EVALUATION OF A PLAY THERAPY TRAINING PROGRAMME FOR YOUTH FACILITATORS OF A RETURNED EXILE CHILDREN'S GROUP

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature Date

SUMMARY

This study was aimed at evaluating the effectiveness of a play therapy training programme for youth facilitators of a returned exile children's group. The effectiveness was evaluated qualitatively by using participant observation to determine whether the facilitators were able to assess the difficulties of these children and implement the techniques of play therapy to address these difficulties. Literature was used as a general guideline to determine the criteria needed for lay play therapists dealing with specifically traumatized children. It was found that most facilitators experienced difficulty in assessing aggression, withdrawal, nightmares excessive shyness and thumb sucking as symptoms of difficult behaviour. They were, however, able to recognize more explicit symptoms like fearful behaviour and excessive clinging behaviour accurately. The majority used drawings and observations rather than interviews and history taking as assessment strategies. Mutual storytelling, painting and unstructured play were the primary means of intervention used. It was concluded that although difficulty with assessing age appropriate behaviour was present, the facilitators succeeded in using non-threatening therapeutic techniques to address difficult behaviours in children. In the classification of Overall Communication the facilitators performed quite well. They excelled at listening, understanding and empathy skills. The programme thus succeeded in providing necessary skills, but can be improved structurally to make these skills more accessible.

OPSOMMING

Die doel van hierdie studie was om die doeltreffendheid van 'n opleidingsprogram in spelterapie vir jeugdiges as fasiliteerdes van kindergroepe vir teruggekeerde bannelinge te evalueer. Deelnemende waarneming is as kwalitatiewe maatstaf gebruik om die doeltreffendheid van die program te meet. Daar word gekyk na die fasiliteerder se vermoë om die kinders se probleemareas te identifiseer en om spelterapietegnieke te implementeer wat hierdie probleme aanspreek. Verder word relevante literatuur gebruik as kriteria vir leke-spelterapeute wat werk met spesifieke getraumatiseerde kinders. Die resultate van die onderhawige studie wys dat fasiliteerders dit moeilik gevind het om simptome soos aggressie, onttrekkingsgedrag, nagmerries, uitermatige skaamheid en duimsuig te identifiseer as probleemareas. Hulle het dit wel moontlik gevind om meer voor die handliggende simptome soos vreesbevange gedrag en oormatige klouerigheid akkuraat te herken. Die meerderheid fasiliteerders het gebruik gemaak van tekeninge en waarnemings vir identifisering van probleemareas eerder as onderhoudsvoering en die insameling van agtergrondsgeskiedenis. Die spelterapietegnieke wat die meeste gebruik was, is die gesamentlike vertel van stories, verf en ongestruktureerde spel. Ten slotte is gevind dat, alhoewel die fasiliteerders gesukkel het om ouderdomsgepaste gedrag te identifiseer, hulle daarin geslaag het om nie-bedreigende terapeutiese tegnieke aan te wend om sodoende probleemgedrag aan te spreek. In die klassifikasie van Oorkoepelende Kommunikasie, het die fasiliteerders uitgeblink in veral luister- begrips- en empatievaardighede. Die program slaag dus daarin om vaardighede beskikbaar te stel, maar sou struktureel verbeter kan word om hierdie vaardighede meer toeganklik te maak.

Financial assistance from the Human Sciences Research Council for this research is acknowledged. Opinions expressed or conclusions reached in this work are those of the author and should not necessarily be regarded as those of the Human Sciences Research Council.

This work is the result of a research project, which is of the same extent as that required for masters theses.

It is a rule within the Department of Psychology that the report of research may take the form of an article, which is ready for submission for publication to a scientific journal.

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TABLE OF CONTENTS

PAGE NO

Statement

Summary

Opsomming

Declaration: HSRC

Declaration: Department of Psychology

Acknowledgement

List of Tables

List of Figures

1.	Introduction	1
2.	Literature review	2
	2.1. Psychological trauma in children	2
	2.2. Trauma: In search of a definition	4
	2.3. Play and trauma	5
	2.4. Play therapy - towards assessment and implementation	6
	2.5. Characteristics of a play therapist	7
3.	Developmental theories	8
	3.1 Theoretical underpinnings of the play therapy programme	10
	3.2 Systems theory - An ecosystemic approach	11
	3.3 A psychodevelopmental focus	14
	3.4 Psychodevelopment and a play therapy training programme for youth facilitators	15
4.	Aims	15
5.	Research method	16
	5.1. Participants	18
	5.2. Method of measurement and measuring instrument	19
	5.3. Procedure	20
6.	Data analysis	21
7.	Results	22
8.	Discussion	28

8.1 Conclusion and recommendations 32

9. References 33

10. Addenda 38

LIST OF TABLES

		PAGE NO
Table 1.	Marginal Frequencies of the Level of Similarity between Facilitators.	23
Table 2.	Level of Similarity between the Facilitators in their use of Assessment Strategies	23
Table 3.	Spearman Rank Correlation between the Facilitators in their use of Assessment Techniques	24
Table 4.	The Performance in the Use of Implementation Strategies per Facilitator	24
Table 5.	Spearman Rank Correlation between the Facilitators in their use of Implementation Techniques	25
Table 6.	The Accuracy Ratings of the Facilitators in Applying Assessment Strategies	26
Table 7.	Accuracy Ratings of the Facilitators in Applying Implementation Strategies (Categories I1 to I19)	27

LIST OF FIGURES

PAGE NO

Figure 1. The child's ecosystemic model adapted from O'Connor & Braverman (1977, p.8) 12

1. Introduction

South Africans living in exile in various European and African countries have been coming home to South Africa since 1994. Literature indicates that exile and return have profound effects on children (Abrahams, 1994). They appear to experience a particularly difficult period of adjustment during and after exile. According to an Abrahams (1994) document, it is not uncommon to find problems concerning trust and communication with peers and adults. Problems tend to manifest as behavioural difficulties such as aggressive play and regressive emotional behaviour like excessive clinging. Bedwetting too, is a frequently presenting symptom.

Needs assessment was undertaken by the Trauma Centre for Victims of Violence and Torture (hereafter referred to as Trauma Centre). Data was gathered by means of a needs assessment questionnaire (Addendum A) developed by Trauma Centre staff members. Based on the results of the needs assessment, intervention programmes for both children and their families were designed and implemented by the Trauma Centre (informal interview with staff).

At least three communities of returned exiles were identified in the Cape Town area. The areas were Khayalitsha, Fish Hoek and Kraaifontein. Associates of the Cape Town based Trauma Centre have been assisting returned exiles since 1990. In 1994 a play therapy group for children was established. Volunteer youths between the ages of 16 and 20 years from the returned exile community were trained in the basics of play therapy. In initial documentation about the training programme, these youths are referred to as assistant trainees, but in practice came to be known as the youth facilitators (in short referred to as facilitators). Each facilitator was responsible for a play therapy group. This play therapy group consisted of 6 to 8 returned exile children (boys and girls) - between the ages of 6 to 12 years. In initial exploratory phases, children from earlier developmental stages were included. Eventually children in middle childhood became the focus of training and practical implementations. The present study is focused on evaluating the training programme prepared for youth facilitators working with returned exile children. It was done by focusing on how the youth facilitators applied the knowledge gained during the training programme in play therapy sessions with the returned exile children's group.

In recent years researchers have given growing attention to the treatment of adults' reactions to trauma and their coping mechanisms during crisis situations (Terr, 1990). However literature contains relatively few public accounts of children's reactions to trauma. In the South African context in particular even less research and literature are available on the effects on children who were exposed to the trauma of exile, war, repatriation, civil unrest, captivity and political strife. Particularly lacking are detailed treatment approaches (Van Der Veer, 1992).

Returned exiles faced trying situations which threatened their mental health during and after exile. For the children this adjustment gave rise to specific symptomatic behaviour. According to Abrahams (1996) the overt manifestations included social withdrawal, and consequently poor social performance, aggressive and destructive play, thumb-sucking, bedwetting and the assumption of foetal positions when chastised. In an attempt to address treatment strategies to deal with this residual trauma, play therapy was identified by psychologists and social workers at the Trauma Centre as the treatment of choice (informal interview with staff).

Literature relevant to psychological problems of, and therapy for exiles and refugees relate mainly to traumatization. What follows is therefore an overview of literature on trauma in children with a special focus on children traumatised by exile, war, repatriation, civil unrest, captivity or political strife as well as its definitions, consequences and manifestations. Play therapy with traumatized children is also addressed with particular reference to the skills and characteristics required by therapists.

2. Literature review

2.1 Psychological trauma in children

Researchers have only recently begun to study the post - traumatic responses of children (Schaefer 1994). In 1987 the American Psychiatric Association listed symptoms of post traumatic stress that are specific to children in its diagnostic and statistical manual of mental disorders (DSM-III-R) for the first time, (APA, 1987). According to the later fourth edition (DSM-IV), pre-school children are likely to report nightmares of monsters and of threats to self and to others (APA, 1994). Children also tend to relive the trauma in their play without realizing they are doing it. Regressive behaviours such as encopresis and enuresis and somatic complaints like headaches and stomach aches are also common. School aged children often exhibit a constriction of affect and reduced interest in customary activities. A foreshortened sense of the future may be expressed. School aged children may, for example, not expect to marry or have a career, or omen formation (belief in the ability to predict future calamities) may take place. Specific fears and an impaired capacity to trust may also be exhibited (Schaefer, 1994).

Based on extensive work with child victims of trauma, Terr (1990), observed several common childhood reactions to disaster. She described four characteristics children exhibit after exposure to a traumatic event: a) strongly visualized or otherwise repeatedly perceived memories of the trauma; b) repetitive behaviours; c) trauma specific fears and d) changed attitudes about people, aspects of life and the future. Trauma related memories seem to come to the mind of a child at leisure. It may happen at night before falling asleep and when they are for example, resting or watching television.

Children, contrary to adults, rarely have sudden flashbacks when they are busy. Repetitive behaviours typically take the form of re-enactment or post traumatic play. Trauma related fears are limited to specific things. They are easy to spot once one knows what the trauma might have been. These fears may also last many years. The final characteristic that Terr (1990) observed involves changed attitudes about people, life and the future. Not only do traumatized children see themselves and others as more vulnerable and helpless, but they view their futures as extremely uncertain and feel as if they are powerless to prevent future calamity (Terr, 1990).

Terr (1983) divides traumatic conditions in children into the following rough categories : traumatic experiences that came as a single, sudden and unexpected blow (Type 1); traumatic experiences consisting of long standing, repeated and therefore anticipated ordeals (Type II); and traumas that appear to settle between the aforementioned major types (Type III). This study focuses on all three types of trauma.

The children of exiles are at risk of acquiring special psychological problems. According to Van der Veer (1992) these may be due to traumatic experiences related to the political situation in their native country, to the loss of a familiar environment, and to difficulties in adapting to life in exile and in returning to their native country. In the latter two situations, estrangement and unemployment of parents often pose as areas which require adaptation. Some children may have witnessed violence in which their parents were involved. They may have been present when their house was raided, their father imprisoned and mother maltreated (Groenenberg, 1991, Van der Veer, 1992). For almost all children of exiles, moving to another country means that they have to leave behind relatives, friends, pets and other belongings to which they are emotionally attached. Both during and after exile these children have problems adapting and learning the languages. They even have to get used to a new school system. Many times they experience 'racism' and estrangement (Groenenberg, 1991).

