MOTHERS AS PLAY THERAPISTS FOR THEIR CHILDREN

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Karotkin, Kenneth M., Mothers As Play Therapists For Their Children. Master of Arts (Clinical Psychology), December, 1970, 36 pp., 3 tables, 3 figures, references, 30 titles.

The problem with which this investigation is concerned is that of determining whether previously untrained, non-professional personnel, in this case mothers, can be trained to undertake and cope with the responsibilities of a play therapy situation with their own children. The hypothesis of this study is that by placing mothers in such a situation, the mother's ability to communicate with her child will be modified as well as modifying the child's perception of her as a warm and accepting parent.

The feasibility of such a procedure was tested by the following means. Both experimental and control groups were composed of fourth grade students and their mothers, randomly selected from all fourth grade students at a local elementary school. All Ss were volunteers with assignment to experimental or control groups being accomplished by means of randomization. Parents and children in the experimental group met twice a week, one hour per session, for four weeks. Control Ss received only the pre and post
therapy measures of change. These included the Semantic Differential and the Roe-Siegelman Parent Child-Relations Questionnaire (PCR).

A standard two by two analysis of variance was computed on each separate scale of the PCR. Similar statistical procedures were employed on the Semantic Differential with analysis of parents rating children, children rating parents, and both the parent and the child rating themselves. An analysis of variance of within subjects cells for the Punishment S-L, Reward S-L, and Love scales of the PCR was also used.

Analysis of the results of the Semantic Differential revealed no significant changes of the ratings of parent's attitudes toward their children, children's feelings about their parents, or in either the parent's or the child's perception of himself at the .10 level.

Analysis of the Love Scale, the Punishment S-L Scale, and the Reward S-L Scale of the PCR indicated that parent-child attitude changes had occurred. These change scores were found to be statistically significant at the .10 level. These findings tend to suggest that (1) mothers in the experimental group changed more than those in the control group in their perception of themselves as a more
loving and less punishing parent; (2) experimental mothers changed in the direction of being more rewarding than those mothers who did not participate in the play therapy situations; and (3) children in the experimental group saw their mothers as becoming less rewarding than those in the control group. These data indicate that mothers involved in the sessions with their children changed towards seeing themselves much more favorably than control mothers, while their children viewed their mothers less favorably than their counterparts in the control group.

This report concludes that the evidence seems to suggest that mothers can be used as play therapists for their own children, and that such procedures can evoke attitude changes in the participants.
MOTHERS AS PLAY THERAPISTS FOR THEIR CHILDREN

THESIS

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

MASTER OF ARTS

By

Kenneth M. Karotkin, B. A.
Denton, Texas
December, 1970
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Statement of the Problem and Review
of the Literature

A great volume of research has indicated that parental child-rearing practices have a distinct influence on the subsequent behavior of the child. While such research suggests a causal relationship between these practices and the child's development, it is the resulting maladjusted behavior which has commanded the most attention from educators and behavioral scientists alike. Examples of this maladjustment may include poor self-concept, lowered IQ score, underachievement, peer rejection, and behavioral dysfunction. As Bandura (1961) has stated, it is these undesirable behaviors, which have been established and maintained as a result of inappropriate reinforcement by the parent, that are the cause of many of the basic social problems exhibited by the child.

An important and relevant dimension of parental child-rearing is that of warm, loving, accepting attitudes versus cool, rejecting ones. The evidence suggests that the child's perception of the parent on this dimension is more highly associated with the child's observable behaviors than in the parent's report of their own attitudes. Accordingly,
it seems that parents frequently do not communicate their professed attitudes of warmth and affection to the child (Cox, 1970).

The present study proposes to use mothers as therapeutic agents for their own children in a play therapy situation with the objective of modifying the mother's ability to communicate with her child and modifying the child's perception of her as a warm and accepting parent.

Furman (1957), Hawkins et al. (1966), Schwarz (1950), Straughn (1964), Wahler et al. (1965), concluded that the advantages of filial therapy far outnumber those of conventional client-centered play therapy. Not only did the parent have more emotional significance to the child, but anxieties that had been induced under the influence of the parent, or in his presence, could be more effectively unlearned. Mis-expectations and mis-conceptions that have occurred between the parent and the child could also be more effectively dealt with.

