PLAY THERAPY WITHIN AN ECOLOGICAL PERSPECTIVE

BY

LESIA SHEPEL

A practicum
submitted to the
Faculty of Graduate Studies
of the
University of Manitoba
in partial fulfillment of the
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How many days has my baby to play?
Saturday, Sunday, Monday,
Tuesday, Wednesday, Thursday, Friday,
Saturday, Sunday, Monday.
Hop away, skip away,
My baby wants to play,
My baby wants to play every day.

- An Old English Nursery Rhyme

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Abstract

This practicum report focuses on the practice of play therapy with children ages four to nine within an ecological perspective. Theory regarding the ecological perspective, developmental attributes of children ages four to nine, and descriptions of various modalities of play therapy are provided. Five case illustrations are given, and efficacy of practice is subsequently evaluated.

Acknowledgments

Acknowledgments tend to be maudlin and this one is without exception.

To my advisor, Dr. Kathryn McCannell, and other members of my committee; Dr. Mary Warmbrōd, and Professor Walter Dreidger, I extend a heartfelt note of appreciation:

To Kathryn for your patience, wisdom and guidance in this travail. Thank you for helping me keep the panic in abeyance.

To Mary for challenging me; making me think and then making me think some more.

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On a personal note, thank you to my support network who have sustained me both figuratively and literally at times:

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"I get by with a little help from my friends..."

L.S.

Preface

The process whereby graduate social work students arrive at a choice of practica has always been of interest to me. My choice of interest area evolved while I was working as a social worker primarily with children at the Canadian National Institute for the Blind. It was borne out of frustration with the paucity of community services in the city to refer children to for play therapy as I lacked that expertise. It was not that people were hesitant to see children who were visually impaired. At the time, there simply were not a large number of people who had expertise in this area. To be seen by them, a child must either already be an in-patient in a hospital, or a client with the play therapist's agency, or his or her parents able to afford private practice fees.

The small number of people doing this kind of work at organizations such as the Psychological Service Centre could only take referrals on a limited basis. What to do? Without--for the time being.

The direction my work and academic experience has taken has always been based on conscious planning rather than accident. Career goals have been molded by my past academic and work background and experience. All my social service work experience has involved work with children either in recreation, child welfare, or rehabilitation.

As children have families and relevant others, they too usually entered the picture. Not only had I encountered a service gap in the community but also in my own skills. Along with my B.S.W. I had a B.A. with a double major in theatre and social psychology. (Not such an unlikely combination when one considers psychodrama, role playing and play therapy using story telling and puppetry.) With my past background and work experience it seemed to make perfect sense for me to develop expertise in this area. I was to approach Dr. Kathryn McCannell who had knowledge and skills in the area to act as my advisor in the M.S.W. program and voila! my decision was made.

My goals in the graduate program were to develop a solid knowledge base of:

- the emotional and cognitive developmental stages of children;

- family therapies which incorporate a systemic approach;

- skills in working with young children incorporating use of play, drama, puppetry, art (such as painting and drawing) and story telling.

I hoped to consolidate all of this academic knowledge and make use of it in designing a practicum which would allow me to develop my individual therapy skills with children and social work intervention with their families and larger social systems.

Although it is customary in clinical social work for practitioners to develop a practicum working with a specific population group such as sexually abused children or children affected by divorce or separation, I chose to focus primarily on skill development and work with a heterogeneous population group of children. I felt this would give me the broadest range of experience possible. For this same reason, a decision was made to see four to nine year olds because this age group, consisting of pre-schoolers and school aged children, also encompassed two distinct developmental periods. As I have a commitment to work with children in their situation, incorporating all their relevant systems, it made sense to centre the individual work with the child within an ecological perspective.

I can say with great satisfaction that my goals both academic and within my practicum, have been met.

INTRODUCTION

The process of entering into a therapeutic encounter with a child is a vastly complicated endeavor. There are a myriad of questions that must be addressed before the first session even begins. We need to have some beginning sense of the child, their history, and what is happening to them now. And since children live with families or caregivers in a larger social setting; all interacting and impacting on each other, we also need to have some beginning sense of what life is like for this child in the larger societal context. This is our "research" and with the information we gather we begin to build a mutable hypothesis of what is going on, why, and how we might be able to effect change.

It is important to make reference to theoretical literature and frameworks to organize our thinking and the information gathered for our work must always be informed and guided by theory. This practicum report is a documentation of the theoretical literature that has informed my practice and lastly, a description of how the literature has been operationalized to direct my endeavours during this practicum.

Section One: The Literature Review

CHAPTER 1

THE ECOLOGICAL PERSPECTIVE

The profession of social work has long recognized that an individual cannot be understood outside the context of his or her environment (Richmond, 1930). Individuals and their environment are seen as mutually shaping systems, each changing over time and adapting to changes in each other. There is an adaptive fit between each of us and our environments by which we achieve a dynamic equilibrium and mutuality (Germain, 1981). An orientation to context and the adaptive balance existing between individuals and their environment defines an ecological perspective (Auerswald, 1968; Bronfenbrenner, 1977). This perspective conceptualizes the person-family constellation in its life-space and focuses on the transaction between the person and the social environment. It presents a framework for the social worker to view the "person in situation" and to organize the complex relationships among the various parties who influence a person's behavior and whom the person, in turn influences. Hoffman (1981, p. 257) describes the "ecological systems approach" as "directed at the total field of the problem, including other professionals, extended family, community figures, institutions ... and all the overlapping influences and forces that a therapist working with ... families would

have to contend with." The arena of action for the helping person is expanded.

Bronfenbrenner (1979) proposes an organizational framework to make sense of all the information regarding the different levels of related social systems involved with an individual. He sees the individual's experience "as a set of nested structures, each inside the next, like a set of Russian dolls" (1979, p. 22). A visual conceptualization is presented in Figure 1.

Insert Figure 1 about here.

At the centre is the individual for we must keep in mind that within an ecological framework, the balance of environmental forces is not the sole determinant of outcomes. The individual brings to the situation a unique arrangement of personal resources, a particular level of development, and various other attributes. Different people react differently to the same environment and vice versa (Garbarino, 1982).

The level most immediate to the individual is the microsystem. The microsystem is the actual setting in which the individual experiences their reality and the

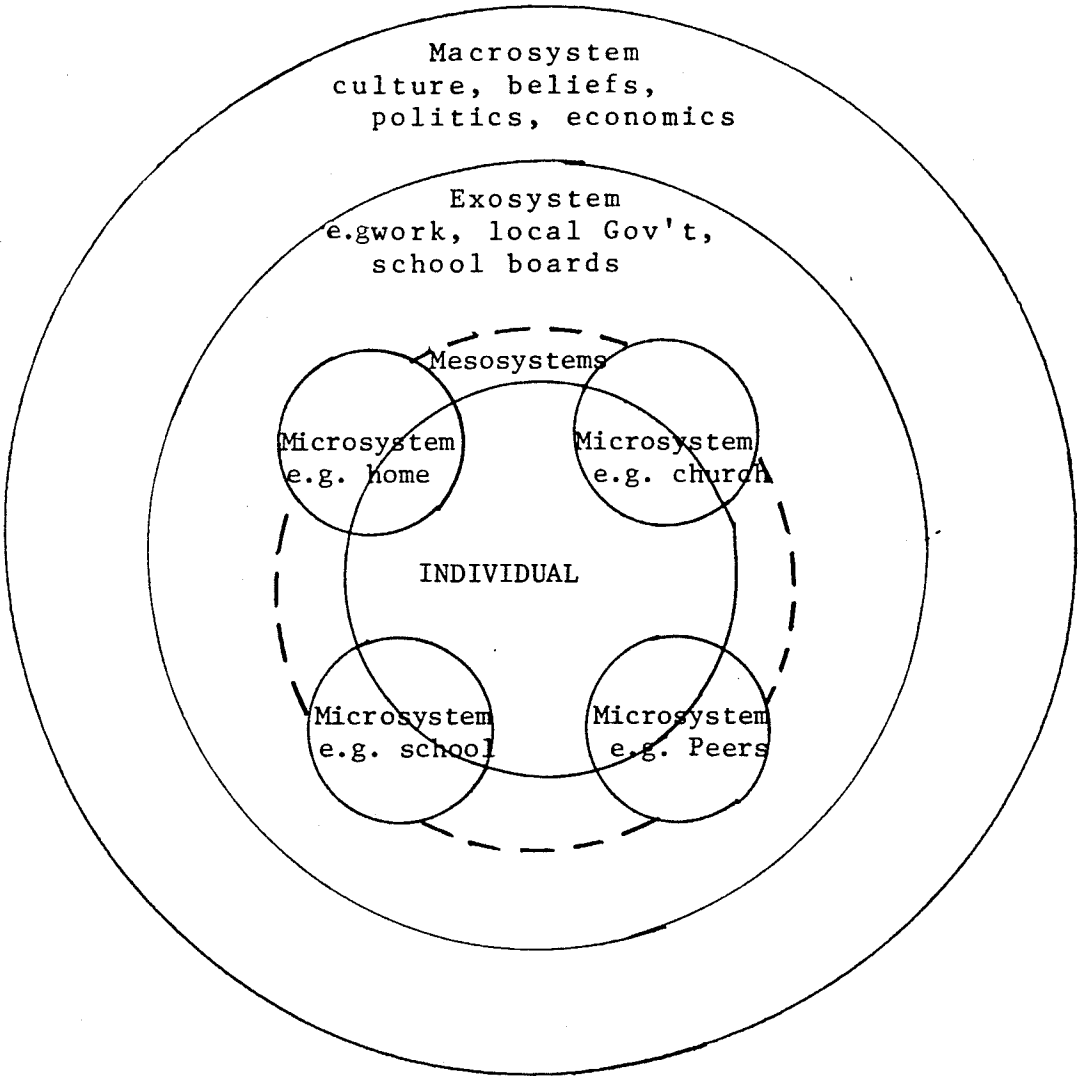

Fig. 1 Conceptualization of Bronfenbrenner's Framework for understanding the individual within an ecological perspective.

people with whom they have the experience. For children their microsystem would be their home, school, peer group, scout or guide group--their immediate context. "As long as increased numbers in a child's microsystem mean more enduring reciprocal relationships, larger and more complex microsystems as a function of a child's age mean enhanced development" (Garbarino, 1982, p. 22).

Bronfenbrenner calls the next level of systems mesosystems. These are the relationships between contexts or microsystems. An example would be the connection between home and school. If parents have not connected with school the child is the only link between the two systems. Richness of mesosystems for a child are measured by the number and quality of connections. It is felt that the stronger and more diverse the links between the settings, the more powerful an influence the mesosystem will be on the child's development.

The next set of systems which Bronfenbrenner calls exosystems are settings where events occur that have direct bearing over the child's life but in which he or she does not participate directly such as parents' workplace, school boards, and local governments.

All systems are influenced by the broad ideological and institutional patterns of our particular culture or subculture called macrosystems. They can effect how we can

perceive childrens' behavior. Children whose native culture encourages them to be respectful of their elders and deferential can be perceived as passive and lacking in spirit by their teachers. Certain types of behavior can be perceived as inappropriate for boys or girls.

In summary, the framework offered by Bronfenbrenner gives the ecological persepctive utility as an outline for assessment and intervention with children in their total environmental context. Interventions must make use of the natural systems and take place within the life space of the child. The child's system should be perceived as an instrument of change. As Hartman and Laird (1984, p. 74) state "the attempt to devise strategies which make use of natural systems is an effort to avoid the development of artificial helping actions which may have unknown but pervasive iatrogenic effects." Salzinger, Antrobus and Glick (1980) feel that a major limitation of most therapies with children is that their gains are not maintained after the termination of professional treatment. They feel it is imperative for helping profesionals to select treatment modes that are socially and culturally appropriate for the child in his or her particular eco-system so as to maximize the possibility that the child's own environment can support the treatment. The professional service providers are not the only parties in the child's eco-system. As

helping professionals we should not be so vain as to assume that only our efforts produce behavioral change--many people have an impact on the child, are part of the development and maintenance of the child's behavior and can be enlisted as agents in the change process. "The goal of intervention programs, wherever possible, should be to fade out the professional, to turn over the responsibility for maintenance, continuation and enhancement of treatment effects to caretakers in the child's everyday environment and to the child" (Salzinger et al, 1980, p.5). By involving significant others in the child's environment we are giving the child support in overcoming whatever difficulty he or she is facing. Change in a child's behavior or communication will impact upon his or her system. It will require strength, power, and support for the child to resist the system's pressure to "change back". Efforts aimed at change will generalize more readily if the rest of the system is engaged and prepared to support the changes in the child. There is less possibility of "sabotage", either deliberate or unconscious, of the worker's efforts.

The ecological perspective sees behavior as multi-causal. Therefore, children are not made to feel as if they are the problem and a "bad person" with all the implications such a label has for their self-concept. So-called maladaptive behavior can be seen as a healthy

adaptation to an unhealthy set of circumstances that does not allow a child to develop more socially acceptable means of seeking a response to his or her needs. It would be important to assess what function the problem behavior serves for the child. Perhaps the behavior aids him or her in gaining some sense of control over his or her environment.

The ecological perspective emphasizes "health" and the coping mechanisms already in place, unlike the medical model which is more prone to focus on pathology and hence, may view the child as a collection of symptoms indicating some disorder residing at a specific time within the child. Salzinger et al. (1980) describe behavior problems as redefined to be a relative rather than an absolute concept. "Disturbed behavior within an ecological framework ... is largely defined by the society itself as behavior that is unacceptable in the situations in which it occurs in its present form and thus is selected for modification" (Salzinger et al., 1980, p. 4). They use the example of the active child who may function well in a stimulating family or sports oriented peer group but is labelled as "hyperactive" on the basis of such behavior in a formal class-room.

This does not mean that the environmental factors are the main determinants of behavior and that it is only necessary to alter the conditions of the environment in

order to effect change in the child's behavior. Behaviors are the result of an on-going organism/environment relationship that is characterized by a process of accommodation and mutuality producing continuous change in both systems. Hartman (1958), talks about a "fitting together" or adaptation taking place between a child and his or her environment.

More specifically, each child brings a unique constitutional make-up or temperament (Thomas & Chess, 1980) to the relationship. The concept of temperament involves such variables as mood, activity level, distractability, persistence, and responsivity. These variables, products of a complex person-environment relationship, prompt further responses from the environment and a pattern of interaction is established. "This pattern can promote or impede many features of a child's cognitive and emotional growth depending upon the goodness-of-fit between the child and his world; that is, the impact of temperament is predicated upon whether a child's behavior fits with the specific demand of the environment at that time" (Brooks, 1984. p. 91).

The role of environment, situations, and the players therein influencing an individual's behavior is crucial but the person's behavioral responses also depend on how the information from the environment is processed by the individual. There is interdependence between behavior and

the environmental conditions which are "mediated by the constructions and cognitive activities of the person who generated them" (Mischel, 1972, p. 279). The process of thinking always involves an interaction between the individual's on-going mode of thinking and what is encountered in the environment. "Individual and environmental can only be viewed as a syncretic whole" (Maier, 1978, p. 27).

Piaget (1952) describes the process whereby a person builds a conception of his or her world based on internal processes and the influence of the environment. According to Piaget, the individual's adaptation of past experience is known as **assimilation.** An individual conceives of an event in terms of his or her way of thinking. An experience is then incorporated, without a break in continuity, into a person's on-going way of thinking in a way that present understanding allows. The individual's adaptation to external or environmental experience involves the Piagetian process of **accommodation.** Accommodation means changing an earlier conception in an attempt to incorporate the information from the present environmental factors as far as the individual can understand and manage at the time. Piaget uses another concept, **adaptation**, to describe how individuals balance their personal experience as it impacts on them within the context of the environment. Maier (1973, p. 23) describes the process aptly; "every

interaction requires an individual to think, to feel and to act as previous experience dictates, and such interaction is always challenged by environmental experience to feel, and to act according to the impact of the new situation". He states that Piaget considers social learning to be a process of personal adaptation between what is understood and mastered previously and what is perceived as new and appropriate to be mastered. In other words, social learning is an ongoing and balancing process between internal and external impressions. New comprehension prompts new behavior.

The cognitive processes outlined above, whereby our conceptions of the world are developed and altered, are especially applicable to children. Children are actively taking in experiences to organize and to try and understand their world. Children construct a copy of the external environment to the best of their capabilities at their particular developmental stage. Feelings are also evolving along with cognitive processes for the two are inseparable. Maier (1978, p. 26) quotes Piaget who states that "both (intellect and affect) are always together as one." The adaptive experience the child is encountering has affective qualities also.

The child's internal construction of their world may be inappropriate given that information may be limited, cognitive processes are only as sophisticated as his or her

developmental level, and life experiences are limited due to age. The child acts on his or her copy of the world and develops a history of interactions and resultant behavior patterns with those in his or her environment. If these behavior patterns are dysfunctional, a worker using the ecological perspective can show parents and significant others in the environment how they maintain the behavior and help them to change how they react to the child. However, the child may still persevere in old patterns along with harboring unexpressed emotions about the environment and experiences within it.

Individual therapy within an ecological perspective has much to offer such a child. The therapeutic experience will give the therapist access to the child's internal constructions of the world and personal perceptions based on how the world has responded to his or her behavior. Based on information gained from the child the therapist can also develop more ideas on how to work more effectively with parents and significant others. The individual therapy session offers both a place for the child to regress safely and a chance to re-work experiences to change behavior patterns the child has acquired. Among these patterns are how the child thinks of self. For example, in working with a child who is visually impaired and having difficulty with fear of new situations, family

and the school system may be made aware of how they have reinforced his or her symptomatic behavior in the past and take steps to remedy it. However, the child still perceives self as powerless and dependent, is bewildered at no longer receiving the support previously accustomed to, and is fearful of embarking on any new experiences alone.

Individual therapy can serve as a corrective experience whereby, children can express themselves and develop feelings of self worth and mastery of their world. Repeated experience with these new ways of feeling will lead to new ways of thinking. New ways of thinking will lead to different ways of experiencing the world.