Danish research with 85 Chilean children whose parents had been arrested and tortured before going into exile, revealed that most of the children had psychological problems (Cohn, 1982). These were mainly related to fear (Cohn, Holzer, Koch & Severin, 1980). Many displayed insomnia, and when they could sleep, they were disturbed by nightmares which were usually about death, murder and abduction, with their parents as victims and soldiers or policemen as perpetrators. Some children became enuretic, depressive and introverted. Others lost their appetite and had stomach aches or headaches. Concentration problems, poor memory and aggression were also common problems. Research into the psychological problems of Chilean children whose parents had been victims of political violence, but had not gone into exile, as well as Argentinean children in Mexico, and

Chilean children in Canada, displayed similar symptoms and syndromes (Allodi, 1980). These studies showed that, given their age, the children in question were very dependent on their mother. The severity of the symptoms seemed to correlate with the age of the child, the duration of the traumatic situation and the extent to which the family received support from the social environment. Extreme dependence on the parents was stronger in children who were directly confronted with violence or who were born in exile. On the basis of later research on the functioning of Chilean and Argentinean children in Canada, it was concluded that the psychological problems resulting from political traumatization hardly manifest in children who feel protected by their parents or guardians (Allodi & Rojas, 1985).

The coping behaviours of children of political prisoners reportedly included solicitation of explanations from parents and other adults, aggressive behaviour towards those they considered responsible for their parents' arrest and playing games based on the themes of arrest and imprisonment (Van der Veer, 1992).

Observation in war zones of Spanish kindergarten children during the Spanish Civil War were documented by Coromina in 1943 (Van der Veer, 1992). Clearly noted were symptoms of anhedonia, isolation, depression and decreased sociability. The constant unpredictability of a war situation can alter children's sense of security and trust in others. Severe stress reactions were found in response to the violent death of their parents in a sample of bereaved Israeli children (Eth & Pynoos, 1984). Ugandan children who witnessed the killing of a family member showed severe grief and post traumatic symptoms following the event. Allodi (1980) showed how children exposed to terror through guerrilla attacks suffer symptoms indicative of post traumatic stress reaction.

Pynoos and Nader (1993) emphasize that exposure to traumatic events may be particularly challenging for a child. According to Osofsky, Cone and Drell (1995), children who grow up with chronic familial, community and political violence frequently lack the facilitating environment necessary for healthy ego development. Primitive defences often emerge early in these children's lives in an attempt to help control extreme anxiety and impulses.

2.2 Trauma: In search of a definition

There is thus no question that war, repatriation and civil unrest have traumatic effects on the development of children, their attitudes toward society, their relationships with others and their outlook on life in general (Osofsky et al., 1995).

Historically the concept of trauma has had different meanings. It has included the notion of conscious ideas that overwhelm the ego, the emergence of unacceptable impulses and the idea of an unbearable situation with overwhelming affect (Freud, 1926). Freud further emphasized a traumatic situation of helplessness as one in which external and internal, real and instinctual dangers converge. Anna Freud (1969) discussed traumatic stress as a shattering and devastating event that alters the course of future development. Strain trauma, a related concept that deals with outcomes of exposure to trauma and cumulative trauma was introduced by Kris (1956). Eth and Pynoos (1984) defined trauma as occurring when an individual is exposed to an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety and instinctual arousal.

What becomes clear is that the concept of trauma is not easily defined. Most theorists nevertheless agree that trauma is a breakdown or disruption in a person's coping or defense mechanisms due to a stimulus that is powerful enough to break the protective shield. Such a stimulus may be either from within or without. A victim of trauma may not be able to integrate the traumatic events (Simpson, 1990). The ego then becomes overwhelmed and a state of helplessness, powerlessness and submisiveness may result (Osofsky et al., 1995).

2.3 Play and trauma

Freud (1920) noted that play offers young children a unique opportunity to work through such traumatic events. Erikson (1968) confirmed this perception many years later when he wrote that play is a means of achieving mastery over traumatic experiences. The make believe element eliminates guilt feelings which would appear if action were to result in real harm and damage. It also enables the child to be victorious over forces otherwise beyond his reach and coping capacity. "To play it out" may be the most natural self therapeutic process childhood offers (Erikson, 1950).

In crisis situations the child can transform experienced passivity and impotence into activity and power, through replaying the traumatic experience (Boyd- Webb, 1993). Instead of being the hurting patient, they become the administrators of pain in fantasy. Boyd- Webb (1993) mentions that "traumatic experiences are repeated to achieve belated mastery ... the painful tension of the original trauma is relived under somewhat more favourable conditions (e.g. play) ... that is under the control of the child" (p. 272). Every new repetition in play seems to weaken the negative effect associated with the trauma and may strengthen a sense of mastery of the event for the child (Schaefer, 1994). The child uses play to come to terms with defeats, sufferings and trauma. Piaget (1962) maintained that play is assimilative rather than accommodative. According to him, play enables the child to relive past experiences and allows for the satisfaction of the ego rather than for its subordination to reality. He also suggested that this form of working through traumatic

experiences enables assimilation and control over future or past stressors. The re-enactment of traumatic events constitutes a gradual, mental effort to digest and master the trauma. This is a slow process of healing by repetition. Winnicot (1971) described play as an interface between a child's intrapsychic reality and the outer world in which a child is attempting to control or manipulate outer objects.

2.4 Play therapy - towards assessment and implementation

The above mentioned aspects of trauma and play were thus utilised to develop a play therapy training programme where play was used as the primary medium through which to address the trauma of the identified target group.

There is no single comprehensive definition of play. It is seen in the literature as a psychotherapeutic method based on developmental principles and specific treatment modalities and is intended to help relieve the emotional distress of young children through a variety of imaginative and expressive play material (Schaefer & O'Connor, 1983). The assumption is that children will express and work through conflicts within the metaphor of play. The therapist works towards removal of impediments to the child's continuing development so that the prospects for the child's future growth are enhanced. According to Schaefer and O'Connor (1983) all play therapists share a common goal regardless of these variations in treatment modalities that include a variety of highly developed theoretical orientations and technical strategies. They all wish to restore the child's natural ability to play. They seek to maximise the child's ability to engage in behaviour which is fun, intrinsically complete, person-oriented, variable and flexible, non-instrumental and characterised by a natural flow. Play therapy as practised by any given therapist, therefore represents an integration of a specific, theoretical orientation, personality and background with the child's needs in play therapy.

According to Brems (1993) many of the techniques and materials appropriate to play therapy with the individual child can also be used effectively in play therapy groups.

Other play therapy pioneers included David Lery (1938), who helped children recreate a traumatic event through a structured play format; and Allen (1942), Claud Mousctakos (1959) and Virginia Axline (1947), who emphasized the power of the therapeutic relationship when coupled with the child's natural growth process, as a key to helping the child individuate and develop basic self-esteem (positive regard). Achievement of these goals in non-directive play therapy occurs through recognition of the child's feelings as expressed in the play and through the therapist's belief in the child's strength and potential for growth and change. Despite remarkable differences between many treatment modalities, these therapist all recognise the unique meaning of play to children and the

importance of understanding the symbolism of the child's play language. The operating assumption is that the child will reveal meaningful information regarding his emotional problems through play (Schaefer,1984).

2.5 Characteristics of a play therapist

According to Axline (1947), the non-directive therapist's role is not a passive one. The therapist requires alertness, sensitivity, warmth and an ever present appreciation of what the child is doing and saying. The therapist must be understanding and accepting at all times. The therapist respects the child and treats him with sincerity, honesty, patience, consistency and sensitivity. She asserts that a therapist accepts the child exactly as he or she is, pays intensive and exclusive attention to the child during a session, is responsive and empathetic, and keeps sessions spontaneous and flexible. In addition, she structures the sessions so that the times, place and persons are clearly defined,- and curtails and prevents excessive anxiety or motor hyperactivity. The same author also describes what a therapist must do to create corrective experiences for the child. These consist in essence of Axline's eight principles of the role of a humanistic play therapist. This means that the play therapist's primary responsibilities include in the first instance the creation and maintenance of the therapeutic setting. This may be regarded as a reflection of the relationship in which the work of therapy will occur. In the second instance, it is the responsibility of the therapist to create experiences that foster the child's development and then to help the child verbally process those experiences. The desired outcome is optimum generalization of the play experience. This requires that the therapist understand the child's experience and attempt to convey that understanding back to the child by both verbal or non verbal communication in play. In the third instance the therapist is thus required to be constantly aware of the child's developmental level and the parameters it sets for therapeutic work. Fourth and finally, the play therapist views herself as an advocate for the child. She recognizes that by choosing to work with the individual child, she has chosen to enter into a number of systems with the child, from the child's vantagepoint (O'Connor, 1991).

These qualities and characteristics are seen as crucial for the training of lay play therapists as facilitators. It may be regarded as prerequisite for their understanding of children and their ability to be trained to implement course material in a non-threatening way. Although these characteristics were not seen as selection or inclusion criteria, they formed a crucial part of outcome criteria after training.

This training involved volunteer youths from the returned exile community (referred to as facilitators) trained in the basics of play therapy. The programme consisted of a practical and theoretical component. This meant that relevant literature on play therapy was studied and then

practically implemented by the facilitators in their play sessions with the returned exile children's group.

A significant part of the training programme is its emphasis on developmental theories. It was hypothesized that having an understanding of developmental theories, tasks, crises and resolutions thereof, would give the facilitators a better understanding of the child. This understanding would aid the facilitator in assessing the child's difficulties and implementing play therapeutic techniques to help the child overcome these difficulties.

3. Developmental theories

According to Schaefer (1984) play is a universal phenomenon in children. Child development researchers over the past few years have produced evidence that play facilitates a child's gross and fine motor development, cognitive and language development, as well as his or her social adjustment (Schaefer, 1984).

Freud, Erikson and Piaget's conception of child development provides useful parameters for the play therapist and represents an intergration of theories and hypotheses. Their views of the development of children in middle childhood was applied in the current programme. The focus was on cognitive, language, physical, motor and psychosocial development and its interaction with trauma.

The middle childhood years - the period between 6 and 12 years old - is a critical period for the child's cognitive, social, emotional and self-concept development. Erikson's theory for this period postulates a crisis of idustry versus inferiority. Children who are successful in this period will become moreso and those who are unsuccessfull, will develop a feeling of inferiority. According to Louw (1991) the following developmental tasks should be mastered during middle childhood: Further refining of motor skills, consolidation of sex-role identity, development of concrete operational thought, the extension of knowledge and the development of scholastic skills, the extension of social participation, the acquisition of greater self-knowledge and the development of preconventional morality.

Cognitive and Language Development. Children from the ages of 6 to 12 years are in the phase of concrete operations, which is marked by the acquisition of the ability to conserve, classify and serialize (Piaget, 1952, 1967). These skills are not acquired all at once but are usually in place by the time the child is about six. Conservation implies that children are able to use cognitive processes to override experiential input in order to make their perceptions more consistent with reality. During this period children become obsessed with organizing all the information they have acquired into absolute categories.

Children in their middle childhood years still tend to retrieve information according to emotional priority or similarity of experience, even though there is a shift to language-dominated storage, and memory retrieval (Piaget, 1967). The development of language literacy during the middle childhood years is quite dramatic (Craig, 1996). According to Louw (1991), the length and complexity of sentences and vocabulary the child uses increases. Language development also involves the increasing ability to adapt language to the context in which it is used.