Guerney et al. (1966) noted that play provided catharsis for the child and at the same time enabled the mother to see how the child reacted to her in symbolic play and in his repressed wishes. She was able to adjust her expectation of his emotional commitment to her to more realistic
levels, and was able to develop a new ability to keep from being manipulated by him in the hope of "buying his appreciation." Finally, the overall parent-child relationship was strengthened.

Play therapy has as its major function the reflection of the child's feelings "to convey through empathy the values or attitudes that the therapist believes to be a basic part of therapy, in the hope that it will lead to emotional clarification [Moustakas, 1953, p. 2]" of the child's feelings. Its main concern is with the kind of relationship which will enable the child to grow through increased faith in himself. The important point lies, however, in the faith that is expressed by the therapist to the child, the belief that the child has the potential to work out his difficulties for himself. Thus, the child is given the opportunity to express his feelings in whatever way he wishes. He can in turn choose to be open and in so doing explore both his own systems of communication and those around him.

The parent, as a relevant person in the child's therapy, must take upon himself certain basic attitudes toward the therapeutic process. He must show interest, attention, and concern for the child in the therapy situation, for without
this he deprives the child of the primary means that he has of coping with his problem and effectively conveying his feelings. The parent must ask himself such questions as "What feelings, what attitudes is this child expressing to me now? What essentially is he telling me?" For example, the sensitivity to the child's feelings should become a natural part of the relationship.

Schwarz (1950) found that parental attitudes changed considerably as a result of observing their children in play therapy. Attitudes tended to become more positive with the child realizing that with the mother in therapy, there was no conflict in loyalties. The physical presence of the mother aided in therapy and indicated to the child an understanding parental attitude, while the mother learned as much about her own attitudes toward the child as she did about the problem itself. Finally, parental attitudes and expectations were geared more realistically to the therapy. Guerney (1969) found that the mother was better able to model her behavior after that of the therapist, alternative behavior learned in therapy was more easily generalized to the home situation, the parent began to see the child as a distinct entity with a personality all his own, and communication between parent and therapist was more easily facilitated with a better
understanding of the therapeutic processes involved. Additional advantages of filial therapy include the opportunity for the therapist to directly observe the emotional interplay between the mother and child and thus more directly ascertain how or if such behavior has contributed to the child's disturbance. Finally, by having the mother work directly with the child, she can see how her own educational approach to the problem need be changed or altered.

Stover (1966) found that because of training in filial therapy, parents were more ready and better able to play the role that was required and expected of them. Studies by Furman (1957) and Bonnard (1950) revealed that with the increased contact and work that was affordable through play therapy, there developed an increased communication and ease in dealing with parent-child problems. Also, in the process of working with the entire child and his problems, the mother was placed in the position of devoting her whole attention and self to the child. As a result the parent often experienced an intense satisfaction not only from being directly involved with but also from helping her child.

Harris et al. (1964) and Wahler et al. (1965), from work done with parent-child interactions and adult-child interactions, found that parental attention acts as a
positive reinforcer for the child. Not only could behavior be shaped in a positive manner when verbalizations were made by the adult, but negative behavior could be encouraged using the same methods. Harris found that behavior which was immediately followed by attention from the teacher, rose markedly. Response rate rapidly decreased, however, when attention was withheld from that behavior and was then given to the previously "incompatible" behavior. Work by Wahler revealed that in addition to the reinforcing qualities of parent and adult attention, the attention may be systematically modified to bring about marked changes in the child's deviant behavior.

Straughn (1964) found that by gradually introducing the mother into the playroom for increasingly longer periods of time, the child experienced a better overall adjustment at home and at school. Reports indicated that the child was not only more relaxed in school, but made several close friends in the process of his adjustment.

