mease, 1975). In fact, Hawkins (1972) suggests that a mandatory programme of parent training be instituted to counter the increasing number of children presenting behaviour problems.

Therapeutic intervention by parents is now being

recognised by mental health professionals, vis a vis professional manpower shortages, questioning of the efficiency of traditional treatment approaches, and an increase in the use of other paraprofessionals as change agents (Reisinger, Ora and Frangia, 1976; Tavormina, 1974).

Clement (1974) and Donofrio (1970) have challenged the practice and claims of traditional child psychotherapy and have argued that the treatment of the child directly by the professional has inherent disadvantages compared to treatment by the parents. Zacker (1978) has reiterated this position, and has cited some of the advantages that can be obtained when the professional helps parents to become the primary change agents for their child: since parents constitute a cheap, continuous treatment source which is able to work conveniently within the home (i.e. the natural environment), generalisation is enhanced; the parents' relationship to their child and their influence upon his behaviour is greater than the professional's; parents control more and stronger reinforcers than does the professional; the child will tend to imitate behaviour of models perceived as more like himself; parents enlisted as change agents are less likely to be opposed to therapeutic effects, and their confidence and competence as parents is strengthened.

By participating in parent education groups, parents become both recipients and agents of therapeutic intervention.

Programmes focus on building stronger family relationships by helping parents better understand themselves and their children (Larson, 1972).

Auerbach (1968) has broadly defined the goals of parent education programmes as (a) helping parents become more familiar with basic concepts of child development, (b) helping them clarify the roles of parent and child and (c) increasing parental understanding and handling of child management issues.

The method and techniques used in parent education have been adopted from disciplines other than psychology. Counselling, psychotherapy, and education have been chief models from which parent education has borrowed (Croake and Glover, 1977). Within the parent education framework itself, approaches and techniques vary. Methods of parent education reported include Parent Effectiveness Training (Gordon, 1970, 1976), Filial Therapy (Guerney, 1969), education groups (Schrader, Altman and Leventhal, 1969), discussion groups (De Rosis, 1970) and behavioural groups (O'Dell, 1974).

Although numerous models of parent education exist, they are often variations of a single approach (Sadler, Seyden, Howe and Kaminsky, 1976). Renz and Cohen (1977) have differentiated four basic models: didactic, group discussion, training and behaviour modification.

3.2 Didactic Groups

According to Renz and Cohen (1977:54) didactic programmes ".... emphasise the presentation of information about parenting problems to a group of parents". Brim (1959:21) describes parent education as ".... an activity using educational techniques in order to effect change in parent role performance". Clearly, this approach requires the presentation of material to parents, and change is facilitated by "educating" the parent (Croake and Glover, 1977; Marsh, 1963).

Brim (1965) discusses three basic types of parent education methods: mass media, individual counselling, and group discussion. Mass media include radio, press and T.V., and any effort which is aimed at an anonymous audience. Individual counselling is information obtained from health services, welfare organisations, schools and churches. Group methods are distinguished by group participation. Today, parent education is becoming less frequently applied to mass media methods, for economical and organisational reasons, and is moving closer to group methods.

Shrader, Altman and Leventhal (1969) have noted that in addition to didactic techniques, parent groups have provided emotional support and mutual assistance to group members. According to Brim (1959), this is clouding the distinction between education and therapy. Auerbach (1961) differentiates between purely didactic groups and those

which have in addition an emotional component on the basis that a purely didactic approach is not concerned with the defences and pathologies of parents. Brim (1959) suggests that didactic parent groups maintain their focus on a conscious and cognitive understanding of the parent-child relationship. This allows for an approach which is separate and distinct from others.

In summary, a parent training group could be considered didactic if the training involved the presentation of instructive material to the parent with the aim of improving the parent-child relationship in a situation that is rational rather than emotional.

Early studies in the field of parent education used only this approach. Three early studies report significant improvement in parent knowledge (Hedrick, 1934; Owings, 1931; Schaus, 1932).

Since these early studies, parent education has focused more on changes in parent attitudes, and in more recent years has begun to focus on parent-child behaviour and interaction. These attitudes have stimulated new developments in approach and techniques.

3.3 Discussion Groups

According to Renz and Cohen (1977:54), group discussion programmes ".... although frequently containing a didactic component, most often provide parents with an opportunity to discuss parent-child relationship problems". This approach places emphasis on personal experience, and uses

cognitively mediated variables, namely, feelings, to bring about change in a child's behaviour and the parent-child relationship (Auerbach, 1968; Tavormina, 1974).

Discussion groups vary greatly with regard to group size, homogeneity of membership, number of sessions, length of groups, and group process (Gabel, 1972). Although this approach bears similarity to the didactic method in that discussion may be a feature of both, it has a number of unique characteristics. Tavormina (1974:828) defines the discussion group method as:

> (a) an exchange of information between parents; (b) development of a group agenda based on interests and problems specific to group members; (c) encouragement of the expression of feelings; (d) creation of a climate of trust and safety in which all can participate freely and honestly.

Encouraging the expression of feeling and emphasising personal awareness are confirmed in the work of Auerbach (1968), DeRosis (1970), Dinkmeyer and Carlson (1973) and Larson (1972). Similarly, Gazda and Ohlsen (1966) describe a discussion group with the emphasis on group acceptance and solidarity, reducing members defensiveness and encouraging self-exploration and acceptance. In addition, information on normal child behaviour was provided, as requested. Thus the discussion group method provides both a rational and emotional experience (Balter, 1976).

DeRosis (1970) includes structure in the design of her discussion groups, but points out that this does not

suggest teaching skills to parents. DeRosis has structured the group around active, repeated participation by members in identifying the problem, planning alternative courses, and encouraging the parents to take action. Zacker (1978) has described a similar model within a psychodynamic framework. Identification of the problem and alternative strategies are discussed with the clinician who assumes an almost consultative role; the real work is done by the parents themselves.

Structure, however, is not an essential part of a discussion group. Rather, the distinguishing features of such a group would be the enouragement of expression of feelings by parents in an accepting environment in order to focus on feelings and needs within the parent-child interaction.

3.4 Training Groups

This is considered by Renz and Cohen to be the most comprehensive approach to parent education.

Carkhuff (1969) has based his training approach on a number of tenets: (a) the core of functioning or dysfunctioning is interpersonal; (b) the core of the helping process is interpersonal; (c) group process has proved to be effective in dealing with interpersonal issues; (d) systematic group training is a preferred mode of dealing with interpersonal problems. Thus, according to Carkhuff and Bierman (1970:157), "....systematic group procedures can be constructed to achieve

operational treatment goals by progressive step-by-step gradations of interpersonal experience".

Carkhuff and Bierman (1970) have suggested that for parent training to be maximally effective, there needs to be parental practice of interpersonal skills as a component of the overall programme. Attitude change is not enough, for while this can be described as a change in cognitive structure, and as indicating the direction of 'potential action', it does not mean that it will be reflected in behaviour change (Anastasiow, Grimmett, Eggleston and Brown, 1974). A training programme aims at translating attitude change into behaviour change through the use of a laboratory or workshop experience designed to facilitate parental attitude change and to equip parents with skills consistent with these newly acquired attitudes (Rinn and Markle, 1977).

It can be seen, then, that training programmes integrate the didactic, experiential (discussion group), and modelling approaches (Renz and Cohen, 1977). A large variety of training programmes exist, including Parent Effectiveness Training (Gordon, 1972), Adlerian Mother Study Groups (Freeman, 1975), Human Resources Development (Carkhuff, 1971) and Microtraining (Ivey, 1974). The definitive component of all these approaches is their emphasis on the training of interpersonal skills relevant to the parent-child relationship. For example, Carkhuff's (1971) approach involves the inter-personal skills of attending, observing, listening, and responding.

Much research has been conducted in the area of parent training groups, but little has been published (Rinn and Markle, 1977). Perhaps the most well-known approach is Parent Effectiveness Training (PET), a programme designed for parents to learn and practice the art of 'active listening' in order to establish a good communication base with their children. Additionally, this programme trains parent in 'no lose' conflict resolution skills (Gordon, 1970; Stone, 1973; Renz and Cohen, 1977).

PET is intended as a preventative and educational programme, rather than as therapeutic and remedial. Courses consist of eight three-hour sessions held weekly. The programme includes lectures, readings, role playing, discussions and homework assignments (Gordon, 1970). Numerous studies have been conducted showing the efficacy of PET (for example, Knight, 1974; Lillibridge, 1971; Schmitz, 1975). The Human Resources Development programme (Carkhuff, 1971) and Microtraining (Ivey, 1974) are both based on the communications approach developed by Truax and Carkhuff (1966). Emphasis is placed on the interpersonal skills of eye contact, body posture, invitations for talking, reflecting and summarising, and expression of feelings.

3.5 Problems with research

Renz and Cohen's (1977) categorisation of parent education groups appears to be a valid means of delineating the various approaches. This categorisation provides a

useful basis for comparative research which is necessary if we are to provide adequate services.

Within the training group model, a large number of different approaches exist. For example, PET focuses on interpersonal communication, while AMP focuses on personal strengths. This means that while the orientation and methods are similar, the processes within the groups may differ. Consequently, an important issue relates to the specific factors which contribute to an improved therapeutic outcome (Korchin, 1976).

Croake and Glover (1977) have criticised research findings pertaining to parent training on a number of grounds: no controls were used; the reliability and validity of the research instruments used were not determined; often the person conducting the research would also run the programme thereby introducing experimenter bias. Reisinger, Ora and Frangia (1976) have noted that the parent training literature has been characterised by insufficient attention to detail.

Stafford (1974) in a review of fifteen parent education studies reported significant differences in parental attitudes which seemed to be related to the specific content of and information provided in the programmes. Croake and Glover (1977:156) state the importance of specifying the content of programmes, and maintain that

> Even within similar theoretical programmes, the content is not set forth clearly enough for subsequent researchers to replicate the existing investigations or to expand or apply them to other populations.

Many studies have provided no documentation of programme material (for example, Murphy, 1976). However, part of this difficulty may be related to the fact that many studies are reported in journals, and space is accordingly limited.

A study by White (1974) provides a good example of content description. Twenty eight parents participated in a parent education programme, with another sixteen parents in a control group. The education programme stretched over eight weeks, with a new topic each week. The programme covered principles of child development; the effects of heredity and environment; physical and motor development; cognitive development; the role of self-concept; emotional development; social development; and personality development. Parental attitudes were assessed on the Parent Attitude Research Instrument. No difference was found on the posttest scores between groups. However, no pretest was conducted, preventing any evaluation of change as a result of the programme. Furthermore, White (1974) did not assess the effects of the programme on children of parents who had participated in the study.

A pre- and post-test design was used by Swenson (1970). Forty-one parents were assessed on the Maryland parent Attitude Survey, and the children were rated on the Personality Rating Scale by their parents and teachers. Teachers' Quarterly Ratings for the school year were included. The two parent training groups included discussion and were described as a lecture-discussion

group, and a film-discussion group. No significant changes were found in parental attitudes on posttesting. There were no significant changes for the children. An examination of pretest scores revealed a significant improvement on school adjustment among children of both treatment groups who began with 'middle' scores. It seems that parent education may have some value for specific population groups, since the increased adaption was relative to the parents attending an education programme. However, this conclusion is tentative, owing to the absence of a control group.

A control group was used in a study by Stearn (1971) who employed a three group design obtaining measurements at pretest, posttest, and a six week follow-up. The experimental group consisting of eighteen parents received a standard PET programme. Fifteen parents who had shown interest in the PET programme were included in a no-treatment control group, while another fourteen parents were placed in the remaining no-treatment control group. The Traditional Family Ideology Test, the Self-Esteem Inventory, and the Relationship Inventory were administered. No significant results were reported on posttesting on the Traditional Family Ideology Test and the Self-Esteem Inventory. Children from control conditions scored significantly higher on the Relationship Inventory. Rinn and Markle (1977) have criticised the study on three counts: the subjects were not selected randomly, there was no placebo control, and differences may have

been a result of placebo effects, and, parents administered tests to their own children, thereby creating the possibility of bias.

Durrett and Kelly (1974) examined the effects of parent training on behaviour. A group of seven parents received Microtraining, while six parents acted as a control. The outcome was evaluated on observations, structured interviews, and questionaires administered pre- and post-treatment. Results revealed that children of counseled parents improved significantly on the amount of talking within the family. No significant differences were reported on the children's responses between groups, and no significant changes were recorded on the attitude scale. Parents participating in the study all felt it had been a beneficial experience. Durrett and Kelly (1974) concluded that while participation in a group was an emotionally rewarding experience, it could also lead to behaviour change in the family.

Carkhufr and Bierman also examined the behaviour of parents following a training group. Forty-two parents and twenty-one children considered to be emotionally disturbed were included in the study. Five couples participated in a training programme based on Carkhuff's (1969) principles of interpersonal functioning. Three 'traditional' treatment groups were used as controls, and consisted of four couples each. Parents were assessed pre- and post-treatment on four measures: written responses to sixteen standard helper stimulus

questions; a role play of a helper-helpee situation and a play interaction with their child; a relationship inventory; some items from the Minnesota Multiphasic Personality Inventory (MMPI). The children were assessed on the Child Adjustment Index. A significant improvement was recorded for the training group parents in the helping role with their spouse, and in their responses to the helper questions. However, no significant changes took place in the play situation, on the MMPI or the Child Adjustment Index. A between groups comparison revealed only a slight gain in interpersonal skills for the parents of the training group.

Renz and Cohen (1977) conducted a study similar to the one by Carkhuff and Bierman (1970). They obtained written assessments and observational ratings of parent-child interaction. Parents supplied a written assessment of their own interpersonal skills. Twenty parents attended the training group following the programme described by Carkhuff (1971). The written results reflected a significant improvement in interpersonal communication, in attending, and in the subjective rating of interpersonal functioning. Renz and Cohen (1977) concluded that the training programme had been responsible for these gains.

In a study by Larson (1972), PET was compared with an Achievement Motivation Programme (AMP), where parents discuss personal goals and values in the context of individual strengths, and with a Discussion-Encounter group (DEG), where parents are instructed in, and practice

being directly and accurately aware of their emotions (Larson, 1972). Pre- and posttest measur s were obtained on a number of instruments including the Hereford scale. PET and AMP groups appeared to profit more than DEG groups, and Larson concluded that PET was the superior approach for parents involved. However, this study is hampered by lack of inferential statistics, and Rinn and Markle (1977) maintain that it is unlikely that these would approach significance.

In summary, parent education programmes which can be categorised as training groups have been poorly researched. Ommission of content description, an absence of adequate data, no pretreatment testing, and a . 'k o. control groups are all factors militating against the proven efficacy of the above studies. However, findings indicate that training parents in parenting skills does lead to improved interpersonal functioning, often in terms of improved communication within the family. So far, findings with regard to children have been inconclusive.

Much research validates the efficacy of the discussion method. However, since many of the studies are non-systematic and poorly controlled, much of their value and scope is diminished (Croake and Glover, 1977; Tavormina, 1974).

Cary and Reveal (1967) were able to increase mothers' understanding of their children, but results are clinical

rather than objective. Bricklin (1970) reports similar findings with parents of learning disabled children, in that parents became more aware of the nature of their child's problem, and more responsive to him as a person.

Shapiro (1955, 1956) assessed the effects of counseling on parental attitudes and feelings. Twenty-five parents attended twelve monthly discussion group sessions, and twenty-five served as a control group. Results on parts of the Hereford Parent Attitude Survey showed significant change in childrearing attitudes for experimental subjects. In addition, relationships outside the group seemed to benefit.

Balser, Brown, Brown, Laski and Phillips (1957) using a similar design to Shapiro (1955, 1956), found that the non-intervention group improved more than the experimental group, where members demonstrated a slight tendency towards attitude change. Other studies yielding non-significant findings are reported by Gildea, Glidewell and Kantor (1957) and Glidewell (1961).

The most definitive study in the area is one conducted by Hereford (1963). He included four experimental conditions for 916 subjects: parents in discussion groups (n=370) meeting for six two-hour weekly meetings were compared with three control groups. These were a lecture control (n = 102) who received six lectures on parent-child relations; a non-attendant control consisting of parents who expressed interest but failed to attend (n = 160); and a random control of parents selected

from school files (n = 271). No specified curriculum or approach was followed in the experimental groups. Each session typically began with a film or skit to stimulate discussion or provide a topic. A few groups requested that no film be shown so that they could use the entire session for discussion. Attitudes were assessed by the Hereford Parent Attitude Survey Form prior to and following the intervention. The experimental parents showed a significantly greater change in attitudes than did the three groups of control parents. Moreover, the children of the experimental groups showed a significant improvement in sociometric standing over the control groups children. The number of meetings attended, participation in the sessions and the individual group leaders were shown to have no effect on the outcome. Hereford's (1963) conclusion was that the treatment method per se was the agent of change.

Gabel (1972) used Hereford's scale in a study of ninety-eight mothers of kindergarten children. There were twelve one-hour sessions focusing on maternal expressions of concern around child-rearing. Experimental mothers showed a significant increase in emphasis on mutual parent-child understanding. Furthermore, experimental mothers improved their confidence in their role of parent.

It is evident from the above mentioned studies that parental attitude change, as a result of the discussion group method leads to: increased confidence in the parental role; a better understanding of the nature of

a child's problems; greater acceptance of the child; improved understanding of and greater trust in the parent-child relationship.

However, conflicting evidence has been reported. Tavormina (1974) maintains that this may be due to the different instruments that are used to assess the programmes. Differences in group content and different approaches may have resulted in these contrary results.

According to Lillibridge (1971), parental attitudes are related to behavioural changes in the child, in terms of enhanced adjustment of the self, and in relation to the environment. Dee (1970) confirmed this in his study. He found that child-centred parent counselling enhanced the overall treatment effectiveness for forty children with school adjustment problems as measured by a personality questionaire and a rating form.

McGowan (1968) conducted research with the aim of helping parents to better understand their child's behaviour. He placed thirty-two underachieving boys in four groups: parent counselling only, student counselling only, both parent and child counselling, each done separately, and a no-treatment control. All treatment groups showed significant gains on home improvement ratings and the ability to express feelings, but only the boys whose parents had participated in the discussion groups showed increased school performance.

A study by Perkins and Wicas (1970) has largely confirmed Dee's (1970) findings. It appears to be based

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A study by Perkins and Wicas (1970) has largely confirmed Dee's (1970) findings. It appears to be based

on McGowan's (1968) design, and 120 underachieving schoolboys were placed in four groups: maternal counseling only, child counseling only, both maternal ard child counseling, and a control group. The mothers participated in a Rogerian-type group with leaders who had been trained in non-directive techniques, minimum levels of empathy, warmth and genuineness towards their clients. The boys of all three treatment groups showed academic improvement. In addition, mothers participating in the discussion group showed greater gains in self-acceptance. At a five months follow-up, this was the only group to show any lasting effects. Thus there seems to be some concordance among researchers that discussion groups can lead to changes in both the parent and the child.

Friedman (1969) correlated parents' attitudes as measured on Hereford's (1963) scale with their children's social behavior as observed by independent raters at a summer camp. Leadership in the child was significantly correlated with parental trust, but no other significant relationships were found. This suggests that changing parental attitudes may not lead automatically to similar changes in parent or child behaviour. Similarly, Hereford (1963) reported that while the sociometric ratings of the children of counseled parents improved over the control group ratings, teacher ratings revealed no changes across groups.

Many criticisms pertaining to parent training groups could be with reference to discussion groups (Croake and Glover, 1977; Tavormina, 1974). One such criticism is the description of a technique without presenting adequate support for it in terms of outcome and inferential statistics. Zacker (1978), for example, presents a psychoanalytic approach which he validates in terms of clinical impressions only. This means of reporting parent discussion groups was also presented by Bricklin (1970), Cary and Reveal (1967), and Hampton (1962). Similarly, DeRosis (1970), who describes a method of structuring groups, and Pasnau, Meyer, Davis, Lloyd and Kline (1976), who describe the advantages of concurrent parent and child groups, have omitted adequate outcome results.

