

PLAY THERAPY AS A COMPONENT OF AN AID PROGRAMME FOR READING
DISABLED CHILDREN: A PSYCHO-EDUCATIONAL PERSPECTIVE

by

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I the undersigned, **NANCY RUTH KOLLER**, declare that:

**Play Therapy as a Component of an Aid Programme for Reading Disabled
Children : A Psycho-Educational Perspective**

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

N R KOLLER

**To
my late mother, Jean,
who instilled in me the love of learning and the love of play**

**and my sons
Bruce, Rob, Darryl and Stephen**

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SUMMARY

PLAY THERAPY AS A COMPONENT OF AN AID PROGRAMME FOR READING DISABLED CHILDREN : A PSYCHO-EDUCATIONAL PERSPECTIVE

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Children with learning disabilities often exhibit emotional problems. Conversely, children experiencing emotional upsets cannot achieve scholastically. The exact nature of the relationship is difficult to elucidate.

Most aid programmes deal with one aspect of the problem, placing little or no emphasis on the child in totality. This study focuses on the learning disabled child as a whole from a relation theory perspective. The aim is to ascertain how the child's difficulties affect his relation structures. Once the interaction between the relation structures had been established a programme was devised to assist the child emotionally and scholastically.

Play therapy has proved one of the most successful methods of child psychotherapy. This study attempts to incorporate the essential elements of play therapy into a remedial programme. It was found that the children benefitted from both components of the programme and that it had a positive influence on their relation structures.

OPSOMMING

SPELTERAPIE AS 'n KOMPONENT VAN 'n HULPPROGRAM VIR LEESGESTREMDE KINDERS : 'n SIELKUNDIGE OPVOEDKUNDIGE PERSPEKTIEF

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Kinders met leerprobleme toon dikwels ook emosionele probleme. Omgekeerd kan kinders met emosionele versteurings dikwels nie skolasties presteer nie. Die presiese aard van hierdie verwantskap is nie duidelik nie.

Die meerderheid hulpprogramme fokus op enkele aspekte van die probleem, met min of geen klem op die kind-in-totaliteit nie. Hierdie studie is daarop gerig om die leergestremde kind vanuit die relasieteorie waar te neem en van hulp te wees. Die doel is om te bepaal hoe die kind se probleme sy relasies beïnvloed. Nadat die interaksie vasgestel is, is 'n hulpprogram ontwerp om emosionele sowel as skolastiese hulp te verleen.

Speltherapie blyk een van die mees geslaagde metodes in kinderpsigoterapie te wees. Die studie poog om die essensiële elemente van speltherapie by 'n remediërende hulpprogram in te sluit. Daar is bevind dat die proefpersone by hierdie program gebaat het en dat hulle relasies positief beïnvloed is.

KEY WORDS

Learning/reading disability

Play therapy

Psycho-educational

Relation therapy

Relation structures

Self-actualisation

Self-concept

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CHAPTER ONE

INTRODUCTORY ORIENTATION, ANALYSIS AND STATEMENT OF THE PROBLEM, AIMS, CLARIFICATION OF CONCEPTS AND RESEARCH METHODOLOGY

1.1 INTRODUCTION

A great many children who struggle with reading also have emotional problems. The exact relationship that exists between reading difficulties and emotional problems has not yet been established (Carmichael 1991:274). The inability to learn to read is known to cause stress and anxiety in the child and can upset emotional stability. Conversely, emotional upsets can result in reading problems.

What is certain is that children who have learning difficulties and accompanying emotional problems have a disability. Like any other disabled children they need to be helped to cope with their problems so that they can overcome their handicaps and develop their full potential.

In order to aid such children the person who is rendering assistance has to help the child to become aware of what his¹ problem is, to explore it and finally to accept it. Then the child and counsellor can work together to overcome the difficulty. In order to do this the counsellor should understand how the child feels and thinks. Children, particularly young children, have difficulty expressing themselves verbally. Play is the child's natural medium of expression and in his play a child reveals a great deal about himself and how he perceives the world around him. Watching a child play can help the counsellor understand him better. Play can also be used to communicate with

¹For the sake of brevity the masculine gender has been used throughout this study, unless specific differentiation between genders is required

children and as a means of carrying out therapeutic work (McMahon 1992:xiii). Since it was first used at the beginning of the century, play therapy has proved extremely successful in treating children with problems.

This study aims to use play to help the learning disabled child realise his full potential and assist him on the path towards becoming a fully self-actualised individual.

In this chapter the awareness of the problem is discussed; specific aspects of this situation are analysed and a formal statement of the problem is made. The field of study is demarcated; research approach and methodology are discussed; the objectives and demarcation of the study are stated and certain key concepts are clarified. The chapter concludes with a brief explanation of the development of the study.

1.2 AWARENESS OF THE PROBLEM

In her work with children over the years the researcher has observed that frequently a child who experiences problems with reading and other scholastic tasks also exhibits emotional and behavioural problems. Such a child is usually referred for remedial assistance. A vast amount of research has been done on the causes of reading difficulties and possible remediation of the problem (Gillespie-Silver 1979; Mosse 1982; Hedley & Hicks 1988; Hosler & Fadeley 1989; Bos & Vaughn 1994). Numerous excellent remedial programmes have been devised, many with good results. However, even with all the remedial help available, there are still some children with average to above average intelligence and no inhibiting physical or physiological factors who do not benefit from this assistance. These children continue to exhibit reading and other scholastic problems which in turn tend to aggravate their behavioural and emotional problems.

Since reading affects all other academic disciplines it is probably the single most important skill that children acquire when they enter school. One of the greatest

problems facing educators today is how to deal with pupils who have difficulty in learning to read. In almost every classroom there is a group of children who for physical, cultural, social or emotional reasons cannot keep pace with their peers. If a child has serious learning difficulties these usually result in his inability to master the skills required for reading. Teachers have always found it difficult to give sufficient help to these children in the normal classroom situation. Today, with large multi-cultural classes, it is even more difficult to assist these pupils. Consequently they fall further behind their peers and this frequently has a negative effect on the children's self-concepts. Behavioural problems result, compounding the learning difficulties.

The researcher has noted that most remedial programmes implemented in schools today concentrate on the academic or perceptual aspect of the problem with little or no emphasis on the emotional component.

This view is supported by experts in the field (Strother & Barlow 1985:29-38; Manzo 1987:408-413; Beck 1988:774-779). In spite of the close connection between reading and emotional problems, few remedial programmes are concerned with both facets of the child. Most programmes do not deal with the child as a whole but work on specific weaknesses. They concentrate, for example, on perceptual and linguistic areas while placing little or no emphasis on the affective side of the child's problem. Manzo (1987:408-409) claims that most of the literature on learning disabilities, dyslexia and remedial reading acknowledges that these conditions are accompanied by emotional problems. He quotes authors who list possible causes of learning disabilities but few, if any, he claims consider psychological causes. Manzo goes so far as to say that between 15 - 20% of learning problems are rooted in emotional disturbances yet this is not generally acknowledged. A survey of the literature confirms Manzo's claims that psychological aspects of reading problems receive far less attention than other areas (Axline 1947:61; Beck 1988:774; Carmichael 1991:273).

Yet as Manzo (1987:409) remarks, when an individual is in any way distressed he becomes preoccupied with the issue or issues causing the emotional upset and this disrupts clear thinking. If a child is preoccupied with emotional set-backs it will be

difficult, if not impossible, to concentrate on the complicated process of mastering the skills of reading. A child must want to learn to read and be ready to read. Before this can happen all the child's basic needs must be met, including his emotional needs. Any attempt to further cognitive development will be unsuccessful if these needs are not fulfilled.

Most remedial programmes used in schools today concentrate on scholastic problems. Generally programmes do not cater for both the cognitive and affective needs of the child. There appear to be few which include therapy to assist the child overcome his emotional upsets. If a child exhibits serious behavioural problems these are attended to in separate therapy sessions. Such a compartmentalised approach does not see the child in totality.

1.3 ANALYSIS OF THE PROBLEM

1.3.1 Learning and emotional problems

As Strother and Barlow (1985:30-31) remark, the relationship between emotional and reading difficulties cannot be overlooked. They claim that there is a definite connection between affective and cognitive development and say that:

When all reading resources have been exhausted and the child is still not reading well, personality and emotional traits can be considered stumbling blocks, concomitant with reading deficiencies.

The converse is also relevant. As Beck (1988:774) remarks:

And associated with their learning difficulty may be emotional issues; poor self-concept, low frustration tolerance, and defeatist attitudes may contribute to impaired concentration or decreased willingness to attempt or persevere at tasks.

Lewis (1984:454) contends that emotional maladjustment, as a cause or effect of reading problems, has been widely debated. He points to the need for a programme focusing on the alleviation of both emotional dysfunction and learning difficulties.

A number of authors (Orlow 1974:669-674; Strother & Barlow 1985:29-38; Manzo 1987:408-413; Beaumont 1991:261-270; Lamm & Epstein 1992:605-615 and Lessing 1995:1) agree that it is essential to work with both cognitive and affective aspects of the child's problem. These authors concur that children who are emotionally unstable cannot make satisfactory academic progress.

Conventional remedial programmes do not include what Vrey (1990:13) terms the "Gestalt of the child's life-world" since they do not look at the child as a whole. The child should not be seen in isolation but should always be viewed in relation to his world around him. As Vrey (1990:6) contends, the child should not be seen in a vacuum. He should always be observed in his relationships to himself, to other people, objects and ideas around him.

1.3.2 Relation therapy

Relation therapy, as propounded by Jacobs and Vrey (1982), looks at the individual in totality. These authors refer to different concepts which make up the individual, such as : the I, the self, the self-image, the self-concept and so forth but stress that the individual must always be seen as a whole:

Die mens as 'n fisieke, psigiese en geestelike wese is te alle tye 'n *eenheid*, wat nie in afsonderlike entiteite geskei kan word nie. ... Die mens is voortdurend in sy totaliteit betrokke by al sy handeling - sowel fisiek as psigies (Jacobs & Vrey 1982:23).

While looking at the child in totality the relation therapist must ensure that he does not see the individual in a vacuum. The child must be seen in relation to his world around him. The counsellor must be aware of the child's relations with:

- his parents and family
- his teachers
- his peers
- objects and ideas
- himself.

A child who experiences problems has difficulty with one or more of these relationships. Since they are all inter-linked, a problem with one relationship is bound to have an effect on other areas as well. For example, if a child has problems in his relations with peers this can affect his school work and also his perception of himself.

Working from an external frame of reference, that is, the child's frame of reference, the counsellor must explore the world of the child in terms of these relationship structures. Once the problem areas have been diagnosed, it is the task of the counsellor to attempt to improve these relations by getting the child actively involved in the problem, assisting him to attribute realistic meaning to the relationship and then promoting positive experiences. This will help the child to develop a healthy self-concept which is a prerequisite for self-actualisation.

1.3.3 Awareness of children's needs

Assisting the child to achieve the goal of self-actualisation should be the aim of every teacher. No child is able to achieve true self-actualisation if his basic needs are not met. Once the basic physical needs are satisfied the educator should look at the child's affective requirements before concentrating on the higher cognitive skills. As stated in paragraph 1.3.1, the learning disabled child almost always has emotional problems. These can be caused by the inability to cope scholastically or can be the result of upheavals in other relationship structures in the child's environment. Many teachers complain about a deterioration in general scholastic achievement but do not seem to take cognisance of the difficult circumstances under which many children live. They do not relate learning difficulties to emotional upheaval.

From the moment children enter school, pressure is placed upon them to acquire the requisite skills for achieving academic success. In addition, many have to make cultural and social adaptations when they go to school and come in contact with children and educators who hold different ideals from their own. The consequence of these factors is that many children have difficulty adapting to the school situation and they develop behavioural and emotional problems. Such emotional problems almost always have a negative effect on school work and result in poor scholastic progress as well as unacceptable behaviour in the classroom. Reading is invariably affected. Such pupils either withdraw and do not take spontaneous part in classroom activities or their behaviour may become aggressive and disruptive. A vicious cycle then develops as the worse a child's academic performance is, the more it has a negative effect on the self image, thereby reinforcing unacceptable, compensatory behaviour. As Lessing (1995:1) remarks, it is important to deal with each child individually since every child has unique problems which need to be addressed. Many educationalists have to be reminded of the importance of assisting the child affectively as well as cognitively. The problem which now emerges is how best to assist the child whose emotional upheavals affect his school work.

1.3.4 Play therapy

Many children who experience emotional problems find it difficult to verbalise their feelings. Some children are, in fact, quite unaware of the specific nature of their problems and feel angry, frustrated, tense or depressed without knowing why. Play is a child's natural medium of expression and through play children are able to express buried feelings. West (1992:11) gives the assumptions of some experts regarding play:

- in the majority of the white Western world play is to [most] children what language is to [most] adults (Axline)
- children usually express themselves more freely using play than in formal "talking" interviews (Bray)
- children can reveal their troubles through play
- play can be a therapeutic tool (Gavshon, Isaacs)

Osterweil (1986:224) remarks that all approaches to psychotherapy with children perceive play as both the child's means of communication and his "work".

In 1928 Anna Freud began to use play therapy as a means of encouraging children to express their inner feelings. Ever since, play has been used successfully by numerous child psychologists when dealing with children's problems. Although approaches and methods differ, experts (such as Landreth 1982; Schaefer & O'Conner 1983; Axline 1989 and West 1992) agree that play therapy has proved successful in assisting children with psychological problems.

The purpose of play therapy is to assist the child to understand himself and his problems better and to help him function more effectively in his environment. The aim is to improve the child's self-esteem, thereby allowing him to see himself as a worthwhile individual with positive attributes (Bell 1990:45).

The different psychological schools of thought approach play therapy from different perspectives and all claim to assist children with their problems.

*** Psychoanalysis**

The psychoanalytical school is based on the theoretical consideration of Sigmund Freud. Anna Freud and Melanie Klein, followers of the Freudian discipline, developed the psychoanalytical approach to play therapy. Their methods, while differing in some respects, basically concentrate on repressed sexual and aggressive impulses (Johnson, Rasbury & Siegel 1986:116). Emphasis is placed on events in the individual's past which are responsible for his present problems. As Schaefer (1979:121) explains:

The psychoanalytical approach to play emphasises the use of the therapist's interpretation of a child's world and actions, as well as the analysis of the transference relationship, to help the child achieve insight into his unconscious conflicts.

In other words, interpretation is done from the therapist's frame of reference rather than from the child's.

*** Client-centred therapy**

The antithesis of this is child-centred play therapy which is based on Rogerian principles. Here everything is viewed from the child's frame of reference. This approach is completely non-directive. The emphasis here is on creating a climate of warmth, empathy and acceptance in which the child feels safe to play freely. Axline (1947:62) maintains the basic philosophy of child-centred play therapy is:

... a deep respect for the integrity of the individual and a belief in the capacity of an individual to help himself when that capacity is given optimum release.

This approach, while proving successful in many instances, has been criticised for being time consuming and for the lack of emphasis it places on diagnosis. (Gumaer 1984:66; Singh 1988:48-51; McMahon 1992:31). Gumaer (1984:66) claims the method is not concerned with looking into the past for the origin of the child's problem. The approach also lacks normative direction. Lewis (1984:454) also criticises the few studies which have used non-directive counselling techniques as part of a programme to assist children with learning difficulties. He claims their methodologies are imprecise and the programmes are not thoroughly described. His contention is that structured programmes are more effective.

*** Behaviourist theory**

The behaviourist approach is a rigidly structured method of implementing play therapy. Schaefer (1979:122) explains that therapists who apply this philosophy use empirically derived principles of learning, such as reinforcement, to help the child to unlearn maladaptive behaviours and acquire new acceptable behaviour patterns. Lewis (1984:454) quotes a number of authors who claim success with behaviourist

techniques like hypnosis, social reinforcement and modelling. These researchers claim a noticeable improvement in reading and a reduction in anxiety after using behaviourist techniques. However, as McMahon (1992:48) remarks, behaviouristic philosophy is contrary to the view of most experts who believe that play therapy should allow the child freedom of expression.

*** Relation therapy**

Like client-centred therapy, relation therapy works from the child's frame of reference, stressing the creation of a warm, empathetic climate. Yet, relation therapy is more flexible. Working within the relation therapy framework the therapist is free to have unstructured, semi-structured or structured sessions, as the needs of the child demand.

Singh (1988, 1991) claims success using this approach both in individual therapy and in play group therapy. She implemented play group therapy from a relation perspective as an aid in assisting pupils with learning problems. Play therapy, as the term is generally understood, is usually conducted on a one to one basis since every child has different problems and emotional needs. The techniques and methods of approach used for play group therapy are naturally different from those used for individual therapy. Little research has been done on implementing play therapy from a relation therapy perspective or using play therapy (as opposed to learning-through-play) as an integral part of a remedial reading programme.

*** Conclusions**

From the literature it appears that most remedial programmes which attempt to assist the child with reading and other scholastic difficulties do not see the child in totality. These programmes concentrate on the cognitive aspects of the problem and pay little attention to the affective component. However, experts (Axline 1947:61-69; Lewis 1984:444-459; Manzo 1987:408-413; Carmichael 1991:273-276) agree that learning and reading difficulties are interlinked. If the child is suffering from an emotional upset he cannot make satisfactory progress at school. Persistent failure causes frustration,

anger and feelings of inferiority. This in turn has a negative influence on the self-concept and compounds both scholastic and emotional problems. Despite teachers and counsellors being aware of this phenomenon, little is done to remedy the situation.

*** Incorporation of play therapy into an aid programme**

A problem which confronts the therapist is how to incorporate an affective component into the didactic programme. Studies have been conducted using behavioural therapy (Lewis 1984:444-459) in conjunction with scholastic assistance. Other therapists (Axline 1947:61-69; Carmichael 1991:273-276; Singh 1991:48-51) claim play group therapy has been successful. Play therapy is used by many child psychologists to assist children with emotional problems. It is always conducted in a safe, non-threatening atmosphere. Nevertheless a child who is struggling with reading can find anything connected with the subject threatening. The problem is therefore how to combine these two apparently contradictory situations.

1.4 STATEMENT OF THE PROBLEM

The problem investigated in this study has three closely related components:

- * The first aspect is to establish the relationship between reading and emotional problems in the learning disabled child and the effect thereof on the child's other relations.
- * Once these relations have been established the second part of the problem is to find a method which will assist the child to improve all his relation structures. In order to do this the child must be looked at in totality. The problem is how to devise a programme which will assist the child cognitively and affectively.

- * A cursory review of the literature has shown that play therapy has proved successful in assisting emotionally disturbed children. The third aspect of the problem is to ascertain whether the essential elements of play therapy be successfully incorporated into a remedial reading programme so that the child will respond positively to both components?

1.5 AIMS OF THE STUDY

1.5.1 General aims

The aim of this study is to investigate the relationship between reading and emotional problems in the learning disabled child and establish how this relationship affects the child's other relations. The intention is to establish whether academic performance and relation structures can be improved by helping the child scholastically and emotionally through play.

1.5.2 Specific aims

The purpose of this study is:

- to investigate the effect of reading disabilities on the child's relation structures
- to compile a remedial reading programme which deals with both emotional and scholastic aspects of the problem from a psycho-educational perspective using relation therapy as a basis
- to establish whether all the essential requirements of play therapy and a variety of techniques, implemented from a relation therapy perspective, could be incorporated in such a programme
- to evaluate the effectiveness of the programme on the child's self-concept, scholastic progress, behaviour and his relationship structures in general.

1.6 DEMARCATION OF THE FIELD OF STUDY

The study will be limited to junior primary school children between the ages of six and nine who exhibit both emotional and reading difficulties and whose intelligence falls within the dull normal to normal limits. Children with severe physiological or neurological dysfunction will not be included.

1.7 RESEARCH METHODOLOGY

The research will be conducted as follows:

1. A survey of the literature will:

- explore the phenomenon of play and play therapy
- investigate the relationship between reading and emotional difficulties.

2. An empirical investigation, in the form of an idiographic study, will be conducted using five junior primary school children who exhibit both emotional and reading problems. Diagnostic tests will be used to ascertain the children's emotional state and level of scholastic functioning. Diagnosis will be done according to the relation therapy model and assistance programmes compiled in accordance with each child's specific needs.

The children will be dealt with on an individual basis. Play therapy will be used to assist them with their emotional and behavioural problems. A variety of techniques will be employed depending on the children's individual problems. The scholastic component of the problem will be introduced once trust has been built up between the therapist and the child, and when the child has shown that he is benefitting from the play therapy. Sessions will then consist of a scholastic component and a play therapy component. After the completion of the programme the subjects will be reassessed.

1.8 CLARIFICATION OF CONCEPTS

1.8.1 Psycho-educational perspective

The basic components of "a psycho-educational perspective" are the essences of involvement, significance attribution, experience and the effect they have on the individual's self-concept formation and progress towards self-actualisation.

Jacobs and Vrey (1982:24) explain it as follows:

Die essensies, te wete betekenisgewing, beleving, betrokkenheid en selfaktualisering, saam met die vooronderstellings, te wete die vorming van relasies, die leefwêreld en die opvoedingsklimaat, vorm die *basis of die fondament* waarop die intrapsigiese struktuur, te wete die ek, self, identiteit en selfkonsep, staan.

1.8.2 Play

The idea of play is usually associated with a pleasurable, frivolous activity entered into for leisure, amusement and relaxation. However experts on child behaviour (Schaefer 1979; Landreth 1982; Axline 1989; West 1992 and McMahon 1992) all agree that for the child, play is more than just a pleasurable activity. Since children, particularly young children, have limited verbal skills they use play as a means of communication. Children use play to express feelings, explore relationships and to achieve self-fulfilment. Play is to the child what verbalisation is to the adult (Landreth 1982:45). In this study the term *play* is used in the broadest sense of the word.

1.8.3 Play Therapy

The significant differences between a child's normal play and play therapy are the therapist's presence in the play situation and the self-realisation and growth inducing process promoted by the therapist. Axline (in Landreth 1982:47) defines play therapy:

... a play experience that is therapeutic because it provides a secure relationship between child and adult, so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time.

For the purpose of this dissertation *play therapy* will refer to the activity in which:

- the child uses play to express his inner feelings
- the child (and/or the therapist) gains an insight into the problems which the child is experiencing
- the child experiences a catharsis by expressing such emotions
- the child is assisted in becoming more meaningfully involved in his life world, in attributing more realistic meaning to experiences and thereby developing a positive self-concept which in turn will assist him in the process of self-actualisation.

1.8.4 Reading/learning disabilities

The term *learning disability*, according to the American National Joint Committee for Learning Disabilities, refers to a heterogeneous group of disorders which are manifested by difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities (Bos & Vaughn 1994:353). These authors (1994:106) say that of the children suffering from learning difficulties the vast majority have reading problems. Reading is claimed to be the most important academic skill that a child has to acquire when he enters school. Other experts (Lerner 1976:234; Strother & Barlow 1985:29; Beck 1988:774) concur with the view that reading disabilities are by far the most prevalent learning disability. Some of these experts use the terms interchangeably when referring to the reading disabled child since most of the discussion found in the literature about learning disabilities in general applies to the reading disabled child. This study has focused on the reading disabled child but the term *learning disabled* is used at times to discuss generalised characteristics of the problem.

1.8.5 Aid programme

The aid programme which is used in this study is a comprehensive programme. It aims at assisting the child emotionally through play therapy and scholastically by means of a remedial reading component based on learning through play activities. The programme addresses both cognitive and affective aspects of the child's problem.

1.9 DEVELOPMENT OF THE STUDY

This chapter has focused on the awareness, analysis and formulation of the problem. The aims of the study have been stated; the demarcation of the field of study and method of research have been discussed. Key concepts have been defined and the development of the study explained.

Chapter two is devoted to the theoretical considerations of play therapy. The following aspects are explored:

- what is play?
- the stages of development and their relation to play
- what is play therapy?
- an historical perspective and the different approaches to play therapy
- various techniques of play therapy.

Chapter three is concerned with reading difficulties. It deals with the causes and effects of learning disabilities and how these affect the child's relationship structures.

The research design is explained in Chapter four. The compilation of the remedial programme is discussed. The inclusion of the affective component (the use of play therapy from a relation theory perspective) is discussed in detail. The selection and composition of the research group, methods of assessment, course of the study and evaluation of results are discussed.

Chapter five is devoted to the idiographic study. This chapter focuses on the practical application of the research design described in chapter four.

In the concluding chapter the findings are critically examined and evaluated in the light of the basic assumptions upon which the study was based. Suggested improvements and areas for further study are presented.

CHAPTER TWO

PLAY THERAPY

2.1 INTRODUCTION

Play therapy is a treatment favoured by many therapists who work with children with emotional and behavioural problems. Play is a pleasurable but necessary activity for a child. He learns through play. It serves as a form of relaxation and enjoyment and also as a means of communication. Through play a child expresses feelings which he finds difficult to verbalise. The therapist utilises this aspect of play for diagnostic and therapeutic purposes. The child's play enables the therapist to gain a better understanding of his client while also assisting the child to get to know himself better.

This chapter is devoted to an in-depth exploration of play therapy. After discussing the phenomenon of play experts' explanations of the term "play" are reviewed. The functions of play and the stages of child development and their relation to play are considered. An attempt is made to answer the question: what is play therapy? An historical perspective is given on different approaches to play therapy. In particular, the psychoanalytical, client-centred, behavioural and relation therapy approaches are discussed. A variety of play therapy techniques is explained.

2.2 PLAY

2.2.1 What is play?

Experts have been unable to give an exact answer to the question "What is play?". No universally acceptable definition has yet been formulated.

As Singh (1991:28) states:

The phenomenon called "play" is neither simple nor readily definable and theorists continue to debate its meaning.

Experts (Schaefer & O'Connor 1983; Axline 1989, McMahon 1992; Landreth 1993) concur that play is the child's natural medium of communication. Since children do not have sufficiently developed verbal skills to express their feelings they use play for this purpose. They also use play as a means of trying to understand and come to terms with their environment.

Zeece and Graul (1990:11) agree that an exact definition of what constitutes play is difficult to determine. They quote Rubin and colleagues who identify the following six criteria from research literature as characteristic of children's play behaviour:

1. *Play is intrinsically motivated*
Children play because they want to, not because they are required to by adults.
2. *Play involves attention to the means rather than the end*
The focus of play is on the activity rather than the end product.
3. *Play is dominated by the child*
Children gain a sense of mastery and self-worth because they are in control. They can be who or what they want to be, determining the course of their play.
4. *Play is related to instrumental behaviour*
The key here is pretence. They can pretend a block is a gun and shoot with it. Pretence helps to widen children's perspectives and lessen egocentrism.
5. *Play is not bound by formal rules*
Unlike games, the flexibility of real play allows children to change the rules as they play. A stool may be a table one minute and a bed the next.

6. *Play requires active participation*

Children must be actively engaged. Play requires them to move and create.

Schaefer and O'Connor's (1983:2-3) criteria of play behaviour concur with those quoted above and they include several other points:

1. *Play is pleasurable*

2. *Play is intrinsically complete*

It does not depend on external rewards or other people.

3. *Play is person rather than object dominated*

It is not aimed at acquiring new information about an object but rather at making use of the object.

4. *Play is highly variable across both children and situations*

5. *Play is non-instrumental*

It has no specific goal, purpose or task orientation.

6. *Play behaviour does not occur in frightening or novel situations.*

Anna Freud (1973:16), one of the first people to attribute significance to a child's play, remarks that " ... play is as important for a child as work is for an adult." McMahon (1992:1) says:

Play is not a mindless filling of time or a rest from work. It is a spontaneous and active process in which thinking, feeling and doing can flourish since they are separated from the fear of failure or disastrous consequences.

Gladding (1993:106) describes it as a "multi-dimensional concept". He claims it is necessary for mental health and says that during play the children (or adults) temporarily suspend reality and have fun enacting fantasies and getting to know themselves better.

It is important to understand what is meant by the term play and to be aware of its functions if it is to be used as a therapeutic technique.

2.2.2 Functions of play

Regarding the function of play Schaefer and O'Connor (1983:4) remark:

The idea of play having a function seems to run counter to its definition as non-instrumental and intrinsically motivated.

However, they add that the function is always secondary to play being pleasurable for the child who is seldom, if ever conscious of the function of his play. The child involved in play, is blissfully unaware that in his play he is, for example, learning about or gaining mastery over his environment or is involved in problem solving. Schaefer and O'Connor (1983:4) give four basic functions of play and these concur with what Landreth (1982:5-14) describes as perspectives of play:

1. *Biological*

Play can serve as kinaesthetic stimulation, exercise and energy release. It also assists the child to get to know and understand his environment and helps him to learn basic skills.

2. *Intrapersonal (Person-orientated - Landreth)*

Erikson and Solbin (in Schaefer & O'Connor 1983:4 and Landreth 1982:9) see this as the ego's attempt to deal with experiences by creating situations over which the individual can gain mastery. It coincides with Piaget's stage of cognitive development.

3. *Interpersonal (Life space-orientated play - Landreth)*

This type of play develops social skills. It deals with a child's interaction with objects and people and the role of play in structuring these. It can be used to assist the child to work out emotional problems and master anxiety.

4. *Socio-cultural*

Here the child imitates role-models in his play and this helps him to understand and come to terms with the structure of the society in which he lives.

Singh (1988:22-23) points out that Landreth's perspectives of play fit with the Relation Therapy view of the child:

Relationship with self	- Person-orientated play
Relationship with objects	- Life space-orientated play
Relationship with teachers, parents, peers	- Socio-cultural orientated play

Rogers and Sharpan (1993:5) suggest that different types of play and different play materials have different functions. They claim that all children have to be problem solvers. They learn while they are playing and play gives children a chance to practise what they are learning. They contend that this is why young children will repeat an action so often. A baby, for example, can spend a long time just putting a block into a box and taking it out again or a toddler will climb in and out of something over and over again. The child is trying to learn about his environment. He is learning about concepts like inside and outside and at the same time practising the skills he has learnt.

Rogers and Sharpan (1993:5) claim that playing at making and building are the result of a desire to feel in control of the outside world and the inner self. It gives children a sense of power to be able to build (and destroy) something. According to these authors this type of play is based on some inner urges such as "I feel like making a tower", or even "How does it feel to be tall?", "How does it feel to be small." Play with items such as pencils, pens and crayons, chalk, paint and clay encourage the child to express feelings and promote creativity. Dramatic play is often used by children to assist them in dealing with everyday problems.

It is important for the therapist to be aware of the various types of play in which a child indulges. Each different type of play is significant and can help the therapist to understand the client better. Bell (1990:45) gives a list of ten different types of play (compiled by the Nuffield Child Psychiatry Unit):

- * *Neutral play*: this is used to build up the therapeutic relationship
- * *Regressive play*: when the child plays at a level below his age and intellectual level this is often done to satisfy unfulfilled emotional needs
- * *Aggressive play*: he expresses pent-up aggression
- * *Projective play*: this is play used by the child to express feelings, fears and fantasies which he cannot express directly
- * *Imitative play*: representational play which uses themes imitating adult activities
- * *Social play*: co-operative play between children
- * *Constructive play*: here the child uses the play material purposefully to make or build something
- * *Creative play*: use of play material to make something unique
- * *Directed play*: here play is structured for a specific purpose by the therapist.

Play serves different purposes for a child at different times. The type of play in which the child indulges depends on his specific needs at that time and at his particular stage of cognitive, conative and affective development.

2.3 STAGES OF DEVELOPMENT AND THEIR RELATION TO PLAY

Children's play activities are directly related to the way they think and feel at any given time. Their play is affected by the level of cognitive functioning they have achieved. Many theorists have propounded ideas on the various stages of child development and how this affects their play. The most famous of these theorists is Jean Piaget.

2.3.1 Piaget

Piaget is well known for his theories on human development. His contention is that intelligence is a biological developmental process which permits the conceptual organisation of experience into complex systems of knowledge.

2.3.1.1 Stages of development

The idea of definite and ordered stages of development is one of the central theories in Piaget's work (Piaget 1977:xxiii). The major stages are:

- the sensory-motor stage (0 - 2 years)
- the pre-operational stage (2 - 7 years)
- the concrete operational stage (7 - 11 years)
- the formal operational stage (11/12 years onwards)

* Sensory-motor stage (0 - 2 years)

Sensory-motor intelligence develops in the first two years of life. To the new born baby the world is chaos, but starting with the use of reflexes and the first acquired association, the child succeeds in constructing a system of schemata capable of unlimited combinations.

Gradually as objects, causality, space and time are elaborated, a coherent universe follows the chaos of the initial egocentric perceptions (Piaget 1977:277).

* Concrete Operations Phase

- Pre-conceptual phase (2 - 7 years)

This phase is characterised by concern with the immediate surroundings and thought is linked to action. The child's thinking is transductive and moves from the specific to

the specific. His thoughts are strongly centred on one single characteristic and he cannot attend to more than one relation at a time. There is little logic in his thought and he cannot compare different relations. His thought is strongly animistic; lifeless objects are personified: "The tree got hurt."; "The chair bumped me." This is relevant in his play. He attributes human emotions to the objects he plays with. In this way his favourite teddy bear or toy dog becomes a "friend" and confidant and he will often tell this toy his about his inner feelings and fears.

- Concrete operations - proper (7 - 11 years)

An operation is an act of thinking (Vrey 1990:107). The child is now able to apply logical ways of thinking to concrete problems but cannot solve hypothetical problems which are totally verbal. New knowledge is either assimilated into existing schemata or new schemata are formed to accommodate the knowledge. At this stage play is not as self-centred and animistic as in the previous phase. While the child no longer sees play objects as having human emotions, he may use them to project feelings.

* **Formal Operations** (11/12 years upwards)

In this phase the child begins to acquire abstract logical thought. The transformation to this phase is marked by:

- the capacity for reasoning on hypotheses
- use of propositional logic whereby the individual can evaluate the validity of a train of reasoning independently of its factual content
- he can replace the concrete by symbolic representations (for example mathematical symbols)
- combined nature of operations (for example given two propositions they can be (i) both true, (ii) both false, (iii) one true, one false, etc
- reality can be inserted in a set of possible cases (Piaget 1977:394-395).

Although Piaget believed that each stage developed out of an earlier stage the early stages are not discarded, grown out of or displaced but "the later stage is rather

'grown into' and depends on prior attainment of earlier stages, hence the idea of necessity of order" (Piaget 1977:xxiii).

It is important for the therapist to be aware of the different stages of a child's development when working with emotionally and learning disabled children. If a child is not functioning at the age appropriate level it is the therapist's task to discover what is retarding the child's development. For example, children used in this study will be between the ages of seven and ten and are expected to be in the concrete operations phase. When observing their behaviour and play it is significant to note whether both are age appropriate and if not to ascertain where the child's problem lies. It is also significant that children in this phase use play to project feelings.

2.3.1.2 Piaget's views on play

Piaget (1977:113) says about play:

Play is a reality which the child chooses to believe in by himself ...
Childish play may therefore be said to constitute an autonomous reality, by which we mean that "true" reality to which it stands in contrast is far less true for the child than for us.

Piaget argues that while play is fiction for adults, it constitutes reality for the child. A child may believe in several "realities" each of which may be equally real in turn. He claims that the child can find himself in an egocentric or a social state. The child sees both these worlds as authentic with neither one supplanting the other (Piaget 1977:111). Within the broad outlines of Piaget's theory, development is largely away from ego-centricity towards objectivity. In other words, the very young child is completely ego-centric and so naturally is his play. As he develops, there is a gradual change towards objectivity (Atkinson 1983:169).

The different stages of play are affected by the child's concept of reality. This concept of reality can be divided into four phases. Piaget names these the stages in "the

evolution of modality" and they correspond more or less to the developmental stages identified by relation theorists (Vrey:1990).

* In the first stage, which coincides with the sensory-motor stage and ends between two and three years of age, reality is simply what Freud describes as the "pleasure principle" which deforms and fashions the world to its liking.

* The second stage, which extends from two to three years of age until seven to eight, marks the appearance of two heterogeneous but equal realities: the world of play and the world which the child observes. At the age of three the child begins to use expressions like "I think", "I believe" which indicate that he has detected a shade of difference between two kinds of existence - what is true and what is imagined. However, he does not try to prove whether his ideas correspond to reality: he just evades the question. The two worlds are juxtaposed, not hierarchised. Both are real for the child.

Play is often accompanied by talking but children tend to talk more to themselves. They talk incessantly to any one present but rarely take note of the other's point of view. They speak as if they were thinking out loud. This type of ego-centric behaviour is characteristic of young children.

* The third stage marks the beginning of a hierarchical arrangement of reality. The child begins to dissociate the world of direct observation from that of stories, fantasies and things never seen. At this stage there is a desire for a system and non-contradiction. The child observes the world and wants to make sense of what he sees. This is the phase of concrete operations and he is capable of logical thinking. The child's play and drawings are based more on the reality of observation. The child's reasoning is based on direct observation. He is still not capable of abstract reasoning.

* The final stage is the completion of the hierarchy as a result of the introduction of formal thought. The child becomes aware of various planes of reality: play, verbal

reality and observation are set in a hierarchy and are defined in relation to a single criterion, namely experience (Piaget 1977:111-113).

Just as the child's view of reality affects his level and type of play so it will influence his drawings. Looking at children's drawings reveals a great deal. Not only are drawings commonly used as a projective diagnostic technique, they can also give an indication of the child's level of development.

Piaget argues that the child's picture of the world is always influenced by his stage of development as well as other personal and immediate factors. For example: a young child in the pre-conceptual phase will draw objects which appear important in his or her life much larger. If, for example, the father in the house is very domineering he will be drawn much larger than the other members of the family (Piaget 1977).

In the early stages children's drawings are not characterised by visual realism. The child does not try to draw a faithful representation of what he sees but rather draws what he knows or believes to be real. The desire for accurate representations is found in the concrete operational phase when the child's thought processes become logical.

2.3.1.3 Conclusion

Piaget (1977:91) sees play as the spontaneous manifestation of thought. He argues that for the child, play is reality. As his level of intellectual development and his concept of reality alters, so his play will change. Initially, in the sensory-motor stage, his play is entirely egocentric and "pleasure-seeking". In the pre-conceptual phase dual reality exists for the child: that of the fantasy world of play and the world of observation. Both are equally real for him and he does not try to distinguish between them. By the time the concrete operational phase is reached, the child is beginning to distinguish between the world of observation and fantasy. This is the result of the desire for logical thought. In his drawings and play he distinguishes between the two but still engages in fantasy. By the time the final stage of formal operations is reached, the child is able to reason logically and think objectively.

2.3.2 Other theories on the development of play

Piaget's theories on the various stages of human development are widely accepted. They concur with ideas on child development propounded by other theorists like Freud, Erikson, Dicker-Drysdale and Peller (McMahon:1992:4-5), although each theorist gives the stages different names and descriptions which relate to his particular theory. For example:

Piaget	- sensory-motor stage
Freud	- oral stage
Erikson	- basic trust versus mistrust stage
Peller	- narcissistic stage
Docker-Drysdale	- primary experience.

Since a child's play is affected by his level of cognitive development, most theorists' descriptions of the development of play do not differ significantly from Piaget's. McMahon (1992:3) remarks that:

The development of children's play follows a predictable pattern and is linked to aspects of physical, intellectual, social and emotional development. It is necessary to recognise the developmental level which a child is at if we are to use play appropriately to help.

She differentiates the following developmental levels of play:

* Sensory Motor Play

McMahon (1992) quotes Winnicott who claims that a crucial part of the relationship between a mother and her baby is play. A baby starts "playing" from a very young age by touching and starting to explore its own and its mother's body. This is the stage of *sensory and motor play*. Play only concerns the present since the infant has no words, symbols or mental images to codify its experience. As the child grows older

he begins to use his whole body to experience its world: sand trickling through toes and fingers, the squelch of mud, smells, sounds and so on. Confidence and self-esteem are increased as the child begins to have a measure of control of himself and his environment. As the child grows, motor or physical play includes activities such as learning to run, jump, hop, throw, kick and catch a ball.

*** Exploratory and social play**

The play themes of one and two year olds often concern attachment and autonomy, separation and individuation. Games such as placing things into containers and taking them out again are common. McMahon (1992:12) quotes Crowe who describes this stage as one of in/out, up/down, push/pull, hide/seek. As the child grows up exploratory play includes making use of objects to solve problems. Through play children build up their knowledge of the physical world and this develops concepts of space, time, number, quantity and volume. Erikson (in McMahon 1992:15) noted the difference between boys and girls at this stage. Boys tend to build towers and make models involving much activity while girls create quieter scenes.

Children often talk aloud while playing but this is usually a monologue. Social play begins to develop in instances such as taking turns but they do not play with other children.

*** Symbolic or pretend play**

This level of play is supported by language skills. It begins when objects take on symbolic meaning. For example a toy animal can be used as a symbol of comfort or the child may tell the toy what to do just as his mother tells him what to do. Imitation, which becomes evident in the first year of life, is expanded. Children start to take on the roles of others. The imaginative or "as if" quality of play develops at this stage. At first children have the real objects, later progress to toys and finally true fantasy play develops. An example of real fantasy play is when children have invisible friends.

Dramatic play also occurs at this stage and social cooperation is important for each child has to have a role and support others in their roles.