Physical and motor development. Between the ages of 6 and 12 the child gains considerable motor co-ordination, acquiring those skills needed in the sports peers play. The child learns to throw, catch and kick a ball; to jump rope, to climb trees, to run and to skip. These skills are influential in determining the course of their relationship with peers. Louw (1991) states that learning and refinement of a variety of psychomotor skills is one of the most prominent characteristics of the middle childhood period. Such skills develop because of an increase in speed, co-ordination, balance and muscle control (Craig, 1996). Growth becomes gradual - arms and legs grow faster than the torso and the brain reaches its adult size in weight.

Emotional and social development. According to Louw (1991) this is a time of greater emotional maturity - meaning that a change takes place from helplessness to independence and self sufficiency. According to Piaget (1962), once children are able to conserve they develop a capacity for internally generated emotions that were not previously possible. They begin to categorize affects, not only by internal sensations, but by the situations in which they occur.

During the middle childhood years social changes are altered dramatically as they develop a stable set of internalized social rules. They develop a sensitivity towards others, take people's needs and feelings into account and become more inclined to interact with children of the same sex and age, as the role of the peer group becomes more important. Entry into school requires a big adjustment from the familiarity of home to the unfamiliarity of school (Craig, 1996).

According to Craig (1996), family continues to be the most significant socializing influence. Children acquire values, expectations and patterns of behaviour from their families. Parents serve as models for appropriate and inappropriate behaviour.

Integration of trauma with developmental level. Children between 6 and 12 years process and store traumatic experience in a more sophisticated way than the preceeding age group, where some children had not yet form stable internal representations of objects. Their autonomy in particular can be affected by repeated, prolonged trauma (O'Connor,1991).

Between 6 and 12 years the child begins to sort his experiences and can intergrate diverse and conflicting experiences in his memory (Piaget, 1967). This means that a number of other unpleasant memories may be re-evoked or retrieved when a new trauma is experienced. According to O'Connor and Ammen (1997) when middle childhood children are unhappy, they usually say that they are unhappy and that things never go their way. Similarly when they are older, they may recall several and concurrent events that occurred during this period of middle childhood. Trauma in middle childhood is likely to cause substantial cognitive confusion over the event and regression in social interaction (O'Connor & Ammen, 1997).

3.1 Theoretical underpinnings of the play therapy programme

The play therapy training programme for facilitators as designed by the Trauma Centre and reported by Abrahams (1996) consists of an integration of aspects of existing theories and techniques with developmental theories to create a single model that is geared to addressing the total child within its context . The children whom the facilitators were trained to practice play therapy on are also returned exiles, as previously discussed in the introduction.The training programme for the facilitators was set up along broad the principles of community psychology and systems theory. Hence, it did not focus solely on the functioning of the child, but rather on optimizing the functioning of that child in the context of his or her system (Schaefer & O'Connor, 1983). According to these authors, conceptualizing and practising play therapy within the framework of community psychology and systems theory does not require the therapist to be eclectic in the sense of maintaining familiarity with many different models of play therapy. The rationale is that although play therapy in this context draws from multiple models, once these are integrated, it may become a free-standing model that is different from the sum of its parts (Litterer, 1969).

This model of play therapy accepts that the child is affected by every model he comes in contact with over the course of his life. The model also recognises that in conducting therapy with the child, the play therapist has an impact on every system with which the child currently has contact. The therapist is thus aware that every change in the child meets with a corresponding change in the child's environment. It is understood that the child's system will not always rejoice as the child changes. In fact, the system may work very hard to prevent the child from changing and altering the system. Recognition of these variables allows the play therapist to plan strategies that will maintain some degree of harmony between the child and his environment. The therapist will aim to promote generalization of changes effected in sessions to the world outside (O'Connor & Ammen, 1997).

The current model incorporates Axline's eight principles of play therapy (Axline,1947), but does not focus exclusively on non-directive play therapy. Combined with this is an emphasis on developmental theories, incorporating the theories of Piaget (1952), Erikson (1968) and Freud (1926). The integration of a treatment model with developmental concepts is somewhat difficult. There are numerous developmental theorists, each emphasizing a different aspect of the child's internal processes or life experience. Consistent with the present trend in psychology towards the integration of theoretical models rather than the creation of new ones, an integrated view of child development is thus adhered to. This developmental conceptualization is the cornerstone against which the training programme rests. The training programme is discussed in further details in the sections to follow.

3.2 Systems theory - An ecosystemic approach

In order to develop a working model which incorporates the above mentioned developmental theories and play therapy principles, an ecosystemic approach is adhered to. This approach is based in general on the ecological systems model of development proposed by Bronfenbrenner (1979). The ecosystemic model is a more specific attempt to identify those aspects of the child's ecosystem most relevant to planning effective play therapy (O'Connor & Ammen, 1997). Figure 1 represents the model in the form of a diagram. The basic unit of this ecosystemic model is the child (O'Connor & Braverman, 1997). The child is seen as operating, behaving and engaging in three critical domains: (a) a physical body, (b) the world of interpersonal relationships, and (c) the representation of the construed working model.

As the child interacts through language, an intra psychic representational system that includes concepts of the self and the world is developed. These concepts are called internal working models by Bowlby (1973, 1980) and Bretherton (1987) and schemas by Stern (1995). These internal representational systems derive from the child's interaction with others, particularly with the primary caretakers (Lyons-Ruth & Zeanah, 1993). Thus history is embedded in each participant's intra-psychic model of his or her interactional past and through this process the present relationship is influenced. This ecosystemic model thus makes room for the child's past experience and interaction with care-givers in exile and how these previous interactions as well as current struggles of adjustment affects development and functioning. The model further takes into account time the ability to observe internal conceptual systems, through reflecting on feelings, thoughts and experiences develops over time. Children can similarly choose to think in other ways about themselves and others and choose to behave differently. This reflective process is greatly facilitated

for children in middle childhood when they represent and work through traumatic events in their lives concretely or metaphorically through play.

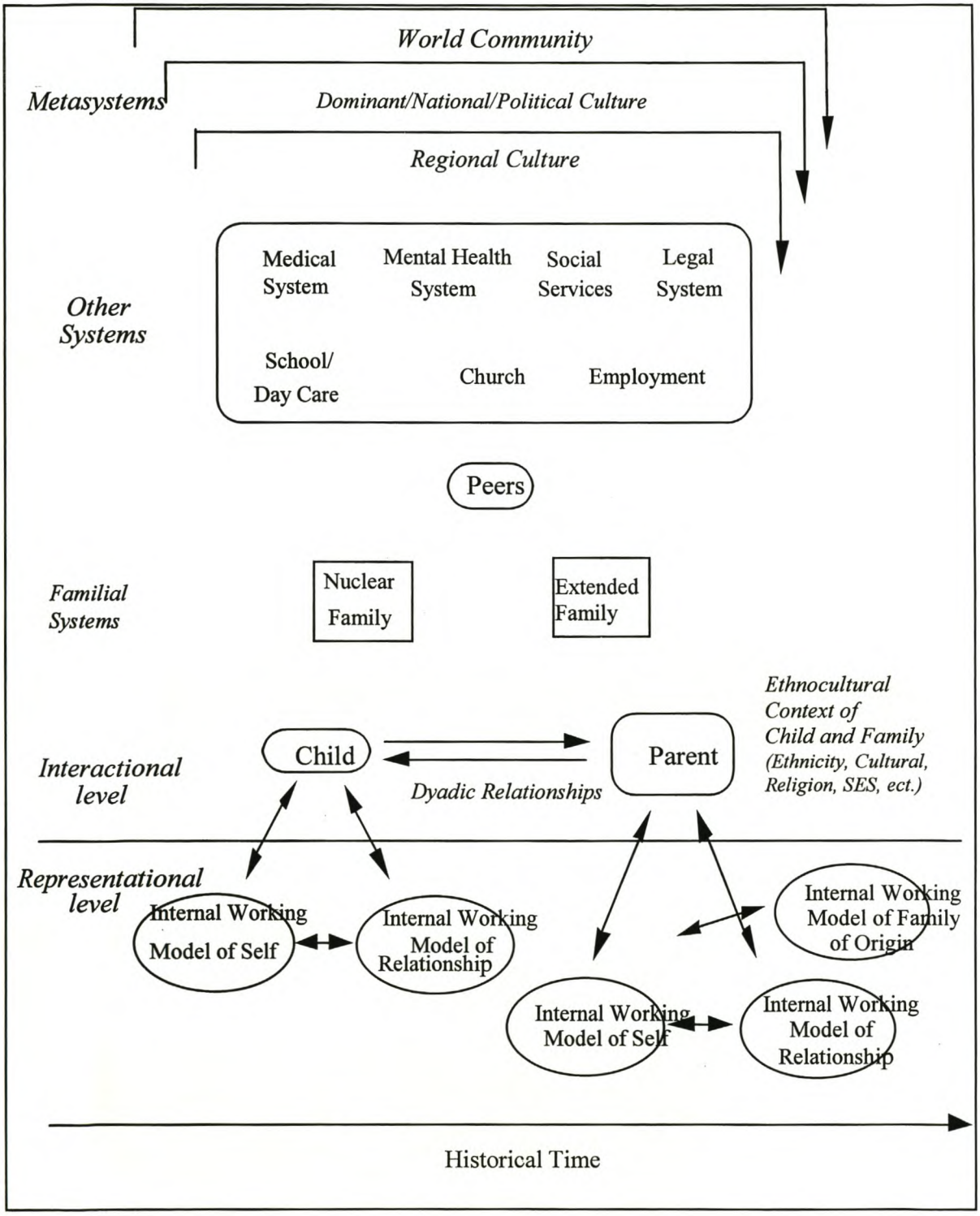

Figure 1. The child's ecosystemic model adapted from O'Connor & Braverman (1977, p 8).

The model starts with the child's individual functioning. Children of returned exiles tend to present with excessive clinging, bedwetting and aggressive or destructive play. Assessment of the child's functioning in a dyadic relationship was targeted next. It was explored in the context of the family, peers, and other social systems in which the child may be involved. The latter include systemic structures such as the school, church, legal, medical and mental health system. Poor communication with adults, parents and peers as well as social withdrawal and poor scholastic performance were identified. The Trauma Centre also offered medical and legal assistance. Many of the returned exiles were without sufficient official proof of identity and thus could not, for example, claim property. It was fortunate that the Trauma Centre was equipped to assist with administrative relocation difficulties. Factors in the contextual environment of the caretaking system inadvertently impacted on the child.

The ecosystemic approach defines the sociocultural and sociohistorical influences as metasystemic influences (O'Connor & Ammen, 1997). Bronfenbrenner (1979) used the term macrosystem to refer to the social cultural influences on a child. Metasystems influence the child (family, therapist and so on) indirectly through their influence on the representational understandings of the culture's expectations, beliefs and values. But it also directly affects the child when these understandings determine the behaviour of the people in systems in which the child is involved. On the metasystemic level, returned exiles and their children suffered due to gross injustices inflicted by the Apartheid regime which caused these families to flee from the threat of imprisonment, violence and ultimately death. Often the neighbouring African countries were also wrought with violence as noted in reviewing literature. Upon returning after captivity, a different kind of discrimination was faced - they were seen as a threat by others in the informal settlements as there was now more competition for already scarce housing and employment. Difficulty in belonging and trying to fit in was also experienced. Thus the child's experience is dramatically affected through constant interactions with its systems.

All of these systems are taken into account when formulating a treatment plan and in conceptualising the current research. According to De la Rey, Duncan, Shefer & Van Niekerk (1997), systemic programme development emphasizes processes which empower members of the system for whom and with whom the programme is designed. Psychodevelopment is thus seen as an important element in making this a workable model. Members of the programme are also empowered to take ownership of programme implementation (De la Rey et al., 1997).