Piaget, as quoted in Maier (1978, p. 27), states that experience rather than maturation defines the essence of cognitive development. The nature of a person's life experiences--"their degree of availability and variation--can bolster, accelerate, retard and vary the rate of a person's development, including whether development can progress to any extent at all." Therapy may provide an experience that a child missed at an earlier developmental level or substitute a corrective experience for an inadequate or negative developmental experience. For this reason it is essential for the therapist to be aware of what the stages of normal child development are

and to be able to assess at what level the child they are seeing is functioning. This will afford the therapist invaluable information on how to engage the child most effectively in therapy. Therefore, the next chapter proceeds with a discussion of the developmental attributes of children ages four to nine.

CHAPTER 2

NORMAL DEVELOPMENT OF CHILDREN AGES FOUR TO NINE

As mentioned earlier, it is important not to lose sight of the individual child within the eco-system. Characteristics such as age, the corresponding developmental level he or she is functioning at, what the corresponding developmental issues may be, and an idea of how the child may characteristically react to situations are items of information that can help us to select therapeutic activities that are most appropriate for the individual child. As the focus of this practicum is clinical work with four to nine year olds it would be important to know what the corresponding characteristics and developmental issues are for this age group. Therefore, this chapter will review normal child development of this age group primarily within Piaget's cognitive developmental framework and Erikson's psychosocial theory which addresses mainly affective development. As both theorists' descriptions of phases roughly fall into the four to seven, seven to eleven year age group, for the purposes of my practicum report, I have also chosen to adopt these headings in my discussion of developmental attributes except for the latter category which will, whenever possible, include material relevant only to the seven to nine year age group.

A knowledge of normal child development is necessary for assessment and design of a subsequent appropriate intervention. The relative normalcy or deviance of any behavior must be viewed against a developmental framework. A normal response at one age can be grossly pathological at another. Assessment of any given child must take into account the dynamic process of development, both in terms of the specific child's development and how they compare with others at their particular stage of growth. A specific example of this would be that of a sexually abused child who exhibits age inappropriate sexual knowledge or concerns about sexual matters (Waterman, 1986).

Further, children of different ages and developmental levels will have differential responses to the same phenomena. Wallerstein (1976), in studying reactions of children to their parents' separation and divorce noticed that those from seven to ten years of age versus five to six year olds in her sample were identifiable as a distinct group in their major initial responses along several dimensions to parental separation and divorce. "The variations were considerably sharper than anticipated and reflected developmental differences in perceptual, cognitive, affective and dense configurations" (Wallerstein, 1976, p. 22). Hess (1981, p. 504), citing a review article by Woody, describes differential behavioral

responses of children experiencing parental divorce, varying from "sad/angry and lost/detached behavior (nursery school aged), high anxiety and adjustment problems (pre-school aged) and a decline in school performance and increase in temper tantrums, scolding, demandingness, and dictatorial attitudes for latency aged children." In order to illustrate differential emotional and behavior responses correlated with age and developmental level, reference has been made to children who are experiencing the specific event of separation and divorce. However, this example can be assumed to generalize to other situations. To understand a child's coping response to an event, his or her developmental needs must be considered.

A child's behavior largely reflects the way in which he or she perceives the world. If we are to understand this behavior, both normal and abnormal, we must grasp the manner by which he or she structures the environment. Knowledge of the cognitive level of the child is very important for an understanding of his or her actions. (This is especially relevant in the case of the seven to nine year old who will be experiencing burgeoning cognitive abilities.) Piaget has made enormous strides in helping us get a glimpse of how the child constructs his or her phenomenological world. However Piaget has also stated that human behavior is not all cognition, nor all affect.

Maier (1978. p. 191) quotes Piaget on this point:

> There is no affective behavior and cognitive behavior. Behavior is always both. Thus, only an analysis, an abstraction for the study of their respective mechanisms separates these two aspects which in reality are always present simultaneously. Hence if one acknowledges affectivity and cognition...as two aspects of behavior, it makes no sense to wonder which causes which or even which precedes which. One aspect does not cause another aspect or precede another aspect. They are complementary because neither process can function without the other.

Erik Erikson's focus on affective interpersonal processes is needed to supplement Piaget's contribution. Each theory alone contains a partial and different answer concerning child development. Together they provide a larger picture. However, there are many facets to a child's being--they are not a dissected entity. If children are to be helped toward successful development they must be viewed in light of their total development.

Piaget's Perception of Development

Piaget believes that at every stage of development the world is experienced by the individual in an age-appropriate manner with the earlier forms of cognition laying the foundation for the later stages, eventually

leading to the abstract concepts of adult thought (Bemporad, 1980). Experience rather than simple maturation defines the essence of cognitive development. Development evolves from individuals' experience of themselves and what they encounter in their environment (Piaget, 1952). According to Piaget, cognitive development proceeds within an orderly, predictive progression which is universal in sequence but which varies in rate and chronology from child to child and between sociocultural groupings.

Although his phases are frequently cited as if they were entities, they are actually no more than points of reference for understanding the sequence of development. Individuals are never aware of being in one phase or another; they merely interact. Piaget's accounts of the phases of cognition may create the false impression of a step-by-step phasal development which an individual descends into whenever the time is right. It is more appropriate to view each individual always as much in transition as within a phase. The phases happen in a definite order at approximate age spans in the continuum of chronological development. Piaget maintains the order of succession is always the same. "Developmental phases are age bound since they depend on the completion of the previous phase, but they are also age free, since age does not determine their occurrence" (Maier, 1978. p. 28). The actual rate and degree of completion of each phase varies

with each individual. Developmental phenomena may easily continue beyond their usual approximate age levels. It is likely an individual will achieve maturity in one area while still struggling with other aspects of development.

Maier (1978) states that a wide range of research on these phasal progressions in children on all five continents of the globe has revealed that while chronological ages cited by Piaget vary from place to place at times, the Piagetian sequential order of stages and phases never varies.

Erikson's Perception of Development

Erikson regards human development as a synthesis of developmental and social tasks. The Freudian notion of the psychosexual development of libidinal phases has been converted to one of psychosocial stages of ego development (Maier, 1978; Achenbach, 1974). The ego, rather than the id becomes the life force of human development. Erikson's major preoccupations are with the processes of socialization; the relation of the ego to society (Erikson, 1963, 1966, 1968). His psychosocial developmental phases are the product of interactional experiences between each child and his or her world.

The progression from developmental phase to phase is not linear but "a zig zag course from phase to phase and within each phase, a constant state of imbalance, a striving to incorporate irreconcilable differences"

(Maier, 1978, p. 86). Each developmental stage is defined as a time of crisis in which the individual's innate maturation encounters and conflicts with social mores. Each stage consists of a task which should be mastered if adequate development is to continue. Depending on how the challenge of the task is met, each stage is a choice point that leads either to continued growth along healthy lines or deviation in healthy development. The solution of the dilemma of each phase generates the struggle for the next. There is no mention that anyone has to solve these dilemmas. Hardly anyone does. Also, each successive phase provides the possibility of new solutions for previous dilemmas. Old developmental issues are taken up anew and differently in each subsequent phase (Erikson, 1963). Individuals develop and move into subsequent phases as soon as they are biologically, psychologically, and socially ready. Individual readiness is matched by society's readiness to relate to him or her in a different fashion. Individuals not only develop, they are socialized. Maier (1978), in discussing Erikson''s theory, summarizes well the interplay between the individual, biological, psychological, and social forces.

> Children, adolescents, and adults grow and develop, first on the basis of innate laws of development which like biological processes, are irreversible. Secondly, they develop on the

> basis of socio-cultural influences which specify the desirable rate of development and favor selected aspects of biological development at the expense of others. Thirdly, their development is based on the idiosyncratic way they manage their development, on their native endowment, and on the way society responds to them (p. 88).

Erikson also focuses on the individual's experience, attempting to describe the child's conscious experience at each stage, describing development in terms of how the child is viewed by himself and others. He also acknowledges the fundamental psychoanalytic concept of innate maturational stages with the sequential unfolding of unconscious instinctual forces (Erikson, 1963).

For both Piaget and Erikson, developmental phases are products of interactional experiences between a child and his or her social environment. They also suggest that human development arises out of the interplay between opposing forces. Erikson ascribes this polarity entirely to tasks presented and the struggle between opposing internal pulls on how to resolve them. Piaget allocates the polarity to the contrast between an individual's internal understanding and the reality of the outside world. New comprehension prompts new behavior. To Erikson, satisfaction obtained in the interaction encourages new behavior.

Section 2.1 Normal Developmental Attributes of Children Ages Four to Seven

This age period corresponds to Piaget's intuitive thought stage; part of the larger pre-operational phase of behavior spanning roughly from two to seven years of age. Simple representations or intuitions of the world begin to occur at ages four to five. These are later followed by articulated representations or intuitions which occur between the ages of five and seven. Due to acquisition of language, increased memory capacity, especially evocative memory, the heightened ability to differentiate perceptual experiences, and knowledge of the rules of arithmetic and logic, the child is capable of increased intellectual performance (Sours, 1980). However, children of this period have difficulty entertaining two ideas simultaneously; they can only think of one idea at a time.

Although internal conceptualization is possible at this stage, the child's internal world is still a concrete mirror of reality. Although concrete, the young child's thinking is far from objective or accurate. Reality will often be distorted to comply with his or her elementary understanding of the world. Reasoning is neither inductive nor deductive but what Piaget calls transductive (Piaget, 1955). "Events may be viewed as related not because of any inherent cause and effect relationship but simply on the basis of spatial and/or temporal continuity or

juxtaposition" (Harter, 1977, p. 421). At this stage, the child is unaware and unconcerned about possible contradictions in his or her logic. This has important implications for adults hearing a child's story which may not proceed in a logical fashion as we know it and who therefore become frustrated or assume that the child is lying because "it doesn't make sense."

This age period also encompasses Erikson's (1963) phase of initiative versus guilt which parallels Freud's phallic stage (ages four to five).* Children of this age have mastered locomotion and their use of language has improved. Strides in this area allow them to access and integrate more information about and in their environment. This permits them to expand their fields of activity and imagination; a fact which may also be frightening. A sense of initiative permeates most of their lives at a time when their social environment is challenging them to master specific tasks. The autonomy they have achieved also

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*For the sake of convenience and because its issues are more relevant to that time period, the next phase, industry versus inferiority, paralleling Freud's latency stage (ages six to eleven) will be discussed in Section 2.2.

causes them to experience and have to overcome a sense of guilt and a corresponding desire to curtail their initiative whenever conflict arises between them and their care-givers. The struggle over whether to move beyond such boundaries or remain as they are (with a corresponding return to dependency) causes further conflict because the developing individuals are denying their own desires and the opportunities offered by the environment. This polarity of initiative versus either passivity or guilt for having gone too far provides the major theme of this period; usually encompassing the pre-school and kindergarten years.

Erikson (1963) implies that the individual's potential capacity to work and achieve economic success within society depends on his or her mastery of this developmental phase. A sense of purpose can be realized during this period.

Role of this Stage in Socialization of the Child

The child's thinking remains largely egocentric with a continuous shift towards incorporating the thinking of important adults as their own. Social contacts in the larger world help reduce egocentricity and increase social participation (Maier, 1978).

Children begin to notice and ask questions about sex and other role differences in their environment. This

awareness affects both their self definition and the course they must pursue according to the social demands of society (Erikson, 1963).

Language

The child is now increasingly able to understand logical rules and syntactical structures of language. Language is used for classifying, describing and comparing objects found in the world (Piaget, 1969). Nuances of language are possible by age five and words can now be differentiated into meanings which are applicable to specific objects and events (Sours, 1980).

Maier (1978) discusses the threefold purpose language serves during this stage. First, language is employed to reflect upon an event and project it into the future. Children of this age can often be heard conversing with themselves. Secondly, language remains a vehicle of egocentric communication. Children assume everyone thinks the same as they. Verbal arguments become vehement because words are readily accepted as the equivalent of thoughts and actions. For this reason children might cry for having been called stupid because they feel being called stupid actually makes them stupid. Thirdly, speech and conversation are extensions of thinking aloud. By the time children start school a large part of their thinking involves verbalizations of their mental activities.

Individual thoughts are projected into the social plane and encourage collective expressions. At this point speech involves a "collective monologue" analogous to parallel play. Speech serves as a mutual excitation to action rather than as a means of exchanging messages and ideas (Maier, 1978).

Children increasingly use appropriate language without comprehending what it implies. For example, children in the early years of this phase may refer to left and right but have no understanding of the concepts of left and right. They speak and act as if they know but their cognition is primarily intuitive.

Relationship

In psychoanalytic psychology this developmental phase is noted for its Oedipal conflict. Erikson's (1963) interpretation of the Oedipus complex talks about purposeful affection where children reach out to parents who have most proven themselves and are available as love objects rather than in any form of incestuous overtures as others may have intimated.

Intuitive thought introduces a beginning awareness of relationships, which in turn introduces a beginning notion of hierarchies (Maier, 1978). To children in this phase, the family consists of all living things in their immediate physical proximity, often including family pets. It is

difficult for children to understand that they belong to a particular family, a particular town and a particular country all at the same time. A child's sense of not being able to belong to more than one person at the same time then becomes understandable, such as in the case of children protesting that they cannot belong to a grandmother because they belong to their mother.

Harter (1977, 1983) cites findings that show how a child's egocentricity during this stage leads to their having difficulty separating their emotional states from those of their parents. This was especially relevant for children ages four to six. The larger majority of the youngest children in Harter's research indicated that they would experience the same feeling as the parent. Generally, the trend decreased as the children got older except for responses to parental happiness and fear. Children of all ages indicated they they would experience similar feelings if the parent were feeling this. In this same study Harter reveals another developmental sequence with regard to childrens' understanding of the cause of parental emotions. Children were first asked what would cause them to feel happy, sad, mad and scared. They were then asked what caused both their mother and father to experience each of these same four emotions. A content analysis showed a three stage sequence:

1. The same event which evokes a given emotion in the child was seen by the child as evoking the same emotion in the parent. Children egocentrically projected the causes of their own emotions onto the parents.

2. The child is the cause of parental emotion. The child places himself or herself at the causal centre of the parents' emotional life. Feelings of responsibility for parental anger are extremely prevalent at every age, from four to eleven. Eighty percent of the sample saw themselves as the cause of this emotion. "While our most mature subjects generally gave the highest level responses indicating their awareness of emotion provoking events as not caused by them, this was not the case for parental anger" (Harter, 1983, p. 107).

3. Events in the parent's life which do not involve the child provoke parental emotions. There is some appreciation for the fact that parents have an emotional life outside the child and that events in the adult's world would also provoke feelings.

These findings have obvious implications therapeutically. A child may over-generalize and incorrectly see himself or herself as responsible for feelings which actually were caused by other factors in his parents' life (i.e.) a child feeling his or her misbehavior was the cause of a marital separation.

Development of Conscience

Moral laws at this stage are viewed as absolute values in real things. Moral values and rules exist as an indivisible part of an object (Piaget, 1955). For example, the command, "Do not touch the stove." becomes a property of the stove. Also, mother and obedience to mother are perceived as one and the same. Obedience to adults remains the prevailing moral code for children ages four to seven. Obedience still means "being good" and disobedience, "being bad".

The child judges a lie by the degree of disobedience involved. Motives and extenuating circumstances are not considered. "The obligation not to lie, imposed upon him by adult constraint, appears from the first in its most external form: lie is what does not agree with the truth independently of the subject's intentions" (Piaget, 1955, p. 143). Disobedience in this phase is perceived by the child as an interruption of adult authority rather than a breach of moral obligation. Adult admonitions to the child based on the child's violations of a moral code will not be comprehended. For example, so called "dirty words" are linguistic taboos because they break taboos imposed by adults. A sense of propriety cannot occur until children see themselves as part of a larger social grouping and understand the need for mutual co-operation to replace restrictive unilateral respect for adults.

Maier (1978) feels that Piaget never traces the development of guilt and its underlying dynamics. Piaget cannot find any place for a feeling of guilt or a desire for punishment on any level until a child has developed a conscious awareness of authority. "Although he (Piaget) questions the psychoanalytic assumption of guilt prior to memory, he seems to accept the hypothesis that guilt is a product and expression of the conscience in later ages" (Maier, 1978, p. 53). Erikson defines guilt as the product of conscious experience from infancy on. Guilt can occur even prior to the conscious awareness of taboos because conscience is developed through social interaction.

Erikson (1963) describes the child's conscience (superego) as being built on the model of the caring adults in the environment; of their superegos and also the culture's values. Gradually, the childrens' conscience; the external voices of caring significant adults in their environment are internalized and increasingly assume the supporting and controlling functions previously served by these adults.

Children perceive punishment as a necessary sequence following any transgression of adult imposed rules. There is a necessity for punishment and atonement in due proportion to the gravity of the misdeed, regardless of what the circumstances may have been. "The sense of guilt

is proportional not to the incidental negligence...but to physical acts themselves" (Piaget, 1955, p. 177).

Children in this phase expect all adult actions to be fair. This unilateral respect slowly evolves to an awareness of many adult authorities whose rules vary and the fact that there may be inconsistencies even in one adult's rules.

Play

On the surface play becomes noticeably social while the child's underlying thinking processes still maintain their egocentric quality. Games such as tag, hide and seek, guessing games and make believe play become part of the child's repertoire (Piaget, 1967). Children have achieved a new level of thinking and can now project themselves into other roles and begin to think in terms of other people (Piaget, 1967, 1969).

Previously, imitation was an end in itself and was employed by children without full awareness of their model's intrinsic values. With a budding awareness of some of the relationship patterns of their social world, children in this phase tend to imitate other people such as movie stars, and cowboys to capture their values or status. The play fantasy often aims at denying the child's anxiety about being small and unable to perform adult tasks. Play is dramatic, often grandiose and filled with feelings of invulnerability.

In play children enact the rules and values of their elders and they may behave as if they had adopted their elder's social conventions as their own. A sense of mutual co-operation and social responsibility may be reflected in group play and speech but it has not yet been integrated into their patterns of thinking. For this reason Maier (1978) tells us that to hold a group of children responsible for the behavior of a few makes little sense to a child of this age.

Erikson refers to this phase as the "play age". Play takes two essential forms in this phase:

1. Solitary; which gives children time to indulge in activities alone and for undisturbed daydreaming during which they can play out or dream out phasal conflicts and resolutions.

2. With other children, in order to play out individual and mutual life crises (Maier, 1978).

At times play objects are used to portray the forces of conflict experienced by the child in his or her life. At other times play relationships with people may serve this purpose.