Later on children start to play *games with rules*. These usually begin around the age of seven and often replace purely imaginative games.

2.3.3 Conclusions

It is important to note that the stages of play overlap. It is obvious that a child cannot indulge in exploratory play before he has been through the sensory-motor phase and social play has to precede pretend play. However, the child can, for example, have reached the phase of symbolic and pretend play but he still continues with motor and physical play in some instances and exploratory play at other times.

It is important that the therapist is constantly aware of the different levels of child development and ensures, when evaluating the child, that play is age appropriate. Inappropriate play behaviour is often the result of an emotional upset of some kind. This type of behaviour is evidenced in children whose level of play has not developed in accordance with the age and intellectual level of the individual. It is also seen in children whose play has regressed and become "babyish" for their age, for example when an older child suddenly reverts to purely sensopathic play or starts sucking a bottle and pretending to be a baby. Children who cannot play at all or children whose play is not age appropriate are usually in need of some sort of emotional support and therapy.

2.4 PLAY THERAPY

2.4.1 What is play therapy?

Neither the question "What is play therapy?" nor the question "What is play?" as discussed earlier, is easy to answer. While experts (Schaefer & O'Connor 1983; Axline

1989; McMahon 1992; West 1992; Landreth 1993) agree on the value of using play in therapy, none gives a truly comprehensive definition of play therapy. It appears that the concept "play therapy" is too complex to define adequately in a few lines.

Axline (1989:8) describes it as "a method of helping problem children help themselves." She remarks that:

Play therapy is based upon the fact that play is the child's natural medium of expression. It is an opportunity which is given to the child to "play out" his feelings and problems just as, in certain types of adult therapy, an individual "talks out" his difficulties.

West (1992:12) describes it from a different perspective:

When we talk about play therapy ... we imply a holistic approach, using play as a means of "helping", in a non-evasive way, the physical, spiritual, emotional and cognitive aspects, both conscious and unconscious, taking account of the past, present and future of the "whole" child. Play therapy is concerned with the child's *feelings*, not just their behaviour.

The basic differences between a child's normal, everyday play and play therapy are:

- the presence of the therapist who creates the atmosphere of warmth and acceptance
- the fact that the child develops an awareness and eventual acceptance of his problems and a healing process takes place.

The purpose of play therapy is twofold:

- the child's play can be used by the therapist as a diagnostic technique. The child will often reveal anxieties, frustrations and problematic relationships in his play. By observing play, the therapist can get a better understanding of the child's world and discover where his problems lie
- the play process is itself therapeutic. Playing out his troubles in the empathetic climate of the playroom has a cathartic effect upon the disturbed child.

The primary objective of play therapy is not so much to solve the child's problem as to help him grow. Landreth (1987:257-258) gives several objectives of play therapy:

- to establish an atmosphere of safety for the child which is promoted by the consistency of the counsellor and the setting of limits
- to understand and accept the child's world
- to encourage the child to express his emotions
- to establish a feeling of permissiveness
- to facilitate decision making by the child
- to assist the child to assume responsibility and develop a feeling of control
- to express in words what is experienced in the child's play behaviour.

The basis of successful therapy with children is the child/therapist relationship. Oaklander (Campbell 1993:52) believes that the therapist's acceptance of, and respect for, the child can, in itself, be therapeutic. She remarks that, at times, therapists feel they have not been able to do anything specific or achieve anything significant. Her contention is: the mere fact that there is someone who listens to the child with understanding and acceptance for what he is, is a wonderful experience for any child, particularly for an emotionally disturbed child.

Gladding (1993:113) remarks that while play therapy is used extensively and successfully there are limitations. He cites lack of well-formulated research and proven results to back up affective based theory and resistance in older clients. He

says a certain amount of tension is necessary in therapy as clients have to face and remedy their situation. In play therapy, the child's energy may be diverted away from the problem and personal exploration towards the more pleasurable aspects of play. In the play situation the counsellor and child do not always relate the play procedures to the child's personal life. Nevertheless, he claims play therapy can be a workable, enjoyable and productive experience.

A review of the literature reveals many different approaches towards and perspectives of play therapy. However, experts agree that certain basic criteria, such as the importance of the therapeutic relationship, are essential if play therapy is to succeed. Osterweil (1986:224) sums up many of the approaches to play therapy by saying:

The perception of play as the child's communication and "work" is shared by all approaches to psychotherapy with children. While these approaches differ in many respects (for example, the role of interpretation), they all view play as a curative factor in the context of a therapeutic relationship.

In order to understand more precisely what play therapy is and the rationale behind the different approaches adopted by various therapists, it is necessary to look briefly at the historical background.

2.5 HISTORICAL PERSPECTIVE AND DEVELOPMENT OF APPROACHES TO CHILD PSYCHOTHERAPY WITH PARTICULAR EMPHASIS ON PLAY THERAPY

Johnson, Rasbury and Siegel (1986:109) claim there are only three major psychotherapeutic approaches which are widely used in the treatment of children: the psychodynamic, client-centred and behavioural models. Schaefer (1985) concurs, maintaining that the three major approaches to play therapy are: psychoanalytical, relationship or client-centred, and the structured approach which has elements of the

behaviourist methods incorporated into it. Since these approaches, particularly the psychodynamic and client-centred schools, have had an influence on the development of play therapy, they and relation theory will be briefly discussed here.

2.5.1 Psychoanalytic approach

2.5.1.1 Basis of Psychoanalysis

Sigmund Freud's theories of psychoanalysis, developed around the turn of the century, have formed the basis for modern psychological schools of thought. To understand the psychoanalytical approach to play therapy it is necessary to look briefly at the theory upon which it is based. In an earlier paper Freud (1950:107) describes it as follows:

Psychoanalysis is the name (1) of a procedure for the investigation of mental processes which are almost inaccessible in any other way, (2) of a method (based upon that investigation) for the treatment of neurotic disorders and (3) obtained along those lines which is gradually being accumulated into a new scientific discipline.

Freud had a deterministic view of human nature. He maintained that man's behaviour was determined by irrational forces, unconscious motivations, biological and instinctive drives and certain psychosexual events which occurred during the first six years of life (Corey 1991:96). Freud postulated that the personality was divided into three parts: the id, ego and superego.

The *id*, Freud believed, is the primary source of psychic energy and is the seat of all the instincts. It lacks organisation and is blind, demanding and insistent. It cannot tolerate tension which it tries to discharge immediately. It is ruled by the *Lustprinzip* whose primary aim is to reduce tension and avoid pain. The id is illogical and immoral. Freud (1964: 73) describes it as, "the dark inaccessible part of our personality". He said most of its negative character could only be described in contrast to the ego.

The *ego* is the part of the personality which is in contact with the world of reality. Freud (1964:75) sees the ego as:

... that portion of the id which was modified by the proximity and influence of the external world, which is adapted for the reception of stimuli and as a protective shield against stimuli ...

It governs, controls and regulates the personality. It mediates between the instincts and the environment. It is ruled by the reality principle and is realistic and logical. The ego is the seat of intelligence.

The *superego* represents the ideal rather than reality. It is the moral aspect of the personality and decides what is right and wrong. The superego represents traditional moral values, striving for perfection (Corey 1991:96-98). Freud (1964:60) introduced the term *superego* as he felt there should be a separation of the "observing agency" from the rest of the ego structure. Freud (1964:66) explains that the functions allotted to the superego are those of self-observation, conscience and of maintaining the ideal.

Freud (1964:353) claimed that early development was all important:

... psychoanalytic research has had to concern itself, too, with the sexual life of children, and this is because the memories and associations arising during the analysis of symptoms [in adults] regularly led back to the early years of childhood.

He postulated that various areas of the body emerge as erogenous during the different phases of development.

- * The first phase is the oral phase which occurs during the first year of life
- * The second phase is the anal phase which is from approximately 1 - 3 years of age and is connected to toilet training and the control of bodily functions

- * The third phase, 3 - 6 years, is the phallic stage when the child becomes preoccupied with the genitals and sexual pleasure
- * From 6 - 12 there is a latency period and final phase is the genital phase and occurs during puberty (Freud 1964:369-370).

Freud believed that most men are unhappy and this unhappiness is the result of inadequate or traumatic experiences in early childhood. These are often the result of conflicts between instinctual drives and social demands, in other words, between libidinal impulses and sexual repression (Freud 1964:484).

The ego deals with these by using defence mechanisms to help the individual cope with the anxiety which results from tension between the id, ego and superego. Neurotic symptoms develop and the person becomes psychologically ill if he cannot cope satisfactorily with these tensions. Freud (1950:108) explains neuroses as expressions of conflicts between the ego and those sexual impulses which the ego sees as unacceptable. These impulses then become repressed and the inhibited libido finds others ways of expressing these impulses, often resulting in neurotic behaviour.

The aim of psychotherapy is to make the person aware of these frustrations which are buried in the unconscious (Corsini 1973:11) Freud believed that only when these unconscious motives are made conscious can they be understood and controlled. Therapy should also help to strengthen the ego so that instinctual cravings do not get the better of it.

The main techniques which Freud used were:

- * Free association: this was considered one of the basic tools to open doors to unconscious wishes, fantasies, conflicts and motivations (Corey 1991:101)
- * Interpretation: here the therapist explains to the client the meanings of his behaviour

- * Transference: negative, unacceptable emotions, often directed towards parents, which are experienced in early childhood and which are repressed and transferred towards the therapist (Freud 1978:494)
- * Dream analysis: Freud considered dreams as symbolic representations of unconscious needs and desires.

2.5.1.2 Treatment of children

Child psychoanalysis began with Freud's treatment of "Little Hans" (Johnson *et al* 1986:113). He was a 5-year old boy who had a phobia about horses. Freud's analysis of "Little Hans" provided the prototype of child analysis and it was conducted on the same lines as adult analysis (Young-Bruehl 1988:169).

However, as early therapists, in particular Anna Freud and Melanie Klein, began working more and more with children, they realised that changes had to be made in psychoanalytic techniques. Free association and dream analysis rely on verbal communication. Many children, particularly very young children, do not have the communication skills necessary for these techniques to succeed. In addition it was found that it was necessary for the therapist to become more actively involved (Johnson *et al* 1986:114). The therapist, therefore, could not remain neutral. This meant that transference could not take place to the same extent as in adult analysis. In addition the young child does not have unresolved conflicts but is engaged in primary conflicts.

The result was the development of a separate branch of psychoanalysis for children. It began with the writings of Anna Freud and Melanie Klein.

2.5.1.3 Play therapy from a psychoanalytical approach

1. Von Hug-Hellmuth

Hug-Hellmuth was the first person to refer to play as a therapeutic technique. As early as 1913 she used toys and drawings as a means of eliciting verbal responses from

children. However, she had no fixed rules as regards its technique or application (Klein 1989:XV). She described the importance of children's self-created fantasies as a source of information about their underlying psychodynamics (Schaefer & O'Connor 1983:259).

2. Anna Freud

Coles (1992:75) remarks that Anna Freud had no reason to forsake the basic psychoanalytic ideas of her father. She accepted the theory that children go through a progression of stages as they become aware of and deal with the intake of food, control of bodily secretions and waste, and a developing sensuality and sexuality. However, she did not allow the terms "phallic" and "oral" to dominate her thinking as they did other psychoanalysts of the day. She looked at the ego's progression and its slow mastery over the id and the world of the child and she categorised two basic drives: the sexual drive and the aggressive drive. She viewed them as opposing forces with more or less equal status as instincts (Freud 1992). She explains this by saying that the child's primitive sexual life is very aggressive and the aggressive instinct develops with the sexual instinct.

In her work with children, Anna Freud soon came to realise that she had to adopt a different approach from the approach used with adults. Anna Freud argues that one of the main reasons for this was because it was never the child himself who decided he should come for analysis. Children were always referred by parents or other adults. Young children seldom perceive that they have a problem. Freud remarks that such a situation lacks all the criteria which have proved necessary for successful adult therapy (1946:5).

Anna Freud advocated a "preparatory period" in which the therapist builds up a good rapport with the child and gains the child's confidence. Here she often used play as a way of luring the child into therapy and of building up the relationship. She believed that play was a valuable tool for observing a child and getting to know its world:

There is this advantage over the observation of real conditions, that the toy environment is manageable and amendable to the child's will, so it can carry out all the actions which in the real world, so much bigger and stronger than itself, remain confined to a fantasy-existence (1946:28).

She goes on to say that play is almost indispensable for getting to know small children who are not yet capable of verbal expression. Unlike Melanie Klein, Anna Freud did not see all child's play as symbolic and did not feel it could be equated with free association which was used with adults. Freud argued that a child's play could be a mere re-playing of real events or even just pure exploration (McMahon 1992:32). Freud argues against the symbolic interpretation given to play by therapists of the Kleinian school. They claim that if, for example, a child overturns a lamp-post, this is seen as symbolic of an aggressive act against the father. Freud argues that a child may have seen such an incident in the street the day before (Freud 1946:29).

Freud (1946:31) also argues that transference, of the kind observed with adults, does not occur with children. She admits that a "positive transference" is a prerequisite for working with a child and agrees that the child can build up negative emotions towards the therapist, particularly when repressed material is brought up from the conscious. However, the child does not exhibit the same type of negative transference as the adult who is undergoing psychotherapy.

Anna Freud's ideas on the analysis and treatment of children with emotional problems have had a major impact on modern psychological schools of thought. While many scholars have discarded the psychoanalytical approach to child analysis Freud's emphasis on a strong positive relationship between child and therapist is now commonly accepted, as are her ideas on the use of play and play therapy.

3. Melanie Klein

McMahon (1992:33) remarks that Klein's most significant contributions to the psychoanalysis of children have been her explanation of the origins of the child's emotions which she traced back to infancy and her specific use of play in therapy. Klein

(1989:7) claimed that children, even very young children, have feelings of guilt just as adults do, although analysis of children differs from that of adults for three reasons:

- * their relation to reality is weak
- * unlike adults, there is often no inducement for them to undergo analysis because they do not feel "ill"
- * their command of language, which is the principal instrument of analytic treatment, is not sufficiently developed for them to express themselves adequately.

For these reasons Klein (1989:8) felt it necessary to find other methods to understand the child's unconscious mind:

These special characteristics of the child's psychology have furnished the basis of the technique of play analysis I have been able to work out. The child expresses its fantasies, its wishes and its actual experiences in a symbolic way through play and games.

Klein (1989:8) saw play as the child's most important medium of expression. She argued that a child's play could be used as the equivalent of free association in adults. As the child plays it talks as well and Klein believed that this talk had the same value as adult association. She contended that a child's choice of toys was symbolic and that one toy could have many different meanings. For example in her treatment of a little girl, Rita, the child's doll was seen at different times to represent, the penis, a child stolen from her mother or the child herself.

In the Kleinian approach interpretation begins early in the psychoanalytic process. Here everything that the child does or says is seen as being invested with symbolic meaning. His play is seen as being affected by the working of the unconscious and not merely as simple, uncomplicated play. The therapist confronts the child with the symbolic interpretation. For example in her case history of a little boy, Peter, she

describes how he got little cars, carts and horses and made them bump into each other. The therapist then suggested to the child that this was representative of his parents having sexual intercourse (Klein 1989:16).

Klein (1989:18) believed that, if the actual situation in play analysis was treated as a transference situation and its connections with the original experience or fantasy were established then the child would have the opportunity of living out and working through the problematic situation in the "safe" world of play. She believed that by doing this the child uncovered infantile experiences and this helped to resolve emotional problems and allow normal development to proceed. Klein argued that children develop a transference neurosis just as adults do, provided the correct methods are used.

Klein is remembered as one of the first therapists to use play therapy as a means of gaining insight into a child's world. Johnson *et al* (1986:114) claim her real contribution was her innovative use of play as a mode of expression in child analysis.

They argue that most of her ideas are given little credence in contemporary psychoanalytic thought. This is largely because of her subjective, psychoanalytical interpretation of child's play which she equated with adult free association.

4. Modern approaches

Modern psychoanalytic approaches to play therapy are more flexible and not rigidly devoted to Freud's libidinal theory. However, the sexual and aggressive impulses are still seen as playing a significant role in child development (Johnson *et al* 1986:116). These authors argue that contemporary thought reflects the basic views of Anna Freud.

Winnicott and Erikson both believed that play is therapeutic and both developed Anna Freud's theories of play. Winnicott (1977) used psychoanalytic interpretation in his case studies. He also saw the value of allowing creative play which could in itself be therapeutic. Erikson recognised that an excess of emotion, excitement or anxiety could disrupt play and he saw this as similar to resistance in adult therapy. The

therapist must try to interpret this for the child and put it into words so that he can understand it (McMahon 1992:34-35).

Kottman and Johnson (1993:42) describe how the rationale, media and strategies of play therapy are combined with the techniques and concepts of Adlerian play therapy. Allan and Brown (1993:30) explain how Jungian theory can also be applied to play therapy by allowing unconscious free expression through fantasy play and games.

The symbolic interpretation of children's choices of toys and games is used by many therapists in their analysis of children's problems. The Scenotest, for example, designed by von Staabs, and based on the Freudian theories of the unconscious, is widely used by many therapists to great effect. Von Staabs (1991:1) says of it that it is "... a way of gaining a concrete and quick look at a patient's *unconscious* problems and conflicts."

2.5.1.4 Summary and evaluation

While most modern approaches to the treatment of emotional disorders of childhood have developed from the psychoanalytic views of Anna Freud and her contemporaries it would appear that traditional psychoanalysis is not extensively used at present. Johnson *et al* (1986:116) claim that there are few psychoanalytical practitioners in America today. One reason which they cite for this is the expense and the length of time taken to effect the treatment. Another argument against it is the subjective interpretation which is given to the child's actions. For example, Winnicott (1977) in his work with a little girl called The Piggie, gives a symbolic interpretation to all the child's play and actions and never works from the little girl's frame of reference. This is illustrated in the following example from Winnicott's (1977:10) case study. The child was referred to him when she developed emotional problems after the birth of a baby sister. The first thing the child did was to pick up various toys in turn. The therapist says they were mainly trucks and engines and each time the little girl said, "Here's another one ..., here's another one" The author interprets this as meaning another baby. Here he has worked from his own frame of reference using information he

obtained from other people rather than from what the child said. Many therapists find this type of analysis too subjective. It is criticised because everything is seen from the therapist's frame of reference rather than the child's .

2.5.2 Client-centred approach

The client-centred or non-directive approach to psychotherapy was developed by Carl Rogers in the 1940's. The work of other non-directive authors is also discussed.

2.5.2.1 Carl Rogers

Two aspects of Rogers' work are considered: his theory and approach to psychotherapy, and the treatment of children and the use of play therapy.

*** Theory and approach to psychotherapy**

Rogers drew on many different schools of thought and personality theories, including the psychoanalytical view, to formulate his theory. Rogers (1942:28) explains the difference between his approach and other schools of thought of his time, maintaining that it has a different goal:

It aims directly towards greater independence and integration of the individual rather than hoping that such results will accrue if the counsellor assists in solving the problem. The individual and not the problem is the focus. The aim is not to solve one particular problem, but to assist the individual to *grow*, so that he can cope with the present problem and with later problems in a better integrated fashion.

Rogers (1942:29-30) characterises his approach with the following four points:

- therapy is a matter of freeing the individual, of removing obstacles so that he can develop normally

- this approach emphasises the emotional aspects of a situation rather than the intellectual. Maladjustments are not the result of not knowing but are caused by emotional blocking
- more emphasis is placed on the immediate situation than on the past
- he sees the therapeutic relationship as a growth experience.

Rogers (1942:87-89) claims that within this relationship the individual learns to understand himself, make significant, independent choices and relate successfully to another person. The therapeutic relationship between client and counsellor is one of the core issues in client-centred therapy. As the name implies the client is all important. The therapist's task is merely to create the correct climate and to help the client to come to a better understanding of himself by reflecting his feelings. The climate which the therapist has to create should be one of warmth and responsiveness so the client can feel completely accepted. He must feel he has the freedom to express all his emotions in a permissive environment where there is no pressure or coercion.

Rogers and Stevens (1967:90-94) mention the following as important characteristics in a therapeutic relationship:

- *Congruence*: the relationship must be genuine without "front" or facade. The therapist must be able to communicate the feelings the child is experiencing.
- *Empathy*: the therapist must try to get an accurate empathetic understanding of the client's private world and he should be able to communicate this to the client. Rogers (1967:91) describes it as being able to "... sense the client's inner world of private personal meanings as if it were your own, but without losing the *as if* quality. (This) is empathy and this seems essential to a growth-promoting relationship."
- *Positive regard*: the counsellor must prize the client as a person and must show he cares for the client in a non-possessive way. The client must realise that he is respected as a separate individual.

- *Unconditionality of regard:* Rogers explains that constructive change and development are more likely to occur if the counsellor displays an outgoing, positive feeling towards the client without reservations or evaluations. He should not make judgements of the client's behaviour.

Rogers believed that if the correct climate were established, under these conditions, growth could take place within the individual. His basic view of human nature was that man has an inherent tendency towards self-actualisation. The individual has an innate drive to develop all his capacities in ways that serve to enhance and maintain growth. Rogers claimed that in the individual there is this drive towards maturity, independence and self-direction. His theory is based on the assumption that the individual of any age has the ability to solve his own problems satisfactorily. He also has a striving for growth which makes mature behaviour more acceptable to him than immature behaviour (Schaefer & O' Conner 1983:23).

Rogers did not place as much emphasis on structures of personality as Freud. He distinguishes two entities, namely, the "organism" and the "self". The organism is the focus of all experience, experience being everything the organism responds to. All consciously and unconsciously experienced events constitute the phenomenal field which can be thought of as subjective reality (which may or may not concur with "true reality"). A sense of self develops out of this phenomenal field as a result of experiences. The self or self-concept is the individual's view of what he or she is. Rogers sees the self-concept as consisting in an organised conceptual pattern of the "I" or "me" together with the values attached to these concepts. Every individual has an "ideal self" and the discrepancy between the ideal self and the view the individual has of himself affects his self-esteem or self-value (Rogers & Dymond 1969:55). The organism's primary motivation is a striving towards self-actualisation.

* **Treatment of children and the use of play therapy**

Rogers is not primarily associated with child psychotherapy, although his client-centred therapy has been used extensively in the treatment of children. Axline is the best

known proponent of this method of psychotherapy. However, Rogers did make use of play therapy in his treatment of children. He claimed that play therapy was the most effective form of psychotherapy for very young children and that counselling using a purely verbal approach was not really effective until the ages of ten to twelve "...since verbalisation of significant feelings is not easy for a child" (1942:74).

He claims that play therapy is similar to verbal counselling. The structuring of the relationship is similar except that the relationship is defined more through action than through words. In both, full expression can be given to forbidden and repressed attitudes and the client gains a gradual measure of insight. Rogers believes that it is important to set limits but within these limits the child is free to express any type of feeling. For example he may smash clay figures, shout, spill water and so on. Rogers remarks that often after such aggressive actions a child will glance up with a guilty look expecting some sort of punishment or rebuke and initially is surprised when none is forthcoming. Gradually he realises:

The fact that it is his time, to be used as he wishes, without pressure, direction, or coercion, is also learned through experiencing this freedom, rather than through verbal definition (Rogers 1946:95).

The therapist's warm acceptance of the child helps the youngster to begin to accept himself.

2.5.2.2 Virginia Axline

Virginia Axline is the name most associated with non-directive or client-centred play therapy (Schaefer & O'Connor 1983; Johnson *et al* 1986; McMahon 1992; West 1992). Axline (1989:15) describes non-directive play therapy as:

... an opportunity that is offered to the child to experience growth under the most favourable conditions. Since play is his natural medium for self-expression, the child is given the opportunity to play out accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion.

Axline claims that by playing out these feelings the child brings them out into the open and is able to face them. He then learns either to control the emotions, or abandon them. The child comes to accept himself and is better able to achieve self-actualisation. The play therapy situation in which the child finds himself is a unique experience. He is completely accepted by the therapist in a warm, empathetic, permissive atmosphere where there are no adult rebukes, restraints, criticisms or even suggestions.

Axline (1989:69-70) has eight basic principles which are still followed today by most non-directive play therapists:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist must accept the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child can express his feelings completely.
4. The therapist must be able to recognise the feelings which the child expresses and must reflect these back to the child so that the child gains insight into his behaviour.
5. The therapist must maintain a deep respect for the child's ability to solve his own problems if given the opportunity to do so. It is the child's responsibility to make choices and institute change.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way and the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such.

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

These points succinctly sum up the most important aspects of non-directive play therapy.

Axline (1989:72) stresses that establishing a good rapport in the therapeutic relationship is one of the most important aspects of non-directive therapy. This is achieved by creating a warm, friendly, permissive atmosphere with few limitations. The child develops a sense of security in such an environment. The therapist never interferes with what the child does, nor makes suggestions. Axline (1989:21) remarks that a child's free play is an expression of his personality. In this situation he does what *he* wants to and orders the play world as he likes.

The therapist's task is to be alert and sensitive, and to reflect the child's feelings back to him so that he can understand them. The sessions are completely unstructured: the child receives no guidance on what is considered morally acceptable behaviour.

The child does not come to therapy of his own accord but usually because he has been sent by an adult. He is seldom aware that he has a problem. However, Axline (1989:21) contends that it is not necessary for the child to know he has a problem in order to benefit from therapy. She claims that many children have benefitted from therapy without realising that it was anything more than just a play period. These children have exhibited more mature behaviour after therapy but have at no time been made aware that they have a problem. As Singh (1988:45) remarks, diagnosis is not particularly important to the client-centred therapist. Unlike the psychoanalysts, Axline and her followers do not place much importance on the origin of the problem. Axline (1989:21) argues that what happened in the past is past and it is the present that is important.

Taking therapy back into the individual's past rules out the possibility that he has grown in the meantime and consequently the past no longer has the same significance that it formally had. Probing questions are ruled out for the same reason. The individual will select the things that are important *when he is ready to do so*.

Axline (1989:54) also believes that when a child's drive for self-realisation is misdirected this results in maladjustment. Such a child is then described as a "problem child". The aim of non-directive therapy is to assist the child to redirect this drive so that he can become a truly self-actualised person.

2.5.2.3 Modern approaches to non-directive therapy

Johnson *et al* (1986:128) point out that client-centred therapy, unlike child psychoanalysis, is not marked by rival schools of thought. The approach outlined by Axline remains essentially unchanged and is still widely in use today. Her guidelines on how play therapy should be implemented continue to be the best single guide for client-centred therapists working with children. Schaefer and O'Conner (1983:53-62) quote numerous studies which have been conducted using the client-centred approach to play therapy. It would appear that it is still widely in use today. Many therapists, like Schaefer (1985:58), believe that when using client-centred play therapy the counsellor must follow all the tenets of the approach and should not try to direct the child's discussion or behaviour in any way. He claims that if there is intervention from the therapist, the full potential of the method will not be utilised and the best effects will not be achieved. He admits that in certain instances other methods can be incorporated but these must be used at different times. The child must understand that: "on this day we play" and play must be completely undirected and "on this day you will receive training in social skills".

Other therapists differ from Schaefer, postulating that some aspects of client-centred tenets can be incorporated into a more directive method. Gumaer (1984:65-67) refers to the "play process" which he describes as both child-centred and counsellor-directed.

The counsellor dictates the speed and direction of the therapy. Many aspects of this approach are identical to the client-centred approach:

1. The first stage of the play process is creating a warm permissive atmosphere in which the child can explore his feelings. The counsellor responds to the child's feelings. He may ask questions but, as with traditional non-directive therapy, he must not give advice, make judgemental statements or indicate to the child how he should behave. During this stage he develops hypotheses about the child's problem.
2. During the second stage the counsellor becomes more directive. Once the relationship of trust has been established he introduces into the play process certain toys which have a high probability of eliciting feelings and behaviours which the therapist feels may be related to the child's problem. At this stage the therapist merely reflects the child's feelings.
3. In the third stage the counsellor is more certain about the child's problem and therefore engages in systematically structured series of play sequences that encourage the child to face the area of conflict.

2.5.2.4 Summary and evaluation

Schaefer and O'Conner (1983:53) remark that in comparison to other therapeutic approaches considerable research has been done into client-centred play therapy. They claim that it has consistently shown itself to be an effective form of treatment for emotionally disturbed children.

There can be no doubt that Axline's child-centred approach has been successful in treating children and has profoundly affected contemporary thinking about play therapy. Many of her basic principles are almost universally accepted as essential in any play therapy situation. For example:

1. The establishment of a facilitative climate to build up a good rapport with the child as soon as possible.
2. The complete acceptance of the child (although not necessarily his behaviour).
3. The establishment of a feeling of permissiveness so the child feels free to express himself.
4. The importance of the therapist being alert and sensitive to the feelings which the child is expressing and of reflecting these feelings accurately back to the child.

However, not all therapists agree with Axline that therapy cannot be hurried along or that the therapist should not direct the course. One of the main criticisms of a completely non-directive approach is that it can be time consuming. Gumaer (1984:66) claims that the Axlinian approach can be effectively used in mental health clinics and child guidance centres where time is not a telling factor. He remarks that sessions where the therapist follows the child's lead sometimes require a full hour a week for a whole year before the therapy is completed. In the school counselling situation no therapist can spend this amount of time on a single child. McMahon (1992:31) concurs with Gumaer. She contends that the client-centred approach offers "... great hope of recovery to some deeply disturbed children." However, she adds that "... its drawback is that it can be a very slow process and there may be few workers who have this time to offer." Gumaer advocates the "play process" as an alternative since it includes most of the important principles of the client-centred approach but, being partly counsellor directed, is less time consuming. Oaklander (Campbell 1993:57) also adopts this approach. She describes her methods as being, "... like a dance. Sometimes I lead, sometimes the child leads". She claims that the child needs the control and power (which is provided by totally non-directive therapy) but at times the therapist needs to be directive.

Another criticism which has been levelled against non-directive therapy is the complete absence of any form of normative direction for the child. As Wiechers (in Oosthuizen, Petrick & Wiechers 1985:109) remarks:

Rogers' theory and method meet educational criteria such as involvement, attribution of meaning, empathy and acceptance of responsibility. On the other hand, the principles of authority and recognition of norms do not feature prominently.

2.5.3 Behaviourist approach

This approach will be discussed briefly as play therapy plays only a small part in the behaviourist approach to child therapy. All behaviour is seen as responses to external and internal stimuli. Skinner, one of the early behaviourists, believed that changes in behaviour are brought about when a particular pattern of behaviour is followed by a particular consequence. If the consequence is positive the behaviour will be reinforced while if the consequence is negative and harmful to the individual that particular behaviour pattern will be extinguished (Corey 1991).

Behaviour therapy attempts to modify current responses that interfere with the individual's adaptive functioning. Johnson *et al* (1986:139) state that although there are many different approaches they all aim to change dysfunctioning patterns of behaviour. They are not concerned with past history but focus on the relationship between problem behaviour and its consequences.

Techniques such as operant conditioning, used in behaviour therapy are not appropriate in play therapy. As McMahon (1992:48) states:

The deliberate use of behavioural methods within play therapy seems to be an unusual intervention and a clear departure from classical play therapy.

While a behaviouristic approach to play therapy would be completely opposed to Axline's non-directive approach, there are instances when some techniques can be applied in more structured play therapy. For example, systematic desensitisation can be used in play therapy when treating certain phobias. For instance, if a child has a

neurotic fear of dogs the child can gradually be encouraged to cope with the fear by first looking at pictures, then playing with toy dogs. Using toys he then enacts situations involving dogs which he finds traumatic, and so on until he is confronted by a real dog. Positive reinforcement can also be applied in a structured play situation.

The uses of behaviour techniques in play therapy are limited. Generally play therapy appears to be more effective when the child is allowed to play in a semi or completely non-directive environment and to express himself without much interference from the therapist.

2.5.4 The release/structured approach

This approach is not related to any specific school of thought. It was introduced by Levy in 1939. It was referred to as "release therapy". Schaefer (1985:98) explains it as follows:

Rather than allowing children to play freely with a variety of toys and material, Levy controlled the play by selecting a few definite toys which he felt the child needed to work out a particular problem.

Schaefer (1985:99) mentions three forms of release therapy:

- * simple release of instinctual drives by encouraging the child to throw objects, burst balloons or suck a bottle
- * release of feelings in a standardised situation such as sibling rivalry by presenting a baby doll getting the mother's attention
- * release of feeling by recreating in play a situation which in real life is very stressful.

If, for example a child had night terrors from watching monster films, the child is given monsters to play with or if the child has a fixation about toilet training, he would be given dolls, a toy toilet, brown clay and nappies. The therapist allows the child to play

freely but sometimes plays with or for the child and reflects feelings as well as asking the child how the dolls feel. In this way the child can release pent up emotions.

2.5.5 Relation therapy approach

2.5.5.1 Introduction

Relation theory approaches therapy from a psycho-educational perspective. It is based on the client-centred approach. The therapist always works from an external frame of reference, in other words, the child's frame of reference. The basis of this theory is that the child should never be seen in isolation but rather, he must be seen in relation to significant others and the world around him.

Aangesien die kind as kind met probleem sentraal staan, word hy voortdurend as opvoeding gesien en ontmoet. As die probleemarea effens van die kind na byvoorbeeld ouer-kind-relasie of ouer-ouer-relasie verskuif, bly die perspektief nog dieselfde. Die verhouding tussen ouers byvoorbeeld moet herstel word sodat die kind in 'n klimaat kan leef waar hy sy moontlikhede kan verwerklik (Jacobs & Vrey 1982:10).

Psychotherapy must take place within the psycho-educational perspective. The essences upon which this structure is built can be divided into three major categories:

1. The child as a person
 - the I
 - the self
 - self-identity
 - self-concept

2. Activities necessary for becoming a mature, responsible adult
 - attribution of meaning
 - involvement
 - experience
 - self-actualisation

3. Psycho-educational requirements
 - relationship formation
 - the educational climate.

2.5.5.2 The essences of the relation therapy approach

* The I

Jacobs and Vrey (1982:16) quote James, Sullivan, Cooley, Mead and Bugental who argue that the self is divided into the *I* and the *me*. The *me* is the object of experience known to the conscious. It includes the physical body, behaviour, memories and feelings. It has no power of its own and is subject to the *I*. The *I*, on the other hand is the subjective or "pure ego". Bugental (Jacobs & Vrey 1982:17) describes it as:

I-process is a term to designate the *subject* of one's being, the *being-ness* of a human life. I-process is a communication device to refer to that which is purely subjective as though it were object [sic] so that we can talk about it.

* The Self

The self can be described as a fact and a construct. As a construct it includes everything that is the object of a person's consciousness. The self as a construct is inert and lifeless. The *I* is the doer.

* Identity

When the child begins to distinguish between himself and his environment he starts to become aware of his own identity. The concept identity answers the question "who

am I?" The child does not have one identity. The concept must be seen in terms of a number of identities, such as the child as a boy/girl, as a pupil, or as a peer.

* Self-Concept

Vrey (1990:13) states that the understanding of the self and the identity always include an evaluation on the basis of subjective norms giving rise to the self-concept. He describes it as a dynamic configuration of convictions and attitudes relating to the self.

As Raath (1985:87-103) observes, the self-concept has two poles: a positive and a negative and the individual's perception of himself vacillates between these two poles. The self-concept which develops is also either positive or negative.

2.5.5.3 Activities necessary for attaining adulthood

If the child is to become a mature, fully self-actualised adult he must develop a healthy self-concept. In order to do this he should learn to know, understand and accept himself as he is. The activities of attribution of meaning, involvement and experience are important for developing self-knowledge and assisting the child to become a mature, responsible adult.

* **Attribution of meaning**

In order to develop towards responsible adulthood the child must be able to orientate himself in his environment. As he develops meaningful relationships with himself and others so he begins to attribute meaning to himself and the world around him. To enable the child to do this he must be able to recognise, know and understand. These cognitive abilities enable him to construct his life world.

However, in addition to the logical dimension of significance attribution, feelings or connotative meanings can also be attributed to experiences. If these are distorted or illogical they can lead to incorrect perceptions. This can cause a break down in communication and the development of anxiety.

* Involvement

The child will not be able to attribute meaning to anything if he does not become actively involved. Involvement implies that the individual must show interest, pay attention, participate, be venturesome, purposeful and responsible. He must want to be involved, be goal-directed, show perseverance and diligence. Psychic vitality is essential for true involvement.

* Experience

As a result of a person's involvement and significance attribution in a certain situation he *experiences* certain feelings, such as success, failure, frustration, and joy. Vrey (1990:40) says that feelings cannot be experienced in a vacuum or summoned at will.

They are an indication of how a situation is being evaluated and experienced. In experiencing a situation to which a certain meaning has been assigned, subjective experience is integrated with meaning and so meaning acquires a personal dimension.

Experience determines the quality of the relationship.

* Self-actualisation

Vrey (1990:42) quotes Maslow who says that self-actualisation is developing the individual to his full potential, the greatest height to which he as a member of the human species can aspire. In other words helping the person "become the best he is able to become". A self-actualised person is a person in the fullest sense of the word. Such a person is fully involved in life. He is able to direct his energies away from himself. He has a realistic attitude towards life and is therefore able to accept himself for what he is. He makes every effort to realise all his latent potential by striving to transcend immediate limits. Full self-actualisation is the state which every child should try to attain and it is the educator's task to assist him. When things go

wrong for the child the therapist must assist the child to realise how his distorted attribution of meaning, lack of involvement and negative experiences are blocking his path towards full self-actualisation.

These categories are all interdependent and mutually interactive. In turn they affect the self-concept and self-actualisation. This interaction can be illustrated by looking at the life-world of the learning disabled child. As mentioned above, an individual attributes meaning to all situations he encounters. This meaning has a cognitive and an affective component. If a child finds he cannot master scholastic tasks like reading, he experiences feelings of disappointment, frustration and anger. He then begins to attribute negative meaning to the object of these emotions, in this case, reading. He develops ideas like: "Reading is horrible, boring ...", "I hate reading", "I can't read", "I am stupid". He tends to withdraw from the anxiety provoking situation. He then becomes less and less involved in the task. He loses motivation in trying to overcome the difficulty and just "gives up". A vicious circle develops with each negative experience, unrealistic attribution of meaning and lack of involvement aggravating the situation. The child convinces himself he is stupid, everyone picks on him because he cannot read, and so forth. This has a negative effect on his self-concept. A poor self-concept hinders a child's progress towards becoming a fully self-actualised person.

2.5.5.4 Psycho-educational requirements

The formation of healthy relationships and a sound educational climate are considered essential by relation therapists.

*** Formation of relationships**

If the child is to orientate himself in the world, he must form relationships with people and objects around him. All relationships must be seen as bipolar. The child is at one pole and the significant other person or object is at the other. Every relationship has a cognitive component (the nature of the relationship) and an affective component (the quality). The way the person experiences feelings of pleasure, happiness, sadness,

aggression and so on determines the quality of the relationships. The individual tries to remain involved in relationships which are associated with positive feelings and withdraws from those which induce negative emotions. A child who experiences predominantly negative emotions needs help and support (Vrey 1990:20).

*** The educational climate**

It is of vital importance that the educational climate is one which induces positive emotions in the child. According to Jacobs and Vrey (1982:15-16) the following components are the essentials of a good educational climate:

- love: this entails unconditional acceptance of the child in an atmosphere of warmth
- knowledge: the child and adult must know one another
- care: each must care about the other's welfare, health, happiness and sorrows
- respect: this means respecting the integrity of the individual and not humiliating or making fun of him
- trust: this is belief in the other person, not showing doubts about him and what he says and believes in
- honesty: there must be complete openness between the two.

2.5.5.5 Relation theory and therapy

As was mentioned in section 2.5.5.1, relation therapy is based on the Rogerian client-centred approach. While there are significant differences between the two schools, which will be observed in the course of this discussion, they also have much in common. Central to both schools of thought is the importance of the client/therapist relationship. A climate of warmth and acceptance must be established. If therapy is to be effective, a good rapport has to be built up between client and therapist.

Relation therapy advocates that the client/therapist relationship should be built upon the essences required for a good psycho-educational climate (as mentioned in section 2.5.5.2). The climate should be characterised by warmth, permissiveness, understanding and acceptance and should be dynamic. West (1992:123) says that the therapist, and in particular the play therapist, should adopt a relaxed but informed approach which must be accompanied by intuition and sensitivity.

It is essential that the therapist should be an accurate listener. Accurate listening according to Jacobs (1987:4) entails:

- * *Accurate hearing (raakhoor)*. The therapist must hear exactly what the child is saying not what the therapist wants to hear. In order to hear accurately the therapist must work from an external frame of reference, that is the child's frame of reference and not put his own interpretation on what the child is saying (as in psychoanalysis where symbolic interpretations are given to what the client does and says).
- * *Accurate seeing (raaksien)*. The therapist must look at the non-verbal communication of the child to see what emotions the child is expressing in this way. He must be aware of anxiety, tension and such like.
- * *Accurate feeling (raakvoel)*. The therapist must be sensitive to the child's emotions and must to a certain extent be able to experience the feelings with the child.

