AN EDUCATIONAL PSYCHOLOGICAL PERSPECTIVE
ON THE USE OF FILIAL THERAPY
IN MOTHER-CHILD RELATIONSHIPS

by

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submitted in part fulfilment of the requirements for
the degree of

MASTER OF EDUCATION
WITH SPECIALISATION IN GUIDANCE AND COUNSELLING

at the

UNIVERSITY OF SOUTH AFRICA

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NOVEMBER 1998
DECLARATION

Student Number: 517-798-7

"I declare that AN EDUCATIONAL PSYCHOLOGICAL PERSPECTIVE ON THE USE OF FILIAL THERAPY IN MOTHER-CHILD RELATIONSHIPS is my own work and that all sources that I have used or quoted have been indicated and acknowledged by complete references."

A. M. ARNOTT

99-03-30
The different reactions of parents to the discovery that their children had ADD/ADHD has an effect on the primary relationship established between mother and child. This is essential in the later involvement, experience and meaning attribution of the child with respect to all subsequent relationship formation on the child's journey towards his ultimate target, namely self-actualisation.

It was felt that psychological intervention could help parents to bond, communicate with and relate to their children without experiencing negative feelings which would enhance parental acceptance.

In this study, ten mothers were used to participate in an adapted group Filial Therapy programme. This unique therapy involves parents as the primary agents to resolve child-related problems and to encourage children’s healthy psycho-social development.

Results were positive. The mothers felt that they had formed better relationship with their children. They were empowered with knowledge and coping mechanisms, such as reflective listening, setting limits and providing choices. For the first time they were enjoying their ADD/ADHD children.

Key Terms

Awareness, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Child-Centred Play Therapy, educational climate, experience, Filial Therapy, lifeworld intrapsychic structure: "I", me, self, self-identity, self concept, self-actualization, involvement, meaning attribution, mother-child relationship, parental acceptance personalization, relationship formation, Relations Model, subpersonalities.
ACKNOWLEDGEMENTS

My sincere gratitude goes to all those who gave me assistance during my study:

☐ My supervisor, Professor H. E. Roets, for her patience, encouragement, guidance and prompt and thorough examination of the text. More importantly for her faith in me which allowed me to grow and self-actualize beyond my wildest dreams. Her belief in me brought this study to completion.

☐ My special friend Mavis Clark who started me on this journey of further study and who during the previous five years has been so generous with her support, love and encouragement.

☐ The headmistress, Lizette Matthews, and staff, all my friends, at the Germiston School of Achievement who gave their cooperation and advice so willingly.

☐ The parents who so enthusiastically participated in the programme.

☐ My parents, Reen and Eric Terblanche, my sister Gwyneth and my brother, David, for their love, pride, encouragement and support.

☐ Dassie Smith, for being there, for my family.

☐ My friends, Linda, Gayle, Gwynneth, John and John-Paul who were always there when I needed a shoulder to cry on, or needed to unwind and relax.

☐ Lorna Latham for helping me with the typing.

☐ Charlene Freedman and Melany Constantinou for their diligent proof-reading of the text.

☐ Shireen Nel for the Technical Layout of the study.

☐ A special word of thanks goes to my children Michael and Lee for their love, encouragement, patience, understanding and acceptance.
To my father, Eric Terblanche, for all his love, encouragement and belief in my abilities.
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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

And a woman who held a babe against her bosom said, Speak to us of children.

And he said:
Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.

You may give them your love but not your thoughts,
For they have their own thoughts.

You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow,
which you cannot visit, not even in your dreams.

You may strive to be like them, but seek not to make them like you.
For life goes not backward nor tarries with yesterday.

You are the bows from which your children as living arrows are sent forth.
The Archer sees the mark upon the path of the infinite, and He bends you
with His might that His arrows may go swift and far.

Let your bending in the Archer's hand be for gladness;
For even as he loves the arrow that flies, so He Loves also the bow that is
stable.

1.2 AWARENESS OF THE PROBLEM

The above words from "The Prophet" have always held a special significance for the writer. They have been pondered on throughout her own life struggles. It seemed more than co-incidence that they always seemed to surface during times of need. Now again while contemplating the ideas for this study, they seemed to encompass all that she has tried to achieve in her life: being a daughter, mother, therapist and facilitator during this study.

The writer first became interested in children with learning disabilities when her brother, 14 years her junior, was diagnosed as having Attention Deficit Hyperactivity Disorder. From personal experience and during her eighteen years of work with these children and their parents, she became aware of the difficulties that the parents experienced in accepting and loving these special children as they did their other children. Different parents reacted in different ways: some overcompensated, and became teachers and/or therapists, others rejected their children, others felt that they were incompetent and that they were failures as parents.

The different reactions of parents had an effect on the formation of their identities as parents and often resulted in the formation of a negative self-concept. The "bows" needed to shoot the "arrows" that had become damaged. These feelings all had an effect on the primary relationship established between mother and child, which can be envisioned as a skewed relationship between the bow and arrow. The primary relationship formed between mother and child is essential in the later involvement, experience and meaning attribution of the child in respect of all subsequent relationship formation on the child's journey towards his ultimate target, namely self-actualisation.

It was felt that there was a need for parents to be trained to bond, communicate and relate to their children without experiencing negative feelings, or feeling ashamed or inadequate.
Brutten, Richardson and Magel (1973: 128) point out that the mothers of learning disabled children frequently become overprotective, increasing the child's dependence on them. Omizo and Omizo (1986: 134) reinforce this statement by stating that the mother may become extremely close to or over-involved with the child. This characteristic may exacerbate an already stressful situation and may lead to marital conflict between the parents.

The writer was becoming increasingly aware of these difficulties, when she attended a course on Filial Therapy presented by Reyhana Ravat. A subsequent course presented by Dr. Sue Bratten was also attended. This proved to be a turning point as the writer felt that this therapy could be used within the Educational Psychological framework to assist parents in enjoying their learning disabled children and at the same time enhancing the relationship with them. This would result in the bow successfully accommodating the arrow so that it could "fly swift and far on life's journey". Filial Therapy seemed to be the ideal tool to do this.

Filial Therapy, which joins two important strategies, non-directive play therapy for children and parent education through direct involvement in the change process, was felt to be the ideal means of doing this. The professional therapist serves as the archer who directs the intervention, serving as both teacher and an empathic support person for the parents.

This awareness lead the writer to the following questions:

Will Filial Therapy improve the primary relationship between mother and child?  
Will mothers learn to enjoy their children through the process of play?  
Can Filial Therapy fulfil both the needs of the children and the parents?  
Can Filial Therapy be used within the framework of Educational Psychology?  
Does Filial Therapy fulfil the basic essences required for self-actualization?  
When is it appropriate to use Filial Therapy?  
Which age group of children would best benefit from Filial Therapy?
Can Filial Therapy be adapted for use with other age groups?
Will the parents feel more empowered through the use of this method?
Will Filial Therapy improve the communication abilities of the parents?
Will it help with disciplining children, and providing structure for them?
Will the parents establish a more positive self-concept with regard to their ability as parents?

1.3 DEFINITION OF FILIAL THERAPY IN TERMS OF EDUCATIONAL PSYCHOLOGY

According to Van Fleet (1994: 2) "Parents become the primary change agents as they learn to conduct child-centered play sessions with their own children." The therapist will use the Psychological Educational perspective to teach parents to conduct specialized play sessions. They will be supervised during play sessions. The ultimate aim being to improve the primary relationship and, eventually to integrate the play sessions and parenting skills at home.

The words quoted from "The Prophet" will be the analogy used throughout this study. These will serve to define and explain what is meant by Filial Therapy from an Educational Psychological frame of reference. This will be depicted in a pictorial form where the archer is seen to be shooting with his bow and arrow at a target.

Figure 1: The Archer shooting at the target with Bow and Arrow which is an analogy of Filial Therapy and educative principles
The archer represents the therapist who will be assisting the bow (mother) and the arrow (child). The arrows will not be perfect, as this is to represent the ADD or learning disabled child. The relationship between bow and arrow is that between mother and child. The adjustments that need to be made will be made by the archer through the process of Filial Therapy. Involvement, experience and meaning attribution all play a role during this stage of adjustment and refinement. If the mother understands the needs of the child, especially the ADD child, or the shape of the arrow, she will more readily be able to make this adjustment. The awareness and exploration take place through the knowledge gained and sharing of experiences. This is personalized through the play experiences at home, where all the various techniques are practised.

An archer usually practises in the company of others, so there are other bows, arrows and targets. A lesson can be learnt from each one. The shooting range depicts the lifeworld of the child, which is duplicated in the play of the child.

The arrow shoots through the air, which is the educational climate of the home. Other factors also influence the path of the arrow, the "weather" in life.

Educational theory and play therapy have the same aim, namely self-actualization, which is depicted by the bull's eye. The other circles in the target, will represent self-identity and self-concept which can be compared to the basic tenets of play therapy.

Just as the bow and arrow start to work in harmony so too will the arrows be closer to the bull's eye in the target.

As the child develops towards self-actualization so too will the mothers feel better about their parenting skills.

The archer develops strong muscles during this sport. This depicts the growth of the facilitator through the literature study as well as through the involvement, experience and meaning attribution that will be gained during this contact with the parents.
1.4 LITERATURE REVIEW

In this section an overview of the literature will be given. The following aspects have been reviewed: Play therapy and its development into Filial Therapy, the ADD child with special reference to the influence on the family. Mother-child relationships and the Educational Psychological perspective have also received attention. The review has been summarized in the following table.

Table 1: Literature Review

<table>
<thead>
<tr>
<th>THEME</th>
<th>SOURCES</th>
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<tbody>
<tr>
<td></td>
<td><strong>PERIODICALS:</strong> <em>Du Plessis in Pre-school Years.</em>* *Campbell (1993) during the Symposium on counselling and children's play written up in Elementary School Guidance and Counselling.</td>
<td>General articles on play therapy for assessment and intervention.</td>
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<tr>
<td>Play therapy with abused children</td>
<td>A great deal of literature is to be found on this theme.</td>
<td>*Cattanach (1991). Play therapy with abused children.</td>
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<td>JOURNAL ARTICLES:</td>
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<td>Nondirective Play Therapy or Client Centered Play Therapy</td>
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<tr>
<th>Direct Play Therapy</th>
<th>JOURNAL ARTICLES:</th>
<th>PERIODICALS:</th>
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</table>

- Adult play
- Play in the treatment of adolescents.
- Play with Children, Adolescents and Adults, in individual, group, couple and family settings.
- Play therapy.
- Case studies in non-directive play therapy.
- Child-centered play therapy.
- Child-centered play therapy.
- Play as the process to resolve issues.
- Touch - developmental play therapy.
- Structured play as intervention for anorexia nervosa patients.
- Direct play therapy with preschoolers having moderate handicaps.
- Developmental play therapy.
|          | *Schafer  
|          | Other Authors are Rubin, Leslie, Mignon, Bundy-Myrow, Bostrom, Martin, Moyer, Booth, Lovegrove and Talen, to name but a few. These are all involved with the institute.  
|          | *Theraplay groups in the classroom.  
|          | *The general technique.  
|          | *The Institute advocate it for children with autism, ADHD, attachment disorders, depression, anger or aggression because of its relationship enhancing aspects.  
|          | * Covers various aspects and applications of the technique. These are all basically based on the Marschack Interaction Method.  
|          | There are also programmes and videos available from the Institute.  
|          |  
|          | *Valentini (1996) Ma (Clinical Psychology) - Cape town University.  
|          | *The many meanings of play.  
|          | *Playground of psychoanalytical therapy.  
|          | *Psychoanalytical reflections in play therapy.  
| Play therapy with children that are disabled in some way- either physically or with serious behaviour and / or emotional problems. | *Boyd (1991).  
|          | *Derrick (1983).  
|          | *Casebook of children in crisis.  
|          | *Play therapy with children with disabilities.  
|          | *Play for hospitalized children.  


**JOURNAL ARTICLES:**


**Play therapy for children with alcoholic parents.**

<table>
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<tr>
<th>Play Therapy Type</th>
<th>JOURNAL ARTICLES</th>
<th>Periodicals</th>
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<tr>
<td><strong>Adlerian play therapy</strong></td>
<td>*Kottman and Jansen in *Elementary-School-Guidance-and Counselling.</td>
<td>*Adlerian play therapy-A tool for school counsellors.</td>
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<td><strong>Short term play therapy</strong></td>
<td>*Reams and Fredericks in *Journal-of-Clinical-Psychology.</td>
<td>*Efficacy of time limited play therapy with maltreated preschoolers.</td>
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<td><strong>Family play therapy</strong></td>
<td>*Ariel (1992).</td>
<td>*Strategic family play therapy.</td>
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<td>*Cwaikala and Mordock.</td>
<td>*The use of multi-family play groups with a parent in addiction recovery.</td>
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<td>*Gil (1994).</td>
<td>*Play in family therapy.</td>
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<td>*The use of play in family therapy.</td>
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### ADD

<table>
<thead>
<tr>
<th>Extensive literature exists in this field. Themes such as historical background, theories definition, etiology, characteristics and treatment have all been well documented.</th>
</tr>
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<tbody>
<tr>
<td><em>Steward (1986) in Doctor of Psychology Research Paper at Biola University, California.</em></td>
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<tr>
<td><em>Filial Therapy with learning disabled children.</em></td>
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<td><em>Non-behavioural Approaches to Paraprofessional Training for Parents.</em></td>
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| *Bruten (1973).*  |
| *Cordini (1987, 1991).*  |
| *Douglas (1989).*  |
| *Knights and Bakker (1980).*  |
| *Knopf (1984).*  |
| *Ross (1977).*  |
| *Lerner (1981).*  |
| *Mcwhirter (1976).*  |
| *Silver (1991).*  |
| *Wicks-Nelson (1991).*  |
| *Cordoni (1987, 1991).*  |
| *Dyson (1993).*  |
| *A parent's guide.*  |
| *Living with a learning disability.*  |
| *Behaviour problems.*  |
| *Treatment.*  |
| *Childhood Pathology.*  |
| *Unrealised potential of learning disabled children.*  |
| *Overview. General information.*  |
| *Guidelines for parents.*  |
| *Behaviour disorders of children.*  |
| *Living with a learning disability.*  |
| *Parental stress and family functioning.*  |

The effects on the family of ADD children.
Parenting a child with Learning Disabilities.

JOURNAL ARTICLES:


Parent-child relationships with special reference to Mother-child Relationship. Many articles have also been written on the mother-child relationship as a result of Post-partum depression. These have not been mentioned here as it was thought that they were irrelevant to the topic under discussion.

JOURNAL ARTICLES:


*Parenting a child with Learning Disabilities.

*Stress and coping in families.

*Family therapy.

*Family climate.

*Participation in parent groups on child rearing.

*Concerns of the family.

*Early attachment experiences as a result of network of family relationships.

*Fantasy play and social status.

*Patterns of change in early childhood aggressive-disruptive behaviour.
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<td></td>
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<td>*Contextual variation in maternal conversational styles.</td>
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### The Educative Psychological Perspective.

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<tr>
<th>The Unisa approach with special emphasis on Professor Jacob's Relationship Therapy.</th>
<th><em>Griesel, in Med-proefskrif (1985).</em></th>
<th><em>Opvoedkundige Essensies in Gesinsterapie.</em></th>
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<td><em>Jacobs, Med Lecture (1997).</em></td>
<td><em>Relationship Theory.</em></td>
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<td><em>Jacobs and Vrey (1978).</em></td>
<td><em>Selfkonsep, Diagnose en Terapie.</em></td>
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<td></td>
<td><em>Petrick, (1986).</em></td>
<td><em>The Equipment of the School Guidance Counsellor as Educator.</em></td>
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<th><em>Raath and Jacobs, (1993).</em></th>
<th><em>Dynamics of the Self-concept.</em></th>
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<td><em>Van Den Aardweg and Van Den Aardweg (1988).</em></td>
<td><em>Dictionary of Empirical Education/Educational Psychology.</em></td>
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<td><em>Vlok, Med - proefskrif (1992).</em></td>
<td><em>Hulpverlening in Groepverband aan Moeders van Leergestremde Kinders.</em></td>
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<td><em>Vrey (1979).</em></td>
<td><em>The Self-Actualising Adult.</em></td>
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<td><strong>JOURNAL ARTICLES:</strong></td>
<td><em>Yonge, in Pedagogiekjoernaal (1987).</em></td>
<td><em>The Adult-Child relationship and Learning.</em></td>
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</table>

#### Table 1: Literature Review

#### 1.5 DEMARCATION

In the literature review many aspects were covered. Play therapy as a medium for therapy was a major theme. Play therapy has been extensively used, and
documented in detail, for the treatment of children. Some of these include children of divorced parents, addictive parents, children suffering from physical disabilities, or deep-seated emotional problems, also children that were hospitalized or had been exposed to some sort of trauma. The different types of play therapy have also been researched extensively. Initially therapists would adhere to their chosen form of therapy. However, the latest trend is to combine the various types of play therapy. Short-term therapy, such as the sandtray technique are becoming more popular as a quicker way of addressing the problem behaviour.

The use of play therapy for adolescents and adults has recently received attention. It is a technique that is being used in family therapy and the concept of Filial Therapy, which is a way of strengthening parent-child relationships through play, is becoming more popular, especially in Texas. It is not a technique that has received much attention in this country. Reyhana Ravat, a social worker from Durban is trying to promote its use in this country. The writer after attending courses and reviewing the literature, feels that it should be more extensively used in this country, especially with ADD children.

ADD, the popular term at present for children with learning disabilities has also been well documented in the literature. There was some documentation of play therapy with ADD children. As this forms a major theme in the study, it will be investigated in great detail.

Mother-child relationships have also been extensively covered, however mainly from a psychoanalytical aspect. A great deal of attention has been given to mothers suffering from postnatal depression. Some writers have stressed the reactions of parents when discovering that their child has a disability. This will be described in some detail. The study will be presented within the Educational Psychological framework as promoted by Unisa.
For the purpose of this study, the following areas will receive attention:

- Indirect play therapy.
- Play therapy as a medium to improve relationships.
- Filial Therapy as a means of empowerment for parents within the supportive environment of the group.
- ADD and the effect that it has on the family and the mothers in particular.
- Mother-child relationships.

The Educative Psychological principles will form the framework whereon the therapy programme is structured.

1.6 STATEMENT OF PROBLEM

Can Filial Therapy be used, within a Psychological Educational perspective to improve mother-child relationships?

Table 2: Statement of the problem

This problem gives rise to the following subproblems:

1. It would appear that because parents in general, find it difficult to come to terms with the fact that their children are not perfect, but may have a learning disability, the primary relationship with the child is hindered. Can they be taught to improve this relationship?

2. The attitude of the parents seems to have a particular influence on their involvement with the child and determines the amount and quality of the support which they provide for the child. This in turn, affects the relationship
with the child. Will they, through Filial Therapy, be taught how to spend quality time with their children?

3. The parents and the mothers in particular are so busy trying to be teachers, therapists and disciplinarians that they often do not have time to simply enjoy the uniqueness of their special children. Will Filial Therapy, within the Psychological Educative framework, be an effective tool for the mothers to learn to understand the uniqueness of their children?

4. The parents often feel isolated and confused. Will the parents learn to feel less isolated because they will have the support of a group and a facilitator?

1.7 HYPOTHESIS

Filial Therapy, within the Educational Psychological framework, can be used as a tool to help ADD children in their journey towards self-actualization by improving the mother-child relationship.

Filial Therapy will help mothers to unconditionally accept and love their ADD children.

Filial Therapy will improve the self-concept of mothers as they realise that they are being the best mothers that they are capable of being.

Filial Therapy, because it takes place within a group, will help provide a support system for the parents.
1.8 PURPOSE OF THE STUDY

1.8.1 General Aims

The aims of the study are:

☐ An in depth literature research of the phenomena, which for the purpose of
the study, stand on two legs:

a. Filial Therapy, tracing the concept of play therapy and how it evolved
to produce the concept of Filial Therapy.

b. ADD, what it is and how a child with ADD, affects the family and in
particular the mother-child relationship. This effect is usually caused
by the way the mother reacts to this problem.

☐ An empirical study will be conducted within the field of Educational
Psychology, using Filial Therapy as a means of allowing mothers to become
aware of, explore and personalize the effects of the child’s learning problem
on their relationship with the child.

☐ The study will provide specific guidelines, a step-by-step programme and the
necessary worksheets so that Educational Psychologists may implement Filial
Therapy in educational settings or in private practice.

1.8.2 Specific Aims

The specific aims of the study are:

☐ To empower mothers with information, so that they can move through the
awareness period to an in depth exploration of ADD, so as to reach
acceptance through personalization.
To allow mothers to enjoy their children and accept their uniqueness through the medium of child-centred play.

To provide the mothers with a forum for sharing their feelings, frustrations and experiences with other mothers who have similar problems.

To encourage greater interest and a better quality of involvement by the mothers in the child's learning process. This will be done through teaching better communication skills, setting of limits, the giving of choices and accepting the consequences of their actions.

To improve the relations between mother and child initially and eventually to bring about a personal growth of both mother and child. This should lead to the child forming a more positive relationship with the self.

1.9 DEFINITION OF TERMS

EDUCATIONAL PSYCHOLOGY:

"Educational Psychology is concerned with the understanding of the nature of the learner and the learning process, the many variables that interact as learning and development take place in the classroom, the role of the teacher and social interaction and behaviour. Educational psychology is the application of psychology to teaching." (Van den Aardweg, 1993:77).

For this study the Empirical-educational criteria to judge educational events will receive attention. Such criteria are designed to promote the realization of the educational act. It is a pedagogical imperative to guide the child towards understanding and involvement, so that his experience may support a positive self-concept, that will promote self-realisation. When the criteria: attribution of meaning, involvement, experience, self-actualisation and positive self-concept are satisfied,
education takes place (Vrey, 1984:49). These aspects will be considered in terms of the children and in terms of the mothers.

FILIAL THERAPY:

Filial is a Greek word that means “1. of, resembling, or suitable to a son or daughter: filial affection blood relationship. 2. Genetics. designing any of the generations following the parental generation. “ (Collins, 1984: 414).

"Filial Therapy has been shown through research and clinical experience to be an effective intervention for children and families experiencing a variety of social, emotional and behavioural difficulties. This unique therapy involves parents as the primary agents to resolve child-related problems and to encourage children's healthy psycho-social development” (Van Fleet, 1994: xi). In this study Filial Therapy will be used to enhance the parent-child relationship, which often suffers when a child is experiencing difficulties that make his journey to self-actualisation more difficult.

This unique therapy involves parents as the primary agents to strengthen parent-child and family relationships. Filial therapists train and supervise parents as the parents conduct child-centred play sessions with their children (Van Fleet, 1994: xi).

MOTHER-CHILD RELATIONSHIPS:

The word relationship refers to a connection between two referents. Relationships must be seen as a bipolar connection between the child as one pole and the significant other (mother) as the other pole (Vrey, 1984: 21). The mutual interaction between the poles manifests itself in attraction or repulsion, acceptance or rejection, friendliness which draws closer together or unfriendliness which pushes them further apart (Vrey, 1984: 21).
It is the writer's contention that this primary relationship is affected when the child is diagnosed as having a problem. The parents go through different stages of acceptance, they themselves may have feelings of inadequacy which negatively affect their self-concept. This in turn negatively affects the primary relationship established between them and their children. This relationship forms the foundation upon which all other relationships are subsequently formed.

1.10 LIST OF ABBREVIATIONS

As a result of the frequency of use of the following concepts, they will be replaced by abbreviations in the subsequent chapters.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ADD</td>
<td>Attention deficit disorder</td>
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<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
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<tr>
<td>FT</td>
<td>Filial Therapy</td>
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Table 3: List of Abbreviations

1.11 OVERVIEW OF CHAPTERS

Chapter one covers the introductory orientation, awareness of the problem, definition of the terminology, a statement of the problem, and the planning of the study which includes a hypothesis and aims.

Chapter two will consist of an historical overview of play therapy as a precursor to Filial Therapy. The task of mothers as primary educators will also be addressed.
This will be based on the theory of Jacobs (1997: Lecture) explained as follows: "Giving meaning to their own lifeworld and that of their child, through involvement experience and achieving self-actualisation, together with the presuppositions, namely, the forming of relationships, the living sphere and the pedagogic climate form the foundation whereupon the intrapsychic structure, namely the I, the self-identity and self-concept rest. The intra-psychic mutual interaction of these components is responsible for the person's eventual behaviour."

An historical background, definition, etiology and characteristics of ADD will be discussed in chapter three. The effect on the family will receive special attention.

The research design will be highlighted in chapter four. Hypotheses will be formulated which will eventually be accepted or rejected.

Chapter five will contain a discussion of the idiographic study which forms the empirical research. The results will also be analysed and interpreted within the framework of Educational Psychology. Guidelines as to how to implement the findings and expand on the implementation of Filial Therapy will be incorporated throughout this chapter. The programme follows a step-by-step format including all the necessary worksheets, making a further chapter stating guidelines redundant.

A summary, recommendations and conclusion of the study will be presented in the final chapter.
2. INTRODUCTION

Chapter one covered the introductory orientation, awareness of the problem, definition of the terminology, a statement of the problem, and the planning of the study which included a hypothesis and aims. The analogy of the archer shooting the arrows at a target was explained.

In this chapter the writer will present a description of client-centred play therapy and an historical overview of play therapy as a precursor to Filial Therapy. This will be followed by a definition of Filial Therapy. The task of mothers as primary educators will also be addressed during the comparison between non-directive play therapy and the Relations Theory of Jacobs (1997). Referring back to the quotation from "The Prophet", this chapter will be looking at the relationship of the bow to the arrow. The different requirements for this relationship, namely various aspects of the educational climate will also receive attention from a client-centred perspective as compared to the relations theory model. The area covering the distance between the bow and the target, namely the lifeworld of the child will be explained. The final focus is the target, the bull's eye being self-actualisation and the outer circles depicting the intrapsychic structure.
2.1 THE MEANING OF PLAY

Landreth (1991) stresses that children must not be viewed as miniature adults but must be understood from a developmental point of view. Their world is one of concrete realities which they re-enact through play. For therapists to understand children they must move into the concrete-expressive world of children, where their natural medium of communication is play and activity.

Play is universal to all children. They do not need to be taught how to play. It is spontaneous, enjoyable, voluntary and non goal directed. Play is intrinsically complete, it does not depend on external reward, and assimilates the world to match the individual's concepts as in the case of a boy using a spoon for a car.

2.1.1 Objectives of Play Therapy

Landreth (1991: 80) believes that the objectives of child-centred play therapy are to help the child:

- develop a more positive self-concept,
- assume greater responsibility,
- become more self-directing,
- become more self-accepting,
- become more self-reliant,
- engage in self-determined decision making,
- experience a feeling of control,
- become sensitive to the process of coping,
- develop an internal source of evaluation, and
- become more trusting of self.

Table 4: Objectives of Play therapy
The present writer believes that the child enters the play room and begins to become aware of the toys and the stimuli with which he is presented. He gradually begins to explore this world and starts to personalise his play so that it encompasses his lifeworld. He uses this time to make sense of his reality. The solutions and conclusions that his fantasy world provide are then carried into his real lifeworld.

Landreth (1993: 20-21) states that the therapist is highly interactive verbally with the child and is actively responsive to him that he feels as though the therapist is part of whatever he is engaged in at all times. The play therapist is never an observer but is always an emotional and verbal participant.

2.1.2 Reflective Listening

Landreth (1993: 21) believes that the following four messages have to be lived out in the therapist-child relationship.

| **I AM HERE.** | Nothing will distract me. I will be fully present, emotionally. I am here for the child. |
| **I HEAR YOU.** | I will listen fully with my ears and eyes to everything about the child, what is expressed and what is not expressed. I want to hear the child completely. |
| **I UNDERSTAND YOU.** | I want the child to know I understand what he or she is communicating, feeling, experiencing, and playing, and will work hard to communicate that understanding to the child. |
| **I CARE ABOUT YOU.** | I really do care about this little person, and I want the child to know that. If I am successful in communicating the first three messages fully, the child will know I care. |

Table 5: Aims of Reflective Listening
The child learns during the play sessions that there are limits which he has to adhere to. Landreth (1991: 209-220) believes that limit setting is one of the most important aspects of play therapy. It provides structure and helps to make the experience a real life relationship. Tolerance or permissiveness in the child-centred play therapy approach does not mean the acceptance of all behaviours. Limits provide children with an opportunity to learn self-control, that they have choices, what making choices feels like, and how responsibility feels. Limits in the playroom should be minimal and enforceable. The establishment of total limits are easier for the child than conditional limits. Limits are only set when the opportunity arises. Limits should be stated in a calm, patient, matter-of-fact and firm way. Limits serve the following purpose:

- Limits help assure the physical and emotional security of children.
- Limits protect the physical well being of the therapist and facilitate acceptance of the child.
- Limits facilitate the development of decision making, self-control and self-responsibility of children.
- Limits anchor the session to reality and emphasize the here and now.
- Limits preserve the professional, ethical, and socially acceptable relationship.
- Limits protect the play therapy materials and room.

Table 6: Aims of Limit Setting

Landreth (1991: 222-223) advises the following procedure for limit setting:

Step 1: Acknowledge the child's feelings, wishes, and wants, this conveys acceptance of the child's motivation. This acknowledges that the child does have feelings that are being expressed in the play activity.
Step 2: Communicate the limit. Limits should be specific and clearly delineate exactly what is being limited.

Step 3: Target acceptable alternatives. The child may not be aware of any other ways to express what is being felt. The therapist provides alternatives for the expression of the original action. A nonverbal cue pointing to the alternatives in conjunction with the verbalized alternatives is especially helpful in diverting the child's attention from the original source of focus and facilitating the choice making.

Table 7: Three Step Procedure for Limit-Setting

2.1.3.1 When Setting the Limits does not work

According to Ravat (1995) it can happen that the therapist (or parent in Filial Therapy) has been careful to:

☐ Reflect the child's feelings.
☐ Set clear, fair limits.
☐ Give the child an alternate way to express his feelings.