As early as 1957, Fuchs reported treatment of her own child through the use of filial therapy. She noted changes in her own attitudes in dealing with her child after therapy; she became more patient, more willing to listen and accept her child and her child's feelings, and more free to express
her own. "When a mother eliminates all value judgments, does not praise or condemn, suggest or divert her child's behavior, the child knows this is different [p. 95]." Thus through showing the child that she, the parent, understood her problem, much tension was released resulting in the child's more easily working through her difficulties with parental approval and support.

Hawkins et al. (1966) reported similar results in the treatment of a four-year-old boy who was difficult to manage and control. Not only did objectionable behavior change in frequency and topography but it tended to generalize out of the treatment time, carrying over to similar situations nearly a month later. Zeilberger et al. (1968) in a replication of Hawkins, obtained comparable results under similar circumstances. Both of the previously mentioned studies were carried out with treatment being conducted in the home. In this situation as in the clinic, a cooperative parent is of the utmost importance.

Additional findings by Levenstein and Sunley (1967) indicate that as a result of using "verbal symbolization [p. 334]" for the treatment of socially and intellectually deprived young children, improvement in verbal intelligence occurred. This improvement, in turn, was directly associated
with the stimulation of verbal interaction between mothers and their children.

Such cases as have been previously cited seem to indicate that filial therapy can be of valuable assistance in the treatment of problems in young children. It can alleviate much of the strain that is placed upon the present supply of trained professionals and at the same time promote the understanding and communication between mother and child that is such a necessary part of the child's basic development.

Although filial therapy has much to offer in the treatment of problems in children, it is by no means without difficulties of its own. Riessman (1967), in working with nonprofessionals in the field of mental health, made several suggestions for training and working with them. He noted (1) that constant support and assistance must be provided; (2) that nonprofessionals frequently expect magic from the training process, i.e., they expect to learn how to do everything they are exposed to quite perfectly and obtain the desired results; (3) that they need to learn that many of the processes are involved with development and thus results may not be so explicit; (4) that a great deal of learning was found to develop on a one-to-one identification
basis; and (5) that the nonprofessional is usually faced with a high amount of anxiety in working through his tasks. Such problems as were discussed by Riessman were studied by Moustakas (1953) and found to occur with some frequency in dealing with parents whose children were engaged in play therapy. To combat such difficulties, Moustakas stated that no pressure of any kind should be placed on the parent. In addition, whatever decision the parent makes is accepted by the therapist in the client-centered tradition. Moustakas further notes that complete acceptance of the feelings of the parents is always in order, as is conveying to them the belief that they are the best authorities in deciding how they should act in the relations with their child. Finally, Axline (1950) reached the conclusion that both mother and child gain emotional insight when the therapist maintains a completely accepting relationship with them, and that the advantages of having the mother and child in the playroom together are definitely beneficial to the child's therapy and to the mother-child relationship.

As mentioned earlier, Stover and Guerney (1967) concluded that filial therapy has many advantages over conventional client-centered play therapy. They found that children
tended to have more positive emotional attachment to the parent, while making it easier for the parent to remove any differences learned or acquired through the parent-child interaction. Thus the parent could make any changes as to the correct behavior of the child and could decide the time and place the modifying process was to be employed. By using the parent as a therapist, fears and rivalry that might develop between the therapist and the parent were avoided. Guilt caused by the parent's helpless feelings was eliminated. The problem that occurred as a result of the parent having little or no responsibility for treatment was precluded. Lastly, Stover and Guernsey note that "an increase in negative attitudes prior to the increase in positive attitudes on the part of the child has been found to be related to the climate of permissive acceptance and respect for the child's feelings engendered by the client-centered therapist [p. 111]."

Stollack (1969) employed the same techniques developed by Guernsey in training parents as filial therapists to test the experimental effects of training college students as play therapists. Results indicated that previously non-professional undergraduate students could significantly change behavior. This tends to substantiate the findings of other researchers in that nonprofessional therapists could
be trained to provide adequate treatment for the disturbed or troubled individual.

Rioch (1966) noted that long years of academic and professional training and experience were not essential for much of the actual work being done in the field of psychology. Studies by Poser (1966) have suggested that quite adequate or even superior results could be obtained with psychotic patients by employing previously untrained therapists in a clinical situation. Such results, it was hypothesized, were possibly due as much from the therapist's attitude as from what was actually done in the therapy itself.