Alternatively, some studies have presented outcome statistics with little description of process. Hale (1976) reported an increase in eighteen parents' attitudes towards their children on acceptance, understanding and trust after a discussion group programme. Iwai (1972) compared attitudes of ten mothers attending a discussion group for ten weeks with eleven mothers who did not. Experimental group mothers reflected greater gains in their capacity for intimacy with their children. Similarly, Gabel (1973) found an increased parent-child understanding among mothers who had attended a discussion group.

From the above studies, it seems that discussion groups improve the capacity for intimacy, understanding, and trust

within the parent-child relationship. However, since the discussion group method was not clearly detailed in each case, it is difficult to evaluate the results of the studies in a rigorous fashion.

Endres and Evans (1969) detailed their discussion group method in a study designed to assess parental attitudes and behaviour following a discussion group. Ninety parents were assigned to three groups: discussion, lecture, and no-treatment control. The focus of the discussion group was on attitudes towards the self, feelings of adequacy, understanding of self and others, and a positive attitude towards change. The lecture groups discussed hobbies, travel and Christmas decorations. Results indicated some attitude change on the part of the parents, but no overt behaviour changes. However, there was a trend for children of discussion group parents to be better adjusted and more self-accepting than control group children, after the programme.

It can be seen that the discussion group approach has been more adequately researched than the training approach. However, problems which pertain to both are the tendency to report novel programmes without accompanying statistical validation, or alternatively, a tendency to present detailed results with little reference to programme content and description of the method.

Nonetheless, the above studies provide the researcher with some fairly consistent findings. Firstly, there

appears to be a greater acceptance of self on the part of parents participating in discussion groups. This is concomitant with greater trust in the child, and an improved parent-child interaction. Secondly, improved adjustment and greater self-acceptance on the part of the child have been reported. Self-esteem seems to improve as often as not, but this may be a function of the type of programme which parents attend. The present study may be able to shed some light on this matter, since three varying treatment modalities will be employed. This will enable a between group comparison on the self-esteem variable.

3.6 Conclusion

It is evident from the literature that parent education is an important interventive mental health strategy. In general, research seems to support the contentions of parent education in altering the parent-child interaction, despite some flaws in design and methodology. However, it is difficult to determine the specific and varying impact of each approach on the parent-child relationship, as results have tended to support the aims of the researchers. For example, the discussion group approach is based on a Rogerian-type group, with the aims of freer and greater expression of feelings, and a move towards greater self-acceptance (Rogers, 1969). That parents participating in a discussion group should show greater self-acceptance is hardly surprising, then. In similar vein, training

groups have focused on improving interpersonal skills, and findings have been related to aspects of interpersonal functioning.

Carkhuff (1971) has criticised encounter groups for changing attitudes only. Although parent training groups aim specifically to alter behaviour, few studies have examined the effects of such training on parental behaviour. Furthermore, while the real target of parent education is the child himself, the impact of such programmes on the child's functioning has been largely ignored. Thus, despite the contention of Reisinger, Ora and Frangia (1976) that the treatment of children has been based on expedience and professional convenience, rather than on the evidence of parent education research, it would seem that the research has not been adequate or definitive.

It therefore becomes necessary that parent education methods be compared in order to determine the relative effectiveness of each approach (Tavormina, 1974). A problem with this is finding a suitable measure on which to evaluate outcome. Researchers should be encouraged to institute more systematic controls and more rigorous definitions of the variables they are dealing with in order to determine the effective components of each approach (Rinn and Markle, 1977; Tavormina, 1974).

CHAPTER IV

SELF-ESTEEM

This chapter is concerned with the definition of self-esteem. The optimal level of self-esteem adjustment is discussed. The developmental approaches of Rogers (1950) and Coopersmith (1967) are presented. This is followd by the relationship between parental and child self-esteem, and, finally, a discussion on self-esteem enhancement.

4.1 A problem of definition

Although self-esteem is generally regarded as a major factor in determining behaviour, there has been little agreement as to its definition. Self-esteem has been a variable of interest in diverse areas of sociological and psychological research, and has been linked with conformity (Gergen and Bauer, 1967), social participation (Coombs, 1969), interpersonal attraction (Leonard, 1973), educational achievements (Purkey, 1970; Felice, 1973), and coping behaviour (Zurcher, 1977).

Self-esteem features prominently in various theories of psychotherapy and child development, and a wide variety of approaches have been formulated upon the old idea that 'you can't like others if you don't like yourself' (Wells and Marwell, 1976). By no means has its use been limited to the 'self' theories, and almost any theory (but the most staunchly behaviouristic) contains some description of the way in which people

evaluate themselves, and how these evaluations affect consequent behaviour.

In addition to wide usage in diverse areas, self-esteem concepts appear under an assortment of names. The same term may assume different meanings with different theorists, or an assortment of names may refer to the same phenomenon. A sample of related terms includes self-concept, self-worth, personal efficacy, and ego strength. However, all these terms describe some basic process of self-evaluation, self-affection, or a combination of the two. Much of the conceptual difficulty stems from this relationship, since the concept of <u>self</u> seems to be one of the more difficult ideas in psychological theory. (There are a variety of meanings for the term 'self' which range from the entire person to a particular kind of sentiment within the person's psychological system).

As is shown, the term 'self-esteem' is vague and subject to manifold interpretation. This makes any attempt at a rigorous definition difficult, but does not remove the problems that a lack of adequate definition provides. Wells and Marwell (1976) point out that the absence of a clear conceptual statement of definition may be serious with regard to construct validity and for the development of further theory and prediction. The remainder of this section will attempt to define and explain the term self-esteem, and expand upon it within the scope

of this study.

In order to understand the construct of self-esteem, it is necessary to understand the meaning of the self. The literature provides many definitions of self which will not be examined here. There appears to be number of conceptual difficulties with the term self, and it is a term which is generally included again in explaining its meaning (Wells and Marwell, 1976).

For the purposes of this study, the self is defined here as an "... abstraction that an individual develops about the attributes, capacities, objects and activities which he possesses and pursues" (Coopersmith, 1967 : 21). The representation of this abstraction is the symbol "me" which is a person's idea of himself to himself. This concept is formed in the course of experience by the same process of abstraction employed in other areas of experience. When the process is directed at self-referent experiences, abstractions about the self result. When directed toward external experiences, abstractions about the physical and social world result. Coopersmith calls this the self and the person. The person which is the object of observation and appraisal differs from the self, which consists of the abstractions formed about that object. The basis for the abstractions are the individuals observations of his own behaviour, and the way other individuals respond to his attitudes, appearance and performance.

The concept of self as an object is complex. It is formed out of diverse experience, is manifest in external objects (the body) and is based on different levels and types of competence in dealing with the environment. According to Coopersmith, the concept of self is multidimensional, with the different dimensions reflecting both the diversity of experience, attributes and capacity, and different emphases in the process of abstraction.

Every definition of self-esteem in the literature considers it a subset of self-conception,whether called a 'dimension' or 'aspect' of self-conception (McCandless, 1961; Gordon, 1971), or a 'mode of orientation' to the self (Miyamto, 1970). Thus, to talk of self-esteem is necessarily to imply something about the nature of the self, and it is usually defined as the individual's perception of his worth (Ziller, Hagery, Smith and Long 1969). However, this definition does not specify how self-esteem operates as a process, how it is different from other concepts, nor why it is necessary for explaining behaviour. A more comprehensive definition is required.

According to Secord and Backman (1965:579), "It is convenient to think of a person's attitudes towards himself as having three aspects - the cognitive, the affective, and the behavioural". This suggests that different features of identity generally have some value

judgment attached to them, and that all behaviour is evaluated on a positive - negative plane (Cottle, 1965). In the same way that a person places value on his actions, he will place value on himself (Shibutani, 1961). According to Wells and Marwell (1976:59), "The evaluative judgemental or affective aspect of a person's self-conception involves the process commonly referred to as self-esteem".

The valuational dimension of the self-concept seems to be regarded as the most crucial, and most attention in the self-concept literature focuses on this dimension. The reason for this, presumably, is that "the person's evaluation or esteem of himself plays a key role in determining his behaviour" (Gergen, 1971). Much of what a person chooses to do, and the manner in which he does it, is presumed to be dependent on his self-esteem. Coopersmith (1967:5) defines self-esteem as the

> ..... evaluation which the individual makes and customarily maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy. In short, self-esteem is a personal judgment of worthiness that is expressed in the attitudes the individual holds towards himself.

However, to identify self-esteem as the valuational aspect of self-conception is inadequate in itself and does not really tell us what it is. The meaning of

such a construct can only be understood in terms of a larger, more comprehensive theory of human behaviour, and is necessarily relative to that theoretical perspective.

Before the theoretical superstructure pertinent to any definition of self-esteem can be dicussed, it is important to define both qualitative and quantitative aspects of esteem.

4.2 Self-esteem levels and adjustment

While most definitions of self-esteem sound fairly similar, the meanings of constructs are still heavily dependent upon their theoretical contexts. This means that identical definitions of self-esteem will not necessarily lead to the same behavioural predictions (Wells and Marwell, 1976). Coupled with each definition is some presumption of the process of the construct, and an assumption of an optimal level of effective personal functioning. A "healthy" self-esteem is related to "healthy" behaviour.

The qualitative distinctions in esteem refer to the uncertainties as to how self-esteem is expressed, and whether it is genuine in its expression. Individuals mayattempt to present a coping and confident facade, but it is important to know whether or not this is a genuine reflection.

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constitutes spurious or defensive behaviour, and it expresses conscious or unconscious distortions from the "true" evaluation.

Different theoretical perspectives differ in the level of self-esteem considered optimal for adjustment. Most commonly, high self-esteem is assumed to be related to "healthy" behaviour. This approach is taken in the developmental theories, such as Coopersmith (1967), as well as in most of the experimental literature. The high self-esteem presumption is essential to the self-acceptance perspective of Rogers (1961) (eg. you can't like yourself if you don't like others). According to this description, the person with low self-esteem is likely to be more anxious, insecure, defensive and less flexible (Coopersmith 1967; Wells and Marwell, 1976). By contrast, high self-esteem persons are seen as more socially acceptable, and hence more active, more successful, and less prone to deviance (Coopersmith, 1967).

The contrasting "low self-esteem" model, while not diametrically opposite, frequently makes behavioural predictions contradicting the high self-esteem perspective. This model does not assert that low self-esteem is always healthier than high, but argues that it may be more functional. This approach is generally associated with "defensive style" characterisations of self-esteem, in which people's self-esteem levels are a function of the

defensive tactics they use (Cohen,1959). High self-esteem people tend to use denial defenses, and thus ignore or repress negative information about themselves; low self-esteem people are far more open to negative information, and therefore more flexible. However, no optimal level of self-esteem is stated, and it is uncertain which group is most "healthy". But low self-esteem persons are regarded as more flexible, more able to admit personal weaknesses, and less authoritarian (Cohen, 1959).

The "medium self-esteem" perspective assets that extremities of behaviour are seldom well adjusted and that a moderate self-esteem level represents a balance between self-criticism and self-enhancement. (Cole, Oetting and Hinkle 1967). This model suggests a curvilinear relationship between self-esteem and indications of healthy adjustment.

Empirical support may be found for each of the approaches, but there seems to be somewhat more evidence congruent with the high self-esteem position (Wells and Marwell, 1976). However, it is noted that most researchers seems to prefer this approach, and hence are more likely to draw conclusions consistent with it. Furthermore, many opposing findings may not be comparable because of different measuring instruments, different definitions of psychological adjustment, and the importance of these phenomena within differing theoretical

frameworks (Wells and Marwell, 1976).

It must be noted that our choice of measures is dependent on our conceptualisation of the construct, and the two must be seen in conjunction. It would be unreasonable to attempt to test between conceptual approaches with the results produced by a particular selected measure.

The writer adopts the standpoint that a high level of self-esteem is optimal for good psychological adjustment.

4.3 Theoretical Perspectives

There are several theories of personality that include self-esteem as a significant variable, but only one (Adler) in which it plays a major role. The neo-Freudians - Sullivan, Horney, Fromm - acknowledge the importance of self-esteem but treat it as a topic separate from their central theories. Adler perceived the importance of self-esteem, but was more concerned with its implications for therapy than a theoretical explanation.

Self-psychologists such as Rogers, and the phenomenologists in general, have been interested in self-esteem but have been more concerned with the general nature of subjective experience and the individual's acceptance of his experiences. Nonetheless, Rogers provides us with a developmental perspective of the self and self-esteem,and his theories have been included for this reason.

Coopersmith (1967) notes that the phenomenologists, in their acceptance of experience per se, and its importance in the therapeutic process, have largely bypassed the issues of defensiveness and external validation. For this reason, Coopersmith's perspective has been included.

4.3.1 Rogers and Self-esteem

Rogers' (1950) approach is primarily phenomenological, and the major focus is on the self-structure: "The central construct of our theory would be concept of self, or the self as perceived object in the phenomenal field" (Rogers, 1950:379). The important self-esteem concept is that of "self acceptance" and this is determined largely by our "self regarding attitudes" - a person's perceptions and cognitions of his abilities, actions and relations within his social milieu. A Rogers (1950) describes it, a self-regarding attitude seems to have three major aspects: the specific content of the attitude (a cognitive dimension), some judgment about that content relative to some standards (an evaluative dimension); and some feeling attached to that judgment (an affective dimension). Self-acceptance (and self-esteem) apply to this last dimension.

Client-centred therapy tries to increase the independence of evaluative and affectual processes; the individual is supposed to accept and esteem himself after openly recognising his flaws and his strengths. Thus the self is regarded not as a means to a specific goal, but an end in itself.

Rogers (1951) views self-esteem as a developmental process. As the infant grows and develops, he begins to discriminate among his experiences, and to own those which are part of his own being and functioning, and to assign ownership of other experiences to other persons and things in his environment. As his awareness of his own being and functioning develops, he acquires a sense of self made up of the experiences of his own being and functioning within his environment. This is his developing self-concept (Rogers, 1950).

The development of a self-concept is a dynamic process strongly dependent on the individual's perceptions of his experiences in his environment. It is not static. His perception of his experience is influenced by his need for positive regard, a pervasive and persistent need which Rogers (1951) views as universal. The individual's need for positive regard can only be satisfied by others, and his need for positive regard from significant others is particularly potent. The writer feels that self-esteem is the principal dynamic in all human behaviour.

Out of the complex of experiences of satisfaction or frustration of his need for positive regard, the individual develops a sense of self-regard, a learned sense of self based on his perception of the regard he has received from others. This sense of self becomes a

pervasive construct influencing the whole organism, and has a life of its own, independent of actual experiences of regard from others Rogers (1951:503) states :

> as experiences occur in the life of the individual they are either symbolised, perceived or organised in some relationship to the self; ignored because there is no perceived relationship to the self-structure; denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self.

In other words, it is the individual's conception of self which determines the quality of the experience perceived. Perception is selective, and is determined according to whether the experience fits in with the conception of self or not. This means that the self-concept limits openness to experience in certain consistent and selective ways.

The way in which this develops is explained by the individual's introjecting conditions of worth (Rogers, 1959).

Inevitably, the child's needs to retain the love of his parent conflicts with the needs of his organism. The values which he is aware of in his own organism are sometimes contrary to those of his parents. His behaviour which springs out of his organismic needs and desires is sometimes contrary to the behaviour which his parents find acceptable. When this occurs, he begins to take into his own system of self-regard the discrimination of experiences worthy of regard from significant others, and

those not worthy of their regard. He begins to avoid or deny altogether his organismic experiences which he has learned are not worthy of positive regard.

These introjected conditions of worth become part of his self-regard system. He experiences positive self-regard when his self experiences are in accord with the experiences for which he has received positive regard; he experiences negative self-regard when his experiences are those for which he has not received positive regard. His experience of self-worth has come to depend on the conditions of worth which he has learned in his interaction with significant others in his world.

The individual, in effect, is faced with the choice of acting in accordance with his organismic sense, or censoring the organismic urging and acting in accordance with the conditions of worth which he has learned. However, in order to maintain his positive regard, he chooses to act in accordance with the conditions of worth. This does not mean that his urges have ceased to exist; they are now denied to awareness. Whenever an individual's perception of experience is distorted or denied, Rogers (1959:226) says "A state of incongruence betwen self and experience, or psychological maladjustment and of vulnerability, exists to some degree". The intervention programmes employed in this study will aim to lessen the incongruence an individual has developed between his experiencing organism and his concept of self.

Snygg and Combs (1949:15) state that

> all behaviour is determined by and pertinent to the phenomenal field of the heaving organism .

In other words, the manner in which an individual behaves is determined by the way in which he perceives a situation at the time of his action. Like Rogers (1951), Snygg and Combs state that it is not the event itself which governs a person's response, but rather his subjective experience of it.

The consequences of this are far reaching. As a sense of self develops, it brings with it a unique perspective of the person's relationship to his world. As stated, what a person perceives, and how he interprets what he perceives, is conditioned by his concept of self. Thus, the more uncertain a person is of himself and the lower his sense of worth, the more likely is he to have a narrowed perceptual field. This 'shrinking effect' limits the data available to an individual that is required for considered and appropriate decision and action. The threatened person's perceptions tend to be limited to the objects or events of the threat. This, then, is the very antithesis of coping and efficient behaviour. Instead of broadening his knowledge and skills, such a person is kept busy defending his already existing perceptual organisations.

In contrast, the individual with a good conception of self and worth is free to devote his energies to

exploring and mastering his world. He is able to approach experience with a sense of confidence and determination acquired from his past. He feels loved and competent. According to Rogers (1951) strong self-concepts are the result of actual positive experience.

Positive expectations tend to elicit the appropriate behaviour required to fulfill the expectation (Rogers, 1951). Therefore, it is almost irrelevant whether a person with a high or low sense of worth is always correct in his expectations. This is best explored by the statement "Reality is what one perceives it to be".

4.3 Implications for child rearing

Rogers' (1951) theory of personality, and more specifically his theory of self-concept, has some implications for child-rearing. The first concerns the child himself. Since the normal child behaves in a way that reveals a strong need for acceptance, respect and love from those who care for him, giving and withholding positive regard can have a profound effect on his behaviour. Parents are able to provide a warm, accepting environment, or they may provide a hostile punitive surrounding. As has been stated, the growth of the child is best promoted by providing him with positive regard, since he will eventually come to regard himself as he has been regarded by others.

Imposing conditions of worth on the child's behaviour is tantamount to making positive regard conditional i.e. the child is acceptable only if he behaves in a certain

way. In impressing upon the child that he needs to improve, many parents seem to convey the feeling that the child is unworthy and undesirable. Rogers (1959) advises that children be given unconditional positive regard by their parents. This means that in disciplining a child, for example, the parent places stress on the disapproval of a certain behaviour, and not disapproval of the child himself.

There are some implications for the parent herself, or any significant other. Since parents are important people in the child's life, what they desire can influence the child a great deal. It is important for the parent to be aware of her own values, beliefs and expectations when dealing with the child.

If the child is able to take action on the basis of a full awareness of all his perceptions, motives and possibilities, among which are his parents wishes, he will be a "fully functioning person". By accepting her child, and his choices, a mother helps to form a congruent and integrated personality.

It must be noted at this point that Rogers' approach has been criticised for being "naively optimistic" (Di Caprio, 1974). It seems that his idea of a begign, unfolding self that requires simply to be accepted is unacceptable to some. It is true that Rogers provides us with few guidlines to attaining congruence, and that to be a fully functioning person may require the learning

specific attitudes and skills of daily living.