Erikson (1968) talks about sex role differences between boys and girls in types of play activities. Although I felt uncomfortable with the stereotypical sex role behavior Erikson postulates, Maier (1978) cites five studies which have replicated Erikson's findings including

an unpublished doctoral dissertation by Wambach who started out in 1970 to question Erikson's findings of thirty years before and found, through careful research, that essentially the same sexual differentiations occurred in play configurations as the ones Erikson had found among children born before the second World War. In his book, Identity: Youth and Crisis, 1968, Erikson describes boys' activities as intrusive, intensely motoric, and full of searching curiosity. Girls' play activity had an inceptive quality--with an urge to include others and to be included in other's lives. Broad cultural values are willed to girls and boys at these periods of their development. Sex roles are also assigned and are to be practised. "He maintains the basically biological position that differential inclinations are an adaptation to the body's language and a cultural acknowledgment of nature's sexual differentiation" (Maier, 1978, p. 104).

Dreams

According to Sours (1980) these childrens' dream images usually involve monsters and threatening animals. "Death is everywhere in these dreams, as the happy wish fulfilling dreams of earlier years are replaced by images of anxiety and guilt" (Sours, 1980, p. 129). Dreams of nakedness and embarrassment are their concern along with failing examinations, falling, flying, swimming or going to the dentist.

Dreams are explained in much the same way as events in the objective world. Dreams are assumed to exist outside the dreamer and persons and creatures that caused events in the dream are believed to be real (Piaget, 1967, 1971).

Animism

Children still believe that anything active is alive. As they do not have a good understanding of causality and natural laws, children will develop their own unique reasoning for phenomena. Therefore, clouds are alive and cross the sky on their own. Chairs may "jump-out' at them (Piaget, 1967, 1971). "The physical and psychological worlds are still intertwined from the child's vantage point; thoughts, things and persons are experienced as if on one plane" (Maier, 1978, p. 49). Perhaps this explains why children's respect for a toy is equal to their respect for people.

Sexual Knowledge

Children of this age are aware of genital differences. They are more inclined towards masturbation and genital explorations. There is a general pre-occupation with making up theories of reproduction (Sours, 1980). Concerns about sexual intercourse or other forms of adult sexual behavior appear to be rare in children who have not been involved in or exposed to such behavior (Waterman, 1986).

Section 2.2 Normal Developmental Attributes of Children Ages Seven to Nine.

This age period corresponds to Piaget's concrete operational phase which spans roughly from seven to eleven years of age.

Perception loses its primary position as a means of making sense of reality and gradually thought becomes dominated by reason rather than appearance. Concrete operation, the first level of conceptual (logical) thought, involves the mental capacity to order and relate experience within an organized whole (Piaget, 1969). In this phase, children can state and eventually sum up what they intend to tell, whereas previously, the entire story without any summary title would be told.

Children can now employ thought structures rather than relying primarily upon perceptual or sensorimotor cues as they had previously. Phenomena were previously explained on the basis of intuition and given highly personalized explanations. Thus, the child in the concrete operations phase will be able to recognize that a shadow is produced because a stick stands between the light and the place where there is no light. A child in the intuitive thought phase would explain that the shadow is hiding from the light because it is afraid.

The focus changes from concrete experience with things

to conceptions of things. Children become pre-occupied with how they can classify objects or actions in order to see them as part of a larger system. Perhaps this explains these childrens' pre-occupation with collecting objects such as baseball cards, stamps, or rocks and labelling them. This behavior may demonstrate the forming of mental structures which can comprehend hierarchical classes based on logical consistency (Bemporad, 1980). Yet, during the first part of this phase, the child can only use logical classification with concrete, tangible objects. Intangible concepts such as laws or mathematical formulas cannot yet be classified. There is a gradual shift from inductive to deductive thinking. Deductive reasoning occurs around eight or older (Maier, 1978).

Children in this phase continue to have an awareness of many correct things without being aware of the judgment involved. Again knowing precedes the capacity to verbalize and apply this knowledge (Piaget, 1969).

This age period is also part of Erikson's phase of industry versus inferiority which parallels Freud's latency stage (ages six to eleven). The major theme of this phase reflects the determination of these children to master the tasks before them. The polarity inherent in this phase exists between the child's sense of industry versus a sense

of inferiority. There is energy for invention and production and also the opposing pull to stay the same--to do less. Children of this age are trying to prove their competence so as not be be perceived as inferior. Erikson (1963, 1966, 1968) elaborates how acquiring a sense of industry and fending off a sense of inferiority helps children to develop a sense of competence. However, they must also accept their limitations. The drive to succeed includes an awareness of the threat of failure and having to incorporate the failure should it occur. There is an urge to work harder to succeed because any mediocrity will come too close to a sense of inferiority. This feeling must be both combated and accepted as a way of life in order to move on to adulthood with self assurance. Erikson emphasizes that many of an individual's later work ethics and work habits can be traced to the degree of success with which a sense of industry was fostered during this phase.

Psychological development slows to consolidate what has already been acquired. Children are now laboring at filling in the vast gaps in their abilities within the limitations of their capacities. Physical and perceptive skill development, as well as becoming more knowledgeable about the world are priorities.

Role of This Stage in Socialization of the Child

Children maintain dependency on parents in some areas while in others they tend to relate to them and other

adults on a more equal basis. Siblings are no longer perceived as significant competitors unless they happen to be members of the peer group. "Nobody to play with" is a familiar refrain of children in this developmental age group even though they might have a number of brothers and sisters.

Children of this age are interested in other adults besides their parents who also become sources of identification. They will identify with those aspects of people which are most meaningful to them without necessarily considering the total personality or situation of the person. People that appeal the most to them for these purposes are those who have a great deal of competence and strength.

The role of peers is significant during this period. They help the girl or boy learn his or her role in society, ease his or her way into associative-cooperative play and teach him or her to subordinate their needs and wishes to the group. The child is given a new idea of their value relative to their peers and helped to learn their role in society (Sours, 1980).

Neighbourhood and school become important social determiners. The focus has shifted from dependence upon the parent as the child's major source of influence to dependence on social institutions such as schools, churches

and youth organizations. School has become the main formal vehicle for the transmission of knowledge; either academic or cultural norms and values. Consequently, learning about the larger social systems, their relationships, and social conventions outside the family also increases dramatically during this period.

Language

In the concrete operation level of cognition, language continues to be a tool of communication as well as possessing a new function--a tool for thinking. However the child adopts words without full understanding of all they convey, employing symbolic speech without a full awareness of its meaning. This is important to consider when a child is relating an occurrence in the course of therapy. Are they really aware of the implications of what they are saying?

Development of Conscience

Piaget's (1955) studies of the child's development of conscience during this period note a shift from a "morality of restraint" to a "morality of co-operation". Under the "morality of restraint", the child does only what he or she is ordered to do by parents. Discussion with the child about the wrongness of his or her behavior is not effective until six to seven years of age. After six or seven a "morality of co-operation" can be set up in which the

misbehaving child is informed on the basis of guilt and capacity to judge right from wrong behavior, that there is a problem to be solved and since he or she is now entering into a more grown-up phase, he or she must be able to make decisions and solve problems with parents rather than in response to parents' demands.

As the child approaches eight years of age, his or her conscience is guided by a tendency to move away from parental influences and begin to seek outside influences. At about eight and a half to nine years of age, children enter into the phase of ethical individuation. Sources other than parents, such as peers and teachers become part of the molding of conscience. An awareness develops of collective obedience. The peer group begins to function as an alternate conscience (Piaget, 1969). This may throw children into conflict with their parents. The child becomes more critical of parents and retracts the omnipotence which was delegated to them in earlier years. There is a shift from respect for adult authority to respect for established standards.

Moral values are now internalized and moral standards exist outside of temporary or specific situations. Lies become defined objectively--the more a lie attempts to deceive, the worse it is. Justice must be served and requires fair punishment. Fair judgment means equality in punishment, exact compensation for damage done, and doing to another exactly what was done to oneself (Maier, 1978).

Play

Games with rules--Piaget's (1967) third category of play, come into prominence during these years. Generally, at the beginning of this phase, rules are viewed as immutable and absolute. Later, situational rules replace universal one. By age nine, the child has some notion of reciprocity with other people. There is more of a feeling of being able to change the rules. Increasingly complicated rules replace simpler ones. The playing with rules becomes the predominant play of the period (Piaget, 1967).

Hobbies which are half way between play and work are now selected. Some might help develop a sense of productive competence and lead to ego mastery (Sours, 1980). During these years there is a special culture with its own rules, rhymes, riddles; games which are forbidden to adult entry. "Rites include peculiar superstitions, excessive counting, tongue twisters, repetitive jokes which make fun of adults and odd collections of objects which may have magical qualities" (Sours, 1980, p. 143). Clubs, packs and gangs of this age group all pride themselves on their group solidarity and children who do not fit into the social identity of the group are excluded. Generally, play is more realistic and based on real life situations.

The two sexes tend to have separate play habits, although, upon occasion, they will enter each other's worlds and participate in play which is generally culturally assigned as being appropriate for the other sex. Nevertheless, psychosocial sex roles ultimately determine the major form and content of an individual's play (Erikson, 1968).

Fantasy

In the early part of this phase the child fantasizes about "amorphous, highly symbolized characters who are coming after him. From eight to twelve years the child's fantasies, especially persecutory fantasies, contain thoughts about real people" (Sarnoff, 1980, p. 159).

Fantasies can be used to cope with stress. Sarnoff states that children of this age experience any situation which is humiliating or overwhelming as potentially harmful and something to be mastered. A child can develop a fantasy to master the circumstances of the situation that caused him or her stress. This takes emotional pressure off the child without affecting the environment or involving other people.

Children of this stage defensively show dissatisfaction with adults and this can appear in the fantasies of the period. This may occur for a number of reasons. These children are functioning more independently in the larger

world but are still dependent in many ways on their parents. They are now more aware of other adults and value systems in the world. Children become more critical of their parents and do not see them as omnipotent as they once were. However, there must be some feelings of guilt for thinking these thoughts, especially when the parent is still needed in many ways. "Often adoption fantasies appear, especially if there were deprivations early in childhood, and they are precursors to the "family romance", as are fantasies of having a twin, imaginary companions, and animal fantasies, all containing objects that love the child more than the parents" (Sours, 1980, p. 139). These soon change into the "family romance" fantasies which grant the child different familial origin and make him or her into a "star" of some sort.

Children now realize that other fantasies in the form of dreams are perceived only by the dreamer. They exist in our heads and only become visible when we sleep (Piaget, 1967).

Animism

Natural phenomena are still conceived of as being made by man for man. More complicated events still do not receive a logical explanation. Events beyond their understanding are centered in a type of socialized ego-centrism. For example, children might think it rains because we need green grass (Piaget, 1967, 1971).

Sexuality

It was originally thought that sexual quiesence was present during this period. Present day child developmentalists feel that sexuality is simply less observable and more likely suppressed because of the child's increased social awareness of sexuality and circumspection about sexual behavior, especially in the company of adults. "Clinical data, a well as Kinsey's research data, show that sexual experimentation and curiosity continue through these years" (Sarnoff, 1980, p. 139). Masturbation and sexually colored play are common.

Fears

When a seven or eight year old begins to feel a sense of independence from his or her parents, fear fantasies of being small, vulnerable, and all alone in the big world emerge. Children of this age will have a fear of monsters. Sarnoff states that the monsters are symbols; masked representations of the fears.

The child's anxieties now focus more on every day performance although he or she still tries to create a balance between the old magical world and the new world of reality.

Death is now seen as something permanent around which the child will build an ideology of after-life, depending on his or her family and culture.

Conclusion

A summary of how normal development impacts on many pertinent areas of childrens' lives between the ages of four and nine has been presented. Theory primarily within Piaget's cognitive developmental framework and Erikson's psychosocial approach which addresses affective development has been discussed.

Rather than a rigid adherence to association of certain developmental steps with age norms we must learn to appreciate what particular developmental sequences a child will pass through, as development is largely uneven. Children may be at one level of understanding in regards to behavioral attributes and yet another in regard to their ability to understand their emotions and motivations. Foremost, let us not lose sight of the total child. In the next chapter several modalities of play therapy which build on a developmental understanding of children will be presented.

CHAPTER 3

MODALITIES OF PLAY THERAPY

Play is creative and creativity is an expression of the self; its source both conscious and unconscious factors. The images we draw, the things we invent, the objects we construct all mirror our inner experiences. The individual's translation of the image, construction, or invention, reflects his or her way of seeing, feeling, and thinking.

Play involves self teaching and self healing. Children's play activity deals with life experiences which they are attempting to repeat, master, or negate in order to organize their inner world in relation to their outer world. "Play activity becomes the means of reasoning and permits children to free themselves from the ego boundaries of time, space and reality while maintaining a reality orientation, because they and others know it is 'just play'" (Maier, 1978, p. 84).

Play therapies tap emotional as well as cognitive processes and deal more directly with primary processes than verbal therapies. Younger children especially have difficulty labeling and expressing their feelings in verbal form. Therefore traditional "talking therapies" would not be effective with this age group. Harter (1983, p. 116) mentions that "an important goal in certain forms

of therapy is to make clients reflectively or analytically aware of their emotions, motives and thoughts to encourage them to invoke the observing ego." Evidence indicates that developmentally a child is not capable of doing so until later childhood or early adolescence when the ability for the self to become an object of its own reflection emerges. Harter does a cognitive developmental analysis (based on Piaget's concrete operational period which coincides with the latency period) to explain why free association is an inappropriate therapeutic technique with children of that age.

She makes the following points:

1) The onset of the concrete operations stage brings with it a proclivity for the logical organization and classification of objects, events, and occurrences in the child's world. This tendency runs counter to the process of free association.

2) These emergent logical abilities are directed toward an analysis of concrete events. Even if a child in this stage were to free associate, their associations would be a logical ordering of observable phenomena in the real world.

3) Harter does not think the ability to think about one's thinking, to reflect on one's thoughts, is present at this cognitive developmental level. She quotes Selman who

postulates that not until level three in his model (ages 10 to 13) does the child have the cognitive capacity to engage in the type of self-awareness associated with insight therapy.

In play children will convey things they might not be able to express in words, even if they were fully conscious of some of the feelings distressing them. The opportunity to project one's thoughts, feelings and conflicts upon fantasy characters provides a tension release. Traumatic experiences may have been repressed or too painful to discuss and the less threatening process of play can offer a vehicle for expression of feelings and serve as a springboard for discussion. The painful tension of the original trauma is relived but under more favourable conditions. Thus play can serve a cathartic purpose. First, the play is in the child's control. He or she can take on or assign whichever roles they wish in the situation, often acting out or imagining they are the powerful character and assigning the weaker, more passive, or suffering role to another person or object and thereby enacting in an active way what has been experienced passively (Mishne, 1983).

The rationale for using different modalities of play in treatment lies in the innate qualities of play as rehearsal--repetition of the event symbolically helps the person to eventually gain mastery over a particular trauma

or situation. Mishne (1983) cites Greenacre and others who note that repetition of experience is necessary in establishing a sense of reality. Overwhelming experiences need to be integrated. "The child assimilates in piecemeal fashion that which was too large to integrate all at once" (Mishne, 1983, p. 273). She also quotes Walder who notes that "play may be a process like repetition compulsion by which excessive experiences are divided into small quantities, re-attempted and assimilated" (Mishne, 1983, p. 273).

All play therapy techniques do not fit all people or their particular problem. As Carl Jung (1963) said "...therapists must tailor what they do to fit the problem at hand and not try to force all problems to fit a single therapeutic mold". And so it is with play therapy. Naitove (1982) says the rationale for selecting specific play therapies lies in part in matching the specific attributes of the play activity with the learning modes through which individuals process information. She describes how some people are kinesthetic attenders--they process information through action and might feel more comfortable with dance, movement, and drama as treatment modalities. Others, being auditory attenders, may be reached most effectively through musical or poetic activities. Visual attenders respond to impression, color, and movement; therefore the graphic and plastic arts may

prove most absorbing to them. In working with a visually impaired or blind child one must use common sense and be sensitive to the fact that their visual sense is compromised and therefore modalities where vision is the primary sense required for participation and source of feedback may be contraindicated (dependent on the degree of vision they have) in favor of more tactile activities such as plasticine or clay play. By understanding the learning modes of a child, (gained by observation and assessment), the play therapist can select appropriate perceptual techniques to enhance the child's skill development and self-image. Schaefer and Millman (1977) discuss the concept of the "prescriptive approach" as it applies to therapy with children. This approach emphasizes the therapist's responsibility to determine the most appropriate therapeutic technique for each child. "Rather than attempting to force a child into one "all purpose" therapeutic mold...therapists are now trying to individualize, to fit the remedies or techniques to the individual child. Ideally, the prescriptive approach will result in maximum therapeutic effectiveness in the briefest time period" (Schaefer, 1977, pp. 1-2). In the introduction to their 1983 book, Handbook of Play Therapy, Schaefer and O'Connor apply the concept of the prescriptive approach to play therapy also. In other words, an

individualized strategy for each child is chosen from the theories and techniques of play therapy. This is in keeping with the use of the ecological systems orientation also, as they further state that "...using the prescriptive approach...implies the possibility of expanding the therapeutic intervention beyond the individual session if necessary" (Schaefer, 1983, p. 1). They are concerned about research findings which show that gains made in the therapeutic setting often are not generalized to the other settings and systems in which the child is involved and describe how therapists have sought to expand their sphere of influence "from the traditional psychodynamic focus on the child's unconscious, to include the child's cognitions, observable behavior, family system and peer or social system" (Schaefer, 1983, p.2).

Following Schaefer's "prescriptive approach" in this practicum, after thorough observation and assessment of the child and his or her ecological system, specific play therapy modalities felt to be most appropriate to the child were incorporated in an individualized intervention. Use of particular play therapy modalities varied during the course of the intervention dependent on demonstrated appropriateness of "fit" to the child and additional information learned about him or her. It was, however, anticipated that several modalities in particular would be

helpful with many of the children. These include elements of Jernberg's (1983) Theraplay, Gardner's (1970) Mutual Storytelling Technique, and use of children's' literature, puppetry, and art therapy. Each will be briefly described.