Mothers have been used as therapists in a variety of situations. For example, a mentally disturbed mother was trained as a therapist to carry out behavior therapy on her four-year-old daughter. A detailed, step-by-step program was outlined for handling the child, for regulating the mother's behavior, and for establishing control in various forms of their interactions (Shah 1969).

Stover (1966) in a study to determine the efficacy of training mothers for use as client-centered, filial therapists noted results comparable to those found by Guerney and Stollack. Overt aggression was significantly increased
in the experimental group in the early stages of therapy, while the control groups, aggression was found to decrease. Verbal negative feelings also were found to increase as a result of the therapeutic procedure.

Play Therapy

Axline (1947) states in her eight principles of play therapy all of the basic tenants necessary in establishing rapport and in effectively bringing about a sound therapeutic relationship between the therapists and the child. These include the development of a warm, friendly relationship between both parties, the establishment of limits, the mutual respect that is such a basic part of any therapeutic relationship, and the basic attitudes with which the therapist attempts to direct the therapy session. Axline's principles are listed in Appendix A.

Ginott (1965) further explores the problems of discipline and limit setting in play therapy. He notes first of all, that although it is important for the therapist to like children, it is important that the therapist should not have an urgent need to be liked by them. Rather, he should be prepared to accept an attitude of permissiveness toward the child. This permissiveness should include the acceptance of both imaginary and symbolic behavior. Limits are set on
undesirable acts; no restrictions are set on wishes. Feelings need to be identified and expressed or reflected. Undesirable acts should be limited and the concomittant feelings redirected. However, limits should be set in a manner that preserves the self-respect of the therapist as well as the child. "The limits are neither arbitrary nor capricious, but educational and character-building [p. 113]."

All restrictions are given without anger or violence. An attempt is made by the therapist to understand the resentment of the child and he is not punished additionally for disliking the restrictions placed on his actions. Children should be given a clear definition of unacceptable behavior at the time it occurs. Not only does this enable the child to function more freely in the playroom, but it makes him more secure when he knows the borders of permissible action. Finally, the limit conveys to the child the feeling that "You don't have to be afraid of your impulses. I won't let you go too far. It is safe [Ginott, 1965, p. 116]."

Ginott further notes that limits should be stated so that it is clear to the child "(1) what constitutes unacceptable conduct; (2) what substitute will be accepted [p. 116]."

Furthermore, the therapist should recognize the child's feelings and put them into simple words. Next, limits
should be clearly stated for a specific act, with ways being pointed out in which the feelings can be sublimated.

Finally, the child should be helped to express some of the resentment that he is likely to feel as a result of the imposed restriction. All the while, it is important to remember that limits should be phrased in such a way that they do not challenge the child's self-respect.

Moustakas (1953) found some distinct differences between play therapy with normal and disturbed children. Play therapy with normal children gave them the opportunity to express their feelings as they saw fit, to be open and free to explore. Characteristics of normal children in play therapy are: they are more spontaneous, more conversational and more prone to discuss the world exactly as it exists for them. When bothered or annoyed they usually bring out their feelings in play in a more concrete way. These children tend to develop the attitude that the therapist is a special kind of person. They employ various strategies to discover the limits of therapy (and the therapeutic relationship) and are often more happy and outgoing in their play. The most important aspect, however, is the concentrated relationship which is established with the therapist in a relatively short period of time. In this respect play
therapy can be more of a preventive program of mental hygiene for the child used to explore attitudes and problems normally not as easily examined in school or in the home.