4.4.1 Coopersmith and self-esteem

It is generally accepted that the concept of self-esteem is theory-bound, and that each usage is relative to the theoretical context in which it occurs, since it is from that theory that self-esteem takes its definition Coopersmith (1967:28) disagrees:

> There is no single theoretical context in which self-esteem can be considered without accepting a number of vague and often unrelated assumptions. It is therefore necessary to develop a context from more specific, topical treatments, and to integrate these and other concepts into a coherent and testable theory .

The approach that Coopersmith (1959;1967) adopts is a developmental one, and his work is largely concerned with the early development of self-esteem. Unlike Rogers, Coopersmith (1967) does not coordinate his treatment of self-esteem with a larger, more comprehensive theory. His discussion of the central concept suggests that different theories are useful in explaining different aspects of self-esteem.

For Coopersmith (1967), self-esteem is a complex construct, involving self-evaluation, defensive reactions, and various manifestations of these approaches. Although, in accordance with other definitions, self-esteem involves evaluative attitudes about the self, it goes further and involves stronger connotations of affection along with evaluation. Coopersmith (1967 :5) therefore defines self-

esteem as a "personal judgment of worthiness that is expressed in the attitudes the individual holds towards himself".

The observation of self-esteem is broken down into two parts : Subjective expression (the individual's self perception and self-description) and behavioural expression (behavioural manifestations of the individual's self-esteem which are available to outside observers). Any description of an individual's self-esteem involves a composite index, reflecting both aspects of self-evaluative behaviour. In this way, Coopersmith (1959) attempts to deal with both true self-esteem (the person who actually feels worthy) and defensive self-esteem (the person who feels unworthy but is too threatened to reveal it).

4.4.2 Coopersmith: A developmental approach

Coopersmith (1967) focuses on the development of self-esteem, and the processes by which certain social phemonena become important to the person's self-evaluation. He postulates four variables as determinants of self-esteem : success, values, aspirations, and defenses. According to this Coopersmith (1967:242) says :

> ....the process of self-judgment derives from a subjective judgment of success, with that appraisal weighted according to the value placed upon different areas of capacity and performance, measured against a person's personal goals and standards, and filtered through his capacity to defend himself against presumed or actual occurrences of failure .

The degree of self-esteem an individual actually possesses, then

reflects the extent to which his successes approach his aspirations in areas of performance that are personally valued. His defenses serve to define and interpret what is 'truly' valued, the 'actual' level of aspiration, and what is regarded as 'successful'.

In order to achieve a positive self-evaluation, the individual would have to reach a level of performance in valued areas that meets or exceeds his level of aspiration, and he would have to be able to diminish and reject any implications to the contrary.

Coopersmith (1967) explains how each of the four postulated variables is employed in the process of self evaluation. Success, he points out, should be viewed in terms of the person's interpersonal environment rather than within his cultural context (i.e. status, wealth, etc.). It is from a person's actions and relative position within his effective interpersonal environment that he comes to believe he is a success or a failure, and not in the broader context of sociocultural standards. The results of Coopersmith's (1967) study indicate that "...favourable attitudes and treatment by person's significant to an individual, be they parents or peers, are likely to have enhancing effects on self-judgment." The child should feel significant to his parents, and this is evidenced as much by their restrictions, as by their discipline and concern.

According to Coopersmith (1967) people weigh their

successes according to values they espouse. It seems that persons at all levels of self-esteem employ very similar standards to judge their behaviour, and that these standards tend to be group norms rather than independantly derived standards. Thus, although individuals are theoretically free to choose their own values, the years they spend at home, in schools, and in peer groups generally lead to acceptance of group standards and values. This means that the child may well take some of his values from the home, regardless of his abilities. Parents ought to be aware of this when dealing with their children. This has implications for the present study, in that parents need to become aware of the values they give to their children, and whether they are realistic for each child.

Self-judgment involves a comparison of one's actual performance and capacities with one's personal standards and aspirations. Where standards are met, or exceeded in valued areas of behaviour, the person is likely to consider himself worthy; if not, he is likely to conclude that he is insufficient. Since this process involves a comparison of goal and performance, it becomes evident that the 'objective' success is not as psychologically significant as the personal evaluation. Coopersmith (1967) maintains that there is little difference in the public goals that people espouse; the difference lies in their personal goals. While people may select similar occupational levels and targets, people with a higher

self-esteem will set significantly higher goals for themselves, than will people with medium and low self-esteem (Coopersmith, 1967). Individuals with high self-esteem seemingly expect more of themselves than do people with less esteem, and presumably maintain their esteem by meeting their expectations rather than by lowering their standards.

Coopersmith (1967) sees family conduct as a crucial variable. Findings in this area suggest that explicit, enforced standards of conduct make it easier for the child to know when he has failed or succeeded. Uncertain, shifting standards are likely to be associated with uncertain or lessened feelings of worthiness rather than with self-enhancing judgments. Rogers on the other hand believes that the child should be unconditionally accepted, and that given this situation the child will behave accordingly.

In the way that individuals differ in their aspirations and values, so they differ in their abilties to deal with failure. A situation which is perceived as threatening will evoke anxiety in the individual, and he will act to curtail or remove it from his consciousness by employing some form of defense. According to Coopersmith (1967:248)

> Defenses represent the ability to resist or reflect devaluating stimuli and events and hence permit the individual to maintain the conviction that he is powerful, capable of dealing with adversity, and successful.

These defences protect him against the long-term effects of feeling helpless. Persons with a higher esteem will

start from a position where they feel confident in dealing with adversity. Thus the prevailing level of self-esteem becomes important in determining how the individual will cope with his environment.

In short, Coopersmich (1967) takes the view that a high level of self-esteem is optimal for competent functioning in the environment. Looking at a variety of retrospective family and school information, Coopersmith (1967) concludes that while there are no distinct patterns which differentiate high and low self-esteem children, certain attitudes and behaviours in the home are conductive to higher levels of self-esteem. These are: (1) acceptance of the child by the parents; (2) enforcement of clearly defined limits for the children by the parents; and (3) respect for individual initiative and latitude within these limits by the parents.

4.5. The relationship between parental and child self-esteem

Given that the child's familial environment is crucial in moulding his self-esteem (Rogers, 1959); Coopersmith, 1967), we may ask whether any pattern of conditions is necessary to produce high self-esteem, whether any single condition or set of conditions plays a greater role than others, and whether the self-esteem of the parents is invariably related to the child's self-esteem and to parental patterns of behaviour. Although findings in the literature do not point to anything

conclusively, there are tendencies which provide a basis for direction (Becker, 1964; Clausen, 1966).

Examination of the major indices such as acceptance (Becker, 1964), expectations (Coopersmith, 1967), discipline (Schaefer, 1965) and parental self-esteem (Sears, 1970) provides support for the view that not all of these conditions are essential for the formation of high self-esteem. Coopersmith (1967) provides data indicating, for example, that 21,2% of mothers of children with high self-esteem rate low on acceptance, while 56,7% of parents of children with low self-esteem rate high on acceptance. These findings suggest that no single variable can be isolated, and that self-esteem is determined by combinations of these variables. In addition, it is likely that a minimum of devaluating conditions - rejection, ambiguity - is required for the development of high self-esteer (Rogers, 1959).

In theory, it seems that high parental self-esteem is likely to be associated with acceptance (Coopersmith, 1967; Harlow, 1963). Greater acceptance of the child is manifested by interest, concern and availability of the mother. The child apparently perceives and appreciates the attention and approval expressed by his mother, and tends to view her as supportive. He also appears to interpret her interest and concern as an indication of his significance; these signs of his personal importance lead him to regard himself favourably.

The rationale for the relationship between high parental self-esteem, acceptance, and the child's high self-esteem stems from the findings of researchers on the child's process of identification (Bateson, 1944; Sears, 1970; Schofield, 1976; Stearn, 1971). Their general conclusions appear to be that the child's identification with his parents is markedly increased, and to a great extent derives from parental acceptance. A close affective tie apparently establishes the desire to emulate, and also the likelihood that parentally approved behaviours will be expressed. In effect, a child will be more likely to emulace his parents and accede to their requests if they indicate their approval of him than if they disapprove of him and treat him in a rejecting manner.

In rejecting families there are conditions of isolation and deprivation which have proved to have debilitating effects in human and animal infants (Goldfarb, 1945; Harlow, 1963). Parents in these families are more likely to withdraw from their children, and thus to create an environment which is physically, emotionally and intellectually impoverished. They are less likely to make warm physical contact with the children.

It can be seen that the rejecting family manifests many of the features of a deprived sensory environment. Thus, many of the frequently noted effects of rejection - shallow affect, withdrawal, docility and mistrust - may

partially be a function of the stimulation level in the household rather than issuing from direct action on the part of the parents. Bruner (1959:91) notes that an impoverish[illegible] environment

> ...produces an adult organism with reduced ability to discriminate, with stunted strategies for coping with roundabout solutions, with less taste for exploratory behaviour, and with a notably reduced tendency to draw inferences that serve to cement the disparate events of its environment.

It is worth noting that many theorists have attributed many of these same deficiencies to lack of self-esteem.

Studies of institutionally reared children (Goldfarb, 1968; Bowlby, 1951) suggest that persons who have not had a history of nurturant experience with a parental figure tend to be socially immature and shallow in their emotional responses. Coopersmith (1967) has found that children with high self-esteem are more likely than others to be close to their parents, to confide in them, to respond to the punishments they administer, to be socially skilled and emotionally responsive. This leads us to the initial conclusion that, to the extent that identification plays a role in the formation of self-esteem, children with high self-esteem are more likely to identify, as well as more likely to have a favourable model with which to identify.

The relation between parental self-esteem and the child's self-esteem indicates that unconscious identification and conscious modelling may well underlie the self-evaluations of many individuals. These processes need

not contribute equally to the history of each person but there does appear to be a general relationship between the parent's self-esteem and the manner in which he treats his children. Parents with high self-esteem have been shown to be more accepting of others, decisive, inclined to lead more active personal lives and convinced of their powers. They recognise the significance of child-rearing, believe that they can cope with it, and are able to provide their children with a definite idea of what they expect and wish (Coopersmith, 1967).

The parent with low self-esteem who is accepting of his child may provide a negative model for esteem building, but at the same time the pattern of his actions may well lead the child to a higher level of self-appraisal than he has himself attained.

In summary, it has been shown that parental self-esteem is important in building child's esteem from two points of view : one is affective, the other behavioural. Where the child feels accepted by a parent, he may relax and function within a supportive familial environment. On a behavioural level, he is able to identify with and emulate the behaviour of his parents.

4.6 Self-esteem Enhancement

A possible reason for the failure of intervention programmes designed to enhance or modify self-esteem is the tendency to overlook the conservative nature of the construct. The individual clings to his evaluation of

himself, and acts accordingly (Rogers, 1951). For example, a person who sees himself as possessing culturally favoured attributes may be shattered when something happens to destroy this conception. Yet even this realisation of the truth about the self does not usually produce change. Similarly, the person with feelings of inferiority may feel depressed when he achieves something. The distorted self-structure and its defenses are firmly established, and habitually the disturbing experience is quickly glossed over as a bad experience, and the distorted self-structure is maintained (Coopersmith, 1967).

It is important to note that being correct about oneself has a certain reward value, even if the assumption is negative. However, while we need to be aware that self-esteem tends towards consistency, changes in self-evaluation nevertheless are possi le. New attitudes filter slowly through to the self-concept, creating a flexibility and allowing for psychological growth. The fact that new ideas are assimilated and old ones cast out may be due to the fact that the individual has a need for positive regard from himself and others, and a need to maintain and enhance this regard (Combs and Snygg, 1951; Rogers, 1959).

Much theory and research points to the importance of the self-evaluation construct in understanding and predicting behaviour (eg. Rogers, 1954). It is generally believed that self-esteem is developed in the early years,

and that it stabilises once self-differentiation and self-definition have taken place (Marcus, 1980).

However, Maddi (1968:225) presents a different view, and suggests that the research supports models stressing an ongoing process of psychological growth :

> There seems ample evidence for radical changes in personality following the childhood years. In addition, there is also evidence suggesting that the dual processes of differentiaion and integration that mark psychological growth continue into adulthood. Perhaps the radical changes and reversals in the content of personality are occurring all the while that the complexity of the person, in the sense of differentiation and integration, is increasing gradually in a generally undirectional way.

This view justifies using parents in self-esteem enhancement programmes. While each parent has an opportunity for psychological growth, she is in a position to transmit new attitudes and feelings to her child, and so is able to shape his self-concept and evaluation.

Some researchers have employed intervention strategies which seek to change the behaviour of significant adults in a child's life in order to increase the child's self-esteem.

Schleicher (1969) assessed whether a parent education programme of six weeks duration would effect changes in the self-concept of the mentally retarded children of these parents. An experimental group (n = 16) and a no-intervention control group (n = 20) were used. The children were all enrolled in classes for the educable mentally

retarded in a rural school. The subjects, all fro ow-income families, ranged in age from seven to ten, and had IQ scores between fifty and eighty. The children were evaluated prior to and after the parent education programme. The experimental group did not show any significant changes in self-esteem when compared with the control group, and the hypothesis was thus not supported.

Mangano and Towne (1970), conducting a similar study with parent education programmes found significant increases in self-concept as a result of treatment. Brookover, La Pere, Hamachek, Thomas and Erikson (1965) concluded that the self-concepts of low achieving students could be enhanced by working with their parents.

Overman (1974) examined the effects of a parent education programme on the self-concepts of parents and their children. Ninety parents and their children were randomly placed in parent education or control groups. The Self-Esteem Inventory, Parental Acceptance Scale, Primary Self-Concept Inventory, and the Inferred Self-Concept Scale were administered to parents, teachers and children. Posttest scores revealed no significantly higher mean scores for parental esteem or acceptance. However, trends were observed in higher mean scores for parental acceptance. There was no significant increase in the children's self-esteem. Significant positive correlations were found between parental esteem and

acceptance of the child. As with White's (1974) study, no pretest was conducted. This limits any consideration of change as a result of the programme. The present study hopes to correct this by pretesting all subjects.

Williams (1975) evaluated the effects of a self-esteem training programme on parents and their pre-kindergarten children. Thirty mothers took part in the programme and were randomly assigned to three equal groups identified as experimental group, control group 1 and control group 2. The experimental group received eighteen hours of training in self-esteem over a three month period. Control group 1 mothers participated in eighteen hours of instruction in areas of child development other than self-esteem. Control group 2 mothers received no intervention. All mothers were administered the following pre-post test: Self-Esteem Inventory, Parent Questionnaire and Behaviour Rating Form (BRF). The teacher also completed a BRF on each child. All thirty children were administered a pre-post Self-concept and motivation Inventory.

Results indicated a significant difference in the self-esteem scores of the mothers of the experimental group as well as several childrearing attitudes, which was not demonstrated in the control group. However, there was no difference between the groups on the children's self-concept or motivation scores, although a trend analysis suggested a difference in self-esteem behaviours (BRF) between the experimental and control group children.

Schofield (1976) examined the effects of two parent education programmes on children's self-esteem and parental attitudes toward child rearing and education. Forty-two parents and their children participated in the study. Group 1 (n = 14) received standard PET instruction, Group 2 (n = 14) were involved in a behavior modifi n programme, and Group 3 (n = 14) was a voluntary control group. Pre- and post-treatment assessment took place on the following measures : the Hereford Parent Attitude Survey, an education scale devised by Kerlinger and Kaya, and the Coopersmith Self-Esteem Inventory, which was administered to the children. Children of parents in both experimental groups showed positive gains in self-esteem that were not significantly different at the 0,05 level. However, when compared with the voluntary control group, significant differences were found on the posttest scores between PET children and the control group. Parents participating in the PET programme showed an increased understanding and acceptance of their children, and made significant gains in the direction of progressive educational practices. Schofield (1976) concluded that PET was a superior mode of parent education to a behaviour modification programme.

Nordal (1976) determined the effects of Adlerian Parent Training on maternal self-esteem and child rearing attitudes, on learner self-concept, and on the home and school behaviour of the pre-school child. Sixty-three mother-child dyads participated in the programme. Parent

training for the mothers in the experimental groups was of five-weeks duration with one two-hour session weekly. The training groups were both didactic and discussion oriented, and focused on understanding the child's behaviour from an Adlerian point of view. The experimental children participated in the DUSO guidance programme thirty minutes weekly over a ten-week period. There were three experimental groups: mother-child dyads where both mother and child participated in programmes, dyads where only the mother participated in the programme, dyads where only the child participated in the programme, and finally a control group which received no intervention.

All mothers completed the Tennessee Self-Concept Scale, and the Anderson Behaviour Rating Scale for their children pre- and post-treatment. The Mother-Child Relationship Evaluation was completed posttreatment only. Children were evaluated on the Florida Key for learner self concept, and on the Anderson Scale by their teachers. The findings of the study indicated that the training groups resulted in increased maternal self-esteem, more positive child-rearing attitudes and in improved child behaviour at home. Additionally, children not participating in the study showed improved peer and teacher relations. Learner self-concept improved as a result of the preschool programme.

From the research, it is evident that there are no consistent findings regarding the efficacy of parent education programmes in altering mother and child self-esteem. It is necessary, however, for the authors of these studies

to provide more detailed information about these parent education programmes in order to determine whether the programme itself is ineffective in altering self-esteem, or whether utilising parents as change agents for enhancing self-esteem is an ineffective strategy.

CHAPTER V

METHODOLOGICAL CONSIDERATIONS

A number of methodological problems may have influenced the outcome of this study. It is important that they receive consideration in interpreting the present findings, as well as in the planning of future research.

5.1 Design

The study was based on the Pretest-Posttest Control Group Design (Campbell and Stanley, 1966). This design is strongly recommended in the methodological literature, since it fulfills many of the requirements for both internal and external validity (Campbell and Stanley, 1966; Kerlinger, 1973; Nachmias and Nachmias, 1976).

The Pretest Posttest Control Group is considered internally consistent, since it controls for extraneous variables such as history and maturation (the events and processes taking place in the subjects between testings), selection bias, and loss of subjects (Campbell and Stanley, 1966). The major problem with the design pertains to its external validity, or generalisability, in terms of interaction effects.

It is felt that the outcome of some experimental variables may be affected by the pretest (Kerlinger, 1973; Solomon, 1949). For example, in the present study, the pretesting on a battery of self-esteem tests may have sensitised mothers to a particular problem, focused their attention on it, and so increased the effects of

the intervention programmes. Conceivably, then, such a programme would be effective for a sensitised (pretested) population group only. However, while a sensitising effect has been mentioned in anecdotal accounts, research results show either no effect or a dampened effect (Campbell and Stanley, 1966).

A further difficulty with the use of pretest-posttest scores is the fallibility of the instruments used to measure the change (Bereiter, 1967). This means that the difference score is affected by the reliability of the scale. Lord (1967) has proposed a mathematical correction which would eliminate the influence of pretesting on the difference scores, and which would allow for the reliability of the scale. The formula for the measurement of true gain scores is denoted by X post - X pre.a, where

$$a = r_{pre.post} \cdot \frac{s_{post}}{s_{pre}} \cdot \frac{1}{\text{reliability}_{pre}} \quad \text{and}$$

r = correlation and s = standard deviation

5.2 Experimenter Bias

Bias occuring in behavoural research is viewed as a systematic error which artificially inflates or deflates scores within experimental or control groups (Crano and Brewer, 1973). Experimenter bias, then, may be seen as the influence of the experimenter which may exert some influence of the experimenter on the outcome of a study. Aspects of the experimenter which may exert some influence are sex, personality, experience and the expectations of the researcher (Kintz, Delprato, Mettee, Persons and

Schappe, 1965). Since bias is non-random, it may not be controlled for by increasing the sample size.

In order to control for experimenter bias, tests were administered in a group situation and instructions were printed on the questionnaires to minimise communication between the experimenter and the group. In addition, all intervention was provided by independent persons who did not have any vested interest in the outcome of the research. In this way, it was hoped that experimenter bias would be eliminated.