Theraplay

Many of the techniques and theoretical positions on which Jernberg's Theraplay method is based were originally developed by Austin DesLauriers in his clinical work. It was DesLauriers' theory that a deficiency in emotionally positive infantile sensory experiences could lead to later emotional problems. This may have resulted because the parent was emotionally unavailable for any number of reasons, or the child may have had an aversion to stimulation as an infant and spurned the parents' efforts to do so. To the understimulated child the theraplay technique provides the corrective experience of receiving the stimulation he or she should have received when very small. Working with schizophrenic and autistic children, DesLauriers used an intrusive approach, physical contact, and focused on the here and now in his therapy. Theraplay incorporates these principles but differs in its "intensity, vigor and perseverance, and in its regressive dimension: nurturing. It differs also in that, while retaining spontaneity and fun, Theraplay sessions are carefully pre-planned and structured" (Jernberg, 1983, p. 3).

Jernberg (1983, p. 51) describes Theraplay's focus as "non-cognitive, non-interpretive and preverbal." The techniques of Structuring, Challenging, Intruding and Nurturing (SCIN) are used and selectively tailored to each child's individual needs to replicate a healthy parent/infant relationship which Jernberg feels must be based on the adult's taking charge.

Using the normal mother-infant unit as the model, maternal behavior that promoted attachment and autonomy enhancing qualities was analyzed to derive the four activity areas of structuring, challenging, intruding, and nurturing. Structuring activities in Theraplay clearly delineate time and space and teach mastery by internalization of rules. Examples of two structuring activities would be the therapist's counting and commenting on aspects of the child's body such as ears, teeth, or freckles or having the child make a life size portrait of themselves on newsprint. Challenging activities provide the frustration that helps the child to see him or herself as a separate entity and also learn that combat, competition, and confrontation can release pent up anger and tension in a safe way. As examples, during therapy a child might be asked to walk with books carefully balanced on his head or perhaps be engaged in leg wrestling. Intruding activities bring stimulation and excitement into a child's

world and enhance his or her experience as an individual separate from the therapist. The child might be engaged in a game of peek-a-boo or while maintaining eye contact, touch noses or share a pretzel with the therapist and child both having their hands behind their back. Nurturing activities such as rocking, holding, cuddling, and hugging communicate to the child that they are lovable and can be loved without having to work for it. All activities during a Theraplay session fall into one of these four areas and are used in combination based on the needs of the individual child. These are assessed according to two criteria: 1) the child's life outside the play room based on information from parents, teachers, social workers, and significant others involved with the child; 2) the child's behaviour during the therapy session. A treatment plan is drawn up and activities decided upon based on the assessment.

Mutual Story Telling Technique

In choosing techniques which are effective in work with children it is important to realize that few children are interested in gaining conscious awareness of their unconscious processes: the goal of so-called "talking" therapies. However, various play therapy techniques such as use of drawing, dolls, puppets, and story-telling are enjoyed by children and give the therapist invaluable

insights into the child's inner conflicts. Gardner's Mutual Story Telling Technique is a therapeutic tool that can be of use in various phases of child therapy and is a creative activity that both therapist and child can participate in at the child's own level. The therapist begins by asking the child if he or she would like to be the guest of honour on a make believe radio or T.V. program (dependent on whether audio or audio-visual equipment is used) on which stories are told. The therapist provides the introduction and relaxes the child by asking a series of brief questions that he or she knows the answers to. The child tells a story and the therapist surmises the psychodynamic meaning. Selecting one or two important themes and creating a story using the same characters in a similar setting, the therapist retells the child's story introducing healthier adaptations and more mature resolutions of the conflicts revealed in the child's story.

Children's Literature

Reading to a child or having the child read children's literature on subjects relevant to their situation during the course of therapy can serve as an invaluable aid to communication and growth enhancing experience. Attention is focused on a particular topic in an indirect way. There is a distancing quality between the fiction and child because the story is something that is happening to the

storybook characters. This allows the child to deal with the more painful events of a story, both as a spectator and as an emotional participant without experiencing undue anxiety.

Some children may gain comfort from seeing that other children, even storybook children or animals, often feel the way they do about situations, that their actions and feelings are not wrong and will be mastered gradually. Along with validation of one's experience, a child may feel reassured that things will work out as they did for the character.

Stories can serve as catalysts for expression of feelings. "They can evoke meaningful responses, give validity to important feelings, reveal serious misconceptions, nourish hope, and build confidence" (Fassler, 1978, p. 152). However, Fassler cautions that it is important to be familiar with the children for whom the books are intended and also to peruse the literature beforehand. Although certain stories may deal with topics currently important in a specific child's life, they may not present the topic in a fashion that will help the child cope with their situation more effectively.

Puppetry

Puppets can be used solely or in conjunction with other play materials during the therapy sessions. They are suitable for the expression of fantasy and can be used in a number of ways. Children can give shows with puppets, playing out their fantasies and allowing the therapist to be the audience. The therapist can then take a turn and bring out more clearly the problems contained in the child's earlier fantasy. Children who are too shy or inhibited to give a show of their own can carry on a conversation between the therapist manipulating the puppet and the child in the audience and vice versa. Hawkey (1976) describes three case studies where he treated boys almost exclusively with puppets. Although he has treated girls using puppets as a treatment modality they also availed themselves of dolls. Hawkey notes that unfortunately, due to socialization, boys may feel playing with dolls is childish or "girlish", but find puppet play acceptable.

Art Therapy

As mentioned earlier, ventilation of feelings in a therapeutic milieu reduces anxiety and the need to act out negative feelings. Art therapy allows expression and objectifying of conflicts and emotions and leads to enhanced control of such behavior. Exploration and the successful resolution of conflicts in this area can lead to the willingness to take risks in other areas.

Naitove (1982) describes art therapy as being able to meet the following objectives and goals in the overall therapeutic plan with the child:

1) To elicit verbal and nonverbal statements and expressions of overt and internalized areas of conflict to facilitate their definition, delineation, and recognition by the child's therapist.

2) By being introduced to creative expressions, media, and modalities and having a gratifying arts experience the child will have ego strengthening successes that will enhance his or her self esteem.

3) Often traumatized children may show behaviors which imply a developmental lag or arrest. As the arts also provide clues to auditory, visual, and kinesthetic modes of learning and deficit, they can be used as diagnostic tools for developmental delay and as remedial experiences to "accelerate maturation of delayed cognitive and functional behavior patterns to an age appropriate level" (Naitove, 1982, p. 280).

Every aspect of the art produced is revealing--the choice of media, use of line, color, form, space, size, relationship to objects, and title. There is often consistency in the child's use of color as well as style. Gray (1978, p. 493) quotes Fischer who says that "changes of color as well as changes of themes can clearly indicate

regressive or progressive developments in the course of the individual's treatment."

Structure of the Art Therapy Session

Naitove (1982) describes art therapy sessions as lasting from one to two hours, dependent upon factors such as the child's or children's (if in group) abilities to concentrate and variables in the environment and group. The structure of the session consists of a warm-up activity, a core activity and closure or declimaxing activity. The warm-up activity involves familiarizing the child with the therapist, modality, and media which will lead to the core activity. It provides a transitional experience from the child's physical and emotional orientation prior to the session to the "here and now" of the therapeutic agenda. The core activity is designed to further therapeutic objectives while the closure or declimaxing activity could also be described as debriefing where the child can discuss the work accomplished and his or her reactions during and after completing the activity. One or two modalities may be carried over into several sessions such as the creation of a sculpture or a mask.

It should be explained at the outset that the child's drawings are special, confidential, and not to be shared with anyone else without the child's permission. The child should always be asked to write his or her name on each

drawing to show them that you value their work. A child's drawings or artwork, especially the particular child's, should never be discarded in front of them.

"To Interpret or Not"?

All the literature reviewed was unanimous about the therapist's need to be non-directive in talking to the child about what his or her picture might mean. An art therapist must be dissuaded from interpreting to the child what causes him or her to create the picture and what it means. Discussion could be prompted by commenting on features of a work such as its color, organization, or subject matter. For example, the therapist might ask the child "What name would you give this?" or "How do you feel about this color?" "How does this picture make you feel?" Children will often interpret significant features of a work with great perception. If children are not forthcoming, we must be careful to respect their resistance and work through their defenses before we approach the material which is being warded off (Bornstein, 1972).

Some schools of play therapy, such as the psychoanalytic, (Klein, 1982) believe in interpreting the meaning of the play while others such as relationship (Moustakas, 1973) and client centered therapy (Axline, 1947) focus on reflecting feelings and affects and staying within the metaphor the child offers.

I agree with Bornstein (1972, p. 405) who states that use of play media and activities are not to be used for interpretation of its contents but "as a source of knowledge about the child and as a stepping stone toward the analysis of defense and of affects."

It is my belief that interpretation of a child's unconscious motivations to him or her is non-productive in light of what we know about the developmental sequence involving children's understanding of manifest versus latent feelings. Not until adolescence is there an appreciation for the unconscious, including the understanding that unconscious emotions may not be readily available to conscious awareness and analysis. Initially children do not appreciate the fact that behavior is motivated until they gradually move through a series of stages ending in adolescence where there is an appreciation for unconscious motivation (Harter, 1983). I agree with Mishne (1983, p. 280) who describes many writers cautioning that "premature interpretations of child's play and dreams may frighten children; they may believe that their mind can be read or that awful ideas are attributed to them. This will produce more defensiveness, cessation of play activity and sharing of dreams and possibly regression." However, non-directive acceptance and reflection of feelings can

permit the child gradual insight and freedom to express feelings in the safety of the therapeutic relationship.

Choice of Toys

Toys should be simple, enabling the child to use them in a variety of situations and to express many different responses. Doll-houses with small figures to represent children and parents, puppets, and a play phone can facilitate expressive story telling during play. Media such as paper, crayons, pencils, paints, and plasticine should also be available depending on the child's interest. A tape recorder can be useful as a prop for producing the "radio show" in the mutual story telling technique and also to play music during creative movement exercises.

Mishne (1983, p. 281) states that chess and checkers are often sought by latency age children "who desire rules, codified games and distance from more repressed, unsettling drive derivatives."

Therapist's Role

a) With the child.

Much has been said about the therapeutic value of play for the child. This should not overshadow or diminish the therapeutic benefits of the relationship between the therapist and child. It should be made clear from the beginning, in the child's terms, what purpose the therapy sessions and therapeutic relationship serves. As Virginia

Axline (1947) outlines, the therapist must develop an engaging and warm friendly relationship with the child as soon as possible where the therapist accepts the child exactly as he or she is. "The therapist establishes only those limits that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship" (Axline, 1947, p. 56). Children should not be allowed to hurt themselves, others, or the therapist or to destroy property. By accepting children for who they are, listening to their productions, and indirectly acting as a role model in problem solving, the therapist is helping them to build competence, mastery, of situations and consequently develop their self esteem.

b) <u>With parents</u>.

Parents may be included in some sessions with the child, where necessary, or met with separately to discuss parental concerns, and to collaborate in weekly activities that may facilitate the therapeutic goals. However, the child in therapy should have a sense that whatever he or she says in therapy is confidential and will not be repeated verbatim unless it is information that someone is presently harming him or her. Upon initial orientation to the therapy sessions and play room, children are told that in such a situation, it is the therapist's responsibility to tell the appropriate parties to facilitate alleviation of the harmful situation.

c) With other components of the eco-system.

Problem solving network meetings, where necessary, with involved systems, such as daycares, school, lunch and after school programs, may be initiated. Support of these systems must be enlisted in achieving therapeutic goals so that effects of the therapy will generalize to other systems and be maintained by them.

The inherent attributes of childrens' play which give it a healing quality have been discussed. Play therapy is especially effective with younger children who have difficulty labelling and expressing their feelings. Traumatic experiences and painful feelings can be worked through symbolically during play therapy.

Several play therapy techniques that may be helpful to many children were outlined. It is important to match the appropriate modality of play and play therapy techniques to the individual child if we are to follow Schaefer & Millman's prescriptive approach to therapy with children. To do so requires a thorough assessment of the child's developmental level, learning modes, and play interests as will be discussed in the chapter on assessment.

CONCLUSION

The ecological perspective as a way of viewing the child in their environmental context has been discussed. This framework has utility for organizing information about the child and the systems impacting upon him or her and in formulating practice hypotheses. At the centre of this framework is the individual, for we must keep in mind that he or she brings to the situation various personal attributes and a particular level of development which impacts on the environment and vice versa. The balance of environmental forces is not the sole determinant of outcomes. There may be a very important role for individual play therapy with the child in conjunction with systems work even if it is clear that systemic influences are primarily responsible for the problem behavior. Individual therapy can serve as a corrective experience whereby children can express themselves and develop feelings of self worth and competence in their world. The particular needs experienced by a child will vary with their developmental level. The developmental level a child is functioning at and the corresponding issues, along with how the child characteristically reacts to situations that have caused emotional upheaval are important pieces of information necessary for a thorough assessment. They help

determine what therapeutic activities are most appropriate for the individual child.

Some modalities of play therapy such as Theraplay, Mutual Story Telling, puppetry, and use of children's literature, and art therapy were outlined. These and other techniques were used in an eclectic fashion in a treatment approach tailor-made to the individual. It is essential that important systems involved with the child are part of the treatment process to provide support to him or her and insure maximum generalization of therapeutic effect.

Section Two: The Practicum

CHAPTER 4

DESIGN OF THE PRACTICUM

Section 4.1: Introduction and Objectives

The focus of this practicum was skills development oriented. Objectives of the practicum were:

1. to offer therapy services to children ages four to nine and their families where the child was experiencing emotional and/or behavioral problems for whatever reason. It was made explicitly clear on first contact to whomever made the referral that families were expected to be involved also.

2. to:

    a) develop skills in use of play therapy, and;

    b) further skills in work with families and systems impacting upon them and;

    c) integrate this within an ecological perspective.

To maximize the range of learning experiences a decision was made to work with a heterogeneous population group of children rather than within a particular problem area such as sexual abuse as has been the custom of many graduate clinical social work students in the past. For the same reason, I chose to see children from ages four to nine because this age group, consisting of both pre-schoolers and school aged children, also encompassed two distinct developmental periods.

Section 4.2: The Setting

Children, and sometimes their parents and care-givers for joint sessions, were seen primarily in the play room at the Psychological Service Centre at the University of Manitoba. Family therapy sessions were also held in the family rooms there. The Centre is an inter-disciplinary training facility of the Faculty of Arts and has as its primary goal the training of students in Clinical Psychology and Social Work.

After intake was completed, a home visit was always done to complete the assessment process. This would allow me to see the child and family in the comfort of their home to get a sense of what their natural interactions were like. Other home visits to see the family were made as necessary. Contact (and intervention where necessary) was also made with significant others such as teachers, social workers, and day care workers in the child's eco-system. Except for the utility and convenience of the play-room and family rooms of the Psychological Service Centre for individual and family sessions, efforts were made, wherever possible, to centre interventions in the community where the child lived.

Section 4.3: The Clients

The target population of this practicum were children between the ages of four and nine who were experiencing emotional or behavioral difficulties in any area of their lives.

As one of the goals of this practicum was to develop generic social work skills with children and their families and specifically play therapy techniques, no differentiation was made as to the specific problem area that children were encountering. Since the Psychological Service Centre does not normally have a great influx of child clients between the ages of four and nine, efforts were made to solicit referrals from the community also.

Letters offering my services were sent to the Child Guidance Clinic, Canadian National Institute for the Blind, Educational Services to Visually Impaired Children, Winnipeg School Division #1, and Child Care and Development Branch, Department of Education. The latter three are community resources who respectively provide co-ordination, advocacy and counselling to the legally blind population and educational support services to school age visually impaired children. As I had previously worked as a social worker with the Canadian National Institute for the Blind for three years, I was familiar with all aspects of visual impairment and felt comfortable in offering my skills to this particular population.

A large proportion of the referrals were also generated through word of mouth.

It was made explicitly clear on first contact with whomever made the referral that families and/or care-givers would be expected to be involved also. This presented no difficulty with any of the cases.

CHAPTER 5

ASSESSMENT AND TAILOR-MADE INTERVENTIONS

Mary Richmond, a person who made very significant founding contributions to the practice of social work, talked about assessment of an individual or family and called it "social diagnosis". Her definition of "social diagnosis" (as quoted in Siporin, 1975, p. 220) was "an attempt to arrive at as exact a definition as possible of the social situation and personality of a human being in some social need--in relation to other human beings upon whom he in any way depends or may depend upon him, and in relation also to the social institution of his community." She presented a problem-persons-situation model for social work assessment of individuals and families. Siporin's (1975, p. 220) contemporary definition of assessment describes it as "an identification, examination, an individualized understanding of the psycho-social problem of a client..., and of the ecological environment, together with an integrated analytical formulation in a recommended intervention plan." The assessment individualizes the clients' needs and the information gathered should assure development of differential interventions that can meet specific needs. The importance of an individualized assessment of the child in all aspects of the ecological environment is even more significant in a practicum of this

nature which involves a heterogeneous group of children with diverse presenting problems. They were not all receiving one standard treatment format but were, along with their significant systems, involved in highly individualized interventions tailored to their specific needs.

As mentioned earlier, we can only understand individuals and their behavior in the context of their environment. While there seems to be little controversy over the fact that human beings tend to exhibit some consistencies across settings (Mischel, 1973) both research and clinical literature strongly suggest the practical importance of situational variables in understanding and treating problem behavior (Mischel, 1968; Wahler, 1969). Childrens' behavior can vary across settings. For them the home, classroom, and playground are very different worlds usually operating under different rule systems and calling forth different patterns of behavior.

Certain response patterns are reinforced in particular settings and not in others, therefore different settings become the occasion for particular behaviors in varying degrees. Mischel (1973) quotes a study done by Rausch who found that in a sample of normal American boys, friendly acts led to unfriendly responses in 31% of instances in game situations but only 4% of the time at meal-times. Such possible variability of behavior is an additional

reason for the worker to acquaint themselves with all aspects of the child's environment; to ascertain the impact of each setting on the child and vice versa for the purpose of a complete assessment.