Moustakas further noted that disturbed and troubled children reacted differently to the therapy situation. He found that upon entering the playroom, they tended to exhibit diffuse and undifferentiated behavior. Feelings were often of a negative nature and there was often a tendency for the child to be withdrawn, distrustful, and anxious. Communication, for the most part, was expressed in sudden verbal outbursts, withdrawal, or by venting emotions on objects in the playroom itself. If the child's feelings of trust and acceptance increased, so too did his anger. Hostility became more specific as the relationship between the therapist and the child was strengthened. Gradually, as more and more of these feelings are expressed, the child usually experiences a release (emotional), becoming less intense while beginning to feel and think of himself more as a total person. He might begin to show a variety of ambivalent attitudes toward relative objects with fluctuations of positive and negative feelings being present. Finally, more positive feelings emerge and the child sees himself and his relationship with people as they are.
In addition, Moustakas stated that anxiety may progress and take on different patterns throughout therapy. In the beginning it may be diffuse and the child will be withdrawn and frightened. As therapy progresses anxiety may become mixed with both positive and negative feelings. Finally in the last stages it becomes clearly differentiated, and positive and negative attitudes towards people become clearly defined with the negative feelings becoming more moderate in their intensity.

The importance herein lies not in the actions of the child and the therapist but in the relationship and subsequent communication that develops through the therapeutic process. For if the child is given the opportunity to fully express his feelings without fear of reprisal, then a major step will have been accomplished in the solution of his problem.

Methodology

Preparations and Subjects

Both experimental and control groups were composed of four male and female fourth grade students, randomly selected from all fourth grade students enrolled in the Stonewall Jackson Elementary School, Denton, Texas, at the time of the study. All Ss were volunteers with assignment
to experimental or control groups being accomplished by means of randomization.

Apparatus and Materials

Play therapy with the experimental group was carried out under identical conditions in comparably equipped play-rooms. Parents and children met twice a week, one hour per session, for four weeks. Pre and post therapy measures of change included the Semantic Differential and the Roe-Siegelman Parent Child-Relations Questionnaire (PCR).

Procedure

The training of parents in the role of filial therapists was described by Guerney (1964). This procedure was followed in the present study. It involved training parents in groups of six to eight, to conduct play sessions with their children, using an orientation and methodology modeled after client-centered play therapy. After training, the parents conducted their play sessions in the clinic. Parents' sessions with the therapist began with discussion of the play sessions, but extended to any other areas that were relevant to the problem. Sessions with parents were designed to lift repressions and resolve anxiety-producing internalized conflicts. These sessions were designed to help the child to
obtain better feelings of self-respect, self-worth, and confidence from the therapy situation.

Therapy consisted of three stages. In the first stage, the parent received a simple explanation of the benefits to be derived from free expression and self-direction within the play therapy situation. The therapist strived to obtain in the parent a release from tension-producing inner conflicts, a freer communication between parent and child. An explanation and introduction of play therapy as it was presented to the mothers in the first stage of training may be found in Appendix B.

Lastly, the four goals of the session were explained to the parents. Guerney listed these as (1) the encouragement of complete determination of the activities of the child by the child, within certain limits, such as no destruction of nonplay equipment, no activities which would be harmful to the child or to the parent (physically), (2) the development of empathic understanding between parent and child with the child using play as a means of communication and expression, (3) the immediate communication back to the child that his needs and feelings are understood, and that he as an individual is accepted whatever his thoughts or feelings are, (4) the child must learn to see and accept
responsibility for his actions. In addition, in this study, a list of the basic principles of play therapy was provided for the parent along with a condensed list of Do's and Do Not's designed to aid the parent in conducting a successful and meaningful session for both herself and her child. These may be found in Appendix C.

Stage two consisted of eight sessions in which the parents began the actual play therapy within the clinic setting. This therapy was conducted under strict clinical observation and was carried out with the parent's own child.

In the study by Guerney (1964), stage three was set aside for the parent in order that she might terminate therapy as she felt the need for it diminishing. This stage was not employed in the present study.

Experimental Treatment

Rogerian client-centered therapy was used with an emphasis on establishing better parent-child relations. A video tape and lecture on play therapy with nonclinic children was given. Each mother demonstrated the therapeutic technique with her own child, receiving comments on her technique from the therapist (trainer). The parent's feelings were explored and their reactions demonstrated. The therapist in being reflective in his approach and primarily seeking
to provide an empathic understanding of their feelings, pro-
vided an example which they were expected to emulate in the
therapy situation.