Unlike client-centred therapy, relation therapy is concerned with diagnosis and the influence of the child's past on his present problems. While relation therapists do not concentrate on the past like the psychoanalysts, they feel that an understanding of the child's past is necessary in order to understand his problems. Diagnosis is based on looking at the child's relations with significant others and forming an "image" of the child on the various levels on which he functions. The different images which Jacobs and Vrey (1982:51-52) refer to are illustrated in Figure 2.1 and discussed below.

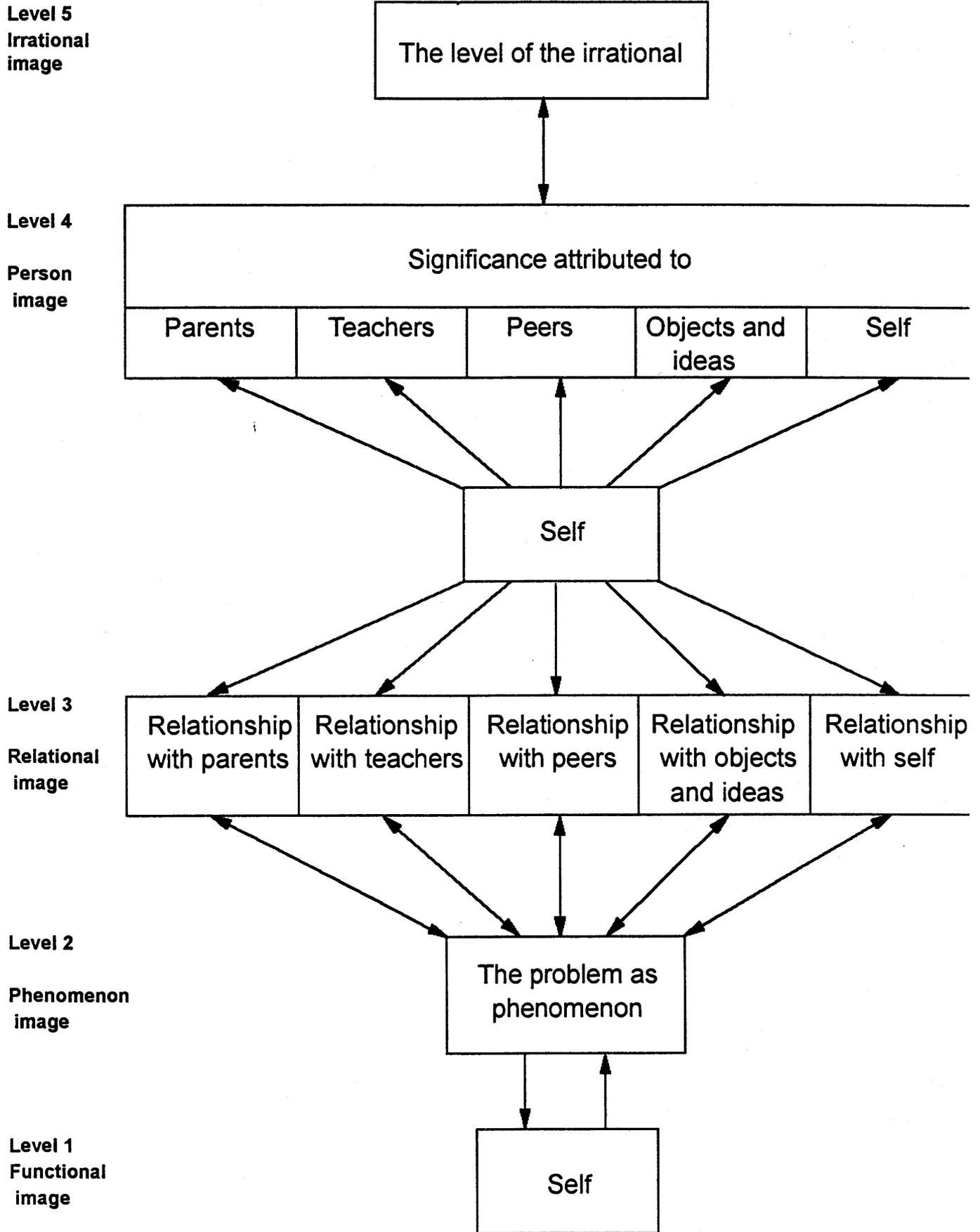


Figure 2.1

Relation therapy diagnostic model

Jacobs and Vrey (1982:51-52) explain the various levels of the model as follows:

- * *The functional image* is the referral problem. This is often the symptom of the problem, for example poor scholastic performance, bed wetting, phobias and so on.
- * *The phenomenon image*. The presenting problem is analysed and tentative hypotheses are proposed. All aspects of the problem are investigated.
- * *The relation image*. The child's relations with others are described. These should give the therapist an indication of possible causes of the problem.
- * *The person image*. This is formed from the relation image. Here the child's attribution of meaning, involvement and nature of his experiences are investigated to see how *he* views his life-world. This is done working strictly from the child's frame of reference.
- * *The level of the irrational*. At this level the therapist looks to see whether the child has attributed realistic meanings to his relations. As a result of the fluctuations of the self-concept between high and low, attribution of meaning can alter. If the self-concept is negative, attribution of meaning is often unrealistic. This can have pathological results.

Jacobs and Vrey (1982:92) stress that diagnosis and therapy cannot be separated. They argue that diagnosis should not be seen as preceding therapy but should form an integral part of the therapeutic programme.

2.5.5.6 Relation theory and play therapy

Little has been written specifically about doing play therapy from a relation therapy point of view but from the above discussion it would appear that play therapy can be accommodated in the relation theory approach.

Singh (1988:51) argues that while the psychoanalytical schools use play more as a diagnostic technique, the client-centred approach is more concerned with therapy than diagnosis. Relation therapy, as propounded by Jacobs and Vrey, sees play diagnosis and play therapy as mutually interdependent. Singh (1988:228) claims that relation therapy can be used effectively with play therapy.

2.5.5.7 Summary and evaluation

Relation theory lends itself to play therapy. Since play is fun for a child, play therapy helps to build the correct climate. Relation therapy focuses on the child's relationships. In play a child reveals a great deal about his life world and his relations with others, often without being aware of it. Thus play can assist the therapist in diagnosis by helping him to build up the person image of the child. It can be used as therapy, where the child can be made aware of his own self-talk and his unrealistic attribution of meaning. Play can also be useful in helping to make the child involved and can help to build up positive experiences.

Relation theory is also flexible. Working from the child's frame of reference the therapist can either adopt a non-directive approach as in Axline's child-centred play therapy or if need be, he can use more structured play. Thus the various techniques of play therapy are open to him. This gives the relation therapist an advantage over others who adhere to more rigid schools of thought which limit play techniques.

2.6 TECHNIQUES OF PLAY THERAPY

Schaefer and Cangelosi (1993:vii) remark that:

Regardless of school or theory, all play therapy plans involve the use of specific techniques or strategies to implement the treatment.

As play therapy has progressed, so many varied and widely differing techniques have been developed. Some are exclusive to specific approaches while other techniques are used by many schools of thought, often with different emphasis. Schaefer and Cangelosi (1993) list a large variety of techniques which will be discussed with other methods of using play therapy. These authors divide play techniques into categories such as symbolic play techniques, play with natural media, drawing and art, storytelling and board games. In this discussion these basic categories will be used to discuss various methods of implementing play therapy. However these categories often overlap. For example, a phenomenon such as metaphorical play could be included in more than one category.

As mentioned in section 2.5.5.7 relation therapy is flexible, allowing the therapist the freedom to use a variety of different approaches, depending on the needs of the child. Many of the techniques mentioned below can be incorporated into the relation therapy approach. A number of the techniques discussed have been used in this empirical study. Many of the other methods could also be used to good advantage and for this reason they are also discussed here.

2.6.1 Symbolic play techniques

In this section some more conventional techniques as well as some which differ from or expand on well known techniques are discussed.

*** The play interview**

Here an interview is conducted with the child through the medium of toys. Unlike non-directive therapy, the child is given some dolls and asked questions relating to their feelings, fears, desires and so forth. For example, a child who expresses tremendous fear of death and dying is given two dolls to play with. One doll is placed lying down to represent a dead person and the child is questioned about the feelings of the other doll.

* **Structured play therapy**

The play situation is rigidly structured and the child uses free play in this situation to play out problems. Situations often used in this type of therapy are:

- a new baby at a mother's breast (sibling rivalry)
- balloon bursting (release therapy) where the child has to pop the balloons in an attempt to give vent to pent up feelings of anger
- peer-attack using "self" dolls and "peer" dolls
- separation
- genital difference.

* **The use of two houses**

This approach can be used with children who experience trauma as a result of changes in family structure through death, divorce or remarriage, long absence of a parent and other similar circumstances. Doll's houses are often used to assist a child to conceptualise areas of conflict and work through repressed fears and fantasies (Schaefer & Cangelosi 1993:65). One of the houses can be a safe, happy house while the other can be the house of strife.

* **Puppets, finger puppets and masks**

Irwin (in Schaefer & Cangelosi 1993:69-80) refers to the use of puppets for assessment and discusses a puppet assessment interview. The method suggested is to have a "warm-up" discussion with the child, then let the child put on a puppet show with the therapist as audience or, if required, as a largely passive participant in the show. Finally an interview is conducted first with the puppet then with the child. The form and content of the session are then assessed. As with many other forms of play, the puppet play offers psychic protection because the child is only acting out a story. The child can safely pretend and anxiety and defence can be by-passed. The advantage of including puppets in play therapy is that they are a variation on conventional toys used in most play sessions and sometimes children are better able to escape into the

play world with puppets than with conventional dolls. The use of the child's own body (hands) in manipulating the puppet can be therapeutic in itself, for example in expressing anger. As Jenkins and Beckh (in Schaefer & Cangelosi 1993:85) remark, the hands of the puppet player become the hands of the puppet and thus aggressive or other tabooed actions are seen to be performed by the puppet not the child himself.

The authors also suggest the making and use of masks in therapy. They claim that the actual construction of the mask is an important therapeutic tool. Masks can be either drawn and painted or made of clay. The authors claim that using the medium of clay has the advantage not only of being physically stimulating but the child is not inhibited by fear of errors since clay can be remodelled until the desired effect is obtained. This can be an important consideration with some children who have learning problems and have developed a fear of failure.

*** Costume play therapy**

Marcus (in Schaefer & Cangelosi 1993:91) advocates costume play therapy for older children who feel they are too big to play with toys. Younger children are more able to express fantasies spontaneously with whatever material is available. Older children, on the other hand, prefer more realistic, true life situations. Play behaviour in latency period tends to be more structured and competitive and contains relatively little emotional content. Marcus claims that costume play therapy allows the therapist to communicate with the child on whatever level the child presents. Costumes and "dressing-up" are enjoyed by people of all ages and are less likely to be considered too babyish by older children. Once the child is dressed up as another character many anxieties and inhibitions can be shed and repressed feelings can be expressed without fear or guilt.

*** Using the telephone**

In therapy toys are sometimes used as a means of communication but the child is often unaware that he is communicating. The telephone, however, is immediately

recognised as an instrument of communication. The child can use a toy telephone as a more direct method of communication. It has the advantage of combining talking and listening, responding and asserting. The symbolic party being addressed at the other end of the line cannot see or be seen (Schaefer and Cangelosi 1993:103). It can be used to help children express unacceptable emotions. For example, an abused child can "talk" to the abuser and express all his feelings of anger and hate.

*** Block play (making and building)**

Rogers and Sharapan (1993:5) say that making and building in children's play comes from the desire to feel in control of the outside world and the inner self. When playing with blocks a child is in control. He can control what is being done and how it is done. This gives him a feeling of power within himself. Block building is a simple technique for a therapist to introduce in a school situation. It can play an important part in helping to give the child, suffering from feelings of inadequacy as a result of learning problems, a sense of mastery over objects in his environment.

Resnick (in Schaefer & Cangelosi 1993:109) takes block play a step further and uses it in parent/child therapy sessions. The parent has to build exactly what the child does and has to follow the child's instructions. The authors claim that this helps parents to listen to the child and assists communication.

2.6.2 Play techniques using natural media

Natural media include sand, water, mud and clay and food. These media have proved to be extremely successful in many different types of therapy and are used extensively in clinics where proper play therapy facilities exist. For practical reasons it is difficult to include them in a play therapy programme in the school situation.

* Sand play

Children often play with sand and water in a purely sensopathic way, simply enjoying the feeling of sand running through their fingers or splashing water. This can be therapeutic, having a calming effect upon children who are tense, anxious or aggressive.

Children may also use a sand tray in which to construct scenes like battlefields, race-tracks, houses and numerous other situations. Allan and Berry (in Schaefer & Cangelosi 1993:119) claim that there are three common stages in sand play:

- the chaotic stage where there is no order in the child's play
- the second stage is the struggle stage where the child tries to come to terms with distressing emotions by playing out conflicts
- finally the resolution when the child seems to be coming to terms with his environment and this is reflected in his sand play where games are orderly.

Miller and Boe (1990:248) claim that sand play, like story telling, makes use of metaphors. They define the term *metaphor* as:

... something known and of our making, or at least of our choosing, that we put to stand for, and so to help us understand, something unknown and not of our making.

The authors cite experts who explain metaphor as something which helps the child express internal experiences which are difficult to understand and cope with. Metaphors establish a bridge between inner and outer worlds and can allow insight into the trauma from a safe distance. It is evident that metaphorical play can be used in most forms of play and is not restricted to sand play.

* **Water play**

Hartley, Frank and Goldenson (in Schaefer & Cangelosi 1993:125) claim that water play is effective in therapy as it gives a child a feeling of mastery, satisfies immature desires, gives an outlet for aggression and can be relaxing for the child. Water is also versatile as it can be used for cleansing, both in a literal and symbolic sense.

* **Mud and clay**

These materials offer the child different creative outlets from the conventional pencil/paint and paper methods. Woltman (in Schaefer & Cangelosi 1993:142) claims there are many advantages in using these media in therapy. The fact that the child uses both hands to model helps with bilateral coordination of arms, hands and fingers and has obvious advantages for children whose learning disabilities result from coordination problems. The construction of a three-dimensional object makes it more realistic for a child. In addition children are able to correct errors more easily than with drawing and painting. This often boosts confidence as the child feels more satisfied with the result.

2.6.3 Drawing and art techniques

Spontaneous play and drawing are a child's natural means of expression (Copeley, Forryan & O'Neill 1987:413). Levick (1983:3) in her significantly entitled book *They could not talk and so they drew* quotes the definition of art therapy accepted by the American Art Therapy Association:

Art Therapy provides the opportunity for non-verbal expression and communication. Within the field there are two major approaches. The use of art as therapy implies that the creative process can be a means both of reconciling emotional conflicts and of fostering self-awareness and personal growth.

It has long been accepted that art can be used both as a diagnostic and therapeutic tool in psychotherapy. As Rogers and Sharapan (1993:6) remark: "Art begins with feelings on the inside of the artist." In art therapy the child is encouraged to use drawing or painting to express these feelings. As in other forms of play therapy strong emotions and unacceptable behaviour patterns can be expressed through the medium of art and worked through. Art therapy forms an important part of most play therapy programmes as children enjoy it and readily participate in it.

Arlow and Kadis (in Schaefer & Cangelosi 1993:161-175) discuss finger painting as part of a total psychotherapeutic programme. They claim that its advantages are that it requires little technical skill and permits the use of larger groups of muscles. In addition, Freudian therapists believe in its therapeutic value in expressing anal regressive needs. Squiggle drawings are an additional form of art which can assist both with diagnosis and therapy. The therapist draws a squiggle and the child has to make a drawing and tell a story about the drawing.

2.6.4 Storytelling, role-play and imagery techniques

These techniques have been used extensively in child psychotherapy. While they are inappropriate with young children, they have been used successfully with older children and can be incorporated in adolescent and even adult therapy programmes.

*** Storytelling and dramatic play**

Like art, storytelling has been used as a means of communication for thousands of years. Miles (1993:71) quotes many leading therapists who have found that story telling can be therapeutic, particularly for children who have poor self-esteem, timidity, inability to cope with change or physical handicaps and anxiety. Storytelling uses the deeper language of metaphor (see discussion of metaphor in section 2.5.2). Children's traumas and fears can be expressed through metaphor in stories (Miller & Bow 1990:251-252). The authors contend that fairy tales are particularly effective since they have a distance from, yet a similarity to, the child's own situation. Fictional

characters can produce psychologically relevant but indirect and therefore non-threatening situations with which the child can identify.

Storytelling can be implemented in various ways. Gardner (in Schaefer & Cangelosi 1993:199-209) suggests that the most effective method is mutual storytelling. The child tells a story. The therapist then selects one or two themes which appear important and creates a story of his own using the same characters and setting, but introduces healthier resolutions. This more structured method would be rejected by Rogerian theorists who use the non-directive and non-interventionist approach. Levenson and Herman (1991:660-666) also criticise Gardner's technique saying that the therapist should follow and expand on what the child has initiated, rather than introduce new dimensions.

Brooks (in Schaefer & Cangelosi 1993:211-223) describes a technique which he calls *Creative Characters Technique*. The therapist selects the major emotional issues confronting the child and develops characters (often animal characters) which can be related to these issues. He then creates stories which involve these characters and revolve around conflict areas in the child's life. The characters and the situations they face are expanded upon during a number of sessions. Brooks claims that when the child physically enacts the story, this promotes cognitive development and stimulates fantasy production.

Rogers and Sharapan (1993:7) claim that "For many children dramatic play is one of their most important tools for dealing with everyday problems." The authors also refer to dramatic play where children become monsters and superheroes. This kind of play fulfils a child's needs to be big and strong in a world where they often feel small and vulnerable. "Gun play", where children play at shooting, has a similar function and can help a child express anger and aggression.

Lessing (1995) uses storytelling from a slightly different perspective. The therapist and child together compile a personal story book or reader on a topic which is of interest to the child or on a theme which the therapist feels should be explored such as family

relations or school. The child illustrates the book. Lessing claims the writing and drawings can be used for diagnostic and therapeutic purposes. It has proved particularly successful with children with reading and emotional problems since the book can be used as a therapeutic technique to assist with affective problems and can also be used as a basis for remedial reading instruction.

* **Role-playing**

Unlike story telling and dramatic play, role-play does not use fantasy and imaginary characters. In role-play the child's real experience with significant others is enacted. The child sometimes acts as himself in specific situations which cause conflict. At other times reverse role play can be used. Here the child takes the part of the significant other (for example, mother, father, sibling, teacher). According to Levenson and Herman (in Schaefer & Cangelosi 1993:230) the advantages of role play in therapy are that it is simple and involves the child in direct, everyday experiences in which they have interacted and which are very real and relevant to them.

... it taps the stream of consciousness and underlying conflictual material by allowing the child to use repetition as a tool towards mastery over an event that stimulated unresolved issues or conflicts.

Mosley (1988:120-126) claims that participating in role play and acting-out specific experiences widens self-understanding, lets the child see the consequences of his actions and assists him to have empathy with other peoples' point of view. Levenson and Herman (in Schaefer & Cangelosi 1991:660-666) say role play can have a cathartic effect upon the child. They explain this by saying the child gains a sense of mastery by playing roles and role reversals. These authors advocate role play as it is simple to employ and involves the child in direct everyday experiences. It taps the stream of consciousness and allows the child to use repetition as a tool to gain mastery over unpleasant events. They quote numerous studies which have found role playing successful in assisting children with depression, hyperkinesia or phobias. Role playing can also be done with dolls which is often less threatening for the child. It is

not only an effective therapy technique but also can help the therapist to understand the child's background and see how the child views his world. It can shed light on a child's relation structures.

*** Imagery**

Myrick and Myrick (1993:62) use the term *guided imagery* which they describe as:

a means of assisting children to use their imaginations to learn more about themselves and others and to help them achieve more at school.

The therapist creates a short guided imagery script. The therapist helps the child to relax and then takes the child on an "imaginative journey" telling the child to make up pictures or images in his mind. The experiences must then be discussed with the child afterwards. The authors quote a case study on which they worked with children with reading problems. In the first session these children were told to imagine a peaceful country setting which was sunny and bright. They were then told to imagine lying under a tree and taking out a book. In the next session they were told to imagine the same pleasant, peaceful scene and then open the book and look at the illustrations. In further sessions this theme was continued until the children imagined they were reading effortlessly. After this visualisation of reading success the researchers found the children's actual reading improved considerably.

*** Using the written word**

All the above techniques require the child to use some form of verbal communication. There are instances where certain situations are so difficult for a child that he finds it too threatening to verbalise feelings or even describe events. In such situations, the child, if he is "literate", may find it easier to write about his troubles than talk about them. Demb (1993:1028-1031) refers to numerous variations of this technique, like

writing diaries, letters and so forth. Demb suggests an interactional form of writing where therapist and client write to each other in the form of a dialogue if the child is unable to talk about or play out his problems.

* **Bibliotherapy**

This can be used with great effect, particularly with older children with reading problems. If the books which are to be used are chosen carefully, this technique can combine emotional therapy with reading remediation. Davidson (1983) claims that reading can be genuinely therapeutic. She distinguishes three stages in the process:

- *identification*: the reader associates himself with a character in the story
- *catharsis*: identifying with a character in a book gives the child the opportunity of sharing his feelings with the fictional character and this helps to release pent up emotions
- *insight*: this Davidson describes as a "self-discovery".

2.6.5 Electronic techniques

The proliferation of computers has changed many things in the modern world including how children play. Ordinary computer games which many youngsters enjoy so much do not have much therapeutic value. However, programmes are being designed to assist in therapy. Johnson (Schaefer & Cangelosi 1993:281-286) mentions *Turtle Graphics, Painting with the computer, Computer Art Therapy and Feeling Painting*.

In many instances a graphics pad is used. It allows the child to draw in colour on the screen by moving his fingers across the surface of the pad. The use of computers is a way of enhancing communication between child and therapist and they help to motivate the child to come to therapy as they enjoy the activities. Computer art can be used for projective assessment, a medium for looking at new ways of perceiving the self and exploring new and better coping behaviours.

2.6.6 Board games

Children in the latency period often tend to move away from fantasy games and play more structured games with rules. While structured games like board games do not have as much therapeutic value and are not as revealing as fantasy games they can still be used in play therapy to build up rapport between child and therapist. These games can also reveal aspects of a child's personality. For example, board games can show how important winning is for the child and can indicate whether the child exhibits perseverance and other similar character traits.

2.6.7 Family play therapy

As early as 1964 the idea was developed of using parents as play therapists. Based on the client-centred principles programmes were developed to use parents as play therapists for their own children. The argument in support of this idea was that parents should acquire the behaviours and attitudes of the play therapist, such as acceptance of the child and a supportive parental role. If this was achieved the parents would have the necessary skills to facilitate healthy development in the child (Guerney & Guerney 1989:334-357). The authors go as far as to say they favour play therapy given by parents above other methods of treatment for children between the ages of three and eleven, if the parents acquire the attitudes and behaviour of the play therapist.

Early (1994:119-130) used play therapy as part of a family therapy programme. In this experiment both the therapist and mother attended the therapy sessions and both participated.

2.6.8 Theraplay

While Schaefer (1979) classifies theraplay as a play therapy technique, it can also be argued that it is an approach on its own. It has a different basis and structure from the above mentioned techniques and toys are used in a different way. Schaefer

(1983:136) says that it was developed to "... replicate the joyful and adoring features of the parent-infant interaction." It is used with children who have experienced a deficiency of sensory stimulation. De Meillon (1989:470) says that through theraplay it is possible to reconstruct the mother-child relationship and to compensate for those aspects of nurturing, challenging, intruding and structuring which have not been adequately realised in the original relationship.

Jernberg (in Schaefer 1979:347) explains the treatment by saying that the child, whatever his age, is tickled and cuddled. He has his hands washed, is carried piggy-back and played with in many ways where body-contact and eye-contact are paramount. The treatment is fun-filled and full of surprises so the child enjoys it.

2.6.9 Summary and discussion of play therapy techniques

The techniques discussed here indicate just how wide a variety of strategies is being used in play therapy today. More familiar methods like art therapy and non-directive therapy are still used and are elaborated on. New methods and techniques like computer therapy are continually being developed. It would appear from the literature that most therapists, no matter to which school of thought they adhere, use a variety of different methods in their work with children. The choice of technique depends on the child's needs and the personality of the individual therapist.

2.7 SUMMARY

In this chapter the phenomenon of play was discussed and the characteristics of play behaviour were examined. Play, for the child, is more than a pleasurable, frivolous activity engaged in for relaxation. Some types of play serve a biological purpose as they assist with development. Play also has an intrapersonal and interpersonal function as well as a socio-cultural role. It is the child's way of communicating. It is important for the play therapist to look at the child's developmental level and his level of play. If play is not age appropriate this can be an indication of emotional upsets in

the physically healthy child with normal intelligence. In this chapter Piaget's stages of development and his views on the different stages of play were examined. These were compared to other theories on the development of play and it was found that most experts concur with Piaget.

The phenomenon of play therapy, as one of the most successful methods of child therapy, was discussed and an historical perspective of the development of various approaches to play therapy was given. The basic principles of the psychoanalytic approach to human behaviour were summarised as a background to child psychotherapy and play therapy in particular. The contributions of Anna Freud and Melanie Klein, the initiators of play therapy were contrasted. Axline's child-centred approach was discussed and assessed against the background of the Rogerian principles of client-centred therapy. The behaviourist approach and structured play therapy were briefly discussed. Relation therapy is a flexible, child-centred theory which looks at the child from the perspective of his relationships with his life-world. This theory was explained at the end of the section.

The final part of the chapter was devoted to the many and varied play therapy techniques which have been developed over the years. Many of these techniques can be used by the school counsellor to assist the child experiencing emotional problems at school. In the next chapter consideration will be given to exploring the world of the child who is experiencing both emotional and learning problems.

CHAPTER THREE

THE WORLD OF THE LEARNING DISABLED CHILD

3.1 INTRODUCTION

A child who does not progress academically and master the skills required for one or more scholastic tasks such as reading, spelling, writing, mathematics, remembering and reproducing information and concentration is often described as being *learning disabled*. These difficulties do not usually exist in isolation but are often interrelated. The problem is further compounded when emotional factors come into play. The world of the learning disabled child is one of continual failure, frustration and disappointment. Ultimately this has a negative effect upon the child's self-concept and unacceptable, compensatory behaviour patterns develop. This behaviour retards the learning process even further.

Reading is the single most important scholastic skill which the child has to acquire since it affects all other aspects of school work which involve the written word. The inability to master reading skills is the most common and often most debilitating learning difficulty which children experience. Lerner (1976:234) argues that children may experience problems in any area of learning and development. She claims that the majority of children in learning disability educational programmes are there because of poor reading skills. Other experts (Strother & Barlow 1985:29; Beck 1988:774; Bos & Vaughn 1994:106) concur with this view (see section 1.8.4). Reading disabilities are an important aspect of general learning problems and since the reading disabled child is the focus of this study, reading disabilities will be looked at more specifically than other learning disabilities.

This chapter is concerned with the world of the learning disabled child. A brief review of different experts' explanations of the term *learning disability* and what constitutes a reading disability is presented. An overview of the possible causes and effects of learning disabilities is given. Learning disabled children often exhibit similar characteristics. Some of these are listed and the emotional problems experienced by these children are then discussed in more detail. The relationship structures of the learning disabled child are explored. Finally, the various types of assistance available to such children are mentioned with emphasis on programmes which include a therapeutic component. The few studies using play therapy as part of a remedial programme are specifically reviewed.

3.2 WHAT IS A LEARNING/READING DISABILITY?

3.2.1 General learning disabilities

Experts (Freeman 1974; Rosner 1975; Lerner 1976; Gillespie-Silver 1979; Hosler & Fadely 1989; Bos & Vaughn 1994) agree that there is no general consensus on what constitutes a learning disability. Many varied definitions are found in the literature. Gillespie and Silver (1979: 21) contend that this is as a result of the many disciplines such as medicine, optometry, speech and language, special education and so on, which are involved in the field of learning disabilities. The definitions differ according to the individual theorist's philosophical persuasion, profession and the social pressures of the particular environment. In the early 1970's Lerner (1976:8-9) claimed that there were five different approaches to the problem of defining the term *learning disability*. These were:

- neurological dysfunction
- uneven growth pattern
- difficulty in academic and learning tasks
- discrepancy between achievement and potentiality and
- definition by exclusion.

Subsequent attempts at explaining the term include most of these points. Freeman's (1974:8-9) explanation of the concept includes most of Lerner's criteria.

Learning disabilities are a condition or disorder in which children of average, above average and even of superior intellectual ability are functioning considerably below their capabilities. These children exhibit problems of perception, conception, language usage and behaviour.

A diagnosis of learning disability is frequently based upon a systematic elimination of other causal factors. The comprehensive evaluation should rule out such conditions as mental retardation, hearing impairment, visual disorder and psychopathology.

Gillespie-Silver (1979:21) gives a definition which states that children with learning disabilities:

... exhibit a disorder in one or more of the basic psychological processes involved in understanding or using spoken or written language.

She goes on to say that these include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia and so on, but exclude visual, auditory and motor handicaps as well as mental retardation, emotional disturbance and environmental disadvantage. Hosler and Fadely (1989:6-9) on the other hand, claim that most learning disabilities can be explained as a result of differences in development or what Lerner terms "uneven growth patterns".

A review of the literature indicates that most of the explanations of the term *learning disability* also include the following features:

- children with learning difficulties do not achieve according to their potential, there is a discrepancy between expected and actual achievement
- such children cannot cope with scholastic requirements.

3.2.2 Reading disabilities

The DSM III (1983:93-94) refers to the phenomenon as a *developmental reading disorder* and describes it as a "significant impairment in the development of reading skills". In order to be classified as a reading disorder the problem should not be attributable to chronological age, mental age or inadequate schooling. A child who is suffering from this impairment performs tasks requiring reading skills at a level significantly below his intellectual ability. A one to two year discrepancy is considered significant if the child is between eight and thirteen years of age. The authors of the DSM III claim that it is difficult to give a significant discrepancy at a younger age.

Stewart (in Gabel & Erickson 1980:399) supports this definition but claims that reading should be on a level of two years or more below what would be expected on the basis of age and intelligence. The disorder must not be confused with retardation in reading which is only age related and which is often due to low intelligence or poor schooling.

Dyslexia is a term which has been used to describe the problem. The DSM III gives the characteristics as: faulty oral reading where omissions, additions, and distortions occur. Reading comprehension is poor. Errors occur in spelling which cannot be phonetically explained such as b/d reversals. Other associated features are impaired sound discrimination and sequencing. Behaviour problems such as Attention Deficit Syndrome are also evident. Miles (1983:2-3) claims that not all "poor readers" are dyslexic but maintains that a person can be described as such if a particular pattern is evidenced in their reading (and spelling). He describes dyslexia as: "a faulty system of information processing which affects the lexicon [internal dictionary] ...". It includes deficiencies in short term memory for symbolic material and a tendency to confuse pairs of words or letters. Today some educators tend to avoid the use of the term *dyslexia* as it is controversial. They claim it is "labelling" a child and thereby compounding the problem. Other authors (Manzo 1987:408-41; Lamm & Epstein 1992:605) use the term to describe children with certain types of reading disabilities.

Despite difficulties in defining, describing and categorising reading difficulties, experts agree the problem can have serious and far reaching consequences if the child does not receive assistance.

3.3 CAUSES AND EFFECTS OF LEARNING DISABILITIES

3.3.1 General remarks

Just as it is difficult to give an appropriate definition of the term *learning disability*, so it is equally problematic to ascertain the causes of the phenomenon. The reasons for children's learning disabilities are many and varied. The problem is compounded since it is often difficult to know whether a particular factor is the cause or the result of the problem. For example, as mentioned in Chapter 1 (see section 1.3.1), if a child exhibits learning, emotional and behavioural problems it is difficult to ascertain whether the emotional problems are the cause or consequence of the problem. What is evident is that they are interrelated with one aggravating the other. Elkind and Weiner (1978:490) claim that one third to one half of children who go to psychiatric clinics are there primarily because of scholastic problems. There is still a vehement debate amongst scholars as to the cause or effect of emotional disturbances and learning problems (Wade Lewis 1984; Strother & Barlow 1985; Beck 1988; Carmichael 1991; Casey, Levy, Brown & Brooks-Gunn 1992; Lamm & Epstein 1992).

It is important for those working with the learning disabled child to know which factors can be responsible for the problem and how these factors interact with and influence each other. If the educationalist or specialist is familiar with the etiology of the disability and all possible effects, he will be better able to give the child appropriate assistance.

3.3.2 Possible causes of learning and reading disabilities

There has been much debate over the years about the interaction of heredity and environment. Sapir and Nitzburg (1973) quote experts who have researched both

areas and who stress the importance of the interaction between the two. Smith (in Hedley & Hicks 1988:40) claims that there are strong similarities between children with reading disorders and their parents and siblings. They tend to have similar brain structures, patterns of brain maturation, biochemical irregularities, and so forth. These can be genetically transmitted and can affect brain functioning and hence reading performance. On the other hand, socio-economic factors such as the kind of environment the child is in, as well as the child's emotional state, can affect scholastic performance. Smith (in Hedley & Hicks 1988) and Gillespie-Silver (1979) advocate an ecological approach which looks at a variety of interacting factors while Hosler and Fadely (1989) look at the child in totality from a developmental perspective.

Sapir and Nitzburg (1973:187-190) divide the causes of learning disabilities into biological and psychosocial factors, neurophysical and psychological factors. Under biological and psychosocial they list problems which occur during pregnancy and birth which can affect the child's central nervous system. They also include factors like nutritional deprivation and its effect on child development, as well as other forms of deprivation like lack of stimulation and its effect upon perceptual and intellectual development. Factors such as brain damage, psycho-neurological disturbances and emotional problems are classified as neurophysical or psychological.

Hosler and Fadely (1989:11-36) claim that in order to ascertain the root of the child's learning problem an assessment must be done on:

- the movement system which includes factors such as muscular strength, posture, balance, coordination, directionality, tactile discrimination, body concept
- the sensory system which includes all aspects of visual and auditory perception
- the cognitive system which assesses cognitive functions like assimilation, classification, association, comprehension, fluency and flexibility
- the personality or affective system involves aspects like self-identification, role definition, emotional endurance, responsibility, autonomy and self-actualisation
- the social system which is concerned with factors like objectivity, social sensitivity, sharing, trust, participation, cooperation, leadership, rebellion.

Experts such as Gillespie-Silver (1979) and Smith (in Hedley & Hicks 1988) advocate an ecological perspective. They argue that the child does not grow up in a vacuum and one cannot, therefore, consider only the child as the cause of the problem. The child's whole milieu must be taken into consideration. Smith (in Hedley & Hicks 1988:38-64) distinguishes:

- physiological learner-based contributors like organic factors, hereditary factors and biochemical factors
- individual characteristics like cognitive abilities and styles, motivation, social-emotional maturity, personality and information processing
- task-based contributors
- family based contributors
- school based contributors.

Gillespie-Silver (1979:23) says that apart from neurological impairment, unsatisfactory educational and environmental situations, inadequate social and emotional development and psychological factors like poor information processing skills may affect the child's ability to cope with reading and other scholastic tasks.

Mosse (1982) gives the following as specific causes of reading disorders:

- * *Organic based reading disorders.* These disorders are due to malfunctioning of those parts of the brain responsible for reading.
- * *Psychogenic disorders.* One cause is deliberate non-learning where the child refuses to learn because, for example, he hates the teacher or wishes to "get back at" his parents. Another reason for the problem is an overwhelming fear of failure and a third is attention disorder. This can be an indication of a number of psychological malfunctions. In order to read the child must be able to concentrate and must be motivated. Depression, anger, sexual preoccupation, neuroses and even day-dreaming, particularly in very intelligent children who get bored, are all manifested in attention disorder and prevent the child from learning reading skills.

- * *Sociogenic disorders.* Mosse (1982:256) explains these problems by saying that the defects lie in society and not in the children. This includes a violent atmosphere at home, at school or in the street (the social environment). Children brought up under these conditions often exhibit reading problems. She also cites the damaging aspects of mass media, whereby reading is adversely affected by the violence and crime glorified in comic books and on television. Further, television can cause an attention disorder which has a negative effect on independent thinking and imagination. Television is a passive medium and the child does not have give undivided attention to what he sees. Children thus become lazy about making active use of their brains.

3.3.3 Interaction between cause and effect

There is much debate in the literature over whether factors which Mosse (1982) has termed psychogenic (and to an extent sociogenic) are the causes or the results of learning problems.

Jorm, Share, Matthews and Maclean (1986:33-43) review a number of surveys done on establishing the connection between behavioural and reading problems. The findings are somewhat contradictory. Studies which compared groups of children with both behavioural and reading problems to those with only reading problems and other children with only behavioural problems generally concluded that behavioural problems arise as a consequence of reading failure. Other projects which were conducted in the form of longitudinal studies did not support this view. The findings of these studies showed that backward readers had behavioural problems when they entered school but these are not necessarily the result of reading failure. It is evident from this paper that no conclusive evidence has emerged to establish the exact relationship between behavioural and reading problems. Gentile and McMillan (1989:26-31) concur with these findings. They refer to the unresolved debate over the etiology of reading difficulties. Their contention is that the two are interrelated and they claim that what is needed is a programme which integrates social and emotional assistance along with skills-based assistance.

Orlow (1974:669-673) believes that reading problems are found in children with a low tolerance for frustration. Her argument is that reading is a very complex task for the beginner and requires a great deal of effort on the child's part. Orlow contends that children who have a low level of tolerance for frustration cannot cope with this kind of stress and try to get out of the situation. They become restless, lose concentration, day-dream and in fact, do anything which will enable them to discontinue the stress related reading task. The result is they do not acquire the skills necessary for reading.

Other factors which some authors claim can lead to reading problems are external pressures from home, school and peers. High expectations and parental pressure can result in some children developing learning problems. Werner and Strother (1987:539) claim that excessive encouragement to read and perform at an early age can lead children to become tense, anxious and afraid of failure. These children feel standards are being set which they are unable to attain. Beaumont (1991:261-270) also claims that anxieties about family relationships and a symbiotic relationship with one parent can result in learning problems. Casey *et al* (1992:256) found that the majority of children with reading problems come from socially disadvantaged environments. However when the child of well-educated parents exhibits learning disabilities these are often compounded by parental pressures, high expectations and consequent disappointment at the child's failure. The authors' findings support the hypothesis that reading disability places children at risk for emotional problems but they claim that they were unable to conclude whether anxiety and unhappiness preceded or resulted from the reading problem.

Casey *et al* (1992:259) further claim that children always compare themselves with others around them and if they feel they do not match up to the level of others, the problem is aggravated as the child's self-esteem weakens. Thus, if a child perceives he is not coping as well at school as his peers he may develop emotional problems. His lack of confidence and poor self-concept can lead him to give up trying rather than face admitting to himself he cannot do as well as his friends. His reading progress is then further retarded and so the vicious cycle continues.

Another factor which can cause or compound reading problems is school pressure. The school system requires that children acquire certain levels of competence in reading and other scholastic tasks at a commensurate stages in their development. For many children this can become extremely stressful and problems result. Strother and Barlow (1985:29-30) remark that the reading disabled child places an extra burden on the teacher in the classroom. This is particularly evident when the disability is accompanied by disruptive behaviour. Teachers become frustrated and if poor rapport builds up between teacher and child, this can aggravate the child's difficulties.

It is evident from the above discussion that several factors may cause learning problems. In some instances these disabilities can result from one factor like brain injury or slow perceptual development. However, there may be many contributors with one factor aggravating the other. Lamm and Epstein (1992) explain that a child with a reading disability may develop symptoms of emotional stress as a result of continued failure and this anxiety compounds the reading problem. Lewis (1984:454) remarks:

Although the role of emotional maladjustment as a cause or effect of reading disability has been vehemently debated it seems that in either situation a comprehensive treatment which would focus on the alleviation of the dysfunction as well as the remediation of reading difficulties

Gentile and McMillan (1989:26-31) concur, believing that it is just as important to motivate pupils with the will to learn as it is to teach them reading skills. The authors claim that children with learning difficulties are reluctant to read, often appear immobilised when required to read, refuse to attempt challenging reading tasks, engage in disruptive behaviour and do not carry out reading assignments. These factors can be seen as both cause and effect of the problem.

It is therefore essential for the person working with the learning disabled child to look at all possible causes of the child's difficulty and their possible effects. A holistic approach should be adopted and emphasis should be placed on all aspects of problem.

3.4 CHARACTERISTICS OF THE LEARNING DISABLED CHILD

3.4.1 General

The question which is often asked of many psychologists, doctors and school counsellors is: "Which children can be classified as learning disabled?" A large variety of responses to this question is found in the literature and the answers depend on how the particular expert defines the term *learning/reading disability*. The incidence of learning disabilities will also vary depending on what type of child experts classify as learning disabled. Sapir and Nitzburg (1973:660) maintain that most writers claim that between 7 - 25 % of children have some form of learning problem. More recent articles like those of Manzo (1987:408-413) and Casey *et al* (1992:256-260) support this. Manzo puts the figure as high as 15 - 20 % while authors such as Hosler and Fadely (1989:8-9) claim that more than 90% of children labelled as learning disabled are merely developmentally different and should not be classed as *disabled*. Casey *et al* (1992:256) say that the estimated prevalence of reading disorders (Developmental Reading Disorder according to the DSM III) ranges from 2 - 15%. Stewart (in Gable and Erikson 1980:399), whose figures are less recent than some authors quoted above, gives lower estimates. He says that what he terms "specific reading disability" affects 4 - 5% of boys and 1% of girls. While his figures may not be as relevant today, the fact that there is a higher incidence of the problem in boys than girls is significant. It is supported by other studies (Elkind and Weiner 1978; Axline 1947). Stewart further notes that reading disability is associated with conduct disorder. He states that one-third of boys with reading disabilities have conduct disorders while one-third of those with conduct disorders also have a reading disability.