However, if the child deliberately continues to disobey, Ravat then suggests that the following plan of action should be followed:

1. Natural causes for rebellion must be investigated, such as fatigue, sickness, extreme stress, abuse or neglect. The physical needs and crises must be taken into account before expecting co-operation.
2. Remain in control, respecting yourself and the child. It must be remembered that you are not a failure if your child rebels, also your child is not bad. All children need to "practise" rebelling.
3. Reasonable consequences for disobedience must be set by allowing the child to choose to obey or disobey, but this must be followed by a reasonable consequence for disobedience, for example: “If you choose to watch TV instead of going to bed, then you choose to give up TV all day tomorrow.”

4. Violence must never be tolerated, if need be the child must be physically restrained when he becomes violent, without being aggressive yourself. The child’s anger and loneliness must be reflected and compassionate control and alternatives must be provided.

5. If the child refuses to choose, you choose for him because the child’s refusal to choose is also a choice. It is important then to explain the consequences, for example: “If you choose not to (choice A……or B), then you have chosen for me to pick the one that is the most convenient for me.”

6. It is essential then to enforce the consequences: “Do not draw your gun unless you intend to shoot” Rule of Thumb, given by Ravat (1995). If you should crumble under the child’s anger or tears, you have abdicated your role as therapist/parent and you have lost your power.

7. Signs of depression must be recognized. The chronically angry or rebellious child is in emotional trouble and may need professional help.

Table 8: When Setting Limits Does Not work

2.1.3.2 Some thoughts on aggression

Landreth (1997) cited Ralph Kantor during his lectures on Filial and Play Therapy: he said that Kantor describes aggression as a process whereby the child (and many times the parent) feels more and more helpless. The helplessness builds through a four stage process as follows:

- Irritant and Inability to remove = Frustration (Awareness).
- Frustration and Inability to remove = Anger (Focused Action).
- Anger and Inability to remove = Rage (Beginning distortion of Action).
- Rage and Inability to remove = Fury (Complete distortion of Action).
After fury is reached, Kantor continues, exhaustion occurs and both child and parent are left feeling temporarily overwhelmed and powerless. The increased powerlessness/helplessness felt by the child and often the parent only serves to feed aggression. In order, then, to successfully break the rise of aggression, the sense of powerlessness must be eliminated. A key to this shifted circle is an understanding by both parent and child that power is not something held over someone else but is, instead, power over self. The final thrust then, in learning to manage a child's aggression is, in fact, managing one's own aggression.

Following is a list of techniques found effective in increasing the power of both the parent and child.

- Lower one's voice and talk softly.
- Use the child's name over and over in a reassuring voice.
- Refer to the child's last success and compliance.
- Use silence for thirty-sixty seconds as the child's aggression builds.
- Leave the room giving the child time to gain self-control and thus, 'save face'.
- Switch the subjects of conflict to some topic of non-threatening nature for a few minutes.
- Give permission to be angry.
- Exaggerate the conflict to humorous proportions.
- Interpret the aggression to the child - determine and discuss the true origin of the aggressive behaviour.

Table 9: Some Thoughts on Handling Aggression

2.1.4 Play Media

Cambell (1993: 11) defined play media as "...the materials and the props counsellors use in the counselling process. They are tools used to engage children's interest, creativity, and spontaneity and to provide children with a medium
for expressing themselves." Art, music and movement, drama, games, expressive writing, sand play, and guided fantasy are among the broad categories.

Landreth (1993: 21-22) feels that even if some counsellors do not have a fully equipped playroom they must ensure that they have the following basic requirements which can be transported in a tote bag:

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crayons (8-count box)</td>
</tr>
<tr>
<td>Newsprint</td>
</tr>
<tr>
<td>Blunt scissors</td>
</tr>
<tr>
<td>Nursing bottle (plastic)</td>
</tr>
<tr>
<td>Rubber knife</td>
</tr>
<tr>
<td>Doll</td>
</tr>
<tr>
<td>Clay or play-doh</td>
</tr>
<tr>
<td>Dart gun</td>
</tr>
<tr>
<td>Handcuffs</td>
</tr>
<tr>
<td>Toy soldiers (two different colours)</td>
</tr>
<tr>
<td>Two play dishes and cups (plastic or tin)</td>
</tr>
<tr>
<td>Spoons (avoid forks because of the sharp points)</td>
</tr>
<tr>
<td>Small aeroplane</td>
</tr>
<tr>
<td>Small car</td>
</tr>
<tr>
<td>Lone Ranger-type mask</td>
</tr>
<tr>
<td>Nerf ball (rubber ball that bounces too much)</td>
</tr>
<tr>
<td>Bendable Gumby (rubber nondescript figure that is malleable)</td>
</tr>
<tr>
<td>Popsicle sticks</td>
</tr>
<tr>
<td>Pipe cleaners</td>
</tr>
<tr>
<td>Cotton rope</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Aggressive hand puppet (wolf, alligator, or dragon)</td>
</tr>
<tr>
<td>Bendable doll family</td>
</tr>
<tr>
<td>Doll house furniture (at least kitchen, bedroom, and bathroom)</td>
</tr>
</tbody>
</table>
Small cardboard box with rooms marked on the bottom (cut door in one side and windows in another, doubles as storage container for toys)

Transparent tape

Costume jewellery

If storage space is available, an inflatable punching bag would be a special asset (a large plastic bag filled with newspapers could also be used).

A dishpan-size plastic container with an inch of sand in the bottom is also a good idea, alternatively rice could be used in the place of sand.

Table 10: List of Tote Bag Toys

Reyhana Ravat (1996) provides the following list of toys and what they represent:

**Anger, Aggression, Power, Control toys**

- Guns
- Handcuffs
- Toy soldiers
- Snakes
- Bobo (punching bag)
- Aggressive puppets
- Dinosaurs
- Rubber knives
- Shark

**Nurturing, Dependency Toys**

- Dolls
- Doll Clothes, Blankets, Beds
- Baby Bottles (could represent regression)
- Dishes
- Kitchen
- Medical Kits
- Iron and Ironing Board
**Communication Toys**
- Telephone
- Ball
- Nerf Ball and Bat

**Family Issue Toys**
- Family House
- Family Figures

**Escape, Speed, Distance Toys**
- Airplane
- Car

**Art Materials**
- Paints
- Easel
- Play-doh
- Clay
- Finger paints
- Magic Markers
- Scissors (blunt end)
- Tape
- Glue
- Paper
- String, Yarn, other scraps

**Role Playing, Identity Toys**
- Masks
- Hat
- Dress-up clothes
Emotionality, Creativity, Feelings, Depth

Water
Sand

Table 11: The Meaning of the Toys

During play therapy it is not the children's obligation to clean up, that remains the therapist's job. If the child is expected to clean up afterwards he will be reluctant to use all the toys, and will not want to mess too much.

2.1.5 Constructing Therapeutic Responses in Play Therapy

Ravat (1995) gives the following stages in constructing therapeutic responses in play therapy:

- Early exploratory stage
- Later exploratory stage
- Limit setting
- Early therapeutic stage
- Later therapeutic stage

2.1.5.1 Early Exploratory Stage

The first phase consists of a description of the content of the child's play, for example: "I see you crashing the cars together."

2.1.5.2 Later Exploratory Stage

During this stage the affect is expressed by the therapist in role play, or by labelling the child's affect, attributing it to the toy taken within the context of the child's play. The affect must be consistently labelled so as to see if the therapist is in touch with
the child. This also enhances the child's affective vocabulary, for example: "The blue car feels hurt if it gets hit." The name of the toy may only be used by the therapist once the child has already labelled the toy.

2.1.5.3 Limit Setting

The importance of this phase is firstly to recognize the feeling behind the testing of the limits, then set the limit and provide an alternative behaviour. An example of this would be: "I know you are angry at me, and that's okay, but I still won't let you throw the toys. You may go and kick or hit Bobo."

2.1.5.4 Early Therapeutic Phase

The therapist now pairs the affect or motivation with the observed growth stage pattern. An example of this would be: "I've noticed that whenever you feel hurt, you like to crash the cars, shoot the guns or boss me around."

2.1.5.5 Later Therapeutic Phase

During this period the therapist's task is to connect the emotion and behavioural growth stage to what happens outside the session. An example of this would be: "The blue car feels hurt when it gets hit, just like you feel hurt when Dad says he'll come and get you for visitation and does not show up."

2.1.5.6 Tracking the Impact of Responses to Children

Ravat (1995) feels that often therapists are not sure whether they are on the right track, however when responses are accurate the child will react in one or more of the following ways:

1. He will intensify the play activity.
2. He will make an additive play response.
3. He will reduce the distance between himself and the therapist.
4. He will have an instant "pause" response.

5. He will include the therapist in the play (ask the therapist to join the play depending upon the meaning of play and the capacity to participate).

6. He may not respond in any of the above mentioned ways, but will also not present with any of the following behaviours, which would be an indication that the therapist's responses are inaccurate:

- He will diffuse from the play focus.
- He will change the play focus to another activity.
- He will distance himself from the therapist.
- He will exclude the therapist from the play activity.
- He will stop play completely.

The present writer feels that this once again indicates that careful observation; reflective listening; allowing the child to lead while you, as therapist, follow; will indicate whether or not the therapist is moving in the right direction. It is essential that the therapist always stays in an external frame of reference and not try to impose her own feelings and beliefs on the child.

2.2 OVERVIEW OF THE DEVELOPMENT OF PLAY THERAPY

The following brief overview of the development of play therapy is taken from Landreth (1991: 25-34). Play has long been recognised as being significant in the lives of children. In the 18th century, Rousseau wrote about observing children at play and stressed the fact that they were not miniature adults.

Froebel emphasised the symbolic components of play and stressed that play was full of meaning. Play therapy developed from the efforts to apply psychoanalytic therapy to children. Following Freud's work, Hermine Hug-Hellmuth (1921) seems to have been one of the first therapists to emphasise play as essential in child analysis and to provide children in therapy with play materials to express themselves.
In 1919 Melanie Klein began to employ the technique of play as a means of analysing children under six years of age. She believed that play provided direct access to the child's preconscious and unconscious. She saw symbolic meaning, especially sexual, in almost every play activity. She reported that additional material was exhibited as a result of her interpretations.

During this same period Anna Freud used play to encourage the child in establishing rapport with the therapist, which she felt was important before interpreting the unconscious motivation behind the child's drawings and play. She felt that direct interpretation should be minimal and cautioned against viewing all play as symbolic.

The second major development in the formulation of play therapy occurred in the 1930's with the work of David Levy (1938), on developing release therapy. This was a structured play therapy technique for children who had experienced a specific stressful situation. The major role of the therapist was to be the shifter of scenes so that, through selected toys, the child re-experienced these situations. Three areas received attention: release of aggressive behaviour, release of feelings in standardised situations, such as sibling rivalry and release from a particular stressful situation. Gove Hambridge (1955) extended this work under the title "Structured play therapy" and was more direct in introducing particular stressful relationships.

The third significant development in play therapy was through the work of Jesse Taft (1933) and Frederick Allen (1934) and was referred to as relationship therapy. This emerged from the philosophy of Otto Rank (1936) who de-emphasised the importance of past history and the unconscious and stressed the therapist-client relationship in the here and now. No effort is made to interpret past events. The child assumes responsibility in the growth process and the therapist concentrates on those difficulties that concern the child.
The work of the relationship therapists was studied and expanded by Carl Rogers (1942) who developed non-directive therapy, later referred to as client-centred therapy (1951) and today as person-centred therapy.

The fourth major development was the work of Virginia Axline (1947). She successfully applied non-directive therapy principles to children in play therapy. Non-directive play therapy does not try to control or change the child but is based on the belief that the child's behaviour is at all times controlled by the drive to self-actualise. In summarising his concept of play therapy, Landreth quoted Axline (1950: 68) who stated "A play experience is therapeutic because it provides a secure relationship between the child and the 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."

2.3 FILIAL THERAPY- A Definition and explanation

Filial is a Greek word that means "1. of, resembling, or suitable to a son or daughter: Filial affection blood relationship. 2. Genetics. designing any of the generations following the parental generation." (Collins, 1984: 414).

"Filial Therapy has been shown through research and clinical experience to be an effective intervention for children and families experiencing a variety of social, emotional and behavioural difficulties. This unique therapy involves parents as the primary agents to resolve child-related problems and to encourage children's healthy psycho-social development. Filial Therapists train and supervise parents. The parents conduct child-centred play sessions with their children. This is an approach which not only helps eliminate presenting problems but strengthens parent-child and family relationships." (Van Fleet, 1994: xi). In this study Filial Therapy will be used to enhance the parent-child relationship, which often suffers
when a child is experiencing difficulties that make his journey to self-actualisation more difficult.

Filial Therapy joins two important strategies: non-directive play therapy for children, and parent education through direct involvement in the change process. The professional therapist serves as both teacher and an empathic support person for the parents.

Johnson (1995) stated that although Filial Therapy was originally designed as a long term group approach (Stover & Louise Guerney, 1967), others have applied its concepts and methods to individual family treatment (Van Fleet, 1994). Landreth (1991) developed a ten week programme which takes advantage of the group format while providing a necessary and motivating time limit. This particular format is the focus of the present writer and will form the basis of the programme to be implemented for the empirical study.

Landreth's (1991) Filial Therapy format consists of a highly structured and task orientated programme in which parents are trained in the skills necessary to conduct weekly home play sessions with their own children using client-centred play therapy techniques. These parents meet once a week for two hours with a Filial Therapy instructor. In the process of the ten, weekly meetings, the therapist will model appropriate therapeutic responses and foster the parents' encouragement of one another, incorporating aspects of support groups. The parents have to obtain all the tote-bag toys as described in the play therapy section. These toys are only to be used during the play therapy sessions. During these play sessions, parents are challenged to focus solely on reflecting the child's actions and feelings rather than correcting and shaping the child's behaviour. They are taught how to set limits and how to give choices. A "Rule of Thumb" is provided during each session. The goal is to have this weekly special time which is intentionally different from "normal" time and which fosters the development of the nurturing parent-child relationship. In building this relationship, it is found that many aspects of daily
parent-child interactions become much less conflicted and the stage is set for addressing other family issues. Parents enter the training thinking their children are going to be changed and discover that their perceptions of their children have changed and their behaviour has become more empathically tolerant and accepting of their children.

A clear advantage of the group format is in provision of peer support. The therapist is able to turn parents to each other for suggestions and feedback, taking advantage of the different strengths parents have to offer each other. This again assists the parents with relationship formation. Johnson (1995) felt that although there were many parent training programmes available these all somehow conveyed that the parents were lacking in parenting skills. Filial Therapy resolves this dilemma by offering an opportunity to become therapeutic agents for their children. It acknowledges their skill in parenting whilst teaching additional therapeutic skills. Filial Therapy addresses systemic issues and focuses on issues of the child. Helping a parent to listen to and to set limits with a child can often be “the difference that makes a difference” in changing problematic interaction patterns.

Ginsberg (1976), felt that Filial Therapy is a useful model and highly structured approach, which can be adapted to the nature of the problem presented. In Filial Therapy the parents have to communicate what they think the child sees, hears, feels and experiences in a nonevaluative relationship. This is done through reflective listening, the technique used by play therapists, as described during the section on play therapy. Limit setting is another important tool that is taught to the parents. This follows the same format as that used by therapists. The parents are also empowered by learning to provide choices. This provision of choices is also step three of limit setting. Ravat (1995) feels that the advantage of offering children choices is based on the fact that making decisions about themselves distracts them from initiating negative interactions. Parents can easily set the limits children need by maintaining control at the same time as offering choices. Dealing with choices and being held responsible for decisions is wonderful practice for youngsters. It
prepares them for a lifetime of decision making required of all responsible people. Effective parents offer choices only when they are willing to make sure the child will have to live with the consequences of the choices. These parents know that children need to learn from their mistakes. They learn better in this way than from parents who lecture. The following example (Ravat, 1996) illustrates this choice making very well: A youngster is making too much noise in the family room. A typical parent response might be: "Quit making so much noise, you are making me mad!" This usually does not work since it gives the child the wrong type of control, as he now has the power to make his parents mad. The wise parent would give the child some control over his own life by offering choices, "You can either stay here with us and be quiet, or go someplace else to make a noise." Everyone is then happy, the child chooses and then accepts the consequences.

Ravat (1995) quotes Dinkmeyer and McKay (1982) on the importance in the use of encouragement rather than praise. She states that although praise and encouragement both focus on positive behaviours, praise actually fosters dependence in children by teaching them to rely on an external source of control rather than self-control. Children come to believe that their own worth depends upon the opinions of others. Praise imposes value judgements. Encouragement on the other hand focuses on internal evaluation, and the contributions that children make. Encouraging parents teach their children to accept their own inadequacies, to have confidence in themselves, and to feel useful through contribution. The following encouraging phrases are recommended:

<table>
<thead>
<tr>
<th>ENcouraging phrases that demonstrate acceptance.</th>
<th>ENcouraging phrases that show confidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I'm glad you're pleased with it.&quot;</td>
<td>&quot;You'll figure that out.&quot;</td>
</tr>
<tr>
<td>&quot;I like the way you tackle that problem.&quot;</td>
<td>&quot;I have confidence in your judgement.&quot;</td>
</tr>
<tr>
<td>&quot;It looks as if you enjoyed that.&quot;</td>
<td>&quot;That's a rough one, but I'm sure you'll figure it out.&quot;</td>
</tr>
<tr>
<td>&quot;How do you feel about it?&quot;</td>
<td></td>
</tr>
</tbody>
</table>

42
Table 12: Encouraging Phrases

<table>
<thead>
<tr>
<th>ENcouraging Phrases That Focus On Contribution, Assets And Appreciation.</th>
<th>Encouraging Phrases That Recognize Effort And Improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Thanks that helped a lot.&quot;</td>
<td>&quot;It looks as if you really worked hard on that.&quot;</td>
</tr>
<tr>
<td>&quot;It was thoughtful of you to...&quot;</td>
<td>&quot;Look at the progress you've made&quot; (Be specific).</td>
</tr>
<tr>
<td>&quot;I need your help on.....&quot;</td>
<td>&quot;You're improving in....&quot; (Be specific).</td>
</tr>
<tr>
<td>&quot;You have a skill in...... would you do that for the family?&quot;</td>
<td></td>
</tr>
</tbody>
</table>

In summary, encouragement is: (1) valuing and accepting children as they are, without conditions, (2) pointing out the positive aspects of behaviour, (3) showing faith in children so that they can come to believe in themselves, (4) recognizing effort and improvement rather than requiring achievement, and (5) showing appreciation for contributions.

This concludes the section on Filial Therapy. As can be seen the whole concept of Filial Therapy is based on child-centred play therapy, which has been adapted for parents. The parents can now engage in a quality relationship during the weekly play sessions. They are empowered through reflective listening, encouraging, providing choices and setting limits. They learn to follow their children rather than lead the way according to their own needs and feelings. This leads to better communication between parent and child.

The concept and implementation of Filial Therapy will become clearer during chapter 5, when this writer presents a detailed account of her adaptation of this therapy to meet the needs of the parents and their ADD / ADHD children. The rationale for using Filial Therapy within the Educational Psychological framework is explained by means of a comparison between the two aspects.
2.4 COMPARISON BETWEEN NON-DIRECTIVE PLAY THERAPY AND RELATIONS THEORY.

Van Niekerk (1986: 2) refers to education as "the assistance given to a child in order that he can become an adult." He states "The phenomena of education, being educated and being dependent on education should be regarded as essentials of being human." Vrey (1979: 3) points out that "... education is an universal phenomenon."

Landreth (1993: 19-20) believes that a child-centred philosophy is "...an encompassing philosophy for living one's life in relationship with children...it is based on deep commitment to certain beliefs about children and their innate capacity for growth." In this approach the child and not the problem is the focus of attention. The relationship that develops and the creative forces this relationship releases in the child generate the process of change and growth of the child. It is not preparation for change, whatever develops in the child was already there. In the process the child is responsible for self and is quite capable of exercising that responsibility through self-direction, resulting in more positive behaviour. The relationship, not the use of toys or interpretation of behaviour, is the key to growth. "Therefore the relationship is always focused on the present, living experience" (Landreth, 1991).

Herewith follows a comparison of child-centred play therapy and the relations theory of Jacobs (1997) explained as follows: "Giving meaning to the their own lifeworld and that of their child, through involvement, experience and achieving self-actualisation, together with the presuppositions, namely, the forming of relationships, the living sphere and the pedagogic climate form the foundation whereupon the intrapsychic structure, namely the I, the self, identity and self-concept rest. The intrapsychic mutual interaction of these components is responsible for the person's eventual behaviour."
2.4.1 THE PRESUPPOSITIONS

These are the requirements or essentials necessary to form the foundation upon which the intrapsychic structure is built:

2.4.1.1 Relationship Formation

The word relationship refers to a connection between two referents. The relationship must be seen as a bipolar connection between the child as one pole and the significant other (mother) as the other pole (Vrey, 1984: 21). The mutual interaction between the poles manifests itself in attraction or repulsion, acceptance or rejection, friendliness which draws closer together or unfriendliness which pushes them further apart (Vrey, 1984: 21).

According to Vrey (1979: 92-93), from birth the child has to orientate himself towards the world, which consists of people, things and God. He orientates himself in the world by assigning meaning and becoming involved. Orientation depends on certain fixed points which serve as reference points in his future exploration of the world.
It is the writer's contention that this primary relationship is affected when the child is diagnosed as having a problem. The parents go through different stages until acceptance. They themselves may have feelings of inadequacy which negatively affect their self-concept, which in turn negatively affects the primary relationship established between them and their children. The initial anchorage point is the mother. The nature of initial meaning depends on affective experience. Therefore, this meaning is emotionally coloured. This relationship forms the foundation upon which all other relationships are consequently formed.

Vlok (1992: 22) refers to the profound effect that the quality of relations, formed with parents and other family members, has on the formation of other relationships throughout the child's life. She names two components of a relation (1992: 23). The first is that the relation is seen as being a bipolar connection between the child as one pole and the referent as the other pole. Jacobs and Vrey (1982: 14) claim that each pole has a cognitive and affective component. The second component refers to the quality of the relation formed. Vrey (1979: 73-74) says, "A healthy relationship will be characterised by love, security, self-giving, acceptance, trust and esteem." These concepts will be discussed in greater detail in the section where the educational climate is compared to client-centred therapy. Vrey further points out that the quality of such a relationship will be one of acceptance and emphasizes that the acceptance by parents and others leads to self-acceptance. Furthermore, he claims that a positive self-concept is largely the outcome of loving, caring and accepting education within clearly defined limits.

Ginsberg (1976) says that Filial Therapy is a relationship-orientated model. The client is the parent-child relationship. In this model the therapist acts as a trainer, model, and consultant to the parents. It tends to focus on the present and emphasizes appropriate skills for a positive parent-child relationship and good parenting skills. Parents are informed that the past cannot be changed but by working on the present relationships and learning skills, one can change behaviour from past experiences. The skills can help in future functioning so there is a preventative component. Often the learning of skills creates self-enhancement for
the parent as well as for the child, reducing the stress of the parent-child relationship in the real world.

According to Caraway (1986: 177), "...an infant begins life as a non-differentiated organism." At about six months, their sense of self, which is totally physical, begins to develop as distinct from the things in their environment. Initially, an almost symbiotic relationship with the mother exists. "...when the process of separation and individualisation is complete the child will comfortably exist as a separate person (and will be) open to the formation of meaningful relationships with others."

Ginsberg (1976) says that parents as therapists is a relatively new concept. The process of change and growth during play therapy is reliant on the relationship established between the therapist and the child. This can take a long time and often never really develops. The parent already has a significant relationship with the child, although there may be stress in the relationship. Parent and child in a one-to-one play situation can reduce the stress and the relationship will continue long after the therapeutic relationship has ended. Busby and Lufkin (1992) state that parents are invited and expected to participate in the play therapy of their children. As children assign roles for parents to play, parents respond and in effect enter their world of fantasy. Thus the powerful role between parent and child is utilized in the treatment of children. Parents are taught to be the therapists for their children, and the parental skills and parent-child bond are enhanced in the process (Guerney, 1989). When parents are involved in this way, the focus is limited to the therapeutic issues discovered in the child's world.

Landreth (1991: 78-79) says that in this child-centred approach "...the child and not the problem is the point of focus...the relationship that develops and the creative forces this relationship releases in the child generate the process of change and growth for the child." He further states that the child is responsible for himself through more self-direction, resulting in more positive direction. The key to growth in this time of therapy is the relationship and not the use of toys or interpretation of behaviour. He stresses that the relationship is always focused on the present, living
experience. The programme provides a knowledge base to parents which can be a springboard for addressing many family issues in constructive ways. The relationship provides the consistent acceptance of the child which is necessary for the development of enough inner freedom and security by the child to express himself in self-enhancing ways. He summarizes the relationship in the following way:

<table>
<thead>
<tr>
<th>Person</th>
<th>rather than</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>rather than</td>
<td>Past</td>
</tr>
<tr>
<td>Feelings</td>
<td>rather than</td>
<td>Thoughts or acts</td>
</tr>
<tr>
<td>Understanding</td>
<td>rather than</td>
<td>Explaining</td>
</tr>
<tr>
<td>Accepting</td>
<td>rather than</td>
<td>Correcting</td>
</tr>
<tr>
<td>Child’s direction</td>
<td>rather than</td>
<td>Therapist’s instruction</td>
</tr>
<tr>
<td>Child’s wisdom</td>
<td>rather than</td>
<td>Therapist’s Knowledge</td>
</tr>
</tbody>
</table>

Table 13: Acceptance of the Child

To conclude this section on relationships this writer would like to quote Landreth’s principles for relationships with children (Landreth 1991:5).

<table>
<thead>
<tr>
<th>I am not all knowing.</th>
<th>Therefore, I shall not attempt to be.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need to be loved.</td>
<td>Therefore, I will be open to loving children.</td>
</tr>
<tr>
<td>I want to be more accepting of the child in me.</td>
<td>Therefore, I will with wonder and awe allow children to illuminate my world.</td>
</tr>
<tr>
<td>I know so little about the complex intricacies of childhood.</td>
<td>Therefore, I will allow children to teach me.</td>
</tr>
<tr>
<td>I learn best from and am impacted most by my personal struggles.</td>
<td>Therefore, I will join children in their struggles.</td>
</tr>
<tr>
<td>I sometimes need a refuge.</td>
<td>Therefore, I will provide a refuge for children.</td>
</tr>
<tr>
<td>I like it too if I am fully accepted as the person I am.</td>
<td>Therefore I will strive to experience and appreciate the person of the child.</td>
</tr>
<tr>
<td>I make mistakes. They are a declaration of the way I am: human and fallible.</td>
<td>Therefore, I will be tolerant of the humanness of children.</td>
</tr>
</tbody>
</table>

48
<table>
<thead>
<tr>
<th>I react with emotional internalization and expression to my world of reality.</th>
<th>Therefore, I will relinquish the grasp I have on reality and will try to enter the world as experienced by the child.</th>
</tr>
</thead>
<tbody>
<tr>
<td>It feels good to be an authority, to provide answers.</td>
<td>Therefore, I shall need to work hard to protect children from me.</td>
</tr>
<tr>
<td>I am more fully me when I feel safe.</td>
<td>Therefore, I will be consistent in my interactions with children.</td>
</tr>
<tr>
<td>I am the only person who can live my life.</td>
<td>Therefore I shall not attempt to rule a child's life.</td>
</tr>
<tr>
<td>I have learnt the most of what I know from experiencing.</td>
<td>Therefore I shall allow children to experience.</td>
</tr>
<tr>
<td>The hope I experience and the will to live come from within me.</td>
<td>Therefore, I will recognize and affirm the child's will and selfhood.</td>
</tr>
<tr>
<td>I cannot make children's hurts and fears and frustrations and disappointments go away.</td>
<td>Therefore, I will soften the blow.</td>
</tr>
<tr>
<td>I experience fear when I am vulnerable.</td>
<td>Therefore, I will with kindness, gentleness, and tenderness touch the inner world of the vulnerable child.</td>
</tr>
</tbody>
</table>

Table 14: Principles for Relationships with Children

2.4.1.2 Living Sphere / Lifeworld

The second presupposition is the living world or life sphere of the child. The physical environment includes all the things he knows and his own self-image. Vrey (1984: 14) states that a child exists not so much in a geographical world as in his "lifeworld". This includes everything in which he is involved or which he understands. Attribution of meaning is based on the totality of an individual's experience. Such meaning is cognitive, affective and conative and includes both experience and expectation. It is always the "person in his totality" who assigns meaning. Vrey (1984: 14-15) goes on to say that an individual's lifeworld can be represented as "...a network of relationships with objects, people, ideas, systems, forces, attitudes, himself and God." These are interdependent and interactive, so that a person's relationships are dynamic: "... the nature and horizons of his lifeworld are never static." He further emphasizes that the "gestalt of meaningful relationships make the individual's lifeworld." A lifeworld is not conceivable apart
from the person, since it is the totality of meanings discovered or assigned by a person. To constitute this lifeworld he uses his genetic potential, instincts, passions and psychological abilities in a particular cultural world, his norms and values being aligned with his ideals and expectations, all constituted as one dynamic, interacting whole in which he is involved and to which he assigns meaning.

Landreth (1993: 17-18) says that because children's language development lags behind cognitive development they communicate their awareness of what is happening in their environment through play. Their use of toys enables them to transfer anxieties, fears, fantasies and guilt to objects and people. They are able to project their lifeworld into a play situation, thus enabling them to come to terms with the lifeworld. Thereafter the solutions that are found during play are carried back into their lifeworld. The unfamiliar becomes familiar. Axline (1947) viewed this process as one in which the child plays out feelings thus bringing the feelings to the surface, getting them out into the open, facing them, and learning to either control them or abandon them. It would seem that play allows children to express themselves in a way that reduces tension and anxiety, and thus allows them to regain control over their lives.

Ginsberg (1976) feels that this direct application and use of parents in the therapeutic process places the treatment directly in the context in which the child lives, thus bringing change into the lifeworld of the child.