Assessment of the child and his or her eco-system for the purposes of this practicum was comprehensive and involved gathering data on three major areas:

1. the child's eco-system
2. the child's developmental level
3. play behavior

The assessment process already constituted an intervention in the ecological sphere of the child (Hess and Howard, 1981). Information was solicited through questionnaires, interviews, and observation. At intake, a Health and History Form used by the Morrison Centre for Youth and Family Services in Portland, Oregon was used (see Appendix II). Information recorded on this form included demographic data and solicited perceptual responses of parent towards child. Parents were also asked to list ways they would like their child or family to change. Both parents were asked to complete the Behavior Problem Scales of the Achenbach Child Behavior Checklist (described more fully in the evaluation chapter), along with an attached social-demographic data sheet that solicited responses about the family, its stress level, and extended family

support network. Children were always present at the intake interview and were asked to draw a few pictures with crayons while parents completed the questionnaires. I always asked the child to do a self portrait initially. Size of the figure, complexity or lack thereof, completeness or absence of body parts, and use of the space were a few of the variables that would give me clues about the child's developmental level and self-perception. A family portrait was then requested. Relative size and sequencing of the figures, along with members included or excluded gave me a quick pictorial display of the child's perception of his or her family and his or her place in it. A child can draw far more than can be expressed in words. I also learned quickly if drawing was a media the child enjoyed.

A lengthy interview was held in the parents' home at a later date to discuss the questionnaires. This was also an information gathering session on birth history, (with its implications for bonding), the child's developmental history, and relevant family history.

Awareness of the parents' emotional state is a very important factor in assessment especially in cases when the child's problem is intimately related to the family situation, for example, marital discord, loss of a spouse through death or divorce, or parental emotional problems.

The younger the child the more likely it is that he or she may take on the same emotional state as the parent (Harter, 1977, 1983) and will need help in correctly identifying the sources of his or her feelings.

Parents were asked about what they felt were the most important goals in therapy, and these were then priorized. Significant collaterals such as teachers, day care workers, and other social workers were contacted for information and to ascertain if the child's behavior was similar across all settings.

As mentioned earlier, data was gathered on three major areas, to be elaborated below.

1. **The child's eco-system:** An assessment from an ecological perspective was carried out using a version of Bronfenbrenner's (1977) model of the ecology of human development as modified by Belsky (1980). A brief outline of this model and the four levels from which all the child's systems were assessed are presented here:

   a. Ontogenic development; what history and individual qualities the child brings to the situation.

   b. Micro-system; the family, school setting, or immediate setting where the problem behavior has arisen; the immediate context of the child's behavior. Hess and Howard (1981, p. 510) suggest evaluating person-environment fit while examining the child's

functioning across settings. "If a behavior occurs in one setting, the worker must explore other settings before concluding that the behavior is a child-centered characteristic rather than behavior prompted by the interaction of the child and a specific environmental setting." It is important to assess what function the problem behavior serves for the child in the setting. Perhaps the behavior is helping the child control their environment or provides some form of rewards such as attention.

c. Meso-systems; the relationships between micro-systems such as the connection between home and school. Richness of meso-systems for a child are measured by the number and quality of connections.

d. Exo-system; the social structures, both formal and informal, that impinge upon or encompass the immediate settings of the individual, for example, role of the extended family or other significant people in the child's life, groups or activities they participate in.

e. Macro-system; cultural and belief systems that effect how the child's behavior is perceived, for example, certain types of behaviors are seen as inappropriate for girls, teachers' attitudes that children should be passive receivers of information in the class-room, or social policies regarding children.

2. **The child's developmental level:** It is important for the person working with the child to have a sense of normal development with which to compare a child's activity and interaction style. Chronological ages should serve only as a general guide for judging a child's progress especially since child development tends to be uneven for all children. It is more appropriate to make use of Piaget and Erikson's developmental phases rather than age norms. "Individual development is never fully completed, never regular, normal or on schedule at any one point in an individual's life. Few children will develop cognitively in all aspects of knowing; few children will successfully resolve all affective conflicts at the respective modal phases" (Maier, 1978, p. 254). One area where it is important to pay attention to developmental level relative to other children of the same age is treatment of children who are suspected of having been sexually abused to ascertain if their concern about or knowledge of sexuality is age-appropriate. If not, it is likely they have been involved in or exposed to such behaviors (Waterman, 1986). Data gathering on developmental levels for assessment purposes can be accomplished through direct observation and parental report.

Sarnoff (1980) gives an excellent description of how drawings can be used to get an indication of a child's developmental level and any lags. If a six year old is

asked to draw a picture of a person in a boat, it is not unusual or abnormal for the child to draw a picture of a boat which is transparent so that the entire body and legs of the man can be seen. Sarnoff states that this sort of transparency is usually acceptable until age nine beyond which it is rare, and if found in an adult, considered to be an indicator of psychosis.

By the time a child reaches six he or she should be able to draw a human figure with eyes, hands, and legs by combining circles, and vertical and horizontal lines. From six to seven years of age children should begin to draw pictures in which the figures are involved in an interaction with others. Sarnoff describes this as the introduction of fantasy content with movement. At about eight and a half, depth is introduced. When drawing a rider on a horse, overlapping parts of a figure without transparencies appear. Details, enrichment, and adornment now appear in the drawings.

3. **Play behavior:** Naitove (1982) talked about the learning modes through which individuals process information. Some people are kinesthetic attenders, processing information through action, others auditory, and still others visual and needing visual displays to integrate information. By understanding the learning modes of a child (gained through assessment by direct observation and parental report) appropriate perceptual techniques can

be selected to enhance the child's skill development and self-image. This is in keeping with Schaefer and Millman's (1977) "prescriptive approach" as it applies to therapy with children. This approach emphasizes the therapist's responsibility to determine the most appropriate therapeutic techniques (as outlined in Chapter 3) for each child (as all play therapy techniques do not fit all people or their particular problem), rather than trying to force the child into one "all purpose" therapeutic mold.

Assessment in the areas of the child's eco-system, development, and play activity were instrumental in development of a beginning hypothesis of why and how to proceed with a particular strategy or therapeutic approach custom tailored to the individual child and eco-system. Later, new information led to re-formulation of hypotheses and change in action. Therefore, the intervention process was fluid and ever-changing as the child's reactions and situation changed.

CHAPTER 6

CASE ILLUSTRATIONS

Section 6.1: Introduction

The practicum afforded the opportunity to do brief play therapy with eight children and work with their families and significant systems as necessary. The term "brief" should be clarified. As I wished to complete my practicum within the year I felt it necessary to prescreen referrals and only take those whose course of therapy would most likely not take more than a year. Therefore, any children with evidence of severe long term behavior problems or psychopathology were referred elsewhere. This was an ethical issue as my supervisor and I both felt it was wrong to establish a supportive therapeutic relationship with a child who had likely had few positive relationships in his or her life and experience with numerous "helping" professionals and then transfer them to someone else upon completion of my practicum. This would follow and reinforce the painful pattern already experienced by these children.

Five case illustrations which were chosen arbitrarily, are presented. Of the remaining three children seen but not discussed here, one terminated therapy prematurely. Of the last two; siblings from a multi-problem family who had been sexually abused, the younger sister finished her

course of therapy with good progress. However, her brother began showing evidence of severe emotional disturbance and was referred for long term therapy upon termination of my practicum.

Section 6.2: A Visually Impaired Child With a Bathroom Phobia

Case 1: Heather

Heather came into the interview room hesitantly while holding on to her mother's hand. A pretty, quite overweight seven year old, she was obviously shy. The second oldest of three children, she had been born with a congenital birth defect. Doctors had advised her parents to agree to remove the life support equipment for even if she was to survive they expected her to be profoundly retarded. The parents prevailed upon the doctors, pleading with them that they wanted to give her a chance. Their prognosis had been unduly pessimistic. Heather survived with no complications thereafter with only her eye sight compromised, "A Miracle Child". Although she was registered as legally blind with the Canadian National Institute for the Blind, she had enough vision for mobility purposes and was in a modified Grade I progam at the neighbourhood school where she was being educated as a low vision child using large print and other visual aides. Her remarkable survival and visual impairment had led to her family being somewhat over-protective. It is not known how much of this may be cultural also as the family was of

Indonesian origin. I can only comment from my experience as a social worker at the Canadian National Institute for the Blind that certain nationalities afforded a special status to their handicapped family member. They were aware of their over-protectiveness but also concerned for her safety because of her compromised vision; a Catch-22 situation. Her parents were pleased with anything she accomplished and did not exercise the same expectations of her as they did with their other two children. Heather was aware of this and knew that simply refusing or at most a good tantrum would cause her parents to back off. She found an ally with her paternal grandmother who lived with the family. Grandmother could not say no to Heather, especially regarding diet and would allow Heather unrestricted access to the refrigerator.

Presenting concerns: Heather and her parents had been referred by the school social worker. Heather refused to use the school bathroom and would void at home at the end of the day. This reluctance to use bathrooms had interfered in other social activities as well. Further she showed dependent, clingy, fearful behaviors; seeking out adults rather than peers for companionship.

Assessment: Seeing a child with a handicap requires that one add additional dimensions to the assessment process. A visual handicap impacts differently on each child and to my knowledge no standardized format exists to

be used by social workers to assess a visually impaired child's psycho-social functioning. Samples of some important questions to consider in addition to those one would ask a sighted child are:

1. Is the child congenitally or adventitiously blind? If adventitious, at what age and under what circumstances?
2. Additional handicapping conditions (i.e.) cerebral palsy, seizures, etcetera. Any medications?
3. History of hospitalizations? (If excessive or lengthy, may have resulted in emotional trauma.)
4. Parental reaction to having a handicapped child.
    a. How do parents/siblings relate to the visually impaired child. Is she or he just "one of the other kids" or "special" and given concessions?
    b. Cultural/socio-economic background of parents.
5. Extended family reaction to the handicap.
6. Neighbourhood/community reaction: "curiosity", "poor kid", or "one of the kids"?
7. Does the child feel comfortable with their handicap or do they attempt to deny and bluff their way through situations? Or have they embraced their handicap and used it to manipulate and avoid responsibility?

8. Socially inappropriate behaviors (which may alienate others) i.e. poor body language such as no face to voice contact, blindisms such as rocking, keeping head down, etcetera.

Heather's parents reiterated the same concerns as the referring social worker. Not only was Heather hesitant to use the school bathroom but she was afraid of any poorly lit enclosures such as department store changing rooms. She had no difficulty with bathrooms at her home or the homes of extended family members at this point.

Heather's drawings at the intake interview at the Psychological Service Centre were done in the fashion of a younger child approximately four and a half to five years old. Figures were essentially stick-like and often did not have arms or hands. This was not surprising as there is ample documentation in the literature (Anderson, 1984; Clay, 1964; Fraiberg, 1977; Gardiner, 1982; Warren, 1977) that visual impairment causes developmental delay. Further, Heather was working with a visual medium and therefore was at a disadvantage. It became quite clear to me that tactile media such as finger painting and plasticine along with gross motor rather than fine motor activities would be more appropriate. These were indeed her favorites.

During the home visit to discuss the information gathered at intake, Heather's parents and I agreed on goals and priorized them. They were:

1. To decrease her weight.

2. To increase her independence and decrease fearful dependent behaviors.

3. To overcome her fear of bathrooms and small enclosed areas.

4. To increase her contact with peers and eliminate teasing (the teasing was minor). Except for her obesity, Heather did not exhibit unusual or socially inappropriate behaviors which would lead to ostracism. She was simply aloof. The extended family was very close knit and Heather enjoyed her friendships with her cousins. However, she and her parents had very recently moved to a new neighbourhood where Heather knew no other children.

Intervention:

a) Home: In a meeting with the parents I emphasized how they, as care-givers, the school personnel, and I all had a part to play in achieving the goals outlined for Heather. It was important that we worked together to insure consistency across all environments if any changes were to be made and generalized. They agreed to enroll Heather in a dance class to help improve her co-ordination and general fitness. They also spoke firmly to Heather's

grand-mother regarding her previously unlimited food intake and began changing her diet. Once she lost weight Heather began to show pride in her "new shape". I also emphasized to the parents that they must be more firm with Heather. I asked them if they felt a seven year old was in the best position to decide which activities were best for her.

b) School: Along with the school social worker, there were a number of educational personnel involved in Heather's educational program: an educational consultant for the visually impaired from the Department of Education, Heather's teacher, her class-room aide, and a resource teacher. Two case conferences were organized for us to share information, discuss and evaluate progress, and develop planning. The teacher and aide were aware of areas in which I was attempting to build competence and reinforced this in their day to day school program.

c) Individual Therapy Sessions: I saw Heather for seventeen therapy sessions. My initial hypothesis was that Heather was not afraid of bathrooms per se but of the poorly lit small space because she used bathrooms in her home and that of relatives. The noise of flushing echoing in a tiled school bathroom may also be frightening to someone whose vision is compromised. However, I felt it was important to address the underlying fears in general rather than simply focusing on her bathroom fear. I

suspected that she needed to see herself as less vulnerable and hoped to accomplish this with activities to build her competence. Regarding her aloofness, I wondered if Heather knew how to approach peers and initiate contact.

Efforts were made from the beginning in the sessions to work on building Heather's feelings of competence. I would escort her down the stairs to the play room initially. Soon she began to go on her own and was heard to announce proudly to her parents "I know the way now". A portion of every session was devoted to "exploring" a new section of the university each week. We constructed and decorated paper exploring hats which we wore on our treks. (On our first foray, Heather remarked in a grown-up voice before we put our hats on, "Isn't this rather silly!") Even though it was anxiety provoking for her, Heather began requesting we go exploring. I emphasized her "bravery" after every new foray. That was to become a cue word for her mother and teacher who also began emphasizing her bravery when she took risks and ventured into unfamiliar territory.

There were recurrent themes in Heather's play that were rehearsed in many different ways repeatedly.

1. Safety issues: She would draw pictures or tell stories about children who were either lost while alone or safe because they were with someone. We would talk either directly or through our dolls and puppets about what to do

to be "safe". At times she would play an aggressive character such as a monster or snake in doll play or with puppets and scare me. She would often ask me if I got scared. We read Phyllis Krasilovsky's (1959) Scaredy Cat together. The story centers upon a little black kitten who is afraid of many things but gradually becomes less frightened. Heather asked to take the book home to read.

2. Making friends: This would occur when she was playing with the puppets and doll-house figures. The sequence would always be the same. Her character would begin by saying "I'm looking to make a friend" and we would play out an interaction between two people who were initiating a friendly contact.

3. Fear of loss of mother's approval and love: On three occasions Heather began questioning me extensively about whether I had ever done something wrong at school. "Had my mother found out?" "And what did she do?" We talked about times in the past when Heather's mother had been angry at her but had never forsaken her.

I contracted with the parents to focus solely on Heather's bathroom phobia for the last six sessions. When I arrived at the family's home to discuss how we should proceed her mother recounted how Heather had had an "accident" at school. In frustration, her mother sat her down for a serious talk and stated firmly that Heather's

toilet avoidance behavior would have to change. She then phoned Heather's teacher and asked her to escort Heather to the bathroom to void or go through the motions four times daily. Heather had complied for the last two days. She had gone unescorted and with verbal prompts only, each time after the first time with her teacher. My goal was to have her explore the bathrooms at the University in hopes that this behavior would generalize to other settings. After researching and designing a desensitization schedule and then experiencing three unsuccessful attempts to have her simply enter a small one stall bathroom I asked Heather why she could use the bathrooms at school but not here. She replied that the toilets were smaller at school and besides, she was afraid of getting sucked through the hole. The desensitization schedule was dropped to work through this erroneous fear. I explained to her that this was not possible, "'cus the hole's too small", and described the workings of a toilet to her. She was given a homework assignment: to check out the toilet at home to see if the information I had given her was correct. In a subsequent therapy session Heather constructed a plasticine toilet and Sara, the little girl character, used it successfully three times, not getting "sucked through the hole, 'cus the hole's too small." I also told her a story about a little girl who had the same fear as Heather and consequently

threw her dolly into the toilet to check out whether her fear was warranted. Although I was never to have the satisfaction of seeing Heather enter and use a bathroom at the University of Manitoba she continued to do so at school and in many other locales. On last report, her mother was happy to state that Heather continues "to be brave".

Section 6.3: Childhood Loss of a Parent

Case 2: Sydney

The curly haired four year old who looked like a miniature of his father seemed quiet and sort of sad just like his father. Sydney's mother had died suddenly only three months earlier shortly before Christmas, leaving behind Sydney, his ten year old half-brother Carl, and their father. She was a young woman who had struggled with diabetes since her teen-aged years but there had been no indication of illness before her untimely death.

Presenting concerns: Usually a gentle easy-going child before his mother's death, his day care reported that he was showing hostility and aggressive behavior to the other children. He was also preoccupied with death and asked his father numerous questions about it. He was digging holes in the snow to try and find his mother but was also afraid of holes at the same time--thinking his mother would try and drag him into her grave. He was afraid of being alone in parts of the house whereas this

had not been the case previously. Sydney's father had approached Sydney's speech pathologist (whom he was seeing for a minor problem) about having his son see someone for counselling and the referral was made to me.

Assessment: Sydney did not really care to draw but what he produced was typical of a child his age. I soon found out he did enjoy building and playing with cars, and he would later construct creative and elaborate street scenes using blocks, cars, and play people on a frequent basis.

During the home visit to discuss the material gathered at intake we talked at great lengths about the circumstances leading up to Sydney's mother's death and her funeral. At the time there had been open and frequent expression of grief on his father's part but three days after her death Sydney and Carl had gone to their aunt's home as their father felt being among grieving adults would be upsetting for the children. According to Sydney's father his aunt had explained at length that his mother was dead and would never return. Her body was still here on earth in her grave but her soul was in heaven. The boys did not attend the funeral but went to the grave site a few days later.

Sydney's father talked at length about his courtship of Sydney's mother and spoke with great fondness of her and

their marriage. He brought out photo albums which he and Sydney looked at while he told anecdotes about the pictures. Initially, Sydney had looked at the albums daily for comfort but this was less prevalent now. Sydney's half brother Carl would say, when asked, that he missed his mother but would not volunteer other information.

When questioned about systems of support, Sydney's father described a family network that was strong, caring, and supportive. However this was primarily his wife's family and he admitted fears that they would abandon him now that she was dead although he had been reassured to the contrary on numerous occasions. He talked about how the adjustment to taking on his wife's roles of cooking, housework, and more involvement with the children and the expectations of his job had been demanding. His own leisure time and time with the children was severely compromised and he was concerned about quality of life issues. However, his sister was to move in soon and he hoped that her involvement with the home and children would alleviate some of the burden.