A standard two by two analysis of variance was computed
on each separate scale of the PCR. Similar statistical
procedures were employed on the Semantic Differential with
analysis of parents rating children, children rating parents,
and both the parents and the children rating themselves.
Difference scores were used to determine the amount of change
that occurred on all tests. These scores were computed by
subtracting the pre-therapy measures from the post therapy
measures, thus revealing a difference or change score for
each of the scales of the PCR and Semantic Differential.
An analysis of variance of within subjects cells for the
Punishment S-L, Reward S-L, and Love dimensions of the PCR
was also used.

Results

Analysis of the results of the Semantic Differential
revealed no significant changes on the ratings of parent's
attitudes toward their children, children's feelings about
their parents, or in either the parent's or the child's per-
ception of himself.
Analysis of difference scores between pre and post tests on the PCR, Love scale, indicated that parent-child attitude changes had occurred, F(3.78)=4.87, p<.10. These results are reported in Table 1.

### TABLE 1

**ANALYSIS OF VARIANCE: DIFFERENCE SCORES, LOVE SCALE**

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<th>Source</th>
<th>df</th>
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<th>F</th>
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<tr>
<td>Between Subjects</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A (Treatment)</td>
<td>1</td>
<td>25</td>
<td>.49</td>
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<tr>
<td>Subjects Within Groups</td>
<td>6</td>
<td>50.625</td>
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<tr>
<td>Within Subjects</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (Family Members)</td>
<td>1</td>
<td>16</td>
<td>.59</td>
</tr>
<tr>
<td>AB (Child-Mother x Experimental-Control)</td>
<td>1</td>
<td>132.25</td>
<td>4.87*</td>
</tr>
<tr>
<td>B x Subjects Within Groups</td>
<td>6</td>
<td>27.125</td>
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</tbody>
</table>

*p<.10.

Further examination of the data revealed a significant interaction which could be accounted for by the changes in attitudes of mothers and children in the experimental group F(3.78)=4.43, p<.10. These mothers tended to see themselves more favorably while their children rated their mothers in a
less favorable light. In addition, although no difference was noted between children's attitudes in the experimental and the control group, an analysis of the change of mother's attitudes in both groups was found to differ $F(3.78)=5.02, p<.10$, with experimental mothers seeing themselves as becoming more loving than those in the control group.

The Punishment S-L scale, Table 2, proved to have a significant treatment effect $F(3.78)=4.35, p<.10$, with mothers in the experimental group reporting themselves as becoming less punishing than those in the control group.

**TABLE 2**

**ANALYSIS OF VARIANCE: DIFFERENCE SCORES, PUNISHMENT S-L SCALE**

<table>
<thead>
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<th>Source</th>
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<td>Between Subjects</td>
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<td></td>
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<tr>
<td>A (Treatment)</td>
<td>1</td>
<td>57.75</td>
<td>4.346*</td>
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<tr>
<td>Subjects Within Groups</td>
<td>6</td>
<td>13.29</td>
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<tr>
<td>Within Subjects</td>
<td>8</td>
<td></td>
<td></td>
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<tr>
<td>B (Family Members)</td>
<td>1</td>
<td>21.75</td>
<td>1.61</td>
</tr>
<tr>
<td>AB (Child-Mother x Experimental-Control)</td>
<td>1</td>
<td>72.75</td>
<td>5.40*</td>
</tr>
<tr>
<td>B x Subjects Within Groups</td>
<td>6</td>
<td>13.46</td>
<td></td>
</tr>
</tbody>
</table>

*p < .10.
An analysis of variance of mother-child interaction within the experimental group was also found to reach the level of significance $F(3.78)=5.40, p<.10$.

A child x mother effect, with mothers seeing themselves as becoming more rewarding and children reporting their mothers as becoming less rewarding for the experimental group, was found on the analysis of variance for the Reward S-L scale of the PCR $F(3.78)=3.8, p<.10$.