Johnson (1995) says that play has been called the "... primary precursor of creativity" (Winnicott, 1972) and has the capacity to moderate affect and anxiety - a rehearsal for life (Ornstein, 1984) through which the child discovers self, potentials and limitations.
2.4.1.3 Educational Climate

The next presupposition forming the foundation of involvement, meaning attribution and experience is the educational climate. When the affective climate between the adult and the child is warm so that relations are positive, the child is able to identify with the values and norms of the adult (Van Niekerk, 1986: 4-5). Furthermore, since the relationship is mutual, a positive relationship with the child will enhance the adult's competency to lead the child towards adulthood.

This educational climate, which is based on the relationship structures as put forward by Kilian and Viljoen (1974), will be presented in a comparative table. The present writer feels that this educational climate as expressed by Jacobs and Vrey (1982: 15) can be compared to the eight basic principles of child-centred play therapy as put forward by Axline (1971) and reiterated by Landreth (1991).

<table>
<thead>
<tr>
<th>CHILD-CENTRED PLAY THERAPY</th>
<th>EDUCATIONAL CLIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist is interested in the child and develops a warm, friendly, caring relationship.</td>
<td>Jacobs and Vrey (1982: 15) express the view that the educational climate must be one of warmth and security so that the educator and educand are able to meet in an environment which is safe and in which communication is enhanced. The components of pedagogical love are knowledge, care, respect, responsibility and trust.</td>
</tr>
<tr>
<td>The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.</td>
<td>Parent and child need to know one another in a mutually intuitive manner. Vrey (1979: 95) is of the opinion that &quot;Knowledge of the child is only possible if the parent lives with the child and not merely alongside him.&quot;</td>
</tr>
</tbody>
</table>
According to Clark (1995) this implies that the parents will completely understand the needs of the child and accept him unconditionally as well as provide him with opportunities for his emancipation from them. By the same token, the child also needs to understand the emotions and moods of the parents (Smith 1989:64). Jacobs and Vrey (1982: 15) stress that knowledge is not only an intellectual aspect but that feelings also play a role.

The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely.

According to Vrey (1979: 95-96), "Knowledge of the other person goes hand in hand with care.... It is more than the provision of food and clothing and includes concern about well-being, health, joys and sorrows." The parent neither over-protects nor rejects the child. Care is not reduced as the child becomes older but becomes more reserved.

The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.

Respect for the dignity of the child as a unique individual implies acceptance in an active and positive sense. Respect has no place for humiliation, ridicule and assault on the integrity of the child but rather, shows concern that only the best is wished for the child.

The therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.

Vrey (1979: 96) underlines the fact that new demands are made on the parents' responsibility with each newly attained level of development. They remain responsible for the child's welfare and educational support, responding to his requests for help and assuring him that his needs will be met. Kilian and Viljoen (1974) state that one of the characteristics of adulthood is responsibility and therefore the child is
| The therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship and resists any urge to direct the child's play or conversation. | The child learns through the stability of his mother on whom he is always able to depend that he is able to surrender himself to her care without effort or anxiety. As his trust and belief in her are enhanced, his own belief in his own abilities is fostered. According to Vrey (1979: 97), "Pedagogical love means trusting the child to embody the norm presented to him without policing him all the time." |
| The therapist establishes only those therapeutic limits which help the child accept personal and appropriate relationship responsibility. | Kilain & Viljoen (1974: 171) state that the relationship of authority is also necessary for the education relationship. The child accepts the parent's authority and the latter assists the child in his craving for support. |
| The educator has something to say to the child and the child listens to what the educator has to say. However, the child will not listen. On the other hand, the adult will not have anything to say if he is not aware of the child's potential. The adult reveals that he not only has authority, but also accepts the authority of norms which have a distinct bearing on his life and actions. | Jacobs and Vrey (1982: 16) add another component - that of honesty. They emphasise the importance of knowing exactly where one stands in relation to another person and stress that honest communication is a prerequisite for the development of an adequate educational situation. |

Table 15: A comparison between the eight principles of Child-centred Play therapy and The Educational Climate
Petrick (1986: 38) believes that the essential characteristics of pedagogic love can be distinguished but not separated and stresses that one presupposes the other. He states (1986: 108) that the authentic pedagogic-love relationship "...entails far more than the intellectual objective knowledge of each other. It is rather an intense involvement in each other's lot, one must experience the other in acceptance" (Petrick, 1986:108).

2.4.2 THE FOUNDATION

The foundation or essentials on which the intrapsychic structure rests are the activities needed by the child to achieve adulthood.

Figure 3: The Essentials necessary for forming of the self-concept and the eventual self-actualizing behaviour.
Vrey (1979: 28-44) maintains that the child needs the help of an adult educator in order to progress towards adulthood. He emphasizes that, in addition to the educational help provided, the child must understand, must be actively involved and form a positive self-identity through experiences which make him feel accepted, if he is to grow toward self-actualisation unimpeded. It is the present writer’s contention that during the process of non-directive play therapy the child is able to achieve this. In the safe environment of the play session the child is able to bring his real world into his play and through involvement with the toys, he is able to come to terms with his experiences in the real world and so attribute meaning. He is then able to transfer this experience back into the real world.

2.4.2.1 Attribution of Meaning

Clark (1995) stated that the child must know, recognize and understand. Cognitive ability orientates him in the world and helps him form a lifeworld. The meaning he attributes is unique. It includes logical and conative dimensions. When feeling or conative dimensions cloud logical meaning, communication is poor and anxiety may develop. Problems result when the child does not understand. This in turn may result in secondary emotional manifestations (Jacobs and Vrey, 1982: 11-12).

2.4.2.2 Involvement

Clark (1995) stated that psychic vitality, known as involvement, is used to strive for and attain a desired goal. It is possible to gain knowledge through physical or psychical involvement. However, the individual must want to act and be purposeful, persevere and show diligence.

Normative aspects play a role since not all involvement is good and the child may become involved in wrong-doing. The child who is not involved is apathetic and listless and requires psychological intervention (Jacobs and Vrey, 1982: 12).
Kilian & Viljoen (1974) state that there is no place for monologue in the education situation, it must be a dialogue. The child has a right to speak in the education occurrence, because he is a participant. The education occurrence cannot be actualized without mutual involvement of both educator and educand. It is the present writer's contention that play therapy provides the ideal situation wherein the educand can practise this participation. In fantasy he can come to terms with aspects that are not yet meaningful for him in reality. In this fantasy situation he is able to practise the involvement required in the real world situation.

Smith (1989: 60-61) believes that one must have a certain amount of knowledge of that in which one wishes to become involved and that "... considerable practice and perseverance may be necessary in order to achieve the anticipated goal."

2.4.2.3 Experience

The quality of significance attribution depends on the degree of involvement and this leads to experience of success, failure, and so on. Experience, therefore, depends on the quality of meaning ascribed which, in turn, determines the quality of relations. Because it is affective, each person's experience is expressed in a unique way. The child who experiences his school life as unpleasant forms negative relationships with teachers and peers and will require psychological intervention (Jacobs and Vrey, 1982:12-13). The opposite is also true. The present writer believes that during the play session the child should be able to have positive experiences as no demands have been placed on him. These positive experiences should negate many of the negative experiences that have come his way. If this "experiencing" is in the company of his mother it should improve and enhance the relationship that already exists between them.
2.4.2.4 Self-actualization

"Self-actualization is the attainment of all that a child / adolescent can possibly attain in every aspect of development and learning. It is reaching of the highest level possible for him to reach and this is individually determined" (Van Den Aardweg and Van Den Aardweg, 1988: 84).

According to Vrey, the self-actualiser is fully involved in all aspects of life, his own and that of others. He is concerned with things outside of the self. He has a realistic attitude towards the self and accepts the self with his limitations. He makes a deliberate effort to realize latent possibilities, physical, cognitive, affective and moral. He is able to transcend the limits of time and space, physical and mental abilities, and work for what he wants in the future. In this way, he is able to distance himself and evaluate his own identity and self-knowledge in a realistic manner (Jacobs and Vrey, 1982:13-14).

Landreth (1993: 19) stated that as the child reacts to his changing world of experience through the medium of play, he does so as an organized whole so that a change in one part results in changes in other parts. Therefore a continuous, dynamic, intrapersonal interaction occurs in which the child as a total system, is striving towards actualizing the self. "This active process moves toward becoming a more positively functioning person, towards improvement, independence, maturity, and enhancement of self" (Landreth, 1993:19).

According to Landreth (1991) his early interventions with children in play therapy awakened for him an appreciation for the unfolding process of life as experienced by children. They led to a new appreciation for the process of his own life of being the person God had created. He accepted that he was being fully human with the ability to accept his strengths and weaknesses. He came to realize that mistakes were only a declaration of the fact that he was fallible and that he was human.
Landreth further stressed that when relating to children the following tenets were essential:

- Children are not miniature adults
- Children are people
- Children are unique and worthy of respect
- Children are resilient
- Children have an inherent tendency toward growth and maturity
- Children are capable of self-direction
- Children's natural language is play.

Table 16 Tenets for Relating to Children

If these are kept in mind the child will be able to self-actualize through his play experiences.

2.4.3 Intrapsychic Structure

The Child as a Person

Figure 4 The interrelatedness of the intrapsychic structure which is essential for self-actualisation
2.4.3 The Intrapsychic Structure

2.4.3.1 The "I"

According to Mead (Raath & Jacobs, 1993:7), the I and the me form part of the whole. Jacobs and Vrey (1982: 16-17) give the I a subjective quality, being the core identity, spirit or pure ego which is subconsciously present in every thought and deed of the individual. They attribute an objective quality to the me, which they use to refer to the physical properties of the body, behaviour, memory, feelings and events of which one is always conscious. The me is a construction of the I and has no life of its own.

2.4.3.2 The Self

Raath and Jacobs (1993: 8-9) see the self as "the gestalt" of what man can call his "own", which includes his ideas, attitudes, values and so on, and "... is the core where the individual's awareness of the different aspects of his personality start." They believe it has many facets and plays an important part in the forming of the self-concept. According to Jacobs and Vrey (1982: 17), the self is lifeless and the I is the driving force.

2.4.3.3 Self-Identity

Purkey (1970: 29) maintains that a baby has not formed an identity by birth but that "he" gradually develops from then, largely influenced by the attitudes and behaviour of the significant people in his environment. As the child gets older, he learns to distinguish between himself and the environment and he begins to form an identity in answer to the question "Who am I?" (Jacobs and Vrey, 1982: 18-19).

Burns (Raath & Jacobs, 1993:10) describes the growth of identity as arising "out of a gradual integration of all identities." Jacobs and Vrey (1982) support the belief
that the identity is multi-faceted and point out the significant effect of meaning, involvement and experience on the development of an identity.

According to Vrey (1979: 45), the self-identity becomes quite stable during adolescence. Nevertheless, he underlines the fact that it is a life-long task which is largely a subconscious process of which neither the individual nor those in his society are aware.

2.4.3.4 The Self-Concept

Clark (1995) states the self-concept is "A term used in various branches of psychology to mean the overall view and perception that people have of themselves" (Roberts, 1993: 125). She goes on to cite Jacobs and Vrey (1982: 21) as claiming that the formation of a self-concept is affected by "... cognitive-affective symbolization of the organism growing over time through maturation and the accretion of experience."

According to Vrey (1979: 47), "A self-concept comprises three mutually dependent components: identity, action and self-esteem." He points out that "... the self-concept refers to a configuration of convictions concerning oneself and attitudes toward oneself that is dynamic and of which one normally is aware or may become aware [and states that it is] the focal point of relationships in the lifeworld."

Carfield (Vrey 1979: 76) says that a positive self-concept is a better indication of success than a high Intelligence Quotient. Caraway (1986: 178-180) echoes the opinion of educators who believe that "... healthy self-concepts are needed in order for children to learn at their full potential." She refers to observations made at kindergarten level. Children with high self-concepts were generally seen as willing to venture, to make friends and to show trust. They were usually cooperative and responsible, creative, participatory, independent, happy and willingly shared their experiences with others. In contrast, children with low self-concepts often showed little initiative, were generally passive, dependent, withdrawn, demanding, aggressive, frustrated and possessive of objects. Noyes and Macneill (1983: x)
maintain that chronic low self-esteem of children can lead to serious social problems in their teenage years. Learning disabilities may, therefore, be caused by or exacerbated by a low self-concept. Noyes and Macneill suggest that the emotional problems which arise as a result of the child's learning disabilities have the most disturbing effect on parents (1983: 19).

In his preface to the book written by Raath and Jacobs (1993), Jacobs states that a negative self-concept has a detrimental effect on the intellectual, social and personality development of the child. However, he refers to research findings which testify to the dynamic quality of the self-concept and underlines the possibility that "... the child who has developed a negative self-concept can be assisted to accept himself and to form a realistic-positive self-concept."

Caraway (1986: 178) warns that "... the parental method of handling infants speaks volumes." From the infant's earliest moments, they receive messages from the significant people in their environment which they appraise and these evaluations have a profound effect on the development of their self-concepts. In the words of Buscaglia (1982: 251), "... we're made mostly, by the people who surround us."

This continuous and subconscious evaluation of identities which cannot be separated leads to the formation of the self-concept which "... has a direct influence on the behaviour of the person" (Raath and Jacobs, 1993: 23).

2.4.3.5 Child-Centred Theory of Personality Structure

The child-centred theory of personality structure is based on three central concepts: (1) the person, (2) the phenomenal field and (3) the self (Rogers, 1951) as cited by Landreth (1991).

The person is all that the child is: thoughts, behaviours, feelings, and physical being. The phenomenal field is everything the child experiences, on a conscious or subconscious level, internal as well as external. Whatever the child perceives
to be occurring is reality for the child. The child is the totality of those perceptions of self.

Landreth (1991) cites Rogers when he states that a basic proposition is that every child "...exists in a continually changing world of experience of which he is the centre" (Rogers, 1951: 483). Landreth (1991) states that as the child reacts to this changing world of experience, the child does so as an organized whole so that change in any one part results in changes in other parts. Therefore, a continuous dynamic intrapersonal interaction occurs in which the child, as a total system, is striving toward actualizing the self. This active process is toward becoming a more positively functioning person, toward improvement, independence, maturity, and enhancement of self as a person.

The third central concept (Landreth, 1991: 58-59) of the child-centred theory of personality structure is the self. Through interactions with significant others in the environment and from the total phenomenal field (the lifeworld), the child, as an infant, gradually begins to differentiate a portion of these new experiences as the self. The self grows and changes as a result of continuing interaction with the phenomenal field. Awareness of the self ushers in the development of the need for positive regard of others. Boy and Pine (1982: 47), as cited by Landreth (1991: 59-60) state that the basic propositions regarding personality can be summarized as viewing the child as:

- being the best determiner of a personal reality,
- behaving as an organized whole,
- desiring to enhance the self,
- goal directed in satisfying perceived needs,
- being behaviourally influenced by feelings that affect rationality,
- best able to perceive the self,
- being able to be aware of the self,
- valuing,
- interested in maintaining a positive self-concept,
behaving in ways that are consistent with the self-concept,
not owning behaviour that is not consistent with the self,
producing psychological freedom or tension by admitting or not admitting certain
experiences into the self-concept,
responding to threat by becoming behaviourally rigid,
admitting into awareness, experiences that are inconsistent with the self, if the self
is free from threat,
being more understanding of others if a well integrated self-concept exists, and
moving from self-defeating values toward self-sustaining values.

Table 16: Basic Propositions Regarding Personality

2.4.3.6 Self-actualization

"Self-actualization is the attainment of all that a child / adolescent can possibly attain
in every aspect of development and learning. It is reaching of the highest level
possible for him to reach and this is individually determined" (Van Den Aardweg and

Maslow’s self-actualising theory also stresses many of the aspects that have been
illuminated: he places a great deal of emphasis on the lifeworld, educational
climate and affiliation needs of the child as percutors to the need for appreciation
and esteem which then leads to self-actualisation. Maslow’s (1970) theory is rooted
in the fact that people have to satisfy their biological needs before they can achieve
self-actualisation. His needs are divided into physiological needs and psychological
needs. The physiological needs, such as hunger, thirst and rest have to be
satisfied before the higher order needs can be realised. The psychological needs
include the need for protection and security. The present writer feels that because
of lack of knowledge and understanding of their ADD / ADHD children parents may
reject their children, there may be physical assault and punishment, strangeness,
lack of love, all of which according to Maslow prevent the need for security being
realised. Once people’s physiological needs and their need for safety have been
realised, according to Maslow, they then strive to be loved and to belong to a family and a group. This can be compared to the forming of relationships as stated by Jacobs (1997). According to Maslow, affiliation needs are the most unsatisfied needs of modern people, hence they remain the chief cause of deviant behaviour. The present writer feels that the ADD / ADHD child, who is described in detail in the following chapter, has great problems in this area. This results in unacceptable behaviour and so hinders self-actualisation. According to Maslow, when the affiliation needs are met the individual aspires to achieving recognition as a worthy person, he pursues appreciation, prestige, self-confidence and a feeling of importance (Maslow, 1970: 45). Failure to satisfy these needs leads to feelings of inferiority, weakness and destitution. The need for self-actualisation is the highest level of need in Maslow's hierarchy. He believes that this can only be achieved when all the other needs have been met. Self-actualisation means becoming what you can become, realising and using your potential to the full: understanding and knowing: achieving and being successful in life, in short fulfilling the need to be yourself. Self-actualised people have no need to impress others or to try to gain their approval they are free to be themselves in the manner which brings them the greatest satisfaction.

According to Vrey, the self-actualiser is fully involved in all aspects of life, his own and that of others. He is concerned with things outside of his self. He has a realistic attitude towards his self and accepts his self with his limitations. He makes a deliberate effort to realize latent possibilities, physical, cognitive, affective and moral. He is able to transcend the limits of time and space, physical and mental abilities, and work for what he wants in the future. In this way, he is able to distance himself and evaluate his own identity and self knowledge in a realistic manner (Jacobs and Vrey, 1982: 13-14).

Landreth (1991) cites Peccei's (1979: 10) "In the Name Of The Children," as encompassing the ongoing growing necessary for self-actualizing. Sometimes, it is children who show the adults the importance of being human.
If we were to allow the wonder of the life of a child to reach us full and truly and to be our teacher, we would have to say: Thank you, child of man...for reminding me about the joy and excitement of being human. Thank you for letting me grow together with you, that I can learn again of what I have forgotten about simplicity, intensity, totality, wonder and love and learn to respect my own life in all its uniqueness. Thank you for allowing me to learn from your tears about the pain of growing up and the sufferings of the world. Thank you for showing me that to love another person and to be with people, big or small is the most natural of gifts that grows like a flower when we live in the wonder of life.

Table 17: In the Name of the Children

2.5 CONCLUSION

The literature study presented has demonstrated the fact that during the early years the parents, especially the mother, exert a tremendous influence on the growth of the child to adulthood and self-actualization, affecting intellectual emotional and social aspects. McWhirter (1976: 27) accepts that the attitudes, beliefs and knowledge of parents play a critical role in the child's development of feelings about himself and in the subsequent achievement in school and adulthood.

This writer feels that the quotation on children, from "The Prophet" encompasses the Educational Psychological aim of education which is to accompany the child on his journey to self-actualization. Kahil Gibran also stresses the mutual dependency of both the arrow and the bow.
The present writer has tried to correlate the cornerstones of child-centred play therapy with the relations theory as presented by Unisa. This correlation formed the foundation upon which the present writer has based her empirical study. Kirk and Gallagher (1989: 8) acknowledge that the improvements in parent-child relationships which are brought about by early intervention aimed at changing the family environment through parent training are of the utmost importance. Tuttle and Panquette (1993: 48) have found that invaluable advice and comfort can be obtained from other parents who have experienced similar problems and who have learnt how to experience success. They can advise on mistakes to be avoided and can help parents to develop trust in themselves.

This writer feels that the concept of Filial Therapy, which is based on child-centred play-therapy, is a wonderful intervention technique. The parents are taught to engage in quality relationships during the weekly play sessions. They are empowered through reflective listening, encouraging, providing choices and setting limits. They learn to follow their children rather than lead the way according to their own needs and feelings. This leads to better communication between parent and child. Filial Therapy is felt to be the ideal means of encompassing the Educational Psychological philosophy while empowering the mothers through knowledge of their child's problems and in the supportive climate of the group teaching them how to relate better to their children.

In chapter three the writer will continue with the literature review, however in this chapter the child, or in Gibran's analogy, "the arrow", will receive attention. The chapter will explore the various aspects of ADD / ADHD children, as it is the mothers of ADD / ADHD children who will be the focus of the empirical study.
3. INTRODUCTION

In the previous chapter the writer described the development of play therapy as the foundation for the rationale of Filial Therapy. Filial Therapy can be summarised as unique because it involves parents as the primary change agents used to resolve child-related problems and to encourage the child's psycho-social development. For the purpose of this study the writer is going to use the process of Filial Therapy to train mothers, whose children have been diagnosed as having Attention Deficit Disorder to conduct play sessions with the children so as to eliminate presenting problems and strengthen their relationship. At this stage it is felt to be important to look at ADD and the effect that it has on the family. In terms of the analogy from "The Prophet" the ADD / ADHD child can be considered to be the arrow which has to be understood, so that it can be adjusted to the bow from which it is to be shot so as the reach the "Bull's eye" of self-actualization.

3.1 EFFECTS OF ADD / ADHD ON FAMILY MEMBERS

3.1.1 Case Study

Although this section is a literature review the writer would like to share her personal experiences of the effects of ADD or learning disability on the family. This will be done as a case study and will be written in the first person.
David was born when I was 15 years old and my sister was 13 years old. My mother was 39 years old and my father was 40. We were all extremely excited at the prospect of having a baby in the family. Everything was ready for the baby. Labour started on a Friday night and my parents rushed off to the hospital. This was two weeks before the due date. The night is still clear to me, now thirty years later. My grandmother and I sat up most of the night. She showed me the two cards that she had bought in anticipation, one for a boy and one for a girl.

Much later that night my father arrived home. Although the waters had broken, there were difficulties as my mother's womb had twisted. He suggested that we should go to bed. At this stage birth difficulties were not as well researched and although my mother's age was a risk factor she was being cared for by a general practitioner and not a specialist. After a very tense, anxiety filled weekend, David was finally born, by normal delivery on Sunday at lunchtime.

The excitement was beyond description. My father phoned everyone that he possibly could phone, even mere acquaintances. This was the only son in the family and the one that would carry the family name.

As I was already 15 years of age, David was more than a brother to me, he was brother and son. He was so loved, spoiled and enjoyed. Developmental milestones were reached age appropriately and talking was advanced. While being fed at about 6 months he jerked backwards and fell off the chair. No damage appeared to have been sustained, however. At a year he had to have corrective surgery for a squint, and then had to wear spectacles. He was always extremely active. Bedtime was especially difficult. I always had a good relationship with him and was able to entertain him for long periods of time. My sister found him to be a nuisance and barely tolerated him. This resulted in many fights. His aggression was always directed at her or her possessions.
Gross and fine motor co-ordination were not that good, but no serious problems were suspected. On going to nursery school the teacher felt that either concentration was a problem or there was a suspected hearing loss. Hearing was found to be normal. However my parents started becoming socially isolated because it was difficult to take David anywhere because he was so demanding and his behaviour often destructive. Advice was plentiful. My parents did not know how to discipline a child; he was naughty; he only needed a good hiding and more criticism in the same vein. He was so demanding that any hobbies my mother had were stopped, as she could not find the time to pursue them. It was still thought that he was merely a very active little boy. He spoke nonstop so it was never suspected that there could be any type of learning disability.

There was a great deal of excitement as David went to school for the first time. At this stage the writer was in her third year of study as a speech therapist. Within days a dark cloud descended on the family. He hated school! His life became a living hell. He was punished every time that his tracing was not satisfactory or when he misbehaved in any way. Behaviour started to deteriorate. There were frequent consultations with various staff members. Finally he was admitted to Muriel Brand School, a school for Cerebral Palsy children, which also caters for children with ADHD, where therapy was initiated. He received physiotherapy for gross motor problems, occupational therapy for fine motor problems, bilateral integration and visual motor integration. Speech therapy for auditory perceptual problems was also recommended.

Behaviour was so bad that he was initially only allowed to attend school for a few hours twice a week. He was extremely aggressive, impulsive, distractible and concentration was almost nonexistent. A neurologist diagnosed that he had suffered a nervous breakdown and that he was ADHD. Ritalin was prescribed. Behaviour gradually improved until he could attend school on a full-time basis. Improvement was slow and he never mastered the ability to read or write. He was finally placed in a special class. During adolescence he started having epileptic fits and at the age of thirty is now a permanent resident at Sanel, a centre for epileptics.
That briefly is David's history. The symptoms for ADHD can be clearly identified from this history.

The effects on the family were great. We were always an extremely close family who thoroughly enjoyed family outings. There was no television so as a family we used to play cards, board games or listen to the radio. My mother never worked and so was always there for us. It was a relaxed happy family. All this changed! It was no longer easy to function as a family because David was always causing an interruption and was never quiet. Family activities were minimised. David and his problem became the focus of the entire family. My sister withdrew completely, as she and David had never really bonded. I think she resented the attention that he was receiving. It was a lot of attention. He required extra help all the time.

I was at University and so was not as actively involved with the family at this stage, although I always felt that I was in the middle of everything that was happening. Everyone's perceptions and feelings were shared with me. It was difficult because I loved them all and especially David. There was always a very special bond between us. He will be my responsibility in years to come.

My mother became more and more depressed and withdrew more and more from society. She became very bitter and blamed everyone for David's problems. From the research, I now know that she never accepted the problem and remained in the depressed stage.

My father was the one who actually kept the family together as he has always had a great enthusiasm for life. He also did not fully accept the extent of David's problem, however he ensured that David still had as normal a life as possible. He managed to involve himself and David in scouts and Judo. David always accompanied him to many sporting activities. It was my father who went to Parents' Days or school meetings as my mother could not face them. She said that it was too difficult for her to face all his problems.
My father, although a very verbal person, could never talk about his actual feelings, disappointments and fears for David's future. My mother interpreted this as not caring. He often felt that she was over reacting to situations and she was not consistent in her discipline. David was always easily able to manipulate her as she felt so guilty and sorry for him. My father then was the one who always had to sort out all the problems and take him to doctors, neurologists or other professionals.

My parents could no longer socialise as a couple because there was no-one to look after David, it was too great a responsibility. There was very little time for leisure as there was always so much that needed to be done for David.

Two years ago my mother passed away and my father is still worrying about and feeling guilty about anything that goes wrong in David's life. It is so important for me to try to empower parents and that is why this study came about, so that everyone in the family can be understood and assisted in every possible way.

The writer has been working with learning disabled children for many years. Parents have all experienced very similar problems to those that were described. These problems are intensified because in these times both parents work and there is usually great stress. Most families try to provide quality time for the children. This is even more difficult with a child with learning problems. Siblings resent the attention the "problem child" is getting. Siblings often develop emotional problems because they may be afraid of the child as often they are the target of the aggression. Parents are torn between trying to protect the one child while still trying to understand and love the other child.

Problems can result in the marriage because the mother is so involved with and protective of her child. Some of these marriage problems have resulted in divorce. Mothers felt that the fathers often did not support them or were overly demanding with regard to the behaviour of the child. Some fathers reported that they chose to work long hours, thus staying away from the home, as they could not cope with difficult children after a day at work. They wanted to come home at the end of the day and relax in front of the television or read their newspapers.
Two parents that were interviewed actually expressed the wish to try in some way, to end the lives of the child and themselves. This would prevent the child from suffering and would end their difficult lives.

From the case descriptions above it can be seen that having a child with ADD or ADHD has a great impact on the family. The mother is especially affected because she is the pivot of the family and always has to act as a buffer between the ADD child and the rest of the family.

3.1.2 Literature Explaining the Effects of ADD on the Family

Amerikaner and Omizo (1984) stated that there have been many attempts to describe typical patterns characteristic of families with learning disabled children. They cite the following authors: Kaslow (1979) as observing that commonly the mother is extremely close to, or over involved with the child, while the father plays a distant or detached role; Humphries and Bauman (1980) also suggest that the mothers of learning disabled children were more controlling and authoritarian; Werner and Smith (1979), have concluded that the mothers are erratic, careless, indifferent, and worrisome, or less encouraging and supportive (Goldman and Barklay, 1974).

Clark (1995) feels that a learning disability has an effect on the whole family: parents, their marriage, siblings and extended family. "Parents are well aware of the crucial role education plays in the lives of their children. When a child is impeded in his progress and already fails at the bottom of the educational ladder, parents become concerned and future expectations are shattered. The behaviour parents display in response to their feelings invariably influences their relationships with their children" (Clark, 1995: 74).

Bloomquist (1996: 3) stated that children with behaviour problems (including ADHD) are challenging to parents, as they display behaviours that have a negative effect on others in the environment, such as parents, siblings, peers, teachers, and this often results in negative feedback and behaviour to the children.
McWhirter (1976:14) points out that the parents are forced to cope with the consequences of the child's learning difficulties and a daily routine which requires extra time and effort. Tuttle and Paquette (1993: 10) found that parents feel powerless and out-of-control. Smith (1991b: 191) believes that parents, in fact, underestimate their capabilities and are too critical of their own performance.

Guerney (1979) felt that for the learning disabled child, the need for dependence in relation to independence is a troublesome area, because the parents are often confused about what constitutes a realistic balance for children who both need more help than others and yet reject it at the same time.

There are indications in the literature that the learning disabled child can improve, and can eventually grow towards becoming normal and happy. Silver (1988: 6) suggests that the success achieved depends on the action, assertion, perseverance and advocacy of the parent. He points out that the task of getting help for the learning disabled child will take strength and determination, it will baffle and frustrate, but eventually it will reward.

Brutten, Richardson and Mangell (1973: 11) also stress the fact that since learning disabled children are intellectually competent, they can overcome much of their handicap with skilled and compassionate handling by their parents. Knowledge of the problems and a sharing of emotional reactions should help mothers to have more self-confidence in their ability to be adequate parents.