Greenberg (1975) talks about grief work for children and their families as proceeding along four developmental phases:

1. announcement; telling about the death in an experiential sense including affective recall of details

along with the perception that the death was a significant loss.

2. acknowledgment; dealing with the irreversibility of the loss which is permanent.

3. mourning; expressing directly and struggling with feelings of anger, guilt, and vulnerability and working "through personal implications relative to the child's life space (that is, developmental stage, family situation) and dealing with annihilation fantasies that the parent's 'abandonment' evokes" (p. 396).

4. renewal; incorporating the deceased, accepting that the parent has died but the family member remains and has survived the trauma, exploring the environment for appropriate replacements, and generally beginning to get on with one's life.

As the family and Sydney were not denying Shirley's passing and were able to openly and honestly acknowledge her significance in their lives and the extent of their loss, it was concluded that their grief reaction was normal. Sydney would need to "play through" his anger at his mother's passing and further ponder the typical questions of a child of his developmental level such as "where had his mother gone?"

Goals for therapy were determined and priorized:

1. to decrease Sydney's anger and aggression to others

2. to help him overcome his present obsession with concerns about death.

Intervention: I saw Sydney for nine sessions, with the final two sessions including his father. An individual session was also scheduled with the father, after a realization that Sydney's stating he couldn't cry but "had to be strong" was a mirror of his father's attitude. The decision to do so was prompted by knowledge according to Greenberg (1975) that successful childrens' grief work depends largely on intrafamilial communication and shared expression of feelings. Becker & Margolin (1967) have also talked about how the remaining parent often does not share emotions with their children about the death. Together, his father and I discussed how his open expression of grief would give Sydney permission to express his pain more openly also. Previously his father had felt that the children would be upset by his open expression of feelings of loss. He was also given a pamphlet on Talking with Young Children About Death by Mr. Rogers (1974) to give him some ideas on how to broach the subject naturally with Sydney.

Sydney's play was often aggressive and destructive. Puppets would eat each other up. Structures would be built and angrily torn down. Truck accidents would be continually staged. Often he did not want me to play with

him. He rejected any of my advances to nurture him because "I wasn't his mother". We would then talk about how no one could take his mom's place and where he could "get hugs" from people that he found acceptable to deliver this affection. He would talk openly about his mother's death if I initiated the conversation. Warmbrōd (1986) reminds us that the concept of death involves many abstract features that would be difficult for a child of Sydney's age to grasp. The concept of "soul" and "heaven" which were used in his aunt's explanation of what had happened to his mother were problematic for Sydney. We read two children's stories with death as the central theme, Ness's (1966) Sam, Bangs, and Moonshine and Viorst's (1971) The Tenth Good thing About Barney, which prompted a thoughtful reaction from Sydney and numerous questions about where the person's grave was, and where bodies and souls go after death.

The last two sessions were scheduled with father present for a number of reasons. Sydney's staging of truck accidents was not incidental. His father was a transport driver in the city and more likely to be at risk for truck accidents. Sydney was far less interested in me than he was in his father's whereabouts during our time together. He openly admitted that he was afraid of losing his father also. "No more mom, no more dad. Just Carl and

me." He also expressed rather sadly that he and his father had no leisure time together at a point in Sydney's life when he needed the reassurance of his father's presence more than ever. Focus of the last two sessions was on Sydney's fears of loss of his father. His father realized that Sydney was needing some individual time with him and made a commitment to involve both boys in leisure activities along with trying to spend time with each of them individually once his sister moved in. More importantly, he reassured Sydney that he and Carl would be taken care of by his favorite aunt and her family in the unlikely event that something should befall him.

Upon termination he was bemused that the boys were beginning to ask him about a new mom. Also, Carl had suggested he call on his friend's mother who was single although his father was firm in saying he was not prepared to date yet.

Subsequent follow-up at the day care found that Sydney's aggressive behavior had decreased. The family had gone on a holiday to Florida and their dad had begun dating.

In retrospect, I would have instituted a change and an addition in my interventions with this family. Carl, Sydney's half brother should have been included in some of the sessions with Sydney and the joint sessions with Sydney

and his father. Although Shirley was not his natural mother, her death also had a significant impact on him as he had been living with her and his father since he was four. Many of Sydney's concerns were likely Carl's also. In addition, this may have strengthened family cohesion as Warmbrōd (1986, p. 352) states "the most important benefit of seeing the whole family is that it supports their existence as a family, despite the death, and encourages members to turn to other family members."

Sydney's father's fear of loss of the support of his wife's family could have been addressed by a network meeting (Saulnier, 1982). This would allow family members as a group to reassure him and offer the continued emotional support he needed.

Case 3: Jason

The blonde boy with the big grey eyes and long lashes stayed very close to his mother. He was very shy and quiet in contrast to his gregarious mother. His father had been killed in a car accident less than two months ago, leaving his mother to care for six year old Jason and his two brothers, ages four years and nine months. Concerned about Jason's change in behavior at home, his mother contacted the school social worker who had made the referral to me. He did not exhibit any behavior changes at school and was described by his teacher as "doing so well".

Presenting concerns: Jason had become very moody. He had begun bullying his brother and his friends, destroying their property at times. His attention seeking behavior had also increased. He complained of more aches and pains and had had significantly more asthma attacks (a long standing condition for which he was receiving treatment) since his father's death.

Assessment: During the intake interview, as was my custom, I asked Jason to draw a self and family portrait. Although the figures indicated form and technique appropriate to his developmental level, the pictures showed thin, tentative outlines of shapes which were not colored in. His family portrait consisted of disembodied faces scattered around the page. The picture conveyed a vagueness and lack of substance. (This was not surprising when I learned that within the past year Jason had started Grade I, both parents had had hospitalizations, his brother had been born, and his father had been killed; a large number of significant life events which combined, led to disequilibrium.)

When I visited the home initially to discuss the intake questionnaires our interview was cut short by his youngest brother's throwing up and Jason's subsequently having an asthma attack and being rushed to emergency. In a second interview we talked about Jason's mourning reaction. Jason had cried frequently during the first week. He then began talking matter of factly about his father's body being

in the grave and his soul being in heaven. He wrote his father a letter saying good-bye which was placed in the casket. All the children attended the funeral and Jason kissed his father good-bye before the interment. Shortly afterwards he stopped expressing his grief and began acting out in an angry fashion.

Darlene's grief reaction was similar but I was not to make a connection until later in the course of therapy. Darlene admitted she was occupying herself constantly with activities and had people around at all times so as not to think of her former husband. She later admitted that the only time she talked about her feelings regarding the accident was with me.

Fortunately Darlene had an extensive family and friendship support network with whom she was actively involved. However, someone had suggested she become involved in Widow to Widow, a peer counselling support network organized through the Y.M.C.A. and she intended to follow up on this.

Darlene and I defined and ranked therapy goals as being:

1. to help Jason work through his feelings around his father's death and decrease his anger.

2. to get along more harmoniously with his family (i.e.) less fights, yelling, tantrums.

I was not certain why Jason had suddenly stopped expressing his feelings about his father's death and begun

acting out. It appeared that the beginnings of mourning (discussion of his father's death, ritual leading up to the funeral and attendance at the funeral) had been well negotiated. However, it was felt that providing a therapeutic experience whereby he could symbolically or gradually express what he liked about his father and the extent of the loss would be instrumental in facilitating his grief work.

Intervention: I saw Jason individually for nine sessions,his family three times, and his mother for one session individually.

Generally, I found Jason did not engage readily with the toys. He would begin to play if I first picked up the toy and initiated play. He never volunteered information. I tried some intrusive Theraplay activities to "invade" his world. We often played checkers, tic-tac-toe, or hangman where he would take quiet pleasure in winning. We read books where death was the underlying theme such as Viorst's (1971) The Tenth Good Thing About Barney. This led to discussions about his father; what he looked like, what he liked about him and what his past memories of him were. I talked about "having memories of your dad in your head and in your heart and how you could think of him and have him there any time you wanted".

An individual session with Darlene at her home focused on her concerns about Jason's not letting her out of his

sight and being worried that she would not return after leaving the house. I explained that this was a normal reaction of a child who had already lost one parent. During this session it became clear to me that Jason became upset when his mother cried. He appeared to resent my presence in his home and attempted to diffuse the focus from what his mother and I were discussing (which was making her cry). Darlene and I were to repeat on numerous occasions to Jason that it might sound funny, but it was very healthy and normal for his mom to cry and that she would be O.K. Unwittingly, by her denial of her grief reactions Darlene had modelled a particular pattern that her son was emulating. Warmbrōd (1986) talks about how children may stop expressing certain feelings when they see that their parent becomes upset. Jason had felt that he was protecting his mother from upset by stifling his own reactions. (Darlene mentioned on another occasion that Jason had withheld information about his unhappiness at school as he had not wanted "to worry" his mother.) Once it was clarified for Jason that he did not need to protect his mother from his or her emotional reactions he began to relate more spontaneously.

Three family sessions were held. During the first, a family tree was drawn with data regarding family members and who attended the funeral and helped the family, a technique described by Warmbrōd (1986). This served as a

springboard for the boys to discuss the death, funeral arrangements, and associated feelings. The second session focused on reminiscing about their deceased father. Darlene also talked about the arrangements that had been made for the children in the event of her death. She also spoke about their forthcoming plans to move. She had purchased a house on the same street as her parents with some of her life insurance money. She mentioned her guilt about leaving the home where she and her husband had spent so much time but acknowledged her need "to get on" with life. While we spoke the children drew pictures of the new house and yard. Jason's drawings had taken on more substance, depth, and he was making bolder use of brighter colors. The most significant aspect of our third family session was Darlene's somewhat tentative discussion of her loneliness without a man and what qualities she would look for in a future boyfriend while Jason, especially, listened somewhat apprehensively.

Darlene's responses on the problem behavior scales of the Child Behavior Checklist indicated that Jason's anger and cruel behavior to his brother and peers had decreased after the course of therapy. In Darlene's words: "Therapy has succeeded in bringing Jason to somewhat accept his father's death. I find I can cope with his moods better, probably because I understand his feelings a little better. His anger has not been as frequent as before."

Section 6.4: Multiple Traumas

Case 4: Darren

When I first came in, Darren had been looking at a science magazine and after we made contact, went on to explain the obscure features of a particular gadget to me. This was a child who, although in grade II at the time, had already completed his grade II Math by February of that year and was reading at a grade VII level.

Evelyn, his mother, had just come from work to bring Darren to the Psychological Service Centre. She had only been working for the past two months and was proud of her independence and how she was managing in supporting her three boys of whom eight year old Darren was the second oldest. She was divorced over a year ago, ending a marriage of eleven years that was characterized by physical and mental abuse. I knew that Darren's father was in prison for murder but did not know the details at the time. Darren's mother had initially contacted the Psychological Service Centre directly.

Presenting concerns: Darren was showing aggressive behavior towards his brothers and very occasionally other children. This was characterized by beating up and bullying and destroying others' property. His mother felt this behavior had gone on for the last six months and was now unmanageable. He was also lying. Always a moody child

who could be described as a loner, Evelyn felt he was becoming more moody and more withdrawn. She could never figure out what he was feeling.

Assessment: It was clear that Darren was a very bright child. His art work showed sophistication of execution and form and the themes were very creative. He said he liked drawing. However he admitted in our first interview that he preferred to draw only things that he could do well. He would abandon or attempt to scratch out whatever he felt was a mistake. His self portrait showed painstaking attention to replication. All colors in the picture had to match what he was wearing at the time. When I spoke with his teacher for the past two years she concurred regarding his perfectionism but felt it had improved since last year. Whereas previously he had been extremely withdrawn, afraid that he would do something wrong and asked very few questions she now found him more relaxed, participating with the group, and "bubbling over with enthusiasm" for his work this year. He did not have any difficulties in school. Significantly, she mentioned that Darren had once told his teacher he did not think his mother loved him. However, Evelyn described him as a child with whom it was to difficult to be affectionate as he kept his distance and would stiffen when hugged.

During the home visit after the initial intake interview it became clear that the most significant event

in this family's lives had been the murder which had precipitated his father's incarceration. At the time, Evelyn and her husband had been separated for approximately four months. Gordon, her former husband, had persisted in jealously tracking her whereabouts. A married male friend of the family had dropped by to check on Evelyn as was often his custom. Obviously assuming a tryst, Gordon burst through the back door of the house and fired nine shots which killed the man. Evelyn said her oldest son had been awake but the other two boys had "slept through the incident". Darren's older brother was still openly emotional about the murder and had been seeing a school social worker for therapy. Evelyn harbored a great deal of anger at her former husband. Darren said he was happy to be rid of his father. "He's where he belongs". Darren refused to have anything to do with his father--throwing any letters in the garbage. As Balicki (1987) notes, the violence children witness in their homes can definitely have a behavioral and emotional impact.

Regarding support systems, this family appeared somewhat impoverished. Evelyn was not close to her family and did not see them often, although the children spent time with their maternal grandfather. Although she appeared outgoing and friendly, she reported having only one close friend and another woman friend in the community.

However, she did not perceive this as a problem.

Goals for therapy that were defined and priorized with Evelyn were:

1. to decrease aggression. She wished Darren would throw fewer tantrums, pick fewer fights with his brothers, and decrease his bullying.

2. decrease his lying.

3. to begin to talk more about his feelings.

Intervention: I saw Darren for seventeen individual sessions and met with his mother individually at her home on two occasions.

Darren enjoyed a variety of different play media such as drawing pictures, use of play figures, board games, story telling, and action play with a ball or frisbee. He was a fantastic story-teller, showing great imagination and creativity in developing his characters and often accompanying the story with sound effects. There was often a recurrent space theme where he or another male would journey into space alone. On two occasions when I asked if he felt his family and friends would miss him if he went away on a space-ship he said no.

Therapy concentrated on four areas essentially; Darren's strong defenses against any types of feelings, his perfectionism, his perceptions about violence and his denial of his father's presence in his life. Each issue

will be discussed briefly.

Darren was very highly defended against any expression of feelings. Sensitive questions would be met with "I don't know." Anytime we talked about feelings or I would tell a story about a character and ask if he had ever felt that way he would say no. He said he never felt sad and he said he never had any problems. The only time he would acknowledge feelings was in playing Richard Gardner's "Thinking, Feeling, Doing" (1973) game. Respecting his defenses, I continued to talk about feelings but always in the context of other characters or myself and never solicited comments from him directly unless he volunteered.

Darren continued to be perfectionistic and show lack of confidence in risking failure in areas he did not excel in. However, he would often admit his shortcomings and we would work in that area to build his feelings of competence. He received positive reinforcement for the many things he did do well. In addition I modelled by personal example and story telling how it was O.K. to make mistakes and that "even adults made mistakes."

There was also a recurrent theme of violence in Darren's stories or he would talk smugly about beating his brothers up. We talked about other ways to solve a problem, either directly or indirectly through story-telling. However, in a section regarding who's to

blame for family violence in Diane Davis's Something is Wrong at My House: A Book About Parent's Fighting (1985) that we read together, Darren was very quick to say without prompting that this was an adult problem for which children should not feel responsible. However, besides getting a divorce (as his parents had done) he could not conceive of another way to solve the conflict.

Reading a book about anger (Simon's, (1974) I Was So Mad) precipitated dialogue from Darren about his not liking his father; even before the shooting. He could not think of one thing he liked about his father. He made references to how he had not liked his yelling and screaming at home but would not go into any further detail when I tried to pursue it.

Any reference to Darren's father was repeatedly met with the retort of "I don't got a father." When I asked him why he said this he said "Well, they got divorced." We talked about how parents can be divorced but he still had a father. He also denied that this was any kind of loss as he could always spend time with his friend's father. It became clear to me that Darren's disdain for his father was a reflection of his mother's angry feelings. This prevented Darren from acknowledging any positive influence, however small, or positive personal qualities attributable to his father that might reside within Darren. His father

was simply a horrible one dimensional character who had committed a heinous crime. In an individual session with Evelyn about this matter she resisted my wish to talk in therapy with Darren about his father in ways such as "how are you different" or "the same as your father". She felt that I was trying to change Darren's mind about his father which I denied. I explained that I was simply in the beginning phases of getting Darren to talk about his father and see him for the individual he was. However, his coming to terms with this and the shooting would be a long process. Darren was only able to acknowledge his father's presence on the fifteenth session.

Upon termination of therapy, Evelyn stated that Darren had begun initiating co-operative play with his older brother. Also, a cousin of Evelyn's who had not seen Darren since therapy began now found him "more open, more fun loving, and out-going."

There is a shortcoming in this intervention. In retrospect, I would have liked to spend more time with Darren on the theme of family violence. As Darren was not the only one affected by this, family sessions would have been helpful also.

Section 6.5: A Remarried Family

Case 5: Leo

Leo arrived escorted by his stepfather Peter. Leo, large in size for his age, full of energy, and dressed in faded blue jeans was a marked contrast to Peter who was small boned, well-dressed, and pleasant but reserved. The seven year old engaged readily with me. While Peter filled out the intake forms Leo drew colorful, cheerful pictures indicating skills appropriate to his developmental level. The forms were bold and he confidently filled in every square inch with drawings or color. I showed him the play room. He wanted to explore further so we walked around the university.

His mother had phoned the Psychological Service Centre, having heard of my work through word of mouth. She explained that this was her second marriage. Leo had a one year old half-brother, Allan, who was a product of the current union. She and Leo's father had separated when Leo was one and a half. The two were alone together until she met Peter a year and a half later. Peter had moved in with them within months. Essentially he had been more present in Leo's life than his natural father who lived in Montreal and whom he saw only a few times a year.

Presenting concerns: Peter and Karen felt they had seen a change in Leo's behavior over the past year. At

home he was becoming more argumentative and Karen especially was having difficulty enforcing daily rules and expectations. At school his teacher described him as being more aggressive, showing poor attention, and not following directions well. However he was not jeopardizing his school year.

Both parents also felt that Leo had never resolved his parents' divorce and appeared in conflict over having two fathers, to neither of whom he attached because of the guilt involved in hurting the other's feelings. Thirdly, both parents, especially Karen were cognizant of their contribution in fostering or escalating Leo's negative behaviors and wanted some feedback about things they were doing that should be altered.

Assessment: the questionnaires completed at intake showed that this family had experienced a great deal of stress recently. They had moved to a new house, had a baby, and Karen and Peter had married. They were willing to acknowledge that all these changes (change in locale and change from only child to older brother) may have had some part in the behavior change Leo was exhibiting. Both Karen and Peter had strong family and friendship support networks. They appeared to be a harried couple who were somewhat over extended with commitments to either work or community activities. Both were employed full time in demanding careers.