Scholars agree that certain characteristics differentiate children with learning problems from their more fortunate peers. Bos and Vaugh (1994:3) claim such children are easily identifiable in the classroom situation since they draw attention to themselves because of learning difficulties which are often accompanied by inappropriate behaviour. Gillespie-Silver (1979:24) lists the characteristics which, she claims, are most cited in the literature:

- hyperactivity
- perceptual-motor impairments
- emotional lability
- coordination deficits - clumsiness
- disorders of attention - distractibility - perseveration
- impulsivity
- difficulty in remembering or thinking
- specific learning disabilities like the inability to learn, remember what is read, spelling or mathematics
- difficulty in remembering, comprehending or expressing speech.

The characteristics which Bos and Vaughn (1994:3-4) list are similar but they add that aggressive, withdrawn or bizarre behaviour often accompanies these other problems. Hosler and Fadely (1989:15) give similar typical problems of the child who is not coping at school:

- inability to attend in class and poor concentration
- the child is very active, cannot sit still and does not complete work
- failure in reading (or other academic subjects)
- inability to understand what he has read
- poor coordination and motor skills
- resists attending school and is emotionally upset about school
- the child cannot keep up with the rest of the class.

Gentile and McMillan (1989:26-31) give the following characteristics of children with reading problems:

- they are reluctant to take risks in reading; they are concerned with making mistakes; they fear reading in front of others; they demonstrate overly dependent behaviour in reading
- they appear immobilised when asked to read; they avoid it whenever possible; they are easily distracted during reading, they complain it is difficult

- they flee from challenging tasks involving reading, appearing lethargic, apathetic and lacking confidence to reach goals
- they engage in disruptive behaviour.

3.4.2 Emotional problems and the learning disabled child

As mentioned above, there is abundant evidence in the literature to substantiate the fact that the child with a learning disability often has behavioural and emotional problems. Andrews (1971:160-166), Beck (1988:774-779), Wade Lewis (1984:444-59) and Casey *et al* (1992:256-260) claim that the child who does not achieve scholastically develops a low self-concept. Lamm and Epstein (1992:605) quote studies which show a positive correlation between "... the emotional status of individuals with dyslexia and their success in reading rehabilitation courses." These authors' findings, however, do not fully support these claims, either that emotional difficulties are causal factors in reading difficulties or that emotional difficulties emerge under such circumstances. They suggest that such scholars have developed alternative behaviours and methods of coping with prolonged frustration much as other people overcome social stigmas such as "the fat kid in the class."

Other writers have contrary views. An earlier study by Andrews (1971:160-166) as well as a more recent investigation conducted by Casey *et al* (1992:256-260) make completely contradictory claims to those of Lamm and Epstein (1992:605). Andrews (1971:166) compared the self-concepts of good and poor readers in the senior primary phase. His findings revealed that poor readers tended to have greater feelings of inadequacy and lacked confidence. They tended towards conformity and dependence and had strong feelings of hostility and aggression while good readers were more confident and independent, and exhibited a notable lack of hostility and aggression. Casey *et al* (1992) conducted a study which compared a group of pre-adolescent reading disabled children with a group of proficient readers. Children (and parents) were given behaviour check lists, mental health questionnaires and self-perception

profiles. The findings suggested that the reading disabled children were more anxious and not as happy as the control peer group. In addition it was found that the older the child the poorer the emotional health.

Manzo (1987:409-410) maintains that, when an individual is emotionally upset he becomes so preoccupied with the problem which is causing the distress that he cannot think clearly or perform as he should. He contends that some types of reading disabilities are a form of psychological defence called Conversion Reaction Syndrome. He explains this as an unconscious process whereby anxiety provoking conflicts and fears are converted into "an external expression of some type" which results in feelings of detachment and indifference. The conflict is repressed and then emerges again in the form of a symbolic representation of the original fear. Manzo (1987:410) claims that reading can have many symbolic meanings for a child such as symbolising maturity and responsibility; the ability to read suggests intelligence and competence. A child's deep-seated fear of, for example, losing his parental protection once he is grown up, can result in a reading block. Manzo has found that some children with reading problems receive considerable attention from parents and others, and this reduces preoccupation with the real underlying fear.

Ephron (1972:10) views reading problems and emotional problems in a similar light when she refers to "surface and underlying threads". Surface threads are presenting symptoms of which the person is aware, such as "I am a poor reader", "I cannot concentrate", "Reading makes me nervous". The underlying threads, she claims, emerge as different expressions of fear. Beaumont (1991:261-270) lists as inhibitors of learning factors such as anxieties about family relationships, lack of assertiveness and curiosity, anxiety about discovering, infantile omnipotence, and the effect of loss of learning. She says the symbolic representation of words is important and believes in using psychoanalytical insights to reveal emotional problems which block reading progress.

Not all experts would agree with these more psychoanalytically based explanations of the connection between emotional problems and the inability to read but, what is evident from the literature is that the two are inextricably linked.

Continual failure makes the child feel that he is stupid and inferior in the eyes of others and he starts to believe this of himself. In addition these children are often punished making them feel even more inferior and inadequate (Gentile & McMillan 1989:29). This leads to further emotional and behavioural problems. The child is frustrated, anxious and often depressed. The result is that he becomes either introverted and withdrawn or angry and aggressive causing him to exhibit excessive acting-out behaviour. Orlow (1974) supports this view. She says that in the lower grades children with low tolerance for frustration exhibit disruptive behaviour and she claims that the problem is not reading *per se*, but the inability to cope with any complex task.

Strother and Barlow (1985:29-38) warn that it is important for teachers to be aware of and learn to recognise behaviour traits which signal emotional and academic problems. They describe the *inflexible child* who cannot handle changes in routine. Such children are usually passive and compliant, do not often voice their own opinions but can become rebellious later. They are often shy and lack spontaneity and resourcefulness, are extremely sensitive to praise and criticism and emotionally unstable. *The cautious child* is anxious and withdrawn. He lacks self-confidence and is chronically concerned about failure. He will exhibit avoidance behaviour in order to prevent failure. *The bully* is usually disobedient and antisocial. He is continually trying to gain attention and engage in negative behaviour rather than risk being ignored. *The helpless child* is the one who has developed feelings of inferiority and has a poor sense of personal competence. Such children are dependent and irresponsible. They often forget things and will not work hard. These authors believe children who exhibit any of these behaviour patterns should be referred for help.

In a discussion on conduct disorders, Stewart (in Gabel & Erikson 1980:399) claims that reading disability is one of the major causes of aggressive behaviour. He describes the behaviour as exhibiting persistent physical and verbal aggression, noncompliance, meanness, with destructive and antisocial tendencies. Parents and teachers complain that such children are demanding, ill-tempered, disruptive and generally difficult to handle.

3.4.3 Conclusion

As Beck (1988:774) explains, the problems of poor readers extend far beyond mere difficulty in decoding and understanding written words. These children also exhibit behavioural, cognitive and emotional problems. The literature review indicates that such children often have average to above average intelligence, yet they have trouble coping with most tasks in the classroom. Since most learning disabled children experience reading problems, all tasks involving reading or writing are difficult for them. Their work is often incomplete and inaccurate. Further, these children frequently have poor concentration, a short attention span and are impulsive. They usually have trouble following directions or staying in their seats and their behaviour is disruptive. Most of the authors quoted above agree that pupils with learning problems have poor self-concepts, low frustration tolerance and can be anxious and tense. In fact, a learning problem can have a ripple effect, influencing every area of the child's life-world and affecting his relations with all those with whom he comes in contact.

3.5 RELATIONSHIP STRUCTURES OF THE LEARNING DISABLED CHILD

Relation theory, which was discussed in Chapter Two, (see section 2.5.5) is a discipline which looks at the child in totality in terms of his relations with significant others:

- his relations with himself
- his relations with objects and ideas
- his relations with his parents
- his relations with peers
- his relations with teachers.

The child's relations with himself and his relations with objects and ideas (in particular the school situation, reading and other scholastic difficulties) will be assessed. The interaction between these two relationships will be considered. The effect which these

relationships have on the child's relations with parents, peers and teachers will then be discussed.

3.5.1 Relations with self

A person who has sound relations with himself has a high self-esteem and a healthy self-concept. Vrey (1990:13) describes the self-concept as a "configuration of convictions" which the person has of himself and this includes the person's attitude towards himself. The self-concept is influenced by the individual's relationship structures. In fact, Vrey claims it is the focal point of relationships in the person's life-world. It comprises three mutually dependent components: identity, action and self-esteem. The self-identity formation begins very early in life, as soon as the baby starts to distinguish between himself and other people and objects around him. As the self-identity develops so self-acceptance or rejection begins. Self-acceptance brings self-esteem which in turn bolsters a positive self-image. The characteristics of a child's relations with himself are evident in his self-concept. These characteristics are:

- the self-concept is dynamic, developing as the child grows up
- individuals act in such a way that their behaviour is in keeping with their self-concept
- there is interaction between the self-concept and achievement (Vrey 1990: 47, 76 and 115).

Jacobs and Vrey (1982: 38) say that a negative self-concept is responsible for:

... 'n gevoel van ontoereikendheid en 'n gebrek aan selfvertroue. Die selfkonsep is hoofsaaklik verantwoordelik vir wat 'n persoon dink hy kan doen, en hoe hy oor die algemeen optree. Indien so 'n persoon 'n lae selfkonsep het, is dit direk verantwoordelik vir die ontstaan van allerlei gedragsprobleme soos byvoorbeeld angs en spanning.

As was indicated in the earlier discussion on the characteristics of the learning disabled child, most experts concur that such children have poor self-concepts. Vrey (1990:268) supports this point of view. He says that the child's concept of himself as a learner is important. If the child sees himself as a successful learner he will tend to achieve success, however if he has repeated unsuccessful experiences in reading, for example, he will see himself as a failure and this in turn will have a negative effect on his self-concept. This can lead to the build up of an unrealistic image such as, "I am stupid", the result of which is often disappointment and frustration leading to anxiety and tension. The child's frustration with himself can also result in aggressive, hostile behaviour. If a child finds a task like reading too stressful he will start to act up in class because he is angry and upset Rosner (1975:16). This behaviour often results in punishment which aggravates the child's feelings and his behaviour deteriorates further. Eventually he becomes what Rosner terms, "another child". In other words each new negative behaviour pattern is reinforcing his negative image of himself and weakening his self-concept even further.

It is evident that the learning disabled child does not have a good relationship with himself. His self-concept is generally poor and he builds up an unrealistic image of himself as being incompetent.

3.5.2 Relations with objects and ideas

A child's relationship structures should be looked at in relation to the essences of involvement, attribution of meaning and experience. If a child is to develop into a fully self-actualised person it is essential that he learn to *attribute realistic meaning* to situations which he encounters. Meaning is not only attributed on a cognitive level: there is also an affective component which can often lead to unrealistic interpretations as can be seen from the example given above of a child thinking he is stupid because he cannot cope with a certain task. The same is true of the child's relations with objects and ideas, and in particular with reading and other scholastic tasks. As Jacobs and Vrey (1982:12) state the child attributes meanings like: "I don't understand" or "It's too hard", "I can't do it". This results in giving up and problems

like playing truant at school, feeling inferior and a whole spectrum of unacceptable behaviour patterns emerge.

This can also result in the child withdrawing from a stressful situation. He is then no longer actively *involved* in the learning tasks. A child must want to do a task and be actively involved in it if he is to succeed. This means being goal-directed, persevering, diligent and dedicated. Non-involvement affects not only the child's cognition but also his affective side and can ultimately have an impact on his values. One consequence of this may be what Carmichael (1991:274) describes as "learned helplessness" where, in trying to avoid failure, the child does not attempt the task at all. In other words he is completely uninvolved and the typical consequential behaviour follows.

Naturally, if a child is not willingly involved in a task and if he attributes negative meaning to it, his *experience* of the situation will also be negative. Experience determines the quality of relations. Since it is connected to the emotions and is unique for each individual, it determines how that person views any particular situation and affects future attribution of meaning and involvement. For example, if a child's experience of a new learning task, be it a new mathematical concept, spelling rule, reading method or even gymnastic technique, is unpleasant he will not attribute positive meaning to the situation and will be reluctant to become involved in such a situation again. In other words his relation with that object or those ideas will be negative (Jacobs & Vrey 1982:11-13). The result of these negative relations is, "Reading is boring", "I hate school", and so forth.

It is evident from the above discussion that a child's relations with himself and his school work are closely related. Carmichael (1991:274) contends that the child feels that his self-worth is "tied to the product". In other words he feels that if he fails to succeed with his school work then he himself is a complete failure. His self-esteem becomes so low that he eventually seems unable to convince himself he can succeed at any similar tasks. In her study on reading disabled children, Beck (1988:778) found that poor readers viewed themselves in a negative light, felt they were bad, stupid, unworthy and defective and saw school work as frustrating or threatening. The

attitudes they had built up regarding themselves and their reading affected their willingness to become involved in any scholastic tasks and impaired concentration during lessons.

Since the child's relation structures affect each other, his relations with himself and his school work will naturally affect his relations with other people in his life-world.

3.5.3 Relations with parents

A young child's most important relationship with other people is his relationship with his parents or a parental figure: an unsatisfactory relationship with parents can affect a child for life. A child stands a much better chance of growing up into a mature, fully self-actualised adult if he has sound, healthy relations with at least one parental figure. If the child feels loved, trusted and accepted by his parents he will grow up with a more positive self-concept and find it easier to form healthy relationships with other people than the child who experiences any kind of parental rejection. Vrey (1990:100) quotes research which he conducted on adolescents' self-concepts. His findings indicated that children with high self-concepts felt that they had received praise and encouragement from their parents even when they hardly deserved it and that their parents had taken an active interest in their school activities. Parental praise and encouragement are important for a child's self-esteem.

Research studies have shown that most parents have high expectations of their children and often feel let down when children do not do well (Singh 1991:79; Werner and Strother 1987:538-547; Casey *et al* 1992: 256-260). Parents may make unrealistic demands of their children. If children are aware of these goals and find they are unable to attain them they can become frustrated and disappointed in themselves. Parents usually want the best for their children but often pressurise them to achieve success at the expense of social and emotional development. Casey *et al.* (1992:256) found that well-educated mothers of learning disabled pupils tended to underrate their children's scholastic competence. This suggests that parents from higher socio-economic status put more pressure on their children to achieve with the

result that learning disabled children from this social strata were "at the greatest risk for poor self-esteem".

Parental pressure is one factor which affects the child's relations with his parents and influences his relations with self and school work. Another extremely significant factor which can have a detrimental effect on all other relation structures is the emotional bond between parent and child. Strother and Barlow (1985:31-35) describe certain types of parent/child relationships which cause anxiety and stress in the child and result in emotional and learning difficulties:

- Children brought up in an *authoritarian atmosphere* tend to lack confidence since their opinions are not considered important. They are often inflexible, passive, compliant and seldom participate actively in class, particularly in situations where they have to express opinions.
- *Erratic discipline and an inconsistent atmosphere* at home can make the child shy, nervous and over-concerned about failure. If parents are unstable, lack self-control and are self-centred, the child never knows what is expected of him, resulting in the child's becoming insecure. He tends to withdraw from the stressful relationship and this withdrawal often extends to other stressful situations such as school work.
- In a *suppressive or competitive environment* the child is reprimanded for saying what he thinks or feels. The child may perceive his parents as anticipating failure and often feels that if he cannot be the best, he may as well be the worst. Such children can become angry and aggressive and their behaviour in class becomes disruptive.
- *Overprotective parents* tend to feel that the child has to be protected from the harsh realities of the world. Everything is done for the child and he is prevented from gaining experience by experimenting. The result is that he gives up, does not try if tasks become difficult and becomes passive and dependent.

Beaumont (1991:263-264) adopts a more psychoanalytical approach to her discussion of the child's relationship with his parents. She maintains that this relationship affects his relations with himself and objects and ideas (in this case reading). She claims reading disorders can result if the child is unable to overcome an oedipal type complex and accept the relationship between his parents and his own relationship with his mother. If the child does not come to terms with these relationships he generally tends to become unassertive. Beaumont claims that assertiveness is necessary for learning.

Guernsey and Guernsey (1989:344-357) view the parent/child relationship as an essential component of any programme which assists a child in overcoming emotional problems. They orchestrated a project in which they trained parents to act as play therapists to their own children (see 2.6.7). Early (1994:119-130) also reported success when integrating play therapy and family therapy to improve relationship structures between parents and children.

It is evident from a review of the literature that a child's relations with his parents have a marked effect on his relations with the self, school work and reading in particular. If the child feels he is not achieving to his parents' satisfaction he will feel disappointed in himself and this will have a negative influence on his self-concept.

3.5.4 Relations with teachers

Once a child enters the classroom his relationship with his teacher becomes important for building up a healthy self-concept. Every teacher can confirm how many children blossom if given a praise and encouragement. Yet there are always children in the classroom, who, no matter what the teacher does, remain problems. Ouzts (1984:153) remarks that in today's schools the teacher is often confronted with children who are experiencing tension and depression. Ouzts quotes Monteith who claims that a great deal of stress, whatever its origin, changes children's behaviour and affects their ability to perform effectively at school. The child's poor academic performance and unacceptable behaviour cause teachers much frustration (Rosner 1975:16).

Teachers' frustrations arise largely because they have big classes with a large number of children, all of whom have varying problems and are at different reading levels. It is difficult for the teacher to give each child the necessary attention. The reading disabled child needs a great deal of the teachers' expertise and the teacher does not have the time to give it. In addition, many of the child's problems are the result of external factors such as the home environment, over which the teacher has no control (Strother & Barlow 1985:29-30).

The result is that the teacher, often inadvertently, blames the child for the problem. As Lerner (1976:3) remarks, children get labelled "lazy", "naughty", "immature", "emotionally disturbed". Any child, particularly a young, impressionable child who continually hears derogatory remarks about himself will start to believe them and these will ultimately have a negative effect on his self-concept. As mentioned in the discussion on the child's relations with himself, the child moulds his behaviour so that it supports the image he has of himself. Thus if the child is told repeatedly that he is "stupid", "naughty" or "impossible" he will behave in this manner.

As Singh (1991:76) remarks, the child begins to see his teacher in a negative light as he is continually in trouble. The teacher conveys dissatisfaction in both verbal and non-verbal ways and the learning disabled child becomes sensitive to this. As a result of his unpleasant experiences in the classroom he often attributes a negative significance to these experiences. For example, "I can't do the work so the teacher hates me!" The consequence of this is that he then withdraws and does not become involved in the learning situation.

3.5.5 Relations with peers

Once the child reaches school-going age peers become more and more important in his life. As the child grows up he finds that adults cannot meet all his needs and he turns to children his own age. It is important for a child that he builds up sound relations with his peer group. As part of the group he learns independence, cooperation and sharing, and he experiments with and experiences many new things.

Vrey (1990:101-102) explains a peer group as:

... an intimate and select group. Admission depends on mutual choice. Status within the group is a function of the group's values and the individual's role in it.

He says that the criteria for admission are: intelligence, family background, social class, appearance, physical skills, personality traits and sex role. The child's physiological maturation and socio-psychological relations must be on a par with his playmates and he must be able to keep personal whims under control so that he can get along with others.

Good relations with his peers, and their acceptance and respect can have a positive effect on his self-esteem. In any group there is a measure of rivalry and competition. An individual usually compares himself to other members of the group to see how he matches up or fits in. If the comparison is favourable this can increase self-esteem. However, when the child who is experiencing learning difficulties compares himself with his friends and finds he cannot cope as well as they can, he begins to develop feelings of inferiority. The problem is compounded when other children draw attention to the child's shortcomings. As the child's confidence decreases so his relations with his peers deteriorate. As has been indicated previously, feelings of inferiority often result in socially unacceptable behaviour patterns like withdrawal or showing off and acting out. This can threaten the group's acceptance of the child.

Casey *et al* (1992:259) quote the Social Comparison Theory which states that people always compare themselves with those in their environments to form estimates of their self-worth. The authors quote studies which say learning disabled students consider themselves more competent when comparing themselves with other learning disabled peers than when they compare themselves with children who achieve scholastically. It is important for the child's sense of self-worth that he feels he fits into his peer group and that it gives him the emotional support he needs.

3.5.6 Interaction of relational structures

From the above discussion it is evident that a child's relational structures are all inter-linked, with each one affecting the others. Negative experiences, lack of or inadequate involvement and unrealistic attribution of meaning in any one of the relationships will have some kind of effect on the other since all interact to form the total "self". This interaction can be diagrammatically represented as in Figure 3.1.

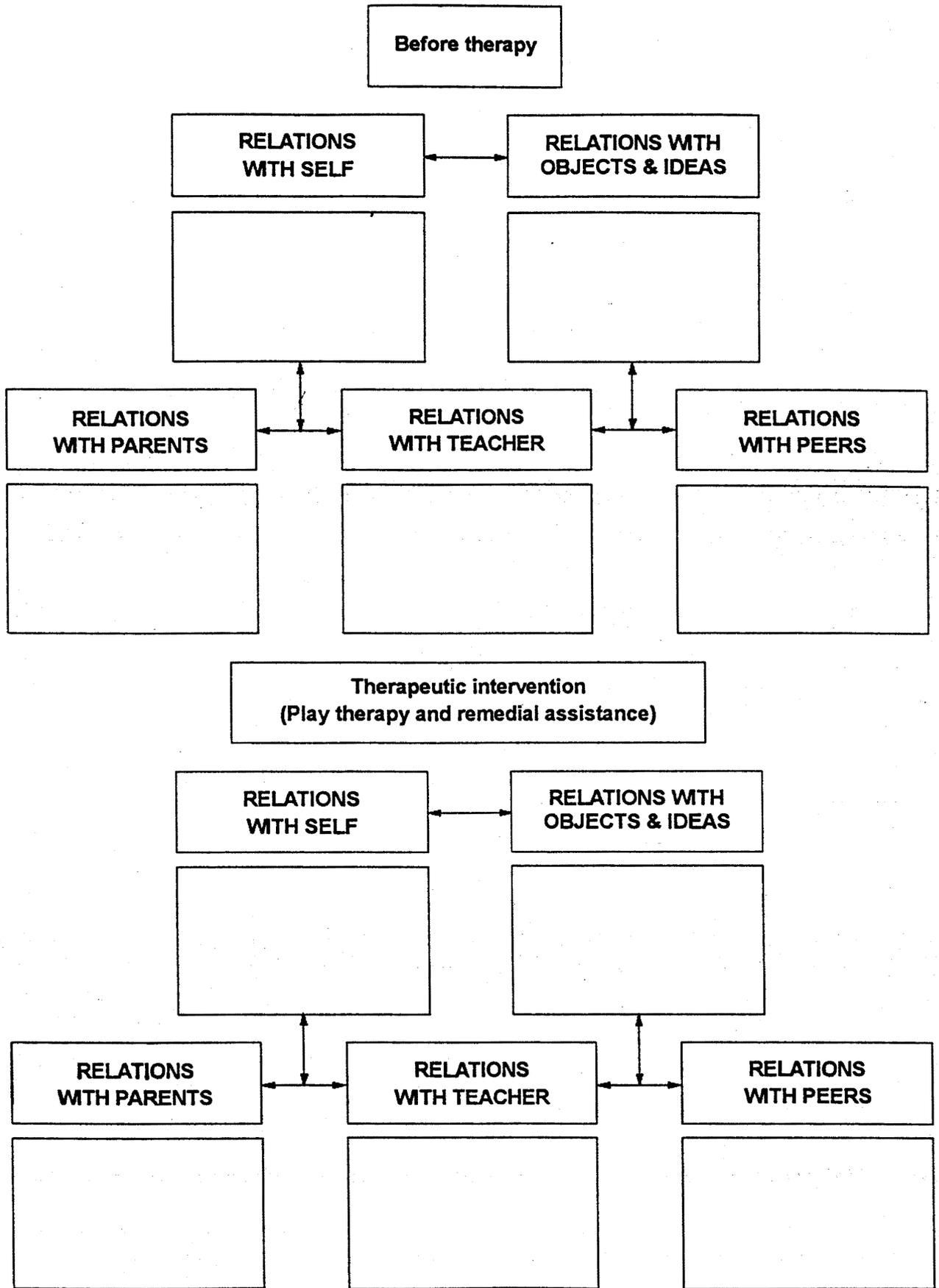


Figure 3.1 Interaction of relation structures

3.6 ASSISTANCE FOR THE READING DISABLED CHILD

3.6.1 Criteria necessary for the child to become a proficient reader

It is important for the person who renders assistance to the learning disabled child to be aware both of the skills required in learning to read and of the problems which prevent the child from acquiring these skills. Lerner (in Hedley and Hicks 1988:8-9) quotes a report compiled in America which gives the following generalisations about "skilled reading":

1. *Skilled reading is constructive.* The reader has to bring meaning to the printed text. In order to do this he has to draw upon existing knowledge and prior experience and construct the meaning.
2. *Skilled Reading is fluent.* This means word identification must be an automatic process, not conscious and deliberate. If the reader has to concentrate on figuring out words he cannot focus on meaning.
3. *Skilled reading is strategic.* A skilled reader is able to change his reading style depending on the purpose of reading and the complexity of the text. He can skim over easy or unimportant text and use "fix-up strategies" like re-reading or rephrasing difficult text.
4. *Reading requires motivation.* Reading skills take a long time to acquire and the reader has to persist if he wishes to acquire the skills. Many poor readers are unmotivated, listless, inattentive and give up easily.
5. *Reading is a lifelong pursuit.* Reading requires practice and it is important that the child has sufficient opportunity to improve his skills.

Allen (1992:202) says that the reading skills most likely to be missing in a child who has difficulty acquiring such skills are:

- adequate attention span
- ability to imitate
- perceptual motor efficiency
- fine motor control
- ability to form concepts
- short and long-term memory
- ability to follow instructions.

From the discussion about the life-world of the learning disabled child with his complex problems, it is evident how difficult it is for him to acquire these skills. As Beck (1988:774) remarks, learning to read is a far more complex process than the mere decoding and comprehension of words. Many other factors enter into the process.

There are certain criteria that are essential if the reading process is to be successful: mentally the child must be the correct age, he must be emotionally and socially independent enough to attempt reading, he must have experiences that give meaning to what he is reading and he must have adequate skills to enable him to translate printed symbols into meaningful words (Axline 1947:61).

3.6.2 A brief discussion of remedial reading methods

The literature abounds with a myriad of different methods which have been used in attempts to assist children with learning problems. Kinaesthetic approaches, phonetic approaches, look-and-say methods, nonsense-syllable approaches, whole story approaches, have been tried with varying degrees of success. Topping, Mallinson, Gee & Hughes (1985:52-55) used paired reading with reading disabled children. They claim these pupils showed improvements not only in reading fluency but also confidence and self-image. Ideas like giving children experiences which develop vocabularies and give meaning to what they read have been tried. Approaches such as using easy books to give the child a feeling of success, waiting until he is ready to read and wants to read and so eliminating pressure have also been adopted.

Axline (1947:62) claims that each method gives the same results: some cases are successful and the child benefits from the approach; in other instances the child still makes little or no progress. Axline criticises these approaches because they only have one objective: teaching reading. She remarks:

... everyone of these devices is pointed directly down the road that says
READING in big letters at the end.

The problem with these methods appears to be that many children who cannot read have already developed a negative attitude towards reading and often have emotional blocks against it. If these emotional blocks are substantial it seems to make no difference what method of teaching reading is adopted: it only meets with minimal success. Axline contends that if children are happier, more relaxed and better adjusted they will be better able to cope with the complex task of learning to read.

Other authors (Orlow 1974:669-674; Lewis 1984:444-459; Strother and Barlow 1985:29-38; Beck 1988:774-779; Beaumont 1991:261-270) concur with Axline's view. While their methods differ quite substantially from one another they all contend that if a remedial reading programme is to succeed, cognisance must be taken of the child's emotional state. Most experts agree that a comprehensive treatment programme should be introduced. In the next section some of these programmes will be briefly reviewed.

3.6.3 Examples of remedial reading programmes which include emotional support

Beck (1988:774-777) and Strother and Barlow (1985:29-35) suggest programmes which can be implemented in the classroom by the teacher and both programmes involve working on the behavioural and emotional aspects of the child's problem. Beck suggests a system of interventions. Once the problem has been analysed the teacher chooses one or two "interventions". The child must be actively involved and his ideas and suggestions encouraged. Records must be kept and progress must be

continually evaluated. An example is a pupil who is always calling out and disrupting the class. The intervention would be to set him an initial goal of only allowing himself to call out three times in a session. He must monitor himself and can write down every time he is able to stop himself disrupting the lesson. This method can be extended and altered to cope with other behavioural disturbances he may have, such as procrastination and day-dreaming.

Strother and Barlow's method also involves working with the child's problem in the classroom. In this study many children also had individual therapy. Their method is for the teacher and counsellor to work together and try to change behaviour patterns in the classroom. For example a child who is always trying to attract attention with disruptive behaviour must be given tasks involving responsibility and then be noticed for positive behaviour.

In an article on reading problems of children with low tolerance for frustration, Orlow (1974:669-674) quotes European school systems which concentrate on multifaceted programmes. These include perceptual training, physical coordination, communication skills and so forth. Orlow remarks that these programmes could be more effective if the teacher also concentrated on dealing with frustration and emphasising emotional support.

Educational therapy is another method which combines therapy and remedial assistance. Part of the sessions are structured on a psychoanalytical basis and concentrate on the emotional aspect of the child's problem while the remaining time is devoted to scholastic problems like reading, writing or mathematics (Beaumont 1991:261-270).

Lessing (1995:1-3) stresses the importance of an integrated approach to assisting the learning disabled child with his individual problems. She says that aid programmes should be flexible and must be adapted to the needs of the individual child. The method she adopts is to compile what she refers to as "n eie leesboek" (see 3.6.3). The book can be used in a remedial programme both for therapy and as a basis for

reading instruction. It assists the child to improve oral communication and acquire better reading skills. In addition the method has the advantage of motivating the child since it is orientated towards subjects which are of interest to him. Lessing (1995:6) remarks:

Die geïndividualiseerde aard van die samestelling van 'n eie leesboek volgens taalervaring en belangstelling van die leergeremde kind, bied voldoende geleentheid vir wysigings in die program om voorsiening te maak vir gevoelsmatige aspekte soos aanpassing, motivering en belangstelling, siening van homself, bepaalde persoons-eienskappe en sukses en genotsbeleving, volgens die behoefde van elke leerling.

While Lessing uses an individual approach many other remedial programmes concentrate on group therapy. The obvious advantages of which are that it is less time consuming than individual therapy, and children with reading problems eventually have to learn to cope in a group situation. Lewis (1984:444-459) quotes a study which was conducted on a structured group counselling programme for reading disabled children. His contention is that it is important to have a comprehensive programme which aims to improve emotional as well as reading difficulties. In the study pupils were divided into six groups. Each group received eight 40 minute counselling sessions over a period of four weeks as well as 30 minutes of remedial reading instruction. For the counselling sessions three groups received non-directive counselling while the other three went through a structured therapy programme. At the conclusion of the study it was found that the structured group produced significantly greater gains in reading comprehension (although not reading rate). They also showed more positive gains in self-concept and lessened anxiety.

In contrast, Axline (1947:61-69) describes a project conducted on a group of poor readers where a non-directive therapeutic approach was used. The rationale behind this approach is "respect for the individual". If the child feels he is respected by others for what he is, he will gain inner respect and then be better able to help himself. The programme used in this study concentrated on providing opportunities for the children

to express themselves through the mediums of art, play, free drawing, puppets, telling stories and so forth. The approach was non-directive, everything was voluntary and no pressure was exercised. Reading was included in the programme in the form of group reading. In the groups children dictated their own stories and read them back, listened to and read easy stories. However the pupils were never forced to join a group. They came if they wanted to and even then were not forced to participate. By the end of the period most of the children were joining the groups of their own free will. No remedial reading instruction was given. A few children were also given individual play therapy sessions. The result was that the programme improved personal adjustment and there was a noticeable improvement in the reading skills of almost all children.

3.6.4 Play therapy as part of a remedial reading programme

Like Axline's non-directive remedial approach (see 3.6.2) many programmes include play therapy as an incidental or separate component of remedial and therapeutic assistance. Axline (1989:55) does, however, remark that reading problems have improved when play therapy has supplemented or sometimes even replaced remedial reading instruction. Werner and Strother (1987:540) remark that the importance of play for emotional and cognitive development cannot be overemphasised. The authors claim that while play helps children to express feelings, explore relationships and the self and resolve conflicts, it is also important for cognitive growth. They quote Piaget who believed that sensori-motor learning through play is a prerequisite for thinking and language development. Reference is also made to a study by Pellegrini who claims that "higher modes" of play like socio-dramatic play are also necessary for developing reading and writing skills. Apart from the emotional benefits of play therapy such as communicating and expressing emotions of anxiety and aggression, play can also be used for the development of skills and modification of life style (Burns 1970:37-41). From these remarks it seems that including play in a remedial programme can be of great benefit to the child. Yet in the literature there are few examples of play therapy forming an integral part of the programme.

One reason for this could be the use of the term *play*. As Carmichael (1991:274) explains, this can be because of the traditional belief that children are sent to school to learn, not to play. The object of many remedial reading programmes is to teach the child to read in as short a time as possible so that he does not get even further behind the rest of the class. Play is time consuming and to spend an hour letting a child play in a sand tray or build houses with blocks when he does not know his sound combinations or has a problem with reading comprehension would appear unnecessary to many uninformed educators.

Carmichael (1991:273-276) claims that many experts incorporate play activities into remedial programmes but do not use *play therapy*. She argues that the advantage of play therapy is that it allows the child a safe environment in which he can express and explore feelings. Negative, unacceptable feelings of anger, frustration and disappointment can be openly expressed and the non-judgemental approach of the therapist helps the child to gain self-confidence. He feels he is unconditionally accepted for all his positive and negative qualities, those directly related to school as well as those which have nothing to do with school. In such an environment failure is not possible. As Carmichael (1991:276) concludes:

The role of the play therapy becomes to support the child, encourage the child and build self esteem; thus creating the optimal learning environment for reading improvement.

Some experiments have been done using various types of play therapy with learning disabled children before embarking on remedial programmes. Most studies used non-directive therapy but some researchers used more structured approaches such as mutual story telling and games. The non-directive studies showed improvements in reading even without remedial reading instruction (Schaefer & O'Conner 1983:425-427). McMahon (1992:124-130) also claims success using non-directive play therapy with children who have learning difficulties.

In these studies the counsellors only dealt with the emotional problems of the child. They worked on the supposition that if the child's mental health improved a better climate would be created for learning. However, once the learning disabled child is emotionally ready to acquire academic skills he usually still needs additional assistance to catch up in areas where he has fallen behind his peers. If he is not assisted to catch up his emotional problems may recur. Landreth (1982:274-293) advocates what is referred to as an interdisciplinary or "team approach". He describes the problem as a "multi-faceted disability" and says that it requires multi-faceted remediation. The trouble is often that the child's difficulties are identified but the most pressing need is stressed and remediation is concentrated on this problem while the others are held in abeyance. The team approach looks at the child in totality. The therapy programme covers the areas of reading, counselling and speech, and hearing while the child receives assistance in one or a combination of the components. The areas do overlap but each requires specialised techniques which can be provided by experts. Landreth advocates play therapy as the best way of assisting the child emotionally. He summarises the advantages as follows:

Through the complete process of play therapy he becomes responsible for himself and thus more self-directing not only in the play therapy room but also in his classroom, his home and his everyday life.

While there are many obvious advantages to such a programme, the author points out problem areas such as difficulties in building up cohesiveness amongst members of the team.

Studies have been conducted using play group therapy to assist learning disabled children. As Slavson (in Schaefer 1979: 244) explains, the advantage of the group in play therapy is that it facilitates the expression of fantasies and ideas. Mutual support often helps the child play out frustrations. Anxiety is lessened by the support and acceptance of others in the group. In addition it has the advantage that children will modify behaviour if they feel it will lead to recognition and acceptance by others, particularly peers. Guerney (in Schaefer & O'Connor 1983:426) quotes studies which

have successfully used this method to assist such children. These studies included the use of structured therapy using puppets, animals and figurines to examine classroom behaviour and game-like situations to teach appropriate behaviour.

Singh (1991) used play group therapy, from a relation therapy perspective, as an aid in assisting learning disabled children. Her study was conducted with two groups of children. The experimental group had sessions of play group therapy as part of their remedial education programme while the control group continued with the normal programme. She found that play therapy improved and strengthened the relationship structures of the experimental group.

To summarise, play has been used successfully in a variety of different ways with learning disabled children. It has been implemented as a supplement or a precursor to remedial assistance to improve the affective component of the problem. Play has also been incorporated into group therapy and in some instances has formed an integral part of the remedial reading programme.

3.7 SUMMARY

In focusing on the world of the learning disabled child, this chapter has considered different experts' explanations of the term *learning disabled*. While there is no simple definition of the term, most authors agree that children with learning disabilities do not achieve according to their potential as predicted by their intelligence. Children with motor, visual and auditory handicaps are not considered learning disabled but the term does include such problems as minimal brain dysfunction, dyslexia, aphasia and retarded perceptual development. Learning disabled children are considered developmentally different. Reading disability, as the single most important aspect of learning problems, was defined and aspects of the problem were discussed.

It is difficult to ascertain exactly what causes learning and reading problems. Factors such as physical and perceptual development, cognitive difficulties, personality and

affective problems and socio-economic circumstances have been suggested as possible causes of the disability. Experts quoted in this chapter generally agree that the problem is complex and may be the result of a combination of factors. It is often impossible to determine which problems are the cause of the disability and which result from the child's difficulties in trying to cope with scholastic tasks. It is generally accepted that learning difficulties are often accompanied by emotional problems.

Some general characteristics of the learning disabled child were briefly reviewed. A more in-depth survey of the literature was carried out to look at the relationship between emotional and reading problems in the learning disabled child. Most of the authors reviewed found the two problems interrelated. Irrespective of what is initially responsible for the reading problem, children who cannot cope academically at school feel frustrated, angry and disappointed in themselves. Continual failure makes them feel inferior and this manifests itself in a poor self-concept. Behaviour problems result and this affects the child's relationship structures.

The relationship structures of the learning child were examined. The poor relations with objects and ideas (the child's school work) have an adverse effect on his relations with himself and vice versa. Since all the relation structures are interlinked, these relations also have a negative effect on relations with parents, peers and teachers.

The last part of this chapter was devoted to a discussion on possible assistance which can be rendered to the learning disabled child. The literature abounds with a wide variety of remedial strategies. The majority of these methods are successful with some children and not with others. Axline (1947) concludes that this is because most of these methods aim at remediating only reading and do not look at the affective side of the child's problem. Programmes which combine reading and therapy were reviewed and generally found to be successful in improving the child's emotional well-being and consequently in many cases reading improved. Play therapy has been used with great success in some case studies as either a supplement or replacement to conventional remediation. Play group therapy implemented in remedial programmes has also had positive results. In spite of the success of play therapy in assisting

children with emotional problems relatively few studies have been done where play therapy has been used as an integral part of a remedial reading programme.

The next chapter presents the methodology used by the researcher in designing a programme which incorporates play therapy into a remedial reading programme from a relation therapy perspective.

CHAPTER FOUR

RESEARCH DESIGN

4.1 INTRODUCTION

A review of the literature has revealed that the learning disabled child's problem extends far beyond the inability to cope with academic tasks at school. The young child enters school for the first time filled with expectations. If these expectations are not fulfilled, instead of developing feelings of competence and independence, doubt begins to set in. The child feels inadequate, frustrated and angry. The self-concept begins to be negatively affected. As was indicated in Chapter Three (see section 3.5.6) this has an adverse effect on all relation structures since they are interlinked. A positive self-concept is necessary for the child to develop into a happy, well-balanced individual. Repeated negative experiences hinder his progress towards becoming a fully self-actualised person.

It is, therefore, important for the child to receive assistance to overcome these difficulties. As the preceding chapters indicated, this aid should aim to assist in all areas of the problem and not concentrate on any one or two specific aspects. The child with learning difficulties is in need of remedial help and emotional support.

Play, usually seen as a pleasurable activity indulged in by children, has been described as a medium through which children express feelings, explore relationships and seek self-fulfilment. Play therapy, as discussed in Chapter Two, provides a situation in which the child can "play out" his repressed emotions in a safe, non-threatening atmosphere. He can just "be himself" and learn about himself, secure in the knowledge that he will be accepted for himself. Play therapy has proved

successful in assisting children with emotional problems. For this reason, the researcher decided to incorporate play therapy into a remedial reading programme.