Gargiulo (1985), felt that all parents go through different phases before they are able to come to terms with the fact that their children have problems. This author feels strongly that the phase that the parents are experiencing will also affect the relationship that they have with their child.

Gargiulo (1985) mentions three basic stages in the process of acceptance: Primary, Secondary and Tertiary. Each of these stages consists of substages as well. Parents need to develop through these stages so as to accept the child in his uniqueness.
3.2.1 The Phases of Acceptance

3.2.1.1 The Primary Phase

a) Shock and Denial

During this stage, which is shortly after having heard that their child has a problem, parents experience feelings of shock, disbelief, irrationality and helplessness.

Then denial usually follows due to uncertainty of action, reservations about their child’s future and doubts as to their ability to help the child. Denial manifests in different ways, the most common being, refusal to accept that their child has a problem. They may even try to rationalise the deficiency, often through seeking professional assurance that there is nothing wrong with their child. Sometimes they might be overly keen to give their co-operation at too early a stage. It is essential that parents go through denial as this gives them a chance to gain time to reorganise and rebuild their interrupted lives. During these stages of acceptance the problem often becomes the focus and not the child, which can hamper the primary relationship of mother and child. Feelings of denial will hamper the gaining of true knowledge and understanding of the child and vice versa.

b) Grief and Depression

During this stage the parents are mourning the loss of their ideal child. They may be concerned for their child's future but at the same time experience feelings of deep disappointment. Grief is a natural and useful response as it compels parents to advance to the next transitional phase and they have progressed from the initial stage of shock and denial. If parents remain in the mourning phase for too long they can fall into a depression. They realise that they are vulnerable. Also they feel that they might have been able to do
something to avoid their child's condition. This could lead to feelings of anger at themselves. At this stage parents need to become aware that there are realities that they cannot change. No matter how much they want to make life easy for their child, they cannot, the children have to come to terms with their own problem in their own way.

3.2.1.2 The Secondary Phase

a) Ambivalence

Normally the love parents feel, may occasionally alternate with feelings of aggression. In children with a disability these ambivalent feelings may be more intense. They experience exceptional feelings of love which may be followed by severe feelings of aggression towards the child. Negative feelings towards a child with a problem may lead to guilt feelings which in turn lead to overcompensation. These feelings have a marked effect on the relationship established with the child. Some of the feelings of ambivalence are guilt versus self-sacrifice. The more guilty the parents feel the more likely they are to make sacrifices. There could be feelings of intense love versus rejection of the child because of the fact that he is not "normal". Then finally there are strong feelings of frustration versus overcompensation, trying to do everything for the child or trying to make allowances for him. These mixed messages also put a strain on the relationship because the climate of trust and honesty is not consistent.

b) Guilt

These feelings become more apparent during this stage. This could lead to the parents feeling guilty because they feel so guilty. They blame themselves as they often feel that they could have caused the child's condition or could have avoided it. This leads to the parents feeling that they
are being punished in some way. Their conversations are full of: "If only I had..." statements. These feelings could lead to overcompensation. Once again the disability becomes more important than the child. The parents often have a great deal of knowledge about the disability but little understanding of their child as a person.

c) Anger

"Why Me?" is a response often heard in this stage. Parents often present with misdirected anger that targets other people. This is intended to make someone responsible for the child's problems. Blame is frequently placed on doctors, friends, teachers, siblings, grandparents or each other. All this mental energy should rather be spent on dealing with the child as an individual who happens to have a problem instead of looking for a scapegoat. The anger can also be directed at the child for causing so much heartache.

d) Shame And Embarrassment

Children with problems can expect pity, social rejection, and derision from peers, siblings, teachers and other adults. The parents are afraid that their children will end up in embarrassing situations, so often prefer to avoid company and all the negative feedback from well-meaning friends and family.

3.2.1.3 Tertiary phase

During this phase the parents are well on the way to acceptance of their child in spite of his problem. Unfortunately many parents never reach this stage. The present writer believes that parents, already part of a multi-disciplinary team, which offers support to the family may find it easier to reach this stage. Parents that are
isolated and feel that they are all alone in the world will find it more difficult to reach this acceptance.

a) Negotiation

This is a very personal response. Pacts are made with God, these are desperate last attempts to make the problem go away. This is one of the final stages in the emotional convalescence of the parents.

b) Accommodation and Reorganisation

The parents start to adapt their lives to cope with the problem. They begin to interact with their children on a higher plane. They start to plan ahead. They start to equip themselves physically and emotionally to accommodate their child and his problems. At this stage they accept full responsibility for the education, stimulation and care of their children.

c) Acceptance

This is the ultimate goal. "You are my child and I accept you as you are." A conscious and sustained effort to try to recognise, understand and deal with problems needs to be made, always remembering that each and every child is a unique individual.

3.2.2 Other Common Responses

a) Chronic Sorrow

This is experienced by some parents who have never been able to come to terms with their own sorrow. This can have a very negative effect on the relationship established with the child. The child might start to feel guilty that he is causing so much pain and anguish.
b) Shopping Behaviour

These parents are always in consultation. They try out every remedy and purchase every programme that comes onto the market. They test all the different treatments. The author feels that this can be very expensive and places a great deal of pressure on the parent and the child. They will always be engaged in a teacher-child relationship rather than a mother-child relationship.

c) Rejection

Some parents reject their children if they are experiencing problems. This rejection can surface in various ways: the parents expect very little from their children, because they see them as failures and so set low goals. On the other hand they might set emotional or social goals that are impossible to achieve, thus reinforcing their belief that the child is useless. Other parents might look for an escape and become very involved in work, hobbies or in community service. Neglect or complete ignoring of the child may also be noted. The child might sometimes be sent away to a boarding school so that the parents are able to get on with their own lives. Another common reaction is response formation, which is the inability to own up to the fact that they have negative feelings towards their child, so they verbalise the opposite, thus feigning love and acceptance. This author feels sure that the child will be aware that the relationship is not genuine, and this, in turn, will affect their concept formation and the relationships that they form in later life.

d) Compensation

Many parents try to hide the negative feelings that they experience towards their children, as they are frightened of being judged as being bad parents, so they compensate in various ways. They try to replace thoughts of
rejection by thoughts of acceptance. The following can be the result: Feelings of aloofness and love can lead to possessiveness of the child. This prevents the child from venturing and exploring his lifeworld. The ambivalent feelings of cruelty and meekness lead to smothering where the child is not allowed to become his own person. Feelings of recklessness and caution could lead to suspicious feelings. These children who are exposed to mixed messages may often suffer from overanxiety and could be anti-social resulting in difficulty forming a realistic self-concept.

Unfortunately, unlike the grief cycle, when mourning the death of someone, which once completed has allowed for closure, this is not always the case with the parents of the ADHD child. Each time there is a problem or during the various stages of development the parent often has to come to terms with different aspects before acceptance can be regained. Adolescence is a particularly difficult period when career placement and tertiary education need to be addressed. The whole acceptance process starts all over. Once again support and guidance are essential.

3.3 BACKGROUND OF TERMINOLOGY

Attention Deficit Hyperactivity Disorder has been given a number of different names in the past, according to the different conceptions of the disorder.

According to Avidon (1986) reports of the 1920's described hyperactivity, antisocial behaviour and emotional instability as symptoms commonly developed after encephalitis in childhood (Wender 1971). Similar symptoms were said to occur after head injuries and it was accepted that "the intensively hyperkinetic form of reaction..." seemed conclusively organic (Bond and Partridge, 1926). A decade later, Kahn and Cohen (1934) as cited by Avidon (1986) coined the term "organic drivenness" to describe this kind of hyperkinesia. Shortly afterwards, Bradley (1937) discovered that overactivity often responded to stimulant medication. This
view of hyperkinesis as an indicator of brain damage drew considerable strength from Strauss and Lehtinen's (1947) very influential studies of what he regarded as "brain injured children".

Avidon (1986) goes on to point out that the next landmark was provided by Pasanick and Kennick's studies in the 1950s and early 1960s of the association between pregnancy complications and a range of outcomes, extending from cerebral palsy and mental retardation to hyperactivity and reading disorders. They indicate that pregnancy complications were linked to hyperactivity in a vague and broad sense. During the following two decades and up until the 1980s the term "minimal brain dysfunction" was applied increasingly to a broad group of behavioural and learning disabilities in children, in which the main features were based on the hyperkinetic syndrome but with additional perceptual, cognitive and specific learning disabilities (Rutter 1982).

"Minimal Brain Dysfunction" was used along with other terms that included the Hyperkinetic Reaction of Childhood, Hyperkinetic Syndrome, Hyperactive Child Syndrome, Minimal Brain Damage, Minimal Cerebral Dysfunction and Minor Cerebral Dysfunction to classify children whose major manifesting symptoms according to Wender (1971) were:

- hyperactivity
- perceptual-motor impairment
- emotional lability
- general co-ordination deficits
- disorder of attention
- impulsivity
- specific learning disabilities
- disorders of speech and learning
- equivocal neurological signs and EEG irregularities

Table 18: Wender's Classification of Children with Minimal Brain Dysfunction.
Prinsloo (1997) stated that the following terminology is still widely used especially amongst the medical practitioners:

- minimal brain dysfunction
- hyperactivity / hypoactivity / hyperkinetic disorders
- dyslexia (reading disability)
- dysgraphia (writing disability)
- dyscalculia (arithmetic disability)
- dysorthographia (spelling disability)
- specific developmental disorders

Table 19: Prinsloo's Summary of Commonly Used Terminology

After much debating and surveying of the literature, clinicians held that an attention deficit was the central feature of the symptoms (Cantwell, 1984; Dyckman and Ackerman, 1971) which coincided with the Diagnostic and Statistical Manual of Mental Disorders' (1980). The concise definition of this problem is of an attention deficit disorder with or without hyperactivity.

Dr. Francis Prinsloo (1997), a Paediatrician with specialisation in Neurology classifies ADD as follows:

Table 20: Prinsloo's Classification of ADD
She prescribes medication according to the category that the child falls into. The reason this brief history of terminology has been included is because it serves to emphasise the confusion that exists in this field. Part of the reason for the confusion is the fact that there are fourteen criteria for the diagnosing of ADHD as given in the Diagnostic and Statistical Manual of Mental Disorders 1987. Some of these criteria will be discussed more fully below. The child should have at least eight of these Criteria to be diagnosed as ADHD.

3.4 PRIMARY BEHAVIOUR PROBLEMS

Prinsloo (1997) stated that children with ADHD will have at least one of the following problems, some will present with two or all three.

- Hyperactivity
- Distractibility
- Impulsivity

Table 21: Prinsloo's Manifestation of Problems

If the onset of the disorder is early and it is chronic, it suggests a neurochemical basis for ADHD. If, however, hyperactivity, distractibility and impulsivity begin after a specific life experience it could have been triggered by anxiety of the experience.

The present writer has found through observation while dealing with these children that these problems lead to further difficulties in the structured situation of the classroom - because of their hyperactivity children with ADHD may have difficulty remaining seated without squirming or may continuously fidget, distracting the other children. Prinsloo (1997) cautioned that there are several reasons that the child may be overly active. This does not mean that the child is “hyperactive”. For example, if he is anxious, worried or depressed he may show an increase in muscle activity and be restless. The term “hyperactivity” refers to a specific
nervous-system-based difficulty which makes it difficult for him or her to control muscle (motor) behaviour.

The present writer feels that these children are easily recognised because they are easily distracted and because of their impulsivity, may blurt out answers to questions before they have been completed. This may lead to an incorrect response which, in turn, may effect the self-esteem which is reinforced by the negative feedback received from the teacher.

Prinsloo (1997) states that the child may have difficulty staying on one task or activity. He or she may be easily distracted and therefore, have a short attention span. Distractibility refers to a specific nervous-system-based difficulty. We are continually receiving inputs from all five senses. Normally we can filter out unimportant stimuli and only pay attention to those that are important. With distractible children, this filter mechanism is not working effectively. Thus all stimuli compete for his or her attention. Distractibility can also be present during anxiety or depression. Prinsloo (1997) felt that further manifestations of ADHD include a failure to complete tasks, as the affected children experience difficulty in sustaining attention to a task, which may also result in task hopping. Prinsloo (1997) further stated that children who have this distractibility often daydream and are preoccupied by their own thoughts because they may have difficulty controlling or inhibiting inner thoughts. The ADHD child may also:

- have difficulty in playing quietly
- talk excessively and shout often
- interrupt or intrude on other children's games

| Table 22: Other Problems Presented by ADHD Children |

Many of the parents that the present writer has interviewed have reported having difficulty with the fact that the child often does not seem to listen to what is being said to him, and fails to complete the expected chores. He often seems to lose or
misplace toys, clothing and other items. Possibly the most concerning is the fact that they may involve themselves in physically dangerous activities without thinking of the possible consequences and so the parents always have to be on the lookout, which often is the cause for the children being overprotected.

It does seem, however, that there is evidence to support the hypothesis that ADHD children have difficulty in maintaining attention particularly during routine activities. According to Bloomquist (1996: 3-4) the attention span problems can be seen in visual and/or auditory tasks and in situations that require mental effort. He further states that these children may not look different from other children when watching television, playing video games, or engaging in activities that have already been mastered, because such tasks require little attention. Differences are noted when tasks which require sustained effort and concentration have to be completed. Many school related activities fall into this category.

This lends credence to Douglas (1989) who found that cognitive abnormalities in hyperactive children can be attributed to defective functioning in the mechanisms governing:

- sustained attention and effort
- inhibition control
- the modulation of arousal levels to meet task demands.

Silver (1991) also supports the theory that ADHD children have difficulty in maintaining attention for any time because their reticular activating system has a filter system which may be working ineffectively. Efficiency here is dependent on neurotransmitters and a shortage of neurochemical transmitters means that the filtering system malfunctions, allowing all information through, which then competes for attention. Bloomquist (1996: 4) agrees with this and states that "Children with ADHD also have difficulty screening out distractions because their brains seem to process too much sensory information."
Bloomquist (1996: 5) cites the DSM-IV Diagnostic Criteria for Attention-Deficit / Hyperactivity Disorder.

A. Either (1) or (2)

(1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

**Inattention**

- often fails to give close attention to details or makes careless mistakes in schoolwork or other activities.
- often has difficulty sustaining attention in tasks or play activities.
- often does not seem to listen when spoken to directly.
- often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to follow instructions).
- often has difficulty organising tasks or activities.
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
- often loses things necessary for tasks or activities for example: toys, school assignments, pencils, books, or tools.
- is often easily distracted by extraneous stimuli.
- is often forgetful in daily activities.

(2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

**Hyperactivity**

- often fidgets with hands or feet or squirms in seat.
- often leaves seat in classroom or in other situations in which remaining seated is expected.
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
D often has difficulty playing or engaging in leisure activities quietly.
D is often "on the go" or often acts as if "driven by a motor".
D often talks excessively.

**Impulsivity**

- often blurts out answers before questions have been completed.
- often has difficulty awaiting turns.
- often interrupts or intrudes on others (for example butts into conversations or games).

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before the age of 7 years.

C. Some impairment from the symptoms is present in two or more settings (such as at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a pervasive developmental disorder, Schizophrenia, or other Psychotic Disorder and are not accounted for by another mental disorder (for example Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality disorder).

Table 23: DSM-IV Diagnostic Criteria for ADD / ADHD Disorder

### 3.5 THE EFFECTS OF ADD / ADHD

Avidon (1986) stated that due to inattentiveness and impulsivity occurring in children with ADD / ADHD, areas of scholastic, social and personal functioning are affected. In the classroom situation they are unable to attend to the relevant material. Their behaviour in most situations causes them to be labelled naughty, and the significant adults in their lifeworld become avoidant and irritated by them. They are often in trouble with authority figures because of their impulsive and aggressive behaviour. As a result of their behaviour, poor contact with others and
poor scholastic performance, these children feel a sense of failure and experience many emotional problems in terms of poor self-image, low self-concept, depression and rejection (Lahey, Schaughency, Frame and Strauss, 1985). These effects will be investigated in more detail within the areas of scholastic, social and personal functioning.

3.5.1 Scholastic Functioning

Avidon (1986) stated that poor school performance is not a diagnostic sign of ADD. However, one to two thirds of ADD children do often manifest with specific learning difficulties, in the areas of reading, spelling, writing and arithmetic, as well as general sloppiness in their work (Wender, 1971; Rie and Rie, 1980).

Dyckman and Ackerman (1976) stressed lack of attention as the 'sine qua non' of poor school performance in children with ADD. They reasoned that attention implies all the neurophysiological mechanisms which determine our conscious awareness at any given point. Hence an inability to attend leads to difficulties with the following processes: perception, conceptualisation, language, speech, memory and concentration (Cantwell, 1984). As a result these children tend to develop specific learning problems such as reading, spelling, arithmetic and writing (Rie and Rie, 1980).

Avidon (1986) stated that the effects of ADD on scholastic performance are severe and far reaching. These children are unable to progress educationally and are often placed in special classes or schools and receive highly specialized educational remediation. The consequences reflect in limited career choices. Thus, it can be seen that the effects of ADD appear to have a severe impact on the child's future life.

3.5.2 Social Functioning

Rie and Rie (1980) state that children with ADD display social impulsivity
characterised by poor planning and judgement as well as considerable resistance to social demands with increased independence and extroversion. Such children are frequently found to be difficult to manage (Wender, 1971). They show a typical picture of an unsuccessful extrovert in that they are able to initiate friendships but their behaviour eventually drives friends away.

Their behaviour is typically characterized as impulsive - (poor impulse control) and a decreased initiative. This in turn leads to a low frustration tolerance, antisocial behaviour such as destructiveness, stealing, lying, fire setting, sexual "acting out" and often poor sphincter control (Wender, 1971). In other words this poor ability to control impulses in children with ADD leads to difficulties in controlling emotional and physical impulses which in turn cause many associated problems. Such children are unable to sustain relationships and behave in a manner that does not foster acceptance and empathy (Hechtman, 1984; Rie and Rie, 1980). Instead these children tend to become socially isolated as they are rejected. The only way to obtain attention is through their impulsive behaviour (Lahey 1985). This commences the "circle of negative reinforcement" (Lahey 1985), in that the more these children behave impulsively, the more they are reprimanded, which becomes the only, or main source of attention and reinforces pathological behaviour.

3.5.3 Personal Functioning

Wender (1971) indicates that children with ADD display increased lability of emotion, altered reactivity and increased aggression and dysphoria. Their behaviour tends to be unpredictable. It is not the total amount of energy but the childrens' inability to inhibit activity when appropriate. These children are no more active than other children on the playground but they cannot curtail their activity in the classroom. As a result these children often become isolated, lonely and the ones who are constantly labelled as naughty, trouble makers and other equally negative labels. It is no wonder that they experience low self-esteem, poor self-image, depression and anxiety (Rie and Rie, 1980).
3.6 PREVALENCE

ADD has been found to have severe long term disabling effects on all aspects of functioning, most importantly in the scholastic, social and personal spheres (Hechtman, Weiss and Pertman, 1984; Rie and Rie, 1980). Considering the severe effects and prevalence of ADD, which is estimated to be between 10% and 20% of primary school children, this condition constitutes a major problem for mental health professionals (Shekim, Kashani, Beck, Cantwell, Martin and Costello, 1995). However according to Bloomquist (1996: 4) research has suggested that between 3-5% of all children have ADHD. Boys have a higher incidence of ADHD than girls by a ratio of 4 to 6 boys to one girl in clinic samples. Many children who have ADHD eventually develop more significant disruptive disorders such as oppositional defiant behaviour and conduct disorder. The present writer feels that the discrepancy in the prevalence figures is due to the fact that there is still confusion in the terminology and many practitioners are hesitant to make a diagnosis of ADD / ADHD.

3.7 ETIOLOGY

The present writer found that the major etiological conceptualizations of ADD appear to fall in the categories brain damage / dysfunction, genetic transmission, pregnancy, diet, psycho-social, foetal maldevelopment as well as psychogenic determinants.

3.7.1 Brain Dysfunction

Prinsloo (1997) during her lecture stated that Ramekin (1990) has found that ADHD affiliated adults have low levels of activity in the frontal and frontal limbic areas of the brain as well as decreased blood flow in these areas. It would seem that in order to receive optimal stimulation, ADHD sufferers are excessively active. Stimulant medication provides this stimulation thus allowing the child to decrease his own activity levels. Together with Silver's (1991) findings it does seem highly probable
that an abnormality in the brain chemistry has a causal relationship or effect with ADHD.

Silver (1991) has isolated norepinephrine as responsible for efficient transmission of messages and functioning of the reticular activating system of the brain. It is here that messages are controlled by a "braking system" and information is monitored. The brain must balance its functions of stimulation and suppression. If these mechanisms are unable to function correctly, impulsivity and distractibility (too much information bombarding the system) result because the braking system is not working. Stimulants which help increase the production of the neurochemical norepinephrine ensure that the brain stem systems transmit messages efficiently.

Bloomquist (1996: 6-7) felt that the cause was primarily biological or neuro-developmental. He reported that these children seem to have subtle abnormalities in those parts of the brain that are responsible for maintaining attention, screening out distraction, and regulating motor activity. He states that emerging evidence seems to suggest that the frontal lobes (especially the right side), the basal ganglia, and reticular activating system are the areas implicated in ADHD children.

3.7.2 Genetic Transmission

It does seem that there is a genetic component to the cause of ADHD, as studies show that parents and siblings of ADHD children show higher rates of the disorder, than would be expected (Wicks-Nelson and Israel, 1991). Silver (1991) states that genetics may be implicated in the etiology of ADHD in 60 % of cases. Bloomquist (1996: 5) states that there appear to be multiple ways in which a child may end up with subtle brain abnormalities, but he maintains that in most cases, heredity plays a dominant role in which predisposition to subtle brain differences are passed on from one generation to the next. In some cases there might be actual structural damage as a result of problems during pregnancy and birth, or by trauma or exposure to toxins after birth. It is always the same areas of the brain that are affected. The present writer strongly supports the idea of a genetic component as
many of the children in the remedial schools, have a history of ADD / ADHD in the family. In such families, the parents themselves experience difficulty with reading and spelling and are hesitant to assist with homework. They avoid written correspondence with staff members. Often, all of the children in a particular family present with learning problems. It is further felt that as many of the parents exhibit these symptoms of ADD / ADHD, they have difficulty with organizational skills and so find it difficult to organize homework activities, discipline their children and help them to adapt to the demands of society. Their social skills are also often lacking. They display impulsive and aggressive behaviour and are therefore unable to provide suitable role models for their children.

3.7.3 Pregnancy

Strissguth, as cited by Wicks-Nelson and Israel (1991), feels that maternal alcohol consumption may be related to an increased rate of ADHD. Silver (1991) while not pointing to a specific cause states that it seems to be something that occurs in the 3rd, 4th and 5th months of pregnancy.

3.7.4 Diet

Feingold (1974) asserts that foods containing artificial dyes and preservatives are related to hyperactivity. As well as this susceptibility to the toxic effect of additives to food, hyperactivity has been linked to an allergic reaction to one or more foods in the diet. While Feingold has largely been discredited, it does seem that a small number of children do benefit from special diets as reported by parents. Thus although scientific evidence is lacking it does appear that for some children, particularly allergic children, diet may play a part but not to the extent suggested by Feingold. Bloomquist (1996) feels that there is no evidence to support diet as being a cause of ADHD.
3.7.5 Psycho Genetic / Social Factors

Avidon (1986) states that in this instance ADD is assumed to be a reaction to environmental or inner "neurotic" anxiety. It may be that deviant, early environments produce a fixed personality structure with many features of the disorder (Wender, 1971).

Avidon goes on to say that other psychogenic influences may be attributed to delays or deficiencies in specific phases of development. In this regard Vygotsky (1962) and Luria (1961, 1981) viewed the development of speech, especially inner speech, as central to the development of cognitive control. Meichenbaum and Goodman (1969) found that children with ADD / ADHD displayed a poor reflective cognitive ability.

Thus psycho-social variables do appear to play some role in ADHD. This does not appear to be a causal one but rather a result of an interaction with an existing disposition to the relevant ADHD behaviours. However, Bloomquist (1996) felt that there was no evidence to support a purely environmental cause such as poor parenting, or poverty. The present writer feels that the poor parenting skills that are often exhibited may be due to the fact that the parents are learning disabled and so provide an impulsive model.

3.7.6 Foetal Maldevelopment

Avidon (1986) found that several authorities have noted the association of inattention, impulsivity, hyperactivity and certain congenital abnormalities which would be of genetic derivation but might also result from foetal maldevelopment (Wender, 1971). There are, however, no known substantive studies which conclusively link ADD and foetal maldevelopment, so this can only be considered to be a hypothesis.
3.7.7 Interaction of Etiological Factors

Avidon (1986), feels that no one determinant can be held up as a dominant etiological factor to the exclusion of all others. Hence it is possible that there may be more than one determinant or that the determinants overlap and interact with each other (Rie and Rie, 1980; Wender, 1971). Cantwell (1972) feels that there could be a certain predisposition to developing ADD that is transmitted and this is socially or environmentally triggered by social interaction, developmental phases, or poor learning acquisitions.

3.8 DEVELOPMENTAL COURSE

Bloomquist (1996) feels that there is a fairly typical developmental course, especially with ADHD children with hyperactive-impulsive symptoms. They may be more active in the womb during pregnancy. As infants they are characterized as active, restless, fussy and difficult to soothe. Regular feeding and sleeping routines may be difficult to establish. Difficult temperaments may be noted as toddlers and preschoolers. From a young age they are extremely active and need monitoring and supervision. Some ADHD children have a poor bonding with the primary caregiver. During the preschool phase they are often more difficult to discipline. In primary school these children's symptoms are diagnosed, as their problems with attention span and concentration seriously hinder academic progress. As a result of poor relationships with family members and peers they often develop poor self-concepts. During adolescence the hyperactivity often declines, but the problems of impulsivity and attention span prevail. Many secondary problems may arise and these adolescents are at greater risk for developing delinquent behaviour, depression, peer relationship problems, school failure and so forth. The problems of ADHD may persist into adulthood and these adults are at greater risk for a range of emotional, interpersonal, psychiatric, and functional problems such as occupational and marriage problems. Bloomquist (1996) further states that it is thought that without
treatment approximately 30-50% of ADHD children can learn to adapt to their disability in later life. The other 50-70% of these individuals are "at risk" for developing problems in later life.

3.9 TREATMENT

In many instances it does seem that the characteristic distractibility and hyperactivity of learning disabled children decrease and disappear in early adolescence, (Ross, 1977). This does not mean that there are not associated problems remaining. Thus, therapy is very necessary in helping to improve a negative self-image and remedial help is necessary for developing enriched schemas and efficient strategies to enable them to cope on an academic level.

Once a thorough assessment has been made by a full team, consisting of psychologist, speech therapist, occupational therapist, remedial teacher and a neurologist or paediatrician, using all the objective measures at their disposal, therapy may commence.

There is some disagreement about the most effective methods of treatment, especially regarding the use of drugs to focus the hyperactive child. Variations in treatment procedures may be required to meet the needs of each individual child.

3.9.1 Medication

Silver (1991) stated that it is important to understand that treatment must start with the causes and not the symptoms. Medication, which treats the neurological dysfunction, enables the child to learn and to control his behaviour. His self-esteem improves, the emotional problems diminish, and he is able to function in line with what is expected of him. It is important to refer the child to a paediatrician, neurologist or psychiatrist if ADHD is suspected. Although a cause of much
controversy, stimulants have proved highly effective in the treatment of ADHD. Ritalin, Dexedrine and Cylert are commonly used and appear to be extremely effective, in that in 75% of medicated children there is increased attention, reduced impulsivity and activity levels, particularly in structured situations such as school. Not only does attention span improve, but social relationships are often positively affected too.

The following limitations and negative implications of medication have been reported:

- Stimulants are not recommended for children under three.
- Long term effects are not yet known.
- Drugs are often over prescribed.
- Children may become psychologically dependent on the drug as they do not have a sense of inner control.
- Some side effects of these drugs may be experienced including insomnia, weight loss and irritability, also headaches and stomach aches.
- The use of stimulants has been implicated in the retardation of growth. This has been disputed rather than proven.

Table 25: Reported Negative Effects of Medication.

3.9.2 Therapy

Avidon (1986) states that the consensus amongst investigators (Coleman, 1980) seems to be that medication should be used with extreme caution, and only with those children for whom other alternatives simply do not work. ADD children, including those who do benefit from medication, may need other therapeutic measures for dealing with existing problems, such as language deficits; visual motor deficits; learning deficits; psychological, interpersonal and family difficulties. The
various experts such as the speech therapist, occupational therapist, remedial teacher and psychologist all have a role to play. The present writer feels that therapy works best when a multidisciplinary team approach is used. The team should meet for discussions on a regular basis so as to ensure that the child is seen as a totality. The parents, as the most important team member, should not be forgotten and should also be present during discussions.

3.9.2.1 Behaviour Modification:

The therapist may introduce a behaviour modification programme which embraces both the home and the school and thus involves the training of both teachers and parents.

3.9.2.2 Parent Management Skills:

During the life-line counselling course (1996) it was stressed that:

"PATIENCE, PRAISE, TOLERANCE, FIRMNESS AND A SENSE OF HUMOUR".

are absolute necessities for parents when dealing with ADD / ADHD children.

The first essential when dealing with children diagnosed as having ADD / ADHD is to give the parents as much information as possible. This can be in the form of literature or tapes; and, where possible, they should join a parent support group. They must understand exactly how and why their child functions in the way that he does. As mentioned before, parents having a child that has been diagnosed as ADHD go through certain phases of acceptance, as described by Garguilo (1985). These phases are similar to the grief syndrome. After a bereavement, when acceptance has been reached, there is a finality. Unfortunately with an ADHD child the process will be re-experienced each time the child encounters another obstacle.
An especially vulnerable stage is adolescence when career choices need to be decided on.