**TABLE 3**

ANALYSIS OF VARIANCE: DIFFERENCE SCORES, REWARD S-L SCALE

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A (Treatment)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjects Within Groups</td>
<td>6</td>
<td>15.83</td>
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<tr>
<td>Within Subjects</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (Family Members)</td>
<td>1</td>
<td>110.25</td>
<td>3.80*</td>
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<tr>
<td>AB (Child-Mother x Experimental-Control)</td>
<td>1</td>
<td>42.25</td>
<td>1.47</td>
</tr>
<tr>
<td>B x Subjects Within Groups</td>
<td>6</td>
<td>28.75</td>
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</table>

*p<.10.*
Discussion

Results of the present study suggest that (1) mothers in the experimental group changed more than those in the control group in their perception of themselves as a more loving and less punishing parent; (2) experimental mothers saw themselves as changing in the direction of being more rewarding than those mothers who did not participate in the play therapy situations; and (3) children in the experimental group saw their mothers as becoming less rewarding than those in the control group. These data indicate that mothers involved in the sessions with their children changed towards seeing themselves much more favorably than control mothers, while their children viewed their mothers less favorably than their counterparts in the control group.

These findings tend to substantiate those of Stover and Guerney (1967) and Stollack (1969), that the mothers tended to view the children in a much more positive manner while children's attitudes toward the parent were of a more negative nature. On the basis of the aforementioned studies, it may be assumed that additional sessions might bring about a decrease in the number of negative attitudes while increasing the amount of positive feelings toward the parent. It is felt that the negative feelings are the result of the client-centered approach which permits the child to express
hostilities openly without fear of repression or censure. In addition, activities and expressions which previously in the child's experience brought effusive praise and reward were simply recognized or reflected back to the child in the therapy situation. Results of parent-child attitudes on the Love Scale of the PCR may be seen in Figure 1.

![Graph showing mean difference scores on loving](image)

**Fig. 1. Mean Difference Scores on Loving**

The increase in positive feelings felt by the mother may possibly be explained by the increased self-satisfaction enjoyed by her in the play therapy sessions. By being placed
in a position where she can gain insight into her own attitudes about her child, as well as her child's feelings about her, she may willfully attempt to improve her relationship with her child under a controlled and supervised situation. Therefore, it seems logical that such conditions, in themselves, would tend to promote both increased self-awareness of one's own attitudes toward one's child as well as a deeper insight into the child's feelings about the parent.

These findings are further revealed in an analysis of mother-child attitudes on the Reward S-L scale of the PCR.

![Graph showing mean difference scores on Reward S-L scale](image)
It is evident from these results that the therapy situation is a more self-satisfying experience for the mother than for the child. This may be explained by the fact that the mother is placed in the session by a trained person. Not only are rules set down to insure the "psychological" safety of her child, but there is the inherent faith that the parent has in the therapist-trainer and in the controlled nature of the study. She believes that whatever is prescribed by the trainer must be for the good of herself and her child for he surely would never let her be punishing or hurt the child. Finally, responses to activities and expressions by the child which previously elicited punishment now produce only recognition and reflection. This gives the parent an obvious example of how, in her new role, she has overcome her old patterns of punishment and is taking on the role of the "understanding" parent. This is reflected in Figure 3, which indicates that mothers who participated in the play sessions with their children did, in fact, see themselves as much less punishing than those mothers in the control group.
Because the combined sample for experimental and control groups was only eight, the level of significance, p<.10, was felt to accurately reflect any attitudinal changes that might occur. It is recommended that in future studies, larger samples should be employed. In addition, a comparison of mothers and children selected from a normal population and a similar sample of mothers of children with behavior problems might reveal greater differences, not only within the normal mother-child interaction, but also in the parent-child relationship of problem children. It is in this area that the greatest applicability for future treatment may be found.
Appendix A

Axline's Principles of Play Therapy

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way, the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.
Appendix B

Explanation and Introduction of Play Therapy

We have asked you here to seek your cooperation in studying the relationship between parents and their children. Specifically, we intend to place both you and your child in a situation in which you, the parent, will serve as play therapist. By so doing, we hope to enhance the relationship between parent and child by opening the lines of communication and thus enable both of you to perceive the other in a more realistic light.