This chapter describes the design of the empirical research. The aims of the study are set out and discussed. The problem, which has emerged, is delineated. The three basic assumptions on which the study is based, are stated. The remainder of the chapter is devoted to a description of the research methodology. The research approach, selection of subjects, diagnostic media and choice of play therapy material are explained. A description of the design of the programme and structure of the sessions concludes this chapter.

4.2 AIMS OF THE EMPIRICAL STUDY

4.2.1 General aims

From the review of the literature it has emerged that there is a relationship between emotional and reading problems in the learning disabled child. The purpose of this empirical study is to investigate how this relationship affects the child's other relation structures. The study proposes to view the child in totality. The aim is to establish whether the child's scholastic performance and relation structures can be improved by rendering remedial and emotional assistance, through play therapy.

4.2.2 Specific aims

The purpose of this study is:

- to investigate how the individual child's reading disabilities and emotional problems are interlinked and to establish how this relationship affects his relations with:

- * self
 - * objects and ideas (specifically school work with emphasis on reading)
 - * parents
 - * teachers
 - * peers
-
- to devise a programme which will attempt to improve relation structures by assisting the child with both emotional and scholastic aspects of the problem from a psycho-educational perspective using relation therapy as a basis
 - to establish whether all essential requirements of a successful play therapy environment can be incorporated into a programme using relation theory as a basis and employing a variety of different techniques
 - to evaluate the effectiveness of the programme on the child's self concept, scholastic progress, behaviour and his relation structures in general.

4.3 DELINEATION OF THE PROBLEM

The problem which is to be investigated has three closely related components.

- * A review of the literature has confirmed the relationship between emotional and reading difficulties. The first aspect of the problem is to establish what the relationship is and how the two factors interact with each other. The effect of this interaction on the child's other relation structures also has to be considered. If the therapist is to understand the child he must discover how the child attributes meaning to the world around him, how involved he is and how he experiences his world. The therapist then has to ascertain the effect of the child's application of these essences on his relationship with self and school work and how this affects other relations. The problem is to establish exactly how these relation structures function in the learning disabled child.

- * In order to render effective assistance, the therapist must address all aspects of the problem. The literature indicates that many educators, while being aware of the complex nature of learning disabilities, attempt to alleviate them by working only with the scholastic aspect (see section 3.6.2). Others include an affective component but it is often artificially separated from the cognitive. However, many authors quoted in the literature study advocate the integration of the two components for the most effective results. The difficulty is how to adopt a holistic approach to the problem that will ensure that the child's problems are all addressed.
- * It is evident that some type of emotional support must be included in the scholastic programme but the questions which arise are:
 - what is the best type of therapeutic assistance to render, and
 - how can the therapy be practically incorporated into the programme?

As the literature indicates, play therapy has proved particularly successful with younger children and for this reason it was decided to use it in this study. In Chapter Two, a number of different approaches to implementing play therapy based on various personality theories, were reviewed. The wide variety of techniques which have been developed were also discussed. However, not all these techniques are compatible with the theoretical bases of the different schools of thought. Many approaches are restricted in the number of methods they can use. For example, non-directive therapy cannot employ any techniques which require structuring (see section 2.4.2.1). Conversely behaviourist therapy is structured and prescriptive and non-directive techniques are excluded (see section 2.4.3).

Relation therapy is based on client-centred therapy but is not as prescriptive in its approach to counselling. The therapist who works from a strictly child-centred perspective is restricted in that he may only use a non-directive approach. Working within the relation theory structure and from the child's frame of reference, the therapist has the freedom to use any approach he considers suitable for the individual child. He can also employ any technique he feels will be of assistance. The question

is: can play therapy be successfully implemented from a relation therapy perspective using a flexible approach and a variety of techniques?

A further problem is the actual incorporation of play therapy into a remedial programme. In addition to practical considerations such as time and available facilities, the structuring of the programme requires careful consideration. There are fundamental differences between scholastic and therapeutic assistance. Axline's (1989:69-71) basic principles of play therapy include developing a warm, friendly atmosphere in which the child feels completely accepted (see section 2.4.2). This climate should be non-threatening. The child must not experience criticism or failure since the intention is to make him feel he is respected and accepted as an individual in his own right. On the other hand, a child who is experiencing reading problems will find any situation involving the written word threatening, no matter how understanding and caring the teacher or therapist is. The problem is how to merge the two so that both the affective and cognitive aspects of the child's problems can be addressed.

4.4 ASSUMPTIONS UPON WHICH THE STUDY IS BASED

In considering the problem set out in section 4.3, three assumptions have been made:

- * **There is a relationship between a child's learning disabilities and emotional problems which has a negative effect on all other relation structures.**

Relation theory, as reviewed in Chapter Two, does not look at the child in isolation but sees him in terms of his relations with himself and the world around him. As figure 3.1 (section 3.5.6) indicates, relations with self and objects and ideas (in particular, school work) can affect each other positively or negatively depending on the child's attribution of meaning, involvement and experiences of events. This relationship, in turn, affects all the child's other relation structures.

- * A remedial programme implemented from a psycho-educational perspective and which includes both emotional and scholastic assistance can improve the child's relation structures.**

In Chapter Three the effect of the various relation structures upon one another was discussed. It is evident from the literature that if a remedial programme is to succeed, it must look at the child in totality and assist both affectively and cognitively. A programme which aims at improving the child's relations with himself by assisting him to know, understand and accept himself will improve his self-concept and his attitude towards his scholastic problems. If such a programme also assists the child by giving him specific learning or reading skills, this will further improve his school work and can, in turn, make him feel better about himself. In this way a positive cycle which builds up the self-concept will begin. This positive interaction will strengthen his relations with all around him.

- * Play therapy, implemented from a relation therapy perspective, can be successfully incorporated into a remedial programme.**

Relation therapy, like client-centred therapy, emanates from an external frame of reference. Client-centred therapy is completely non-directive. The child takes all the initiative while the therapist's role is merely to create the climate of acceptance by reflecting the child's feelings. The most important aspect of non-directive therapy is the creation of a warm empathetic climate in which the child feels accepted for himself. Using this method the therapist can neither adopt a more structured approach nor use play techniques which require direction from the therapist. Relation therapy has the advantage of being able to combine all the positive aspects of the client-centred theory with other approaches. In relation therapy, the therapist works from the child's frame of reference and has the freedom to employ any techniques which meet the needs of the child. With the variety of approaches available to the relation therapist it will be possible to include all the essential elements of play therapy into the programme.

4.5 RESEARCH METHODOLOGY

4.5.1 Research approach

The research will be conducted as an idiographic study. The subjects' problems will be diagnosed according to the model of Jacobs and Vrey (see Figure 2.1). A flexible programme aimed at assisting all aspects of the problem will be implemented. The interaction of the reading and emotional problems and their combined effect on other relations will be assessed in terms of the model suggested in Chapter 3 (see Figure 3.1) in order to determine the course of further therapy.

4.5.2 Selection of subjects

Five subjects were used in the study. All subjects had to meet the following criteria.

- * They had to be junior primary children between the ages of seven and ten.
- * No subjects were used whose IQ's were below 80. The subjects I Q fell within the "normal" range of intelligence and ranged from dull normal to above average.
- * The subjects' problems were not of a neurological or physiological nature.
- * All subjects had to have both emotional and scholastic problems. (In some cases the emotional problems were more severe than in others; in half the cases the scholastic problem was the reason for referral; the others were referred for both behavioural and learning problems.)
- * The subjects reading levels were below expectations and approximately a year below their chronological ages. The children could therefore be described as having a reading disorder according to the DSM III (see section 3.2.1).
- * All subjects had had some form of remedial help which had resulted in minimal improvement in their reading skills.

4.5.3 Selection of diagnostic media

1. Orthodidactic tests

* *One Minute Reading Test*

In the One Minute Reading Test the child has to read as many simple two, three and four letter words as he can in a minute. The test is arranged so that some words which can be sounded are interspersed with "sight words". This assists the tester with diagnosis in determining possible problem areas. The beginning of the test also includes words which can be easily misread, like "was" and "on", so reversals can be easily identified. This test was included because it is an easily administered test and has a norm table giving a suggested reading age for word recognition. The words are all basic so a child with a different cultural background will not be disadvantaged.

* *Neale's Analysis of Reading Ability Test*

The Neale Reading test is an individual reading test which measures a child's reading speed, accuracy and comprehension. The test consists of graded reading passages which the child has to read and then answer set questions on the passage.

* *Sound and sound combination evaluation*

If a child is very weak at reading it is impossible to use the Neale test and sometimes such a child can only master a few words on the One Minute Reading Test. It is nevertheless important that the tester establishes whether the child has acquired any reading skills. For diagnostic purposes, if the child could not cope with either of the above tests the researcher tested his knowledge of basic sounds and sound combinations. An evaluation can also be done with an older child to establish specific problem areas (See Appendix 1).

* *J-JICIB Spelling Test*

There is a close connection between reading and spelling, and many problems in a child's reading can be noticed when he spells words. For this reason it was decided to include a diagnostic spelling test. This particular test is short and can be easily

administered individually or in a group. It gives an indication of basic sound combinations and spelling rules which the child has not mastered.

* *TED battery of visual perceptual tests*

The TED battery includes tests to assess:

- analysis/synthesis
- figure-ground
- discrimination
- position in space
- visual sequencing
- visual memory.

It is implemented on an individual basis and gives the child's perceptual age for each separate area. Experts (Rosner 1975; Lerner 1976; Hosler & Fadely 1989; Bos & Vaughn 1994) agree that children with learning disabilities often have accompanying perceptual problems. If the child is to be assisted in all aspects of his learning problem it is important that the tester ascertain whether there are weaknesses in any areas of visual perception.

* *Bender-Gestalt Test*

The Bender-Gestalt Test, which requires a child to copy nine different geometric type figures as accurately as possible, measures the maturational level of the child's visual motor gestalt function. It assesses problems of distortion, rotation, integration and perseveration and can give an indication of minimal brain dysfunction and possible neurological impairment.

* *Senior South African Individual Scale - Revised 1991 (SSAIS-R)*

The SSAIS-R is an individual intelligence test, standardised for English and Afrikaans speaking children between the ages of seven and sixteen years eleven months. The test is used to give a differentiated image of specific cognitive abilities. It is based on the assumption that intelligence is a combination of related abilities which, when grouped together represent a general intelligence level (Van Eeden 1991:3).

In this study it was important to ensure that the children's learning disabilities were not the consequence of low intelligence. This was the reason for the inclusion of this test. An advantage of the SSAIS-R is that, apart from the overall intelligence figure, each individual sub-test measures a different aspect of intelligence and gives an indication of the child's ability in that particular field. This facilitates diagnosis of a child's learning problems since it gives an indication of his potential and his innate strengths and weaknesses in any specific area. Certain types of behaviour are required for the execution of some of the sub-tests. The child's responses give an indication of behaviour patterns which can also affect scholastic performance.

2. Projective tests

* *Draw-a-Person (DAP)*

The DAP is a simple pencil and paper test in which the child is asked to draw a human figure. No other instructions are given and he may draw the figure just as he wishes. This test is used to understand the life-world of the child who does not have, or cannot use verbal skills to express his emotions. The test was developed from the ideas of Machover who believed that certain sensations, emotions and perceptions are associated with certain parts of the body (Jacobs & van der Merwe 1992:3). Conventional interpretation is done using:

- a structural analysis which looks at aspects such as size, position on the paper, quality of line formation and so on
- a contents analysis which considers details of how the figure is drawn.

In this study, the interpretation is done from a relation therapy perspective according to the methods of Jacobs and van der Merwe (1992). This will be discussed in Chapter 5 when interpreting the drawings.

* *Kinetic-Family-Drawings (KFD)*

Like the DAP test, the KFD is also a pencil and paper test in which the child has to draw a picture. In this case he is asked to draw each members of his family doing something. The inclusion of a kinetic aspect to the drawing is intended to give an

indication of interpersonal relations as well as the child's feelings towards the self. Such drawings often reflect primary disturbances in family relations more effectively than any other technique (Burns & Kaufman 1972).

* *Childrens' Apperception Test (CAT) and Langeveld's Columbus Series*

The CAT and Columbus were developed from Murray's Thematic Apperception Test which is based on the premise that pictures can act as a stimulus onto which the client will project conscious and unconscious needs and emotions.

The CAT is designed for children between the ages of three to ten. It consists of ten plates with animal figures, most of whom are performing human activities. The theory behind this is that children would be more attracted to animals and that many children's fantasies, both personal and in books, contain animals. In addition young children may need animal figures to distance themselves from the stimulus since, generally, they have difficulty separating fantasy from reality. If the stimulus becomes too personalised projection may not occur (Palmer 1983:153).

The Columbus is a further development form of the TAT. It also consists of a series of pictures, most of which are vaguely drawn and chromatic while there are a few coloured cards to alleviate fatigue. The pictures have children's figures and are designed to assist the therapist to analyse the child's relations with things inside and outside school, relationships with other children and relationships with adults.

In this study the CAT was used predominantly but in some cases if the therapist wanted to explore a specific relationship some Columbus pictures were included.

* *Play therapy*

The child's play was also used as a diagnostic medium to explore relation structures. A largely non-directive approach was adopted for diagnosis. If the child was reluctant to indulge in spontaneous play encouragement was given in the form of suggestions, such as "Why don't you build a house?", "Why don't we put people in the house/school and see what they do?" Interpretation was from an external frame of reference.

4.5.4 Selection of play media

Landreth (1987:255-257) remarks that toys for play therapy should be selected not accumulated. He claims that randomly selected media can doom the therapy to failure. He claims that toys should cover the following three broad categories:

- real-life toys such as dolls, furniture, crockery, cars
- acting-out or aggressive toys like guns, rubber knives and toy soldiers
- toys for creative expression and emotional release such as pencils, paints, play dough and puppets.

The material for the study was selected with the following objectives in mind:

* It was considered important to provide the type of material with which children could identify. It was essential to include toys which could serve as projection media to enable children to express repressed feelings. For this reason it was decided that the basic play material used for this study would be modelled on the objects used in the Sceno-test devised by Von Staabs (1991). It contains many of the basic toys experts have found useful for diagnosis and therapy. Von Staabs (1991:1) says of his materials that they enable the therapist to obtain information about the child's mental problems and how these relate to environmental factors.

* There had to be a variety of toys to keep the children interested and involved. Since this study was done by the researcher in her capacity as a school psychologist she had to work with children in the school situation (as opposed to a therapy playroom) and had to travel from school to school.

For this reason it was necessary to choose material which was easy to transport while, at the same time ensuring that the chosen media was able to meet the requirements mentioned above. The basic kit contained:

- small figures representing people of various ages, both sexes, and different races (some dolls were made to represent white and black people while others symbolise formal and informal parental figures, grandparents, children, teenagers and babies as well as representative figures such as a doctor)
- small wooden animals like cows, dogs, birds as well as a crocodile and fox which can be seen to represent aggression, and a larger cow representing a mother figure
- vehicles such as cars and a train
- a number of wooden blocks of different shapes and sizes
- wooden trees and flowers
- various household objects like items of furniture, cutlery, crockery, fruit and bedding
- other miscellaneous objects like symbolic figures (angel, Father Christmas), a doll's feeding bottle and a soft piece of fur.

Additional objects included were:

- toy soldiers
- animals like snakes, spiders, bats, rats
- puppets
- materials for drawing, painting and finger painting
- plasticine and play dough.

4.5.5 Diagnosis and therapy programme: design of sessions

*** Overview and general remarks**

The initial sessions were devoted largely to diagnosis but as Jacobs and Vrey (1982:92) contend, it is impossible to separate diagnosis and therapy. Assessment is an on-going process which can continue in the therapy sessions as more of the child's problems are revealed. On the other hand initial diagnostic sessions like drawing or play can be therapeutic for the child.

In the first sessions all the diagnostic tests were administered and an assessment was made on the basis of Jacobs and Vrey's model (see Figure 2.1). The phenomenal image was obtained from interviews with parents and teachers. The diagnosis concentrated on the child's relation structures and their effect on his self-concept. From this a therapy programme was compiled for each child. The intention was to make the therapy programme as flexible as possible so that it could be adjusted to suit each child's needs. In each case the first few therapy sessions were devoted to play therapy. The remedial aspect of the programme was only introduced once the child appeared more relaxed and emotionally stable. It was felt that if the scholastic component commenced too soon resistance might result. The reading programme was introduced in an informal way. The approach was "learning through play" and in the initial sessions all scholastic work was done in the form of games. Later more formal reading was introduced.

In the cases of older children who had acquired some reading proficiency a personal reading book was compiled and used as the initial basis for reading material (see 2.6.3 & 3.6.3). Responses to CAT and stories which emerged in play therapy sessions were used as material for the book. Children were required to illustrate the book.

*** First session**

In this important session the objective was to build up rapport and establish the correct climate. The Draw a Person and Kinetic Family Drawings were given and a short interview was held with the child using the drawings as the point of departure. The CAT / Columbus was then administered followed by a short discussion. Six to eight cards were presented to the child. The researcher chose cards with which she thought the child would identify.

*** Second session**

In this session the scholastic evaluation was done. The One Minute Reading Test, Neale Reading Analysis Test, Visual Perception tests, Spelling Test and Bender

Gestalt were administered. If time allowed a short play therapy session followed the tests.

*** Third session**

If the child had not had a recent I Q assessment this session was devoted to administration of the SSAIS-R.

*** Diagnosis and planning of the therapy sessions**

Once the diagnostic tests had been completed the child's emotional and scholastic problems were assessed. The diagnosis was made from a relation therapy perspective. Using all the available information the child's relations with himself and his school work were determined. An assessment was also made of his relations with parents, teachers and peers. In this way the child's relational image (see Jacobs & Vrey's diagram Figure 2.1) was built up. Figure 3.1 was used to give a diagrammatic representation of the child's relation structures and this model served as the basis upon which the therapy programme was based. It was also used to assess the changes in relation structures after the completion of the programme.

The structure of the programme itself was determined by the individual needs of each child and was therefore flexible. The initial part of the programme was devoted exclusively to play therapy. The purpose of this was to assist the child emotionally before attempting the remedial help. The number of sessions devoted exclusively to play therapy varied according to the child's progress. In this study the minimum number of sessions was three and the maximum six, after which the remedial component was gradually introduced.

*** Play therapy sessions**

Initially these sessions were left as unstructured and non-directive as possible so that the correct therapeutic climate could be established. The child had to experience the

programme as non-threatening and had to feel completely accepted by the therapist. Where possible, it was left to the child to determine the course of the play sessions. However, if the therapist, working from an external frame of reference, felt a particular conflict should be explored and dealt with, other play therapy techniques, such as those described in Chapter Two were adopted. The "play process" advocated by Gumaer (1984:66-67) (see 2.4.2.3) is both client-centred and counsellor-directed and provided a good combination, particularly where time was limited.

*** Combined sessions**

When the scholastic component was introduced half the session was devoted to "learning through play" and the second half was left for play therapy. Towards the end of the programme the therapy sessions became shorter and more emphasis was placed on reading.

There was a minimum of formal tutoring in the remedial component. Games like snap and pelminism were used for word or sound recognition and visual memory training, while dramatisation, functional reading and storytelling/writing were used to encourage reading skills.

*** Conclusion - assessment**

The programme continued for twelve sessions and then an assessment was done to gauge whether improvements in behaviour and reading skills were evident:

- a second reading analysis was conducted to assess whether the child had made any significant progress
- the DAP or Kinetic Family Drawing were repeated
- formal interviews were held with parents and teachers to see if any improvement had been noted: questionnaires were compiled (see Appendix 2 and 3) and used as the basis for the interview (the teachers and parents were asked to respond verbally to the questions and discuss changes in detail)

- the child's relation structures were reassessed by observing his play and self-talk
- a final assessment was made on these findings.

4.6 SUMMARY

This chapter has described the research design of the study. The aim of the study is to examine the relation structure of the learning disabled child according to the model in Figure 3.1 and then compile an assistance programme which incorporates play therapy and remedial reading with the intention of improving the relation structures. The purpose of the programme is to address both the cognitive and affective problems which the child is experiencing. The assumptions which are made are that learning disabilities and emotional maladjustment have an adverse effect on each other and this relationship has a negative effect on all the child's relation structures. A remedial programme which views the child from a psycho-educational perspective and which incorporates emotional and scholastic assistance can improve relation structures. This, in turn, builds self-concept and can help the child towards self-actualisation. Behavioural disorders can be improved through play therapy. Play therapy can be successfully incorporated into a remedial programme using relation therapy as a basis.

The following chapter describes idiographic case studies in order to demonstrate the practical application of the research design.

CHAPTER FIVE

EMPIRICAL INVESTIGATION

5.1 INTRODUCTION

In Chapter Four the research design of this study was expounded. In this chapter the empirical investigation will be discussed. Five children were used in the study. One case will be discussed in detail. The diagnostic process will be explained in full and the child's relation structures explored. The therapeutic programme which was based on the diagnosis and adapted to the individual child's needs will then be discussed and commented upon. The programme will be evaluated by looking at the child's relation structures at the termination of the therapy programme to see if any improvement can be detected.

It was decided that two of the other cases studies would be reported more briefly and a short summary made of the remaining two. The reason for this was to avoid the discussion becoming repetitive since many of the procedures were similar. These studies will also be used to evaluate the effectiveness of the programme.

5.2 THE SUBJECTS

All the subjects were Junior Primary children between the ages of seven and ten. The children had been referred for assessment and assistance because of reading problems. They also exhibited varying degrees of emotional disturbance. Assessments were done to ensure that the reading disabilities were not the result of neurological impairment or low intelligence. All children had had some form of remedial assistance in the past but had not benefitted significantly.

5.3 DETAILED CASE STUDY: SARAH

5.3.1 Background

Sarah was seven years of age and was repeating Grade 1. She was referred to the school psychologist because of lack of cooperation in class, out-bursts of temper, stealing, poor concentration and poor academic progress. Sarah is the elder of two children. She has a brother who is two years younger. Her father is an engine driver and does shift work. He is sometimes on night duty and then sleeps during the day so Sarah does not see very much of him. Her mother has a clerical job. Sarah spends the afternoons at a creche. She lives close to her grandmother of whom she is very fond.

5.3.2 Session 1: projective tests

In this session Sarah did the Draw a Person test and Kinetic Family Drawing. A short interview was held with her on the basis of the drawings. The C A T/Columbus was administered and was followed by a short interview.

*** Comments on the session**

Sarah was cooperative and responded well. She was interested and enjoyed everything she did, although she did exhibit some resistance with a few of the C A T cards. The results of the diagnostic tests are given in detail as they are important in assisting the therapist to understand the child's relation structures and are used as a basis for the therapy programme.

*** Draw a Person**

Her drawing (see Figure 5.1) was of a female figure. She talked about how she enjoyed drawing while she was busy with the picture and remarked that the hair was "jumping out". When the drawing was completed the therapist discussed it with her.

She said she had drawn her teacher. She was then asked, "What does this person like and what doesn't she like?" Her reply was, "She likes Merry-go-rounds, aeroplanes and she loves her granny. She doesn't like winter because you cough, rain because it wets me and bumping my head!"

Formal interpretation

A diagnosis made from a purely formal interpretation of a drawing is of necessity done from an internal frame of reference. The psychologist makes the interpretation from a personal, psychological point of view. He does not see the drawing from the *child's* perspective. When working from a relation therapy perspective emphasis is placed on using an external frame of reference. The drawing should be used to make the child reveal how *he* attributes meaning, is involved in and experiences his life-world (Jacobs & Van Der Merwe 1992:94-95). In this study a formal interpretation is, therefore, only done to assist the therapist to form or support hypotheses about the child's problem. The basic interpretation is made from information obtained from the child.

The formal interpretation was done according to the method of Van Niekerk (1978). Significant points which emerged from the drawing were:

- *drawing an older figure*: this can suggest good identification with an older person; it can also suggest over-dependence and uncertainty
- *position on the paper*: if the drawing is on the left this can indicate self-consciousness and basic insecurity
- *size*: the smallish size of the figure can signify feelings of inadequacy and possible rejection
- *over-emphasis of hair*: this can indicate childish over-emphasis on aspects of specific interest; this type of over-emphasis is not appropriate to Sarah's age (it is usually found in children of four to five years of age or younger) and can indicate immaturity

- *open emphasised mouth*: this can mean over-dependence
- *prominent nose*: this can indicate aggression
- *out-stretched arms*: these are sometimes an indication of a need for love, protection, acceptance and basic insecurity
- *hands emphasised*: these may suggest problems with interpersonal relationships, glove type-hands can mean repressed anger
- *buttons*: the inclusion of buttons can suggest dependence inferiority, infantility.

Summary

The salient facts which emerged from this interpretation suggested that Sarah was suffering from basic insecurity. She lacked maturity and was over-dependent. She was uncertain of herself and harboured feelings of inadequacy and inferiority. This could be the result of poor interpersonal relationships which made her fear rejection and gave her a need for love and acceptance. She also exhibited signs of repressed aggression which could be the consequence of her feelings of frustration both with herself and with her failed attempts to gain love and recognition.

Figure 5.1
DAP - SARA

* Kinetic Family Drawing

The original drawing contained three figures (see Figure 5.2):

- the mother (1) whom she said was ironing and brushing her hair

- the father (2): when asked what he was doing she said he had "goggas" in his hair and was smoking: she then added that the fire was burning him (her body language here was particularly expressive: especially when describing the "goggas", she seemed to enjoy demonstrating how they were crawling in his hair)

- the brother, Sean (3), who was crying because he wanted bread and an ice-cream and had been smacked with a ruler: she added that she didn't like playing with him because he always fought.

When asked about herself she did the little drawing at the top of the picture (4) and said that she was flying in the sky in a balloon that touched the clouds. She added that Sean was crying because he wanted to get into the balloon.

Comments

From the drawing the following hypotheses were made regarding her relation structures.

- * *Relations with mother:* her comments regarding her mother were fairly neutral

- * *Relations with father:* there could be feelings of repressed aggression against her father

- * *Relations with brother:* she was quite open about the fact that she did not like her brother because he fought with her; her hostility towards him and desire to be "one-up on him" is evident in her comments on his crying to get into the balloon

- * *Relations with the family as a whole:* the fact that she did not include herself in the drawing at first and when she did it was in a balloon, flying away, suggests that she did not feel part of the family and may, in fact have had a desire to escape from the family situation

- * *Relations with self:* she did not appear to have positive feelings about herself since she did not draw herself at all.

As with the formal interpretation of the DAP, these comments had to be verified or rejected by working from Sarah's frame of reference and looking at her attribution of meaning, involvement and experiences of these relationships. This was done by talking to her about her family and by observing her play and other behaviour patterns as the therapy progressed.

Figure 5.2
KFD - SARAH

*** CAT/Columbus**

Sarah was told that she was going to be shown pictures and that she must try and tell a story for each picture. She was asked to say what was happening in the picture, what she thought had happened before and what was going to happen afterwards. She was generally responsive but had to be prompted in a few places with comments like: "And then ...?", "What happened next?"

Columbus 1 (Baby under the table)

(This card was included as it is said to elicit responses relating to family relations, particularly attitudes towards younger siblings)

Sarah: There is a mother and a father and a baby under the table. The baby is playing with blocks under the table because he likes playing with blocks.

Pause

Therapist: What is going to happen?

Sarah: Nothing.

Pause

Sarah: He goes to the toilet because he pees in his pants. He falls into the toilet and drowns in the toilet.

Therapist: And then

Sarah: The mom and dad are frightened. The big sister checks to see if the brother is in the toilet. She calls the mom and dad.

Pause

Therapist: How does the sister feel?

Sarah: She feels bad.

Columbus 2 (Boy going downstairs)

Sarah: He walks down the stairs. He wakes up and goes down for breakfast. He goes to school. He puts his shoes on and goes to the door. He comes back after school. He walks down to the dam with his mother. The dam is full of green water. He drowned in the water.

CAT 1 (Mother hen and chickens)

Sarah: What are these? They're chickens. The chickens ate porridge with a spoon. One didn't he chewed it. He asked for more porridge. He said, "Quack, quack, quack."

CAT 2 (Bears having a tug-of-war)

She giggled a great deal before beginning.

Sarah: There's the baby bear at the back. The baby is with the Daddy against the Mommy. The Daddy is the strong one. He is going to fall down. He falls down. He is going to bump his head. There is lots of blood.

CAT (Dogs)

Sarah: The small puppy is happy. He barked. The mother is cross. She is holding the puppy. There's a towel hanging... There's a toilet at the back.

Pause

Therapist: Why is the Mummy cross?

Sarah: The mother is cross because she saw the other dog. He barked because he was happy.

CAT (Bunny in bed)

At first she refused. After a little encouragement she responded hesitantly.

Sarah: The Bunny is asleep in bed. The door is open ... the door in the bedroom. The curtains are open. He saw the window, he looked out of the door.

Long pause

Therapist: How is he feeling?

Sarah: Sick because he's in a hospital bed.

CAT (Two Bears in cot)

Sarah: The bears talk in their hospital bed. There's a big bed. They talk about their mother who is dead. The mother didn't die. They are talking about the mother.

Pause

Sarah: Yes - they don't like Daddy because he smacks them. They keep throwing flowers off. The Daddy gives them a hiding.

CAT (The Lion)

Sarah: He is sitting smoking. There's a hole in the wall. Nice carpet.

Pause

Therapist: How do you think the lion is feeling?

Sarah: Sad.

There's his tail next to his legs! (*Giggled for a while about the tail*)

Therapist: Why do you think the lion is sad?

Sarah: Because he doesn't want to have children but he has children. The rat looks through the hole.

Therapist: Why do you think he doesn't want children?

Sarah: Because children pee in their beds. He's got long hair.

Pause

Therapist: What does the lion do?

Sarah: He bites them and pinches them, They hit him in the face. He bites sore and they die.

Comments

The themes which occur most in Sarah's responses are death, punishment and some type of violent behaviour and/or anger. Only two cards did not evoke responses of this nature. Three of the cards refer to death, two to some type of violence related behaviour or punishment and the last card contains all the themes.

- * *Relations with brother:* the first card (Columbus 1) and possibly the second as well (Columbus 2), can be seen to indicate jealousy and repressed anger against her brother, since in both cases the boy drowns.
- * *Relations with father:* anger towards the father figure is expressed in CAT (2) and more direct references are made to her fear of and perceived treatment by the father in the last two cards.

- * *Relations with mother:* there appears to be an ambivalence here since she does not know whether to side with the mother (CAT 2) and in the second last card says the mother is dead and then immediately negates the statement. The mother is, however, also perceived as part of the harsh, (unfair?) disciplinarian atmosphere (CAT 3).
- * *Relations with self:* she feels herself rejected and misunderstood by her family, particularly her father. As a result she is uncertain of herself.

5.3.3 Session 2: orthodidactic tests

This session was devoted to an orthodidactic evaluation. The T E D battery of visual-perceptual tests (analysis/synthesis, figure-ground, discrimination, spatial orientation, sequencing, visual memory) and the Bender-Gestalt were done. The one-minute reading test, spelling assessment and sound recognition tests were also administered. The Neale reading ability test was not done since her word recognition was so weak she could not have coped with the test.

Results

Chronological age	7 years 3 months
Perceptual Age on the Bender Gestalt	7 years 6 months
Visual Perceptual Tests:	
Analysis/Synthesis	6 years 5 months
Figure-ground	slightly below average
Discrimination	8 years 6 months
Spatial Orientation	5 years 2 months
Sequencing	5 years 8 months
Visual Memory	8 years 6 months
One Minute Reading Test	she could barely read any words

Knowledge of sounds and sound combinations: she knew the names of most of the sounds (Sammy Snake - s) but could not always identify the letter on its own. She did not know her sound combinations.

Comments

Sarah was co-operative but easily discouraged and either tried to guess quickly when she was unsure of something or else said, "I can't do these...", "This is too hard...". Her concentration was poor and she often tired and stopped trying before the end of a test.

5.3.4 Session 3

In this session an SSAIS-R was administered.

Results

<u>Test</u>	<u>Scaled Score</u>
Test 1: Vocabulary	5
Test 2: Comprehension	11
Test 3: Similarities	3
Test 4: Number problems	7
Test 5: Story memory	7
Test 6: Pattern completion	7
Test 7: Block designs	10
Test 8: Missing parts	10
Test 9: Form Board	12
Verbal Scale	77
Non-verbal Scale	99
TOTAL	86

Comments

Test behaviour. As with the orthodidactic tests, Sarah gave up easily if anything became a little difficult for her. She lacked perseverance and often guessed instead of trying to work out an answer. Her concentration was poor.

Test results. Her total I Q falls in the dull-normal range. The 22 point difference between her verbal and non-verbal I Q is significant and could be, in part, responsible for her reading problems. Her vocabulary score was low and this could be attributed to deprived cultural circumstances. Her score on the *similarities test* was particularly low. She was quite unable to form the necessary associations and this suggests a below average ability to think in the abstract. Deprived cultural background can also be responsible for poor scores in this test. Her scores for the *memory, numbers and pattern completion tests* were also low and this indicates poor concentration and can suggest anxiety. Low scores in pattern completion can be an indication of problems with logical reasoning and visual perception. This concurred with her orthodidactic test results which indicated problems in certain areas of visual perception.

Although Sarah's I Q fell in the dull-normal category and she had visual perceptual problems, it was felt that she should have acquired some reading skills by this stage. From the results of the orthodidactic and intelligence tests it would appear that factors other than perceptual and intellectual disabilities must also be contributing to her lack of scholastic progress.

5.3.5 Interview with teacher

The teacher said that Sarah was difficult to manage in class. Academically, she said her work was very weak. She said that initially Sarah had kept up with the class but she got further and further behind the others as the year progressed. Emotionally she found Sarah immature. She liked to get her own way and was difficult to discipline. On occasions she had temper-tantrums. Then she screamed and refused to cooperate at all. The teacher found her moody with some "good" days when she was far more responsive and responsible than at other times. Her relations with peers were reasonable but she tended to be very demanding and had stolen in class. Older children described her as "... that weird, naughty girl."

5.3.6 Interview with mother

Sarah's mother admitted at the outset that she found her daughter difficult to manage. She described her as naughty and often disobedient. She said that when she was naughty she was quite severely punished. The punishment usually took the form of being sent to the bedroom. The mother admitted that she favoured Sarah's younger brother, whom she described as being a much easier child. When asked how she viewed Sarah's relationship with her father she denied that there were any serious problems but did say he was strict with Sarah. She said that Sarah got on better with her grandmother than with either of her parents.

The interview concluded with some parental guidance but the therapist gained the impression that Sarah's mother did not want to face the severity of her daughter's problem.

5.3.7 Diagnosis from a relation therapy perspective

Personal particulars

Name	Sarah
Class	Grade 1 (repeating)
Date of birth	1987-11-27
Age when assessed	7 years 3 months

Functional image (level 1)

Sarah was referred by her teacher because she was causing problems in class: stealing, lack of co-operation, temper outbursts. Her concentration was poor and she lacked perseverance. She was not promoted to Grade 2 at the end of the year because of poor academic progress.

Phenomenal image (level 2)

Sarah experienced both learning and emotional problems. When she started school she initially appeared to cope with the school work but from the start she had

behavioural and concentration problems. However, her academic progress became less and less satisfactory and her behaviour deteriorated during the year. It would appear that her emotional problems may have originated as a result of difficult home circumstances: jealousy of favoured younger brother and fear of punishment particularly from her father. Emotional instability, as well as poor concentration ability and perceptual difficulties in some areas have affected her scholastic achievement. Since she lacks self-assurance her failure to master reading and other skills have made her discouraged and frustrated with herself. This has resulted in her adopting a defeatist attitude towards her work. Her feelings of inferiority resulting from poor academic performance and feelings of rejection at home and at school have caused her to develop patterns of behaviour which demand attention from the teacher and significant others in her life-world.

Relational image (level 3)

Relations with parents and family

Sarah did not appear to have a good relationship with any members of her close family. Her most satisfactory relationship was with her grandmother. She openly admitted to dislike and jealousy of her younger brother who was favoured by the mother (on her own admission). Sarah's relations with her mother appeared ambivalent. She did not seem to be as afraid of her mother or harbour as much anger against her as she did against her father. While neither Sarah nor her mother openly admitted there were bad relations between the father and the child, her projective tests indicated a great deal of fear and repressed anger towards him.

Relations with teacher

In the interview when she drew her teacher, Sarah said she liked her teacher but said that the teacher got cross with her for "nothing". She was continually demanding the teacher's attention and the teacher became very frustrated with her.

Relations with peers

Her relations with her peers were reasonable but her attention-seeking behaviour annoyed them and this had an adverse effect on relations.

Relations with objects and ideas (school work)

Her relations with her school work were very poor. Her significance attribution was unrealistic since she said every task was "too hard" and if it could not be mastered easily she gave up. Thus she was not actively involved in scholastic tasks and as a result her experiences were negative. This led to a vicious circle of further unrealistic attribution of meaning, lack of involvement and unpleasant experiences with school work.

Relations with self

Her feelings of rejection and unacceptance at home and at school because of academic failure led to poor relations with herself. She saw herself as inferior to her brother and peers who coped better at school. Her self-image was very low.

A summary of her interaction of relation structures is presented in Figure 5.3.

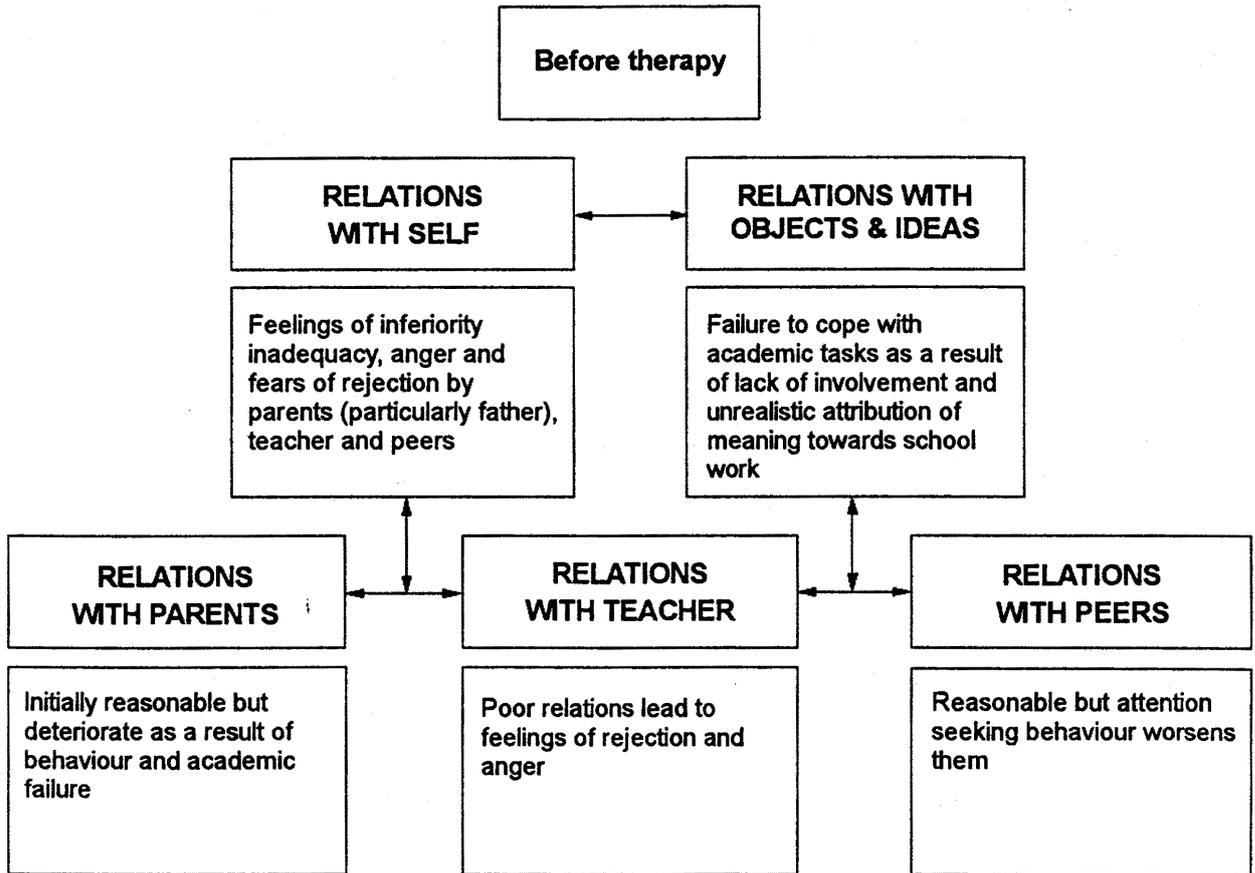


Figure 5.3 Interaction of relation structures (Sarah)

5.3.8 Play therapy sessions

* Session 1

Sarah had been told in the previous session that she was going to play next time she came. She was very excited and giggled a great deal when she came in. She took a long time looking at all the toys and eventually asked what she should do. She was told she could do as she pleased. When she again asked what she should play the therapist asked if she would like to build a house. She responded at once and after she got started the rest of the session was purely non-directive. The therapist merely watched her and reflected her feelings. She took great care getting all the blocks in line and having blocks of the same size and shape together. She was "put out" when she could not get enough blocks to complete her house. (In this and every subsequent session when she built a house she was very careful to have everything neatly enclosed inside the house.) After building the house she carefully chose furniture to put in and then she made the garden. She took a long time constructing the house and she had to be reminded that time was limited. She carefully considered all the dolls and eventually chose a "mother" doll, a "father" doll and a baby. She placed them in the house (positions 1 and 2 in Figure 5.4). She moved the dolls, particularly the mother doll around in the house for a while but did not really play. She then asked if she could build a church, which she put next to the house (Figure 5.5).