The writer has formulated the following advice for parents after reading much of the literature and working with ADD children as part of a multidisciplinary team. It is difficult at this stage to give recognition to the many authors that have provided this framework, as it has been internalised over the years. The writer's advice is as follows: Parents must not try to teach the child themselves as this usually leads to a no-win situation. Rather they should try to help him to get organised, then let him work independently, unless he asks for help. Encouragement is very necessary and should be used wherever possible. Parents should be cautioned against the overuse of praise where it is not actually warranted. They should learn to encourage rather than praise and to praise the effort rather than the end result, while always keeping the child's capabilities in mind. They need to learn to expect small gains and not to make a big issue of the problem or of the homework. The parents need to develop positive control.

They would be advised to increase attention to social behaviour and to reinforce compliance with a tangible reward such as a token, or points that can be accumulated, or with non-tangible praise. Very clear limits for the child's behaviour are to be set and, importantly, maintained. The use of choices and the consequences thereof empower the parents. Consistent discipline, structure and a definite routine are essential. Often this is difficult for the parents as there is a strong hereditary factor in ADHD and the parents therefore find it difficult to organise themselves as well as they would like to. Serfontein (1990: 33) advocates a steady routine, discipline and consistency as being the components of an essential route to success in overcoming problems. If the child does not comply he is punished by removal of points or other means.

Instructions given must be clear and directed at the child even to the extent of the parent crouching down and looking directly at the child's face while giving instructions. Parents should realise that the child cannot follow a list of instructions
given all at once. Parents should ensure that they have the child's attention before they speak. Calling the child's name before giving an instruction, to enable him to focus his attention, is another useful technique.

Parents can also help the child in other ways such as finding a sport which enables him to use his pent-up energy, such as swimming or cross country running. Expect his participation in normal family chores. Such activities are essential to teach him self-discipline. However, remember that it will at first, take extra time, effort and many calm reminders on the parents' side to get the job done. It is acceptable to withhold privileges if the job is not done. Structure the child's chore - for example showing him a place setting as an example and letting him copy it when setting the table, is also helpful.

ADHD is a valid reason why the child finds certain things difficult, but he should not be allowed to use it as an excuse and neither should the parents. He has to learn to function in the world we live in. To feel sorry for him or let him get away with things is to do him a disservice. The parents are therefore taught how to implement and maintain effective management techniques and the importance of utilising these. Positive reinforcement is emphasised.

3.9.2.3 Self-regulation by The Child

The child may be taught to observe and record his own behaviours. Self-monitoring may require the child to award himself points that can be exchanged for reinforcers, such as toys, privileges or other rewards important to the child. Thus self-regulation also includes self-reinforcement as well as self-instruction, which is a cognitive behavioural strategy, involving the child in self-verbalization.

3.9.2.4 Cognitive Behavioural Training

The child is given a clear explanation by the therapist of his particular difficulties and
how he can help to overcome these as they are treatable. The importance of
behavioural training is that it allows the child an opportunity to experience internal
control (unlike medication). The therapist and, in particular, the teacher need to
ensure that the pupil is able to achieve success. The child is taught to assess the
task and develop his own strategies to tackle it while he continually verbalises to
himself what he is attempting to do. He continually reminds himself to slow down
and examine the clues and possible solutions. Thus the child accepts responsibility
for himself. The present writer has found that self instruction only slightly reduced
the effects of ADHD and often this was only of a temporary nature. Parents and
children found it extremely time and energy consuming.

3.9.2.5 Play Therapy and ADHD Children

Guerney (1979) feels that while play therapy had been used for many years with
children with emotional disorders, it was not widely used with children with
adjustment problems, secondary to the primary problem of an essentially physical
origin. In recent years, the Individual and Family Consultation Centre of the
Pennsylvania State University introduced the concept of Filial Therapy for ADD /
ADHD children. This consisted of play therapy being conducted by the parents.
There have been very positive results. Parents, serving as play therapists, can
promote the parent-child relationship, reduce their own stress and improve their
children's behaviour. The concept of Filial Therapy has already been described in
chapter two and so will not be dealt with in detail at this point. It must be stressed,
however, that Guerney (1979) reported that Filial Therapy with learning disabled
children showed that a child could move from negative feelings toward the self and
others to positive feelings, from dependence to independence and from impaired
impulse control to acquisition of greater self-regulation.
3.9.3 The Role And Task of The Teacher

TEACHER  MARY MCCracken

(Life-Line advanced training manual 1994)

I will know you
I will touch you and hold you
And smell and taste and listen
To the noises that you make— and the words, if any.

I will know you
Each atom of your small, lonely
Aching, raging, hurting being
Will be known to me
Before I try to teach you
Before I try to teach
I must first reach you.

And then, when I have come to know you, intimately,
I will insist, gently, gradually, but insist
that you know me
And later, that you trust me
And then yourself.

Now, knowing each other, we will begin to know the world—
The seasons, the trees, animals, food, the other children,
The printed word, books,
The knowledge of what has gone before and been recorded.

Then as surely as I moved toward you
I will move away.
As I once insisted on being close to you,
Demanding entrance to your half wild world
Of fear and fantasy, refusing you aloneness

So now, I move away
As your words come and your walk quickens
As you laugh out loud
Or read clearly and with understanding,
I stand behind you, — No longer close —
Available, but no longer vital to you.

And you — you grow!
You are! You will become!

And I, the teacher,
I turn, with pride in you,
Towards my next child.
Although this poem depicts the ideal teacher with absolute dedication, this does not always happen in reality. It is very demanding and energy draining trying to teach ADD / ADHD children.

The hyperactive and impulsive child clearly needs aid to focus on the correct clues. Basic techniques need to be taught, for example stopping an activity in order to look at the person who is talking. The teacher is able to help the pupil by ensuring that the day has a definite structure to it, so the child is able to anticipate events. Behavioural expectations should be clear and enforced in the same manner each time. Frequent repetition is often necessary because of the fluctuating attention span of the child. Complex activities need to be broken up into small steps so that the child is able to grasp these and experience success.

Some teaching strategies that may be helpful include:

- Having a special place to keep important materials.
- Utilising a special notebook for classroom assignments.
- Making lists of things to be remembered.
- Keeping a diary.

Table 26: Some Helpful Teaching Strategies.

The teacher should also be aware of the importance of positive reinforcement. It is not helpful to criticise things done incorrectly but it is more important to offer specific techniques for approaching tasks. One very important aspect for the teacher to remember is the frustration and low self-esteem the child may experience. These need to be dealt with in conjunction with the family who also need help to carry out many of the management requirements in the home. It is important to tailor these tasks to the child's abilities.
3.9.4 Comparing Treatments

There appears to be little consensus on the most effective manner to treat ADHD children. Medication, diet, behavioural techniques, or a combination of these, suit different children differently. Parent management techniques are useful particularly when children are temporarily off their medication or merely to rid parents of a sense of helplessness. Self-regulation techniques are also useful for ADHD children who are moving into adolescence as it is less appropriate for them to have continuous external control from teachers and parents.

3.10 CONCLUSION

Attention Deficit Hyperactivity Disorder children may vary widely from one another in the symptoms they display. However, in general, hyperactivity, attention deficit and impulsiveness are the most common behaviours and the ones which show up most in structured environments. It does seem that ADHD children are both unable to focus their attention selectively on a task and have difficulty in sustaining this attention. Having said that, it is important to acknowledge that conceptualising and measuring of all the manifestations of ADHD has been problematic. Children with ADHD, although often impulsive and prone to acting without giving thought to possible consequences, fall within the normal range of intelligence. They often are unable to utilise this intellectual potential and are sometimes several grades or standards below others in their age group. Although there is often a major reduction in ADHD by adolescence, academic and social difficulties often persist, which need to be addressed.

The schematic representation of the course and effects of ADHD (Life-line, 1994) shows clearly how the children presenting with underachievement and behaviour problems eventually present with poor self-esteem. This results from their involvement in different relationships, experiences thereof and the ultimate attribution of meaning.
ATTENTION DEFICIT HYPERACTIVE SYNDROME

CHILD PRESENTS WITH:
UNDER-ACHIEVEMENT
BEHAVIOUR PROBLEMS

CAUSES
Inborn
Genetic
Neurological

NOT CAUSED BY:
> Low I.Q.
> Emotional factors
> Sensory or motor impairment

SYMPTOMS
Inattention
Fails to Finish Things
Easily Distracted
Does not Listen

HYPERACTIVITY
Difficulty sitting still
Fidgeting excessively
Excessive running/climbing
Disruptive

IMPULSIVITY
Acts before thinking
Shifting activities
Poorly organised
Needs supervision
Can't wait his turn

SPECIFIC LEARNING DISABILITIES
Reading, writing, arithmetic, spelling, language

ASSOCIATED FEATURES
Poor Relationships
Low Frustration Tolerance
Obstinacy, Negativism

Emotionally labile
Temper outbursts
Bossiness, Bullying

Reactions from
PARENT/TEACHER/OTHERS:-
Labelling:
"You are 
- naughty
- lazy
- nasty
- useless
- impossible
- stupid
- cheeky"

Effects on
CHILD/ADULT SUFFERER:-
Self-fulfilling prophecy:
"I am 
- naughty
- lazy
- nasty
- useless
- impossible
- stupid
- cheeky"

POOR SELF-ESTEEM

EMOTIONAL PROBLEM

Figure 5: Diagrammatic Representation of ADD / ADHD
ADHD is a disorder which often results in poor self-esteem of the child, and one which may also lead to tremendous stress for the family, and teachers of a child who has behavioural manifestations of the disorder. It is vital that they are not only given support and encouragement but practical techniques as well. Medication, while not an ideal long-term solution, might well be valuable if it enables the child to achieve better levels of concentration, and if it improves family and social relationships.

In chapter four the writer will discuss the proposed study keeping in mind the needs of the parents and of the ADD / ADHD child. She will describe how she plans to meet the needs of parents, who have not previously enjoyed a support system, by empowering them with knowledge and strategies to cope with their children. They will be made aware of all the aspects leading to acceptance. These will be explored and then personalised by the introduction of the Filial Therapy programme.
CHAPTER 4

RESEARCH DESIGN

4.1 INTRODUCTION

In chapter one, the awareness of the writer in terms of the problem was covered. This then led to a definition of Filial Therapy in relation to the Educational Psychological philosophy. A review of the literature and demarcation of the areas for research purposes was covered.

Chapter two detailed an historical overview of play therapy as a precursor to Filial Therapy. Although Filial Therapy was originally used with individuals, it has more recently been adapted for use with groups, and will be used as such for this study. The concept of Filial Therapy from an Educational-Psychological perspective was described. This was followed by a description of the task of mothers as primary educators and how this task was influenced by the relationship established with the child with a learning disability. This relationship is often affected by the unconditional acceptance of the child.

In chapter three ADD was described in terms of the historical background, etiology, characteristics, prevalence, developmental course, treatment and how a child with ADHD affects the family and in particular the mother-child relationship. This effect is usually caused by the way the mother reacts to this problem, and her acceptance of the child as being a unique individual.

4.2 HYPOTHESES

- Filial Therapy, within the Educational Psychological framework can be used as a tool to help ADD children on their journey towards self-actualization by improving the mother-child relationship.
Filial Therapy will help mothers to unconditionally accept and love their ADD / ADHD children.

Filial Therapy will improve the self-concept of mothers as they realize that they are being the best mothers that they are capable of being.

Filial Therapy, because it takes place within a group, will help provide a support system for the parents.

After a ten week "Filial Therapy" programme the mother-child relationship will improve.

The mothers will accept that their children have an inherent tendency toward growth and maturity and are capable of self-direction.

The mothers will be able to discipline their children more realistically by the setting of limits and the giving of choices.

The mothers will be able to listen to their children effectively and understand their hidden communication by responding to verbal and non-verbal communication.

The mothers will be able to accept their children as being unique and respect them for their uniqueness.

4.3 PURPOSE OF THE STUDY

4.3.1 General Aims

The aims of the study are:
An in-depth literature research on the phenomena which, for the purpose of the study, have two components:

a) Filial Therapy, tracing the concept of play therapy and how it evolved to produce the concept of Filial Therapy within a group context.
b) The ADD / ADHD child and the effect that the child has on the family and especially on the establishment of the mother-child relationship.

An empirical study will be conducted within the field of Educational Psychology, using Filial Therapy as a means of allowing mothers to become aware of, explore and personalize the effects of the child's learning problem on their relationship with the child.

The study will provide specific guidelines, a step-by-step programme and the necessary worksheets so that Educational Psychologists may implement Filial Therapy in educational settings or in private practice.

4.3 2 Specific Aims

The specific aims of the study are:

To empower mothers with information so that they can move through the awareness period to an in-depth exploration of ADD so as to reach acceptance through personalization.

To allow mothers to enjoy their children and accept their uniqueness through the medium of child-centred play.

To provide the mothers with a forum for sharing their feelings, frustrations and experiences with other mothers who have similar problems.
To encourage greater interest and a better quality of involvement by the mothers in the child's learning process. This will be done through teaching better communication skills, setting of limits, the giving of choices and helping the children to accept the consequences of their actions.

To improve the relations between mother and child initially and eventually to bring about a personal growth of both mother and child. This should lead to the child forming a more positive relationship with the self. Cordini (1987: 70) believes that a major goal of all individuals is to form positive relationships with others so we feel accepted by those with whom we live, work or socialize.

Jacobs (1981) as cited by Vlok (1992: 22) found that problems with relation formation resulted in various psychological problems. When relations go wrong, they crystallize in unacceptable behaviour, such as aggression, shyness, emotional lability and so on, so that the growth towards self-actualisation is impeded.

During the study the writer will try to realize her aims by empowering the mothers and enabling them to:

- Establish an educative or pedagogic climate through knowledge, care, love, respect, trust and honesty.
- Improve relationships.
- Understand and give meaning to the lifeworld of the child.
- Understand and give meaning to their own lifeworld.
- Develop and improve their own self-concept and that of their child.

These are the presuppositions, which together with the attribution of meaning, experience, involvement and self-actualization form the foundation whereupon the intra psychic structure, namely, "I", "Self", "Identity", and "Self-concept" rest. The intra psychic mutual interaction of these components is responsible for the person's eventual behaviour or self-actualisation (Jacobs, 1981: 150).
For the purpose of this study the focus will be on the mothers' awareness, exploration and personalization of the problems experienced by their children and the effect that it has had on them as mothers. Then, via the process of Filial Therapy, to teach them to build up a meaningful relationship with their child through empowering them with techniques such as communicating effectively; enjoyment through playing with the child while setting limits; allowing the child to make choices, the consequences of which must be accepted. Information on the ADHD child and the way in which he becomes involved, experiences and attributes meaning on his way to self-actualization will also be explored. This will be done in a supportive, educative, group environment.

4.4 RESEARCH DESIGN

4.4.1 Rationale for the Study

From the literature study presented in chapter three, it is evident that parents, and especially mothers, are overwhelmed by the discovery that their child has a problem. Their reactions and the ability to accept their child as a totality has an effect on the primary mother-child relationship that is being established. There is also a marked effect on the family dynamics as a whole. These mothers need to be empowered with knowledge and skills for dealing with these unique children. They often feel isolated as there is nobody who truly understands. They are cut off from society because the child is often an embarrassment, is aggressive and generally disruptive. Hobbies and personal interests are not pursued as there is no time to fulfil their personal needs. Their life becomes controlled by the ADHD child and they become the buffer between the child and everyone else in the world around them. They need opportunities to voice their heartache and their difficulties with coping. If the mother is able to establish a quality relationship with her child, that is to understand him as a unique individual, she will be providing him with the foundation on which to form positive relationships with people, things, God and himself. These relationships can only be formed through involvement, the
attribution of meaning and the subjective experience he has of these relationships. These all lead to the child establishing a positive self-concept and actualizing his full potential.

The present writer feels that the mothers of these children often seem to start doubting their own adequacy. They blame themselves for the child's problems. This generates feelings of negativity as mothers, which often generalize into a negative self-concept.

Clark (1995: 148) felt that Pelser (1987: 37-38) explained it clearly. She maintained that ADHD children with learning problems often experience failure. They perceive themselves as inadequate and they believe that they do not live up to the expectations of family, teachers and peers. They may withdraw and experience feelings of depression, aggression, frustration and anxiety. This behaviour often has a negative effect on the parents who may become depressed, over-protective, angry, overly strict and so on. In Pelser's view such a disharmonious situation can only be improved with professional help. Clark (1995) found that this view was in accordance with that of Kotze (1984: 72) who referred to the "vicious cycle" which negatively influences the parent-child relationship. Clark further cited her as saying that parents frequently used a trial-and-error approach to control their child's behaviour. She stressed that it was the task of the specialist to provide the parents with concrete guidelines to bring about harmony and recommended that a guidance programme be established according to the particular needs of the family.

The School where the writer is employed, caters for the needs of the ADHD children through specialized teaching, but does not seem to meet the needs of the parents. This is partly due to the fact that the children in the school are admitted from a wide feeder area so parents do not meet each other on a social level. A second contributing factor is that there were no extra mural activities (this is at present also under review). This, once again, prevented the parents from coming into contact with other parents. During interviews with parents they all expressed a desire for a support group where they could learn to understand the reason for the children's
behaviour and could become empowered by this knowledge which would help them to accept their children as unique individuals.

Bruten, Richardson and Mangel (1973: 40) acknowledge that parents can take effective action which assures a productive life for their child once they have reached a stage of acceptance. Clark (1995: 149), states that she "...fully recognizes the need for a multi-modal approach which may include medication for hyperkinesis, educational remediation and therapy or support for individuals and/or families," as proposed by Gitterman (1979: 217), Feighner and Feighner (1974: 460) and Baird (1976: 581). Clark (1995) feels that it cannot be stressed enough how very significant the influence of parental feelings on the whole process is considered to be.

4.4.2 Professional Studies

Amerikaner and Omizo (1984) state that there have been many attempts to describe typical patterns characteristic of families with learning disabled children. They cite a number of authors who have commented on this aspect. Kaslow (1979) observes that commonly the mother is extremely close to, or over involved with, the child, while the father plays a distant or detached role. Humphries and Bauman (1980) also suggest that the mothers of learning disabled children are more controlling and authoritarian. Others have concluded that the mothers are erratic, careless, indifferent, and worrisome, (Werner and Smith, 1979) or less encouraging and supportive (Goldman and Barklay, 1974). Amerikaner and Omizo (1984) then conducted a study exploring the relationship of family systems theory in understanding the problems associated with learning disabilities in school children. Their results indicate that the interaction in families with a learning disabled child is significantly different from non problem families. They recommend that plans for effective intervention should include assessment of family functioning and assisting the family to understand and possibly change its interactive style so that it does not
inadvertently exacerbate the child’s problems. From a family systems perspective, the academic problems are seen as interwoven with family interaction.

Guerney (1979) feels that the prevention of secondary adjustment problems at an early stage is extremely important. This should be in conjunction with the therapeutic programmes used to overcome primary problems. Some time for the development of social and emotional needs should be built into the lives of the learning disabled child. She feels that client-centred play therapy is a means of achieving this. It is felt to be of even more value if the parents or other significant adults are the ones to offer the children these special, quality-relationship times. She quotes the following reasons:

- "client-centred play therapists convey the message that the adults care about how the children feel at least as much as how they perform;
- the children receive acceptance sorely needed from people whose opinions are already highly influential in shaping the children’s self-images;
- these significant adults are with the children most of the time and therefore can utilize the positive behaviours and attitudes of the play therapist which can be transferred to real life, for relating to the children on a daily basis."

Clark (1995: 149-150) stresses that the benefits gained by parents, learning disabled children, and entire families, when parents participate and become actively involved in parent support groups is incalculable. Many writers in this field have expressed this need for parents to belong so as not to feel so isolated. The present writer feels that it would be appropriate to combine the work of other writers for the purpose of this study. She employs the group support as a forum for creating awareness of the problem and for the sharing of information which creates a feeling of not ‘being all alone’. Together the group and facilitator explore the various implications of having a learning disabled child. This then is personalized by teaching the parents to conduct play therapy sessions with their children so as to improve the mother-child relationship.
4.4.3 Therapeutic Point of Departure

Clark (1995: 153-154) feels that since the parent-child relationship has a significant influence on the child's becoming, particularly in the formative years, it is considered essential that the parents be helped with their difficult child-rearing task so that an educational climate which is conducive to healthy relationships and optimization of self-actualization can be established. For the purpose of this study the intended method of approach will be through the stages of awareness, exploration and personalization.

4.4.3.1 Awareness

The parents become aware of their attitudes and behaviour towards their ADHD child. In addition, awareness of the way that the ADHD child is experiencing his lifeworld should be highlighted during the process of sharing. An attempt will be made to facilitate awareness of the child's individual needs. These will include the need to express his feelings, the need to be understood and loved unconditionally and accepted as a unique individual. Also, the child has a need to experience success.

4.4.3.2 Exploration

Once the parents have become aware, exploration takes place. This will be done with the aid of facilitation within the group, reading material that will be provided, videos and tapes as well as self-study. Clark (1995: 154) states that self-acceptance as well as acceptance by the group leader and other members lends itself to solving problems in a supportive environment.

4.4.3.3 Personalization

Discussions, demonstrations, role play and the learning and practising of client-
centred play therapy with their children will give the group members the opportunity of personalizing and internalizing the various techniques that will be covered during the programme. Clark (1995: 154) feels that as the parent grows in a more positive way, he or she will become more accepting of the child in need, providing the necessary support and aid so that he or she may optimize the child's educational potential. She cites Kotze (1984: 74) who said that parents must be helped to change or break "...the circular dynamic movement in order to get the total educational dialogue going again."

4.4.4 Method of Research

A qualitative research method will be used. A qualitative researcher according to Schumaker and McMillan (1993) uses an emergent design and makes decisions about the data collection strategies during the study. They go on to say that qualitative researchers become immersed in the situation.

The current investigation consists of a literature as well as an idiographic study, where changes of behaviour in terms of the relationship between mother and child will be brought about as result of the intervention during the process of Filial Therapy.

Van Den Aardweg (1993: 114) defines an idiographic approach as "...an approach which attempts to understand and describe the individual without attempting to generalize such findings to groups. This is a different approach from its contrasting approach, the nomothetic approach which concentrates on groups." Although this study will consist of a group of ten mothers, the growth in each one's individual behaviour will be observed and a qualitative analysis will be made.

Smith (1989: 116) expresses the view that an idiographic study is a scientifically accountable manner in which an effort is made to give direction to an empirical
study, to evaluate the progress made and to accurately demonstrate changes which may take place. In a lecture at Unisa in 1997, Jacobs pointed out that the advantage of carrying out an idiographic study is the personal nature of the findings. However, he stated that the fact that the results could not be generalized to a wider population is somewhat limiting.

The literature study was performed in an effort to empower the facilitator with the knowledge of the ADHD child so as to assist the parents on their path of exploration of this phenomenon. It was also necessary to prepare for the role of facilitator of the parent support group, because the parents would not be seen in isolation but as part as a group. According to Lerner (1993: 168), "Parent support groups offer parents a way to meet regularly in small groups to discuss common problems." She maintains that by meeting in this way, the sense of isolation felt by parents may be reduced and, furthermore, that they may be "...useful in altering the community, school personnel, other professionals and legislative bodies to the plight of their children."

The empowerment will be achieved through the medium of non-directive play therapy, guidance, information and group support. Parents will be taught skills through demonstration, role play and practice. The literature, courses and workshops on client-centred play therapy and Filial Therapy were also ways of empowering the writer so that these concepts could be shared with the parents. She was thus ensured that she was adequately qualified to do play therapy with children, and so could teach the mothers themselves to become better mothers through the numerous strategies available.

The mother-child relationship as the primary relationship had to become personalized by the writer so that the Filial Therapy could be conducted within the Educational Psychological framework.
With regard to the idiographic study, Fox (Griesel 1985: 57) states: "...the basic rationale for the close study is that there are processes and interventions such as aspects of personality and social functioning which cannot be studied except as they interact and operate within the individual. The probability is that if we learn how these processes interact in some individuals, we shall learn all there is to know about them." Schumarker and McMillan (1993: 15) state that the qualitative researchers believe that human actions are strongly influenced by the settings in which they occur. Vosters (1986:71) warns that "...variables over which the researcher has little or no control will inevitably influence the final result." Bearing these inherent weaknesses in mind Clark (1995: 155) believes "...that there is much to be gained from organizing a support group programme for a small group so that intimacy is maintained."

4.4.4.1 Selection of Group Participants

The idiographic study will involve the forming of a support group comprising 10 mothers. These are all mothers that have expressed that they experience difficulty within their relationship with their children as a result of their ADD/ADHD and have a need to improve this. They all had to complete a questionnaire (Appendix B) so as to determine whether or not they were truly experiencing difficulty with the mother-child relationship. The mothers may then be regarded as being self-referred and would typically ally themselves with the counsellor, whereas referred parents tend to present more of a challenge (Briard, 1976: 582-583). They will be empowered to take control of their relationships by allowing the child to lead while they follow, whilst also setting limits and giving the children choices, the consequences of which have to be met.

McWhirter (1977: 173) finds that "...eight to twelve parents constitute an optimal group size allowing opportunity for involvement of everyone and generating enough data for lively discussion." Van Fleet (1994: 57) feels that when Filial Therapy was
used in a group, six to eight parents was ideal, however, Reyhana Ravat (1995) during her lectures, felt that ten to twelve parents worked well. McConkey (1985:191) feels that "...between six and ten is generally the ideal number for a working group. More than ten make it harder for people to contribute effectively....If the numbers fall below six, this may make for difficulties in keeping a discussion group going or in forcing people to talk when there is little they wish to contribute."

The children will all fall in the age range of six to nine years, and be a pupil in grade one, grade two or the bridge class. The bridge class affords struggling children the opportunity of completing the grade one syllabus before gradually beginning with the grade two syllabus. Hereafter they are all promoted to the same grade two class. The teacher continues with the work, where the previous teacher ended off. This results in the junior primary phase being completed over four years instead of the usual three years. The child never experiences an actual failure. The children in the group will all be pupils of the School of Achievement, which caters for children diagnosed as having Attention Deficit Disorder, and as such are learning disabled. The school only accepts children whose intelligence quotients, according to the criteria laid down by the Murray Commission (1969: 24), "...are at least average or normal but who have learning disabilities which retard their progress at school and whose disabilities are severe enough to necessitate the institution of special measures by the educational authorities to alleviate the learning disabilities."

The description of average intelligence levels, according to Madge (1981: 81) is as follows:

<table>
<thead>
<tr>
<th>IQ RANGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>110-119</td>
<td>High Average</td>
</tr>
<tr>
<td>90-109</td>
<td>Average</td>
</tr>
<tr>
<td>80-89</td>
<td>Low Average</td>
</tr>
</tbody>
</table>

Table 27: Madge's Description of Average Intelligence Levels.
4.4.4.2 Time and Duration

The group will meet for two to two and half hours per week over a ten week period. Ten weeks is the recommended period as put forward by Reyhana Ravat (1995). According to Gazda (1968: 48), the duration varies, depending on the degree of behaviour modification required, the frequency of sessions and whether treatment is preventative or remedial, the former requiring less time.

4.4.4.3 The role of the facilitator

The researcher will be the facilitator of the group sessions. However, being a parent, the sister of an ADHD child and the daughter of a mother with an ADHD child, the group leader will not only be a facilitator but someone who is personally involved, and as such will also share in the experiences.

The group will be taught to "play" with their children bearing in mind the following tenets for relating to children (Landreth 1991):

- Children are not miniature adults.
- Children are people.
- Children are unique and worthy of respect.
- Children are resilient.
- Children have an inherent tendency toward growth and maturity.
- Children are capable of self-direction.
- Children's natural language is play.

4.4.4.4 Therapeutic programme

A programme will be followed, within a supportive environment in an attempt to
accommodate the specific needs of these mothers as established through the analysis of responses to the initial questionnaire (Appendix B), adapted from Clark (1995). Roth and Weller (1985: 487-495) recommend that parents needs should be evaluated prior to their referral to join a particular programme. Bloomquist's Rating of Self, Family, and Child in Ten Areas of Focus will be completed in the initial session (Appendix E). The ten areas of focus are:

☐ Parents' stress.
☐ Parents' thoughts.
☐ Parental involvement and positive reinforcement.
☐ Family interactions.
☐ Discipline related to compliance and rule following in children.
☐ Children's social behaviour skills.
☐ Children's social and general problem-solving skills.
☐ Children's ability to cope with anger.
☐ Children's ability to engage in self-directed academic behaviours.

The rating scale consists of a variety of descriptions, thoughts and behaviours that may describe the parent, the family and / or the child. Each sentence has to be read and then is rated on a five point scale depending on whether or not the parent agrees with sentence.

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree

Table 28: Bloomquist's Rating Scale.

The areas with higher total scores may indicate problem areas for the parent,
family, and I or child. The items rated with a 3, 4, or 5 may indicate specific problems.

It is hoped that the parents will be empowered with knowledge and understanding so that acceptance of the child's handicap is promoted and the mother-child relationship is enhanced. The mothers can then learn to listen to and understand the needs of their child, reducing the guilt that they all seem to experience because of the problems that their child is experiencing.

Porter (1954: 176-182) sees acceptance of the child as one of the essential elements in the parent-child relationship. In his opinion, parental acceptance is defined as "...feeling and behaviour on the part of parents which are characterized by unconditional love for the child, a recognition of the child as a person with feelings who has a right and a need to express those feelings, a value for the unique make-up of the child and a recognition of the child's need to differentiate and separate himself from his parents in order that he may become an autonomous individual."

Porter developed a scale to measure acceptance which requires parents to rate themselves on a self-inventory type questionnaire with regard to their feelings and the actions they take in their relationship with their child (Appendix D). Responses are selected from five multiple-choice responses which follow each of 40 items. They are scored according to a scoring key. Items are weighted from one to five, with one representing low acceptance and five representing high acceptance. The higher the total acceptance score, the more accepting the parent is considered to be. The possible range of scores is from 40 to 200 (1954: 1-2).