3.3 A psychodevelopmental focus

Brammer (1979, p. 14) describes the concept of psychodevelopment as " ... an effort to make the specialized skills and knowledge of helping specialists more widely known and used by the general population".

Ivey and Simek Downing (1990) define the purpose of psychodevelopment as: the prevention of mental illness and the development of human potential. This entails developing skills of groups and individuals to make their lives more meaningful and focused.

Psychodevelopment may be seen to address those potentials and abilities in a society that enable people as individuals of any age, colour, gender or religion, to live a contextual life of quality in interaction with each other as members of a group or community.

Psychodevelopment is an educational model (Authier, Gustafson, Guerny & Kasdorf, 1975). Education implies training in skills which the client does not yet have. Training and development of skills are thus emphasised when the term psychodevelopment is used.

According to Schoeman (1983) general systems theory is ideal as a meta theory to psychodevelopment because it entails the development of complex systems which psychodevelopment may address in the context of community psychology. In the present study particular attention is given to living, open, social systems which are continually changing, growing and developing.

According to Ivey and Simek-Downing (1990), psychodevelopment has as its goal the identification of those skills necessary at a given time or which could be necessary in the future. It implies the effective development of people in general and of specific skills which promote the mental health of the community. Schoeman (1983) suggests that prevention occurs on primary, secondary and tertiary levels.

The current study primarily incorporates secondary prevention. Kaplan, Saddock and Grebb (1994) define secondary intervention as the early identification and prompt treatment of an illness or disorder. The goal is to reduce the prevalence of the condition and to shorten its duration. Crisis intervention and public education can be components of secondary prevention. Authier et al. (1975) emphasize the value of psychodevelopment to make reintegration of the client back into the community easier and to stall new difficulties. The family of the client is co-opted to improve interpersonal communication.

Ivey, Ivey and Simek-Downing (1987) are of the opinion that psychodevelopment also incorporates the meaningful development of man across the life span as one of its goals. This highlights the

contribution of developmental psychology (Scheepers, 1993). It is thus clear that psycho-development can be useful where impaired development is evidenced in fixation or regression.

3.4 Psychodevelopment and a play therapy training programme for youth facilitators

Psychodevelopment presents a guideline by which the deficiencies, needs and problems of a training programme can be addressed through, for example consultation.

Here the Psychodevelopmental consultant is responsible for the development of clients who are going to carry out preventative and developmental services like these particular youths who were trained to carry out the curative task of play therapy. According to Barkhuizen (1994) the client can act as an agent of change in a system. Youths or youth leaders in a community could be trained to deal with emotional and behavioural problems in crisis situations. These trained people can provide services like basic play therapy to their community with the psychodevelopmental consultant in a supervisory and advisory position. In this particular case the Trauma Centre acted as the basis of supervision. It had as its long term goal and vision the possibility of the facilitators generalising the skills taught them to the rest of the community.

The counselling function of psychodevelopment could be realised by training laymen in play therapy. Misinterpretations of and stigmas about Psychology can be lessened. Individuals as well as the community can thus become more positive toward Psychology in practice and maybe seek help more readily from mental health care institutions which serve an important preventative function. The structure of such programmes provides the opportunity for interaction, which, according to the principles of systems theory, can bring about change, growth and healing. Many members of the returned exile community can be reached through the regular interaction they have with the Trauma Centre where they are engaged in therapeutic intervention sessions. In this regard, the Trauma Centre sees itself as meeting challenges which asserts that Psychology must become involved in a preventative, developmental and remedial capacity to address the current and future needs of all South Africans (Schoeman, 1991).

4. Aims

The aim of the study was to formatively evaluate the effectiveness of a play therapy training programme for facilitators. Facilitators were previous exiled youths aged between 16 and 20 years old and selected and trained by the Trauma centre. Facilitators were trained in the use of a play therapy based intervention to support returned exiled children.

Since the training of the facilitators in an adjusted form of play therapy is aimed to help traumatised returned exiled children, the ultimate criteria to evaluate the effectiveness of the training is

observing the change in these children. For example, are the children able to cope more constructively with their trauma after the intervention? Such an evaluation study would require a quasi-experimental design. The fact that exiled children submitted to the trauma centre were considered as highly traumatised and received direct attention, made the use of an quasi-experimental design inappropriate.

The study was thus alternatively designed to evaluate a) the theoretical principles of play therapy as a treatment for traumatised returned exiled children; b) the theoretical validity of the taining programme and c) the implementation of the training programme. This 'three-angled' approach was operationalised in the following way.

a) The issue of the theoretical principles of play therapy was evaluated by the question: Is play therapy an adequate treatment for traumatised returned exiled children? The issue of the theoretical validity of the training programme was evaluated by the question: How are the principles of play therapy translated by the Trauma Centre into a training programme aimed to train returned exiled youths between the ages of 16 and 20 years in an adjusted form of play therapy? These issues were implicitly addressed in the literature section. Both questions are discussed in further detail in the discussion section.

b) The principles of play therapy and that of the training programme were evaluated theoretically. In contrast, to evaluate the implementation of the training programme, a field study was required. This was done by evaluating whether facilitators were able to:

- apply assessment strategies to identify the difficulties of the children,
- implement play therapy techniques to address these difficulties.

c) The skills acquired by the facilitators as a result of the training programme were evaluated by a participant observation method. The method and results are presented below. The overall results of this 'three angled' approach are discussed in the discussion section.

5. Research method

In order to address the above mentioned research questions, literature was used as the main criteria with which to assess the results of the programme. In other words, the evaluation was primarily theory based. This type of evaluation focuses on programme implementation (Fitz-Gibbon, 1987). According to Fitz-Gibbon (1987) theory-based evaluation first asks on what psychological theory is the programme based? In other words, what does the staff view as critical to obtaining good results towards which the programme aims? To this end the critical theories to the programme are already detailed in the discussion of literature. Fitz-Gibbon (1987), further states that this kind of non-

experimental design is adequate for formative purposes. It can provide a preliminary look at the effectiveness of the programme.

This type of design was particularly chosen as the group being studied was identified as a special population where design could present problems (Fitz-Gibbon, 1987) in terms of access to comparison and/ or control groups. This author sees a theory-based evaluation as a good approach to assessing special education programmes. Participant observation was used as the main method to carry out this evaluation.

Participant observation is a method of research that refers to "forms of research in which the investigator devotes herself to some kind of membership or close attachment to the special group she wishes to study" (Patton, 1993 p.169). In doing so the participant observer attempts to share the world view and adopt the perspective of the people in the situation being observed (Patton, 1993). The data are collected in the field, where the action is, as it happens. Participant observation, field observation, qualitative observation, direct observation or field research - all these terms refer to the circumstances of being in and around an ongoing social setting for the purpose of making a qualitative analyses of that setting. Participant observation thus, became the measuring instrument of choice in the current research project.

Participant observation furthermore is an unobtrusive measure of data collection. An experimental design, the administration of standardized instruments, and the collection of quantitative data typically affect programme operations by being overly obtrusive (Patton, 1987). Such instruments can in themselves create a reaction which, because of its intrusiveness and interference with normal programme operations and client functioning, fail to reflect accurately what has been achieved in the programme. Educational researcher, Edna Shapiro (1973) found in her study of Follow Through classrooms, that standardized tests can bias evaluation results by imposing controlled and obtrusive stimuli, unknown to the researcher.

The purpose of unobtrusive evaluation is to reduce negative reactions to being evaluated. Another means of reducing negative reactions to evaluation is to consider that qualitative evaluation approaches are perceived by the programme staff and clients as more personal and relevant. The present evaluation is based on humanistic concerns and ideologies and the objections to the impersonal nature of quantification held by the programme's staff and clients were treated as real. The views of these decision makers and information users are respected by the researcher. The advantages to observational fieldwork is that by directly observing a programme the evaluator is better able to understand the context within which the programme activities occur (Patton,1987).

A second strength of observational methods is that the evaluator has the opportunity to see things that may routinely escape conscious awareness among participants in the programme. According to the above mentioned author, all social systems involve routine. Participants involved in those routines might take it for granted to the extent that they are not aware of nuances that are apparent to the participant observer.

A third value of observational approaches is the extent to which the observer can learn about things that programme participants may be unwilling to talk about in an interview. The sensitivity of some topics in an interview may make interviewees unwilling or unable to provide important information. Through direct experience with and observation of actual events, the evaluator can gain information that would otherwise not be available.

A fourth and closely related point is that observation permits the evaluator to move beyond the selective perceptions of others. By making their own perceptions part of the data, evaluators are able to present a more comprehensive view of the programme being studied.

Finally, getting close to social settings through first hand experience permits the evaluator to access personal knowledge and direct experience as resources to aid in understanding and interpreting the programme evaluated. These understandings become important in analysing the data and making recommendations for programme improvement.

5.1 Participants

The sample consisted of six female, voluntary youths from the Returned Exile Community, between the ages of 16 and 20 years. They served as group facilitators. Natural selection took place in that whoever volunteered from the returned exile community to be a facilitator in response to the initial advertisement was included. Associates of the Cape Town based Trauma Centre have been assisting returned exiles since 1990. All youths from the Returned Exile Community attending the Trauma Centre were thus made aware that a training programme in play therapy was being offered with the purpose of implementation for children in difficult circumstances. Training was free and voluntary - there was thus no specific criteria for selection. The participants for the children's group was also naturally selected. Two of the facilitators who were 16 and 20 years old respectively, had one and two years of tertiary education, but no degree, diploma or certification of any qualification before their exposure to the programme. One 16 year old facilitator was at school, the remaining 20 year old and two 19 year olds had left school without completion. All the facilitators were literate in English and at least one other language.

The children's group consisted of 32 returned exile children ranging between 6 and 11 years. Children were drawn from the returned exile communities in Fish Hoek, Khayalitsha and Kraaifontein (Wallacedean and Scottsdene). All children were second or third generation returnees, and all came from low income families (see Addendum B).

The clinical director of the Trauma Centre chose youth for the following reasons:

1. Their knowledge of the various languages spoken by the children, reduced the pressure of the children to be proficient in English.
2. It was hypothysized that they would generalize the skills taught them to others in their community.
3. Their knowledge and sensitivity to the social and cultural context from which these children come, could facilitate a slow, but significant process of acculturation into a new context (Abrahams, 1994).

5.2 Method of measurement and measuring instrument

Participant observation was used as the primary method of data collection. The researcher made direct observations of facilitators' behaviour during group time on their ability to use assessment strategies and subsequent implementation of play therapy techniques. The use of assessment strategies and implementation techniques were observed in a semi structured way. The main reason for this approach was that the facilitators were trained to use a set of pre-established assessment and implementation categories: ignorance of these categories as observation items, in evaluating the effectiveness of the training programm would threaten the validity of this part of the study. Throughout, their attitude toward and interaction with the children gave a clear indication as to whether or not they met the characteristics of a play therapist.

Assessment: Twenty-eight categories subdivided into three main assessment categories were pre-established in the training programme (see Addenda B and D; A1 to A28). The main categories were:

- Symptomatic Behaviour
- Spotting Difficult Behaviour
- Overall Communication

The evaluation was focused on how the assessment was conducted and interpreted by the facilitators. For example, when applying assessment strategies, were the facilitators able to spot difficult behaviour, did they use the child's developmental stages, age appropriate behaviour and

thus their knowledge of developmental theories as signs and symptoms of possible developmental lags and/ or manifestations of trauma? The 'accuracy' in the use of assessment strategies was rated on a five point scale.