The procedure to be employed in the therapy situation is commonly referred to as play therapy. It has as its major function the reflection of the child's feelings to convey through empathy the values or attitudes that the therapist believes to be a basic part of therapy, in the hope that it will lead to emotional clarification of the child's feelings. Its main concern is with the kind of relationship which will enable the child to grow through increased faith in himself. The important point lies, however, in the faith that is expressed by the therapist to the child, the belief that the child has the potential to work out his difficulties for himself. Thus, the child is given the opportunity to express his feelings as he sees fit, to be open and free to explore without fear of reprisal. By criticizing or disapproving, rewarding or approving, the therapist directly threatens those feelings of acceptance that he is striving to establish.

The parent, as a relevant person in the child's "therapy," must take upon himself certain basic attitudes toward the therapeutic process. He must show interest, attention, and concern for the child in the therapy situation, for without this he deprives the child of the primary means that he has of coping with his problem and effectively conveying his feelings. The parent must ask himself such questions as "What feelings, what attitudes is this child expressing to me now? What essentially is he telling me?"

Although results of this study will be published in the future, all names or other identifying remarks will be changed or disguised so as to insure the identity of the participants. Finally, any notes or discussions of therapy sessions will be kept in such confidence as to honor the patient-psychologist relationship.

Are there any questions?
Appendix C

Principles of Play Therapy

1. Be permissive. Encourage the complete determination of the activities of the child by the child, within the specified limits.

2. Place limits. Do not permit activities which would be physically painful either to the child or to others and activities involving destruction of nonplay material. Set total limits, not conditional limits. Use the passive rather than the active voice when setting limits. Do not associate the child's self with the limited behavior.

3. Develop empathetic understanding. Be aware of the basic needs and feelings of the child as communicated or expressed through his play. However the therapist must maintain his own integrity, and self-respect and should not be subservient or self-derogatory in an effort to obtain the child's affection.

4. Recognize and reflect the child's feelings. Reflect feelings which can be observed from the child's verbal or nonverbal behavior. Do associate the child's self whenever reflecting feelings. Do not interpret the child's behavior or try to explain who he acts or feels a certain way. Paraphrase the child's verbalizations without altering the meaning. Grammatically, reflections take the form of simple sentences, never questions. Through the technique of reflection, communicate to the child that his feelings and needs are understood and that he is accepted as an individual whatever his needs and feelings are.

5. Social reinforcement. Social reinforcement is inherent in interpersonal contacts and may be either positive (rewarding) or negative (punishing). Positive reinforcement tends to increase the rate at which that behavior occurs while negative reinforcement tends to suppress the rate at which such behaviors occur. Some examples of negative social reinforcement are a frown, tone of voice, smack, shaking of the head. Some examples of positive social reinforcement are a smile, nod of approval, tone of voice, smile, a pat on the head. The therapist like the parent must be continually on
guard against inadvertently reinforcing undesirable behaviors and must reward desirable behaviors at least occassionally in order to prevent their extinction.

Do

1. Accept the child as he/she really is.
2. Set limits on physical acts harmful to himself or to you.
3. Give clear definitions of acceptable and unacceptable conduct when appropriate measures are needed.
4. Set limits in such a way that the child's self-respect and the self-respect of the parent remains intact.
5. Set limits in such a way that the child can tell clearly what substitute will be accepted. (4 step sequence, 7-10)
6. Recognize the child's wish and put it in simple words.
7. State clearly the limits on a specific act.
8. Point out a way in which the wish can be at least partially fulfilled.
9. Help the child express some of the resentment that is likely to arise when restrictions are imposed.
10. Establish a feeling of permissiveness in the relationship so that the child is free to express his feelings completely.
11. Establish only those limitations that are necessary to anchor the session to reality.

Do Not

1. Possess an over-riding need to be liked by your child.
2. Restrict your child from expressing his feeling in symbolic play.
3. Apply restrictions with violence or anger.

4. Attempt to direct your child's actions or conversation in any way. Let him lead the way during the session.

5. Attempt to hurry the "therapy" along.
REFERENCES


Harris, F. R., Montrose, M., & Baer, D. M. Effects of adult social reinforcement on child behavior. *Young Children*, 1964, 20, 8-17.