Parents are classified by scores into groups which reflect high, middle and low acceptance as follows:

<table>
<thead>
<tr>
<th>HIGH</th>
<th>MIDDLE</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>159 - 187</td>
<td>130 - 157</td>
<td>87 - 129</td>
</tr>
</tbody>
</table>

Table 29: Porter's Acceptance Scale.
In selecting the sample, Porter drew heavily from middle and upper middle-class levels of occupation, income and education within the United States of America (1954: 180-181). Thus the scale has not been standardised for the South African population. Nevertheless, findings of the questionnaires seem to provide valuable insight into acceptance levels. The acceptance scale will be administered during the introduction and termination sessions. While the questionnaires will be analysed qualitatively, the acceptance scale will possibly provide more objective results.

Effectiveness of the programme will be evaluated by the quantitative analysis of the responses of parents to a second questionnaire adapted from that designed by Clark (1995), (Appendix E), which they will be requested to complete at the end of the 10 week period. Questionnaires, (Appendix D and E), will be repeated three months after the group has terminated in order to assess whether or not the changes in maternal acceptance and the relationship with their ADD / ADHD children have been maintained.

4.4.4.5 Procedures

The following procedures will be adopted:

☐ The headmistress of the Germiston, School of Achievement will be approached for permission to invite certain parents to participate in the programme. The Governing Body of the school had expressed the need for parent support groups at the school as the parents were felt to be floundering and in need of support. Since the school is a remedial school, the children enrolled will already have been diagnosed as having a learning disability, or ADD / ADHD.
A number of parents, who specifically expressed a need for assistance in handling their children will be invited by means of a telephonic interview. During the interview the process of Filial Therapy will be explained. An indication of specific times for meetings which will or will not suit them will be requested.

This will be followed by a letter thanking them in advance for their participation and containing a brief explanation of what is to be expected of them during the ten week period. They will be informed of the time decided upon and the date of commencement of the meetings.

Data regarding the children concerned will be obtained in order to allow the facilitator the opportunity of preparing for possible problems with which the parents may be faced. The children will all be seen by the facilitator in order to provide her with the opportunity of establishing rapport with each one of them.

Topics for the group sessions will follow the programme as provided by Reyhana Ravat (1995) but will be supplemented by the specific needs of the parents who participate, as established in the initial session. Towle (1980: 166) confirms that when goals and topics are aimed at parental needs, attendance is usually good.

Lehner (1993: 5) cautions that the needs of parents differ according to the length of time they have been aware of the child's difficulties and the age of the child. This will be taken into account when parents are selected and topics decided upon.

With regard to the selection of meeting format, Towle (1980:166) feels that the format chosen must appeal to the participants. For the purpose of this study, the following format will be adopted:

- Tea and informal chat. Each mother will be given the opportunity to provide refreshments. This will be arranged by one of the mothers.
- Feedback or debriefing and review of homework.
Information will be presented to the parents by the facilitator.

Demonstration or video, highlighting the different techniques.

OR

Video or play therapy demonstrated by one of the parents. Each parent will have an opportunity to demonstrate one therapy session with their child.

Home activities will be given.

Useful books will be recommended. The mothers will be encouraged to read and share any interesting information that they may have come across in articles, or books. One mother will be placed in charge of the miniature library.

Closing of meetings.

Permission will be obtained from the members to tape record each session, leaving the facilitator available to note non-verbal reactions and concentrate on group dynamics. The parents will be encouraged to interrupt the facilitator at any time with questions, advice or to share personal experiences. Turner and Macy (1980: 281) stress that parents must be accepted in a co-operative manner and stress that their knowledge and skills should be drawn on for the benefit of other parents.

4.4.4.6 Venue

Meetings will be held at a venue in the school. This will be in a suitable area where disturbing influences will be minimized. The participants will be seated on comfortable chairs arranged around a large table, where everyone can see and hear everyone else since it is important that each person should be encouraged to participate and become personally involved in each session.
4.5 CONCLUSION

The literature study conducted in the previous chapters has led the present investigator to conclude that the mothers are experiencing difficulty with accepting that their child has a problem. They often have feelings of guilt and inadequacy which impinges on the primary relationship formed with the child. As a result of the difficulty the ADHD child has with attributing meaning to his various experiences on his road to relationship formation it is even more essential that he forms positive relationships with parents, other adults, peers, objects, self and God to enable positive concept formation, essential for self-actualization. The mothers need to be involved in the overall treatment plan so that they can become empowered and can enjoy their special child in his uniqueness.

The urgency with which intervention should take place once ADHD is suspected is reflected in the view of Martin and Maertens (1986: 191) who say "... the earlier intervention and treatment can begin, the greater the child's chance of learning how to overcome or compensate for these problems and become successful in learning to interact with others."

Clark (1995:165) stresses the importance of professionals in the field of education assisting parents to obtain information and support. The present investigator using Filial Therapy, education principles within the Relations theory, and information on the ADHD child, has devised a plan to address these needs. The following chapter will be devoted to the idiographic research as outlined in this chapter.
CHAPTER 5

THE IDIOGRAPHIC STUDY

5.1 INTRODUCTION

The empirical study which took the form of an idiographic study, as outlined in the previous chapter, will be addressed in this chapter. This has been built up from the literature study in chapters two and three. Reference will be made to these chapters during the group sessions.

Guerney (1979: 242) feels that it is common for children with learning disabilities to experience secondary emotional problems. These children usually present with a history of poor performance, inadequate judgement and impatience. Their parents are always acting as a buffer between their children and the environment. She felt that parents, teachers and children learn to function on a very low trust level. The children soon learn to feel that they are not worthy. The present writer feels that the mothers start to have these same feelings of inadequacy and begin to feel very isolated.

Guerney (1979: 242) emphasizes that the prevention of secondary adjustment problems at an early stage is extremely important. It is essential that, along with the intensive programmes designed to overcome the primary problem, some time should be spent on the social and emotional needs and that this should be built into the lives of these children. She went on to say that Filial Therapy or as it is also called Child Relationship Enhancement Family Therapy (CREFT) is of particular value as it offers the parents, the opportunity to offer their children these special, quality-relationship times. She states the following reasons:
a) client-centred play therapist behaviours convey the message that the adults care about how the children feel at least as much as how they perform.
b) the children receive acceptance sorely needed from people whose opinion is already highly influential in shaping the children's self-images.
c) these significant adults are with the children most of the time and therefore can best utilize the positive behaviours and attitudes of the play therapist, which can be transferred to real-life, for relating to the children on a daily basis.

Using this philosophy as the foundation, a programme will be planned taking into account the special needs of the parents. This will be superimposed on the University of South Africa's Relations Model as described in the literature study, in an effort to create awareness and provide opportunities for exploration thus so ensuring personalisation in this "hands on" approach.

5.2 METHOD OF RESEARCH

The method of research, as previously outlined will now be discussed as it occurred during the Filial Therapy group sessions.

5.2.1 Selection of Group Participants

The mothers that were selected were all mothers who had expressed a need for counselling to assist them in managing their children. They all seemed genuinely concerned about the needs of their children and were willing to make sacrifices in their normal routine to enable them to attend the group sessions and carry out the relevant homework. They were all very enthusiastic to enter the programme. Many of them were working mothers and had to arrange for leave from work.
Ten parents agreed to participate. Nine of them have children, who are pupils at the School of Achievement. The tenth was a pupil at Protea School, which is a sister school. Originally it was planned to use only mothers whose children attended the School of Achievement, however, the mother of child G appeared to be desperately in need of help. She has applied to have her child transferred to School Of Achievement as he has a serious behaviour problem which manifests as verbal and physical aggression. He also has poor social skills. She was very pleased to be allowed to join the group.

The children all have intelligence quotients which, according to Madge (1981:81), fall in the average intellectual range. Eight of the pupils are boys, and two are girls.

Originally only pupils in Grade i, Grade ii/iii and Grade ii were considered for the group. However, the mother of Child I, a teacher at the school, expressed the desire to join the group, so she too became a member even though her child is already in Grade iii, at the School of Achievement.

CHILD A (Male)

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<tr>
<th>Date of Birth</th>
<th>1989-07-05</th>
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<tbody>
<tr>
<td>Position in Family</td>
<td>Youngest of three</td>
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<tr>
<td>Status of Parents</td>
<td>Biological Mother and Stepfather</td>
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<tr>
<td>Standard</td>
<td>Grade ii</td>
</tr>
<tr>
<td>IQ</td>
<td>JSAIS 1996 - Average</td>
</tr>
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</table>

Discrepancy between Verbal and Performance Scores: 18 points in favour of the performance skills

Interest Scatter:
- 9 for Picture Riddles
- 15 for Form Board

Medication: No medication

Diagnosis: ADD
**CHILD B (Male)**

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<tbody>
<tr>
<td>Date of Birth</td>
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<tr>
<td>Position in Family</td>
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<tr>
<td>Status of Parents</td>
<td>Single Mother</td>
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<td></td>
<td>No knowledge of Father</td>
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<td>Standard</td>
<td>Grade ii</td>
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<tr>
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<td>JSAIS 1995 - Average</td>
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<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>Actual scores were not available from his report.</td>
</tr>
<tr>
<td>Interest Scatter</td>
<td>7 for Word Association</td>
</tr>
<tr>
<td></td>
<td>15 for Form Board</td>
</tr>
<tr>
<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD with Tics</td>
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</tbody>
</table>

**CHILD C (Female)**

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<tbody>
<tr>
<td>Date of Birth</td>
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<td>Position in Family</td>
<td>Younger of two</td>
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<tr>
<td>Status of Parents</td>
<td>Biological Mother and Biological Father</td>
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<tr>
<td>Grade</td>
<td>Grade ii</td>
</tr>
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<td>JSAIS 1996 - Average</td>
</tr>
<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>27 points in favour of the performance skills</td>
</tr>
<tr>
<td>Interest Scatter</td>
<td>5 for Number Problems.</td>
</tr>
<tr>
<td></td>
<td>18 for Pattern Completion.</td>
</tr>
<tr>
<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD</td>
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**CHILD D (Male)**

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<tr>
<td>Position in Family</td>
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<tr>
<td>Status of Parents</td>
<td>Biological Mother and Biological Father</td>
</tr>
<tr>
<td>Grade</td>
<td>Grade i</td>
</tr>
<tr>
<td>IQ</td>
<td>JSAIS 1997 - Average</td>
</tr>
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<td>Discrepancy between Verbal and Performance Scores</td>
<td>29 points in favour of the performance skills</td>
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<tr>
<td>Interest Scatter</td>
<td>6 for Vocabulary, 16 for Block Design</td>
</tr>
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<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD with Tics</td>
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**CHILD E (Male)**

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<th>Date of Birth</th>
<th>1988-11-29</th>
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</thead>
<tbody>
<tr>
<td>Position in Family</td>
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<tr>
<td>Status of Parents</td>
<td>Biological Mother and Biological Father</td>
</tr>
<tr>
<td>Standard</td>
<td>Grade ii</td>
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<td>IQ</td>
<td>SSAIS-R 1997 - Average</td>
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<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>11 points in favour of the verbal skills</td>
</tr>
<tr>
<td>Interest Scatter</td>
<td>1 for Coding, 15 for Vocabulary</td>
</tr>
<tr>
<td>Medication</td>
<td>Respidol</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADD with Hypoactivity</td>
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### CHILD F (Male)

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<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<tbody>
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<td>Date of Birth</td>
<td>1990-10-02</td>
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<tr>
<td>Position in Family</td>
<td>Youngest of three</td>
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<tr>
<td>Status of Parents</td>
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<td>Grade</td>
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<td>IQ</td>
<td>JSAIS 1996 - Average</td>
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<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>10 points in favour of the verbal skills</td>
</tr>
<tr>
<td>Interest Scatter</td>
<td>7 for Memory for Digits</td>
</tr>
<tr>
<td></td>
<td>15 for Vocabulary</td>
</tr>
<tr>
<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD</td>
</tr>
</tbody>
</table>

### CHILD G (Male) attending sister school

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>1990-03-14</td>
</tr>
<tr>
<td>Position in Family</td>
<td>Middle of three (older step-sister, younger biological sister)</td>
</tr>
<tr>
<td>Status of Parents</td>
<td>Biological Mother and Biological Father</td>
</tr>
<tr>
<td>Grade</td>
<td>Grade i</td>
</tr>
<tr>
<td>IQ</td>
<td>Average</td>
</tr>
<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>Non-significant difference in favour of the verbal skills.</td>
</tr>
<tr>
<td>Medication</td>
<td>Fluoxan, Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD with Tics</td>
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</tbody>
</table>
### CHILD H (Male)

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Date of Birth</td>
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<tr>
<td>Position in Family</td>
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<td>Status of Parents</td>
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<td>Grade</td>
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<td>IQ:</td>
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<td>Discrepancy between Verbal and Performance Scores</td>
<td>7 points in favour of the non-verbal</td>
</tr>
<tr>
<td>Interest Scatter:</td>
<td>8 for Ready knowledge and Absurdities B, 14 for Form Board</td>
</tr>
<tr>
<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADD</td>
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### CHILD I (Female)

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<td>Date of Birth</td>
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<td>Grade</td>
<td>Grade iii</td>
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<td>1 point</td>
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<tr>
<td>Interest Scatter</td>
<td>4 for Picture Riddles, 11 for Vocabulary</td>
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<tr>
<td>Medication</td>
<td>Ritalin</td>
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<td>Diagnosis</td>
<td>ADD with Hypoactivity</td>
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**CHILD J (Male)**

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<th>Date of Birth</th>
<th>90-07-26</th>
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<tr>
<td>Position in Family</td>
<td>Older of two</td>
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<tr>
<td>Status of Parents</td>
<td>Biological Mother and Biological Father</td>
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<td>Grade</td>
<td>Grade i/ii Bridge</td>
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<td>IQ</td>
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<tr>
<td>Discrepancy between Verbal and Performance Scores</td>
<td>3 points</td>
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<td>Interest Scatter</td>
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<td>Medication</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ADHD</td>
</tr>
</tbody>
</table>

### 5.2.2 Time and Duration

The meetings took place on Friday mornings over a ten week period. Each meeting lasted between two and two and a half hours.

Ravat (1995) based on the work of the Therapists at the Centre for Play Therapy at the University of Texas, feels that the Filial Therapy programme lends itself to a ten week programme. The present researcher did warn the parents that it might take longer as additional information was being imparted and if the need arose the programme would be extended to accommodate all of the important issues. However, this was not necessary as all the relevant issues were handled within the estimated time. It was decided during the course of the programme that monthly follow up meetings would be scheduled.

### 5.2.3 Time Schedule

- 11:30   Tea and informal chat
- 11:45   Feedback on home activities
12:15 Facilitator presents information, role play or demonstration.
13:00 Parents participate in discussion, and later actually take turns demonstrating play therapy with their children.
13:25 Feedback and discussion on this.
13:40 Rule of Thumb. This was taken directly from Ravat's (1995) Filial Therapy lecture.
13:45 Integration and home activities.
14:00 Close Session.

This time schedule was followed as closely as possible.

5.2.4 Venue

The meetings were held at the school, in a suitable facility. An overhead projector, television, video machine and flip chart were all readily accessible. The school was considered to be centrally positioned, which was suitable for all the mothers. The children were readily available to participate in play therapy sessions. These were conducted in a play room where the parents were able to observe the sessions through a one-way mirror. The parents and children were pleased that the opportunity was provided for the children to travel home with their parents at the end of the day, instead of having to make use of the school transport.

The venues chosen were adequate. However, a disadvantage was the noise level: the children speaking and walking in the corridor could be heard and there were often interruptions from the intercom.

5.2.5 The Role of the Facilitator

The researcher was the facilitator of the group sessions. However, being a parent, the sister of an ADHD child and the daughter of a mother with an ADHD child, made
for the group leader being not only a facilitator but someone who was personally involved, and as such also shared in the experiences. The researcher has also worked with ADD and ADHD children for the last fifteen years. Initially she worked in the capacity of a speech therapist and is presently employed at the School of Achievement as an intern psychologist, which has resulted in a professional and personal understanding of these children and their parents.

McConkey (1985: 193-194) comments on the fact that there has been much research into the relative effectiveness of either a democratic or an authoritarian style of leadership. He feels that parent groups led by a teacher or a therapist inevitably require a balance of both. He goes on to say that the parents expected such a leader to be an authority by virtue of the special knowledge and possessed skills. At times the leader is also expected to give guidance on solving problems. McConkey (1985) cautions that if this authoritarian role is taken on exclusively it can inhibit the parents' confidence in themselves and of learning from each other. He stresses the importance of finding the balance.

The researcher tried to follow this advice of McConkey. Initially the role was very much that of a professional authority as the mothers were being given information and were being taught skills. During the feedback and discussion times they were encouraged to ask each other questions and to give suggestions.

The researcher provided the mothers with notes on all the aspects that were covered in each session. These were bound after the ten weeks. This resulted in each parent having a workbook that could be used for future reference.

5.2.6 The Group Filial Therapy Programme

The Filial Therapy programme, as presented in this research, was originally developed by Gareth Landreth. Much of the information was adapted from the work of Louise Guerney, Ph.D. Sue Bratton and Reyhana Ravat adapted and refined the
Filial Therapy, and it is their programme that was used as the foundation for this study. The researcher attended courses presented by Gareth Landreth, Sue Bratton and Reyhana Ravat. Diploma's were issued on completion of the courses. Permission was granted to use the programme and any of the handouts that were received during the training course.

The investigator has also borrowed extensively from the following works: University of South Africa's Relations Theory, Gestalt Theory and Techniques, Gordon's Parent Effectiveness Training, M. Van Niekerk's Parent Enrichment Course (An adaptation of STEP) (1990), and the study of Clark (1995). The investigator also incorporated into the programme the information presented in the literature study. Other interesting articles, poems and quotations were given to add interest to the groups. A "Rule of Thumb" (Ravat, 1995), was also given each week as this provided the parents with something that was easy to remember and very relevant.

The specific and indirect aims have been recorded in chapter one and four. These were kept in mind when planning and facilitating the groups. As issues arose these were included in subsequent sessions. The specific goals of each session will be included in the following detailed description of each session. The handouts distributed during each session will be included in Appendix F and indexed according to the session in which they were used. Most of these handouts were the ones received from Ravat (1995), during the training course attended by the facilitator. Ravat (1995) received them from Landreth (1991) and Bratton (1997) during her training. Ravat (1995) was used as the reference even though she received the handouts from other writers.

### 5.2.6.1 Session One

**Goals**

- To become acquainted.
To create a safe atmosphere where confidentiality can be established.
To organise practical aspects and establish rules.
To give the mothers a chance to share their feelings.
To explain the aim of the group and briefly introduce the concept of Filial Therapy, child-centred play therapy and reflective listening.
To provide a "Rule of Thumb."

1. Introduction

The session began with tea and refreshments provided by the facilitator and an informal chat.

The facilitator provided each member with a name tag. This was in the shape of a heart because Filial Therapy represents feelings and emotions and comes from the heart.

As an ice breaker each member was presented with a balloon. They were requested to blow up their balloons and to divide into groups of two. They were requested to play with their balloons initially without any communication and thereafter they were allowed to communicate. This was to make contact with their inner child and to note the importance of communication (Bratton 1997).

The facilitator then read Kahil Gibran's "Speak to us of Children" (Appendix F, session 1:5). She then welcomed everyone and introduced herself and explained the reasons of the study. Members were encouraged to participate fully and to create an atmosphere in which they would feel comfortable. The importance of confidentiality was discussed as this would allow for the sharing of difficulties and advice.

Each mother was asked to draw her family: each member had to be depicted as an animal. Each mother then had to describe her drawing and why she had represented her family as she had. The child who would be included in the Filial Therapy programme had to be identified. At this stage, each mother had to talk
about the first time that she was confronted with the fact that her child had a problem and to discuss her feelings at the time.

Practical aspects were given consideration. Each member was asked to commit herself to the ten week period and to be punctual for meetings. One of the mothers was asked to volunteer as convener. It was her responsibility to arrange for refreshments for each session, and to obtain and circulate a list of the members names, addresses, telephone numbers and birth dates. A second volunteer was needed for the library of reference books that had been provided and a third mother was made responsible for the tape library.

2.  **The presentation of information**

a)  Definition of Filial Therapy:

Below follows a definition of Filial Therapy and some technical terms which were included merely to serve as an introduction. The mothers were assured that these would all become clear as the programme progressed.

Filial Therapy is a means of strengthening parent-child relationships through play, this will be done from an Educational Psychological perspective.

The aims of Filial Therapy are:

- The establishing of an educative or pedagogic climate through knowledge, care, love, respect, trust and honesty, which would lead to acceptance of the child as a totality and not as a child with a problem.
- Improving relationships.
- Understanding and giving meaning to the lifeworld of the child.
These are the presuppositions, which together with the attribution of meaning, experience, involvement and self-actualisation form the foundation whereupon the intra psychic structure, namely, "I", "Self", "Identity", and "Self-concept" rest. The intra psychic mutual interaction of these components is responsible for the person's eventual behaviour or self-actualisation. The mothers will be taught the necessary skills through demonstration, role play and practice.

The following expectations were conveyed to the group:

- Each one would have to be prepared to spend one half-hour play session with her child every week.
- Each mother would have to tape one play session at home, for replaying in the group. Alternately she would be permitted to use the playroom to demonstrate her session with her child. Everyone opted for the second choice.
- Demonstration of client-centred play therapy would be provided by the facilitator before the mothers would be expected to commence with their own sessions.
- It was stressed that patience is important in learning anything new.

b) Introduction to play therapy:

1. The meaning of play was very briefly discussed and the following points were highlighted:

   - Play is the child's means of expressing himself: his toys are the words and his play is the language.
   - Play is based on actions not words.
   - Play is a way of preventing problems because adults become aware of their child's needs.

2. The mothers were assured that the techniques from play therapy would achieve the following:
Return control to them.
Provide closer happier times with their child.
Give a key to their child's inner world.
After ten weeks they were going to perceive their relationship with their child as different.

c) Video tape of child's emotions.

This was a ten minute video, bought from Reyhana Ravat (1995), in which an experiment was carried out with very young babies. The typical parental reactions, of smiling and gurgling in response to the babies' attempts at interaction was withdrawn. The babies eventually stopped trying to initiate an interaction. They also stopped smiling and gurgling. This was used to illustrate the importance of total communication. It was stressed that as mothers of babies, we could all differentiate the different crying patterns and could anticipate their every need. As verbal communication increased so we stopped responding as much to the total communication patterns. This then served as an introduction to reflective listening.

d) Reflective listening:

This was described as being:

- A way of following rather than leading, that is of taking the child's needs into consideration.
- A time when questions are to be avoided as they inhibit the child's ability to lead and often put the child on the defensive.
- A way of reflecting or verbalising behaviour patterns and feelings.

The responses made by parents should stress that:

- I am here; I hear you.
- I understand.
- I care.
The responses should not stress that:

☐ I always agree.
☐ I must make you happy.
☐ I will solve your problems (Table 5).

3. **Demonstration of Play Therapy by The Facilitator**

One of the children (whose mother was in the group) was chosen to come for play therapy. The demonstration lasted 15 minutes, and was followed by a discussion. The facilitator pointed out what had been happening. She stressed the importance of a therapist sitting on a conveniently placed small chair so that the child could be observed at all times. Ravat (1995) states that, as a therapist, it is important to do this as the floor is the child's space. The facilitator felt that as, parents, they could do what was comfortable for them.

4. **Rule of Thumb:** "You Can't Give Away What You Do Not Possess" (Ravat, 1995).

This was explained as follows:

As mothers we may be coming to the sessions deeply aware of our perceived failures. Yet we cannot effectively enter this process by being impatient and unaccepting toward ourselves while trying to extend patience and acceptance to our child.

5. **Closure of Session**

   a) Integration
The facilitator provided a short summary of the session. The parents were encouraged to phone each other or the facilitator if there was anything that they were uncertain of.

Each one had to give a quick summary of what they were taking home from the session, that is, they had to tell everyone what they had found the most relevant.

b) Homework:

- Each mother was to bring a cute photo of her child to the following meeting.
- They were to notice some physical characteristic about their child that they had not seen before.
- They had to complete the questionnaires and rating forms (Appendix B, C, D).

- The following reading for the week was handed out:
  - "What is a child" (Ravat, 1995; Appendix F, session 1:1)
  - "Listening" (Ravat, 1995; Appendix F, session 1:2).

- Copies of
  - *How to really Love your Child* by Campbell, R. (1997) were made available for reading.

- They had to practise reflective listening using the hand-out of "Four Basic Feelings" (Ravat, 1995; Appendix F, session, 1:3).
The session closed with the reading of "A New Day" (Appendix F, session 1:4). It was explained that this was like a new day as they were starting afresh. They were not to dwell on past mistakes.

**Overview of Session One**

The mothers were initially very reserved as they did not know each other, nevertheless they were enthusiastic. They were already beginning to establish rapport as a result of the many tears and laughs that were shared.

The balloon activity was enjoyed and this resulted in easy laughter. The symbolic (animal) family drawings also caused some mirth. This proved to be a good way of introducing the family and establishing some idea of the family dynamics.

The foundation was laid for the following sessions. The video was enjoyed and provoked much comment. All were grateful for the opportunity to share and felt relieved that they were not alone.

### 5.2.6.2 Session Two

**Goals**

- To foster an awareness in the mothers of their children through observation, which lays the foundation for reflective listening.
- To lessen the mothers’ feelings of anxiety through understanding the process of acceptance.
- To introduce some of the terminology that will be used in terms of Unisa's Relations Theory Model and correlate this with the tenets for play therapy.
1. **Introduction**

The session began with tea, refreshments and a friendly chat. During this time the facilitator read "Believe You Can" (Appendix F session 2:1). The focus was then on feedback of homework activities and the collection of the questionnaires.

A discussion of the photos brought by the mothers and the observed physical characteristics of the children in the photos, started the session. The mothers displayed great love for their children. They were all surprised that they had been able to observe a physical characteristic that they had not previously been aware of.

The completed handout of the "Four Basic Feelings"(Appendix F, session 1:3) was discussed. They were encouraged to give each other feedback, as to the best response in terms of reflecting feeling.

2. **The Presentation of Information**

a) Typical phases of acceptance

The various phases of parental reactions as put forward by Gargiulo (1985:22-37) were discussed. The full description appears in Chapter three of this study.

b) Discussion of terminology

The following aspects of Unisa's Relationship Theory were explained. Behaviour was described as being the outcome of the interaction between experience, involvement, attribution of meaning and the self-concept. This was explained in detail in chapter two.
3. **Live Demonstration in Play Room**

The facilitator, having obtained the permission from two parents, demonstrated therapy with their children in the play room, while they observed behind the one-way mirror. The fact that the child led was emphasized. It was also pointed out that the toys and games should never be labelled, as this was directing the child's play and not allowing for fantasy to be stimulated.

4. **Tour of Playroom**

- All the toys were shown and an explanation as to the use of the various toys was given.
- The mothers paired off and had to engage in role play to practise reflective responding. They were encouraged to track what they saw and heard. No asking of questions was allowed. The importance of the tone of voice was stressed. They then swapped partners.
- This activity ended with the giving of feedback to each other.

5. **Rule of Thumb:** "When A Child is Drowning Don't Try to Teach Him to Swim" (Ravat, 1995).

If a child is feeling upset, that is not the moment to impart a rule or value.

6. **Closure of Session**

a) Integration

The following aspects were stressed:

- Children have needs and they will do whatever they can to have their needs met.
The children should be encouraged to become involved in new experiences. The techniques taught may initially only be used during the scheduled thirty minutes playtime.

The concept of Filial Therapy was to be introduced to the children in the following way: "I'm going to a special class to learn how to play with you. The teacher told me to get the toys on this list. Let's see what we can find and then we'll buy the rest."

They were only to buy what was on the list. These toys should only be played with during their special play time.

It was suggested, that if at all possible, the mothers should try to have a play session with the other siblings as well so as to prevent resentment of the ADD child, who already receives a great deal of attention. They all thought that this was a good idea.

The fact that patience was necessary when learning a new technique was again emphasized. The mothers were learning to communicate in a more effective way with their children.

Each one had to sum up something that they would be taking home from the session.

b) Homework

The following handouts were distributed for reading during the week:

- "Believe You Can" (Appendix F, session 2:1)
- "What children learn in play therapy" (Table 4).
- "Tenets for relating to Children" (Table 15).
- "Eight Basic Principles of Child-Centred Play Therapy" (Table 14).
- "Constructing Therapeutic Responses in Play Therapy" (Ravat, 1995; Appendix F, session 2: 2).
- "Child-Parent-Relationship-Training" (Ravat, 1995; Appendix F, session 2: 3).
- "Toys and Materials" (Table 11).
- "List of toys to start selecting and buying" (Table 10).
Copies of:

- *The Hidden Handicap. How to help children who suffer from dyslexia, hyperactivity and learning difficulties* by Serfontein, G. (1990) were made available for the mothers to read.

- Complete "Facilitating Reflective Communication" (Ravat, 1995; Appendix F, session 2:4).

- Pick out time and place for sessions - report back next week. It may not be the child's room and timers are forbidden.

- Make a "Do not Disturb" sign together and give your child a "special play time" appointment card and complete "The Contract" (Ravat, 1995; Appendix F, session 2:5).

- Keep a journal of all your feelings and experiences.

- Start collecting and buying toys for special play sessions.

**Overview of Session Two**

The group appeared to be moving into an easier phase as many of the issues of expectations and guidelines had been settled. The facilitator was still the undisputed leader as she was still perceived as the professional, who was there to impart knowledge and teach skills. There were still some uncomfortable feelings. Some of the members were still very quiet and reticent to share information.
A great deal of information was once again imparted by the facilitator. This was necessary as it was the precursor to the actual play sessions. The stages of acceptance resulted in a great deal of discussion: various mothers were in various stages of acceptance. Some very intense feelings were shared, initially with a great deal of embarrassment.

The demonstration and role play activities were greatly enjoyed. The mothers were surprised at what resulted as an outcome of being non-directive. The two children chosen for this session were very different: the one was quiet and unsure of the situation and kept looking to the facilitator for guidance; the other child was very verbal and darted from one activity to the other. Both of them thoroughly enjoyed the session. The parents were warned not to over interpret information but merely to follow where the child was going.

Some insecurity as to being able to do play therapy was also expressed. They had to be reassured that the most important aspect of the play therapy was the quality time that they would be spending with their children. They had to try to enjoy the play and not be frightened of it.