Implementation: Nineteen categories of implementation techniques were pre-established in the training programme (see Addenda B and C; I1 to I19). Since the use of these techniques is related to the adequate use of assessment strategies, the evaluation was focused on the extent to which the techniques were implemented. The 'accuracy' of the use of implementation techniques were rated on a four point scale.

5.3 Procedure

The programme evaluation was undertaken in consultation with the Trauma Centre. The clinical director of the centre, the head of research and a clinical social worker were involved in arranging schedules for evaluation times as well for supervision.

Initial, informal interviews were conducted with the above mentioned persons to gain information about the management and structure of the Trauma Centre, and the contents and structure of the training programme for the facilitators. The researcher was also introduced to the facilitators and the children and met with them informally on various occasions before the evaluation.

The evaluation was conducted once per week over a period of 8 weeks intermittently - one session per week. Each session was an hour long and each facilitator had a play therapy group of 6 to 8 children of a specific age group. These groups were either facilitated outside, or on rainy days, inside the hall at the Trauma Centre. Before each session the facilitators came together to discuss what they would be doing that day and what their goals were; and after each session a post- group discussion took place in which reflections of the session were held, with particular emphasis on obstacles encountered, and which ended off with planning for the following week.

Facilitators were observed by the researcher individually and for every facilitator an observation script was made. The first two sessions were used to observe and evaluate the facilitators' skills in the use of assessment strategies based on the categories in Addendum D. The next 6 sessions were used to observe and evaluate the facilitators' intervention skills based on the categories in Addendum C. The scripts also contained field notes as to the effective use of the strategies.

The researcher facilitated the process by scheduling times for effective running of the groups and negotiating ground rules with the group members as well as being aware of individual needs and difficulties so that all could be equally accommodated. Members were aware of their responsibilities and had a keen affiliation with their groups. Care had to be taken not to become too involved so that

researcher bias was controlled, but also not to be too distant as to appear unapproachable. This process was partially administered by a social worker, who was involved with the group members on a regular basis at the Trauma Centre.

6. Data analysis

Data was analysed in two stages. The first stage consisted of a content analysis of the observation scripts. The content analysis was conducted separately by the researcher and one other methodologist to increase the reliability of the analysis. The content of each script was exhaustively specified into the pre-established categories of the training programme (Addenda C and D). As argued earlier, evaluation of the performance of the facilitators is only valid in regard to what they were trained for. The results of the content analysis was then used for further analysis, the second stage of the analysis.

The second stage of the analysis was aimed to reveal insight in the overall performance of the facilitators as well as a breakdown of their performance in their use of assessment strategies and implementation techniques. The analysis in the second stages, consisted of two steps: a homogeneity analysis and an accuracy analysis.

Firstly the homogeneity of the group of facilitators was analysed. Since the training of a random group of subjects with corresponding characteristics should result in a decrease of variability due to the skills acquired through training, homogeneity can be regarded as an indicator for the effectiveness of a training programme. Moreover, since the effective use of a strategy and technique rather then the type of strategy and technique evaluates the performance between the fascilitators, the differences between the children as a source of variability is relatively controlled. Thus, although homogeneity cannot be expected to be very high it reveals insight in the effectiveness of the training.

Secondly, the accuracy of the facilitators' performance was analysed, since a group may be homogeneous, but not necessarily perform accurately. Since the data was ordinal, the homogeneity of the group was analysed by using PRINCALS and Spearman Rank correlations. According to Gifi (1990) PRINCALS is extremely useful in carrying out complex forms of qualitative analysis. PRINCALS is a combination of Principal Component Analysis and Alternating Last Squares. It rearranges the categories of the variables so that optimal transformation is found. According to Aldridge and Aldridge (1996), qualitative variables can be analysed by categorical and (non-numerical) multi-variable techniques irrespective of the method of discovery (as long as transformation of variables is invariant).

7. Results

The results are presented in two steps. The performance of the facilitators was analysed by first analysing their homogeneity and secondly, by analysing their accuracy in the use of assessment strategies and the implementation of play therapy techniques.

Step One: First, the homogeneity of the facilitators was analysed with regard to their overall performance in the use of assessment and implementation. In order to reveal insight in the differences between the use of assessment strategies and implementation techniques, two additional homogeneity analyses were conducted. The results of the homogeneity analyses are presented in chronological order.

To evaluate the level of similarity (homogeneity) between the facilitators, the data matrix was rotated and a type of Q Factor analysis was conducted. For this purpose, Categories '0' and '1' of the 'assessment' ratings, respectively 'not used' 'poorly used', were recoded as one category. In Table 1 the overall frequency of occurrence of the categories per facilitator are presented.

The level of similarity between the facilitators in their overall performance: The homogeneity of the group of facilitators,was calculated by using a one dimensional PRINCALS analysis (Gifi, 1990). The Eigenvalue with assessment and implementation ratings as objects in one analysis, yielded 0.48. The Eigenvalue can be considered as the squared multiple correlation of the optimal scaled scores. Thus 48% of the total variance is explained by similarity.

Table 1 gives an indication of why the similarity between the facilitators is relatively low. F1 to F6 refer to the six facilitators, while the rating categories indicate: 1- poorly used; 2- average: 3- good; 4- very good. So for example F1 (facilitator 1) scored 19 times in the rating category 1 (poorly used), 10 times in rating category 2 (average), 12 times in rating category 3 (good), and 6 in rating category 4 (very good) in both assessment and implementation. Facilitators F1, F3 and F5 follow the same rating pattern but differ from the rating pattern of facilitators F2 and F6.

Table 1

Marginal Frequencies of the Level of Similarity between Facilitators.

	Rating Categories			
Facilitators	Poorly (1)	Ave (2)	Good (3)	Very Good (4)
F1	19	10	12	6
F2	17	7	11	12
F3	18	10	9	10
F4	19	8	13	7
F5	20	11	10	6
F6	18	8	11	10
Total	111	54	66	51

The level of similarity between the fascilitators in their use of assessment strategies: The Eigenvalue of the One Dimensional PRINCALS with assessment as objects, yielded 0,55 and explained 55% of the similarities between the facilitators. Table 2 shows how the facilitators performed and presents a different and more consistent pattern than shown in Table 1. The original rating categories used were, 1 'not used', 2 'poorly used' 3 'average' 4 'good' 5 'very good' respectively. Thus facilitator one (F1) scored 5 times in the rating category 1(not used), 6 times in rating category 2 (poorly used) and so on. The pattern in Table 2 seems to explain the relatively high level of homogeneity.

Table 2

Level of Similarity Between the Facilitators in their use of Assessment Strategies.

	Rating Categories				
Facilitators	Not used (1)	Poor (2)	Average (3)	Good (4)	Very Good (5)
F1	5	6	9	6	2
F2	4	7	5	8	4
F3	4	4	7	8	5
F4	6	7	6	7	2
F5	7	6	6	5	4
F6	4	9	5	8	2
Total	30	39	38	42	19

The breakdown of the homogeneity, however, becomes clearer by analysing the similarities between the facilitators statistically. Table 3 presents the matrix of the Spearman Rank Correlations between the six facilitators (N=28) and the significant 'p' values, are presented. Table 3 indicates that some facilitators performed quite different to the rest when all the facilitators are compared with each other.

Table 3

Spearman Rank Correlation Between the Facilitators in their use of Assessment Techniques.

	F1	F2	F3	F4	F5
F2	0,30				
F3	0,34*	0,25			
F4	0,54**	0,26	0,39*		
F5	0,54**	0,66**	0,29	0,56**	
F6	0,02	0,47**	0,15	0,03	0,35*

* P < 0,05 ** P < 0,01

The level of similarity between the fascilitators in their use of implementation strategies: The Eigenvalue of the one dimensional PRINCALS with 'implementation' as objects, yielded 0,45 and explained 45% of the 'similarities' between the facilitators. Table 4 shows the performance in the use of implementation strategies per facilitator. The rating categories are as follows: 1 'Not used'; 2 'Sometimes used'; 3 'Often used' and 4 'Always used'. Table 4 indicates the variability between the facilitators which explains the decrease in homogeneity.

Table 4

The Performance in the Use of Implementation Strategies per Facilitator.

	Rating Categories			
Facilitators	Not used (1)	Sometimes (2)	Often used (3)	Always used (4)
F1	8	1	6	2
F2	6	2	3	8
F3	10	3	1	5
F4	6	2	6	5
F5	7	5	5	2
F6	5	3	3	8

In Table 5, the matrix of the Spearman Rank Correlations between the six facilitators (N=19) and the corresponding 'p' values is presented. These correlations are somewhat lower than in Table 4. Facilitator F5 seems to act very differently from facilitators F1 and F6.

Table 5

Spearman Rank Correlations Between the Facilitators in the use of Implementation Techniques.

	F1	F2	F3	F4	F5
F2	0,05				
F3	0,45*	0,13			
F4	0,14	0,13	0,21		
F5	-0,21	0,10	0,42*	0,45*	
F6	0,42*	0,24	0,02	0,35	-0,17

* P < 0,05 ** P < 0,01

Step two: The second step in the analysis was aimed to analyse the accuracy of the facilitators' performance. Although the marginal totals of Tables 1, 2 and 4 provides a fair indication of how accurate the facilitators were in the use of the strategies, accuracy ratings per assessment category and per implementation reveals more insight.

The accuracy of the facilitators in their use of assessment strategies: Table 6 represents the accuracy ratings of the facilitators in applying assessment strategies (categories A1 to A28). Rating categories for A1 to A10 are respectively: 1, poorly assessed; 2, inaccurately assessed; 3, average; 4, accurately assessed; and 5, very accurately assessed. Rating categories for A11 to A28 methods used in assessment: 1, poorly used; 2, inaccurately used; 3, average; 4, accurately used and 5, very accurately used.

Twenty eight assessment categories were divided into three classifications: Symptomatic Behaviour, Spotting Difficult Behaviour and Overall Communication. The first two classes show the same pattern of performance: about as much categories are rated as bad (ratings 1 and 2) as there are categories rated average to very good (ratings 3, 4 and 5). Overall communication is largely above average. Furthermore, a number of criteria are used very accurately, some very inaccurately and some averaged out. For example, although included in their training, facilitators did not investigate the clinical significance of having nightmares (A7). In contrast, facilitators were very accurate in the use of drawings (A11) to identify the children's difficulties.

Table 6

The Accuracy Ratings of the Facilitators in Applying Assessment Strategies.

		Rating Categories				
		1	2	3	4	5
Symptomatic	A1 (Anxiety)	0	3	2	1	0
Behaviour	A2 (Fear)	0	2	4	0	0
	A3 (Regression)	0	3	3	0	0
	A4 (Aggression)	0	4	0	2	0
	A5 (Withdrawal)	0	4	2	0	0
	A6 (Att. Seeking)	0	3	3	0	0
	A7 (Nightmares)	0	5	1	0	0
	A8 (Exc Clinging)	0	1	3	2	0
	A9 (Exc. Shyness)	0	4	1	1	0
	A10 (Thumb Suck)	0	5	1	0	0
Spotting	A11 (Drawings)	0	0	0	4	2
Difficult	A12 (Mut Story)	3	0	0	1	2
Behaviour	A13 (Games)	4	0	1	0	1
	A14 (Parent. Interv)	4	1	0	0	1
	A15 (Hist. taking)	5	0	0	0	1
	A16 (Devel. Theor)	2	0	3	1	0
	A17 (Diagn. Toys	3	0	2	1	0
	A18 (Ob/Play Sit)	1	0	0	1	4
Overall	A19 (Empathy)	0	0	0	4	2
Communication	A20 (Understand.)	0	0	0	5	1
	A21 (Discipline)	0	1	1	4	0
	A22 (Threats)	4	0	0	2	0
	A23 (Appr. Quest)	4	1	1	0	0
	A24 (Listening)	0	0	1	5	0
	A25 (Comfort)	0	0	3	1	2
	A26 (Support)	0	0	4	2	0
	A27 (Patience)	0	2	0	1	3
	A28 (Compreh.)	0	0	2	4	0

See Addendum D for unabbreviated list of assessment categories.