5.3 Subject Bias

This may be conceptualised as the systematic influence of the subjects on the outcome of a study, and includes their expectations, the response set bias and the tendency to respond in a socially desirable fashion. However, while such bias may have influenced the subjects' responses, it was assumed that it affected all mothers and the effects would then be equalised for all groups.

An analysis of variance conducted on the pre-scores revealed no difference between groups, suggesting the absence of any bias which would affect one group unequally.

5.4 Situational Variables

A bias may arise as the result of specific reactions in specific settings. Such differences were not intended, but may have arisen since the posttest questionnaires were completed at the mothers' convenience at home. Pretesting, however, was conducted in one room with the mothers present

as a group. It is hoped that the effects of completing the tests at home were equalised for all groups.

5.5 Generalisability

A number of sampling problems have limited the generalisability of these findings. First, the total sample size was twenty-four, a number which is not big enough to generalise to the population at large. Second, the group was homogeneous, and the outcome would apply specifically to a given population group. However, the advantage of this is that population characteristics would remain fairly uniform across the groups, and would be less likely to influence the results between the groups.

Nevertheless, it may be said in criticism of this study that the findings are limited to a specific population. Further consideration is given to sampling problems in Chapter VI.

CHAPTER VI

EXPERIMENTAL METHOD

The effects of three intervention programmes on mother and child self-esteem were evaluated. This chapter describes the design and method used in this study. A description of the tests and programme content is included.

6.1 Design

The effects of parent education programmes on mother and child self-esteem were investigated in the present study by comparing mothers receiving parent education to a control group. The study employed a Pretest-Posttest Control Group Design described by Campbell and Stanley (1966). Subjects were divided into four groups, three experimental and one control group. Pretesting of the total sample took place one week prior to the intervention programmes. The control group received no intervention. Posttesting took place one week after the intervention programmes finished. The effectiveness of the therapeutic intervention was evaluated by computing pretest-posttest difference scores for each group. This is shown in Table 1.

Table 1

The Pretest-Posttest Control Group Design for three experimental groups

Groups	Pretest	Intervention	Posttest	Difference
E_1	O_1	X	O_2	$O_2-O_1=d_{e1}$
E_2	O_1	X	O_2	$O_2-O_1=d_{e2}$
E_3	O_1	X	O_2	$O_2-O_1=d_{e3}$
E_4	O_1		O_2	$O_2-O_1=d_c$

The flexibility of the design is demonstrated. Comparisons may be made both within groups and between groups, making absolute and relative comparisons possible. Thus, in the present study, each intervention strategy may be assessed on its effectiveness in revising self-esteem, and also on its efficacy relative to a different intervention.

The size of the groups was an important consideration in the design of this study. Thomas and Fink (1963) note that the larger the group, the lower the participation by each member. In answer to this, Durrett and Kelly (1974) suggest that either the group sessions be lengthened accordingly, or the number of members in each group be reduced. Due to the practical difficulties of extending group sessions, Durrett and Kelly (1974) recommend smaller groups. The present study followed this suggestion, and thereby limited the total number of subjects.

Where the sample size is small, Roscoe (1975) suggests that the subjects be matched, or that there be tight control of extraneous variables. This was avoided, since, as Brownlee (1980) and Fincham (1976) have noted, unless there is a perfect correlation between the dependent variable and the matching variable, the matching of groups with possibly different population means may lead to unequal regression of the groups. Therefore, the groups were chosen from a homogeneous population in an attempt to control for any extraneous subject variables which might influence the outcome of the study.

Randomisation of subjects is considered important in any research, in order to control for the effects of history and maturation (Kerlinger, 1973). This was not entirely possible owing to practical considerations. However, it is hoped that the homogeneity of the sample and the pretest-posttest design will correct any bias arising out of this.

6.2.1 Subjects

The subjects of the present study consisted of twenty-four mothers of children attending a Primary school in the northern suburbs of Johannesburg. All children were in the first or second grade. Where there was more than one child who qualified for inclusion in the study, the eldest child was chosen as the subject. The reason for this was that most children in the study were the eldest of a number of

siblings. It was hoped that this would control for any bias resulting out of sibling rank.

6.2.2 Mothers

At the time of the study, all the mothers in the sample were living with their spouses. Only one mother, in the training group, had been married a second time. The reason for this was the death of her first husband. Since the child included in the study was from her present marriage, it was assumed that this would not bias any results.

The religious backgrounds of the subjects differed widely: 10 were Protestant, 3 were Catholic, 3 were Jewish, 1 was Anglican and 7 did not affiliate with any religious group. Although this grouping appears to be unequal, it was hoped that it would not exert any influence on the results of the study.

Two factors which may have influenced the reactions of the mothers to the intervention programmes were age and the number of years which they had been married. The average age of the mothers was 35,7 years, with a minimum of 26 and a maximum of 43. A chi-squared analysis revealed no significant difference between the groups on the basis of age.

6.2.3 Socio-Economic Status

Socio-economic status has been shown to be an important factor affecting the outcome of groups (Anchor and Thomason, 1977). The most important

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determinant of socio-economic status in western society is occupation (Oppenheim, 1972). An examination of the occupations of the fathers of children in the study showed that 75% were professionals and 25% were businessmen. All fathers ranked in the first two classes of the Hall-Jones Scale of Occupational Prestige for males (Hall and Jones, 1954).

All mothers had matric, and 83% had received higher education. The mean education level was three years of university education. A chi-squared analysis revealed no significant difference on the basis of education.

It appears that the sample is reasonably uniform with regard to socio-economic status, and that this is a factor unlikely to influence the results of the present study.

6.2.4 Volunteer Subjects

According to Rosenthal (1965) volunteering is a non-random event, influenced by situational and personal variables. Since the mothers were contacted by letter, any situational variables described by Rosenthal would appear to be minimised. However, personal variables would definitely influence a subject's decision to participate in a research programme. Rosenthal describes the personal variables common to volunteer subjects as greater intelligence, interest, motivation, unconventionality and need for approval. Consequently, any programme may

reflect better results on such a population than on another population not possessing these traits.

6.2.5 Systematic Error

Systematic error occurs when the sampling is non-random (Cochran, Mosteller and Tukey, 1971). Two instances of non-random sampling may have had some bearing on the outcome of this study.

First, mothers were not always randomly assigned to groups. Due to the schedules of the group leaders, different groups were held at different times. This meant that only certain mothers could attend certain groups. Consequently, working mothers attended the evening group, while housewives attended the morning and afternoon groups. A systematic error occurred with all the mothers in the training group being housewives while others were mixed.

Second, a number of mothers dropped out of the programme. After an initial dropout rate of 12,5% of mothers who had agreed to participate but then opted out, the programmes were begun with ten subjects in each group. Eventually, the number was reduced to six per group, since some mothers were dissatisfied with their groups, some did not attend all sessions and one mother became ill. A high dropout rate has been reported by other researchers, and appears to be a fairly common occurrence (Chilman, 1973; Tracey, 1971).

Although there does appear to be a systematic sampling error, this occurred as a result of practical issues and could not be avoided.

6.3 Testing Material

6.3.1 Coopersmith Self-Esteem Inventory (SEI)

This is a 25-item self rating form based on items from the Rogers and Dymond (1954) scale; several original items have been included. Five psychologists sorted the items into two groups - those indicative of low self-esteem and those indicative of high self-esteem. Items that seemed repetitious, ambiguous, or about which there was disagreement, were eliminated. The set of items was then tested on a group of 30 subjects for comprehensibility. The final inventory consisted of 50 items concerned with the subject's self-attitudes in four areas: peers, parents, school and personal interests.

This study used Form C of the Coopersmith SEI, a scale developed from an item analysis of the original inventory and modified for use with adults. The form of the distribution is skewed in the direction of high self-esteem, with the mean score for groups 76.1, and S.D. 11.1. Coopersmith (1967) views the upper quartile as indicative of high esteem, lower quartile as indicating low self-esteem, and the interquartile range as indicative of medium self-esteem.

The test-retest reliability after one week was.93, after a five month interval it was .88 on a group of thirty subjects. After a three year interval, the test-retest

reliability on a group of 56 subjects was .70 (Self-Esteem Institute, 1974). Bedeian, Ralph, Teague and Zmud (1977) cite a test-retest reliability of .81 after a five week period. The internal consistency of the inventory is validated by Kuder-Richardson KR20 coefficients of .73 and .71 for both administrations.

Coopersmith (1967) provides more validation for his scale than exists for many others, and there are more than 150 studies which have employed these inventories. In general, these show that the scales are valid for adults and children, ranging across the entire socio-economic groups, and members of many ethnic and subcultural groups (Donaldson, 1974; Fullerton, 1972; Ketcham and Morse, 1965; Kimball, 1972; Kokenes, 1973; Strodtbeck, 1972).

Although the Coopersmith scales have obvious advantages in the high reliability and validity coefficients, they are not without problems. The Coopersmith SEI is a single-stimulus scale, where the respondent reacts to the description stimulus by indicating whether it applies to him or not. There are thus only two categories to the rating scale - appropriate or inappropriate, yes or no. The number of steps in the rating continuum are considered important. Guilford (1954) reports that the reliability of a scale tends to increase rapidly as the number of steps is increased from two. It seems that in this format, the rating of a stimulus is undoubtedly affected by the nature of the other stimuli in the list in producing

mental sets or semantic frameworks. These stylistic response sets are not supposed to be a problem with scales which use multiple-point ratings. However, in defense of simpler rating scales, Wells and Marwell (1976) note that self-esteem measures involve collections of items as a sample from some broad content areas. Characterising a person's self esteem is dependent on the entire set of items and its adequacy as an item sample. Thus, the number of items in the measure may be more important than the number of items in the rating scale for each item. The use of more items may present a more thorough sampling from the range of possible descriptions, resulting in increased validity and generalisability, thereby producing a better instrument (Wells and Marwell, 1976).

Bedeian and Zmud (1977) examined the convergent validity of the Coopersmith SEI and found that the correlations were fairly low with the three Adjective Checklist Scales. They concluded that this data did not provide strong evidence for convergent validity of the inventory, and that it underscored the ambiguity surrounding the definition of the self-esteem construct

In general, the psychometric literature cautions the researcher against response sets, in particular, social desirability responding. Essentially, social desirability responses refer to stereotypical responses which reflect what is socially accepted or valued,

rather than individual differences in self-evaluation. Many studies consider social desirability to be the most serious validity threat for self-esteem measurements, even suggesting that such measures principally index social desirability differences (Crowne and Marlowe, 1964). The Coopersmith SEI has a correlation of .75 with the Edwards Social Desirability Scale (Crandall, 1973). However, Wells and Marwell (1976) regard the threat of social desirability distortions to measured self-esteem as plausible but largely unsubstantiated. The possible influence of social desirability does not routinely invalidate self-esteem indexes, but suggests that care should be taken interpreting and labelling measurement responses.

Despite its problems, it was felt that the Coopersmith SEI was a good test for use in the present study because of its wide usage and good reliability co-efficients.

6.3.2 Coopersmith Behavio r Rating Form (BRF)

The items on this scale were selected after a series of observations of child behaviour in and out of the classroom, repeated interviews with teachers, principals and a clinical psychologist, and evaluations and discussions with a research committee. On theoretical and empirical grounds, the behaviours were assumed to be an external manifestation of the person's prevailing self-appraisal.

There are two parts to the thirteen items on the Coopersmith BRF. The first ten items provide an appraisal

of behaviours that have been associated with pose, assurance and self-thrust. These ten items include reactions to new situations and failure reactions to criticism and failure, sociability with peers, self depreciation and hesitation to express opinions publicly. The second part of three items provides an index of behaviours that are frequently defensive in nature. These include bragging, domination or bullying and attention seeking.

Each behaviour is rated on a five-point scale. The rating indicative of high self-esteem behaviour has been varied in position from right to left, always to never, to minimise superficial response bias. Each part of the test is scored separately, according to a key. Since the maximum score on each item is five, the maximum total is fifty (10x5 = 50) on Part I. This total is multiplied by two to provide a base of one hundred (50x2 = 100). For Part II, the total of the scores reported *per se* provide a maximum of fifteen. Higher scores indicate greater defensiveness, and Coopersmith (1967) considers a score of ten or more significant. Thus, the Coopersmith BRF yields two scores : Esteem Behaviour and Defensive Behaviour.

The test was standardised on 1,748 children. In the initial use of the BRF, two raters were used for each in order to establish an estimate of inter-rater reliability. On a sample of 71 subjects, the inter-rater reliability

yielded a correlation co-efficient of .73. On the basis of this co-efficient, Coopersmith concluded that behaviour was being consistently observed, evaluated and interpreted.

The form of the distribution is skewed in the direction of high self-esteem, with a mean of 68.4 and an S.D. of 13.6. The mean for the girls is significantly higher than for boys ($F = 4.2$, $p < .001$). The test-retest reliability by one teacher after an eight week interval was .96.

A number of problems exist with this scale. Despite the seemingly high correlation of.73, Coopersmith (1967), among others, has found marked differences in the scales of measurement used by different raters. The auther of this study has attempted to obtain teacher ratings in addition to maternal ratings. These ratings will be correlated. It is hoped that this problem will be minimised in this fashion.

Coopersmith (1967) has found that there is a general tendency to rate girls higher than boys. To correct for systematic biases favouring one sex, and to control for differences in range, males and females have been separated, and separate scaled scores established. The mean for males is 65 and the S.D. = 16.2; for the girls, the mean rating is 71.3, the S.D. = 13.6.

The BRF was chosen because it seemed to fit well with the Coopersmith SEI. This means that both tests are measuring self-esteem according to the same definition. The chances of both scales measuring differing things

are minimal. It is hoped that the problems mentioned will be dealt with in a way that eliminates or minimises them.

6.3.3 The Relationship Change Scale (RCS)

The Relationship Change Scale (RCS) was developed by Schlein and Guerney (1977) as a measure that would be sensitive to change in the quality of a relationship. The scale assesses seven variables considered crucial in a relationship : satisfaction, communication, trust, intimacy, sensitivity, openness and understanding. The scale was modified slightly by the author of this study so as to assess the mother-child relationship. Three of the twenty-seven questions were removed, leaving a total of twenty-four items. Each item is presented with a rating continuum consisting of five steps. The subject checks the response appropriate to himself. The rating indicative of most change in the relationship has been varied from left to right to eliminate response set. In each case, choice a=1, b=2, c=3, d=4, and e=5. The maximum score on the test is therefore 120, and this was reduced to provide base 100.

Used as a postmeasure, the RCS provides a retrospective view of change in a relationship over the treatment period. The time period may be varied to fit the requirements of the research. In the present study, the time period used was eight weeks; the time period from the administration of the pretests to one week after the treatment.

To date, no test-retest reliability estimates are available. Because the scale is designed to assess short-term change, the retesting interval would have to be very brief : a matter of days or a week (Guerney, 1977). The retesting of the subjects in studies using this measure was done after a much longer interval than that, and consequently, there is no reliable estimate of reliability available from these studies. Nor have any independent studies been conducted. However, adequate reliability for purposes of group testing, as well as construct validity, can be reasonably inferred from the fact that experimental hypotheses tested via the RCS were confirmed by Schlein (1971) and Rappaport (1976) both reported in Guerney (1977)

Further evidence of concurrent validity is afforded by Schlein's (1971) study. The RCS correlated with two measures designed to assess specific components of relationship change. With the ninety-six couples used in his study, there were significant correlations of the RCS with the Satisfaction Change Scale (.49, $p < .001$).

The main drawback to this scale is its lack of empirical validation. However, it is felt that the areas it assessed were important to the present study, and consequently it was used.

6.3.4 The Satisfaction Change Scale (SCS)

The Satisfaction Change Scale (SCS) is a simple measure devised by Schlein, Guerney and Stover (in

Guerney 1977) to evaluate change in a subject's satisfaction in a given relationship over a specified period of time. The measure consists of two items only; the first probes a relationship retrospectively, the second, the current relationship. Each item is rate on a five point scale.

In scoring, answers a through e are assigned a score of 1 through 5 respectively for each of the two items. A comparison of the two questions assesses change, and the score for item 1 is subtracted from item 2. Thus the higher the difference score, the greater the improvement.

This scale will be administered post treatment only, and the difference score will yield a measure of the subject's view of her current satisfaction in the relationship with her retrospective view of her satisfaction prior to treatment.

The same statements concerning reliability that were made for the RCS apply to the SCS. Construct validity for the measure can be inferred from the confirmation of Rappaport's (1976) hypothesis using this measure (i.e. a treatment programme would result in various kinds of relationship improvement). A similar hypothesis by Schlein (1971) was not confirmed. However, Guerney (1977) views this failure as a result of the population Schlein (1971) used, rather than of a lack of reliability or validity on the SCS.

The Schlein (1971) study also affords some evidence of concurrent validity in that the SCS correlated with some other measures designed to assess change in the relationship. The correlation with the RCS was .49 ($p < .001$).

The SCS will be used in conjunction with the RCS, and as a check on it. Because of its brevity and simplicity, it has been included in the test battery.

6.3.5 Semantic Differential

This is a technique rather than a scale developed by Osgood, Suci and Tannebaum (1957). The semantic differential generally consists of two-stimulus or bipolar rating tasks which involve responding simultaneously to two stimuli which jointly define a bipolar dimension of content. As a kind of quantified pairwise comparison, respondents indicate which of the two descriptions (each usually a single adjective) is most appropriate by locating themselves along a numeric scale where the two descriptive stimuli define the opposite poles. An advantage of double-stimulus scales is that the meaning of an adjective may be unequivocally defined, enabling the subject to respond to the correct connotation. The juxtaposition of adjectival opposites thus specifies or clarifies the joint meaning.

Semantic differentials almost always have a seven-point rating scale, but this is rather convention than requirement. While the discriminatory information in a

rating scale might be seen as a function of the number of points, a common argument seems to be that most people cannot consistently discriminate their feelings and attitudes beyond a seven-point classification (Osgood, Suci and Tannebaum, 1957; Wells and Marwell, 1976).

Since the semantic differential is a technique rather than a scale, it may be used adaptively. Each researcher can design a measuring instrument to fit his particular needs in terms of time and content. The semantic differential scale used in this study was devised by Shmukler (1978) and used in a study by Oppler (1978). (See Appendix D). The scale consists of sixteen bipolar opposites, and requires the mother to rate her child. A second identical scale requires the mother to rate her ideal child. The purpose of this was to compare real and ideal concepts of the child.

The semantic differential lends itself conceptually to the technique of factor analysis, and the development of the technique has been heavily dependent on factor analytic research (Wells and Marwell, 1976).

6.3.6 Parent - Attitude Survey

This study used only one of the five subscales comprising the Hereford Parent-Attitude Survey, namely, the confidence in the parental role subscale. It was felt that this was an important aspect of parenting which relates to self-esteem.

The scales initially constructed by Hereford in 1963 for use in research on parental attitudes towards childrearing. More than 200 items were assessed by five judges working independently of one another, and were classified according to their appropriateness for the respective areas. Through this method, twenty-five items for each subscale were selected. The majority of items showed 100 per cent agreement among the judges, and most of the remainder obtained agreement from four of the judges. An item was not adopted unless three of the judges agreed on its placement in the scale.

The 125 items became the preliminary form of the scales, and were tested on seventy-two parents. After this, the scale was refined, and the discriminatory power of each item for its particular scale was assessed. Items were eliminated when there was no relation between the item score and the total scale score. The discrimination index employed for this selection consisted of the product-moment correlation co-efficient between each item and its total scale score.

The fifteen items with the highest correlation co-efficients in each of the five areas were used in the final version of the Parent-Attitude Survey, making a total of seventy-five items. Most items are negatively phrased since these appear to have the highest item-scale correlation. An additional two items were included as "buffers", to counteract the tendency of many people to form response sets.

Items on the confidence subscale are concerned with the parent's feelings that she has more problems than most parents, and feelings of uncertainty and unsureness as to what to do about these problems. Other items imply that being a parent requires suffering and sacrifice, and is a time-consuming and thankless task.