This was Peter's first marriage. He had become a father at the time he became a live-in partner.

Peter talked about his frustration at times with Leo's not acknowledging him in more of a father role. There was also some disappointment regarding Leo's having divided loyalties between Peter and his natural father, especially since Peter had been more of a father figure for a longer period of time than Leo's natural father. He and Karen still had unresolved parenting issues regarding Leo that had caused such serious conflict in their relationship that he had retreated on his stand simply to keep the peace. At this point, Karen was primarily responsible for any major decisions or disciplining regarding Leo. This family was facing issues common to many remarried families. McGoldrick and Carter (1980, p. 273) outline a number of predictors of difficulty in making the transition to remarriage. Three were especially evident in this family:

1. "The inability to give up the ideal of the intact first family and move to a new conceptual model of family". Peter had no previous experience with parenting and expected that Leo should respond to him in the same way as his own child would.

2. "Efforts to draw firm boundaries around the new household membership and push for primary loyalty and cohesiveness in the new family." Although Karen and Peter

never restricted Leo's access to his father, they could not understand how he could have divided loyalties. This made it difficult for Leo to accept both fathers in his life.

3. "Denial of differences and difficulties and acting 'as if' this is just an ordinary household." After four years of living with Leo, Peter was still relegated to the background regarding parenting of Leo. He and Karen still had unresolved parenting issues.

Thomas and Chess (1980) talk about fit between temperament of parent and child. Leo, the highly kinesthetic, rambunctious child was matched with two cerebral parents who spent leisure time involved in more sedentary pursuits. His high energy and need to be active was especially bothersome to Peter who was not interested in the typical boyhood pursuits of baseball, football, or soccer.

We defined and priorized therapy goals:

1. To change the interaction between Leo and Karen to a more positive tone, for example, less disagreements.

2. To help Leo resolve his divided loyalty to both fathers.

Intervention: I saw Leo for twelve sessions individually. Two family sessions, one couple session, and one individual session with Karen were also scheduled. My general focus was to facilitate expression of what the

remarried family experience was like for this family and offer ways that it could be improved. I also felt it important to provide some education to Karen and Peter in this area.

Play activities with Leo were varied; story-telling, reading, board games, exploring, and a broad range of kinesthetic activities that were his favorite, such as soccer, kicking a ball, throwing a frisbee, playing catch, and dodge ball. The first half of sessions were usually sedentary and the later action oriented.

One day, after reading a book called All Kinds of Families by Norma Simon (1976), which talks about many different types of families, I asked Leo who was in his family. He perceived his biological father Claude as part of his family and wished that he could live with he, his brother and Peter and Karen. I told him I thought he was extra lucky because he had two dads. He said he didn't think so. After the fifth session Leo began asking his mother questions about their divorce and blamed her for the break-up. She explained to him that neither Claude nor she had been happy and that it had been best for all involved.

During the first family session we worked through a genogram. Karen's was the only divorce on either side of the family. There were no role models in either family regarding how to form a remarried family. In addition, Leo

knew of only one child whose parents were divorced. As both Peter and Karen were highly cognitively oriented, I gave them McGoldrick and Carter's chapter on remarried families (1980) to read in preparation for our next session. Our second session focused on this and a discussion regarding Peter and Karen's different parenting styles. I knew Peter was relegated to the periphery in parenting matters regarding Leo. I asked if this was their intention also with their new son. Neither had thought of this and agreed that they should attempt to resolve this matter. Peter had previously felt Karen did not want him to take more of an active role. Meanwhile, Karen was now wanting his support.

In an individual session Karen was able to talk about how she had more of an appreciation of Leo's qualities and realized perhaps his environment could at times be changed to match his temperament. She gave an example of his private school where he may not "fit" because of its emphasis on study, rules, and conformity. She now saw it as more acceptable that he did not "fit" in certain environments. We also talked about how one aspect of Karen's parenting style was ineffectual with Leo. Rather than imposing her will on him she had always appealed to his sense of reason and conscience. I explained that developmentally these concepts were only now approaching

Leo's grasp. Furthermore, children need and expect parents to impose some sense of structure in their lives to give them a sense of security. She was later to report that her interactions with her son were becoming more harmonious.

At the conclusion of therapy Peter listed the following points as being salient outcomes of their experience with therapy:

1. It had served as a catalyst for communication about previously unresolved issues between he and Karen.

2. They had more of an understanding of Leo.

3. They could be more firm and clear in enforcing certain limits with him.

Both also felt that they had changed their expectations of their family experience and no longer sought to replicate a typical first marriage nuclear family model.

CHAPTER 7

EVALUATION

Section 7.1: Introduction

Evaluation must be considered an integral part of practice. Ultimately, our interventions must be guided and validated by quantitative data that points to the efficacy of our methods rather than a subjective feeling that "this seemed to help". During the assessment period, practitioner and client define the problem(s) and a comprehensive assessment is done on which specific goals for treatment arrived at by practitioner and client are based. An instrument may be used to aid in the assessment and help measure the problem prior to intervention to gain a baseline. Based on the total data gathered, a specific intervention is planned. The same instrument may be used on a post-intervention basis to see if behaviors outlined as part of the goals have changed (Bloom & Fischer, 1982).

For the purposes of this practicum, the behavior problem scales (see Appendix II for a copy) in Achenbach's Child Behavior Checklist were used as the instrument to assess a child's pre and post intervention functioning. Consisting of 118 items (along with two questions for parents to write in answers) that can be scored with three values from zero to two to a maximum total value of 240, this measure has been standardized on 2,300 children ages

four to sixteen. The scales are designed to contribute to diagnostic formulations by providing pictures of parents' views of their childrens' problems rather than categorical or diagnostic labels. Achenbach & Edelbrock (1983, p. 124) advise that parents' data "can be integrated with the developmental history, clinician's observation of the child and parents, interview impressions, family dynamics, school reports, psychological and achievement test data, and medical findings" to help gain a holistic overview of the child and their behavior during the assessment phase.

The behavior problem items have demonstrated a high test and retest reliability. Intraclass correlation coefficients (ICC)* were .838 ($p<.001$). Content validity was demonstrated by the fact that clinically referred children received significantly higher scores ($p<.005$) than demographically matched nonreferred children on 116 of the 118 behavior problem items. Significant correlation with other behavior rating scales and between empirically derived syndromes and the behavior problem scales provided

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*The ICC reflects the portion of total variance in item scores that are associated with differences among the items themselves, after the variance due to a particular source of unreliability has been subtracted (Achenbach & Edelbrock, 1983).

evidence of construct validity. Using referral for mental health services as a criterion, Achenbach & Edelbrock present evidence for criterion related validity by showing significant differences ($p<.001$) between demographically similar referred and nonreferred children on all scores for all sex/age groups.

Raw behavior problem scores will be referred to as Achenbach & Edelbrock felt these were superior to any of the more specific scales as a good index of differences between children whose reported behavior problems are in the "clinical" versus "normal" range. "The total behavior problem score can also be used...for assessing change as a function of time or intervention" (Achenbach & Edelbrock, 1983, p. 173). Table 1 shows the cut off points for total behavior problem scores. Behavior problem scores above those in Table 1 are considered to be in the clinical range.

Table 1 - Page 132

The behavior problem scales were administered to parents (preferably to both parents if at all possible) at the intake interview and then again after termination of therapy. It was hoped that improvements in behavior would

Table 1:

Cut off points for total behavior problem scores (Achenbach & Edelbrock, 1983, p. 63).

Age	Girls	Boys
4-5	42	42
6-11	37	40
12-16	37	38

be shown by decreases in scores; preferably to below clinical levels. However we should not be too quick to herald changes in ratings of children receiving clinical services as undisputed indicators of the efficacy of our brilliant treatment strategies. Changes may reflect a variety of factors, individually or cumulatively, which we would have difficulty controlling for. They may have occurred simply because of the healing qualities of the passage of time such as with a grief reaction or mastering of a developmental milestone. Rater's judgments that are determined by their own attitudes and behaviors toward the children may have changed a well as actual changes in the children themselves. All we can clearly say is there have not or there have been changes in the scores. Causality, at best, can only be speculatively inferred.

Section 7.2: Evaluation of Outcome

As stated in Chapter 4, one of the objectives of this practicum was to offer therapy services to children ages four to nine and their families in the community where the child was experiencing emotional and/or behavioral problems for whatever reason. It was felt that decreases on the behavior problem scales of the Achenbach Child Behavior Checklist (on the basis of pre and post intervention scores) would give an indication if the child was experiencing fewer emotional or behavioral problems after

the intervention. Whether parents reported satisfaction with the services they received as reflected in their response on the Client Feedback Questionnaire (see Appendix III), administered upon termination of service, may also be taken as an indicator of some success in service provision. As parents of all five children discussed earlier completed pre and post intervention behavior problem scales, results of each will be discussed. Results are summarized in Table 2.

Table 2 - Page 135

However it is not appropriate to make comparisons between any childrens' scores because each intervention was individualized to the particular child and their unique situation.

Case 1 Heather: Heather's mother's pretest behavior problem scales indicated a raw score of 19 and an increase to 23 on the post test. Although both pre and post test scores are well below the clinical range, Heather's general fearfulness and specifically, her fear of entering the school bathroom certainly made her life difficult. The increase in scores remains a puzzles since by my observation parents' and school personnels' reports, Heather made

Table 2:

Differences Between Pre and Post Intervention Scores on the Behavior Problem Scales of the Achenbach Child Behavior Checklist.

	Pretest	Post test
Case I: Heather Completed by: Mother	19 below	23 clinical range
Case 2: Sydney Completed by: Father	23 below	10 clinical range
Case 3: Jason Completed by: Mother	82 in clinical range	38 below clinical range
Case 4: Darren Completed by: Mother	51 in clinical range	26 below clinical range
Case 5: Leo Completed by: Mother	73 in clinical range	25 below clinical range
Step-father	91 in clinical range	90 in clinical range

significant progress towards meeting her goals. Indeed, there are decreased scores in the items of "nervousness", "fearfulness", and "anxious", and "shy or timid". It is interesting to note that Heather's mother rated some items as higher such as over eating post test, although she reported Heather had lost weight. She also rated her at almost always "under-active and slow moving" when initially this had been scored zero. Perhaps the therapeutic encounter which included consistent input from the school personnel and myself may have served to heighten her awareness of the extent of the difficulties Heather was experiencing relative to her peers.

Case 2 Sydney: Sydney's father's score on the behavior problem items was 23 at pretest and 10 post test. Both scores were well below the clinical range for a child of his age. At termination he showed scores of zero on the items describing "obsession with death", "meaness to others" and "having temper tantrums". These had been presenting concerns and goals for therapy.

Case 3 Jason: Jason's mother's pretest score on the behavior problem items was 82 and 38 post test. The pretest score was more than double the cut off score for the clinical range. Post test was below the clinical range. Two goals for therapy had been a decrease in Jason's angry and aggressive behavior. He showed decreased scores on the

"arguing", "cruelty and meaness to others", and "disobedience" items. Also, getting along with others became no problem. Whereas he previously showed psychosomatic symptoms in four areas this was only a problem in one area post test.

Case 4 Darren: Darren's mother's pretest score on the behavior problem items was 51 (in the clinical range) and 26 post test (not within the clinical range). Two behavioral goals for therapy had been a decrease in aggression and temper tantrums. Darren showed post test scores of zero on items such as "destroying of his own or other's property", "disobedience at home", "getting along with children", and "physically attacking others". Previously these had been scored as two or happening often or always. There was also a decrease in the items regarding "arguing a lot" and "cruelty and bullying of others".

Case 5 Leo: Leo's step-father's scores pre and post test for the behavior problem items were 91 and 90 (in the clinical range) respectively. His mother's pretest score was 73 and 25 post test. This is unusual because Achenbach & Edelbrock talk about a very high interparent agreement of .985 on item scores. They go on to state that when two parents disagree markedly, the reasons should be explored. "If one parent reports many more problems than the other, it should be asked whether this reflects such factors as

one parent's ignorance, lack of tolerance, greater sensitivity, poor reality testing, or more negative impact on the child" (Achenbach & Edelbrock, 1983, p. 46).

Karen had many of the same concerns about Leo's behavior but generally scored them as less prevalent than Peter had. She admitted in the intake interview that she tended to be less objective and more lenient because she had seen Leo grow and develop from infanthood whereas Peter did not have that history. Also, one of the presenting concerns had been her conflict with Leo re: expectations and limit setting. They reported less conflict in these areas at termination of therapy and it is very likely that she may have perceived a significant improvement in his behavior. Indeed there were positive changes in scores on items such as "argues a lot", "disobedient at home", "stubborn, sullen, and irritable", and "sulks a lot".

In summary, three children showed marked decreases in scores on the behavior problem scales, especially on items that were problematic at time of referral and designated as behaviors to be decreased or eliminated by the therapeutic process. While one parent felt no changes had been made the other parent scored the pre and post tests differently, possibly reflecting changes in her behavior and attitude towards her son. A fifth child's parent showed her post test score as increasing although many of the presenting problem behaviors had improved according to parental and

school personnel's report and therapist's observation.

On the client satisfaction questionnaire all parents ranked the quality of service received as either good or excellent. All said that the services received helped them deal more effectively with their problems. In an overall, general sense all were mostly satisfied with the service they received. All would also return to the program should they wish to seek help again.

In retrospect, I would have made two changes in my evaluation process. First, where appropriate I would have used additional measures such as the Teacher's Report Form and Direct Observation Form (Achenbach & Edelbrock, 1983). Secondly, it would have been informative to have sent the behavior problem scales to parents three or six months after termination of therapy to evaluate long term effects of the therapeutic endeavour.

CHAPTER EIGHT

CONCLUSIONS

I considered the opportunity to do a practicum a privilege, a tremendous luxury. One is afforded the opportunity to practice social work under the most ideal kinds of circumstances; with a select number of cases in an area of your own choosing. Supervision is usually excellent. There is an opportunity to develop a depth of knowledge, plan, discuss, and ponder the course of therapy. This is in direct contrast with the realities of day to day social work practice.

I have had the opportunity to see theory come alive. It is tremendously exciting to read something and then later see it unfold in front of your eyes in a totally predictable fashion and having the assurance that you know what you are doing.

As outlined earlier, one of the objectives of this practicum had been to:

a) develop skills in use of play therapy and;

b) further develop skills in work with families and systems impacting upon them, and;

c) integrate this within an ecological perspective.

These objectives have been satisfied through the rich and challenging learning experience afforded by this practicum.

I have been exposed to theory regarding child development, the ecological perspective,and used various

therapeutic modalities such as play and family therapy. As my practicum was skill based and the presenting concerns varied, it was also necessary to develop a knowledge of literature and the associated methodologies in most of the problem areas children I saw were having difficulty in, such as sexual abuse, phobias, grief, violence in the family, and adjustment to a remarried family situation. The knowledge base for such a practicum must necessarily be broad. It was necessary for me to expand my array of intervention techniques and skills and become more creative in employing those techniques and skills with which I was already familiar.

As I had no previous therapy experience with children prior to my practicum, this was the area of greatest growth for me. My appreciation for children and their unique world views was broadened. I had to become accustomed to the demands of this type of therapy with its noncognitive focus and highly symbolic content. I became more spontaneous and creative in the use of myself and various media such as toys, tape recorders, books, and art materials. Clearly, social work education needs to incorporate knowledge about child development and how to engage with children in its curriculum.

Although it would have been tempting to have maintained my primary focus in the play therapy area, this

would have been largely self serving and simply poor social work practice.

In every circumstance where a child was "stuck" or having difficulty making therapeutic progress, no change would occur until parents also had an opportunity to explore and discuss their own feelings about the issues the child was struggling with. Harter's (1977, 1983) discussion about how children's feelings are inextricably linked to and affected by those of their parents came alive in my therapeutic work. Based on this experience in my practicum, I would urge everyone doing therapeutic work with children to incorporate family sessions in the assessment process and whenever necessary in the course of therapy. This view is also borne out in the literature on therapeutic work with children experiencing grief reactions (Becker, 1967; Kane, 1979; Warmbrōd, 1986) and receiving treatment for sexual abuse (Waterman, 1986).

In conclusion, I must say that completion of this practicum has strengthened my commitment to centre practice within an ecological perspective. We can never lose sight of the individual in context of their situation.

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Appendix I: Letter Offering Services

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

October 4, 1985

Director of Rehabilitation Services
C.N.I.B.
1080 Portage Ave.
Winnipeg, Mantioba
R3G 3M3

Dear

As you are aware, I have returned to the University of Manitoba to finish my graduate degree in clinical social work. Part of my learning experience requires an extensive practicum in my area of specialization. Therefore, I am offering my services as one other community resource to consider for therapeutic intervention for visually impaired children during the 1985-86 school year.

My target population is children between the ages of four and nine who are showing behavioral or emotional problems in the home or at school. In addition, therapy may be considered for children who have suffered a particular trauma such as recent extensive hospitalizations, loss of vision, or loss in the family due to separation, divorce, or death of a family member. I will be able to provide extensive involvement with the child along with his or her significant others as necessary, as my work proceeds from a holistic perspective which considers both child and social context. For this reason, upon referral, it should be made clear that parents and significant others should expect to be involved in the therapeutic process. (Convenient evening appointments can be arranged.)

All work will be done at the Psychological Service Centre, University of Manitoba, under close supervision of my advisor, Dr. Kathryn Saulnier. Reports will be prepared for referral resources upon request.

If you should have any further questions or wish to make a referral at this time, please do not hesitate to contact me at the Psychological Service Centre (474-9222) for messages or at my home

Thank you for your consideration.

Sincerely,

Lesia Shepel, B.A., B.S.W.

Kathryn M. Saulnier, Ph.D.
Assistant Professor
Clinical Associate

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

October 4, 1985

Assistant Director
Child Care and Development Branch
Department of Education
Rm. 206-1181 Portage Ave.
Winnipeg, Manitoga
R3G 0T3

Dear

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Thank you for your consideration.

Sincerely,

Lesia Shepel, B.A., B.S.W.