The accuracy of the facilitators in their use of implementation strategies: Table 7 represents the accuracy ratings of the facilitators in applying implementation strategies (categories I1 to I19). Rating categories 1 to 4 indicate how well a particular strategy was used: 1, poorly used; 2, average; 3, good and 4, very good. The nineteen categories refer to the basic play therapeutic techniques used by the facilitators as part of their implementation plan. Some of the techniques,- I12, I14 and I17 - are accurately used, as evident in the good rating obtained. Whereas the facilitators failed in their use of I15 and I16.

Table 7

Accuracy Ratings of the Facilitators in Applying Implementation Strategies (Categories I1 to I19).

Implementation	Rating Categories			
	1	2	3	4
I1 (Self Portr)	2	3	0	1
I2 (Expr.Feel)	1	1	2	2
I3 (Art Techn)	3	0	2	1
I4 (Understanding)	2	1	1	2
I5 (Dancing)	0	4	1	1
I6 (Role Play)	2	0	2	2
I7 (Games)	3	1	2	0
I8 (Drawing)	4	1	1	0
I9 (Reading)	5	0	0	1
I10 (Struct.Play)	3	0	2	1
I11 (Ego Build)	1	1	2	2
I12 (Mut.Story)	0	0	2	4
I13 (Interac.Play)	0	2	2	2
I14 (Painting)	0	1	1	4
I15 (Sh.Exper.)	5	0	0	1
I16 (Senso.Play)	5	0	0	1
I17 (Unstr.Play)	0	0	2	4
I18 (Singing)	4	0	0	2
I19 (Empathy)	2	1	2	1

See Addendum C for unabbreviated list of implementation categories.

8. Discussion

According to the above mentioned results and qualitative observation it becomes clear that insights are exposed as to the effectiveness of the programme. It thus indicates areas for theoretical and practical improvement in addressing the aims of the study. These insights were based on the evaluation of a) the theoretical principles of play therapy as a treatment for traumatised returned exiled children; b) the theoretical validity of the taining programme and c) the implementation of the training programme.

The use of the theoretical principles of play therapy was evaluated by the question: Is play therapy an adequate treatment for traumatised returned exiled children? The discussion on literature provides sufficient evidence to support the claim that play therapy is the treatment of choice for specifically traumatised children. Although it can be said that play therapy is traditionally used to treat pre-school children, Erikson (1950) asserts that play is the most natural self therapeutic process that childhood offers. He makes no distinction in age and middle childhood is included. Furthermore, literature indicates that traumatised children reinact traumatic events through play in order to mentally digest and master the trauma. This supports the Trauma Centre's choice of play therapy as an appropriate medium to address the residual trauma of returned exile children.

Play therapy as a treatment modality, however, is not the only criteria by which the validity of the training programme was evaluated. Validity was evaluated by the question: How are the principles of play therapy translated by the Trauma Centre into a training programme aimed to train returned exiled youth between the ages of 16 and 20 years in an adjusted form of play therapy? It was not the aim of the Trauma Centre to produce play therapists. It was rather to train lay volunteer youth from the return exile community in the basics of play therapy. A limited set of play therapeutic principles were chosen and included for use in the training programme. These principles were operationalised into a set of assessment strategies and a set of implementation techniques which were the focus of the training. Literature reveals that these strategies and techniques are the main proponents of play therapy. While basic, they are highly effective when properly employed. The training programme was developed and implemented by a clinical psychologist and a social worker at the Trauma Centre. The course of the training programme run over 20 weeks and trainees graduated with certificates of aknowledgement (see addendum B). A final aspect affecting the validity of the training programme is the extent and characteristics of the traumatised children. Access to the characteristics of the children, however, was limited to the available information of each child provided by a need assessment questionnaire (see addendum A). Besides these limitations, all children participating in the childrens group were diagnosed as having a residual trauma. Thus, the

preconditions to train facilitators in main assessment strategies and implementation techniques seem to be sufficiently addressed to evaluate whether facilitators were able to apply assessment strategies to identify the difficulties of the children and to implement play therapy techniques to address these difficulties.

The use of assessment strategies and implementation techniques was evaluated in two ways. Firstly, the homogeneity of the group was analysed because, a certain level of similarity between the facilitators would be expected as a result of the training process. Secondly the accuracy of the facilitators' performance was analysed. The Eigenvalues of the homogeneity analyses generated by PRINCALS, varied between 45% and 55%, suggesting multiple correlations between 0,67 and 0,74. Thus, the performance of the facilitators can be regarded as relatively similar and as a result of the effectiveness of the training. The difference between the Eigenvalues of Assessment strategies and Implementation techniques, 0,55 and 0,45 respectively, suggests that the facilitators had relatively more difficulties in addressing problematic behaviour then assessing problematic behaviour. This is also indicated by the correlations in Table 3 and Table 5 and the relative high occurrence of the poorly used implementation techniques (see Table 4). These tables also show that not all facilitators performed equally in their use of these techniques as evident in the performance of facilitator 6 in her assessment strategy and facilitators 4, 5 and 6 in their implementation techniques. Other sources of variance might explain these differences in performance.

Although the homogeneity analysis suggests that assessment strategies are better used then implementation techniques, the accuracy analysis, however, reveals more insight. The results presented in Table 6 show that overall, the facilitators performed above average in the use of assessment techniques.

In the classification 'Symptomatic Behaviour', most facilitators were not able to recognize aggression (A4), withdrawal (A5), nightmares (A7), excessive shyness (A9) and thumb sucking (A10) as symptoms of difficult behaviour. Many were, however, able to recognise fear (A2) and excessive clinging (A8) behaviour accurately. In contrast to the explicitness of fear and clinging behaviour, the relative inaccurate diagnoses might be explained by facilitators underestimating the impact of these symptoms; which could be considered as normal and age appropriate rather than problematic. This might also indicate the complexity of understanding the severity of these symptoms and applying it to a particular child of a particular age. It may be argued that symptomatic behaviour can be regarded as an appropriate regressive response to trauma by some or as age inappropriate by others. Whether appropriate or inappropriate, the emphasis of the facilitators in the training was to address symptomatic behaviour arresting development. According to O'Connor

(1997), assessment is used to refer to the therapist's formulation of a psychological explanation for the child's current pattern of symptoms and level of functioning. Thus according to this author most of the information needed by the play therapist for an assessment formulation, is obtained from the intake interviews with the parent and child. Although intake interviews (A14) and history taking (A15) were designed as part of the programme it was not structurally implemented. The one interview that was conducted was out of the facilitators own initiative. The absence of intake interviews by the facilitators is thus an additional explanation for difficulty experienced in making a thorough assessment.

In the categories 'Spotting Difficulties', most of the facilitators relied mainly on drawings (A11) and observations of children in their interaction with others (A18), as assessment tools. Parental interviews (A14) and history taking (A15) were used to a much lesser degree. Limited time, resources and access to families are some of the reasons why thorough interviews and history taking were not conducted with both parents and children by the facilitators. On the other hand the facilitators felt more comfortable with using drawings and observations as their primary diagnostic tools. It was non-threatening to the children, yet semi-structured. Observation of play is a widely used routine measure for assessment of developmental level. Observations provides information about other aspects of the child's life and thus useful in shaping both treatment strategies and goals (Harter, 1983). According to O'Connor and Ammen (1997), it is advisable that assessment play sessions be somewhat semi-structured in addition to pure observation, at least to the extent where the child is presented with specific materials. One such use of semi-sructured diagnostic play sessions is to explore the impact of specific trauma on the child victim (O'Connor and Ammen, 1997).

Finally, in the classification of Overall Communication the facilitators performed quite well. They excelled at listening (A24), understanding (A20) and empathy (A19). This could be partly due to the emphasis placed on empathy and understanding as the foundation of any therapeutic situation, but also because of the good rapport between facilitators and children. Thus when one looks at the characteristics of a play therapist as mentioned by Axline (1947), it is evident that in a large degree they succeeded to meet the basic requirements of establishing a warm and friendly environment, developing good rapport understanding the child, listening and respecting. These characteristics were evident to the researcher in her observation of the facilitators both while they assessed the children and in their approach to treatment.

According to the results of Table 7 (assessment variables), mutual storytelling (I12), painting (I14) and unstructured play (I17) were the primary means of intervention used. These are also the main

proponents used in play therapy as they are quite basic and highly effective if properly employed. Shaw (1938) reported how painting enabled children to overcome their inhibitions and permitted fuller expression of their fantasy life. Painting out hostile fantasies served as a means of catharsis for conflicts. Another reason for the popular use of painting is that it facilitates the emergence of fantasies and personality trends and in a controlled situation it is easy to observe the children as they express themselves through this medium. Afterwards the children can be helped to explore the individual trends in their creation. This, in turn provides valuable insight into how the child perceives himself, others and his world (Boyd Webb, 1993). According to Brems (1993) art in general can be used by the child to symbolically gratify wishes, control impulses, express affects and needs and recreate interpersonal processes and relationships without any fear of consequences or retaliation from the environment. Art techniques can be be uniquely adapted to the individual needs of the child to help overcome resistance and serve to introduce and discuss difficult topics or affects (Brems,1993).

It was observed that mutual storytelling gave the facilitators opportunities to communicate to the child stories of their own which are meaningful and pertinent to the child's problem - she thus speaks the child's own language and has a better chance of being heard. Characters, although similar are fictional and appealing and takes the pressure and anxiety of more direct probing, off the child (Landreth, 1993). According to Brems (1993), children use storytelling in general to reveal information about themselves to family members, friends, teachers and other significant individuals in their lives; to express affects and needs indirectly; and to engage in problem solving. All three of these uses of storytelling combine the purposes of facilitation of relationships, uninhibited self disclosure, and catharsis that result in psychological growth.

The main reason for unstructured play is that, it was found that especially with the younger children, their feelings are often inaccessible at a verbal level (Axline, 1947). Developmentally they lack the cognitive, verbal ability to express what they feel (Landreth, 1983). Facilitators allow the children to play freely, to feel comfortable and at ease and, at the same time, convey understanding and allow them an opportunity to do what they want to. The aim is to release pressurising feelings and attitudes.

Drawings (I8), reading (I9), and shared experiences (115) were used less often. The researcher is of the opinion that the primary reason why drawings and reading were used less, is not a reflection of the facilitators inability to recognise them as relevant therapeutic tools. Neither is it the possibility of pilfering and thus the possible beginnings of a conduct disorder or adequate limit setting or even the taking of transitional objects. The lack of sufficient resources was regarded by the Trauma

Centre and the researcher as a structural defieciency when results were discussed as reading and drawing material were less available.

Shared experiences, although attempted by various facilitators, were not successful. As mentioned previously, children are not able to focus on the intensity of what is felt in a manner that can be adequately expressed in verbal exchange. They much rather engage in activities that permit them to express themselves through fantasy, symbolism and play which were safer and less threatening (Landreth, 1983).