Each item consists of a statement for which the parent marks one of five responses : Strongly Agree, Agree, Undecided, Disagree, or Strongly Disagree. The extremes of this five-point scale were scored +2 or -2, depending on whether the item was stated positively or negatively. Likewise, the Agree and Disagree choices were scored +1 or -1, and the Undecided response was scored zero. The algebraic sum of the item scores in each area served as the parent's total score for that attitude area.

The reliability of the five attitude scales was computed by the split-half method. The reliability co-efficient for the confidence subscale was .78. This is well within the satisfactory range of reliability for a scale of this type. In addition, Hereford (1963) supplies an intercorrelation matrix showing that the subscales are independent and measure specific attitude areas.

Since its use by Hereford (1963), the Parent-Attitude survey has been used by numerous researchers in the field. These include Andelin (1975), Gabel (1972), Hanley (1973), Larson (1972), Lillibridge (1971) and Schmitz (1975). Most of these studies are well controlled, and the Parent-Attitude Survey has been used successfully.

6.3.7 The Incomplete Sentences Test

Lytton (1971) recommends a multimethod approach to data correlation, in order to minimise the effects of bias or distortion arising from the use of single criterion measures. Tavormina (1974:833), discussing parent education research, states :

> A combination of parent reports attitudinal measures and observer variables will provide a broad-based, representative comparison of effectiveness.

Accordingly, the present study includes a subjective report of mothers' perceptions of the value and outcome of the groups. The Incomplete Sentences Test is intended to guide members' reports of the group process only, and three open ended sentences were included (See Appendix C).

No categories for the ratings of mothers' responses were developed. The analysis of the data is qualitative rather than quantitative.

6.4.1 The Intervention Programmes

The intervention stretched over a six week period, and mothers met weekly for a two-hour session. The programmes were conducted by people with specialised knowledge in each particular field. The training group was conducted by a psychologist who had attended Carkhuff's training programme. The discussion group was facilitated by a psychologist experienced in encounter groups and group process. The didactic group received lectures from five different people (one provided two lectures), each with experience and interest in a field of child development.

Although an intervention period of six weeks is not considered adequate by some researchers (eg. Tavormina, 1974), the length of the programmes was influenced by practical issues.

The duration of the intervention was somewhat shorter than that of Carkhuff and Bierman (1970), but Carkhuff (1971) has stressed the flexibility of his programme. The length of the present programme compares with those of Hereford (1963) and Renz and Cohen (1977). Trakas and Lloyd (1971) describe an encounter group programme which lasted six sessions. Seventy-eight group members improved fifteen per cent over ninety patients receiving individual psychotherapy. Furthermore, Corsini (1968) and Waxer (1977) have noted that pervasive and desirable changes are possible with very short-term group intervention. In the light of these findings, it does not seem that the effects of the present intervention will be limited by shorter programmes.

In conceptualising short-term therapeutic intervention, Phillips and Weiner (1966) stress the importance of precise, carefully planned communication as a means to increased structure and hence to efficient behaviour change. To this end, they advocate detailed delineation of current problems, rational and effective communication between the parent and the therapist, and planning successive steps in the proposed change programme.

Each intervention strategy used in this study has attempted to follow these suggestions, but each has layed stress on a different aspect. The didactic approach has

focused on common problems experienced in relation to child development rearing. The discussion approach focused on communication between the therapist and the group, and the training group received instruction in bettering parent-child communication.

6.4.2 The Didactic Group

Some of the earliest parent education programmes employed a classroom model in which the therapist lectured for part of each meeting (Marsh, 1963; Pratt, 1963). The treatment described here differs from these earlier methods in that the didactic technique is employed within an interactional group setting. This meant that parents were able to discuss personal problems relative to the lecture topic, and obtain feedback from the lecturer and the group. The goal of this approach, then, may be seen as the didactic treatment of the common problem (Shrader, Altman and Leventhal, 1969).

In describing their method of short-term group therapy, Shrader, Altman and Leventhal (1969) have emphasised a relatively homogeneous group of parents seeking help with a common problem, and a carefully prepared body of information relevant to the problem. This would then allow for "Efficiency, clarity of goals and direction, and an atmosphere of positive problem solving in the group process ..." (Shrader, Altman and Leventhal, 1969:496).

It was decided to follow the recommendations of Shrader, Altman and Leventhal (1969) in principle when

designing the programme content. However, since one of the goals of the intervention is prevention, problems common to parents from a developmental aspect of child rearing were focused on, rather than personal problems. Despite this emphasis, individual problems were dealt with as they arose.

Donofrio (1976) proposed a method of short-term group intervention which is both preventative and curative. He suggested that didactic parent groups could be based on a system revealing the origins of children's problems. Accordingly, Donofrio (1970) delineated the source of childhood problems into three developmental areas. These are (a) deprivation of one or more psychological needs (i.e. love, security, recognition and a sense of success), (b) constitutional and developmental deficits or lags, and, (c) a hyperkinetic syndrome or minimal brain disfunction. It can be seen that a didactic programme aimed at the treatment and prevention of childhood emotional disorders could be based on Donofrio's (1970) scheme, and that the content would be sufficiently broad in its applicability to common and personal problems.

The didactic programme attempted to provide a series of lectures which followed Donofrio's (1970) scheme. Six lectures were presented on the topics of children's growth, and learning disabilities. Most aspects of Donofrio's scheme were covered, although the area of developmental deficits was not directly

covered in a single lecture. A brief outline of each lecture is presented below.

The first lecture focused on creativity and the importance of play. Free and spontaneous play was emphasised as a facilitator of social, emotional and intellectual growth. The rationale was drawn from Rogerian theory, and mothers were presented with the idea of a fully functioning person as one who is creative, spontaneous and open to change. Imaginative play is seen as leading to the development of increased self-awareness, imagery skills, verbal skills, emotional awareness and sensitivity, an awareness of varied social roles, flexibility in social stiuations and creativity.

Two means of promoting imaginative play in children were described. First, emphasis was layed on congruence, unconditional positive regard and empathic understanding within the mother-child relationship. Second, more direct ways of stimulating imaginative play were discussed. To this end, mothers received a handout (See Appendix B) which describes fantasy games and methods of encouraging creativity.

The second lecture was designed to complement the first. The topic under discussion was child art. A number of drawings and art works by children were displayed, and the lecturer showed how these could be used as a means of communicating with the child. Mothers were presented with the thesis that a child's art reflects his perception of his world, and also the feelings and emotions he has in

relation to it. The focus of the lecture was on allowing the child freedom to express himself artistically, whatever the results of his efforts. Furthermore, these artistic efforts could be used as a means of improving interpersonal communication.

The third lecture was much more formal, and dealt with learning disabilities. These areas were covered : the nature of learning disabilities and contributing factors, identification of learning disabilities, and finally, treatment. Both physical and psychological disabilities were discussed, as well as available treatment. Part of the lecture was devoted to discussion, and many mothers brought up personal problems. Informal advice on dealing with a learning disabled child was given to mothers.

The fourth lecture dealt with the topic of discipline, and mothers were introduced to the concept of child abuse. A wide definition of abuse was given, which aimed at drawing attention to forms of abuse (e.g. psychological) other than physical punishment. A distinction was made between abuse and control. The lecture focused on the child's need for limits, and the difference between allowing the child sufficient autonomy for healthy adjustment and being too permissive. The idea of control was discussed in relation to child rearing, and a warm, accepting relationship with firm control was seen as desirable. Furthermore, the tone of the parent-child interaction was seen as more important than an isolated reaction to

any single situation. In conjunction with this, the difference between punitiveness and control was discussed. Means of attaining healthy control for the benefit of the child's emotional development were discussed.

The fifth and sixth lectures were fairly informal, and the topic dealt with was the emotional development of the child. The presentation focused on emotional development from infancy through to middle childhood. Emphasis was layed on the emotional climate within the family that would facilitate healthy adjustment. These conditions would enable the child to value himself, trust others, and have faith in his own abilities. Three facilitative conditions were stressed : (a) the natural bond that exists between the mother and child, and the intuitive response of the mother to her child. Parents were urged to act in accordance with their intuitive feelings, rather than pay heed to the 'shoulds' of so many authorities. However, it was clearly stated that the marital bond assumed precedence over the bond between either parent and child. (b) The Importance of encouraging autonomy and independence while still meeting the child's dependency needs where necessary. The lecturer stressed that parents should not give in to the child easily, and that, in fact, at times the child needs control and feels relief when his parents 'take over'. (c) The importance of the child's self esteem was discussed, and the significance of the parental role in the healthy

development of self-esteem.

6.4.3 The Discussion Group

The discussion group focused on parental awareness, understanding and acceptance of the child's feelings. The facilitator aimed at providing a setting in which members could discuss feelings and problems related to motherhood and child-rearing. A non-directive approach was used. Emphasis was on promoting group acceptance and solidarity, reducing members' defensiveness, and encouraging self-exploration and understanding. Information on normal children and their behaviour was provided as requested. The approach followed Tavormina's (1974) recommendations.

The rationale for the discussion group was twofold. Firstly, in providing a climate of initial trust, it was hoped that mothers would share their problems openly and honestly. This would lead them to the realisation that other mothers have similar problems, and would enable them to move to a greater acceptance of themselves. Secondly, the group aimed at providing an experience of meaningful and growth-promoting interpersonal relationships. It was hoped that members would in this way develop an increased sensitivity towards themselves and others, in particular, their children.

6.4.4 The Training Group

The training group followed the procedure outlined by Carkhuff (1971). It is a skill-oriented approach, and is designed to provide parents with better communication skills.

The programme was a workshop or laboratory experience to train parents in the interpersonal skills of attending, observing, listening and responding. Mothers were provided with a set of notes (see Appendix A) and these provided the text for each session.

At each of the training sessions, an interpersonal skill was defined and explained, demonstrated, and practised by the parents. The latter is in accordance with Carkhuff and Bierman's (1970) assumption that for parent training to be maximally effective, there needs to be practice of the interpersonal skills as a component of one overall training programme. Without such practice, although the parents can learn skills, there is little generalisation of skill usage to the parent-child situation. Furthermore, the parents were given homework assignments between sessions to read the notes and practise the skills with their child.

The rationale of the training group was that mothers would be able to listen to and accept their children, and in doing so provide them with warmth and understanding. This would help the child to feel secure and better about himself.

The training was conducted by a psychologist who had experience with the programme, and who was functioning well above the minimum facilitative levels of the interpersonal skills being taught.

6.5 Procedure

Subjects for the study were obtained from a primary school in the western suburbs of Johannesburg. All children in grades I and II were requested to take home a letter describing the education groups (see Appendix E). The benefits of participating in these programmes were discussed, and interested parents were asked to respond by returning the tearsheet to the school.

The letters informed the mothers that they would have to complete some psychometric tests before and after the programme. The letter stressed that all data would be treated in confidence.

Mothers who responded positively were requested to indicate on a timetable when they would be able to attend groups. They were then placed as randomly as possible into three groups. In some instances random placement was not possible since a few mothers could attend at one time only.

The control group consisted of mothers who had initially expressed interest in the programme, but who had been unable to attend. The reason for this was a difficulty in co-ordinating programme times with work demands.

The first group meeting was devoted to testing. The experimenter handed out the questionnaires, and was available to answer any questions should they arise. The session lasted approximately two hours, and the confidentiality of the material was stressed again.

The intervention programmes began the following week, and continued for six consecutive weeks. Groups met formally for two hours at each meeting. Each programme was conducted by qualified and experienced people.

Post-testing was conducted one week after the intervention programmes had formally ended. Test batteries were handed out by group facilitators in two cases. Again mothers were assured of confidentiality, and were thanked for their co-operation.

CHAPTER 7

RESULTS

The first part of this chapter presents the empirical findings of the study. The second part discusses the qualitative results of the Incomplete Sentences Test.

7.1 Quantitative findings

All the data obtained were analysed using parametric statistical procedures. Although the data were obtained from a small sample, Roscoe (1975) notes that the F - distribution is quite robust with respect to the assumption of normality, even if very small samples of equal size are used. Boueau (1960) and Lindguist (1953) have confirmed this. Furthermore, the measures used were continuous with equal intervals, and homogeneity of variance in the pretest data was established using Hartley's F maximum test, as it has been shown to be the most robust and simple test of its kind (Winkler, 1967). The results of this analysis are presented in Table 2.

Table 2

Fmax ratios for homogeneity of variance on pretest data

Instrument	Fmax ratio	df,k	p
SEI	4,2	5,4	< 0,05
BRF (mothers)	4,3	5,4	< 0,05
BRF (teachers)	4,5	5,4	< 0,05
Hereford PAS	1,76	5,4	0,05
SD	5,65	5,4	0,05

It can be seen that the pretest scores are homogeneous. This implies that any differences in the variances on the posttest would be a result of the intervention techniques used in the study.

Since the various treatment effects only influence the posttest scores, it would be quite legitimate to subject the posttest data to a simple ANOVA and the resulting F ratio would then be measuring the main effect of treatment (Huck and McLean, 1975)

Although such an approach is valid, Huck and McLean feel that pretest data should be included in order to adjust the posttest means to account for initial differences between the treatment groups, and to increase the power of the analysis by reducing the within group variability. They discuss three ways in which the pretest data can be used together with the posttest data to ascertain significance

of the main effect (treatment). First, if an analysis of covariance (with pretest scores as the covariate) is used, the resulting F ratio will provide an indication of treatment differences. Second, if gain or difference scores are used in an analysis of variance, there will be a single F ratio which deals with the main effect. Third, if the data is analysed on a repeated measures ANOVA, the F ratio for the Groups X Trials interaction will also point to the main effect of treatment.

However, Huck and McLean point out that there are a number of factors which suggest that a repeated measures ANOVA is the least appropriate technique to use for statistical analysis of pre and posttest data. They state that the F ratio for the main effect of the between subjects factor is too conservative, since the treatment effects influence the posttest data only. Since the various group means will probably be very similar on the pretest, there will be differences between the treatment effects which exist at the time of posttest only, causing the effect to be 'spread out' over both trials. This means that estimated treatment effects when computed will be only half as large as they should be.

Furthermore, it has been demonstrated algebraically hat the calculated interaction F ratio is closely related to the calculated F ratios in the gain score analysis and the analysis of covariance. In fact, the interaction F and the 'gain score F' will always be identical, while the

F ratio from the analysis of covariance will always approximate both these scores; the slight difference arising out of the lost degree of freedom in the covariance analysis. Finally, Huck and McLean contend that the third F ratio from the repeated measures ANOVA, the main effect of trials, is worthless from an experimental point of view, since causality is not demonstrated.

It has been shown, therefore, that the repeated measures ANOVA does not field any additional information beyond that which can be determined from a gain score analysis or a covariance analysis. However, in choosing a statistical procedure to analyse one's data, the power of the test is an important consideration. Huck and McLean argue that the analysis of covariance is a more sensitive test, and it has been shown to be a more powerful technique ith greater versatility. Furthermore, since a covariance analysis can do everything a gain score analysis can do, but not vice versa, they recommend the covariance analysis in place of the repeated measures ANOVA.

In keeping with the contentions of Huck and McLean, this study uses covariance analysis and simple ANOVA where the data have not lent themselves to covariance analysis.

In order to determine whether participation in a parent education programme held significantly raised the mothers' level of self-esteem, the scores attained on the Self-Esteem Inventory were calculated. Table 3 shows the means and standard deviations for maternal self-esttem.

Table 3

Means and standard deviations for mothers' ratings of self-esteem on the Self-Esteem Inventory

Group	Pre		Post	
	$\bar{x}$	SD	$\bar{x}$	SD
Training	66,6	25,8	69,3	22,3
Discussion	77,7	12,2	69,7	22,1
Didactic	74,3	25	79	13,4
Control	65,8	15,3	63,8	22

In order to determine whether there were significant differences between groups on the variable of self-esteem, the data were subjected to a covariance analysis (Table 4).

Table 4

Summary table for the Analysis of Covariance of mothers' ratings on the Self-Esteem Inventory

Source of variation	Sum of squares	df	Mean Square	F	p
Covariates	5051,92	1	5051,92		
Main Effects	696,27	3	232,09	1,17	$\geqslant$0,10
Between	5748,19	4	1437,05		
Within	3763,62	19	198,09		
Total	9511,81	23	413,56		

No significant differences between groups were observed which indicates that the parent education programmes failed to raise the level of maternal self-esteem.

Related to each mother's self-esteem is the confidence she feels in her role as a parent. This was measured by the Hereford Parent-Attitude Survey, and Table 5 shows the means and standard deviations of these scores.

Table 5

Means and standard deviations for mothers' ratings of confidence in the parental role on the Hereford Parent Attitude Survey

Group	Pre		Post	
	$\bar{x}$	SD	$\bar{x}$	SD
Training	15,3	5,8	19,3	5,4
Discussion	17,7	5,2	18	5,3
Didactic	13,6	6,9	18,2	4,3
Control	16,6	6,9	16,2	7,5
Total	15,8	6,25	17,925	5,725

In order to ascertain any significant differences between groups on this variable, the data were analysed using covariance analysis. Table 6 presents these results.

Table 6

Summary table for the Analysis of Covariance of mothers' ratings of confidence in the parental role as measured by the Hereford Parent-Attitude Survey

Source of Variation	Sum of Squares	df	Means Square	F	p
Covariates	378,46	1	378,46		
Main Effects	79,08	3	26,36		
Between	457,54	4	114,38	1,69	$\geqslant$ 0,10
Within	296,47	19	15,60		
Total	754,01	23	32,78		

There are no significant differences between the groups on the variable of confidence in the parental role.

Although no increase in mothers' self-esteem or confidence in the parental role took place, a measure of the mothers' acceptance of her child was ascertained using a semantic differential. This scale was developed by Shmukler (1978) by means of factor analysis. The level of parental acceptance was obtained by subtracting the 'real child' score from the 'ideal child' score (i.e. the difference score) on each bipolar scale and thus the lower the score the greater the level of acceptance. The means and standard deviations are shown in Table 7.

Table 7

Means and standard deviations for mothers' ratings of acceptance on the semantic differential

Group	Pre		Post	
	$\bar{x}$	SD	$\bar{x}$	SD
Training	13	10,69	16	15,31
Discussion	11,28	7,565	7,71	10,95
Didactic	15,14	4,67	9,7	7,4
Control	14,71	6,44	12,57	2,5
Total	13,53	7,34	11,49	9,04

An analysis of covariance was used on the acceptance scores of mothers to determine whether or not there were differences in acceptance scores between the groups and the result is presented in Table 8.

Table 8

Summary table for the Analysis of Covariance of mothers' ratings of acceptance as measured by the semantic differential

Source of variation	Sum of Squares	df	Mean Square	F	p
Covariates	11,09	1	11,09		
Main Effects	346,31	3	115,44	1,86	$\geqslant$0,10
Between	357,40	4	89,35		
Within	1179,93	19	62,10		
Total	1537,33	23	66,84		

There are no significant differences between the groups for the variable of parental acceptance, indicating that the mothers did not alter either their perceptions of the child as he is or the idealised perceptions in order to make them congruent.

Although there were no significant increases in the level of mothers' self-esteem, it is possible that the programmes facilitated some change in child self-esteem via the mother. This was tested using the Behavior Rating Form. Both mother and teacher ratings of child self-esteem were obtained and the means and standard deviations are presented in Table 9.

Table 9

Means and standard deviations of mothers' and teachers' ratings of child self-esteem as measured by the Behavior Rating Form

Group	Mothers				Teachers			
	Pre		Post		Pre		Post	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Training	66,3	20	71,4	14,8	66,5	14,03	69,4	14,7
Discussion	72,4	13,6	71,7	15	75,1	15,4	77,1	15,4
Didactic	64	13	73	12	76,3	13,3	76	14,4
Control	66,8	9,7	71	11,8	63,7	29,4	73,1	7,7

In order to determine whether there were any significant differences between the groups on this variable, mothers' ratings of child self-esteem were analysed using covariance analysis. The results are presented in Table 10.