Kathryn M. Saulnier, Ph.D.
Assistant Professor
Clinical Associate

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

February 5, 1986

c/o Daniel McIntyre School
720 Alverstone St.
Winnipeg, Manitoba
R3E 2H1

Dear

As you are aware, I have returned to the University of Manitoba to finish my graduate degree in clinical social work. Part of my learning experience requires an extensive practicum in my area of specialization. Therefore, I am offering my services as one other community resource to consider for therapeutic intervention for visually impaired children during the 1986 school year.

My target population is children between the ages of four and nine who are showing behavioral or emotional problems in the home or at school. In addition, therapy may be considered for children who have suffered a particular trauma such as recent extensive hospitalilzations, loss of vision, or loss in the family due to separation, divorce, or death of a family member. I will be able to provide extensive involvement with the child along with his or her significant others as necessary, as my work proceeds from a holistic perspective which considers both child and social context. For this reason, upon referral, it should be made clear that parents and significant others should expect to be involved in the therapeutic process. (Convenient evening appointments can be arranged.)

All work will be done at the Psychological Service Centre, University of Manitoba, under close supervision of my advisor, Dr. Kathryn Saulnier. Reports will be prepared for referral resources upon request.

If you should have any further questions or wish to make a referral at this time, please do not hesitate to contact me at the Psychological Service Centre (474-9222) for messages or at my home

Thank you for your consideration.

Sincerely,

Lesia Shepel, B.A.,B.S.W.

Kathryn M. Saulnier, Ph.D.
Assistant Professor
Clinical Associate

Area Service Director
Child Guidance Clinic
700 Elgin Avenue
Winnipeg, Manitoba
R3E 1B2

Dear Sir,

My name is Lesia Shepel and I am a graduate student in clinical social work. As you may know, part of my learning experience requires an extensive practicum in my area of specialization. Therefore I am offering my services as one other community resource to consider for therapeutic intervention for children during the 1986 school year.

I am presently looking for referrals of four to nine year old children whom you feel could benefit from short term individual therapy incorporating various modalities of play. As I am using an ecological perspective, all relevant systems in the child's life such as family, extended family, school and others are worked with as necessary. Use of particular therapeutic approaches such as art, story-telling, movement and puppetry are determined after assessment and individually tailored to each child's needs and interests.

Examples of some appropriate referrals would be children who may be undergoing medical or surgical procedures, suffering loss from death of a family member or separation of a parent or any recent trauma such as sexual abuse that has adversely affected their lives.

All work will be done at the Psychological Service Centre, University of Manitoba, under close supervision of my advisor, Dr. Kathryn Saulnier. Children will be seen until June. Reports will be prepared for referral resources upon request.

If you should have any further questions or wish to make a referral at this time, please do not hesitate to contact me at the Psychological Service Centre (474-9222) for messages or at my home ( ).

Thank you for your consideration.

Sincerely:

Lesia Shepel B.A., B.S.W
M.S.W. Graduate Student.

Kathryn Saulnier, Ph.D.
Assistant Professor
Clinical Associate

Appendix II: Instruments Used During Assessment

- Behavior Poblem Scales of the Auchenbach Child Behavior Checklist
- Morrison Centre Health and History Form
- The Social-Demographic Data Sheet

CHILD BEHAVIOUR CHECKLIST

CHILD'S NAME: _____ DATE: _____

CHILD'S SEX: _____ CHILD'S AGE: _____

This form is filled out by:

MOTHER___ FATHER___ OTHER___

YOUR NAME _____

Parent's type of work. (Please be specific- for example: auto mechanic, high school teacher, homemaker, show salesman.)

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

Below is a list of items that describe children. For each item that describes your child now or within the past 12 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Circle either "Y" (Yes) or "N" (No) to indicate whether the behaviour is currently a problem.

			Is this a problem for You?
Very or Often True	2		
Somewhat or Sometimes True	1		
Not True 0			
1.	Acts too young for his/her age.	0 1 2	Y N
2.	Allergy (describe) _____	0 1 2	Y N
3.	Argues a lot	0 1 2	Y N
4.	Asthma	0 1 2	Y N
5.	Behaves like opposite sex	0 1 2	Y N
6.	Bowel movements outside toilet	0 1 2	Y N
7.	Bragging, boasting	0 1 2	Y N
8.	Can't concentrate, can't pay attention for long	0 1 2	Y N
9.	Can't get his/her mind off certain ..... thoughts: obsessions (describe) _____	0 1 2	Y N
10.	Can't sit still, restless or hyperactive.	0 1 2	Y N
11.	Clings to adults or too dependent	0 1 2	Y N
12.	Complains of loneliness	0 1 2	Y N
13.	Confused or seems to be in a fog	0 1 2	Y N
14.	Cries a lot	0 1 2	Y N
15.	Cruel to animals	0 1 2	Y N
16.	Cruelty, bullying or meanness to others .	0 1 2	Y N
17.	Day-dreams or gets lost in his/her thoughts	0 1 2	Y N
18.	Deliverately harms self or attempts suicide	0 1 2	Y N
19.	Demands a lot of attention	0 1 2	Y N
20.	Destroys his/her own things	0 1 2	Y N
21.	Destroys things belonging to his/her family or other children	0 1 2	Y N
22.	Disobedient at home	0 1 2	Y N
23.	Disobedient at school	0 1 2	Y N
24.	Doesn't eat well	0 1 2	Y N

Very or Often True			2			Is this a	
Somewhat or Sometimes True				1		problem	
Not True		0				for you?	
25.	Doesn't get along with other children	0	1	2		Y	N
26.	Doesn't seem to feel guilty after misbehaving	0	1	2		Y	N
27.	Easily jealous	0	1	2		Y	N
28.	Eats or drinks things that are not food .. (describe) _____	0	1	2		Y	N
29.	Fears certain animals, situations or places	0	1	2		Y	N
30.	Fears going to school	0	1	2		Y	N
31.	Fears he/she might think or do something bad	0	1	2		Y	N
32.	Feels he/she has to be perfect	0	1	2		Y	N
33.	Feels or complains that no one loves him/her	0	1	2		Y	N
34.	Feels other are out to get him/her	0	1	2		Y	N
35.	Feels worthless or inferior	0	1	2		Y	N
36.	Gets hurt a lot, accident-prone	0	1	2		Y	N
37.	Gets in many fights	0	1	2		Y	N
38.	Gets teased a lot	0	1	2		Y	N
39.	Hangs around with children who get in trouble	0	1	2		Y	N
40.	Hears things that aren't there (describe). _____	0	1	2		Y	N
41.	Impulsive or acts without thinking	0	1	2		Y	N
42.	Likes to be alone	0	1	2		Y	N
43.	Lying or cheating	0	1	2		Y	N
44.	Bites fingernails	0	1	2		Y	N
45.	Nervous, high strung, tense	0	1	2		Y	N
46.	Nervous movements or twitching (describe). _____	0	1	2		Y	N
47.	Nightmares	0	1	2		Y	N
48.	Not liked by other children	0	1	2		Y	N
49.	Constipated, does not move bowels	0	1	2		Y	N
50.	Too fearful or anxious	0	1	2		Y	N
51.	Feels dizzy	0	1	2		Y	N
52.	Feels too guilty	0	1	2		Y	N

Very or Often True			2			Is this a	
Somewhat or Sometimes True				1		problem	
Not true			0			for you?	
53.	Overeating	0	1	2		Y	N
54.	Overtired	0	1	2		Y	N
55.	Overweight	0	1	2		Y	N
56.	Physical problems without known medical cause	0	1	2		Y	N
	a) aches or pains	0	1	2		Y	N
	b) headaches	0	1	2		Y	N
	c) nausea, feels sick	0	1	2		Y	N
	d) problems with eyes (describe)	0	1	2		Y	N
	_____						
	e) rashes or othe skin problems	0	1	2		Y	N
	f) stomach aches or cramps	0	1	2		Y	N
	g) vomiting, throwing up	0	1	2		Y	N
	h) other (describe)	0	1	2		Y	N
	_____						
57.	Physically attacks people.....	0	1	2		Y	N
58.	Picks nose, skin or other parts of body... (describe) _____	0	1	2		Y	N
59.	Plays with own sex parts in public	0	1	2		Y	N
60.	Plays with own sex parts too much	0	1	2		Y	N
61.	Poor school work	0	1	2		Y	N
62.	Poorly coordinated or clumsy	0	1	2		Y	N
63.	Prefers playing with older children.....	0	1	2		Y	N
64.	Prefers playing with younger children	0	1	2		Y	N
65.	Refuses to talk.....	0	1	2		Y	N
66.	Repeats certain acts over and over compulsions (describe)	0	1	2		Y	N
	_____						
67.	Runs away from home	0	1	2		Y	N
68.	Screams a lot	0	1	2		Y	N
69.	Secretive, keeps things to himself	0	1	2		Y	N
70.	Sees things that aren't there (describe)..	0	1	2		Y	N
	_____						
71.	Self-conscious or easily embarrassed	0	1	2		Y	N
72.	Sets fires	0	1	2		Y	N

Very or Often True			2			Is this a problem for you?	
Somewhat or Sometimes True				1			
Not true		0					
73.	Sexual problems (describe) _____	0	1	2		Y	N
	_____						
74.	Showing off or clowning	0	1	2		Y	N
75.	Shy or timid	0	1	2		Y	N
76.	Sleeps less than most children	0	1	2		Y	N
77.	Sleeps more than most children during day and/or night (describe)	0	1	2		Y	N
	_____						
78.	Smears or plays with bowel movements	0	1	2		Y	N
79.	Speech problem (describe) _____	0	1	2		Y	N
80.	Stares blankly	0	1	2		Y	N
81.	Steals at home	0	1	2		Y	N
82.	Steals outside the home	0	1	2		Y	N
83.	Stores up things he/she doesn't need ..... (describe) _____	0	1	2		Y	N
84.	Strange behaviour (describe) _____	0	1	2		Y	N
	_____						
85.	Strange ideas (describe) _____	0	1	2		Y	N
	_____						
86.	Stubborn, sullen, irritable	0	1	2		Y	N
87.	Sudden changes in mood or feelings	0	1	2		Y	N
88.	Sulks a lot	0	1	2		Y	N
89.	Suspicious	0	1	2		Y	N
90.	Swearing or obscene language	0	1	2		Y	N
91.	Talks about killing self	0	1	2		Y	N
92.	Talks or walks in sleep (describe)_____	0	1	2		Y	N
	_____						
93.	Talks too much	0	1	2		Y	N
94.	Teases a lot	0	1	2		Y	N
95.	Temper tantrums or hot temper	0	1	2		Y	N
96.	Thinks about sex too much	0	1	2		Y	N
97.	Threatens people	0	1	2		Y	N
98.	Thumbsucking	0	1	2		Y	N
99.	Too concerned with neatness or cleanliness.	0	1	2		Y	N

Very or Often True			2		Is this a problem for you?	
Somewhat or Sometimes True				1		
Not true		0				
100.	Trouble sleeping ..... (describe) _____	0	1	2	Y	N
101.	Truancy, skips school	0	1	2	Y	N
102.	Underactive, slow moving, or lacks energy	0	1	2	Y	N
103.	Unhappy, sad or depressed	0	1	2	Y	N
104.	Unusually loud	0	1	2	Y	N
105.	Uses alchohol or drugs (describe) _____ _____	0	1	2	Y	N
106.	Vandalism	0	1	2	Y	N
107.	Wets self during day	0	1	2	Y	N
108.	Wets the bed	0	1	2	Y	N
109.	Whining	0	1	2	Y	N
110.	Wishes to be of the opposite sex	0	1	2	Y	N
111.	Withdrawn, doesn't get involved with others	0	1	2	Y	N
112.	Worrying	0	1	2	Y	N
113.	Please write in any problems your child has that were not listed above.					
	a. _____	0	1	2	Y	N
	b. _____	0	1	2	Y	N
	c. _____	0	1	2	Y	N

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS

Date: _____

HEALTH AND HISTORY FORM

Child's Name _____ Family Name _____

Form Filled Out By _____

Please check the box that best describes the current male parent:
Natural Father ☐ ; Step-father ☐ ; Live-in Boyfriend ☐
Adoptive Father ☐ ; Foster Father ☐ ; Other ☐ ; No Current Male Parent ☐

Please check the box that best describes the current female parent:
Natural Mother ☐ ; Step-Mother ☐ ; Foster Mother ☐ ; Live-in Girlfriend ☐ ;
Adoptive Mother ☐ ; Other ☐ ; No current Female Parent ☐ .

Family History

Rows 1-9: Please put a yes (y) or no (n) in each box. If you don't have information on a specific item put a question mark (?)
Rows 10-11: Please fill in each box as indicated or put a question mark (?).

	Child Client	Other Children	Current Female Parent	Current Male Parent	Natural Mother if not current	Natural Father if not current
1. Received counselling or therapy before						
2. Been psychologically evaluated before						
3. Attempted suicide before						
4. Mental illness in the family						
5. History of drug or alcohol abuse						
6. History of problems with the law						
7. Long term physical illness or handicap						
8. Separated from parents as a child						
9. Been held in custody by Juvenile Authorities						
10. Been admitted in a psychiatric hospital (number of times)						
11. Education level (indicate last completed grade level)						

Current length of time the male parent has been living with the child client:
Since the child's birth ☐ ; Other (years and months) _____
Separated less than 6 months ☐ ; Separated six months or more ☐ .

Current length of time the female parent has been living with the child client:
Since the child's birth ☐ ; Other (years and months) _____
Separated less than 6 months ☐ ; Separated 6 months or more ☐ .

Pregnancy: Normal ___; Complications ___; Birth Weight _____
Delivery: Normal ___; Complications ___; Premature ___.

Describe any difficulties as a newborn or small child: _____

_____

Name of child's doctor _____

List any current medical or health problem or physical complaint your child has:

_____

List any regular medication your child takes and the reason it is taken:

_____

Describe any injuries or surgeries that your child has had: _____

_____

Is any member of your immediate family currently receiving counselling elsewhere?

_____Who? _____ Where? _____

Please list three of your child's interests

1.

2.

3.

Please list three things you especially like about your child:

1.

2.

3.

Please list three ways you would like your child or your family to change:

1.

2.

3.

Is there any other information that may enable us to be more helpful to you and your family? Please consider such areas as family background, life style, religious beliefs, employment, behavioural or physical information. Use the back of this form.

Social-Demographic Data Sheet

In order to better help us understand your child, please answer each of the following questions about your child and family. When describing your child, please think about his/her behavior during the past month. Please try to answer each question. All information will be kept confidential. Select only one answer for each question.

The following questions apply to you. Please circle the best answer as it applies to yourself.

1. You are the child's:

   1. Mother
   2. Father
   3. Stepmother
   4. Stepfather
   5. Other, specify

2. Education: (circle one)

   1. None
   2. Grades 1-4
   3. Grades 5-8
   4. Grades 9-12
   5. Tech. or Voc. Training
   6. University Education

3. What is the appropriate yearly family income from all sources:

   1. less than $5,000.00
   2. $5,000.00-$9,999.00
   3. $10,000.00-$19,999.00
   4. $20,000.00-$29,999.00
   5. $30,000.00-$39,999.00
   6. over $40,000.00

4. How many people are dependent on this income?

   _____

5. Are you currently:

   1. Married
   2. Living as married
   3. Separated
   4. Divorced
   5. Widowed
   6. Never married

6. Please list the people living in your home:

Name	Age	Relationship to you

7. The following questions ask you to describe <u>your life</u> as you now see it. Circle the best answer to each question.

   a. Are there adults you know whom you could call upon for help if you really needed it?

YES	NO	NOT SURE
1	2	3

   b. If you needed to leave town quickly, is there someone whom you would trust to look after your house and belongings?

YES	NO	NOT SURE
1	2	3

   c. If you had to leave town quickly, is there someone whom you would trust to look after your child(ren)?

YES	NO	NOT SURE
1	2	3

   d. Have you engaged in a social activity with other adults outside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

   e. Have you engaged in a social activity inside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

f. Have you talked with an adult who cares about you, and you care about, in the last:

24 HOURS	WEEK	MONTH
1	2	3

g. Are most of your contracts with other adults initiated

1. By you
2. By others
3. Sometimes by you and sometimes by others

h. Are most of your contacts with other adults:

1. Positive, supportive or pleasant
2. Neutral, neither positive nor negative
3. Negative, conflictual or aversive

8.

Sometimes significant events in a child's life are important in understanding a child's behavior and emotional reactions. Following is a list of events. Please read through the list two times. As you read through the list for the first time, please place a check mark in Column 1 beside any event with has occurred in your child's life anytime in the past year.

Whether any of the events listed are in fact stressful to a particular child is very much individually determined. Please read the list a second time and for each event which has happened in your child's life in the last year, if you believe that event has been stressful to the child, place an X in Column 2.

Column 1 Dit it occur? (√)		Column 2 Was it stressful? (x)
_____	Death of a parent	_____
_____	Serious injury/illness to child	_____
_____	Serious injury/illness to parent	_____
_____	Serious injury/illness to brother or sister of child	_____
_____	Change of schools	_____
_____	Family moved to another house or apartment	_____
_____	New infant or adult joined the family	_____
_____	Family income significantly decreased	_____
_____	Child's parents divorced or separated	_____

9. For each of the following statements, indicate whether the statement is true or not true by placing an (x) in the apporpirate column.

		TRUE	NOT TRUE
a.	My family is usually under some kind of stress	_____	_____
b.	My child is behaving more or less like she/he always does	_____	_____
c.	I do not handle stress well.	_____	_____
d.	I have close friends whom I trust.	_____	_____
e.	I am able to tolerate stress and problems well.	_____	_____
f.	My child is able to tolerate stress and problems well.	_____	_____
g.	My child is usually not happy.	_____	_____
h.	I am basically alone with no one to help or support me.	_____	_____
i.	Our family life is often hectic and chaotic.	_____	_____
j.	I am usually happy.	_____	_____

Appendix III: Client Satisfaction Feedback Form

The Client Satisfaction Questionnaire (CSQ)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

4	3	2	1
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?

4	3	2	1
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of help you received?

4	3	2	1
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

(OVER)

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes they have helped a great deal	Yes they have helped somewhat	No they really didn't help	No they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

4	3	2	1
No definitely not	No I don't think so	Yes I think so	Yes definitely

---

ADDITIONAL COMMENTS:

PLEASE ATTACH ADDITIONAL SHEETS IF YOU WISH