Once again the facilitators displayed characteristics such as listening to and responding to the child expressing feelings, were alert to those feelings, allowed some freedom by being permissive and yet with adequate limits. These characteristics were consistently observed.

8.1 Conclusion and recommendations

Conclusion: When considering what the research aimed at doing, that is evaluating the overall characteristics and abilities of the facilitators in assessment and implementation as set out in their training programme for dealing with specifically traumatized children through play therapy, much insight was gained. Tables 5, 6 and 7 indicated that the facilitators generally performed above average in both assessment of difficulties and implementation of techniques as well as room for improvement in other specific areas

Thus the programme has done well considering the educational level of the facilitators in conjunction with the demands of the programme. Areas for improvement have nevertheless been identified. When interpreting the results of Table 6, it was noted that the facilitators did not have a full comprehension of how to assess certain difficulties. Treatment planning and intervention depends on an accurate assessment of the child's development across areas of functioning (Kaplan et al., 1994).

Recommendations: It is therefore suggested that more theoretical emphasis is placed on developmental stages and symptomatic behaviour experienced at a specific stage. Learning material as well as its practical relevance and implementation should be simplified and explained in terms that are easy to understand. In addition, when initial intake sessions are held with parents, it would be advisable to have the facilitators sit in or to have them conduct their own relevant interview with parents. If this latter option is chosen it would structurally mean including an extra module on interviewing in order to have good enough assessments done. Assessments, in this instance would mean reaching a therapists formulation of a psychological explanation for a child's current pattern of symptoms and level of functioning.

Secondly, facilitators need to work simultaneously with child and parent or guardian. Caregivers of traumatized children are often themselves survivors or victims of trauma. This is often acted out in a transferential relationship.

A third area for improvement, and perhaps the most crucial, is more detailed notes. The theoretical foundation forms the backbone of the programme. Each topic on play therapy should have a heading, sub headings and explanatory notes on each. There should also be sections for practical implementation and further reading. Notes should be properly structured for easy reading and understanding. When in doubt, a facilitator should be able to refer to literature for guidance. In accordance to the principles of psychodevelopment, opportunity should be made for individual supervision or consultation as the primary linkage space between theory and practise.

Summary: Facilitators were able to acquire skills in assessment as well as in the treatment of children traumatized by civil unrest, political violence and repatriation. There was evidence of the required abilities to do so. The training programme assisted in the integration and implementation of learning material for its participants in that it is a) coherent, b) increased understanding of learning material and c) it can be of consequence to those who will put it to use. This is in accordance with the assertion of Patton (1993). The training programme has also addressed the goal of psychodevelopment by making the specialised skills and knowledge of the helping specialist more widely known and used by the general population (Brammer, 1979).

Trauma in children is increasingly being identified. Most children unfortunately cannot receive treatment. Sometimes it is direct and other times it is witnessed trauma. Few people are trained to treat the complexities with which trauma presents (Munson, 1995). This is also true for South Africa. New models of treatment of children need to be developed. The programme evaluated in this study is such a specialised model. This study showed that the programme has in essence attempted to give a basic understanding required to intervene with traumatized children and presented treatment considerations and strategies.

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ADDENDUM A. NEEDS ASSESSMENT QUESTIONNAIRE

THE TRAUMA CENTRE

FOR VICTIMS OF VIOLENCE

AND TORTURE

THE TRAUMA CENTRE FOR VICTIMS OF VIOLENCE AND TORTURE

Processed by: Date: Place:

BIOGRAPHICAL INFORMATION

Full Name of Child :

Sex:

Name of Parent of Guardian :

Address :

Telephone : (Home) (Work)

Age last birthday: Date of Birth:

Present School : Standard:

Name of Teacher: Name of Head :

Consent of Parent\Guardian: As parent\legal guardian of my son\daughter, I hereby give consent for my child to be admitted to the lay Therapy Group at the Trauma Centre. I agree that the said TraumaCentre may contact other authorities (i.e. schools and medical practitioner) to obtain or to supply information which the Trauma Centre regards as in the interest of the child.

SIGNATURE:

GENERAL

Do you have any concerns about your child?_____

If yes, state why:_____

Any previous advice\assessments\therapy:_____
(Place or person, date\Plek of persoon, datum)

PERSONAL HISTORY OF INDEX CLIENT

1. Development History

1.1 Pregnancy
No. of previous pregnancies:_____

Age difference between index and previous child/pregnancy:_____

Was the pregnancy planned?_____

Was the pregnancy normal?-_____

Were there any significant events related to this pregnancy?_____
_____
_____

Comments:_____
_____
_____
_____

1.2 Birth
Was he/she fed by a tube?_____

Was he/she breastfed?_____ If yes, for how long?_____

If no, what were the reasons?_____
_____
_____

Comments:_____
_____
_____
_____

1.3 Early Development

1.3.1 Motor

When did he/she sit?_____

When did he/she crawl?_____

1.3.2 Language

When did he/she say his/her first words?_____

When did he/she start putting words together to make a sentence?

_____

When did he/she use full sentences?_____

Comments:_____

_____

_____

_____

1.3.3 Bladder and Bowel Control

Has he/she had any difficulty with bladder control?_____

_____ day _____onset _____till_____ Situations_____

_____ night_____ onset _____till_____ Situations_____

Has she/he had any difficulty with bowel control?_____

_____day_____ onset_____ till_____ Situations_____

_____ night_____ onset _____ till_____ Situations_____

Comments:_____

_____

_____

_____

1.4 Significant Childhood Illnesses

1.4.1 Physical Health

Did he/she suffer from the following?

Ear infection_____ Convulsions_____

Suspected hearing loss_____ Accidents/Injuries_____

Meningitis_____ Operations_____

Physical Disabilities, please describe:_____

_____

_____

Other illnesses, please list_____

_____

_____

Hospitalisation:_____ Period/Duration:_____

Separation:_____Period/Duration:_____

Care Arrangements:_____

_____

_____

_____

Comments:_____

_____

_____

_____

2. Current History

2.1 Language

Does he/she have any of the following speech or language problems:

Pronunciation_____ Vocabulory_____

Grammar_____Stuttering_____.

Comments:_____
_____
_____
_____

2.2 School

Did he/she attend nursery school?_____How Long?_____

Language medium at nursery school_____

Any problems at nursery school?_____

Age at school entrance_____

Number of schools attended_____

Did he/she change language medium?_____Reason_____

Did he/she fail any standard(s)_____Which Standard(s)?_____

Was he/swhe put over to any standard(s)?_____ Which Standard(s)_____

Which subjec(s) is/are a problem?_____

Which subject(s) is/are not a problem?_____

What was his/her average percentage/symbol in recent exams?_____

How much time does he/she spend on homework?_____

Who assists him/her with homework?_____

Has the child ever had extra sessions by:

Teacher?_____ No. of sessions_____

Remedial Teacher_____ No. of sessions_____

Occupational Therapist_____ No. of sessions_____

Speech Therapist_____ No. of sessions_____

Physiotherapist_____ No. of sessions_____

Comments:_____
_____
_____
_____

2.3 Behaviour

Has he/she any problems at home?_____If yes, when did they start?_____

Describe the problem(s)_____
_____
_____

Has he/she any problems at school?____If yes, when did they start?_____

Describe the problem(s)_____
_____
_____

What time is bed time?_____

Where does he/she sleep?_____

Does he/she wet the bed?_____

Does he/she make friends easily?_____

What age are the children he/she prefers to play with?_____

What are his/her main interests/activities?_____
_____

Comments:_____
_____
_____

2.3.1 Behavioural Profile

Does he/she have any habits, e.g.

Nailbiting_____ Onset_____Till_____Situations_____

Thumbsucking_____ Onset_____Till_____ Situations_____

Object-sucking_____ Onset_____ Till_____ Situations_____

Head-banging_____ Onset_____ Till_____Situations_____

Clingingness_____Onset_____Till_____Situations_____

Does he/she have any fears?_____

Explain_____
_____
_____

How does he/she show it?_____
_____
_____

How do you deal with it?_____
_____
_____

Comments:_____
_____
_____

2.3.2 Play

How does he/she play, i.e.

Spontaneous_____

Make-believe_____

Favourite games/toys_____

Destructive play_____

Cruelty_____

Acting out life experiences_____

Under what circumstances?_____

_____

_____

Access to play facilities_____

Is play encouraged_____

Comments:_____

_____

_____

3. **Current Personality Profile**

3.1 Personality Description

How would you best describe your child's personality_____

_____

_____

_____

_____

Comments:_____

_____

_____

_____

3.2 Self-Help skills
Does your child help him/herself with e.g.
Feeding_____Toiletting_____Dressing_____

What responsibilities does he/she have?_____
_____
_____

Comments_____
_____
_____
_____

A. FAMILY BACKGROUND

Family Name:_____

First Names (Mother/Father/Guardian)_____

Date of Birth:_____ Age:_____ Sex:_____

Place of Birth:_____

Marital Status:_____

Present Address:_____
_____
_____

For how long?_____

Type of Dwelling:_____

With whom:_____

Relationship to Household:_____

Previous Address:_____
_____
_____

For how long?_____

Type of Dwelling:_____

Number of Dependants:

South Africa

NAME	AGE	SEX	RELATIONSHIP

Outside South Africa

NAME	AGE	SEX	COUNTRY	CITIZEN OF RESIDENT COUNTRY Y/N	RELATIONSHIP

B. EDUCATIONAL BACKGROUND

LANGUAGES	SPOKEN	UNDERSTOOD	WRITTEN
Home			
Other			

Father's Home Language:_____

Mother's Home Language:_____

Language spoken to child:_____

Language spoken between parents:_____

Language child is using the most now:_____

Comments:_____
_____
_____
_____

Highest Standard passed:_____

Further Educational Qualifications:(e.g. B.A. (UWC) 1984)_____
_____

Skills acquired:_____
_____
_____

ADDENDUM B. INITIAL DOCUMENTATION

CHILDREN'S PLAY THERAPY GROUP: RETURNED EXILES

CHILDREN'S PLAY THERAPY GROUP : RETURNED EXILE CHILDREN.

1. INTRODUCTION.

This programme was designed to establish a play therapy group for children in difficult circumstances, exhibiting behavioural and/or emotional difficulties, as well as difficulties with language and/or social communication.

Children in difficult circumstances refers to children who have been exposed to the trauma of exile, war, repatriation, civil unrest, captivity or political strife.

2. OBJECTIVE

1. To create an environment which will enhance the emotional, social and communication development of children in a group situation.

2. To provide a training/educational programme for the group facilitators, in order to equip them with the skills relevant to this programme.

3. To provide the parents with skills enabling them to recognise the signs and symptoms of the trauma their children might be experiencing and to create and environment which would stimulate familial bonding.

3. MOTIVATION FOR THE ESTABLISHMENT OF THE GROUP.

The group was started in mid-April,1994 with the help of a part-time worker.

Following feedback from some pre-schools, primary schools and parents, there were indications that many of the returned exile children are having considerable difficulty adjusting to their home and school environments. The overt manifestations were,inter alia:

i aggressive play

ii. poor communication with peers

iii. poor communication with adults, including their parents

iv. social withdrawal, and consequently poor school performance.

v. emotionally regressive behaviour eg excessive clinging behaviour, thumb sucking, bed-wetting, frequently assuming foetal positions when chasticed, aggressive or destructive play.

Play therapy was identified as an appropriate medium to address the residual trauma some of these children were displaying, while at the same time creating an environment which would facilitate closer contact with their families.