Table 10

Summary table for the Analysis of Covariance of mothers' ratings of child self-esteem as measured by the Behavior Rating Form

Source of variation	Sum of Squares	df	Mean Square	F	p
Covariates	2363,36	1	2363,36		
Main Effects	228,09	3	76,03	1,65	⩾0,10
Between	2591,44	4	647,86		
Within	876,39	19	46,13		
Total	3467,83	23	150,78		

There are no differences between groups on mothers' ratings of child self-esteem. However, since mothers' ratings are notoriously biased, it was thought that there were not an accurate reflection of child self-esteem, and therefore an analysis of covariance was used on the teacher ratings of child self-esteem. The results are presented in Table 11.

In order to determine whether there were any significant differences between the groups on this variable, mothers' ratings of child self-esteem were analysed using covariance analysis. The results are presented in Table 10.

Table 10

Summary table for the Analysis of Covariance of mothers' ratings of child self-esteem as measured by the Behavior Rating Form

Source	df	SSx	SP	SSy	df'	SS'y	MS'y	F	p
Between	3	263,79	16,58	101,83	3	-161278,66	176,81		
Within	19	4096,83	26511,66	3366	19	3359,52	-53759,55	-304,04	<0,05
Total	24	4360,62	26528,25	3467,83	24	-157919,13			

There are no differences between groups on mothers' ratings of child self-esteem. However, since mothers' ratings are notoriously biased, it was thought that there were not an accurate reflection of child self-esteem, and therefore an analysis of covariance was used on the teacher ratings of child self-esteem. The results are presented in Table 11.

Table 11

Summary table for the Analysis of Covariance of teacher ratings of child esteem as measured by the Behavior Rating Form

Source of variation	Sum of Squares	df	Mean Square	F	P
Covariates	3280,09	1	3280,09		
Main Effects	36,77	3	12,26	1,44	⩾0,10
Between	3316,87	4	829,22		
	162,46	19	8,55		
	3479,33	23	151,28		

Again, there were no significant differences between the groups in terms of the children's self-esteem measure.

Although no treatment condition brought about any significant gains in self-esteem for either mother or child, there is a suggestion that some change in mothers' self-esteem has taken place, since the correlation of the pre and posttest data is only 0,38 ($t = 1,926$, $p \geqslant 0,05$). The smallness of this correlation implies that although there were no systematic changes in esteem, there were definitely fluctuations and inspection of the raw data indicates that both gains and losses in esteem occurred. The correlation between pre and post maternal ratings of child self-esteem is 0,83 ($t = 6,98$, $p \geqslant 0,0001$) suggesting that mother's ratings remained fairly stable across both testings. As a result of the difference in magnitude between these two correlations, the relationship between mother and child self-esteem was investigated. Data from the Self-Esteem Inventory and Behaviour Rating Form were analysed using a Pearson Product-Moment Correlation. The correlation between mothers change in self-esteem and child change in self-esteem (as rated by

(as rated by the mothers) is 0,69 (t =4,471, p 0,001). However, the correlation of these changes using the teacher rating of the child's self-esteem is significant but lower (r = 0,59, t = 3,42, p 0,01).

In order to determine whether there had been any gains in the quality of the mother-child interaction, the Relationship Change Scale was administered. This scale was developed by Guerney (1977) as a posttest only, and was administered accordingly. Hence, the control group was not given this test. The data were analysed using a simple ANOVA. The results are presented in Table 12.

Table 12

Summary table for the Analysis of Variance for ratings on the Relationship Change Scale

Source of Variation	ss	df	ms	F	p
Total	1756,5	17			
Between groups	52	2	26	0,229	0,05
Within groups	1704,5	15	113,6		

Inspection of Table 12 shows that the analysis of variance on parent-child interaction failed to indicate any significant differences between the three groups. In other words, no one method of parent education is significantly better in improving the parent-child relations

The Satisfaction Change Scale was developed as a check on the Relationship Change Scale. It, too, was administered as a posttest measure only and the results were analysed using a simple ANOVA. Table 13 below presents the findings.

Table 13

Summary table for the Analysis of Variance on the Satisfaction Change Scale

Source of Variation	ss	df	ms	F	p
Total	10	17			
Between groups	0,3	2	0,15	0,24	n.s
Within groups	9,7	15	0,65		

From Table 13 it may be seen that the analysis of variance on the Satisfaction Change Scale ratings also failed to yield any significant differences between the three groups. This is in keeping with results obtained on the Relationship Change Scale. This means that none of the intervention techniques are effective in facilitating change in the parent child interaction.

7.2 Qualitative findings

At the completion of the parent education programmes the participants were requested to complete a brief questionnaire (See Appendix C). Some comments about and attitudes of the parents towards various aspects of the intervention programme are reported. The assessment

which follows is based on the analysis of the questionaires which the eighteen participants completed and returned. There were no differences between the groups in the type of feedback. All mothers were positive about the groups they attended, and expressed many of the same sentiments, regardless of the type of programme. Responses to the questions are presented below.

I feel that the value of the group was for me .....

All mothers said that they came to realise that their problems were not unique, and that their child had the same difficulties as many of his peers. Parents gained insight into their own behaviour in relation to their child, and ways in which the relationship could be improved. One mother, writing of the "insight which Sandy (the facilitator) gave to the complex communication relationship" between parent and child reports, "For the first time I had a concrete way of initiating it".

Participants became aware of other parents' problems, with the effect that their own difficulties were placed in perspective and often appeared to be less serious. In addition, they felt they gained from hearing the problems of other parents. One mother (didactic group) writes, "It was a relief to be able to listen and talk to mothers who all have their own problems to solve". Another mother (discussion group) said, "Sharing my feelings and attitudes in the group helped me to know what other parents were doing, and I felt much better about my own problems".

The discussion group, in particular, created bonds between the members, and feelings of solidarity, warmth and caring were expressed. Some mothers experienced relief in being able to share their problems. One mother (discussion group) felt the value of the group lay in the "sisterhood discovery" and another (training group) felt it gave "a reaffirmation of my social potential and therefore my parental value".

Some parents appreciated the informality and friendliness of people involved, and the positive approach to solving problems. In particular, the warmth and caring of the group leaders was noted.

I feel the dangers in these groups are .....

Many participants felt the dangers were negligible, particularly if group leaders were competent. Problematic areas seemed to be self-exposure and support. One mother (discussion group) writes, ".... some people get critical responses from group members from whom they need support prior to the realisation that change needs to come from within".

Members of the discussion group in particular commented on self-exposure. Mothers report the pain experienced at "exposing a tender area without the necessary time to work through it with the support of the group". Some mothers commented on their own inability to help other members, and the frustration that resulted. One mother (discussion group) felt that "the less well adjusted members with major

problems to solve tend to envy the unproblematic members without solving their problems".

The most significant situation in this group for me was when .....

Most members reported some situation of sharing and solving a problem as being most significant. One mother (discussion group) said, "I admitted my fear, and gained support and positive affirmation". Another (training group) writes, "We discussed specific situations that have arisen in our daily lives and how we might be able to handle them". Many mothers mentioned the warmth they had experienced in relation to the group. One (discussion group) said she had valued the caring when "each member summed up what she had found true in all present members".

I would enter into another parent group .....

All members said they would enjoy participating in another group, and members of the discussion group wished to meet again.

I would advise friends to enter a parent group .....

All members responded 'yes' to this question. Many members attached notes of thanks to their questionnaires.

CHAPTER 8

DISCUSSION

It was the aim of this study to investigate the effects of three parent education programmes on the self-esteem of mother and child. Such programmes were found to be ineffective in facilitating this change. All groups were shown to have fairly high self-esteem scores prior to the experiment and these did not change significantly after the programme, contrary to expectations.

In this chapter, the results presented previously will be examined and interpreted. Shortcomings and limitations in the design and execution of the study are also discussed. Finally, suggestions are made regarding future research programmes of this nature.

8.1 Discussion of results

Contrary to prediction, the didactic, discussion and training programmes all failed to promote any significant gains in mothers' self esteem. The nature of these findings is consistent with those of Overman (1974) whose study showed no significantly higher mean scores for parental esteem following a parent education programme. Schofield's (1976) study also showed no significant gain in parental self-esteem scores. However, these results are contrary to those of Nordal (1974) and Stearn (1971) who demonstrated significant gains in parental self-esteem following parent education programmes. However, since both Overman and Schofield and the present study used the Self-Esteem

Inventory, it may be that this test although reported to have adequate reliability and validity is not sensitive to fine gradations in behaviour and is therefore unable to register subtle change.

That mothers did not show any increase in confidence in the parental role is also unexpected, since the programmes focused on the mother-child interaction and on mothering skills. These findings are contrary to those of Gabel (1972) and Hereford (1963) who demonstrated improved confidence in the parental role as a result of parent ecucation. The fact that there were no gains in the mothers' confidence in their parental roles suggests that the mothers' perceptions of themselves as mothers did not alter. This, in turn, is related to each mother's acceptance of herself and her child for she would have to have confidence in her own parenting ability before she could allow her child to be himself and free of any expectations. In other words, a mother who has very high expectations of herself might have very high expectations of her child.

Rogers (1961) stresses the value of accepting rather than evaluating others, and insists that an acceptant attitude towards oneself is favourable to healthy personality growth and functioning. Self-acceptance is a condition for bringing about change in personality, and it promotes acceptance of the individual by others. It is possible, therefore, that if mothers were unable to

change their perceptions of themselves, they would be unable to alter their perceptions and expectations of their children. Certainly, this is supported by the empirical findings of this study, as no significant gains were observed on the variables of maternal self-esteem, confidence in the parental role and acceptance of the child.

In view of the fact that maternal self-esteem did not increase across any of the groups, it is not surprising that no gains in child self-esteem were observed. These findings are consistent with those of Schofield (1976) and Stearn (1971) who demonstrated no gains in child self-esteem following parent education programmes.

A possible reason for the non-significant findings is that the mother is not actively conveying a message of greater acceptance to her child. According to Rogers (1961:44) it is the manner in which the therapist's

> ..... attitudes and procedures are perceived which makes a difference to the child, and that it is this perception which is crucial.

Therefore, without some overt expression of the attitudes they would not be perceived by the child.

Despite the lack of significant increases in mother's and child's self-esteem as a result of the programmes, there does appear to be some relationship between the two. Mothers appear to rate their children according to their perceptions of their own self-esteem, and hence the correlation coefficient for this rating was higher than the more objective rating of

the teacher (0,69 vs 0,59). In view of this highe rating by the mothers, it may be possible that the mechanism of a self-fulfilment prophecy does bring about real changes in child self-esteem, which becomes discernable to others e.g. teachers.

Although there were no significant empirical findings, responses on the open ended questionaire always expressed positive feelings. The nature of these findings is consistent with those of Anerbach (1968), Cary and Reveal (1967) and Gabel (1972) who all reported positive observations despite non-significant empirical results.

This disparity between the empirical and subjective results poses a problem. It is possible that mothers reported changes because they knew they were participating in a research programme, and felt this to be an expectation. Or they may have felt positive about being involved as mothers improving themselves and their parenting skills, and consequently reported gains. However, it seems most likely that there were benefits from the programmes, but that the tests did not measure these areas.

There are several factors which might have contributed to the lack of significant empirical findings. Solomon (1978) in discussing non-significant findings suggests that participants in intervention programmes may be reticent to report noticeable changes in their children. They tend rather to underplay the improvements in their children's behaviour until they are certain that these

gains are permanent. However, the results of the present study suggest that mothers tended to overrate the gains in child-esteem. Moreover, it is unlikely that this pattern would apply to the mothers ratings of themselves, and the programmes themselves should be seen as ineffective in this regard.

Another possible reason is that changes in the area of self esteem may not have had sufficient time to manifest themselves by the time of the posttest. Van der Veen, Huebner, Jorgens and Neja (1964:46) note that :

> The family concept can change as a result of experiences within the family members themselves or with other significant persons. The amount of change can vary widely from person to person. Also some aspects of a person's family concept may change more readily than others, and certain situations may be more likely to bring about change than others.

This statement has some relevance for the present study, since it is from the family that the child draws his self-esteem. The child with a low self-esteem may be hesitant to accept change in the family, and may consequently be slower to alter his esteem. Furthermore, the mother plays an extremely important role in that her degree of openness to change will facilitate change in her child, and determine the extent of the change. This diversity in degree of change, then, is a factor that may have contributed to the nature of the results.

In addition to the above factors, several methodological

gains are permanent. However, the results of the present study suggest that mothers tended to overrate the gains in child-esteem. Moreover, it is unlikely that this pattern would apply to the mothers ratings of themselves, and the programmes themselves should be seen as ineffective in this regard.

Another possible reason is that changes in the area of self esteem may not have had sufficient time to manifest themselves by the time of the posttest. Van der Veen, Huebner, Jorgens and Neja (1964:46) note that :

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In addition to the above factors, several methodological

problems / limitations may have contributed to the non-significant findings.

The group size was small, and there may not have been sufficient gains within the group to demonstrate change. As has been shown, the reason for the small sample size was the high drop-out rate (see Chapter 6.2.6). While there was no absenteeism among mothers who attended the programme, there was a total drop-out rate of 52,94%. This figure is comparable with that of Tracey (1970) who reported an attendance rate of 50% at a parent education programme conducted in a clinic setting. However, Tracey used a middle-class sample in his research while the present study used an upper-middle class sample. Initially, the present study was conducted using low-income families but attendance was so poor that the research had to be abandoned. According to Anchor and Thomason (1977), a middle class socio-economic sample is more likely than a low socio-economic class to attend a parent education programme. Related to the above is the problem that arises when we consider the type of mother who volunteers for a parent education programme. Anchor and Thomason state that these mothers have a higher education level and attend such programmes because they are active in the community rather than that they experience childrearing difficulies. Chilman (1973) has noted that mothers attending parent education programmes are more interested in their children and tend to be more effective mothers. This suggests that parent education programmes

may well be preaching to the converted. Chilman's contention has far reaching implications for the use of parent education programmes as primary and secondary intervention techinques. He suggests that community psychologists find more ways of motivating and maintaining attendance in parent education groups of mothers who need help, but would never seek it of their own accord.

Apart from being an upper-middle-class sample, and therefore biased, subjects in the present study were drawn from a so-called normal population. Therefore, the non-significant findings may be attributed to the fact that the mothers were well adjusted and that an un-differentiated programme would be of little value in effecting change. Linked to this is the possibility of the results being influenced by the 'ceiling effect'. Anchor and Thomason (1977) suggest that parent education programmes may not be effective with an upper-middle class sample (as in the present study) since it is likely that many of the attitudes and principles emphasised in the programmes are already being held an practised. This 'ceiling effect' might not influence a clinic sample, and it is therefore possible that the findings might have been significant had a less privileged sample been used.

A further difficulty concerned the length of the programmes. The present study used a smaller number of group meetings than is recommended by some researchers (eg. Carkhuff and Bierman, 1970); Tavormina, 1974).

However, Corsini (1968) and Waxer (1977) have demonstrated change with shorter programmes. Linked to the length of the programmes is the content, and it is important for future research to establish the reasons for the failure of a programme. It is possible that the programme content of the present study was too undifferentiated to obtain significant findings. More direct training in self-esteem enhancement may have been provided. This stresses the importance of measuring the variables that are changing. For example, in the present study, although warmth and empathy are crucial aspects of Rogers (1961) approach to parenting, changes in this dimension were not measured. Had they been evaluated the results may have been significant.

Although the findings of this study have not approached statistical significance, it may be that methodological problems contributed to its failure. Consequently, the field of parent education can not be dismissed. Rather, the limitations of this study provide some indicators for future research.

If parent education programmes are to be evaluated with any accuracy, it is important to run as many programmes as possible with as large samples as possible. Since the drop-out rate is high with low income families (Chilman, 1973) and with unstructured rather than structured programmes (Tracey, 1971) it appears that some groups or conditions within a group are more effective than others in maintaining attendance in a

group. If parent education programmes are to become an effective preventive or interventive technique, research is required into factors associated with absenteeism and high-drop out rates.

In fact Chilman's (1973) research seems to indicate that parent education may not be meeting the needs of some communities adequately. It is possible that the community psychologist is attempting to fulfil an unvoiced need, or that he is intervening at the wrong level. For these reasons, it is imperative that the community psychologist maintains close ties with the general public, and that he be sensitive to its needs. In addition, any intervention programme should be flexible enough so as to allow for adjustments as needs in the community arise.

Finally, it is important that an agency attends not just to those people presenting themselves for treatment, but also to those whose needs have not been expressed. This means that programmes should be well planned, advertised and executed so as to attract a section of the population who would not usually avail themselves of any intervention.

In conclusion, future transitions in parent education may be extrapolated from recent trends in the behavioural sciences and from speculations about emerging societal changes. Technological advances will impact on institutions, while changing political and economic environments will,

in turn, interact with modified life styles revolving around changes in the nuclear family and redefinitions of the quality of life (Trend Report, 1974 in Chapman and Elpers, 1975). By providing a basic service in parent education, mental health agencies can play a vital role in helping society to accommodate to such radical change.

However, facilitating change in the parent-child interaction is only one aspect of the work of the community psychologist. As Chapman and Elpers (1975:250) state:

> The mandate for mental health professionals extends beyond increased effectiveness in alleviating the symptoms of mental illness: The more challenging problem by far is that of seeking, in combination with other disciplines, diagnosis and treatment of society's ills that derive from radical and inevitable enviromental change.

Transitioning mental health care to meet future needs requires dealing with man in the context of the institutions he forms and which form him, as he strives for quality of life in a changing world.

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APPENDIX A

TEXT OF PROGRAMME BASED ON CARKHUFF'S TECHNIQUES

SESSION I

THE NECESSITY FOR INTERPERSONAL SKILLS

1 All manner of life grows physically, but there are other areas in which children can grow i.e. emotionally and intellectually.

2 In order to find fulfillment, children must get the growth in these three areas (physical, emotional, intellectual) together, and we have to help our children to do this.

3 The child goes through many crises in his life. Each crises may be a "for better" or "for worse" situation, depending on what we do to help him.

4 There are real skills involved in being able to help effectively. Being a mother does not automatically mean that we possess the necessary skills to facilitate the child's emotional and intellectual growth.

5 Just as you judge your children, so they, too, will be judging you. They can sense warmth, attentiveness, concern, coldness, understanding, they can see your discomfort, experience your vitality, your humanity.

6 Thus the interpersonal skills are of crucial importance bebecause these are communication skills that allow you to develop your relationship with your child in such a way that he can grow from it, not only physically, but also emotionally and intellectually.

7 Interpersonal skills also make a difference in terms of what and how your children learn from you.

ATTENDING IS THE FIRST SKILL OF HELPING

1 Attending means that you are attending physically to your children and observing them and listening to them.

2 How we posture ourselves is a critical part of attending physically. Our posture communicates our readiness to

respond to the child's needs. Often our posture reflects our thoughts and feelings. When we posture ourselves for our own comfort and convenience, we tend to think of ourselves. When we posture ourselves to attend to others, we tend to think of them.

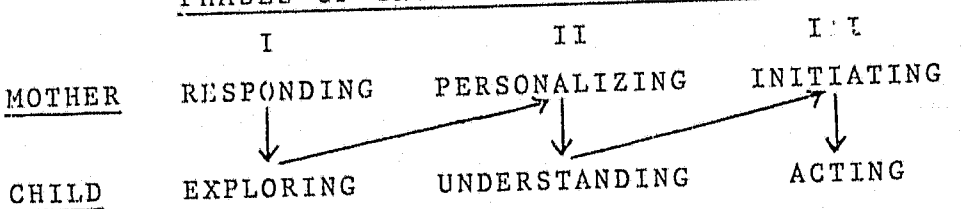
3 Attending physically therefore means:

a. Facing the child fully - shoulder-to-shoulder - when he is talking to you.

b. Leaning forward slightly.

c. Maintaining eye contact with the child - through your attempts to make contact with the child's eyes, the child becomes aware of your efforts to make contact with him as

PHASES OF INTERPERSONAL SKILLS



1 The child attempts to learn as much as possible about himself and the situation or problem in which he finds himself (exploring).