She then said, "What do you call those things you put dead people in?" After being told she took a long block and said, "That's the coffin." (1) Then she added, "He's dead." She put the father doll on the coffin and repeated, "He's dead." She then went to a great deal of trouble to make a seat for the mother in the church. (2) She was reluctant to leave at the end of the session but did appear to have finished her game.

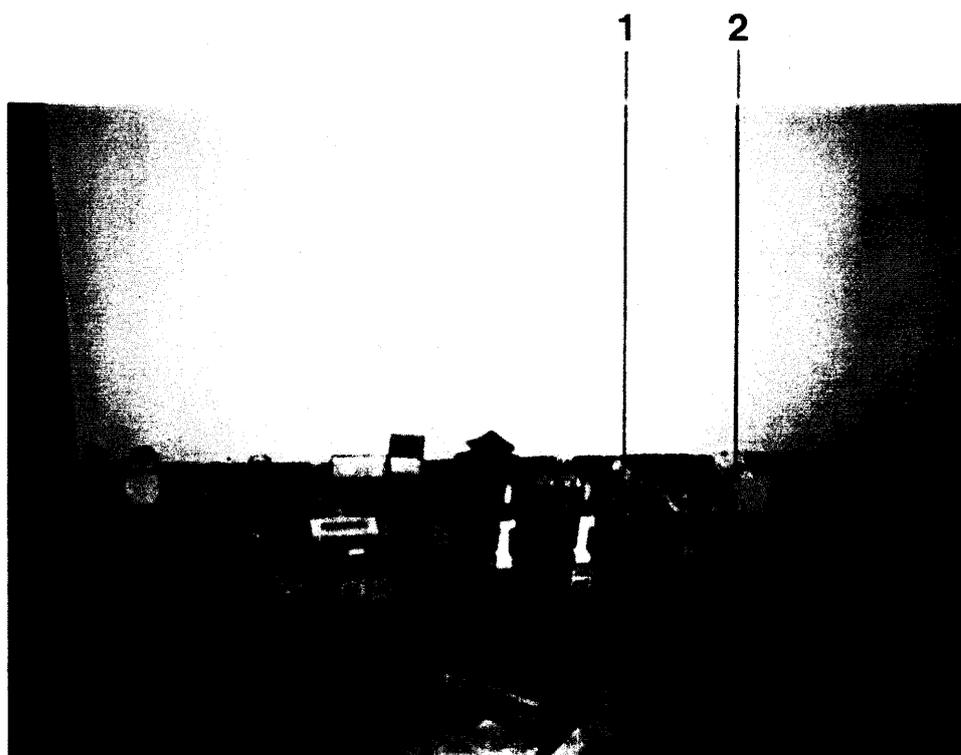


Figure 5.4
PLAY THERAPY (SARAH) - SESSION 1



Figure 5.5
PLAY THERAPY (SARAH) - SESSION 1

Comments

Sarah responded very well and appeared to enjoy the whole session. Her insistence on getting the blocks carefully placed and enclosing everything can suggest insecurity. Her choice of dolls for the house is significant. As with her drawings, she did not choose a doll to represent herself. After putting the baby in the cot she ignored that doll. That action could be symbolic for the desire to have her brother ignored. The hostility towards a father figure was again evident here as in the Kinetic Family Drawing and the CAT. She put the father doll in the coffin in an unemotional way but there was finality in her voice when she remarked that he was dead.

* Session 2

As soon as she walked in she asked, "Can I play all the time? Is there a long time to play?"

She began to play immediately. The first thing she did was point to the father doll and say, "Remember, he's dead!"

She proceeded to build a house similar to the one she built in the previous session. She put the mother doll (she did not call it the mother doll) in the house and said, "Her husband is dead."

Therapist: Does she live by herself now?

Sarah: Yes, she likes being by herself. But these things are also here.

She proceeded to take out all the "horrible creatures" she could find. She chose crocodiles, snakes, scorpions, spiders, bats and similar creatures. Then she made them go in, in turn into the house and bite the mother doll who was sitting in the house. She continued with this game for the rest of the session. Sometimes some creatures fought with each other to save the doll but generally most attacked her (Figure 5.6).

Comments

Her initial comments about the father being dead seemed to reassure her. (Apart from referring to him as dead in one or two subsequent sessions she never again mentioned the father doll or played with it until right at the end of the programme.) She got rid of tremendous amount of aggression in this session most of which was directed towards the mother figure. Her body language and remarks all indicated complete absorption in this expression of aggression. The repetition of the actions (creatures biting the lady and each other again and again) was not really age appropriate and was more the behaviour of a younger child in the earlier stages of Piaget's pre-conceptual phase.



Figure 5.6
PLAY THERAPY (SARAH) - SESSION 2

* Session 3

In this session she again built a house. A large proportion of most of the play therapy sessions were taken up with constructing houses. She built carefully, making sure all the blocks were neatly positioned and the furniture correctly placed. She talked happily all the time and kept asking for reassurance. "Does this fit here?" "Do you think this looks right?", "It's nice, isn't it?"

Once the house was completed she gave the therapist a doll to play with, but in this and in most of the subsequent sessions, she refused to play with any of the human figures herself. She played with the animals and they all, in turn, came to visit the lady in the house. The animals were played with as though they were human and slept on beds, sat on chairs and so on. Aggressive play was again evident. She included all the animals which could represent aggression and there was a great deal of fighting and disharmony in her play, particularly towards the human figure.

Comments

Sarah appeared to enjoy the session. She showed no hesitation or guilt when using aggressive play, even when it was directed against the therapist. She appeared to have a need to express these emotions and enjoyed doing so. The fact that she would not play with the human figures was significant. Animals are seen as less threatening than humans, particularly for a child who has relationship problems. Burns (1970:39) remarks that a child who exclusively plays with inanimate objects or animals rather than human figures is less aware of or less able to deal directly with his or her feelings than the child who plays people. This appeared to be the case with Sarah.

* Session 4

Her play in this session was similar to the previous session. She again built a house and spent a great deal of time organising everything just as she wanted it. Again the therapist was given a doll to play with but Sarah refused to play with any human figures herself. She played only with the animals. In this session she made a great

deal of use of the crocodile. The crocodile was made to eat up the other animals who "came alive" at various times only to be attacked again. Eventually she took the baby doll and tried very hard to push it right inside the crocodile saying: "I wish the baby would go right inside the crocodile so he could really eat it." Finally the crocodile ate the therapist as well!

Comments

As with the previous sessions, here again, Sarah showed evidence of aggression, particularly towards the baby. Her refusal to identify with human figures could be interpreted as an indication of rejection of other people and suggests poor relationships with others.

*** Session 5**

When Sarah came in she appeared a bit upset and asked if she could draw first. In her drawing (see Figure 5.7) she started off by saying she was going to draw her brother eating dog-food (1). She said that this had really happened, that he had really eaten the dog's food and demonstrated how he had gone on all fours and eaten the food. She made continuous derogatory remarks about him while she did this part of the drawing. She drew her mother and father watching T V (2). She then drew herself in bed (3). She said her bed was under the garage. Then she added that the rocks and car were falling on top of her (4). The dialogue continued as follows:

Sarah: Do you know what happened?

Therapist: No, what happened?

Sarah: There was lots of blood and then the ambulance came to fetch me.

Therapist: And then...?

Sarah: I went to hospital, then I got better.

Pause

Therapist: How did your mommy and daddy feel?

Sarah: They were very sad because I actually died.

Sarah then drew the sun and cloud (5). She coloured the cloud in dark blue and scribbled over the sun in red.

Sarah: The sun is covered in blood and its falling down (6). It is covering my mom and my dad and my brother with blood.

She proceeded to scribble all over the figures in red pen with tremendous aggression.

Sarah appeared a little more relaxed after she had completed the drawing. For the remainder of the session she played with the toys in much the same way as the previous sessions. She played with the animals and the therapist with a human figure and the animals all came to visit or live with the lady and many attacked and bit her while others helped her. She was, for example, eaten by the crocodile but she "came alive again".

Comments

Some incident at home appeared to have upset Sarah which she was either unwilling or unable to discuss. Her feelings of rejection, isolation and possible desire to escape her situation were depicted in her drawing and comments about the picture. Tremendous repressed aggression towards all members of the family, particularly towards her brother, was evident in the drawing. The drawing did appear to have a cathartic effect for she seemed more at ease when she resumed her play activities.

SARAH

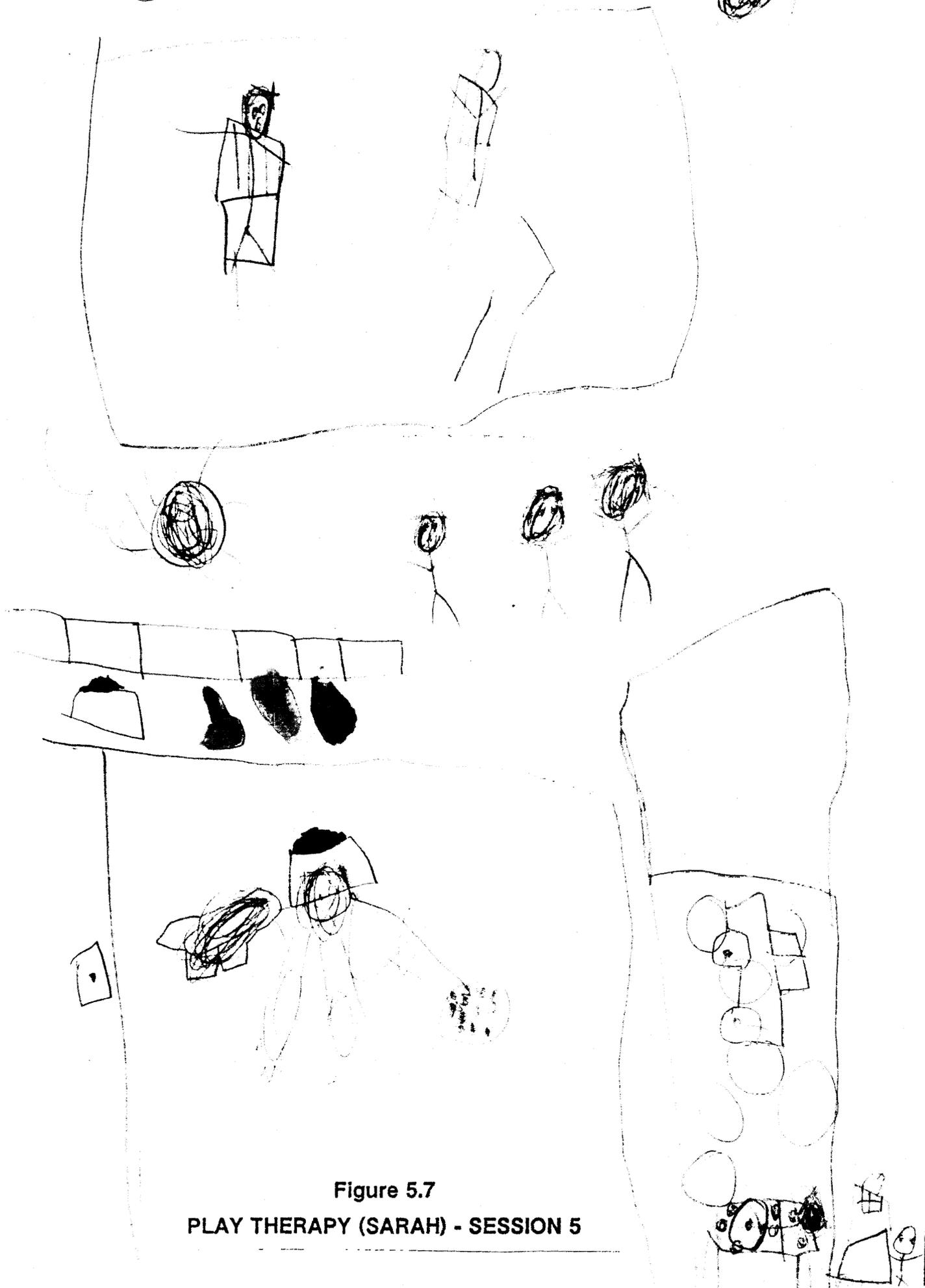


Figure 5.7
PLAY THERAPY (SARAH) - SESSION 5

* Interview with father

At this point, the therapist decided that it was important to speak to Sarah's father directly and try to get some clarity on why her relations with her father were so poor. It was important to try and understand why she rejected him in her play and stories.

The interview did not prove particularly revealing. Sarah's father appeared unaware of his daughter's attitude towards him but was concerned about her. He admitted that he spent little time with his children, particularly Sarah. He said he found her disobedient, wilful and sometimes difficult and said he was strict with her. He said he did smack her on occasions but said the usual form of punishment was being sent to her room and denied privileges like T V. The interview concluded with some parental guidance. Sarah's father appeared more perceptive of her problem and his attitude towards trying to help her was more positive than the mother's.

* Session 6

There was a break of three weeks between this session and the previous sessions. Sarah appeared pleased to be back and spent a few minutes looking at all the toys. She finally decided to play with the hand puppets. There were four puppets: a king, a witch, a sheep and a cat. Sarah chose to be the king and the therapist was the cat. There was a wrestling match between the two which ended when Sarah remarked: "The king won and he ate the cat."

The same happened with the sheep and the witch. The game was repeated with Sarah as the witch.

Sarah then proceeded to play with the toys. She built pens, carefully enclosed, for the animals. She then got the crocodile, the pig and the lion to bite the therapist. In previous sessions the therapist was a doll which she always distinguished by saying, "That's you". In this session it was the therapist herself who was "attacked". Sarah then placed all the animals out and said they were having a braai. The lion smelt the meat and came and ate the therapist's doll. The wolf and the lion then ate up all the

animals. She then broke up her construction. She then took the two "beautiful dolls", wrapped them up in blankets and gave them to the therapist. She then proceeded to give the therapist, "...more beautiful things because it's Christmas." The present giving game continued for a while and then she returned to her game with the animals and her play became more aggressive with the snake eating the wolf and then making a trap for the snake and burning the snake on the braai fire.

Comments

While there was still a lot of aggression in Sarah's play, there seemed to be change in her approach. Her giving "presents" to the therapist was the first truly non-aggressive play she had indulged in. The present giving could have been making up for feelings of guilt because of the previous game where the creatures attacked the therapist. However, she appeared to enjoy this part of the game.

5.3.9 Combined remedial and play therapy sessions

*** Session 7**

It was decided at this point to introduce some remedial work into the sessions. This was an important session since the therapist had to be careful to maintain the climate of trust and acceptance which had been built up. It was considered essential to allow Sarah to experience success and build up her confidence. Up to now the sessions had been largely non-directive with Sarah taking the initiative. Since she had such a negative attitude towards her school work it was decided to introduce it slowly, initially only doing a little work in the form of games.

In this session only a few elementary visual perceptual exercises were done. The remedial component only took up fifteen minutes of the session which lasted an hour. The emphasis was on work which she could manage easily. As far as possible the exercises were presented as games and were made as much fun as possible. She was given a great deal of encouragement and praise and was allowed as much

freedom as possible. If, for example, she wanted to play a game again or colour in a picture on a work sheet she was allowed to do so.

When told she was going to do something a little different that day she appeared disappointed, but after being reassured that there would be time to play at the end of the session she was cooperative. She enjoyed the initial exercises which did not involve writing but when she was given a few work sheets she immediately said in a very negative tone,

"We do ones like those in class."

However once she saw she could do the work sheets easily she became more relaxed about them and kept saying,

"That's right isn't it? This is easy." After this session and all the subsequent sessions she was given stars for good work. These became very important to her. She took the stars back to class with her and got the teacher to stick them on her "ladder".

In the play session she again built a house and as before she was careful about making it neatly and enclosing everything within the walls. Once she had done this she picked up the small baby's bottle and pretended to suck it. She then gave it to the therapist to suck. This continued for a while and then she went back to her house. She said there was shooting at the house and played with the toy gun for a while but her play was aimless and soon stopped. She built on some more rooms and then put the angels and the Father Christmas in the house. It was the first time she had engaged in fantasy play.

She then wanted to know if she could draw. She drew a picture of a girl (Figure 5.8). The therapist asked her if she would like to tell a story to go with her picture. She responded readily. The story is given below since it appeared significant, particularly in the light of her changing relation structures.

There was once a little lost girl. Her name was Mary. She was lost in the forest. This is grass and there was a beautiful bush and there were flowers. This is the tree. These marks (little marks she made with crayon on the tree) are ants. And it was a

lovely day. The mother and brother went looking for her and they couldn't find her so they got another girl and her name was also Mary. They were both the same, they were twins. When she got bigger she got married. She's got a yellow face, she's very pretty and she's got blond hair.

Comments

It appeared at this stage that Sarah still had a negative attitude towards anything which she considered to be connected with school work. Her uncertainty about her abilities was evident in her continually looking for encouragement and confirmation that what she was doing was correct. However, since the work she did was simple she did not find it threatening and cooperated well. The awarding of stars proved successful in motivating her. She was able to take them to the classroom and the teacher allowed her to display them on a wall chart where all the children put their good work awards. This gave her self-confidence a great boost because for the first time she had as many stars as the other children and this became very important to her.

There was now a marked decline in the themes of violence which had predominated the earlier play sessions. She no longer played exclusively with aggressive animals. There was only one violent theme in her play and even this lacked the intent of previous aggressive games. Her sucking the baby's bottle can be an indication of her need for nurturance. According to Guernsey and Guernsey (1989:349) the predictable stages identifiable in the play therapy process are a warm-up phase followed by aggressive and then regressive themes. It would appear then, that Sarah was behaving in the expected manner in her play.

In her story, if viewed as a projection of her feelings, it seemed as if she still felt rejected and "lost". It was as though she wished to reject her "old self" completely and become this new person who was acceptable to her mother and brother (the father figure was again omitted) and who was pretty. This became more apparent in the next session.

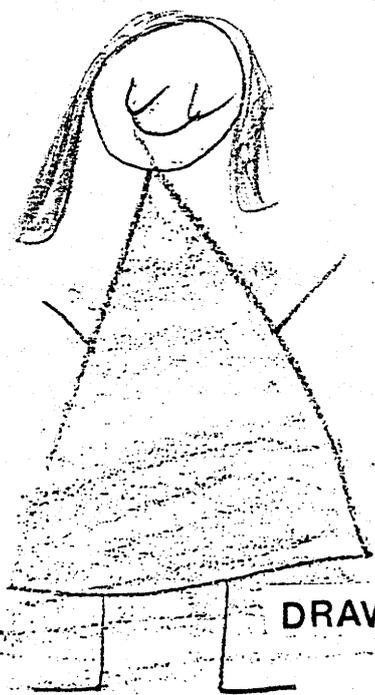
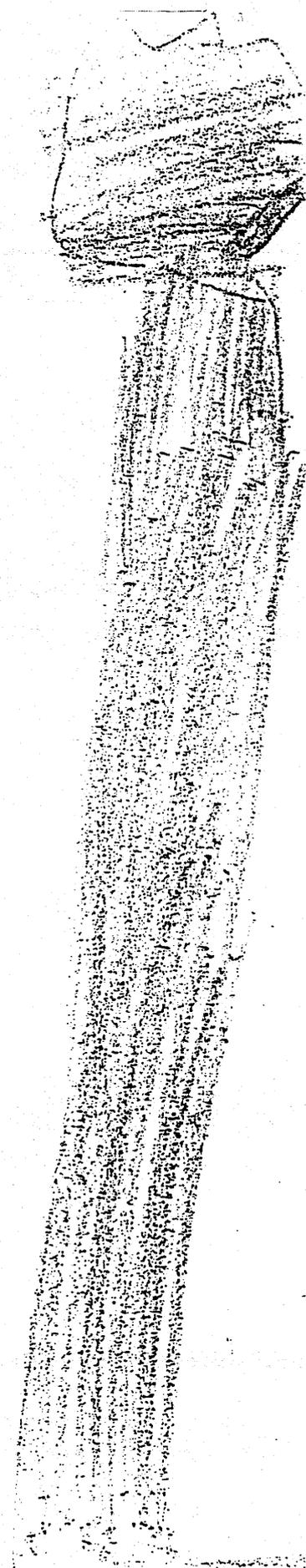
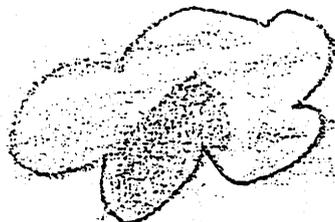
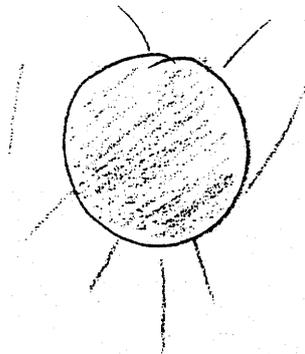


Figure 5.8

DRAWING (SARAH) - SESSION 7

*** Session 8**

When she entered the room and the therapist greeted her with the words, "Hello Sarah."

She immediately replied, "I'm not Sarah. My name is Judy."

A short discussion followed on how she now wished to be called Judy. She asked whether she was going to be able to play. She was told she first had to do some other things and then she could play as she liked. She asked if she could first draw a picture. She drew a butterfly. She giggled and acted out while doing this as if unsure of herself. She started off doing the drawing very neatly and carefully but grew impatient and hurried the last part.

As in the previous session, the remedial part of this session was devoted to perceptual exercises in areas where Sarah experienced problems. The exercises were slightly more advanced than in the previous session but were still not difficult. Play therapy was left completely unstructured.

Sarah cooperated reasonably well while doing the visual perceptual exercises. She appeared to enjoy anything she found easy but gave up quickly if she thought a task was a little difficult. She tended to hurry and guess rather than try to get a thing correct. She showed obvious resistance in a visual memory exercise where she had to write a few words. Her lack of self-confidence and defeatist attitude towards school work were immediately evident in remarks like, "I can't do that, it's too hard." However with encouragement she did manage to write some of the words. When asked to write her name on the work sheet she again said she wasn't Sarah but Judy and asked how to write Judy.

In her play session she built a house and then took out the fairy dolls and put them in the garden which she constructed around the house. She said the angels were in the garden because it was "Father Christmas" time. She got the baby doll and put it in the cot. Then she put all the animals in the garden. Finally she got the "mother"

figure and put it in the house. She was very careful to put a light in the baby's room saying, "This is a light for the baby because he doesn't like the dark." She then brought numerous figures into the house and said they were the visitors. There was no coherent thread to her game but she played with the mother and baby several times in between moving the animals and "visitors" around (Figure 5.9).



Figure 5.9
COMBINED THERAPY (SARAH) - SESSION 8

Comments

The most significant aspect of the play session was that for the first time since the initial session she used the human figures as well as the animals. While she did not play comfortably with them, she did at least include them. According to Burn's (1970:39) theory (see comments on Session 3) this would mean that Sarah was more aware of her feelings and was slowly becoming able to cope with them. There was also very little aggression in her play. It was thought that this change in her play behaviour could indicate a possible improvement in her relation structures with other people. Her request to be called Judy seemed to tie up with the story which she made up in the previous session and strengthened the idea of wanting to reject her "old self".

A short interview with her teacher revealed that there was a slight improvement in her behaviour in class although she still had bad days when she was completely uncooperative. The teacher said she did try at some tasks at school but her concentration and perseverance were still poor.

*** Session 9**

There was a slight improvement in Sarah's relation structures but her attitude towards her school work and reading seemed to have shown little improvement. For this reason it was decided that for the remaining sessions more emphasis would be placed on Sarah's actual reading problems.

This session began with a few visual perception exercises and a game to try and improve concentration. The reading part of the programme was based on the Letterland scheme. It was decided to use this method since it was the one used in the classroom and in addition it has been found to be successful in remedial education (Bald 1992:40-41). Sarah was familiar with most of the names of the characters but was not really able to recognise the letters without the characters. Bald (1992:41) cites this is a problem with Letterland. He claims it occurs in slow learners when character names are over-used and sounds under-taught. Efforts were made to stress sounds

rather than character names. Using games and Letterland work books which include perceptual exercises she worked through all the letters and some sound combinations in the remaining sessions. She enjoyed the Letterland approach and was keen to tell the stories about characters she could remember.

The house which she had built in the previous session was still in place so she was able to start playing immediately. She decided to build a bathroom onto the house and then she took the baby doll and removed the nappy ".. because he's peed in his nappy". The mother then bathed and dressed the baby and put it in the cot. Then she remarked, "The baby doesn't want to sleep. He's crying." Then she said, "I'm a monster in the night."

The story in her play became disjointed as she was then both a monster for a while, presumably to frighten the children, but she also played with children making them get out of bed and steal fruit. Her game continued with "normal" family interaction: the mother bathing the baby again, scolding the children and the children's cheeky replies (which sounded very authentic). For the first time she included the father doll in the game but she did not play with him. She merely said he was a "noodle" and that he was watching T V and sleeping. She ended the game with people coming to visit and filled the house with almost all the dolls in the collection.

Comments

Sarah responded positively to the introduction of formal work and participated well. Since she was repeating Grade One most of what was done in the session was familiar to her and this made it easy. She was, however, anxious to complete the "work" so she could begin her play. It was felt that this was a normal reaction, particularly since she enjoyed the play sessions so much.

The therapy part of the session indicated again that her play activities were becoming more like those of an average seven year old girl and not the bizarre games of the initial sessions. The fact that she used human figures rather than animals was significant and could be indicative of an improvement in her relationships with others

close to her. The continual changing of the baby's nappy could be seen as part of the anal fixation evident in earlier sessions. However she played predominantly with the baby rather than a doll more her own age. This can suggest the desire to regress to a younger, less stressful time of her life and a wish to be nurtured. The dialogue between mother and children also evidenced considerable conflict. Perhaps the most significant part of the play was the inclusion of the father figure, even though it was in a passive role.

Sarah responded well to the remedial part of the programme and seemed to be continuing to benefit from the therapy. It appeared, in this session, that Sarah was responding to both components and that the inclusion of the scholastic component had not destroyed the therapeutic climate built up during the therapy sessions.

* Session 10

In the remedial part of the session more Letterland characters were introduced, games played and work sheets completed. She was familiar with all the characters at this stage and could identify quite a number of the letters with out the pictures. She again responded well but kept asking when she could play. Sarah still insisted that she be called "Judy".

Some new clay had been purchased for the play therapy kit and Sarah asked if she could play with it. Her play was purely sensopathic. She merely rolled the clay into balls of different colours. She appeared angry but said nothing. However, after playing with the clay for a while she appeared more relaxed and went back to the toys. Her play was similar to the previous session. She again filled her house with "visitors" and played with the mother and the baby. In this game she included the angel figure. This section went as follows:

Mother: Daughter, daughter, I've got to go out.

Daughter: I want to come with you.

The mother goes off, the daughter (angel) goes out of the house and a car comes out

and almost runs the angel over. The mother returns and smacks the angel.

Mother: Now you listen to me, this time you stay at home.

Time had elapsed so she had to conclude the game at this point.

Comments

The scholastic part of the session was uneventful. While she still exhibited a bit of resentment at having to "work" rather than "play", the play was used as an incentive to make her complete the work and not day-dream, and use distractive tactics which she was accustomed to do. The work being done in the remedial sessions was reinforcing what was being done in class but in a relaxed manner and she seemed to be learning the letters easily and enjoying the work sheets and making definite, if slow progress.

The most remarkable part of the therapy session was the fact that for the first time she had played with the angel doll. This figurine was a small girl, looking about Sarah's age, but dressed up as an angel. This figure was a fantasy character and Sarah's choice of it, rather than an "ordinary" girl doll, suggested that she still could not face her true self and was escaping behind an imaginary person. However, this figure is a favourite with many little girls and the fact she played with it rather than other toys indicated a progression in her play towards more appropriate age-related play. Much of her play in previous sessions, for example the repetitiveness of her aggressive play in the early sessions, her sucking a baby's bottle and even her play with clay earlier in this session, had not been age appropriate.

*** Session 11**

Sarah came running in at the beginning of the session, obviously very excited and announced:

"I was the only one in the class who knew who "Jumping Jim" was (the j letter character in the Letterland series). The other children in the class said I was clever and the teacher gave me a star!"

It turned out that in the previous remedial session she had revised some letters which

had not been done in class so she was ahead of the others. She was obviously delighted by this but over-excited.

In the reading part of the session she made words with the letters she knew and then played games like snap and memory game with them. She coped well with any words which could be sounded but when sight words like "put" or "ball", which could not be sounded out were given to her, she tended to resort to her old attitude of, "I can't", "I don't know that one" and then gave up.

In the play session she chose four puppet type figures. There was a boy figure, a girl figure, a mouse and a rat. The girl puppet had long hair and at one stage she remarked, "She's got long white hair just like mine. She's pretty." She made the girl and the mouse sit on one side and the boy and the rat on the other. She then made the mouse fight the rat. Her play was quite aggressive, with the toys really bumping into each other. Then the boy and the girl fought and she made the comment, "The brother is always fighting with his sister." The therapist was then given some of the figures to fight with but she always reserved the girl figure for herself. The fights entailed pulling the girl puppet's hair and a great deal of hitting and knocking about. The result of each "fight" was that the girl and whoever was on her side won each time. She gave a continuous commentary on the fight and kept remarking on the boy's behaviour.

Comments

There was an improvement in Sarah's attitude towards her school work. At this stage she had mastered the sounds of all the letters and was able to read, construct and write some words. There was still a problem with "sight" words and she became discouraged easily when she could not cope with new words.

It appeared, from her play session, that she still harboured a great deal of aggression towards her brother. Her anger was expressed in the "fights" between the puppets and her desire to be revenged on him was evident. However, here she was able to express her feelings more overtly than in earlier sessions. Her remark about the

similarity between her hair and the puppet's suggests that she was identifying with the puppet. This was significant, particularly as she remarked that it was pretty. It suggested that she could be viewing herself in a more positive light.

* Session 12

Sarah had been told previously that this was to be the last play session. She was clearly disappointed when she was reminded of the fact but was consoled when she was informed that someone would still play games with her (further remedial assistance) and that the following term she might be able to play again sometime (if further therapy was considered necessary).

She asked if she could draw a picture before she "worked" (Figure 5.10). First she drew the small figure (1) then she asked if she could draw a dinosaur. She had previously given the therapist another drawing she had done of a dinosaur. While drawing this picture she kept remarking on the dinosaur's teeth and how big they were and how they could bite. She then drew another picture (Figure 5.11). It was bizarre and was accompanied by a commentary of what she was drawing. There was, however, very little logic in the order of the drawing or her explanation. She began by drawing the dinosaur at the window (1). She remarked that he was a very vicious dinosaur. She then spoke about her mother and ice-cream and she drew the table (2) and then the ice-cream (3). Then she said the ice-cream was floating up in the air and drew (4). Then she spoke about a ghost who floated in through the window (5). She explained that the object in the window was a knife (6) and that it had cut her mother's arm and that there was lots of blood (7). A disjointed story about her mother going to hospital followed and then she announced that the drawing was finished.

She completed her Letterland Workbook and asked if she could play the word and memory games she had played in the previous session.

When she was told she could play she seemed unable to settle down to anything in particular at first. She fiddled with the animals and eventually told the therapist to

close her eyes. She then put all the "creepy creatures" on various parts of the therapist's body and the therapist had to pretend to be afraid and then guess what creature she had been given. Sarah clearly enjoyed the game and laughed a great deal. Initially she was a bit aggressive in her actions but afterwards was very gentle and said, "You don't have to worry they won't really bite." At the conclusion of the session she left quite happily and said casually as she left, "See you next term."

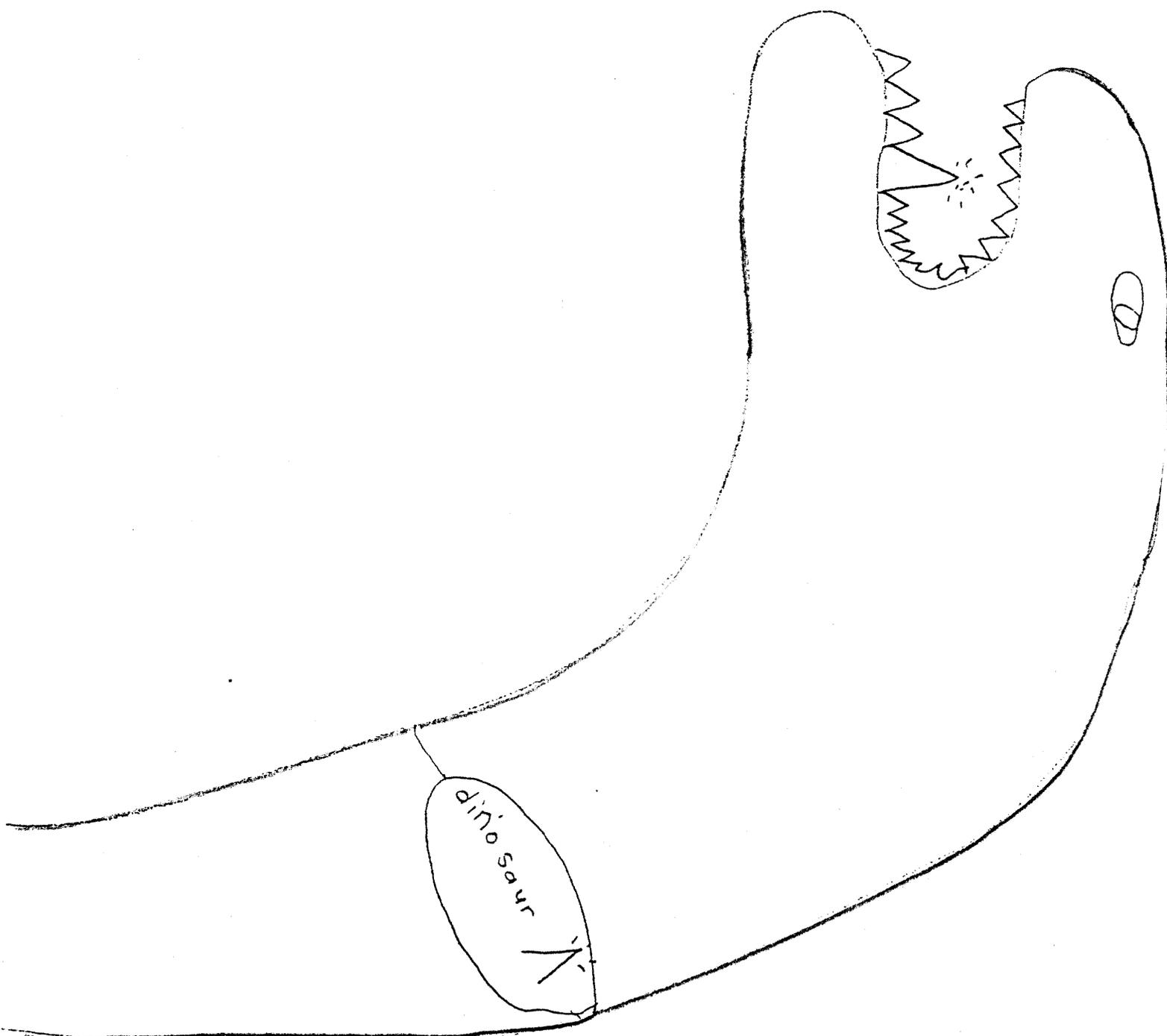


Figure 5.10
COMBINED THERAPY (SARAH) - SESSION 12
DRAWING
1

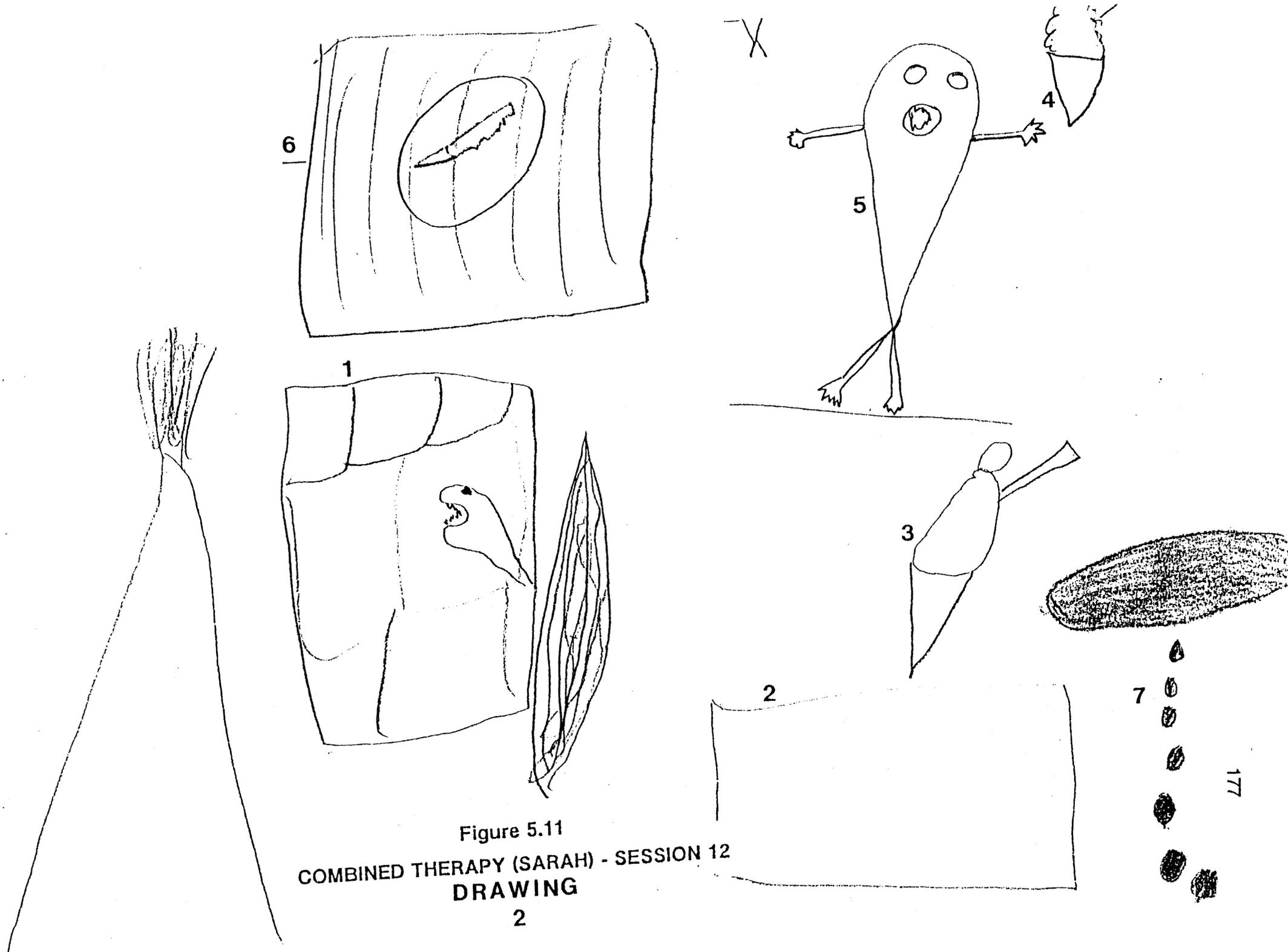


Figure 5.11
 COMBINED THERAPY (SARAH) - SESSION 12
 DRAWING

Comments

There was a noticeable improvement in Sarah's attitude towards her reading and she had made some progress, although she was still not up to standard. While her self-confidence had improved her biggest problem remained her lack of perseverance and failure to believe she could master difficult tasks.

Since she said that they had been learning about dinosaurs in class no particular significance was attached to the first drawing she did. The second drawing was rather bizarre and was an indication that further therapy might be necessary since there still appeared to be underlying aggression evidenced in the dagger and the blood and cutting the mother's arm. Her play with the therapist seemed to have had a cathartic effect upon her since she became calmer as the game progressed and was genuinely affectionate at the end. She was cheerful when she left and the termination of sessions did not seem to bother her unduly.

5.3.10 Final assessment of progress

The following assessments were conducted in order to gauge Sarah's progress:

- The One Minute Reading Test was administered again and her knowledge of sounds and blends were tested to see whether the therapy had improved her reading skills.
- The DAP and Kinetic Family drawing test were repeated to assess her emotional functioning and family relationships.
- Interviews were also held with her teacher and mother on the basis of the questionnaires (see Appendix 2 and 3).
- The final assessment was made using the above findings as well as taking changes in her play and self-talk into consideration.