The list of toys also caused much discussion, especially the feeding bottles and dummies. All were eager to get started and to do all the necessary homework. A bond was developing amongst the group members. The facilitator praised the mothers for sharing their feelings.

5.2.6.3 Session Three

Goals

☐ To provide information on ADD / ADHD so as to lead to a better understanding of their children.
☐ To start preparing for the play sessions.
1. **Introduction**

The session started with tea, refreshments and a friendly chat. The homework was reviewed. They had all bought most of the toys. A "Do Not Disturb" sign had been made, and an appointment card had been given to each of the children. A time and place for play sessions had been chosen. The children were reported to be all be very excited.

The handouts on facilitating reflective communication were discussed. This was done as a sharing activity and all the mothers were encouraged to comment on the various responses. By the end of this discussion they all seemed to understand the concept.

2. **The Presentation of Information:**

Information on ADD / ADHD was presented, (Tables 18, 19, 20, 21, 22, 23, 24, 25). The mothers were encouraged to comment, relate personal experiences and ask questions throughout the presentation. This was presented in great detail, as described in chapter three of this study. This information was related by means of the flow chart (Figure 5) showing the progression of a child who manifested with underachievement and/or behaviour problems which result in his developing poor self-esteem and eventual emotional problems, because of his inefficient manner of becoming involved, the concomitant experiences and the eventual attributing of meaning, as described during the previous session. Children like this usually also present with specific learning problems.

Each mother was given the workbook compiled by Marita Brink on "How to cope with a learning difference." They were also provided with the first of the quarterly bulletins that are compiled and edited by Linda MacFarlane and the Psychology
Department of the School of Achievement. This bulletin deals with various aspects of ADD.

3. **Working Phase**

a) The following handouts adapted from Guerney and presented by Ravat (1995) were discussed in the group.

- Tables 12 and 13 were discussed.
- Pictorial representation of feelings (Life-Line, 1997; Appendix F, session 3:1).
- "Basic rules for Filial Therapy" (Ravat, 1995; Appendix F, session 3:2).
- "Rules for play session" (Ravat, 1995; Appendix F, session 3:3).
- "Setting of Limits" (Tables 6,7,8).
- "Techniques Of Limit Setting" (Ravat, 1995; Appendix F, session 3:4) was discussed in great detail, emphasizing the following:

  - ACT
  - ACKNOWLEDGE FEELING
  - COMMUNICATE LIMIT
  - TARGET ALTERNATIVES

Once the limit was set they were to be very firm and ensure that it was adhered to, or that the consequences were accepted.

b) "Empathic grunts" - Umm / Ohh / Ahh were explained and how important these were to show that you were still with the child. This is an important aspect of reflective communication.

3. **Live demonstration with two of the children.**

The facilitator again demonstrated play therapy, using two of the other children for fifteen minutes each.
4. **Role play:**

The mothers had to again reflect content but also practise the setting of limits during the role play.

5. **Rule of Thumb:** Be A Thermostat, Not A Thermometer (Ravat, 1995).

Reflecting feeling as opposed to merely reacting to feeling creates an environment that is comfortable and accepting.

6. **Closure of Session**

a) **Integration**

Each one had to summarise what they learnt during the session.

The facilitator summarised the session, stressing the importance of limits and reflective listening.

b) **Homework**

- Review handouts that were given out during the session. It was suggested that the mothers should discuss each session with her spouse so that he might also reach a better understanding of their child.

- The play sessions at home were to begin. The appointed time and place should be strictly adhered to. The parents were advised to focus initially on the content of the play. The new concepts learnt should only be practised during the 30 minute play period.
One volunteer was requested to demonstrate play therapy with her child the following week.

**Overview of Session Three**

The mothers all expressed having a better understanding of their children's problems. They realised that they were not the cause of their children's behaviour problems. This seemed to negate some of the guilt feelings. It seemed that they had a real need to share some of the embarrassing behaviours that their children manifested. The feelings of isolation and rejection by family and friends was also a strongly shared experience. These strongly shared feelings of trust, care, knowledge and acceptance were creating an educative climate.

Generally the mothers seemed to feel that their husbands would really benefit from this type of interaction. The facilitator said that this would be followed up and a fathers' group would be initiated.

The need for more knowledge about the use of medication and especially Ritalin was expressed. The facilitator indicated that information regarding this would be presented during the following session.

There was a general feeling of excitement tinged with apprehension about starting the play sessions.

**5.2.6.4 Session Four**

**Goals**

- To provide information on medication.
- Total commitment and involvement in the play therapy.
- Feedback and sharing of information.
1. *Introduction*

The session began with tea, refreshments and a friendly chat. This was followed by a debriefing as to how the mothers found the play sessions. They provided feedback for each other and shared common experiences. The facilitator used their examples to illustrate the rules of Filial Therapy. Reinforcement was provided by the facilitator on the progress they had made. They all appeared to be more attuned to the feelings that their children were expressing.

Limit setting was again discussed and they were asked to give experiential examples. The concept of choices was emphasized, using the Oreo Cookie story, described by Ravat (1995): "Say to the child YOU CAN CHOOSE, to have one cookie OR YOU CAN CHOOSE to have no cookies at all. If the child says, I want two cookies. Repeat YOU CAN CHOOSE to have one cookie or YOU CAN CHOOSE to have no cookies at all. REPEAT A MAXIMUM OF THREE TIMES. If the child still says, I want two cookies, Say: YOU CHOSE to have two cookies so YOU CHOSE to have no cookies at all." It was stressed that once the choice had been made, they were to be firm and should under no circumstances capitulate. This was the first step in the discipline process. Once a choice was given and made, parents should be unyielding. The goal is for children to live with their own choices. They were warned against "overdosing" on choice giving. They were encouraged to work on one aspect at a time. It was stressed that they should not use choice-giving with FEELINGS because only BEHAVIOURS need correcting not children's personalities. Their behaviours are unacceptable; as people remain unconditional acceptable.

Some handouts were briefly discussed. They were encouraged to read them at home and bring a list of any questions or issues that they would like raised to the following session. The handouts included:
3. The Presentation of Information

a) The group listened to the tape "Attention Deficit Disorder: Controversies and Treatment" by Larry B. Silverman. This tape was made by the Lab School of Washington. A mindmap (Appendix F session 4:4) and a summary of the tapes contents was provided for each parent so that they were easily able to follow as the tape played and they had the information for future reference.

b) The article "Ritalin's Support System" which appeared in the November, 1992's issue of Living and Loving was handed out and discussed.

c) Each parent received the pamphlet on "Hyperkinetic Behavioural Disorders - A Guideline for Parents" put out by the Ciba-Geigy Medical Information Services. This was also discussed.

d) The Cognitive Control Battery compiled by Sebastiano Santostefano, (1985), was demonstrated and explained. This was a means of empowering the parents so that they could understand the concepts that often appeared to be jargon.

3. Live Demonstration with the Children

The facilitator demonstrated play therapy, this time using two of the other children.
The mother who had volunteered to present a play session for the group fetched her child. The group observed the therapy in progress. A discussion followed. The facilitator found some positive aspects to encourage.

4. **Rule of Thumb**: Good things come in small packages (Ravat, 1995).

We enter our child's world in little ways, not big ones. We cannot expect to be part of only the big events in our child's life.

5. **Closure of Session**

a) **Integration**

The facilitator summed up the issues surrounding medication stressing the fact that if a child is felt to need medication, or if the parents are wondering whether the child is a candidate for medication, they should consult a neurologist. The visit to the neurologist should be accompanied by as many reports as possible. If possible, the child should have been tested on the Cognitive Control Battery (Santostefano 1985) as this provides objective information on:

- Tempo of Work
- Inner and External Distractibility
- The Ability to retain a Visual Image.

The objective information is accompanied by subjective information obtained during the testing procedure. This information is a description of the child's behaviour during testing. Verbal and non-verbal responses are reported.

Arrangements were made for the next two parents to be observed during the following session.
b) Homework

- The mothers were to continue with play sessions.
- Handouts were to be reviewed.
- The mothers had to be aware of one intense feeling that they experienced during the play session.
- One choice was to be given to the child outside the play session.
- Each parent had to make a list of all their own strong points, no matter how seemingly trivial.
- The last instruction was that they were to relax so as to enjoy the play session with their children.

**Overview of Session Four**

Once again a great deal of factual knowledge was presented. The parents needed this. They enjoyed being able to discuss their fears of medication, especially as Ritalin has received a great deal of negative feedback recently.

This was an enjoyable session. Although many of the parents were still a little apprehensive about the play sessions, the mothers were already feeling more relaxed and had enjoyed the time spent with their children. All of them had created a time slot for all their children.

During this session the facilitator also shared some of her own experiences. She reassured them that although, at this stage, she might sound like an expert, she still made mistakes as she had done in the past. She had not been aware of many of these parenting skills when her children were young. A few examples of totally inappropriate behaviours were described. The facilitator's openness in sharing her
own feelings and admitting her mistakes helped the group to move through this phase. Her disclosure helped the group to realise that we are all only human. This was stressed throughout the sessions. Any choices that we make are made with the best intentions; at the time of making the decision it was the best decision that could have been made.

A strong sense of group cohesiveness was taking place. The mothers were beginning to laugh with each other and give advice. They were also beginning to feel empowered and started to realise that each mother could only be the best that she was capable of being.

5.2.6.5 Session 5

Goals

☐ To empower the mothers to take control of their lives by gaining confidence in themselves as people and as mothers.

☐ To continue encouraging group support.

☐ To provide knowledge on the formation of identity and an understanding of the dynamics of the self-concept.

1. Introduction

The session began with tea, refreshments and easy-going, relaxed conversation. This was followed by a debriefing on the play sessions and a report on the one experienced intense feeling. The mothers had to focus on an awareness of themselves in the play sessions, so that these feelings could be explored. Examples from the mothers comments were used to reinforce the basic principles of Filial Therapy. Difficult situations were pointed out and focus was placed on their feelings during the sessions. Encouragement and support was offered to each
mother during her sharing time. Connecting between group members was facilitated, to enhance group affiliation.

The “Doughnut Exercise”, a Gestalt technique demonstrated by Brink (1997), was used to facilitate the expressing of needs in an attempt to reconcile all the various subpersonalities.

2. **The Presentation of Information and Discussion**

a) A talk was given on identity formation, personalising this information so that it referred to mothers and children, especially ADD / ADHD children. This was based on the information presented in chapter two. (Appendix F, Session 5 :1)

b) A discussion and ways of reconciling the different subpersonalities was held. Not one of the mothers ever seemed to have enough time to pursue any of her own interests. It was stressed that each mother has the right to be her own person and should try to find time for herself.

c) Each mother had to discuss her list of strong points. They initially gave very few. They were encouraged to think of others; the group helped with suggestions.

d) Dynamics of the self-concept were discussed so that the mothers could understand what their children were feeling, but also to help them realize that they were allowing their children’s difficulties to affect their own self-concepts, thus hampering their own self-actualisation. This was described in chapter two of this study (Appendix F, Session 5: 2).
3. **Live Demonstration with the Children**

The facilitator demonstrated play therapy, using two different children. Two mothers demonstrated their play therapy with their children. Comments and suggestions followed. The mothers were encouraged and praised for their dedication.

4. **Role Play**

The mothers again paired off, in different combinations and had to reflect content and feeling. They also had to try to provide choices and practise the setting of limits during the role play. They were encouraged to role play situations that they had found difficult to handle and to be as defiant as their children sometimes were.

5. **Rule of Thumb**: The most important thing may not be what you do, but what you do after what you did (Ravat, 1995).

It's not whether we make mistakes but how we handle our mistakes that counts. We are all human, and so are our children. Their mistakes also need to be handled with respect and love.

6. **Closure of session**

a) **Integration**

A short summary of the session followed. The mothers were commended for their willingness to change and to persevere with the important task of parenting their very special children. It was stressed that they had to allow their children to grow and to make their mistakes, as this was the only way that they would learn.
b) Homework

- They were to review the handouts at home. Any questions that might have arisen would be discussed in the following session.
  - "When setting the limits doesn't work" (Table 8).
  - "Are you an enslaved parent?" (Ravat, 1995; Appendix F, session 5: 3).
  - "For All Children" (Ravat, 1995; Appendix F, session 5: 4).
  - "Only You can make the Difference" (Appendix F, session 5: 5).
  - "My Personal Strengths Sheet" (Canfield and Wells, 1994; Appendix F, session 5: 6) to be completed by each mother for discussion in the following session.
  - "Where am I going"? (Canfield and Wells, 1994; Appendix F, session 5: 7).

- Copies of the book:
  - "How to Talk so Kids will Listen and Listen so Kids will talk" by Faber, A. & Mazlish, E. (1980) was made available.

- The mothers were to continue with their weekly play sessions.

- The mothers were to find an opportunity of giving one choice outside the session.

- The mothers were to practise setting limits. They were warned not to overdo limit setting but only to implement it for the essential aspects.

- The mothers were each given a Self-Concept inventory (Vrey and Venter, 1983) to complete.
Overview of Session Five

The group has now moved into a phase where an atmosphere of love, knowledge, care, respect, responsibility, trust and acceptance has been firmly established. The morale, mutual trust and self-disclosure are increasing. Members are now able to use the group to support and enhance each other's growth.

One mother shared her feelings when her son had expressed the wish to go and live with his own father instead of with her and his step-father. She was experiencing a great deal of difficulty coming to terms with this. The child's biological father was very wealthy and his relationship with his step-father was not a good one. The group supported her and reassured her as she was feeling that she was a failure.

The completion of the Self-Concept inventory had not been included in the initial planning of the study. However, the facilitator thought that it would help the mothers have a better understanding of themselves. They were all very aware of their weak points, but were unable to mention many strong points.

5.2.6.6 Session 6

Goals

- To help the mothers develop a better self-concept by focusing on their strong points.
- To help the mothers realise that they can only support their children in their growth to adulthood and self-actualisation. They cannot live their lives for them.
- To discuss structured play as a method to teach their children to work through anxiety about specific events.
- To assist the mothers in building up the self-esteem of their children by allowing them to realise the consequences of their choices.
1. **Introduction**

The session began with tea, refreshments and an informal chat. This was followed by a debriefing on their play therapy. The mothers were encouraged to focus on the choice given to their children outside the therapy situation. During the debriefing, the common problems experienced with Filial Therapy, reflective listening, setting limits and giving choices were all emphasized. They were also encouraged to use choices in their own lives and not only when involving their children. This could be transferred into their marriage relationship and into the work situation. This would empower them by giving them control.

2. **The Presentation of Information and Discussion**

A talk on the predispositions necessary for building up the child’s self-concept was presented by the facilitator. This was based on Unisa’s Relations theory. A schematic presentation of the Psycho-Educational theory (Figure 2) was presented to the mothers. All the terminology was explained, based on the information already presented in chapter two of this study. During the presentation the facilitator mentioned that all these aspects were necessary for the formation of any relationship; marriage was used as an example. A discussion on marriage followed and the lack of support that the mothers received from their husbands was mentioned. The fact that the fathers were continually criticizing their children was again mentioned.

This was followed by a discussion on the identifying of responses to build self-esteem in the child. The following words were provided as being helpful during reflection and for use in the letters of appreciation they would write to their children as homework for the week.

- compassionate
- co-operative
- courteous
- decisive
- enthusiastic
- flexible
- confident
- courageous
- creative
- diligent
- fair-minded
- forgiving
3. **Live Demonstration with the Children**

The facilitator demonstrated play therapy, this time with the last child. All the children had now had a turn to be observed in the playroom participating with the facilitator. Two mothers demonstrated their play therapy with their children. This was once again followed by a lively discussion and many laughs.

4. **Rule of Thumb:** Grant in fantasy what you can't grant in reality (Ravat, 1995).

It is acceptable for the father doll to be thrown out of the window during play. This is a way of expressing aggressive feelings in an acceptable way.

5. **Closure of session**

a) **Integration**

A quick summary of all the sessions took place. The mothers were commended for their good work and praised for all that they had already achieved. They were each asked to give one sentence illustrating what they had gained so far.

b) **Homework**

The following handouts had to be read:
They were encouraged to make a list of any queries or comments, that may arise during the week, for discussion during the following session.

Each mother had to write a note to each of her children, every week, for the following three weeks. She had to point out a positive character trait that she appreciates. Thereafter this was to be continued on a periodic basis.

An example of the format the note should take was given:

Dear...

I was just thinking about you and what I was thinking is that you are so...
That is such an important quality that we are going to put this note where everyone can see it.

Love...

The mothers were to continue with play sessions, and try to be aware of patterns of play that may be emerging.

The mothers were to notice, without making any special effort to do so, how many times they touch their children.

Arrangements were made for the next two demonstrations.
Overview of Session Six

Once again an easy, sharing session was experienced as the group are now firmly established in a phase, where they are able to risk opening-up, sharing and trying out new behaviours.

One mother was disappointed as her child had not been accepted at the school. The others all supported her while she felt comfortable enough to give vent to her emotions. One of the others was very elated because, for the first time in two years, she had had a positive report about her child's progress. More tears and emotion followed. It was wonderful to see the support and sharing that took place. The group was really starting to function as a unit. However, they still looked to the facilitator for professional help. It was felt that the disclosure by the facilitator that she was also only human, established a closer bonding. The mothers were there to offer her their advice as well. One of the mothers felt that the talk on the educative climate was a real eye-opener to her, especially in terms of the marriage relationship. The facilitator decided that issues surrounding the marriage relationship seemed to be presenting problems in most of the homes, hence it would be discussed in the following session.

5.2.6.7 Session Seven

Goals

☐ To gain some self-awareness.
☐ To provide insight into the concept of praise.
☐ To enjoy the support and friendship of the group.
☐ To promote some awareness with regard to the marriage relationship.

1. Introduction

The session began with tea, refreshments and a friendly chat. This was followed
by a debriefing on the play sessions, the focus being on specific patterns of play and the amount of times that the mothers physically touched their children. This turned into an interesting group discussion. The group was really relating to each other on a deep level. One of the mothers had been involved in an accident and so had not been able to do therapy with her child during that week. Once again support was offered.

All the concepts learnt, (choices, setting of limits and reflective listening) were quickly reviewed. The self-concept aspects were again reviewed and emphasised. A time for questions was allowed for. The group members usually provided the answers, after discussion amongst themselves.

2. **Presentation of information**

The following handouts were discussed:

- "Praise versus Encouragement" (Ravat, 1995; Appendix F, session 7: 1).
- "Learning to be Perfectionistic" (Ravat, 1995; Appendix F, session 7: 2).
- "And What Of Marriage" (Gibran, 1991; Appendix F, session 7: 3).

These handouts were related to all the previous aspects that had been discussed.

3. **Live Demonstration**

Two of the mothers demonstrated play therapy with their children. A short discussion followed.
4. Activity

The "Rosebush" exercise was done. This was taken from "Windows to our Children - A Gestalt approach to therapy with Children and Adults" by Violet Oaklander (1978). A discussion about the rose bushes followed. They were told to try to relate this to their own lives.

5. Rule of Thumb: Praise the Effort, Not the Product (Ravat, 1995)

This was explained using the handout on "Praise versus Encouragement" (Ravat, 1995).

6. Closure of Session

a) Integration

A summary of all the salient points that emerged during the session was given. Each mother again had to summarise in one sentence what she had gained from the session.

b) Homework

Various ways of initiating physical contact between the members of the family were recommended. The following examples were given by Ravat (1995):

- Family wrestling: everyone is involved and a wrestling match follows.
- Sandwich hugs: this involves everyone hugging together, the one in the middle is the filling for the sandwich.
- "And that was for nothing." The child is spontaneously given a hug, or kiss for no apparent reason.

- The mothers were to continue with the play sessions.
The mothers were to think of any questions that they would like to discuss.

Arrangements were made for the next two parents to demonstrate their play sessions.

Overview of Session Seven

A definite routine has been formed in the group. The different personalities have jelled. Although some members are more outgoing than others, everyone is given an equal opportunity in sharing. All the group members seem to be relaxed about sharing experiences. One mother shared a confrontation she had had with her parents-in-law. It was the first time that she had stood up to them, when they blamed her for her child's problems. She provided them with the choice of accepting her son and having them visit, or victimizing him and forfeiting the visits. This led to her explaining what his problem was. She reported that it was the first time she had really come to terms with the problem.

The single mother was experiencing problems with her son, who was finding it difficult to come to terms with the fact that he did not have a father and he had lost his grandfather at the end of the previous year. These were aspects that had come to light as a result of the play sessions. He was referred to the male psychologist at the school for therapy. The issue of death would be dealt with in the following session as all of the children would be exposed to this at some stage.

5.2.6.8 Session Eight

Goals

To empower the mothers by teaching them effective communication skills.
AN EDUCATIONAL PSYCHOLOGICAL PERSPECTIVE
ON THE USE OF FILIAL THERAPY IN MOTHER-CHILD RELATIONSHIPS

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SUMMARY

The different reactions of parents to the discovery that their children had ADD / ADHD has an effect on the primary relationship established between mother and child. This is essential in the later involvement, experience and meaning attribution of the child with respect to all subsequent relationship formation necessary for self-actualisation.

It was felt that psychological intervention could help parents to bond, communicate with and relate to their children without experiencing negative feelings which would enhance parental acceptance.

In this study, ten mothers participated in an adapted group Filial Therapy programme, which involves parents as the primary agents to resolve child-related problems and to encourage children's healthy psycho-social development.

Results were positive. The mothers felt that they had formed better relationships with their children. They were empowered with knowledge and coping mechanisms, such as reflective listening, setting limits and providing choices. For the first time they were enjoying their ADD / ADHD children.

KEY TERMS

Awareness, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Child-Centred Play Therapy, educational climate, experience, Filial Therapy, lifeworld intrapsychic structure : "I", me, self, self-identity, self concept, self-actualization, involvement, meaning attribution, mother-child relationship, parental acceptance personalization, relationship formation, Relations Model, subpersonalities.
5. **Rule of the Thumb**: If you draw your gun, shoot (Ravat, 1995).

Idle threats harm your relationship with your child. Rather give choices and see that you follow through on these.

**Closure of Session**

a) **Integration**

The session was quickly summarised and each one had to summarize in one sentence what they had learnt during the session.

b) **Homework**

- The mothers were to continue with play sessions.
- The mothers were to try to use more effective methods of communicating, starting with the use of "I-messages."
- Arrangements were made for the last mother to present her play demonstration.
- The mothers were once again invited to think of any questions or queries that they might still have.
- Each mother was to give every other mother a "Gift of Love" at the last session. They were to start thinking about these.

**Overview of Session Eight**

All the mothers seem to be managing the play sessions. They have expressed that they experience great enjoyment during these sessions. Their children look forward to the sessions and count the days until the following one.

This was a lovely, relaxed session. There is now wonderful support and rapport amongst the members. The quieter members have started to participate more in
group discussions. Some definite leaders have come to the fore. The parents look to each other for support. They have arranged to meet for a social get-together.

A great deal of discussion about marriage-related issues occurred. All of the wives, except one, seemed to be experiencing some difficulty in their marriage relationship. It was felt this could be due to the spouses resenting the attention devoted to the children. Also the general feeling was that the mothers always had to act as buffers between the fathers and their children, especially their sons. One mother admitted that she and her husband had previously got divorced, but were now living together. She was now able to be more assertive in their relationship and had started to respect herself as a person. They all felt that the communication skills and the giving of choices would benefit them in their marriage relationships.

5.2.6.9  Session Nine

Goals

☐ To prepare the mothers for closure the following session.
☐ To clarify any issues that are still unclear.

1.  Introduction

The session began with tea, refreshments and a chat. This was followed by a debriefing on the play sessions. Special attention was given to changes noted in play.

Quite a few questions were raised and were answered by the group. The issue of quality versus quantity time was discussed. The suggestion of spending quality time alone with their spouses was also discussed. It was stressed that each and every one of them deserves and needs her own space and her own quality time.
The facilitator asked each mother to arrange a separate session with her to discuss the results of the Self-Concept questionnaire, as it was felt that there were many personal issues that needed to be addressed.

2. **Working Phase**

Copies of the original reflective listening and setting of limits worksheets were handed out for the group to complete. These were then discussed in the group.

3. **Live Demonstration with children**

The tenth mother demonstrated her play session. This was once again followed by feedback from the group.

4. **Rule of Thumb**: Don't answer questions that haven't been asked (Ravat, 1995).

Look behind the question for the deeper meaning but do not over interpret, or give more than the child is ready to deal with.

5. **Closure of Session**

a) **Integration**

The facilitator briefly reiterated all that been covered in the group up to this stage. The mothers were all very pleased with the progress they had made and amazed at the amount of knowledge that had been absorbed in nine weeks. The various group members made arrangements for a party during the final session.
b) Homework

☐ They were to complete the evaluation form and the Emotions Profile Index (Plutchik and Kellerman, 1970).

☐ They were to continue with the play sessions.

☐ The mothers were reminded to bring their "Gift of Love" for the last session. This should not be bought but should be some thought, inspiration, verse, or poem.

☐ There were two handouts to be read:

☐ Risking in Love (Buscaglia, 1992; Appendix F, session 9:1).

☐ If you want Joy (Johnson, 1997; Appendix F, session 9:2).

Overview of Session Nine

The group had now entered the final phase where the group has to deal with its own death. The termination time was known in advance so everyone was prepared for this. The group chose to deal with the termination in the following way:

The mothers all decided that they would benefit from meeting on a monthly basis. One of the mothers was made responsible for co-ordinating this. Topics of interest would be presented to the facilitator so that she could try to find the relevant information or invite suitable speakers.

The following topics were immediately brought up: sibling rivalry, time management and homework issues. These would be looked into.

5.2.6.10 Session 10 - Final Session

Goals

☐ The closing process and the sharing of gifts.
1. **Introduction**

A party had been arranged as this was to be the last session and also the last day of school. The session therefore took place during the party.

Each mother had a turn to summarize and review some of the important aspects that she had learnt and each had to explain how she perceived her child at this point in time. Feedback on positive changes was encouraged.

The facilitator stressed the importance of continuing the play sessions. The mothers were to sign the contract guaranteeing continued play sessions with their child (Appendix F, session 10:1). They were warned that if the sessions should now end, the children would feel that the play therapy had taken place only because the mothers were doing the course and not because of the importance of the children. The concept of "The Butterfly" was once again stressed. It was important to experience pain in order to grow.

They were all reminded to continue with the acknowledgement letters and to always remember to appreciate the uniqueness of each and every child, and that there was no other child as special as their own child. They were the best mothers that their children could have.

The handout "Rules of Thumb and Other things to remember" (Ravat, 1995; Appendix F, session 10:2) was discussed.

2. **Rule of Thumb:** If you can't say it in ten words or less, don't say it! (Ravat, 1995).

A concept, choice or behaviour should not be over explained.

3. **Presentation of Certificates And Gifts**

Each mother was presented with her diploma (Appendix F, session 10:3). The facilitator's gift to each mother was "A Butterfly" (Life-line, 1996; Appendix F,
session 10: 4). The facilitator concluded her gift-giving by telling each mother to always be the best that she was capable of being and to continue to grow.

Each mother then had a turn to present her gifts to all the others. They were all excited about the giving and receiving of their presents. The session ended as the bell had rung and it was time to fetch their children.

**Overview of Session Ten**

The session was both happy and sad, with much laughter and tears. There was a great deal of genuine love and warmth shared amongst the group members. All have shown tremendous growth in their own paths to self-actualisation. The facilitator found this experience very rewarding and also underwent a great growth.

**Termination of Programme**

Throughout the programme, the mothers appeared to develop strong bonds which allowed them to offer advice and support to each other. The sharing was remarkable and the empowerment of the mothers was clearly visible. They felt that they were more in control and had skills with which to confront many of the difficult situations that still lay ahead of them.

Extreme appreciation was expressed by the entire group. They also expressed a willingness to either demonstrate or assist in compiling a video of their play sessions to assist other mothers. A few also expressed that they would be willing to co-facilitate future groups.

The monthly meetings would be organised and a fathers' group would be established in the near future.

Each of the mothers was to make an appointment with the facilitator so that the Self-Concept inventory could be discussed. They were also to bring the completed Emotions Profile Index and the drawing of their rose bush.
5.3 QUALITATIVE ANALYSIS OF QUESTIONNAIRE

5.3.1 Qualitative analysis of initial questionnaire

Mother A

Personal Details

Age : 43 years
Occupation : Junior Primary School Teacher

Functional Image

She appeared to be a very straight-forward, honest, no nonsense type of person. However, she exhibited a good sense of humour. She expressed concern about her child's progress. She has experienced a great deal of support from her husband, friends and colleagues. She felt that she had a good understanding about learning disabilities, but would really like to get to know her child better. She is still harbouring feelings of guilt because she had not realised that her child had a learning disability; perhaps she had been denying the problem. His previous school referred him when he was experiencing problems in Grade One. This seems to have had a negative effect on her self-esteem. The Self-Concept inventory revealed a very low self-esteem, only scoring a stanine equivalent of 1. She saw her role as an educator to be someone who reaches out to encourage and help when necessary.

Family situation

There are differences of opinion with regards to discipline. She regards herself as "a softie" whereas the step-father is over-strict. The other siblings are much older than her learning disabled son and are very helpful, often assisting him with his homework. His step-father is not as involved with the child as she would like him to be. She would appreciate assistance from him with occupational therapy.
exercises and with sporting activities. The marital relationship appeared to be strained, seemingly as a result of different cultural backgrounds and the fact that the mother is always a buffer between her three children and their step-father.

Mother B

Personal Details

Age : 35 years
Occupation : Data Capturer

Functional Image

Mother B initially appeared to be very quiet and unsure of herself. Her initial reaction to the diagnosis was guilt. She felt that having an ADHD child has had a negative effect on her self-esteem. On the Self-Concept test she scored the equivalent of a stanine of 5, which is indicative of a self concept that falls in the medium range. She is a single mother but has always received a great deal of support from her parents. Her father passed away at the end of last year. She has not had time to really grieve for him as she has tried to be strong for her mother and her son. She has expressed a need to learn as much as possible about ADHD so that she can be of assistance to her son. She was keen to be involved in the educative task so that her child could reach his potential. She finds him most difficult when he does not listen and he cannot distinguish between right and wrong. Her reactions fluctuate between being loving and caring and feeling annoyed with him.