2 This will help the child understand what he wants to do about the situation.

3 The child must then act to accomplish whatever he has decided to do.

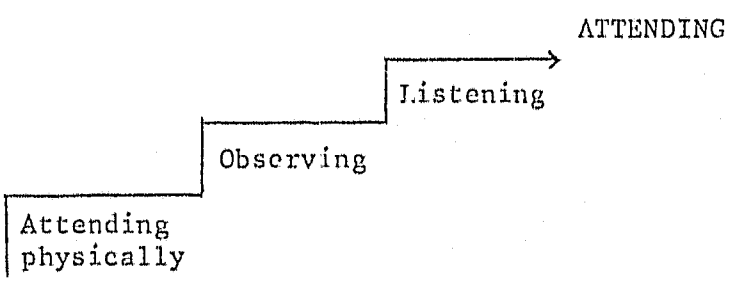
The mother facilitates the procedure with the necessary interpersonal skills.

1 The mother responds to the child in a warm accepting, non-judgmental way. This makes the child feel comfortable exploring himself in the particular situation.

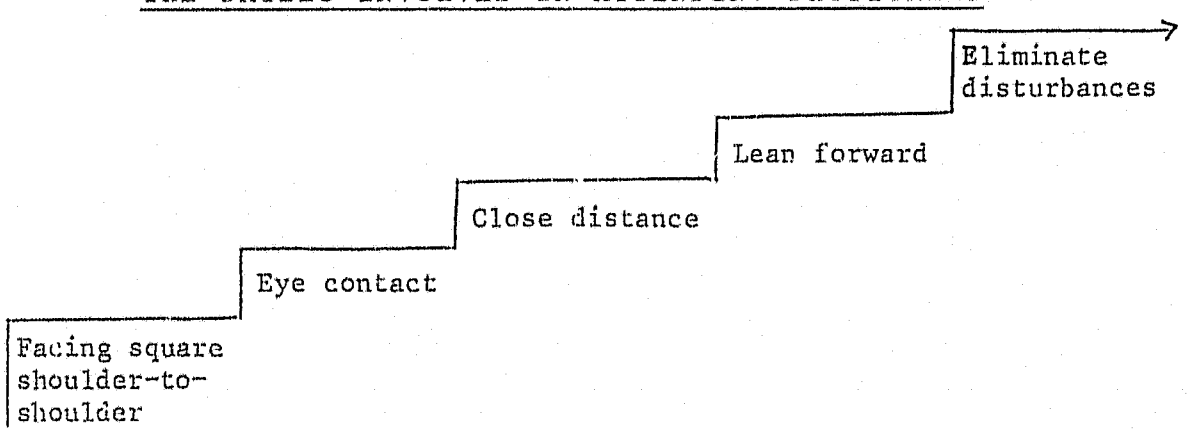
2 By personalizing or using your own experience to provide insights, you help the child gain a better understanding of himself in relation to the situation.

3 You can then initiate and facilitate action for the child.

THE SKILLS INVOLVED IN ATTENDING



THE SKILLS INVOLVED IN ATTENDING PHYSICALLY



an individual. In addition, what you observe will allow you to make inferences concerning the child's reaction to the situation.

d. Eliminate distractions - be relaxed, not nervous and fidgety.

4 Your attending says to the child: "I am right here with you, I am paying attention, I hear what you are saying."

5 At the same time, it allows you to say to yourself: "I see the child, I see how he looks and acts, I hear what he is saying, and how he is saying it."

6 How you attend can really help the child grow, or can hold the process back.

7 Do you perhaps remember yourself in a situation where you asked a question and got an answer that didn't help; asked it again and got another answer you could not use; then quietly withdrew and said to yourself, "Forget it, you don't understand, you didn't hear a word I said."

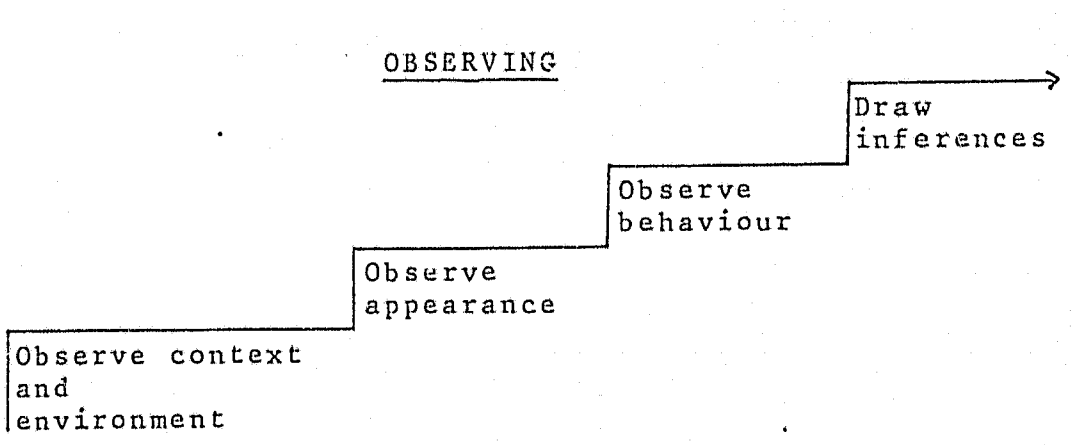
8 Attending thus sets the stage for developing the interpersonal relationship with the child which is crucial for any further communication. It is a precondition of effectiveness.

9 If you attend well physically then you will be in a position to observe and listen well enough to respond effectively.

OBSERVING

1 Observing involves accurately seeing the non-verbal cues that your children send out.

2 Thus you must observe the child's context, appearance and behaviour, and only then can you make any inferences. The inferences will only be accurate and useful if they are based on a large amount of observational information.



3 Thus the function of attending to the child is to give him the feelings of security so that he feels safe to explore his feelings and anything that is relevant for him. We can then move to the next stage - RESPONDING.

STEPS INVOLVED IN THE SKILL OF LISTENING

1 The skill of listening involves the mother's ability to hear and recall all the important verbal cues presented by the child. (If you cannot recall the statement, then you have not heard it in the first place.)

2 When listening, it is important to suspend judgement initially. Suspending judgement helps you to avoid

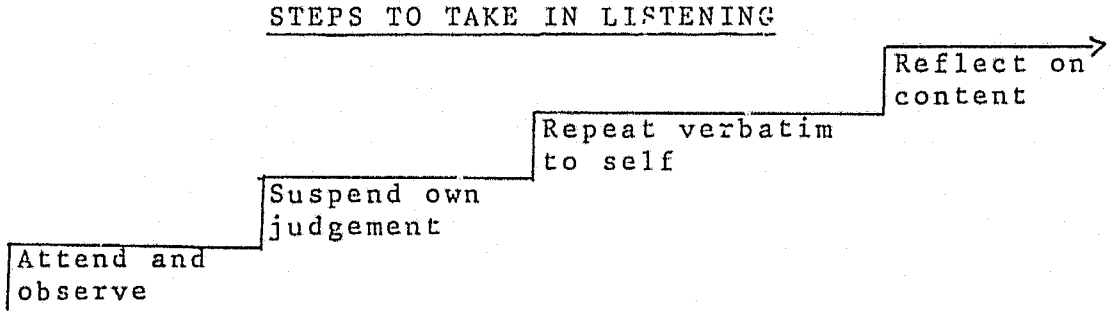
distorting or misunderstanding what the child is saying. Do not judge, just focus on what the child is saying.

3 Thus learn to reflect on what the child is saying i.e. practice <u>waiting before responding</u> in any way.

4 Remember, the most important themes will be repeated over and over with the most intensity.

5 Listening is therefore HEARING the important things your children say. Now you can put your skills of
   a attending physically
   b. observing, and
   c. listening, all together, and you will be prepared to <u>respond</u> effectively.

<u>STEPS TO TAKE IN LISTENING</u>



<u>RESPONDING TO FEELING</u>

1 We can respond to the child's experiences in different ways:
   a. We can respond to them in our physical behaviour
   b. We can respond <u>verbally</u> to the level of distress which he is experiencing i.e. we may directly attempt to tell the child of our level of understanding.

2 Thus <u>responding</u> is letting the child know verbally that you understand him and what he is saying.

3 <u>How</u> you <u>respond</u> to these expressions is critical. If you communicate accurate understanding then you and your child may go on together to solve problems or achieve goals. If not, then the child will turn

away from you, feeling that you do not understand, and therefore cannot help.

4 However, if you respond accurately, you communicate that you understand the child at the level that he has presented himself.

5 If you are inaccurate, you either add to, or subtract from, the experience. If you subtract from:("Don't worry so much") you may be harmful taking away some of the experience. If you add to: ("I know just how inadequate you must feel, and here is what you should do") you may not in fact be helpful because you are premature.

6 Thus we must be able to respond to the child's feelings by capturing the essence of his feelings in one or more feeling words. This way we can communicate to the child our understanding of his feelings.

7 We do this by using a simple "You feel ---" formulation. e.g. Tom says: "Things are not going so good for me. Not in school. Not with my girl. I just seem to be floundering. I'm not sure of what I want to do, or where I want to go."
You can answer: "You feel sad" or "You feel confused".

If Tom says: "I feel like I am getting pulled both ways."

You can answer: "You feel torn" or "You feel conflicted".

When Tom is simply unable to express himself, you might respond to this inability with: "You feel blocked" or "You feel frustrated".

8 This "You feel ---" format may seem stereotyped, but it is actually very effective. When you have practised this, you can change it later to: "That's a ----- feeling", or, "You must be feeling ---", or, "That must make you feel ----".

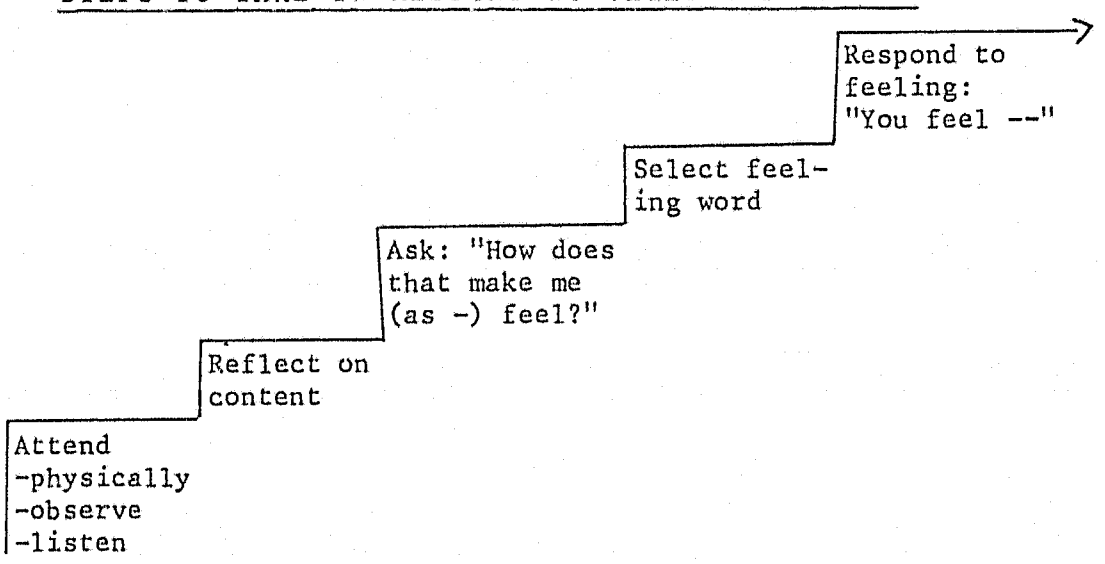
9 It is better to use "gut" feeling words which will be more meaningful to the child than extremely intellectual

words. eg. depressed = down in the dumps; angry = seeing red. Not only must the child be able to understand the feeling word, but he must also be able to accept the word you choose.

10 Watch out for responses such as: "You feel <u>that</u> you are picked on". "You feel <u>that</u>" responds to an event (picked on), rather than a feeling (hurt).

11 Responding to feelings in this way sets the stage for responding to the <u>reason for the feeling</u>.

<u>STEPS TO TAKE TO RESPOND TO CHILD'S FEELINGS</u>



<u>RESPONDING TO MEANING</u>

1 Responding to how the person feels is critical, but imcomplete. You also have to respond to the <u>meaning</u> of the statements. Meaning is the <u>reason for the feeling</u>.

2 Thus a response is not complete until it rephrases the content of the child's statement in such a way as to provide a meaningful reason for the child's feelings, i.e. it communicates both <u>feeling</u> and <u>meaning</u>. Thus: "You feel (<u>feeling word</u>) because (<u>cause of feeling</u>)." e.g. "You feel sad because she was the most important person in the world to you, and now she is gone."

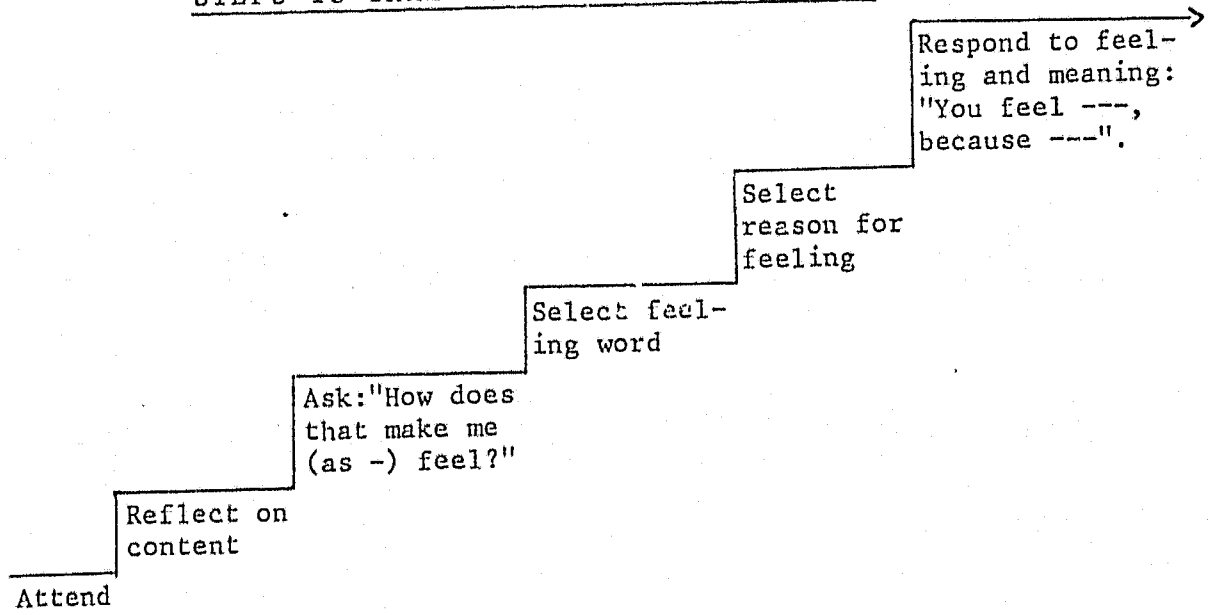
3 This type of response facilitates the child's own exploration by letting him or her know that you have

a complete understanding of the experience or problem that has been presented.

4 This will help the child explore and understand where he is in relation to where he wants to be. This lays the base for the next stage - INITIATION.

5 Example: When Peter swears, your <u>responding skills</u> are the first steps you can take towards <u>changing his</u> behaviour. So you answer: "You feel angry because you didn't do it right, Peter." Your response tells Peter that you heard him swear, and that you know <u>how</u> he feels, and <u>why</u>. Now Peter is ready for the next step - iniating changes in his verbal behaviour.

<u>STEPS TO TAKE TO RESPOND TO MEANING</u>



<u>SUMMARY</u>

1 Please note that <u>empathy</u> is crucial. You must first respond fully in terms of the child's frame of reference and only then <u>initiate</u> from your own frames of reference. If you do not respond in this way, you may be written off as just another mother who doesn't understand.

2 The transition from <u>responding</u> to <u>feeling</u> and <u>content</u> to responding to <u>feeling</u> and <u>meaning</u> is often difficult, but it is a crucially important transition. Otherwise the child will not really listen.

3 Some mothers may find using the format "You feel ---- because --" either confining or artificial. Once you have mastered the format as a means of responding to feeling and meaning, you can experiment with other formats eg. "When --- it makes you feel ---".
"You're saying you feel --- because ---"
"It's really a ---- feeling when ----"

4 The only way of developing the skill of responding to feeling and meaning is through as much practice as possible.

5 Skills discussed thus far:

ATTENDING - eye contact
- lean forward
- shoulder-to-shoulder
- no distractions

OBSERVING - viewing behaviour
- viewing appearance
- drawing inferences

LISTENING - suspend judgement
- reflect on content

RESPONDING - respond to feeling "You feel ---"
- respond to meaning "You feel --- because --".

SESSION II

HOW HAVE WE HELPED THE CHILD THUS FAR?

1 Thus far we have fixed the child's security needs by our attending behaviour. We have laid a base for understanding by responding to him. Now he needs "something more".

2 Part of this "something more" involves our being able to go beyond his expressions - to be able to put together pictures that will guide his understanding of himself in relation to his world; to be able to initiate new directions.

3 If we cannot be additive in our understanding, we cannot help the child to go beyond the experiences that were overwhelming for him in the first place.

4 Thus we began by responding to feeling and meaning - this is called laying a base of interchangeable responses.

5 Esablishing a base of interchangeable responses is important to both mother and child for the following reasons:

   a. It prepares both for movement to deeper levels of understanding.

   b. It gives you an opportunity to check out the child's readiness for movement to a higher or deeper level of understanding.

   c. The child can determine if you are "with" him.

   d. You can determine if you are "with" the child.

   e. If you have responded to Tom, he might go on expressing himself in ways to which you can respond.

6 With each statement, the child is spelling out more and more of his experience, and we are becoming more and more attuned to the child's experience.

HOW DO WE KNOW WHEN THE CHILD IS READY TO GO ON TO THE NEXT STAGE?

1 The child often informs us directly in his behaviour of his readiness to move to the next stage. He alerts us to his readiness by:

a. Demonstrating his ability to sustain his self-exploratory behaviour without help i.e. he goes on talking about his experience, and how he is feeling about it.

b. Deomonstrating his ability to responses that are interchangeable with his earlier statements i.e. he does for himself what we have been doing for him.

c. At the same time, he asks us to do more for him. He asks us to go beyond what he was first able to do only with our help, and now is able to do for himself. He asks us to go to additive levels.

PERSONALIZING - the act of relating to the child's frames of reference to situations. If the mother relates to the child's frames of reference in a situation, then he will know where he is in relation to where he wants to be; so that the mother will be able to help the child to take steps to get to that goal.

FORMULATING PERSONALIZED RESPONSES

1 The source of your understanding of these responses is the child's deficit behaviour, or the gap between where they are and where they want to be. This deficit behaviour is what makes the child vulnerable.

2 Understanding the deficit will help the child understand the goal.

3 We call those responses that help the child understand where he is in relation to where he wants to be additive understanding responses because they go beyond what the child has expressed himself. The responses add to their own understanding of themselves.

4 These additive understanding responses lay the base for developing programmes to get the child from where he is to where he wants to be.

5 Understanding where the child wants to be helps establish the goal of the programme.

6 Understanding where the child is, helps to establish the first step in the programme.

7 The child very often relates his experience in terms of something external to him. It is often difficult to do anything with expressions about third parties or situations. Children often blame their friends or parents or teachers or a test for their current predicament.