*** One Minute Reading Test**

At the start of the programme Sarah was barely able to read any of the words. When the test was administered for the second time she was able to read fourteen words in a minute and only had trouble with sight words like "by" and "so". While this was still well below average for her age it showed some progress. The most significant improvement was in her approach which was far more positive. She knew the sounds of most of the letters without having to associate them with their "names" and could recognise some of the blends.

*** DAP and Kinetic Family Drawing**

She was asked to draw a person but ended up drawing both her parents. She drew two figures. The first she said was her mother baking and then she drew another figure which she said was her father making a "dog-house".

Comments

The drawing indicated improved relations with her family. There was a sharp contrast between the bizarre drawings she had done at the start of the programme and her final drawing. The most noticeable change was the lack of aggression. The fact that she still had not drawn herself in a family suggested that she still harboured feelings of isolation and rejection but her attitude towards her parents appeared far more realistic.

*** Interview with teacher**

The final interview held with Sarah's teacher was based on the questionnaire in Appendix 2. The following points emerged:

- There was a definite improvement in Sarah's behaviour and approach to her school work. She confirmed that Sarah's work was still weak and that a great deal more effort had to be put in but at least Sarah knew all her basic sounds now and was coping with simple reading pieces. The teacher said that Sarah still lacked perseverance, tended to give up quickly and was easily distracted.
- Sarah's self-confidence had improved a great deal and the teacher confirmed that she was becoming more responsible. She was able to send Sarah on errands and get her to assist other children in the class at times. She said that Sarah still had "bad days" but these were less frequent than before. On these days she could do very little with her. Sarah was uncooperative and would not sit still or listen.
- The teacher felt her relationship with Sarah had improved. At times Sarah still indulged in attention-seeking behaviour which annoyed other children. However, she appeared to be getting on better with her peers.
- The teacher concluded that while there was still room for a great deal of improvement, Sarah had made such good progress that she had been given a merit award. These awards were highly prized at the school and were given for a combination of academic achievement or progress and responsible behaviour.

*** Interview with mother**

The interview with Sarah's mother revealed:

- Sarah appeared to be taking more interest in her school work
- While Sarah could still be stubborn and moody at home there was a definite improvement in her behaviour. She said she found Sarah more cooperative and easier to handle.

- The mother denied any problems with Sarah's relationship with her father but said she was still antagonistic towards her brother.

5.3.11 Conclusions: changes in relation structures

In order to assess the success of the programme it was necessary to look at Sarah's new relation structures and see whether any improvement could be detected.

Relations with parents and family

Of all Sarah's relation structures this was the most difficult to assess. It was evident that she still felt hostile towards her younger brother. However her aggression was now more openly expressed and she seemed to have better control over her feelings and understand them better. She had never openly admitted any problems in her relations with her parents, except to complain about their being too strict and punishing her too severely. From her play and her general attitude it appeared that there was an improvement. For example, from wishing the father dead in her initial play sessions, in the end the symbolic father figure was included in the family structure, even if in a passive role. The mother figure was also included in a more acceptable way in her play too. The mother played a maternal role in her later games and was not just a figure to injure, emotionally and physically and a target of her aggression as she was in the first four play sessions. Little comments passed in the therapy sessions about events at home also pointed to improved relation structures, although there did appear to be some tension, particularly regarding her brother. Her final drawing also suggested a more positive attitude towards her parents.

Relations with teacher

While this relation structure had never been really poor, Sarah had felt that her teacher had criticised her unjustly and had seen her as stupid. She now felt her teacher accepted her and when she was reprimanded and punished she was more reasonable about accepting discipline.

Relations with peers

Since Sarah's work had improved and since she had received many stars on the class ladder she felt that other children accepted her better and did not look down on her because she was stupid. The fact that she was sometimes asked to help younger children also helped her to feel important amongst them. The decline in her disruptive behaviour made her more acceptable, although there were still times when she annoyed and bullied children.

Relations with objects and ideas (school work in particular)

This relation structure showed a definite improvement. Her approach to reading and other school work became more positive. While she did still lack confidence in tackling difficult tasks, her attribution of meaning was more realistic than before. She no longer saw all school tasks as "horrible" or impossible and thus her involvement in class activities improved. The result of this increased involvement and more realistic attribution of meaning was that her experiences with reading and other scholastic activities were more positive. Her level of reading was still below her mental age and academic grade and this gap needed to be bridged. However, her change in attitude and improved relations with her school work suggested that with remedial assistance she could reach the desired academic standard.

Relations with self

While Sarah still exhibited a lack of self-assurance in certain situations her self-concept had become more positive and her person image had been strengthened. She no longer attributed such unrealistic meaning to herself. She did not see herself as rejected by her family or by her peers and teachers because she was stupid and unable to cope with school work. Comments like: "The doll is pretty, it's got hair like mine", "My teacher said I was cleverer than the other children" indicate how she was viewing herself in a more positive light.

5.3.12 Summary

The relation structures which showed the most improvement were Sarah's relations with herself and her relations with objects and ideas (her school work). The play therapy programme helped Sarah to express all her pent up aggression against the members of her family and school situations which she found frustrating. Through the therapy she played out her anger and was able to become more aware of her repressed emotions and attempt to understand and deal with these feelings more directly. As she learnt to understand herself better so she began to accept herself and see herself as a person of worth. She no longer saw herself as stupid and unacceptable to others. Her progress in reading and other scholastic tasks also contributed to the improvement in her self-concept. While her reading skills were still poor, her attitude had become more positive and she had made some progress. Through the assistance of the remedial programme and the aid and encouragement in class she gradually became more involved in her school work. As her involvement grew she began to view her school work in a more realistic light. She no longer saw it as threatening and an impossibly difficult task. The result of this was that her experiences of school work became less negative and this encouraged her to become more involved. In this way a more healthy relation structure was built up.

The improvement in her relations with self, objects and ideas had a ripple effect on her other relation structures. As her behaviour and attitude towards her work changed so her teacher found her easier to manage in class. As a result she did not get into trouble quite so much. Sarah, in turn, came to view her teacher in a more realistic light. She no longer saw the teacher as criticising her unfairly or as the perpetrator of unjust disciplinary measures and punishment.

Since she was coping better with her school work Sarah no longer saw herself as inferior to her peers. Having been given the merit award meant she could view herself as their equal. Her improved self-assurance meant that it was not necessary for her to engage in attention-seeking behaviour and this made her less objectionable to other children.

It was evident that there were still areas of conflict in her relations with her family. Her jealousy of her brother remained a problem but she was now able to cope with it in a more acceptable manner. Her relations with her parents, particularly her father, were not yet satisfactory but as a result of her improved self-concept she no longer felt as rejected or isolated from the family situation.

It appeared that the therapy and remedial programmes had helped to improve all Sarah's relation structures but it was evident that there was still room for further improvement. Additional therapy and remedial assistance would be necessary to sustain the progress and strengthen the structures further.

5.4 SUMMARIES OF FURTHER CASE STUDIES

The first two case studies have been summarised in more detail than the last two (see 5.1). Both Christopher and Neil exhibited more problems at the start of the programme than the other two children and their progress was also more marked. Michael and Ann came from more stable family backgrounds and their emotional problems were less severe. Their difficulties arose largely as a result of poor scholastic progress.

5.4.1 Christopher

Personal particulars

Name	Christopher
Class	Grade 1 (repeating)
Date of birth	1987-05-21
Age when assessed	7 years 9 months

*** Functional image (level 1)**

Christopher was referred for assessment by the school for behavioural and scholastic problems. His behaviour was reported to be disruptive and aggressive. He was continually fighting with other children and bullying them. In addition he was reported to be extremely sexually aware. Other children complained that he sometimes exposed himself and tried to encourage other boys in the class to do the same. He also frightened the little girls by trying to touch them in a sexual manner. Scholastically he was making no progress. He could barely read, although this was his second year in Grade One. He did not put any effort into his work and seldom completed tasks he was given.

*** Home circumstances**

Christopher's father was self-employed and his mother was not working as she was pregnant and gave birth to a daughter shortly after Christopher's referral. There were only two children in the family. The family interaction did not appear particularly good. The mother, while concerned about Christopher's behaviour, tended to absolve herself of responsibility by saying he was naughty and she could do nothing about it. The father was a domineering character and portrayed the image of being "tough". His approach was that his son should be tough too and that if his behaviour was unacceptable he should receive corporal punishment. He refused to admit his son could have serious academic problems. His reasoning was that if Christopher could compete and out-perform boys almost double his age in motor-bike championships he could not be stupid.

Christopher's father belonged to a motor-bike club and Christopher also took part in the sport. This brought him into contact with older boys many of whom, reportedly, also had behavioural problems.

*** Phenomenal image: (level 2)**

It appeared as if Christopher wished to emanate the role models in his life. These were his father and older friends. They aspired to being "tough guys" and Christopher wished to be like them. He tried to act "big" and show off in front of his peers. His behaviour suggested that he was covering up for feelings of inferiority, both socially and scholastically by his acting-out behaviour. While idealising his father he was afraid of him and this added to his sense of insecurity.

*** Results of diagnostic media**

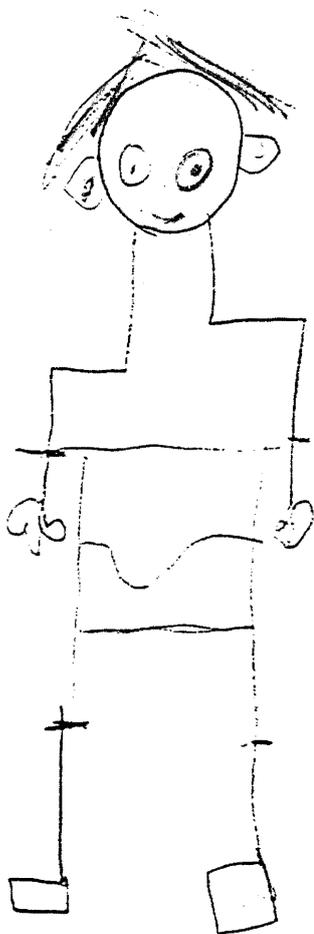
Projective Tests

His DAP test revealed immaturity (see Figure 5.12). His drawing was not age appropriate and indicated basic insecurity and aggression. There was evidence of suspicion and a desire for social acceptance. His Kinetic Family Drawing (see Figure 5.13) showed little family interaction and included a cousin with whom he said he played and another boy whom he called Geoffery but who was not part of the family. When asked about his family after the drawing he began a story about going shooting with his father. The story then became a long fabrication of chasing "baddies" on motor-bikes and running over them and squashing them. He described the events as though they were true and he expected to be believed. There was tremendous aggression and violence in his story.

The CAT was attempted but did not prove successful since he found it difficult to do more than merely describe the pictures. Aggression was evident in the few meaningful responses he gave.

Christopher

1995-01-25



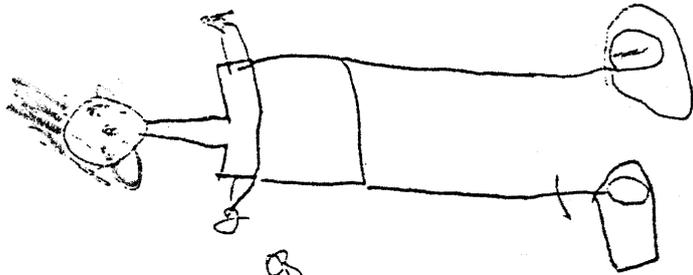
my friend

6 years old

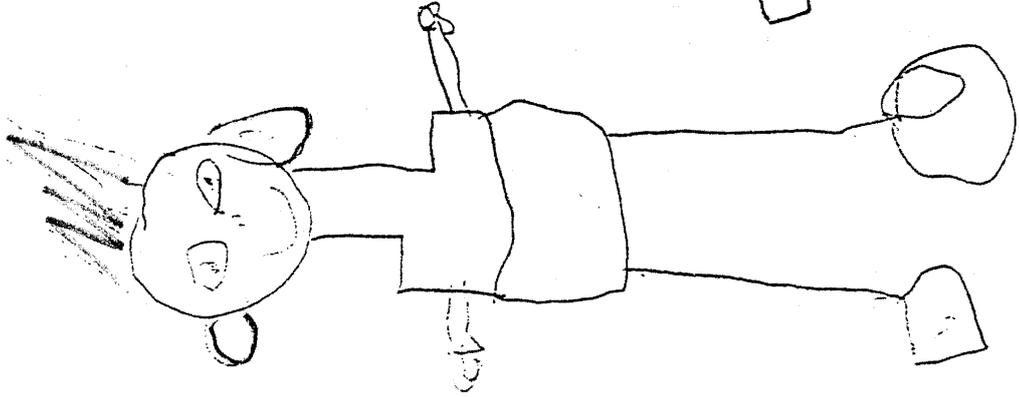
John K.

Figure 5.12
DAP - CHRISTOPHER

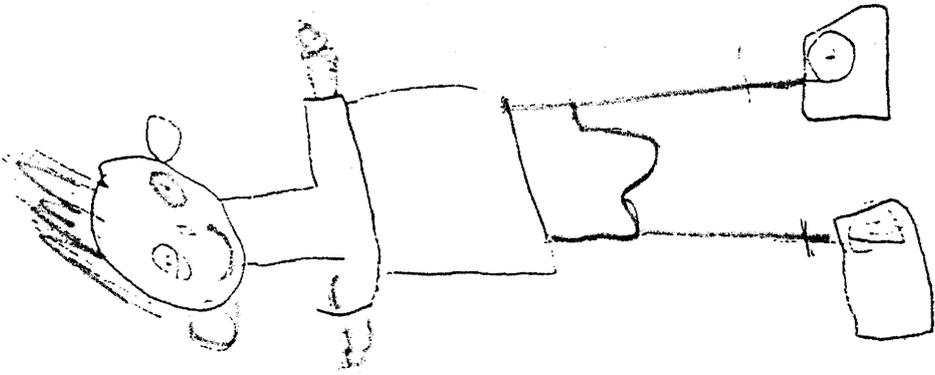
Christopher



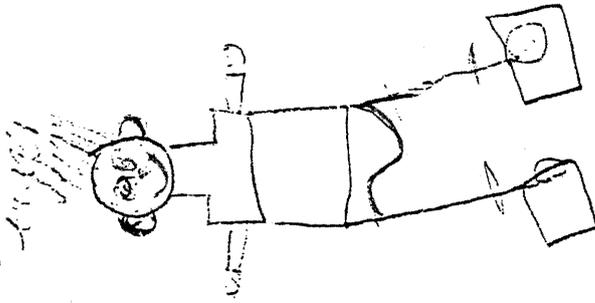
Mom



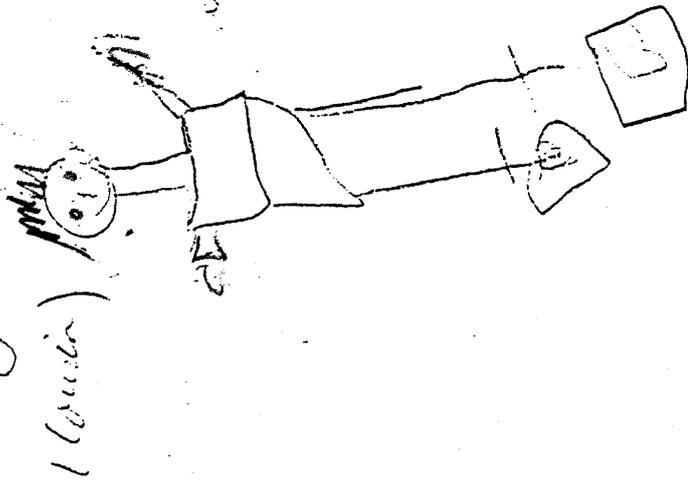
Dad



Gary



Gareth



(Lavin)

*** Orthodidactic Tests**

Chronological age	7 years 9 months
Visual perceptual Battery:	
Analysis/Synthesis	6 years 10 months
Figure Ground	below average
Discrimination	6 years 10 months
Spatial orientation	below 6 years
Sequencing	7 years 8 months
Short term memory	7 years
One Minute Reading Test	10 words
Spelling Test	very poor - he could hardly spell any words
Neale Reading Test	not done as word recognition too poor
Sounds	He knew the names of most letter characters but could recognise few of the letters
SSAIS-R	
Verbal	80
Non-verbal	85
Total	82

*** Relational image (level 3)**

Relations with parents and family

These appeared to be poor. His mother described him as naughty and uncontrollable and continually told Christopher this. This was obviously the self-image he built up of himself and he lived up to it. His father was very domineering and while being afraid of him Christopher appeared to idealise him. His father expected him to be tough. Christopher seemed to feel inadequate since he could not always live up to his father's expectations and his acting out behaviour was a way of trying to project this "big-boy" behaviour which his father expected.

Relations with teacher

His relations with his teacher and everyone in authority at school were poor. As a result of his bad behaviour he was continually in trouble and being punished. He felt that everyone was against him.

Relations with peers

Christopher's relations with most of his peers were unsatisfactory. He was continually fighting with other children in his class and showing off. He always blamed others and said they started the fights.

Relations with objects and ideas (school work)

Christopher had a very negative attitude towards his school work. The fact that he was repeating Grade One made him feel he was stupid. He did not try at all with his work and as a result made no progress. It appeared that he was afraid to admit failure so to avoid this he did not become involved in school tasks at all. As a result he attributed unrealistic meaning to school work complaining it was boring and thus his experiences were all negative.

Relations with self

The pressure on Christopher to be big and tough made him feel insecure and inadequate. In order to cover up for these feelings he resorted to aggressive, acting out behaviour and inappropriate sexual insinuations. He did this to make himself appear more acceptable in his own eyes and in the eyes of his role models, his father and older friends who condoned much of his behaviour. His poor academic performance helped to enhance his feelings of inferiority.

*** Therapy sessions**

Christopher had five play therapy sessions before the remedial component was introduced into the programme. He was initially a little reluctant to play freely. He needed encouragement and continual reassurance that he was free to play and do as he liked with the toys. He was very unsure of himself and was not used to the type

of toys (dolls, animals, blocks) with which he was presented. While efforts were made to make the sessions as non-directive as possible, at first Christopher responded better if he was given suggestions and prompted on occasions.

At the start of the first session he built with the blocks and used some of the animals, but as he had done with the CAT he merely described what was in front of him rather than playing. Eventually he did play with the toys more freely, using the aggressive animals to hurt the people. Aggression and violence were evident in his play. The theme was people dying and going away in ambulances and animals being aggressively punished. He was unable to stick to any particular thread of a story for long but jumped from one idea to the next.

His play in the next three sessions was on similar lines. He played with both animals and human figures. Aggression and violence were prevalent themes and most of his games included shooting animals or fights between people. Twice he constructed his games around a theme of a "baddie" or "black (man)" attacking people and stealing the children. However, many of his games were unimaginative. He indulged in sensopathic play rolling clay into snakes and balls. He enjoyed racing the toy cars around imaginary ramps and talking about his motorbike races. Quite often towards the end of the session he would stop playing with the toys altogether and just tell stories. There was always a great deal of exaggeration in his stories, particularly when referring to feats which he was reported to have achieved.

He cooperated well during these sessions and there was no evidence of resistance. However, it was felt that there was a certain reserve in Christopher's play. He appeared not to be completely at ease in the play situation and the therapist was initially concerned that the correct climate had not been established. The most successful parts of the sessions were when he told of his personal imaginary or exaggerated escapades. His feelings of insecurity and inferiority were evident and he seemed to need to boast about himself to overcome these emotions.

* Combined sessions

An interview with the teacher revealed that Christopher's work was making no progress and that most of his bad behaviour seemed to result from his frustration with his school work. She complained that when he found a task difficult he didn't attempt it and then tried to prevent other children from doing their work. It was decided, at this point to include some remedial work in the sessions to see if this could improve Christopher's relations with his school work for it appeared as if his self-concept was not going to improve if his experiences at school were so negative.

At first only simple visual perceptual exercises were given. Christopher responded well and enjoyed the exercises because they were simple. His success seemed to boost him and the therapist found him as keen to do the work as he was to play. In the next two play sessions most of the time was spent playing soccer with a marble and the dolls. The therapist had to play with him and he got great pleasure out of the games. He won most of the games but on the odd occasion when he was beaten he admitted defeat gracefully. This was encouraging as it seemed to indicate more self-assurance.

Since Christopher's I Q fell in the dull normal-range, it was not expected that he would learn reading skills quickly. However, once the Letterland alphabet was introduced he responded well. The remedial work was aimed at reinforcing what he was doing in class and it was found that he learnt the letters in a surprisingly short time. He was most encouraged by his success.

In the eighth session he was working on a work sheet with happy and sad faces and was asked, in conversation, what made him happy and sad. His reply involved a long story about how bullies made him sad and then he told of how his father had thrown him into the pool while he was asleep and had teased him for being upset. The event had obviously been very traumatic for the child. He continued with the story and fantasised how he had retaliated against his father. The story was one of tremendous aggression and he was able to express a great deal of repressed anger towards his father.

In the following session, after the scholastic work had been completed the therapist suggested a more structured game. Christopher was given the father, mother, boy and baby dolls and asked to make a story. (Christopher now had a baby sister who was doted on by everyone. The mother described her as "my good angel" and Christopher as "my bad boy" in front of him.) The play which followed was extremely dramatic. Christopher became completely oblivious of everything around and merely acknowledged the therapist's presence if he wanted a particular toy which he could not find in a hurry or wanted to remove the dolls' clothing. The aggression in his play was excessive. He began by using the boy doll to hit the "baby brother". His play became so violent he had to be restrained as he was liable to break something. He took the father doll, hit it, threw it around, made the boy doll kick it and then got the toy gun and shot at all the figures again and again. There was a lot of sexual play in his games too. The boy had a girl-friend and they were made to kiss and were put into bed together. He then almost ripped the clothes off all the figures and finally used the girl and boy doll to "mess everything up" and toys were thrown around the room. When the game ended he seemed far calmer and left the room looking relaxed and happy. This session appeared to have a cathartic effect upon him and became a turning point in his therapy.

In the remaining sessions he made a degree of progress with his scholastic tasks. He was slow at learning and it took constant repetition before he could remember sight words or sound combinations. However, he remained cooperative and appeared to enjoy the work, particularly if it was in the form of a game. His reading skills were still poor but his attitude had shown a marked improvement.

The rest of the play sessions were not remarkable. It did not appear necessary for him to repeat the violent game again and he spent the play therapy time playing soccer with the therapist and the dolls, racing cars, playing war games with soldiers or just telling stories about himself. There was still violence and aggression but to a lesser degree and his stories became more realistic although he was still the fastest bike racer or best soccer player. His sexual awareness was still evident. He made remarks like, "I can't handle my soccer coach's girl friend." When asked about it he

replied, "She's just too sexy for me!" However, his embarrassed expression afterwards suggested that he was aware of how silly the remark was and admitted he had heard older boys say things like that. It appeared most of his acting out sexual behaviour was learnt from older children and possibly also pornographic material to which he had been exposed.

An interview with the teacher at the end of the sessions (based on the questionnaire in Appendix 2) revealed a marked improvement in Christopher's behaviour and progress in his school work. The teacher said that while he was still sometimes naughty, he was much easier to reason with and that he did try. He had received several stars for good work and had been given some responsibilities which he had coped with. The teacher said he seemed calmer and less of a bully in class.

The interview with his mother (his father did not attend) revealed an improvement in his behaviour at home. While he displayed affection towards his baby sister she said that he was demanding when the baby received a great deal of attention.

*** Conclusions**

Changes in Relation structures

There was a noticeable improvement in Christopher's relations with his school work and his relations with himself. He had become much more positively involved in his work, tried harder and was therefore attributing more realistic meaning to it. While Christopher could never be expected to perform really well at school as a result of his low I Q there was still much room for improvement. Nevertheless his change in attitude had made it possible for him to realise that there were tasks he could cope with and that school work was not something to be avoided because he could not master it. This appeared to have a positive effect on his self-image, since he no longer felt himself stupid. The play sessions had helped him to express a great deal of his pent up anger and aggression and he appeared to be able to handle it better. The result was that his relations with himself had improved.

His relations with his teacher improved as his school work and behaviour improved. As his self-image strengthened he no longer had the need to show off in front of his friends and his unacceptable behaviour decreased. Other children were not as hostile towards him now that he felt more secure in himself. His increased self-confidence also helped him to feel more acceptable in his parents' eyes. However, his father was still demanding and it was evident that Christopher would need further assistance in developing his self-image so that he could cope with these demands and the attention his baby sister received.

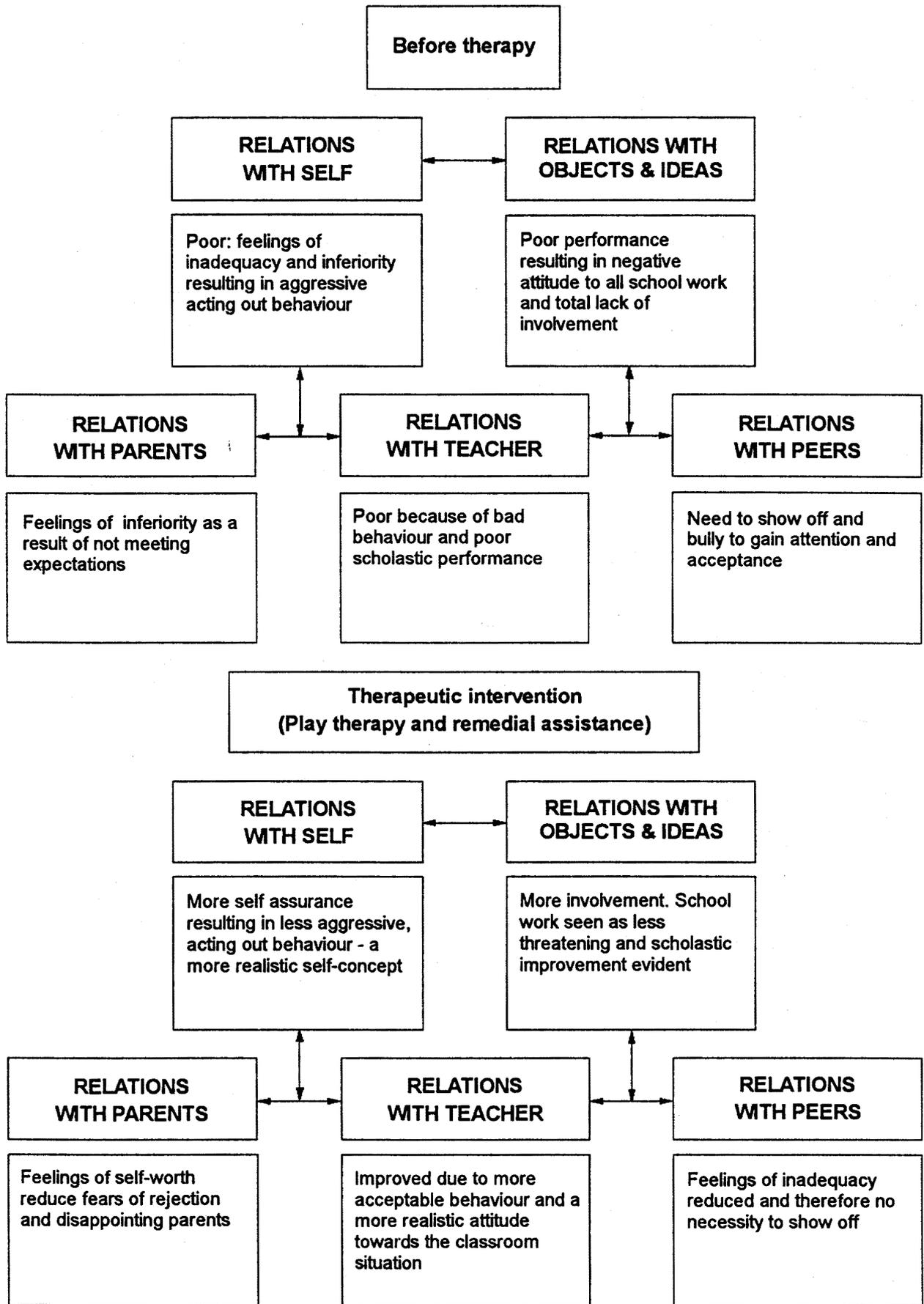


Figure 5.14 Summary of changes in relation structures (Christopher)

5.4.2 Neil

Personal particulars

Name	Neil
Class	Grade 2 (repeated Gr 1)
Date of birth	1986-10-14
Age when assessed	8 years 6 months

* Functional image (level 1)

Neil was referred for assessment by the school for behavioural and scholastic problems. He was described as disruptive and aggressive. He was reported to lie, steal and bully other children. Scholastically he was very weak and he was said to have extremely poor concentration.

* Home circumstances

Neil was one of two children. His sister was two years younger. His parents lived together but his home circumstances were not satisfactory. His father spent very little time with the children. The mother worked from home and was occupied with her work. Neil was reported to be "impossible" at home. He often had temper tantrums, threatened to leave home and manipulated his mother. She admitted Neil was an unwelcome child. It appeared as if the father resented Neil since he was the reason why he had had to get married and he blamed the child for the unhappy marriage.

* Phenomenal image (level 2)

Neil's problems were two-fold. There was evidence of an unstable home background where mother and father did not always get on and Neil was often held responsible for the upsets. His parents, and particularly his father, did not devote enough time to him and the result was that he felt neglected and rejected. His response to this was to indulge in attention seeking behaviour such as temper tantrums. The other aspect

of his problem was that he was not doing well at school and this led to his feeling inferior to other members of the class. He then resorted to bullying and other aggressive behaviour to vent his frustration and to cover up for feelings of inadequacy. Neil appeared to have a poor self-concept and a negative attitude not only towards school work but also to life in general.

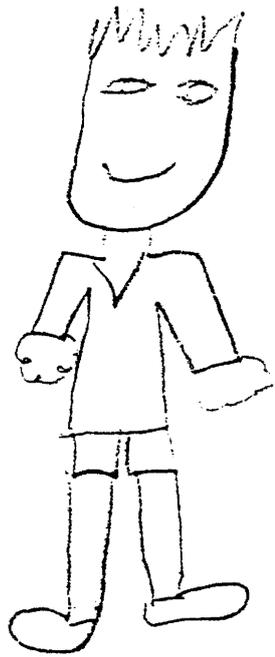
* Results of diagnostic media

Projective Tests

His projective tests revealed feelings of inadequacy and a great deal of repressed aggression and anger. According to van Niekerk's (1978) interpretation (see 4.5.3) his DAP showed feelings of inferiority and rejection as abstracted by the size of the drawing (see Figure 5.15). It also suggested possible repressed aggression (line formation) and indicated communication problems (hands and short arms).

Neil's Kinetic Family Drawing (see Figure 5.16) included all members of his immediate family under an umbrella with rain pouring down on them. Burns and Kaufman (1972:250) contend that the inclusion of rain in a drawing can be associated with depressive tendencies. While Neil could not be classified as depressed, much of his behaviour and his remarks in interviews indicated that he was not particularly happy at the time of assessment because of his home situation and scholastic problems. The drawing of the tree with the owl peeping out of the hole could suggest a need for security and nurturance.

His CAT/Columbus stories were short and unimaginative. Themes of aggression and punishment were predominant with the weaker character retaliating against, and often overcoming, the more dominant figure. (For example, one of his responses to the CAT cards was: "the monkey hit the tiger"). There was a problem in his relationship with his father and he had a desire to "punish" his father and force his father to take notice of him: this theme was evident in his stories. He appeared to reject discipline as something unjust. Manipulative behaviour was evidenced in his responses.



Self.

✓ Rugby
Running across
playing Tennis
Swimming

TV

couldn't think
of anything X

Figure 5.15
DAP - NEIL

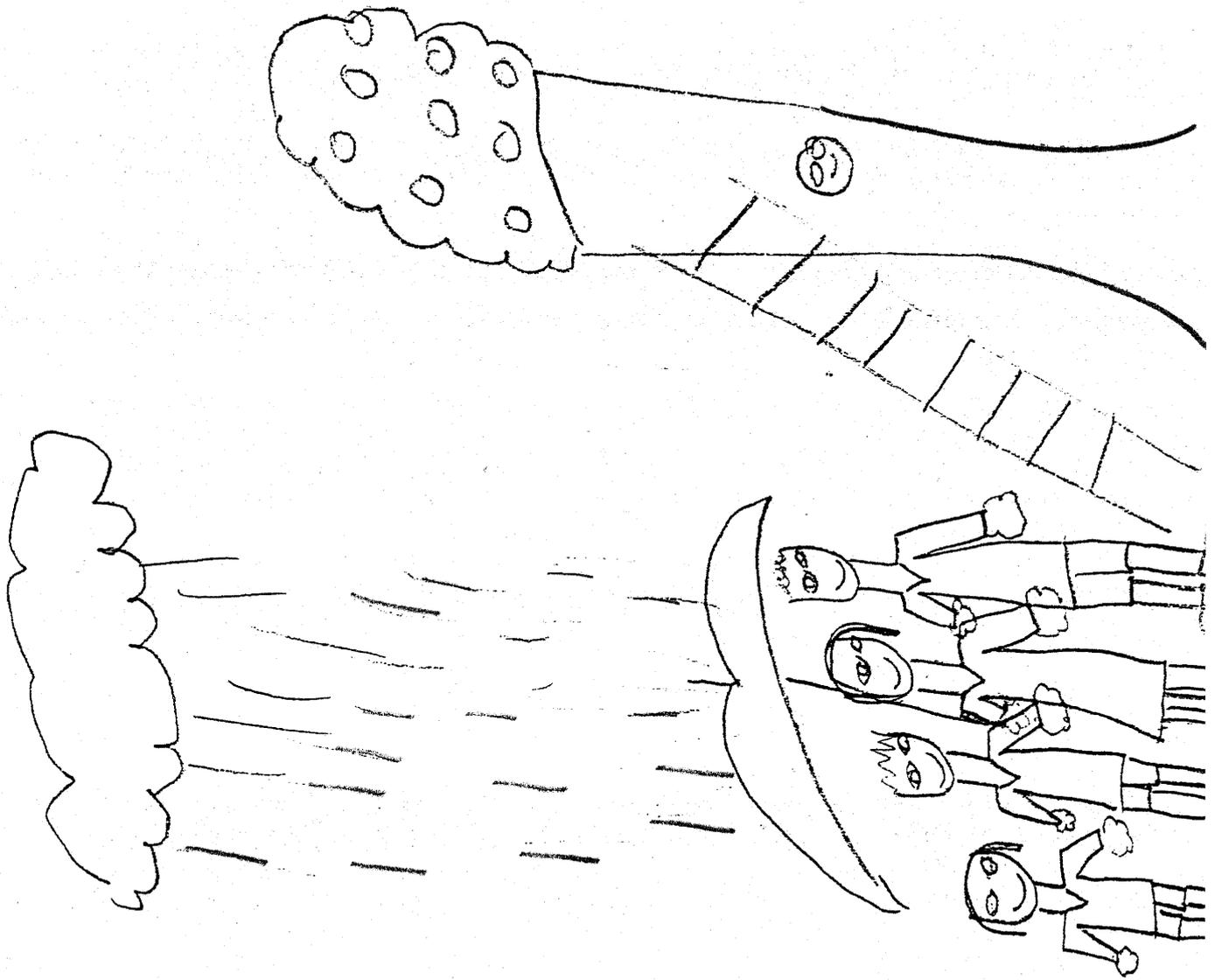


Figure 5.16
KFD - NEIL

*** Orthodidactic Tests**

Chronological age	8 years 7 months
Visual perception:	
Analysis/synthesis	8 years
Figure-ground	average
Discrimination	8 years 6 months
Spatial Orientation	11 years 10 months
Sequencing:	7 years 2 months
Visual memory:	9 years 4 months
One Minute Reading Test	7 years 3 months
Spelling Test	7 years 10 months
Neale Reading Test	Accuracy - 7 years 1 month Comprehension - 6 years 8 months Speed - 8 years 9 months
Sounds	he knew all the sounds but was unsure of most Grade 2 sound combinations

I Q - 102 (he had been assessed fairly recently on the OSAIS so it was not considered necessary to do a second I Q test.)

No serious perceptual problems were evidenced. His sequencing was below average but his poor concentration appeared to be largely responsible for the low score. His word recognition and spelling ages were more than a year below his chronological age but only a few months below his academic level. His reading was weak, particularly his comprehension and he was careless. He said repeatedly that he "battled" with school work.

* Relational image

Relations with parents

Neil's relations with his parents were poor. They paid him little attention and he felt rejected by them. His relations with his father were particularly poor. He craved his father's attention and affection. Discipline at home appeared to be inconsistent with the parents frequently contradicting each other. The result was that Neil had little conception of discipline. He saw any attempts by his parents to discipline him as unjust and a sign that they did not love him.

Relations with teacher

These were unrealistic. Since his behaviour in class was so disruptive his teacher had to be very firm with him and he interpreted her actions as unjust. He felt she did not like him as much as other children and thought he was stupid.

Relations with peers

His relations with his peers were not good. He felt other children did not like him and picked on him. He complained that he had few friends. His poor scholastic performance and accompanying feelings of inadequacy made him feel inferior to them. This resulted in compensatory aggressive behaviour like bullying.

Relations with objects and ideas

Neil had a very negative attitude towards his school work. He repeatedly talked about "battling" with it and when he had to do any academic work his reaction was often, "I bet I won't get this right." He had adopted a defeatist attitude towards all scholastic tasks. His significance attribution was unrealistic and this led to a lack of involvement and negative experiences.

Relations with self

Neil had an extremely poor self-image. He saw himself as disliked by peers and teacher, and rejected by his parents. This led to his developing an unrealistic image of himself as stupid and worthless.

* Therapy programme

Play therapy

It was evident that Neil needed a great deal of emotional support since he felt inadequate both socially and academically and he had troubled relations with his parents. The initial play therapy sessions were not particularly successful. Neil cooperated well but his play was stilted and lacked imagination. It took a number of sessions to build up the correct climate. He admitted afterwards that he had felt "shy" in the initial sessions and it appeared as though he was sceptical of trusting adults.

Initially most of his play was "constructive" play. He built with blocks making towers and houses, played at soldiers shooting each other, or made objects from clay. He was not spontaneous in using imaginative play but when given a little encouragement he could play out his own "stories". In his play themes of aggression and thwarting discipline were evident. An example of this was in a semi-structured situation when it was suggested that he take some figures and make up a story about a boy who found things were difficult for him. His theme was of a boy who was unfairly punished by his parents, ran away and was eaten by a crocodile. The parents' distress was emphasised. The boy was saved and he ended the story by saying, "After that the boy could stay up late and do whatever he liked." This story appeared to sum up most of Neil's problems in his home situation. His desire for attention, the methods used to obtain it and his unrealistic attitude towards discipline and punishment.

In the fifth play therapy session it was suggested he might like to try finger painting. This proved extremely successful. He enjoyed the creative aspect of it and it appeared to have a cathartic effect upon him since he was able to express a great deal of aggression. His favourite activity was making ink-blot type paintings. In almost all the remaining sessions he requested to use the finger paints. He enjoyed painting monsters and these were then made into paper puppets and were used for further therapy. He made up stories using these puppets. Themes of aggression and rejection were evident in these stories.

* Combined sessions

His stories were used as a basis for the remedial component of the programme when it was introduced and a personal reading book was compiled (see 4.5.5). The stories were rewritten, as far as possible using words which he could read. The intention was to use them for therapeutic and remedial assistance. This proved successful, especially as far as the reading was concerned. He enjoyed reading his own stories. He was far more motivated to try and master all the words and read them as well as he could. He cooperated in words games but poor concentration was evident.

As the sessions progressed he became more and more relaxed and his active participation in all components increased.

* Conclusions

Changes in Relation Structures

There was definite evidence of an improvement in Neil's work and attitude towards school in general. He was still unsure of himself and in the last session when playing a word game he started off by saying, "I'm sure I won't get it right." This had always been his approach to challenging tasks. However his involvement in the game and non-verbal behaviour suggested that he felt he could succeed. This change in attitude was a positive sign. He received an award for improvement in school work at the end of the term and was thrilled by this. He kept referring to it and remarking how pleased his parents would be. His teacher and headmaster were delighted in his improvement.

His self-image appeared to have improved considerably. His aggressive behaviour was reported to have decreased although it had not disappeared and he appeared happier and more relaxed. At the termination of the programme his relations with his parents and peers had not shown significant improvement but as his self-esteem and behaviour improved it was hoped that these relations would also improve.