4. THEORECTICAL FRAMEWORK.

The programme was set up along the following broad principles of community psychology:

i. seeing the child within his/her wider social context - a questionaire exploring the child's developmental milestones and the dynamics within the family has been drawn up and has aleady been administered to a large number of families.(see questionaire attached)

ii. identifying volunteers from amongst the returned exile youth community to act as group facilitators - complying with the principle of "survivor helping survivor"

iii. providing appropriate training to the group facilitators, so that they in the medium to long term can run smaller groups themselves, thus creating the opportunity for the regeneration of skills.

iv. Providing group facilitators with an honorarium (monthly), and on completion of their training a certificate of acknowledgement.

v. creating the possibility of taking smaller groups into the communities where the children live, including other children in difficult circumstances, and thus facilitating the returnees' integration into Cape Town.

5. THEORECTICAL APPROACH

A broad systems approach is used, focusing on the inclusion of the following groups.

5.1 Teachers.

Teachers are often not familiar with the difficulties returned exile children might experience. Due to the children's lack of knowledge of the major South African languages, our experience indicates that many often have difficulty grasping some basic educational concepts. This often leads to the children withdrawing socially.

To date contact with individual class teachers has been limited,due primarily to the spread of schools children attend.
It is important, however, to raise the awareness of teachers so that they would be in better position to identify and assist children affected by trauma.

5.2 Parents.

Literature from a number of different refugee/exile situations (eg Palestine, Latin America etc) indicate that returned exile parents are often so pre-occupied with their own survival issues, manifesting outwardly in feelings of disempowerment, feelings of inadequacy in providing nurturance and care. parental control ,emotional and economic support to their children.

In order to assess family functioning, and parents' involvement in their children's lives a structured questionaire has already been administered to most families

Parents have also been included in social activities arranged for the children eg visits to the zoo, museums, a Xmas party etc.

The next step would be to identify parents' specific needs and to arrange parenting skills workshops accordingly.

5.3 Group facilitators.

Through a process of voluntary selection, eight (8) returned exile youth have been trained as group facilitators, capitalising on the following:

i. their knowledge of the various languages spoken by the children, thus reducing the pressure on the children to be proficient in English.

ii. their knowledge and sensitivity to the social and cultural contexts from which these children come, facilitating a slow but significant process of acculturation into a new context. Activities such as song and dance are important elements in this regard.

5.3.1 Training of Group facilitators.

Initially training was conducted by the principal facilitator (a trained speech-therapist , working at T. C on a part-time basis) for one hour, once per week, and immediately after the children's group.

With the departure of this part-time worker to England,however, and at the request of the group facilitators, this method was reviewed and a qualified psychometrist /Montessori teacher was contracted to provide the training of group facilitators only. Group facilitators were also requested to sign a contract committing themselves to the duration of training and their availability to run the children's group. (See attached contract form).

The complete training package spanned over twenty weeks, taking place over two hours once weekly. In November,1995 training was completed and group facilitators graduated with certificates of acknowledgement.

Ways of providing more meaningful supervision and support to group facilitators are currently being explored by a Psychology Masters student from the University of Stellenbosch, who is presently also evaluating their training .

Course material and schedules for both training periods are attached.

6. THE TARGET GROUP.

The group consisted of 32 returned exile children ranging between 3 and 9 years. Children were drawn from the returned exiled communities in Fish Hoek, Khayelitsha, and Kraaifontein (Wallacedean and Scottsdean)

All children are second- or third generation returnees, and all come from low income families. As most children have foreign-born mothers, most of them speak at least three languages or more. A more complete demographic profile is attached.

A questionaire was used to assess parents' socio-economic and educational status and the psychological, social and educational trends amongst the children. In addition to this progress reports are kept on each child. Details are available upon request.

The children meet once weekly at the Trauma Centre. Their transport to and from home is provided for by the Trauma Centre.

Each group facilitator is attached to a group of 3 to 4 children, dependant on the children's ages and the levels of maturity and readiness of the group facilitator.

7. LIMITATIONS OF THE PROGRAMME.

Since its inception the programme has been fraught with difficulties, both within itself and externally. It is important to point out that due to the multiplicy of stake-holders in the programme it is often difficult and complex to determine accurately exactly where the problem areas are.

An evaluation of the programme conducted round about May,1995, confirmed that hitches occur at several levels, and that each hitch impacts significantly on the smooth running of the programme.

7.6 Resources.
Initially appropriate toys were purchased for the group, but because of a lack of physical space and adequate lock-up storage space, the toys have disappeared.

7.7 Transport.
Transport arrangements have at the best of times been problematic, as this required the T.C full-time driver to work over weekends, sometimes for long hours, and often with or without the assistance of an additional driver. This means that at times part of the group reaches the T.C past 11 o'clock or later, whereas activities are scheduled to start at 10 o'clock.

7.8 Lack of Organisational Support.
Since community-based programmes are currently set up within different T.C projects, it is often extremely difficult to rally moral and practical support for a programmatic issue/ problem from within the organisation. Verbal support is frequently forthcoming, but as frequently breaks down when it comes to operationalising matters, e.g difficulties with transport, a readiness to criticise rather than exploring ways of consolidating the programme.

There is a distinct perception that the children's programme often has to fashion its schedule around organisational needs rather than the other way around.

8. Successes of the Programme.
8.1 Potential for a Model.
Despite the above setbacks, the programme offers an important theoretical and practical model for working with children who are experiencing trauma. It would be interesting to observe whether the symptomatolgy evident amongst returnee children is a function of their exile/repatriation experience, or whether it is common to most children exposed to trauma eg socio-economic deprivation.

8.2 Breaking down old patterns
It is our impression that, to a significant degree, the children's participation in the play therapy group has helped them negotiate their integration into a wider social circle. Parents report that their children are doing better at school, that communication with peers and in some instances with parents has improved, and that there is greater willingness to socialise with others.

8.3 Pre-teens Scout Group.
Of the original 32 children in the group, 14 children, now aged 10 years or older (11 boys and 3 girls), have formed a pre-teen group, meeting every Friday afternoon. At their request they have been integrated into an existing scouts group.

This seems to indicate that they are making sense of their own developmental needs and are ready to become part of a wider peer group.

8.4 Parents' Involvement.
As indicated above, parents have, over a of period of time, taken a greater interest in the lives of their children. Last year's Xmas party was run and organised by the parents themselves.

8.5. Raising Trauma Centre's Profile in the community.
Trauma Centre's active involvement in at least 3 returned exile communities, is an important way of promoting the services we offer,raising the T.C profile, and for returnees is a central point for accessing other services and resources.

9. Conclusion.

It is the feeling of the team, involved in this programme, that the Trauma Centre should commit itself to ironing out the difficulties the programme has been and currently is experiencing, that we consolidate and strengthen the group, and that this model could be used for a Trauma Centre Children's Programme.

Bea Abrahams
On behalf of the Returned Exiles and Refugees Project Team.
February,1996.

PLAY THERAPY TRAINING PROGRAMME - OUTLINE OF COURSE MATERIAL AND SCHEDULE.

Requirements:

- compulsory attendance to 90% of the lectures
- complete reading assignments
-participation in class activities
-participation in the sessions with children
- record observations on children.

Topics:

1. Child development (middle childhood). Piaget, Erikson. - 2 lectures
2. Play therapy (what it is, how to use it and why it is used) -6 lectures
3. Observational and diagnostic skills (use of check lists and questionnaires) - 4 lectures.
4. Play therapy techniques (how to administer and its value)- 4 lectures
5. Communication with children (relationship between child and adult) - 3 lectures
6. Role of therapist (person centred, secondary care giver) - 2 lectures

LIST OF PLAY THERAPY TECHNIQUES

1. Structured play - gathering the group, providing goals with a direct focus and guidelines for play activity.
2. Unstructured play - only limit setting to anchor child in reality.
3. Senso-pathic play - play involving the child's senses like touching, smelling and kneading. Basic materials like sand, water and clay are used.
4. Games - see play activity list for some ideas.
5. Singing - self expressive, lullabies to nurture, cultural songs for group enhancement.
6. Empathy - as primary means of communication and first guideline to non - threatening interaction and play.
7. Drawings - can be used as a tool for self expression by the child and thus says much about their world, can also be used as diagnostic tool.
8. Painting - a natural medium for children to express themselves, especially finger painting.
9. Reading - offers children options and alternatives on how to deal with their own difficulties through fictional characters.
10. Self portraits - helps build identity and encourages relaxed expression of self.
11. Dancing - for social interaction and motor development.
12. Mutual story telling - includes the therapist and the child in telling their stories and sharing it.
13. Expression of feelings- especially to help withdrawn children who have difficulty with talking.
14. Ego building - strengthening from within, helps with self esteem boosting
15. Understanding - valuable in rebellious children in need of trust.
16. Graphic art - very visual allowing creative expression of intrapsychic processes.
17. Interactive play - usefull for bringing removed children into a group.
18. Role play - non-threatening expression of person.
19. Shared experiences - encourages expression of feelings and experiences with others especially peers

LIST OF PLAY ACTIVITIES.

Collages.
Story Telling. (dramatize the story)
Beginning a story and letting the child finish the story.
Reading to them. Talking about what has been read. Get child to bring favourite book.
Sharing news of the previous weeks events.
Working with play-dough.
Working with plasticene.
Drawing activities.
Playing with beads.
Creative dramatics - child relives familiar experiences and explores new ones
Playing with dolls.
Naming games.
Number games
Outside play (running, skipping, balls etc.)
Letter writing.
Completing the sentence.
Lego
Working with discarded materials - wood, paper, raffia, cardboard etc.
Flash card games
Play with discarded clothing (handbags, purses etc.)
Role playing (What if.....?) (Being the teacher, nurse etc)
Painting.
Koki pen drawing.
Paper folding and cutting.
Card games.
Sequencing cards.
Threading beads.
Guessing games - show then recall.
Making something together (eg putting pot plant into a pot, gardening)
Show pictures - make up a story.
Make finger puppets.
Draw your favourite food, talk about it.
Body Awareness (get children to be pretzels etc) (Body touch by naming) (match my position)
Playing with a ball (bell ball, Patsy ball, catching ball)
Hop skip and jump (hopscotch)
Who am I?
Co-operative story telling.
Animal sounds.
Because game.
ABC game.
Simon says
I spy or I see something and it sees me.
The eating and drinking game.
What is my job?
Take a trip (Make a sentence and leave out the nouns)
dot to dot linking.
The shopping game.
Vocabulary game.

ADDENDUM C

Implementation techniques

I1	Self portraits
I2	Expression of feelings
I3	Art Techniques
14	Understanding
I5	Dancing
I6	Role play
I7	Games
I8	Drawings
I9	Reading
I10	Structured play
I11	Ego building
I12	Mutual Storytelling
I13	Interactive play
I14	Painting
I15	Shared experiences
I16	Senso-pathic play
I17	Unstructured play
I18	Singing
I19	Empathy

ADDENDUM D

Assessment strategies

Symptomatic behaviour

A1 Anxiety

A2 Fear

A3 Regression

A4 Aggression

A5 Withdrawal

A6 Attention seeking

A7 Nightmares

A8 Excessive clinging

A9 Excessive shyness

A10 Thumb sucking

Spotting Difficult Behaviour

A11 Drawings

A12 Mutual Storytelling

A13 Games

A14 Parental Interviews

A15 History taking

A16 Developmental theories

A17 Play and use of diagnostic toys

A18 Observation of play situations

Overall Communication

A19 Empathy

A20 Understanding

A21 Discipline