8 What you need to do is personalize your responses i.e. involve the child directly in his expression of his experience. By personalizing your responses, you make the child responsible directly for the feeling and meaning which they have expressed. In this way, you help them assume control.

PERSONALIZING SKILLS

PERSONALIZING GOALS	-	Reflecting behavioural goals
	-	Formulating behavioural goals
	-	Discovering behavioural problems
PERSONALIZING PROBLEMS	-	Reflecting behavioural deficits
	-	Formulating behavioural deficits
	-	Discovering behavioural deficits
PERSONALIZING MEANING	-	Reflecting personal responsibility
	-	Externalizing the reason
	-	Building a responsive base

PERSONALIZING MEANING

1 This is the first step in helping the child understand where he is in relation to where he wants to be.

2 We personalize the meaning when we relate the meaning directly to the child's experience. In other words, you want to make the child directly responsible for his part in the experience.

3 We allowed the child to externalize the meaning when we made interchangeable responses. We used the format "You feel ---- because ----". This was effective because he was not yet ready to assume responsibility for his role in the experience.

4 Now we are asking the child to internalise the meaning. Now we are asking the child to own his experience.

HOW DO YOU DO THIS?

1 Sorry to repeat, but as mentioned before, your personalized response should clearly pinpoint the child's part in his own experience. The format that you can use to do this most effectively is as follows: "You feel ---- because you ----"

2 The first step is to ask: Given the experience which they have expressed, what are the implications for the child?
e.g. In establishing an interchangeable base with Paul, you might have formulated the following response to his statement concerning his experience of having to leave his old home to move to a new home.
"You feel sad because all the people you like will be left behind".
In personalizing the meaning, you must answer the questions of the implications of the experience for Paul. Here it may become clear that Paul's experience revolves around his being alone. Thus you might formulate a response that incorporates this personalized meaning:
"You feel sad because you will be alone".

PERSONALIZING THE PROBLEM

1 We personalize the problem when we help to understand what he cannot do that has led to his experience i.e. where he has a behavioural deficit.

2 Then you could modify the format as follows:

"You feel ---- because you cannot ----"

3 It is not a difficult step from personalizing the meaning to personalizing the problem. Thus to use the example of Paul, you personalize the meaning with the response:
"You feel said because you will be alone."
Now we can express his being left alone in terms of a deficit in his repertoire of responses. In other words, he is being left alone because he is unable to make new friends in his new home. Thus you might formulate a response that incorporates the personalized problem:
"You feel said because you will be alone and you might find it hard to make friends in your new home."

4 Sometimes you might find yourself going directly to personalizing the problem. But please do this with care. Personalizing the meaning provides an intermediary step that makes the personalized problem more acceptable to the child.

5 Also, please remember that when you personalize the problem it is never in the past. When we personalize the meaning we allow the child to formulate the problem in the past. (You feel worried because you couldn't cope with the reading.) In personalizing the problem, we are formulating the problem in the present.

PERSONALIZING FEELING

1 The next step in helping the child understand where he is in relation to where he wants to be is personalizing the feeling.

2 Now that we have personalized the meaning and the problem, we need to check back and see whether we have used the correct feeling response. The feeling may, or may not, need to be changed.

3 In order to do this, we ask and answer the following questions:

a. What are the implications of the personalized meaning and problem for the feeling?

b. Does our new-found meaning change the child's feeling?

4 In personalizing the feeling, we will use the same format that we used for personalizing the problem: "You feel ---- because you cannot ----"

5 Using the example of Paul, you personalized the meaning and the problem as follows:
"---- because you will be alone and you may not find it easy to make friends in your new home."
Now you must answer the question: What are the implications for Paul's <u>feelings</u> of being alone and unable to make friends? The answer will provide you with the personalized feeling response. Clearly Paul is <u>not sad</u> about being alone. Paul is <u>scared</u>. Thus:
"You feel <u>scared</u> because you will be alone and you may not find it easy to make friends in your new home."

5 Personalizing in this way provides you with a means for going <u>beyond</u> what the child has <u>expressed</u> i.e. the techniques of personalizing allow you to search out new, deeper and more accurate feelings and meanings in responding to the child.

<u>PERSONALIZING THE GOAL</u>

1 Where the child wants to he can be best understood in terms of his personalized problem i.e. the <u>goal</u> behaviour is the <u>flip-side</u> of the <u>problem behaviour</u>.

2 Thus the way to <u>personalize the goal</u> is to determine the behaviour that is opposite to the personalized problem.

3 You can understand where they want to be if you understand what <u>deficits</u> limit them to where they are.

4 The goal here is for you to establish a direction which the child can use within his frame of reference.

5 The longer you explore the child's concerns, the easier these steps will be:

a. First, think about where the child is saying he is in his past few responses.

b. Second, think about any behaviours or capabilities that the child lacks.

c. Third, think about where the child is saying he is in relation to where he wants to be.

d. Fourth, think about the feeling he has about that goal.

e. Fifth, in personalizing the goal, we use the format:
"You feel ---- because you (cannot) ---- and you want to ----" The child is now able to put his experience into perspective in a way that he was unable to do prior to speaking to you about it.

6 He is now able to understand where he is in relation to where he wants to, or needs to, be. It is, in fact, the overwhelming nature of the problem (for the child, that is) that prevented him from getting a perspective and led to speak to you in the first place.

7 The key to formulating effective additive responses is discipline - discipline in making the feeling and meaning responses (i.e. laying an interchangeable base), and discipline in using this base to search out the deficit themes.

SESSION III

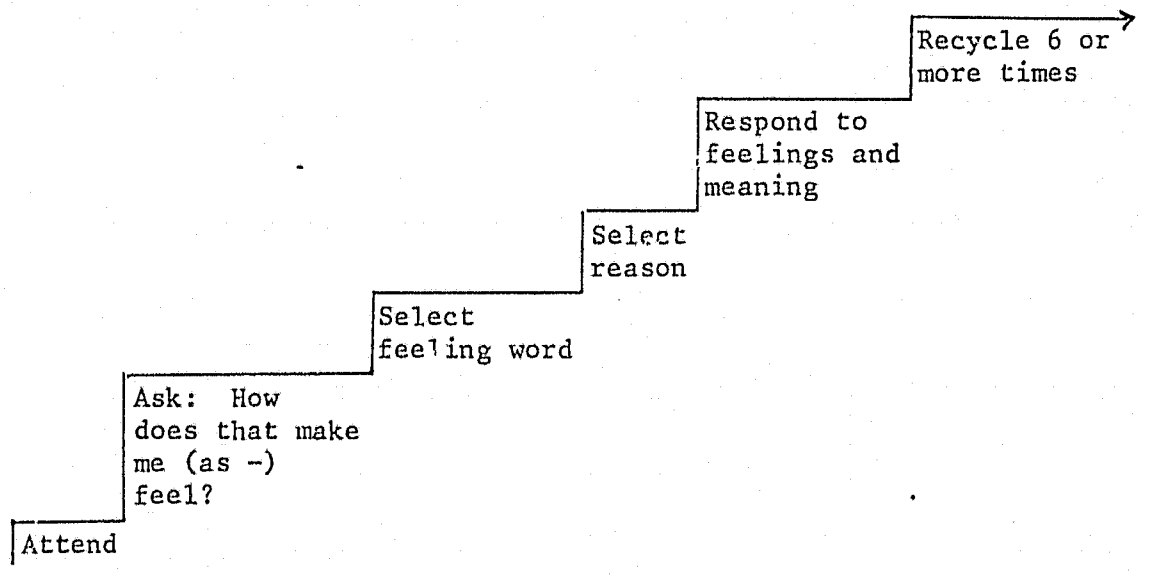
SUMMARY OF WHAT WE HAVE DONE SO FAR

ATTENDING
OBSERVING
LISTENING
RESPONDING TO FEELING
RESPONDING TO MEANING

SEE SUMMARIES OF EACH WHICH FOLLOW

LAYING A BASE (REVISION)

1 This is the process of making a series of feelings and meaning responses to the child i.e. attent, observe, listen, reflect on what has been said and then respond to feeling and meaning again and again (You feel --- because ----")



STEPS TO TAKE IN LAYING A BASE

2 Thus, laying an effective base with the child will usually require that you will be able to respond a number of times.

3 The better the base laid, the more you will be able to identify and solve the child's problems later.

4 If you are perhaps worried about losing old responses that you have found effective with your children in the past ADD this new responding skill to their repetoire.

5 If you lay an effective base with the child you will be on top of where they are at so that you can guide them more effectively -- i.e. it helps you to gather additional pieces of information and thus get a more complete and accurate picture of the child and his problem.

6 LAYING A BASE - SUMMARY

WHAT IS IT?	A series of feeling and meaning responses to a learner.
WHAT DOES IT DO?	Helps child to fully explore where he is.
WHY DO IT?	Builds a base of understanding. Increases the effectiveness of later direction that you give to the child.
HOW DO YOU DO IT?	1. Attend. 2. Ask: How does that make me (as ---) feel? 3. Select feeling word. 4. Select reason for feeling. 5. Respond to feeling and meaning 6. Recycle 6 or more times.
HOW DO YOU KNOW IF YOU HAVE DONE IT RIGHT?	If the child continues to use what you say to explore himself or his relation to the world.

EXAMPLE OF LAYING A BASE

Child 1 : "Yech! I don't want to do a maths test."
Mother : "You feel bad because the test might be hard to pass?"
Child 2 : This stuff we've been studying is really hard.
Mother : You feel worried because the work is difficult to learn.
Child 3 : It just doesn't make any sense to me. I don't know how to do it.
Mother : You feel lost because you don't understand it.

Child : I wish we could practice it some more before we have a test.

Mother : You feel scared because it will be impossible to do well on a test with what you know now.

Laying this base builds and strengthens the child's trust in you and increases the probability that when the time comes, the child will be able to accept those things which you will initiate.

Example 2

Child says: I just don't know what I am going to do. My parents want me to stay in school, but I'm not sure.

Your response: You feel confused because your parents want to make your decision for you.

Child 2: They say they only want what's best for me but they never take me into consideration.

Your response: You feel smothered because they never ask you how you feel about it.

Child 3: They're everywhere. Everything I do they have something to say.

Your response: You feel frustrated because they don't give you a chance to make your own decisions.

Child 4: I know exactly how I feel but I just can't seem to tell them.

Your response: You feel frustrated because you don't stand up for your point of view.

Child 5: I really feel that I know what is right for me but I don't know why I don't have the courage to tell them.

Your response: You feel weak because you can't explain yourself to your parents.

Now you have personalized the meaning, the problem and the feeling. It is right at this stag[illegible]ause you have laid an adequate base by responding to [illegible]s and meaning a number of times, but had you responded in this way too soon,

you would have broken down the child's confidence in your understanding and he probably would not have continued exploring his feelings.

PERSONALIZING RESPONSES

E.g. I've been working really hard but the work that has reading in it is holding me back.

Response:

1 You're feeling bad because the reading is really hard.

2 You're disappointed because you are not moving ahead very fast.

3 You're sad because things just aren't working out.

4 You're sad because you just haven't been able to handle things.

5 You feel really bad because you haven't been able to handle the reading and you want to be able to handle it.(be able to read better)

EXAMPLE OF NECESSITY OF PERSONALIZING:

The morning before the science project was due, your child panicked and came to talk to you because he hadn't done it yet. You replied that it was too bad that he didn't know how to work with deadlines and organize himself properly. Your child got annoyed and left. And still its true - he still never meets deadlines! (Nor does he discuss much with you!)

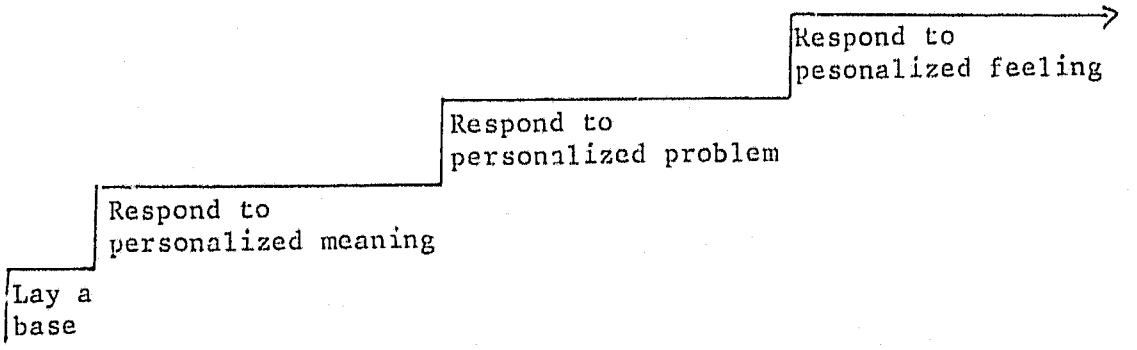
REASONS FOR PERSONALIZED RESPONSES

Personalized responses do the following :

1 Involve the child directly by focussing on his role in the experience.

2 Help the child increase the level of self-responsibility

PERSONALIZING RESPONSES



Steps to take in Personalizing Responses

3 From this we see that the first step in personalizing responses is to personalize the meaning. Do this by asking yourself:
What is the child's role in the experience?
Then use format:
"You feel ----- because you ----------".
eg. You feel sad because all the people you like will be left behind / You feel sad because you will be alone.

4 (i) The second step in personalizing responses is to personalize the problem. Do this by asking yourself:
What is it tne child cannot do that creates this experience for him?
Then use the format:
"You feel --------- because you cannot ----------".
eg. You feel sad because you will be alone.
You feel said because you will be alone and you may not be able to make new friends in your new home.

4 (ii) Personalized problems are behavioural i.e. be sure to check that your personalized problem identifies a behaviour that the child lacks that contributes to the problem.

(iii) The purpose is to help the child assume responsibility, not to assess blame or fault. If the child can

assume responsibility he can then choose to handle the existing environment, change the environment or find a new environment.

(iv) By personalizing the problem you will help the child to see that the problem is not "out there" where nothing can be done about it but right "in here" were the child can control and change it. (It goes without saying, of course, that you can and should assist the child by improving an external environment when appropriate. Helping a child gain control over his or her life is not the same as "throwing someone to the wolves!")

5 The third step in personalized responses is to personalize the feeling. Do this by asking yourself:
How does this deficit make the child feel about himself?
Then use the format:
"You feel (new feeling word possibly) -------- because you cannot.---------". eg. You feel sad because you will be alone and may not be able ----------".
You feel scared because you will be alone and may not be able ----------".

Thus, so far we have:

1	You feel ----------	Responding to feeling only.
2	You feel ---- because ----	Responding to feeling and meaning.
3	You feel --- because you --	Personalizing meaning.
4	You feel --- because you cannot ----------	Personalizing the problem.
5	You feel --- because you cannot ----------	Personalizing the feeling (i.e. same format as 4 but new feeling word if necessary)

PERSONALIZING RESPONSES - SUMMARY

WHAT IS IT?	Involving the child directly in the expression of his experience. Focussing on the child.
WHAT DOES IT DO?	Makes the child responsible for his experiences and for himself.
WHY DO IT?	1. Provides you with a means for going beyond what the child has expressed. 2. Identifies what the child cannot do. 3. Helps the child assume control of himself.
HOW DO YOU DO IT?	1. Lay a base. 2. Respond to personalized meaning (because you). 3. Respond to personalized problem (because you cannot) 4. Respond to personalized feeling (new feeling word)
WHEN DO YOU DO IT?	When the child needs to be prepared for personalizing goals.
HOW DO YOU KNOW YOU'VE DONE IT RIGHT?	By the child's reaction - they can use what you are saying by continuing to explore.

PERSONALIZING UNDERSTANDING (PERSONALIZING THE GOAL)

Child : I try to get along but the kids don't like me.
Response: You feel bad because they are not friends with you.
Child : They never ask me to play with them.
Response: You feel hurt because they leave you alone

Child : I'm always by myself.
Response: You feel terrible because you are alone.
Child : I'd like to have friends, why can't I?
Response: You feel terrible because you can't make friends with anybody.

PERSONALIZING RESPONSES - SUMMARY

WHAT IS IT?	Involving the child directly in the expression of his experience. Focussing on the child.
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Response: You feel bad because they are not friends with you.
Child : They never ask me to play with them.
Response: You feel hurt because they leave you alone

Child : I'm always by myself.
Response: You feel terrible because you are alone.
Child : I'd like to have friends, why can't I?
Response: You feel terrible because you can't make friends with anybody.

Child : I guess I'll never have a friend.
Response: You feel scared because you can't make friends and you're always alone.

What could you do next that would be useful to the child? These responses describe where the child is at and how he feels about it but not where he wants to be - i.e. no goal has yet been identified (where he wants to be)

Example

Child: I didn't make the team.
Your response: You feel discouraged because you didn't measure up and you want very much to be good enough to play in the team.
Child: Unless I can handle Maths I'm not going to do it this year. I guess I'm never going to be good at business.
Your response: ?
Child: Unless I can handle Maths I'm not going to do it this year. I guess I'm never going to be good at business.
Your response: You feel very disappointed because you just haven't been able to handle Maths and you want to go into the business world and this requires a good maths background.
Child: Those kids keep calling me 'fatso' because I'm so big. Well if they don't cut it out, they're going to find out just how big I am.
Your response: You're angry with them and with yourself too because you let them make fun of your size and you want to stop them from treating you that way.

Thus the response is to the child's feeling and the reason for it. But it also supplies a direction by personalizing his understanding of the implied goal - i.e. the response is to where the child is and where he wants to go.

PERSONALIZING UNDERSTANDING

1 Personalizing understanding responds to where the child wants to be.

2 It establishes direction for the child.

3 If you can personalize understanding you will be ready to deal with the actual problem.

4 Use the format "You feel ---- because you cannot ------ and you want to ----------".

5 Please remember that you increase your chances of success and your chances of the child being able to follow your initiative if you lay the responsive base carefully. The more of a responsive base you have the easier it is to formulate personalized understanding responses.

6 Here is a personalized understanding response which you might have made to Paul based on the responsive base which you have already established with Paul: "Paul, you feel vulnerable because you don't know how to make friends and you want very much to be able to". Here you have responded to Paul's feeling of vulnerability and the reason for it, and you direct Paul toward the implied goal of learning how to make friends.

This response is high in responsiveness and high in initiative. Such responses communicate a personalized understanding of where the child is and where he wants to be.

Example:

Andy says : "Mr. Smith's got some favourites. Even though I try so hard to please him, he never talks to me."

Response : "You feel miserable because you can't figure out how to get Mr. Smith to like you and you really want him to be friendly toward you".

Let's try personalizing understanding to the following:

Mary 1 : I can't see why she gave me a C on my Social Studies paper. I worked at it a lot harder than some other kids who got A's.

Mary 2 : Nobody cares how hard you work around here or anything.

Mary 3 : Sometimes I think teachers have favourites and that's all that matters.

Mary 4 : I also wonder what's wrong with me that I don't do better. Like, I don't know what I did wrong on this paper. But it's not just this paper. It happens on other things too.

PERSONALIZING UNDERSTANDING - SUMMARY

WHAT IS IT?	Responding to where the learners want to be.
WHAT DOES IT DO?	Establishes a direction which the child can use within his frame of reference.
WHY DO IT?	1. Identifies where the child wants to be. 2. Helps the child assume control of herself. 3. Provides you with a means of responding to the discrepancy between where the child is and where he need to or wants to be.
HOW DO YOU DO IT?	1. Review child's theme. 2. Recall personalized problem. 3. "Flip" problem to goal. 4. Select feeling word. 5. Respond to personalized understanding.
WHEN DO YOU DO IT?	After you and the child understand what he cannot do.
HOW DO YOU KNOW IF YOU'VE DONE IT RIGHT?	The child continues to explore where he is in relation to where he needs to or wants to be.

Author Rudick K
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