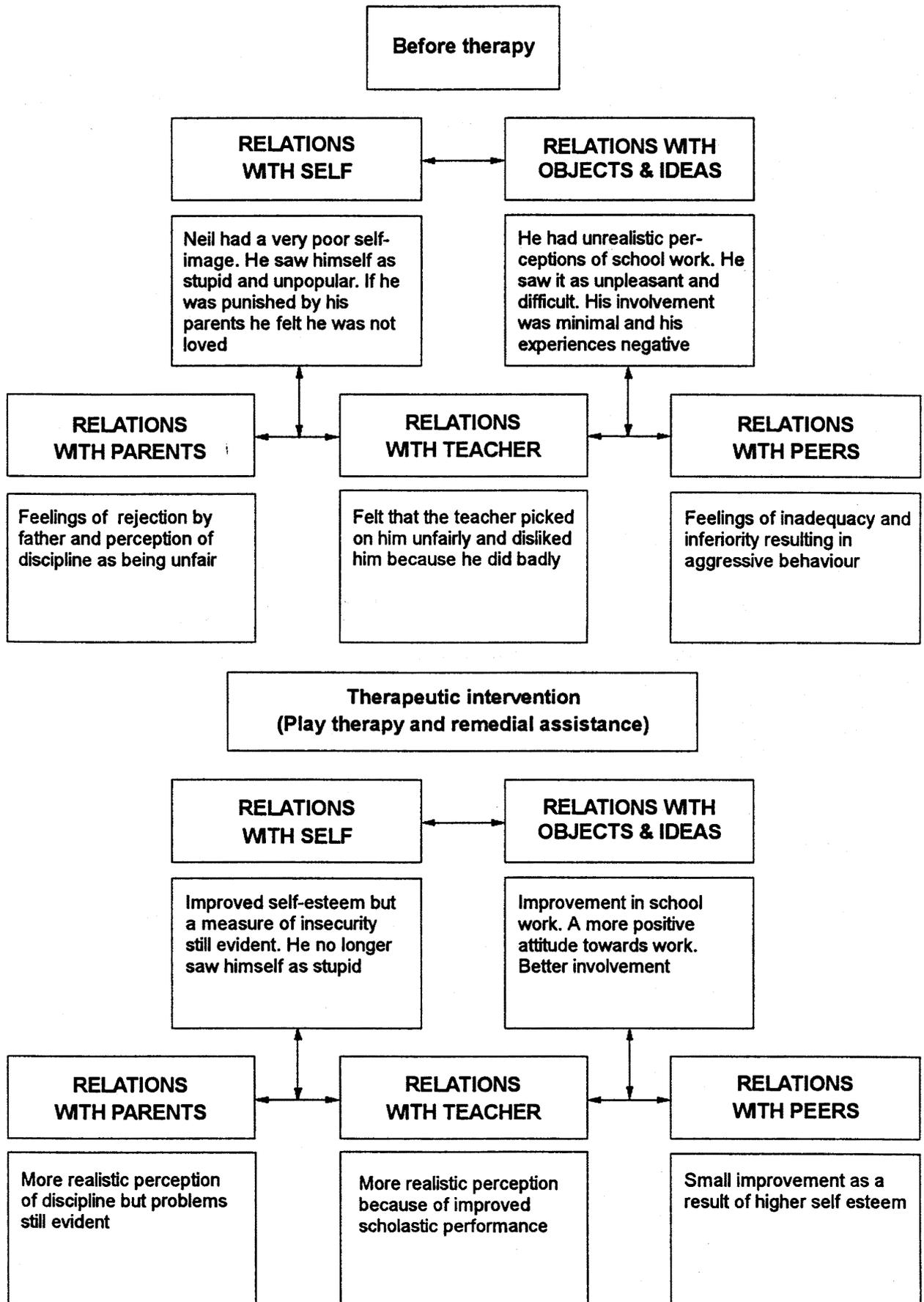


Figure 5.17 Summary of changes in relation structures (Neil)

5.4.3 Michael

Personal particulars

Name	Michael
Class	Grade 2
Date of birth	1987-07-08
Age when assessed	7 years 9 months

* Functional image (level 1)

Michael was referred for assessment mainly for scholastic problems. He was reported to be slow, have poor concentration and problems with fine motor control. His application of learnt sounds and reading was poor. He had been on an a remedial programme at the school and had made little progress. Emotionally Michael was said to be immature and lacking in self-confidence.

* Home circumstances

Michael was one of two children. He had a brother two years younger. His parents lived together and his home circumstances appeared satisfactory. His father, however, had a demanding job and he was not able to spend much time with the children. His mother admitted family relations were rather strained since the family were living with the grandparents while waiting for their home to be built.

* Phenomenal image (level 2)

An interview with Michael's mother indicated that his emotional problems had begun when he went to school. She said that at nursery school he had been quite happy and well-adjusted. He complained that other children bullied him at school and his mother said that he seemed to have less self-confidence now that he was at primary school. It appeared that Michael's learning problems and difficulty with school work were having an effect upon his self-esteem. His feelings of neglect and lack of attention from his father also seemed to have an adverse effect upon him.

* Results of diagnostic media

Projective Tests

His DAP revealed feelings of inferiority and possible repressed aggression. He drew his father and in the interview which followed the drawing it emerged that he had a longing for communication with his father. His initial family drawing suggested little family interaction with each member of his family doing something different. He drew himself waiting to play at sword fighting with his father. In a second family drawing done later he initially omitted himself, saying there was no room. He eventually included himself dwarfed by his parents. The discussion following the drawing suggested rather troubled family interaction. He said his mother was always shouting at his brother. He also did a drawing of a tree which seemed to indicate repressed aggression.

Michael responded positively to the CAT. The dominant themes in his stories were conflict, punishment, isolation and retribution. There was an element of competition in many of the stories and there was always one clear victor: in one case the father figure and in another the weaker creature.

* **Orthodidactic Tests**

Apart from a slight problem with spatial orientation, Michael's visual perception was satisfactory. His spelling, reading accuracy and comprehension were all more than a year below his expected level estimated from his I Q, which was 104 on the JSAIS. In the One Minute Reading Test he was only able to read 18 words.

* **Relational image (level 3)**

See Figure 5.18

* Therapy programme

Play Therapy

Michael found it very difficult to play on his own. He appeared to feel uncomfortable in a completely unstructured situation. He did not like initiating games but was quite happy to play once the therapist had given him some direction. However, he tired of games quite quickly due to his poor concentration. In his play there was evidence of his feelings of insecurity. He enjoyed creative play and liked drawing and playing with clay. He always wanted to make something which he could take home to his mother. He also enjoyed making up stories in his play.

Combined sessions

Since Michael's emotional problems largely resulted from his poor scholastic performance and since he seemed more relaxed in structured situation, it was deemed appropriate to begin the combined sessions after the fourth play therapy session. The therapist decided to use storytelling to combine the two sessions. Michael had been pleased with his CAT stories so these were used to initiate the reading programme, and a personal reading book was compiled (see 4.5.5). This proved successful as he enjoyed reading his own stories.

The games he enjoyed most were games using words from his stories. Words were written on cards, and various toy animals were taken and made to play words games. He asked repeatedly to play these games and sometimes would play these games for a whole session in preference to free play. The games seemed to serve a therapeutic purpose and helped with his reading. In each game he identified with a particular animal and that animal had to triumph.

An example of these games and one which was his favourite involved using words as "stepping-stones" across a river. The animals had to "read" each word correctly before they could move to the next stone. If they could not read the word they were eaten by the crocodile. He became very involved in the game and sometimes at the beginning he became agitated if he could not read the words and the animal had to

be eaten. However, once he decided upon his favourite he felt "safe". He displayed aggression when other animals were "eaten". It was as if he identified with the success of the chosen animal. It seemed as though this game helped to meet an underlying need to achieve success since he was faced with so much personal failure in the classroom situation. He was also able to express some of his underlying aggression and frustration. A few semi-structured play scenes were suggested by the therapist towards the end sessions. The aim of this was to try to help him understand and face his problems.

*** Conclusions**

While there was an improvement in Michael's relation structures after the programme, the alteration was not as dramatic as in the cases of Sarah, Christopher and Neil. This could perhaps be attributed to the fact that at the start of the sessions Michael's relations had not been as poor as the other children's. The greatest improvement was in Michael's relations with his school work. His teacher said that while he was still in the weaker half of the class he was coping with the work and completing all tasks he was set. She said he was becoming more self-reliant and less unsure of himself.

It was only possible to interview the mother towards the end of the sessions. She was positive about trying to improve the situation and obtaining Michael's father's cooperation. The sessions were terminated before any real improvement could be detected in Michael's relations with his father. However, in the last session he spoke about the games he had played with his father. It was hoped that this would continue and would help to build Michael's self-esteem which was improving as his school work improved. Further remedial assistance and possible Aid Class placement were suggested.

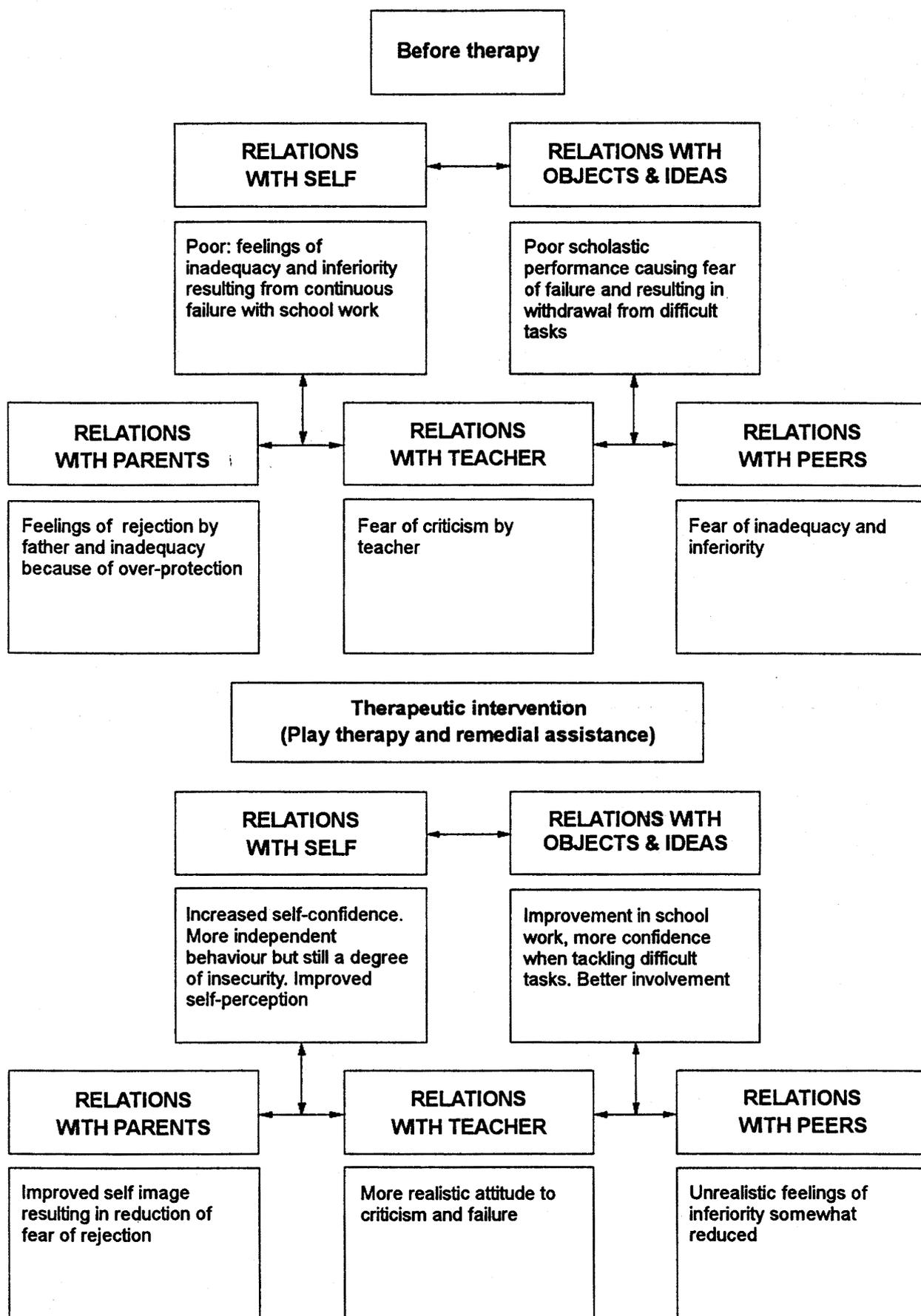


Figure 5.18 Summary of changes in relation structures (Michael)

5.4.4 Ann

Personal particulars

Name	Ann
Class	Std 1
Date of birth	1986-08-22
Age when assessed	8 years 10 months

*** Functional image (level 1)**

Ann was referred because her reading was not up to standard. She was reported to be a quiet child and somewhat shy but exhibited no serious behavioural or emotional problems.

*** Home circumstances**

Ann's home circumstances were sound. She came from a wealthy home and was an only child. While her parents doted on her, they were both busy and Ann spent a lot of time at home playing on her own. She was spoilt but not excessively so. Ann's mother expected a great deal from the child and wanted her to do well. She attended an exclusive school where the standard of education was high and Ann's mother was concerned that she was not coping as well as she should.

*** Phenomenal image**

It appeared that Ann was being pressurised by her mother to achieve beyond her capabilities. This was making the child frustrated and causing her to develop a negative attitude towards her work, particularly reading which was her biggest problem.

* Results of diagnostic media

Projective Tests

Ann's DAP revealed a fairly healthy self-esteem but underlying aggression. This was confirmed in her CAT stories where themes of aggression were evidenced in all her responses. The most common theme was that the younger or weaker character was persecuted in some way or other and often children were lost or eaten up. Ann's Kinetic Family Drawing showed little family interaction. Each member of the household was doing something on his or her own.

* Orthodidactic Tests

Ann's visual perception and her spelling were above average but her reading was below average.

Word Recognition 7 years 7 months

Speed 8 years

Accuracy 8 years 1 month

Comprehension 8 years 7 month

Since Ann had an above average I Q she should have had better scores on the reading test.

* Relational image

See Figure 5.19

* Therapy programme

Play Therapy

Ann thoroughly enjoyed all the play therapy sessions. She had a vivid imagination and for a relatively shy child she was surprisingly uninhibited in her play. She made up long fanciful tales using almost all the toys. She made a great deal of use of puppets and loved giving puppet shows. There was evidence of repressed aggression in her play and many of the games included violent scenes where animals and dolls

were eaten by other creatures. Ann's therapy was conducted at home and a problem emerged in that Ann's mother often did not really listen to her daughter. It was therefore decided to encourage the mother to attend the "puppet shows". The intention was to attempt to incorporate Gurney and Gurney's (1989:334-357) and Early's (1994:119-130) technique's of family play therapy. It was, however, only partially successful since Ann's mother kept remarking on the aggressive themes and this inhibited the child's play.

Combined Sessions

Ann had a negative attitude towards reading. She said it was boring and difficult, and she was rather hesitant when the reading component was introduced. It was decided to use her own stories as a basis for the initial remedial sessions as was done in the previous two cases. The compilation of a personal reading book again proved successful. Ann enjoyed seeing her stories "in print" and tried hard to read them well. They seemed more meaningful to her. Most of her stories were written out in the form of little plays with the therapist or her mother reading some parts and Ann reading others. Errors which occurred in Ann's reading indicated faulty eye movements such as regression, so eye exercises and phrase reading were also included in the programme.

*** Conclusions**

While Ann's reading was weak and did have an effect on her relation structures, her emotional problems were not as severe as the other children in the study and hence the improvement was not as obvious. The progress in her reading was also not as significant. However by the end of the programme her attitude towards reading and her scholastic identity were more positive.

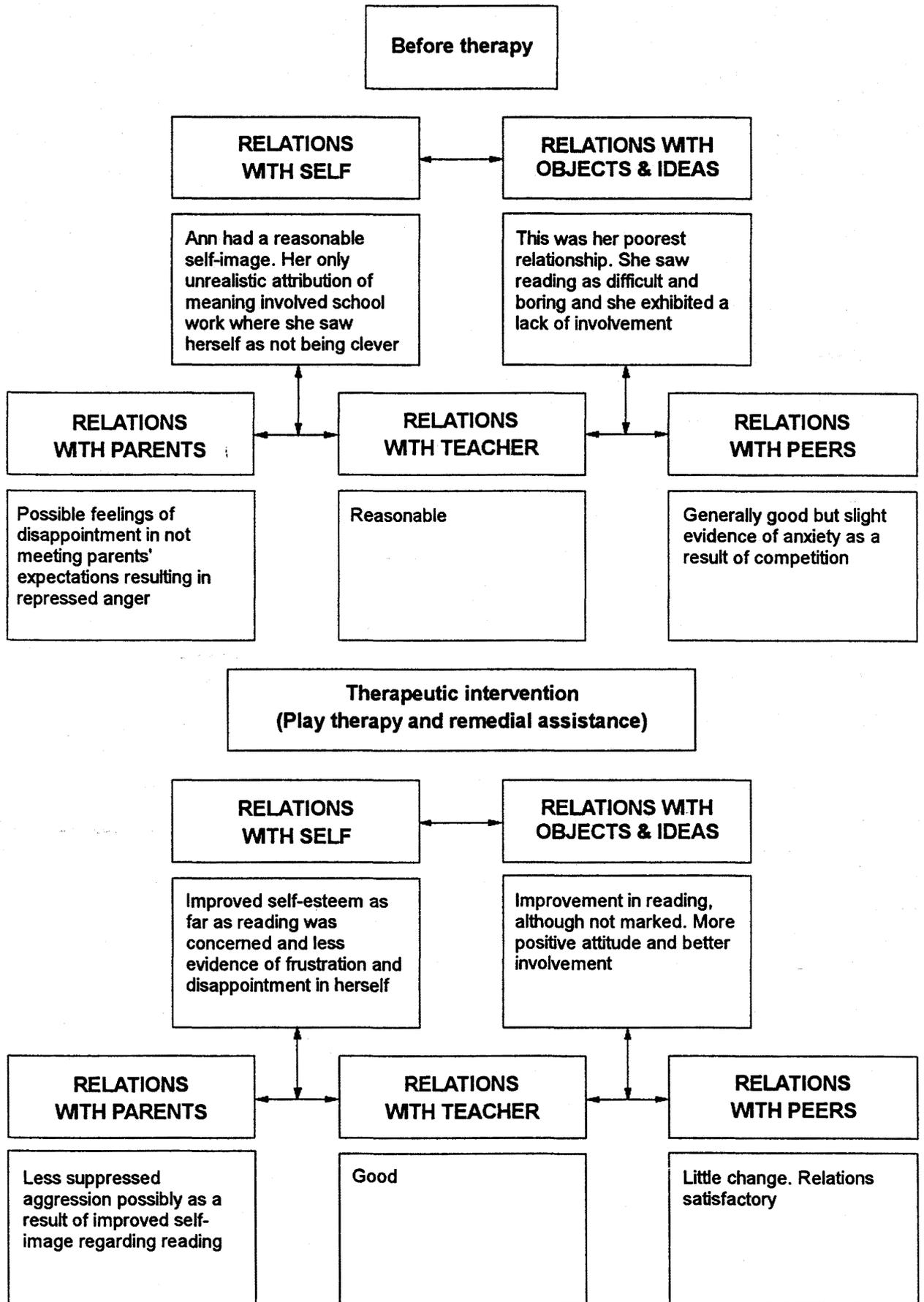


Figure 5.19 Summary of changes in relation structures (Ann)

5.5 CONCLUSION

In this chapter the five case studies were discussed, one in detail and the others less intensively. The method of including play therapy in the remedial programme was explained and comments were made on its effectiveness and the children's reactions to the different parts of the therapy. The relation structures of the children were examined before the programme was introduced and were reassessed at the termination of therapy. The model discussed in section 3.5.6 was used to summarise the changes in the children's relations.

Changes in the relation structures of all the children were evident. Some were more meaningful than others. It appeared that the children with more disturbed relationships and with more serious emotional problems benefitted more from the programme than those whose problems were predominantly scholastic. These findings will be used to evaluate the effectiveness of the programme in the next chapter where the findings will be examined and conclusions drawn to assess the extent to which the aims of the study have been realised.

CHAPTER SIX

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This study was prompted by the researcher's observations that learning difficulties in children are often accompanied by emotional problems (see paragraph 1.2). Most therapy programmes are mutually exclusive and remedy only one aspect of the problem. The intention in this research was to compile a programme which could assist the child emotionally and scholastically. The study focused on incorporating play therapy into a remedial reading programme.

In this concluding chapter the following aspects will be considered:

- * the findings from the literature study regarding important aspects of play therapy will be summarised; the different perspectives and techniques which can be incorporated into the programme will be discussed
- * observations in the literature regarding the world of the learning disabled child and how his problems affect his relations with other people, objects and ideas and himself will be considered
- * the results of the empirical study will be discussed and assessed
- * conclusions will be drawn to ascertain the extent to which the aims of the study were realised

- * limitations of the study will be discussed
- * recommendations for further research will be suggested.

6.2 FINDINGS FROM THE LITERATURE STUDY

6.2.1 Findings regarding important aspects of play therapy and their relevance to the study (Chapter 2)

* Play is a child's natural medium of communication. Children use play to express feelings which they have difficulty verbalising. Play serves a diversity of purposes for the child. It is pleasurable and relaxing but it also serves biological, inter- and intrapersonal functions as well as a socio-cultural purpose (see section 2.2). None of the children in the study was able to communicate their feelings of anger and frustration and the sessions gave them the opportunity to express their emotions through the enjoyable medium of play. It was also found that the children learnt more readily through play.

* As the child's level of intellectual development and concept of reality alters so his type of play changes (Piaget 1977:91; see section 2.3.1.4). While the stages of play may overlap, a healthy child's play should be age appropriate. Inappropriate play behaviour is often an indication of emotional upheaval in a child. This fact was of assistance in diagnosis and evidence of this type of behaviour was seen in the play of most of the case studies. For example when Sarah sucked the baby's bottle (see section 5.3.9) this was seen as regressive behaviour. Later, her more age appropriate play was an indication that she was achieving greater emotional stability.

* Over the years play therapy has been found to be one of the most successful methods of assisting children with emotional and behavioural problems. Experts agree (see paragraph 2.3.1) that the most important aspect of play therapy is the creation of an empathetic climate of warmth and acceptance in which the child feels free to

express his emotions. The purpose of this is to allow the child to develop an awareness and eventual acceptance of his problems so that a healing process can take place.

The children in the study had experienced feelings of rejection at school as a result of poor academic performance. They needed to feel accepted and respected before they could face their problems and develop a positive approach towards reading. The establishment of an empathetic climate was found to be essential. In some cases this was readily established while in others (for example Christopher and Neil, where rejection both at school and home was keenly felt), it took longer. The play therapy situation proved ideal for the creation of this climate and once it had been established the children's self-esteem increased, improvements in behaviour were detected and then, through play, remedial assistance could be initiated.

* The three major psychotherapeutic approaches to the treatment of children are the psychoanalytical, client-centred and behaviourist models. Play therapy is used in all three approaches but the methods of implementation differ. Many other different approaches, based on these schools of thought, have developed over the years.

* Psychoanalytical play therapy is based on the pioneering work of Anna Freud and Melanie Klein. Today this method is seldom used (see paragraph 2.4.1.5) as it is time consuming and many experts criticise the subjective approach which the therapist is required to adopt. This method was not considered suitable for this study because the therapist is compelled to work largely from an internal frame of reference.

* Child-centred play therapy was developed by Axline and is based on the theories of Carl Rogers. This method is non-directive. The therapist's task is merely to establish the correct climate and to reflect the child's feelings. It has proved extremely successful and is still practised by large numbers of therapists throughout the world. A disadvantage of this method is that it can be time consuming because the child directs the course of the therapy. Another criticism is that it offers the child no form of normative direction (see section 2.4.2.4). While most of the basic principles of

child-centred play therapy were adhered to in this study, a completely non-directive approach could not be adopted as it would not have been appropriate for the remedial component of the programme non-directive.

* Since behaviourist therapy is a structured approach only certain types of play therapy are compatible with this method. While it would have been possible to include some behaviourist techniques in this programme, none of the children in this study exhibited phobias or other similar problems and behaviourist therapy was not considered appropriate.

* The method which was considered the most suitable for this study was relation theory since it is a flexible approach to child therapy. Any method of play therapy, non-directive and unstructured, semi-structured or structured or a combination of approaches can be used depending on the needs of the individual child. This method is based on the child-centred approach to therapy and looks at the child from the perspective of his relationships with people and objects and ideas in his life-world, as well as his relations with himself.

* As play therapy developed so a large variety of widely differing techniques has emerged. Some of these techniques are exclusive to specific approaches while others like drawing, art therapy or role playing, for example, are used by therapists from different schools of thought, often with different emphasis. The literature (see section 2.5.7) indicates that most therapists use a variety of techniques depending on the needs of the child. Working from a relation therapy perspective the therapist is able to incorporate any techniques which he/she feels will assist the child. A wide variety of the techniques discussed in section 2.5 were used in this study. The techniques ranged from more conventional methods like drawing, painting, role-play, puppets and finger puppets to compiling personal story books and family play therapy.

6.2.2 Findings from the literature concerning the world of the learning disabled child (Chapter 3)

* Most experts concur that there is no universally accepted definition of the term *learning disability* (see section 3.2.1). They do, however, agree that a child who does not achieve according to his expected potential can be described as having a learning disability. According to the DSM III a child is said to have a *reading disorder* if his skills are significantly below his intellectual ability. A one to two year discrepancy is considered significant. The children used in the study could be classified as *reading disabled* according to the DSM III description as they were all performing significantly below expectations (see section 4.5.2).

* Learning disorders include problems such as minimal brain dysfunction, hyperactivity, dyslexia, aphasia and perceptual difficulties. Children with visual, motor and auditory handicaps are not considered learning disabled. The pupils selected for this study complied with these criteria (see section 4.5.2).

* It is difficult to establish the causes of a learning disability. The problem is often found to be the result of a combination of cognitive, affective and socio-economic circumstances. There is much debate over which factors can be described as causal and which are the consequence of the problem. This finding from the literature was substantiated when an assessment was made on the children who were used for this study. It was difficult to establish precisely which factors were responsible for their reading difficulties.

* The literature stresses that learning difficulties are often accompanied by emotional problems. The children chosen for the project all had a reading disability and accompanying behavioural problems and every child exhibited one or more of the behaviour traits cited in the literature. The subjects all had impaired concentration and tended to be impulsive. They used avoidance tactics when faced with scholastic tasks which they considered difficult. This applied particularly to reading. Almost invariably learning disabled children develop behaviour problems which take the form of withdrawal or aggressive acting-out behaviour. In this study three of the subjects

(Sarah, Christopher and Neil) were antagonistic and disruptive while the other two (Michael and Ann) tended to become withdrawn. Such children are often frustrated, anxious and tense and almost always have poor self-concepts. These behaviour traits were evident to a greater or lesser degree in all the children.

* The relation structures of the learning disabled child are often poor. He has an unrealistic, negative attitude towards his school work. This has an adverse effect on his relations with himself since he sees himself as a failure which in turn worsens his relations with his work. A vicious cycle is established and since the relation structures are interlinked all other relationships are negatively affected. This phenomenon was evident in all children as was indicated in the tables which were drawn up to summarise their relation structures (see Figures 5.3, 5.14, 5.17, 5.18, 5.19).

* Most attempts at assisting the learning disabled child are aimed at remediating his scholastic problem. Some children never seem to benefit from these programmes and experts (see section 3.6.2) claim this is because the emotional aspect of the problem is ignored. This finding has proved true for the children involved in this programme. All had had some form of remedial assistance which was not successful. None had had any form of emotional support.

* Programmes which include some form of therapy to assist with affective problems in addition to the scholastic assistance, have been found to be effective. One of the assumptions upon which this study is based is that improvements in the child's relation structures will only be effective if the child is assisted both cognitively and affectively (see section 4.4 and section 6.3.2 for results).

* Studies have been conducted using play therapy with learning disabled children but the therapy was usually conducted independently of the remedial programme. This method proved successful in improving the child's emotional health and in some cases reading improved as well, but frequently the play therapy had to be followed by

remedial instruction because the child still lacked the necessary reading skills. The aim of this programme was to combine emotional and scholastic assistance in order to overcome these problems.

* The literature contains few examples of play therapy as an integral part of a remedial reading programme. A reason which is suggested for this is that play therapy is conducted in a relaxed, non-threatening environment. A child who has scholastic problems finds any task which is associated with learning threatening. One of the problems which was investigated in this study was whether it was possible to combine the essential elements of play therapy with a reading programme.

6.3 FINDINGS FROM THE EMPIRICAL STUDY

6.3.1 Findings regarding the relation structures before therapy

* The results of the study indicated that the relation structures of all the children had been adversely affected by their learning problems.

* The children's relations with objects and ideas (school work, in particular) were distorted. Meaning was attributed to reading and other scholastic tasks on an affective rather than a cognitive level. School work was described as "boring", "horrible" or "too difficult". Their experiences of academic tasks became unpleasant and threatening, resulting in a lack of involvement. The consequence of this was further unrealistic attribution of meaning and the problem was aggravated. This concurs with the findings of Jacobs and Vrey (1982:11-13) (see 3.5.2).

* In this study all the children had poor self-concepts regarding their scholastic abilities. Continual failure resulted in their seeing themselves as stupid and inferior: the poorer the academic performance the more negative the self-image. This finding supports the views of experts like Andrews (1971), Lewis (1984), Beck (1988) and Casey *et al* (1992) (see section 3.4.2).

* The findings of this study suggested that the weaker the self-concept and the poorer the child's relations with himself the more unacceptable his behaviour became.

* It was found that if the child had sound relations with his parents then his poor scholastic performance had less effect upon his relationship with them. If the family situation was already problematic then learning difficulties and the resulting effect upon self-image and behaviour aggravated the situation. Parental expectations and fear of disappointing parents were important factors in most cases. Feelings of rejection (or of being ignored) by parents, were also evident. Erratic or inconsistent discipline was found to be a cause of problematic relations with parents, as was overprotection in two of the cases. These findings are consistent with studies done by Strother and Barlow (1985:31-35) (see section 3.5.3).

* In most cases relations with the teachers were reasonable. Some unrealistic meaning was attributed to discipline, punishment, grade and quantity of work but generally the children had fairly good relations with teachers.

* In all cases the children saw themselves as inferior to their peers who were not experiencing learning problems. In the more severe cases this resulted in anti-social compensatory behaviour such as bullying.

* It became evident that all relation structures had been negatively affected by the child's learning and emotional problems.

6.3.2 Findings regarding the implementation and effectiveness of the therapy programme

* The method of using the first sessions for play therapy was found to be effective. This approach enabled the therapist to create a climate which the children could experience as non-threatening and in which they could feel they were unconditionally accepted.

* The initial sessions were left as non-directive as possible. In some cases the children responded positively to the non-directive approach. However some children, particularly those who were especially uncertain of themselves (for example Michael and Neil), seemed bewildered and uncomfortable in a completely non-directive situation. It appeared that it would take time to get these children to feel comfortable in an unstructured environment. One of the criticisms levelled against non-directive therapy is that it can be extremely time-consuming (see section 2.4.2.4). Most school counsellors' programmes only allow a limited number of sessions with an individual child. For this reason it was decided that in cases where the children did not respond positively to a non-directive environment, a semi-directive approach would be adopted. It was found that these children responded better if they were given tentative suggestions as to what they could do. However, choices were left open to them. The method of using a different approach for each child, depending on his personality and individual needs proved to be effective.

* Using a child-centred approach but working from a relation theory perspective it was possible to incorporate a wide variety of techniques into the play sessions. Many of the techniques mentioned in Chapter 2 (see section 2.5) were successfully incorporated into the individual programmes. Examples of such techniques were play interview, structured play, puppets, finger puppets and masks, block play, modelling with clay, drawing and finger painting, storytelling, role play and family play therapy.

* The introduction of the remedial component was the most difficult part of the programme. It could only be introduced once a positive relationship had been established and trust had been built up. Even then great care had to be exercised so as not to destroy the climate of acceptance and trust. This was particularly important since academic tasks were viewed as threatening. It was found that in all cases there was an initial resistance to the inclusion of "work" in the play sessions.

* This resistance was best overcome if the remedial component was introduced slowly and on a level below the child's present level of functioning so that the child experienced success rather than failure. It was found that children responded more

positively if the academic component was introduced in the form of games and play acting so the children were not really aware that they were reading or learning. By the end of the programme all the children in the study were participating eagerly in both components. Most of the children showed a preference for the "free play" part of the programme. This was seen as a normal reaction since the latter required no effort on the part of the child and children naturally chose to play in preference to more taxing tasks like reading.

* The compilation of a personal reading book (see 2.6.3, 3.6.3 & 4.5.5) using the children's CAT responses and stories which emerged in their play therapy sessions proved successful both as a diagnostic and therapeutic technique. The children responded particularly well when their own stories were used as remedial reading material.

6.3.3 Findings regarding the relation structures on completion of the programme

* There was an improvement in the relation structures of all the children after the termination of the therapy. The improvement was more noticeable in the children who had more serious emotional problems (Sarah, Christopher and Neil). The children who showed the most dramatic alterations in their relations were those who had had emotional problems before they developed scholastic problems. The children whose problems had arisen chiefly as a result of poor scholastic performance did not have such severe behavioural disturbance and the change in their relations structures was not as marked (Ann and Michael).

* In all cases the relation structures which showed the most improvement were the relations towards school work and self.

* Relations towards school work were less negative, significance attribution was more realistic, the children were more actively involved in their school work and their experiences were becoming more positive. In all cases further remedial assistance

was necessary. Although all the children had made some progress further improvement in reading skills and other academic tasks was required in order to strengthen the relation structure still further.

* In all cases the children's relation with themselves had improved. Their self-concepts had been strengthened although a measure of insecurity was still evident. Their significance attribution towards themselves was more realistic. They no longer saw themselves as stupid or unacceptable to others because of their poor scholastic performance. Behavioural problems had decreased but were still evident at times.

* Improvement was noticed in other relation structures as well. Strengthening of relations with parents depended on the parents' reactions and in difficult family situations this improvement was not as marked. Slight improvements were noted in relations with teachers and in most cases relations with peers were strengthened.

6.4 CONCLUSIONS

6.4.1 Realisation of the aims of the study

The aims of the study (see section 4.2.2) were realised.

* The literature was reviewed to investigate the relationship between emotional difficulties and learning problems. The empirical study established how this relationship affected the child's relations with himself, objects and ideas, his parents, peers and teachers.

* A programme was devised to assist the child emotionally and scholastically using play therapy and later introducing a remedial reading programme in addition to the play therapy.

- * Play therapy was implemented from a relation therapy perspective and a variety of different techniques was included in the programme.

- * The children were reassessed at the end of the programme. Orthodidactic and projective tests (DAP and KFD) were repeated and interviews were held with teachers and parents. This was done to see if changes had occurred in the children's relation structures. The programme was evaluated by comparing the child's relation structures before and after the therapy.

6.4.2 Conclusions drawn from the findings

The conclusions drawn from the study generally support the assumptions upon which it was based (see paragraph 4.4).

- * Findings both from the literature and empirical studies confirm that there is a relationship between learning disabilities and emotional problems. Learning difficulties result in a child developing poor relations with his school work. The child feels frustrated and disappointed in himself. This results in his developing a poor perception of himself and affects his relations with himself. The negative interaction between these two relations also has an adverse effect on all the child's other relation structures.

- * The therapy programme was evaluated by comparing the child's relation structures before and after the implementation. In all cases improvements in relation structures were evident but some were more marked than others. The children with more serious emotional problems showed more improvement than the other children, particularly in relations with school work and self.

- * It was possible to include play therapy, implemented from a relation theory perspective, in the remedial programme. Problems were encountered in trying to uphold all the essential elements of the successful client/therapist relationship while introducing the potentially stressful scholastic component of the programme. However,

because of the flexibility of the relation therapy approach, it was possible to use a wide variety of different techniques and cater for the child's individual needs. As a result it appeared that generally the two components were successfully combined.

6.5 LIMITATIONS OF THE STUDY

6.5.1 Limitations with regard to the implementation

* It was felt that, in some cases, twelve sessions were insufficient to assist with both emotional and scholastic aspects of the programme. In all cases further remedial assistance was required to help the children acquire reading and other learning skills which they had not already mastered and in some cases therapy needed to be extended as well.

* In most cases more parental involvement in the programme should have been included since not all the children had sufficiently improved relations with parents.

* The school environment was not ideal for play therapy. The quantity and type of material which can be transported by the school counsellor who travels from school to school are limited. If it had been possible to conduct the sessions in a proper playroom with all facilities including sand and water, more non-directive play could have been encouraged. The problem of the child getting bored with limited material had to be prevented. This resulted in the therapist having to be more directive in suggesting different types of play using existing material.

6.5.2 Limitations regarding the evaluation of the programme

* The fact that only five children studies were used in the study means that it is not possible to evaluate the effectiveness of the programme comprehensively.

* It is difficult to evaluate an abstract phenomenon like changes in relation structures accurately. The evaluation is, of necessity lacking in objectivity. More detailed, objective questionnaires or further projection tests could perhaps have been used at the end of the programme to obtain a more objective evaluation. In the present study time was one factor which prevented this being done. (It was felt that to repeat the CAT, for example, only six weeks after its first administration would not have been meaningful.)

6.6 RECOMMENDATIONS FOR IMPROVEMENTS AND FURTHER RESEARCH BASED ON THIS STUDY

* While it appears that play therapy and remedial assistance were successfully combined in the programme, this still remains a controversial issue. Many could argue that merging the two components is contradictory to the basic principles of successful play therapy, which requires a relaxed atmosphere completely free of anxiety-provoking situations like reading. Further research needs to be conducted, using larger groups of children to test the effectiveness of the programme. Studies could be done using two groups of learning disabled children. One group could be used as a control group receiving only play therapy while the others take part in a combined programme.

* The long term benefits of such a study need to be investigated to ascertain whether improvements in relation structures can be maintained.

* Research could also be conducted on different applications of the programme. For example, comparisons could be made on the effectiveness of different play therapy techniques for assisting the learning disabled child. Different methods of combining therapy and remedial components can also be investigated.

* Methods need to be devised to obtain a more accurate, objective assessment of a learning disabled child's relation structures.

6.7 CONCLUDING REMARKS

The child with a learning disability and emotional problems does not look any different from other "normal" children in the classroom and yet he *is* different. He has a handicap which can be as debilitating for him as a physical or mental disability can be for another child. As this study has shown, his problems affect his relations with everyone and everything in his environment. Since his relation structures are interlinked, difficulties in one area affect all other areas. If negative relations develop in one area, all other relations can be negatively affected. This affects the child's self-concept and retards his progress towards becoming a fully self-actualised individual.

Fortunately for these children methods have been devised to assist them to overcome their difficulties. The programme devised for this study has shown that by helping children overcome both aspects of their problems it is possible to improve their relation structures and assist them to achieve self-actualisation.

As Otto von Bismarck (1815-1898) said:

Man kann alles erreichen mit Kindern wenn man nur spielt mit ihnen.

(You can do anything with children if only you play with them.)

Through play it is possible to help children reach their full potential.

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APPENDIX 1

KNOWLEDGE OF BASIC SOUNDS AND SOUND COMBINATIONS

1. SAY THE SOUND

h c m b

l s d l

r a k n

e j q o

2. SAY THE NAME

x g y

f p

u t

w v

3. PHONICALLY SIMPLE WORDS

if up on van ten

cut kit jug six log

rub had jam win yes

4. CONSONANT DIGRAPHS

ship chop thin when

with mash that rich

sing queen long this

5. INITIAL BLENDS

brag clog grim stop glad

drop flag snap smell span

trip swim frog bless plan

skip crop sled prod strap

6. FINAL BLENDS

help	send	jump	felt
desk	bent	rest	lisp
dogs	sits	sink	bench

7. LONG AND SHORT VOWELS

tube	cut	mate	ride
meet	mat	rid	mane
met	hope	tub	cute
hop	man	dome	rip

8. VOWEL DIGRAPHS

loud	blow	day	road
meat	join	head	joy
flown	pain	oil	cloud

9. VOWEL-CONSONANT DIGRAPHS

new	saw	harm
horn	car	dirt
fern	calm	turn
haul	chalk	light

APPENDIX 2

QUESTIONNAIRE USED IN FINAL INTERVIEW WITH TEACHER

1. RELATIONS WITH SCHOOL WORK

1.1 Has there been an improvement in the child's school work? If so how significant is the improvement. Give details.

1.2 Has there been a change in the child's attitude towards school work?

2. RELATIONS WITH SELF

2.1 Has there been any change in the child's behaviour?

2.2 Have you noticed any improvement in the child's self-confidence? Do you think his/her self-concept has altered at all?

3. RELATIONS WITH TEACHER

3.1 Has there been any change in the child's relationship with you?

4. RELATIONS WITH PEERS

4.1 How does the child relate to his/her peers? Has there been a change in his/her attitude towards them and how do they react to the child?

5. RELATIONS WITH PARENTS

5.1 Have you had any feedback from the child's parents concerning changes in attitude or behaviour?

APPENDIX 3

QUESTIONNAIRE USED IN FINAL INTERVIEW WITH PARENT(S)

1. RELATIONS WITH SCHOOL WORK

- 1.1 Have you noticed any change in your child's approach towards school and school work?

2. RELATIONS WITH SELF

- 2.1 Is there any change in the child's behaviour at home?

- 2.2 Do you find there is any alteration in the child's perceptions of him/herself?

3. RELATIONS WITH FAMILY

- 3.1 Are there any changes in the child's relationships with other members of the family:

- mother
- father
- siblings
- other members of the immediate family

4. RELATIONS WITH PEERS

- 4.1 How do you see the child's relations with peers?