Family Situation

Mother and son seem to have a loving relationship but she needs to find a balance between disciplining and spoiling him, because of her own guilt feelings. This is made more difficult because he is an only child and there is no father figure.
Mother C

Personal Details

Age : 31 years
Occupation : Bookkeeper

Functional Image

Mother C appeared to be a very quiet, withdrawn person, who was not very sure of herself. She revealed feelings of being overwhelmed and upset by the extent of her daughter’s problems and found it difficult to handle her behaviour. She felt that at times she did not relate well to her daughter as her behaviour was often socially embarrassing and she found this very annoying. She also reported that she often found her daughter irritating when she got upset and wouldn't calm down. There were times when her child was very loving and helpful. Mother C perceived her self-esteem as fluctuating. When her daughter is having a bad day she felt that she was not a good mother. At other times she felt that she was okay. On the Self-Concept scale she scored the equivalent of a stanine of 2 which is indicative of a very low self-concept. She expressed a need to know about ADHD and how to cope with specific issues. Her daughter is extremely impulsive, distractible and hyperactive resulting in poor social skills and difficulty with being accepted. The educative process was seen as helping the child through the steps of life.

Family Situation

The family members seem to be emotionally close, although the child’s volatile behaviour tends to cause a great deal of tension. The father also feels guilty about the fact that his daughter has a problem because his father has ADHD. The child often upsets him, but he tries to deal with it. There is a great deal of fighting as a result of sibling rivalry. The brother, also a pupil at School of Achievement, gets very frustrated and cannot understand why she reacts the way she does. He was diagnosed as having ADD without hyperactivity so appears to be a very quiet,
withdrawn child. There is not much support from relatives and friends resulting in them not socialising as much as they had previously. They are all experiencing feelings of isolation.

Mother D

Personal Details

Age : 45 years
Occupation : Housewife

Functional Image

Mother D appeared to be a very quiet, reserved person who experienced great difficulty expressing her emotions. She appeared to find it difficult to accept on an emotional level, that her son had a problem, although she had accepted it on an intellectual level. She felt very isolated and did not have any family or friends to support her. She felt that she would like to be a good mother, but did not always know what was expected of her. Motherhood required far more input and stricter discipline than she had envisioned. She did not perceive her child as having any effect on her self-esteem. On the Self-Concept test she obtained a stanine of 3, which places her self-concept in the low range. She finds it very difficult to deal with her son’s loudness, whining and crying. She expressed enthusiasm in learning as much as possible about ADHD so that she can have a better understanding of her child and so help him.

Family situation

The father seems to experience difficulty accepting that his child has a problem. He blames the mother, feeling that she is too soft and does not discipline him enough. There is a great deal of sibling rivalry, resulting in fighting and arguing. This leads to a great deal of tension in the home with resulting marital problems. The mother
also expresses the fact that she does not enjoy going out socially because she cannot relax, as she is afraid that her son will either hurt other children or be rejected by them. Her husband seems to be very impatient with her in social situations and seems to enjoy socialising with other women.

Mother E

Personal Details

Age: 37 years
Occupation: Housewife

Functional Image

Mother E appeared to be a very outgoing and happy person. She seemed to be very supportive of her learning disabled child, sometimes to the extent of pushing him too hard with homework. She expressed that she felt very sorry for her son. She would like to take over his difficulty so as to make his life easier for him. She expressed a need to know as much about his ADD as possible. She experienced parenthood as being far more difficult than she had anticipated. She indicated that although there is no support from extended family members, she has experienced support from friends and the professionals that have dealt with her son over the years. She reported that her self-esteem was not at risk because of the fact that her son had been diagnosed as having ADD. This was confirmed by the Self-Concept test. She scored a stanine of 9 placing her in the high range for self-concept. She saw her educative role as always being there for her son to give him a helping hand, but always letting him try to do things for himself first.
Family Situation

The family members seem to be very close, abounding in love and support for each other. They handle all situations together and present a united front in terms of discipline. Both parents are involved in homework and play. The siblings also seem to love each other, and apart from the occasional fight they generally seem to relate well with each other. The family are sincere in their religious beliefs and place a high value on their faith in God.

Mother F

Personal Details

Age : 41
Occupation : Mother and Home Executive

Functional Image

Mother F appeared to be very quiet and unsure of herself. She found it difficult to handle her child's behaviour and dreaded any feedback from the school as he was always portrayed in such a negative light. She has found him to be very stubborn and always wanting his own way. She experienced a great deal of support from one of her friends, but otherwise there was very little from other friends and family. She did not feel that her child has had an effect on her self-esteem. The Self-Concept test revealed that she fell into the medium range with a stanine score of 5. She felt that she did not have a great deal of knowledge about ADHD and would like to learn as much as she could. She also expressed a need to be able to deal with specific issues that might be relevant to her child. From an educative perspective she felt that parents should always be there to offer a helping hand when this was needed by the child.
Family Situation

The father seems to be absent most of the time due to work commitments. There is a great deal of tension in the home because of sibling rivalry, which results in screaming, shouting and fighting. The parents do not seem to be consistent in the discipline of their children. Mother F feels that the father should be more involved with his children and that he should also be available to do homework. The educative process is perceived as a mother leading the way, pulling the child behind her, almost forcing him to follow the right path.

Mother G

Personal Details

Age : 37 years
Occupation : Self-employed

Functional image

Mother G appeared to be a very friendly, outgoing and happy person. She spoke easily, and with absolute honesty. She had the ability to laugh at herself and her mistakes. She experienced parenthood as far more difficult than she would ever have imagined. She found it very difficult to cope with her son’s aggression, which manifests as physically lashing out at others, temper tantrums and lack of social skills. She reported that he was least annoying when he was sleeping. She had enjoyed little support from her family and friends, who did not always understand the full extent of her son’s problem. Friends offered advice, which was not always relevant, as the majority of them feel that he is undisciplined and naughty. The child’s problem was not perceived as having a negative effect on her self-esteem. She scored a stanine of 7 on the Self-Concept test which placed her in the high range.
Family Situation

Mother G appears to be the dominant one in the family. The father seems to play a very passive role and is always in the background. The schooling, disciplining and stimulating all seem to fall on the mother's shoulders. She is also responsible for all the extra-mural activities and therapies that need to be attended. Socialising is difficult because her son is always the one who is stirring up trouble. There is a great deal of sibling rivalry, resulting in fighting and screaming. The mother feels that the youngest sister is scared of her brother and is developing problems as a result of this.

Mother H

Personal Details

Age : 40
Occupation : Area Manageress for a Cosmetic Company

Functional Image

She presented as a confident, competitive, self-assured, independent person. She appeared to be very honest, keen and willing to do anything to help her children. She was easily able to laugh at herself and the situations that she found herself in. She reported that she tried to be firm with her son, at the same time giving him a lot of love. She found it very annoying when he had temper tantrums, was cheeky, backchatted or cried for nothing. She had experienced no support from family or friends. The therapists that she had been dealing with over the years had been a great support. She reported that having a child with ADHD has not had an effect on her self-esteem. She scored a stanine of two in the Self-Concept test, which
placed her in the low range for self-concept. This conflicted with the way she presented in the group. She was enthusiastic to learn as much about ADD / ADHD as possible. She understood the educative task "as the mother leading the way and asking the child to take your hand so that you can lead him to higher places and lending a hand so that he can come out tops."

**Family Situation**

There appears to be a great deal of tension in the home and serious marital problems. The father has not ever accepted that the boys might be experiencing difficulties. He is not supportive and does not provide the recognition the whole family is looking for. The parents are not consistent in their approach to discipline. The father also seems to resent the fact his wife is so successful in her work. There is a great deal of sibling rivalry and competition. The children are continually at each other and very aggressive fights take place on a continual basis. An added tension is the fact that the paternal grandmother lives with the family and is always interfering with the boys.

**Mother I**

**Personal Details**

**Age** : 38 years  
**Occupation** : High School teacher

**Functional Image**

Mother I appeared to be very emotional and extremely tense. She came across as being a perfectionist and an achiever. She felt disappointed in her child because she was easily frustrated, seemed unable to persevere, and was totally
disorganised. She spoke very little about her child's disability and felt that she did not get support from anyone. She appeared to be defensive and protective although she appeared to be well aware that her child needed to learn independence. Although she has gained a great deal of knowledge about ADD / ADHD she felt that there was always something more to learn. Initially, she felt that her daughter's problems did have an effect on her self-esteem, but that she has now come to terms with them. The Self-Concept test revealed that she fell into the high range with a stanine of 9. She described the educational task as: "a child needing to rely on parents to help them make sense of their world. This should be a gentle guidance, a walking forward and up together. Going through the stepping stones of life together with the adult as the leader/role player / example setter."

Family Situation

The family seems to be struggling with acceptance. The parents do not agree on discipline. The mother tends to be overprotective and the father rather strict. Marital relations are becoming strained. The parents seem to have a more positive relationship with their younger daughter who does not experience any difficulties. There is reportedly sibling rivalry as the younger girl is jealous of all the attention that her sister is getting.

Mother J

Personal Details

Age : 31 years
Occupation : Assistant Accountant
Functional Image

Mother J seemed very quiet and reserved. She reported that she was relieved when she received a diagnosis as she always felt that there was a problem with her son. She accepted the diagnosis. She found it difficult to cope with him when he became frustrated or presented with aggressive or impulsive behaviour towards people and things. She felt that she did not have enough knowledge about ADD / ADHD and wanted to be empowered with more knowledge. Her support comes from two colleagues at work who have children in remedial schools. She also received a great deal of support from their family doctor and the pre-primary school teachers. There has not been a great deal of support from family and friends. She felt that having a child with ADHD did not affect her self-esteem as she believed that God had given her a special boy to care for and she would do everything in her power to help him. The Self-Concept test revealed that she fell into the medium range with a stanine of 6. She explained the educative experience as follows: "A parent guiding a child up the stairs of life by way of example and by lending a hand to steady the climb."

Family situation

Initially there were marital problems which led to a divorce. She and her husband are back together again and she feels that things are going well. She feels that her husband has also accepted the problem although sometimes he expects too much of his son. The parents generally agree on discipline, but not always on how to handle the problem. The siblings are too young to react to the problem. There is, however, a certain amount of sibling rivalry and many fights. She feels that the father could be more involved with his child and should assist with homework and so forth. Their social life has not changed a great deal with having an ADHD child, although friends and family do not always understand.
Mother A showed a great deal of growth during the sessions. Initially she was the one who expressed the most scepticism about the use of reflective listening, maintaining that it was not her style.

She felt that she had gained an understanding of her son on a personal level. She also felt that she was relating far better to her son and had a better insight into his feelings and frustrations. She was empowered by the setting of limits and giving of choices where he had to accept the consequences. She reported that she had also begun to apply this technique in the classroom situation with her pupils.

She also reported that she did not feel as guilty any more. She had felt responsible because she felt that she had rejected her son as soon as she had heard that she was pregnant. She had not wanted to have another child as her marriage was going through a difficult time. She had just left her husband and filed for a divorce when she discovered that she was pregnant. She continued with the divorce. She remarried in 1995. She thoroughly enjoyed the play sessions with her son. He would keep reminding her that it was their special time. She reported that thanks to the Filial Therapy she was able to allow her child to go and live with his biological father without feelings of being manipulated. Originally, when he had expressed this wish, she had felt that she was a bad mother and had experienced deep feelings of guilt and hurt. Through the power of choice-giving the child was allowed to make the decision. However, when the time drew closer he actually started to have second thoughts. She stood firmly by his decision. He was to stay there for a trial period of six months and then the situation would be reassessed. She now firmly believed that she was the best mother that she was capable of being, and looked forward to continuing her growth process. She expressed gratitude for being part of the group and felt that she would benefit from the planned monthly meetings. She felt that she was not ready to facilitate a group, but would be willing to share
her experiences with others and she would be prepared to video play sessions for use in future groups.

Mother B

Mother B reported a better understanding and acceptance of her child's problems. She found that giving her son choices had led to a better understanding of one another and their bond was much stronger. This was far more effective than "always ranting and raving." The play therapy sessions provided opportunities to enjoy her child. He counted the "sleeps" to their next session together.

The mother felt that it was a relief to find that other mothers were experiencing the same problems as she was. She had always blamed many of her feelings of guilt and inadequacy on the fact that she was a single mom.

She initially described herself as being in the secondary stage of acceptance, but felt that she had now moved into the tertiary stage.

She really appreciated the confidentiality and openness of other members of the group. She felt empowered as a result of gaining a great deal of knowledge and many new friends. Initially she was very quiet and unsure of herself, but soon became a very active member of the group. She expressed her gratitude for being allowed to participate in the group and said that she would definitely appreciate keeping contact on a monthly basis. She did not feel that she would be able to facilitate a group, but would be prepared to share some of her experiences with future groups. She would be prepared to video her play sessions.
Mother C

Mother C experienced tremendous personal growth. She reported that she had gained a better understanding of her daughter. She was better able to deal with her behaviour problems and could now relate to her in a more loving way. She felt that the information gained was useful and helped her move from feelings of ambivalence in the secondary stage to adaption and organisation in the tertiary stage. She found the discussions with other mothers to be a relief and as she said it made her realise that "she was not such a bad mother after all, more human and makes mistakes". She felt that being able to understand her child, giving choices and limit setting equipped her better in coping with her ADHD child. The play therapy sessions were very special and she and her daughter both looked forward to these as an opportunity of spending quality time together. She added that these provided an ideal opportunity to practise the skills that she had been taught during the sessions. She found the information on creating an educative climate very useful especially in terms of her marriage. She expressed gratitude to all the group members for the opportunity of being allowed to grow in a supportive atmosphere. She would appreciate the ongoing monthly contact with the group. She also expressed that she would enjoy the opportunity of being a co-facilitator and organising a group.

Mother D

Mother D reported gaining a different perspective and better understanding of how to cope with and help her son. She had gained more confidence in her parenting skills. She felt that the group assisted her in having a better understanding of her child's problems which led to a great deal of introspection. She really appreciated the session where the mothers had to list their strong points as she had not felt that she had any. The concepts of limit setting, reflecting and providing choices practised during the play sessions were invaluable. The special weekly play
sessions were very special to both mother and child. She reported that she had already been on the organisation level in the tertiary stage of acceptance when she started with the group. However, from comments that she had made the facilitator felt that she had still been in denial and was suffering from depression (Confirmed by the Emotions Profile Index). Her child was the only one in Grade one. The facilitator has found that this is usually a very difficult year for the mothers. The mother reported that she felt that she had reached the adjustment phase by the end of the group sessions. The facilitator felt that by the end of the course she was still blaming herself and a great deal of anger was directed towards her husband, who is totally non supportive. She said that she would like to continue meeting on a monthly basis because she needed the support and it helped with her feelings of isolation.

**Mother E**

Mother E reported that she had learnt to see her child as a totality and not to let his ADD problem become the focus of their relationship. She felt that she understood him better and realised that she was not alone in experiencing problems with her child. She thoroughly enjoyed the play sessions with her son. She had always been so busy trying to help him, protect and teach him that there was little time left for simply enjoying him. Through these sessions she learnt to allow him to make mistakes and he learnt to become more assertive and to venture more. The play sessions were ideal for learning to set limits and give choices. The reflective listening gave her an insight into the feelings of her child.

The knowledge and advice empowered her in difficult situations. She shared all the sessions with her husband who also tried to apply them. He also expressed a need to attend such a course. This mother was an inspiration to the rest of the group because she was always so friendly, bubbly and outgoing. Although she felt that her acceptance had grown she still felt sorry for her son and wanted to take his
difficulties away from him. Her religious belief was also a strength: she did not blame God but always relied on his support and strength. She felt that she would like to be a co-facilitator and would be more than happy to share her experiences in future groups. She would also be willing to have her play sessions taped for future use. She felt that it would really be beneficial to continue meeting on a monthly basis as she was very grateful for the experience gained while being part of the group.

Mother F

Mother F reported a real benefit from the group. She came into the group feeling isolated. She felt that she was a real failure as she did not understand her son and therefore could not cope with him. She showed a great deal of growth and courage. She felt her relationship with her son had become far more positive and she was more understanding and patient. She and her son enjoyed the play sessions. During the play sessions she was able to practise the setting of limits and providing choices. It was also very rewarding to be able to understand her son's feelings through the use of reflective listening. She reported that her husband had also become more relaxed and patient. The information provided led to a better understanding of ADHD and the group discussions reinforced this. The group provided a wonderful support system and helped her realise that she was not alone and that she was not an inadequate mother. Having a child with problems was far more demanding than just being a mother. Initially, in the group sessions, she was very quiet, but slowly and surely she started sharing and expressing her feelings. Initially she was in the secondary stage of acceptance, experiencing ambivalence, guilt, shame and embarrassment. By the end of the course, she appeared to be coming to terms with her child's problems and accepting them. She said that she would like to continue meeting on a monthly basis, but was hesitant about co-facilitating. She would also be prepared to video play sessions with her son for future use.
Mother G

Mother G reported that she was now able to see her son in a different light and was able to understand how he is feeling. This had enabled her to handle him and the whole situation differently. She felt that the sessions have led to a better understanding of herself. The support from the group was invaluable as she realised that other mothers were as emotional as she was and that "it was okay to feel like that". She experienced the support as being sincere and heart warming with much kindness and understanding from all. She experienced the sessions as being "in the real world, because she could understand and be understood because everyone was standing on the same ground. She looked forward to each session as this was her top up to sanity which would last for the week." The play sessions had opened up her son's world to her. She was better able to cope with him and enjoy him. She had learnt to listen to him and not always try to discipline and lecture him. This led to her getting more out of him than she ever has before. She realised that her son was not an only child and that the others also needed her. She initiated play sessions with all of them and this led to a more friendly and loving relationship with all her children. The setting of limits and giving of choices has empowered her, and generally things are running more smoothly at home.

The information imparted at each session also fulfilled a great need. This also led her to develop a better understanding of her son.

At the beginning of the group she was still in shock and denial and was very emotional when talking about her problems. She felt that by the end of the course she had progressed to the tertiary stage of acceptance. She expressed sincere gratitude and said that this had been the most "meaningful and growing experience," that she has ever been through. She expressed a very real need to continue meeting on a monthly basis but was not, as yet, ready to co-facilitate a group. She would gladly video her play sessions for future use.
Mother H

Mother H reported that she felt that she was now more in control of the situation. She had been trying before but this was often a “hit or miss” situation. She felt that she gained great insight into her child’s problems. Through play therapy she learnt to let her child take the lead and to accept challenges. He was becoming more responsible and independent. She learnt to understand her sons through reflection of feeling and they have benefited from this and are now better able to express their feelings. She enjoyed the play sessions with her sons and shared some very moving experiences with her elder son. She enjoyed the support of the group, which made her realise that she was not alone. The information provided was useful and the setting of limits and giving choices proved to be powerful tools. She felt that she had accepted her son’s problem before joining the group, “as they had walked the path before.” She was unsure about co-facilitating a group but would be willing to share her experiences and to have her play sessions videoed. She expressed her gratitude for being part of the group and said that she would like to continue meeting on a monthly basis.

Mother I

Mother I showed growth and some change of attitude throughout the sessions. She felt that she had gained sincere understanding and support from the other group members. Although she already had a great deal of intellectual knowledge about the ADD child, she gained emotional knowledge through the group discussions. She enjoyed the play sessions with her daughter as this provided quality time and afforded an opportunity to understand her child’s feelings. So much time was spent on homework, which resulted in a great deal of stress, because time was limited and her daughter presented with a very slow work pace. She realised that she had to encourage her daughter to become more independent, but found this difficult as she still felt so sorry for her.
The giving of choices and setting of limits were valuable tools as they allowed her daughter to experience control and accept responsibility. She felt that she would like to attend monthly meetings, but did not feel confident enough to consider facilitating or videoing her play sessions. Although she maintained that she has accepted her child's problem, the facilitator feels that she is still having difficulty with fully coming to terms with it. She still expressed a great deal of anger towards teachers who she felt did not really understand her child.

Mother J

Mother J showed great courage, excitement and growth during the sessions. She reported that the play sessions and the information provided were useful to her. She realised that children also have very deep emotions, but the way they try to deal with them is very different from the way that adults express emotions. She felt that this has often led to them being misunderstood. It was a revelation to her that children could speak without words. The message she received from the group support was "Your child has a problem but hey, that's okay." She really appreciated being able to share with the other group members. She also realised that her husband was far more supportive than she had thought. It really excited her that she was able to read her son's emotions and assist him in talking about them. The giving of choices and setting of limits have made a big difference in her life. She reported that she was now able to:

- "Let him deal with the consequences of his actions."
- "Make him feel better about himself by giving him choices."
- "Teach him to express his emotions."
- "Allow him to try things on his own, before stepping in and doing them for him."
- "Try to assist him with time management."
She further reported that she felt empowered because she no longer felt that her son's problems were her fault, but that, with the right tools and guidance, she was able to understand her son. She really appreciated the fact that she and her son had grown very close. There were no longer all the fighting and tears. She felt that she was on the same wavelength as her son.

5.4 QUANTITATIVE ANALYSIS

5.4.1 Results of Parental Acceptance Scale

(Blaine Porter 1954)

Scores

<table>
<thead>
<tr>
<th>PARENT</th>
<th>INITIAL PARENT</th>
<th>FINAL PARENT</th>
<th>IMPROVEMENT</th>
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<tbody>
<tr>
<td>Mother A</td>
<td>128 Low</td>
<td>148 Medium</td>
<td>20</td>
</tr>
<tr>
<td>Mother B</td>
<td>119 Low</td>
<td>140 Medium</td>
<td>21</td>
</tr>
<tr>
<td>Mother C</td>
<td>118 Low</td>
<td>135 Medium</td>
<td>17</td>
</tr>
<tr>
<td>Mother D</td>
<td>141 Medium</td>
<td>156 Medium</td>
<td>15</td>
</tr>
<tr>
<td>Mother E</td>
<td>128 Low</td>
<td>148 Medium</td>
<td>18</td>
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<td>Mother F</td>
<td>128 Low</td>
<td>139 Medium</td>
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<tr>
<td>Mother G</td>
<td>135 Medium</td>
<td>144 Medium</td>
<td>9</td>
</tr>
<tr>
<td>Mother H</td>
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<tr>
<td>Mother I</td>
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<td>168 High</td>
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<tr>
<td>Mother J</td>
<td>132 Medium</td>
<td>148 Medium</td>
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Table 30: Results of Acceptance Scale

5.4.2 Results of Rating of Self, Family and child in Ten Areas of Focus

<table>
<thead>
<tr>
<th>M</th>
<th>P/S</th>
<th>P/I</th>
<th>P/I</th>
<th>F/I</th>
<th>D/C</th>
<th>S/B</th>
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<td>50</td>
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<tr>
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<td>10</td>
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Table 31: Results of Bloomquists Rating Scale

<table>
<thead>
<tr>
<th>Mother</th>
<th>Initial rating</th>
<th>Rating three months after completion of programme</th>
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<tbody>
<tr>
<td>C/1</td>
<td>26 28 24 16 26 22 40 35 28 15</td>
<td></td>
</tr>
<tr>
<td>C/2</td>
<td>20 20 19 13 20 16 32 26 22 12</td>
<td></td>
</tr>
<tr>
<td>D/1</td>
<td>28 15 22 20 15 31 23 17 14 20</td>
<td></td>
</tr>
<tr>
<td>D/2</td>
<td>17 12 13 11 12 24 21 18 13 17</td>
<td></td>
</tr>
<tr>
<td>E/1</td>
<td>16 21 18 22 21 31 30 30 21 13</td>
<td></td>
</tr>
<tr>
<td>E/2</td>
<td>12 20 17 19 19 24 33 19 22 35</td>
<td></td>
</tr>
<tr>
<td>F/1</td>
<td>29 27 25 26 21 29 36 34 25 25</td>
<td></td>
</tr>
<tr>
<td>F/2</td>
<td>25 18 14 22 20 23 32 32 18 28</td>
<td></td>
</tr>
<tr>
<td>G/1</td>
<td>38 29 18 32 28 33 27 43 33 29</td>
<td></td>
</tr>
<tr>
<td>G/2</td>
<td>25 23 9 30 23 37 40 35 27 28</td>
<td></td>
</tr>
<tr>
<td>H/1</td>
<td>28 21 28 33 32 34 38 35 35 36</td>
<td></td>
</tr>
<tr>
<td>H/2</td>
<td>15 12 9 15 9 14 21 18 6 15</td>
<td></td>
</tr>
<tr>
<td>L/1</td>
<td>23 10 16 22 16 27 28 21 22 22</td>
<td></td>
</tr>
<tr>
<td>L/2</td>
<td>20 20 20 22 14 19 29 30 21 20</td>
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<tr>
<td>J/1</td>
<td>14 16 10 12 16 26 24 28 20 25</td>
<td></td>
</tr>
<tr>
<td>J/2</td>
<td>19 15 12 14 14 25 23 25 16 14</td>
<td></td>
</tr>
</tbody>
</table>

KEY: M = Mother  
1 = Initial rating  
2 = Rating three months after completion of programme  
P/S = Parental stress  
P/T = Parental thoughts  
P/I = Family interactions  
D/C = Discipline related to compliance and rule following  
S/B = Children’s social behaviour skills  
S/P = Children’s social and general problem-solving abilities  
C/A = Children’s ability to cope with anger  
S/A = Children’s ability to engage in self-directed academic behaviours  
W/S = Children’s emotional well-being and level of self-esteem.

5.5 Results of Group Filial Therapy Programme

Over the ten-week period, as reported by many of the mothers, they developed a better relationship with their ADD / ADHD children. They became empowered with
knowledge and learnt different techniques to handle their children. Through the medium of non-directive play therapy, they were able to practise these techniques. These were personalised and so they experienced great success in these areas.

They enjoyed the support of the other mothers with whom they could share their feelings. They were able to cry, laugh and share advice and experiences.

The results of the Blaine Porter Parental Acceptance Scale of 1954 indicated increased acceptance for all the mothers. The range of improvement in acceptance scores was from 8 to 21.

The results of Bloomquist's rating of self, family and child in ten areas of focus also showed improvement in most areas: lower scores were obtained during the second filling out of the questionnaire. These areas were not worked on specifically so it was interesting to note the improvement.

The mothers did not report any criticism of the programme. They felt that the length was sufficient. They enjoyed all the sessions and always felt that they had learnt something.

The need to include the fathers was a recurrent theme. It was decided that the group would meet once a month for an indefinite period of time. Many of the mothers were prepared to co-facilitate groups. All of them reported that they would be prepared to share their experiences with other mothers, and assist them wherever necessary. Nine of ten mothers were prepared to video tape their play sessions for future use.

5.6 CONCLUSION

Results of the idiographic study undertaken confirm that Filial Therapy is a useful tool to help ADD / ADHD children on their journey towards self-actualisation by
improving the mother-child relationship. The mothers learnt to accept, love and enjoy their children unconditionally in totality, through learning better ways of communicating, such as reflective listening and the use of "I-messages". They learnt the value of setting limits, providing choices and ensuring that their children come to accept the consequences of their behaviour. This is important for self-actualisation. This learning took place in a group setting where the group dynamics enhanced and intensified the acquisition of these skills. The mothers all came to realise that they were not guilty of causing their child's problem and that they were being the best mothers that they could be. The mothers all reported personal growth and felt that they were more aware of their own needs. They had all achieved a greater level of self-actualization.

The summary, conclusions and recommendations of the empirical study will be outlined in the final chapter.
CHAPTER 6

SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The writer began the study with an introductory orientation, awareness of the problem, definition of the terminology, a statement of the problem, and the planning of the study which included a hypothesis and aims. This was all contained in chapter one.

Chapter two consisted of an historical overview of play therapy as a precursor to Filial Therapy. The task of mothers as primary educators was also addressed. This was based on the theory of Jacobs (1981: 150) explained as follows: "Giving meaning to their own lifeworld and that of their child, through involvement, experience and achieving self-actualisation, together with the presuppositions, namely, the forming of relationships, the living sphere and the pedagogic climate, form the foundation whereupon the intrapsychic structure, namely the I, the self, self-identity and self-concept rest. The intra-psychic mutual interaction of these components is responsible for the person's eventual behaviour."

An historical background, definition, etiology and characteristics of ADD / ADHD were discussed in chapter three. The effect on the family also received special attention.

The research design was highlighted in chapter four. Hypotheses were formulated which would eventually be accepted or rejected.

Chapter five contained a discussion of the idiographic study which formed the foundation for the empirical research. The results were analysed and
interpreted within the framework of Educational Psychology. Guidelines as to how to implement the findings and expand on the implementation of Filial Therapy could be taken directly from this chapter. As the programme was explained in step-by-step detail with all the necessary worksheets, it was felt that a further chapter would have been superfluous.

This final chapter will consist of a summary, leading to recommendations and a final conclusion.

6.2. MOTIVATION FOR STUDY

The writer first became interested in children with learning disabilities when her brother, 14 years her junior, was diagnosed as having Attention Deficit Hyperactivity Disorder. From personal experience, and during her eighteen years of work with ADD children and their parents, she became aware of the difficulties that the parents experienced in accepting and loving these special children as they did their other children. Different parents reacted in different ways. Some overcompensated and became teachers and/or therapists. Others rejected their children. Others felt that they were incompetent and that they were failures as parents. Brutter, Richardson and Mangel (1973: 128) pointed out that the mothers of learning disabled children frequently become overprotective, increasing the child's dependence on them. Omizo, Williams and Omizo (1986: 134) reinforced this statement by stating that the mother may become extremely close to or over-involved with the child. This characteristic may exacerbate an already stressful situation and may lead to marital conflict between the parents.

The different reactions of parents had an effect on the formation of their identities as parents and often resulted in the formation of a negative self-concept. Figure 1, in chapter one, was used as an analogy throughout the study.
The "bows" needed to shoot "arrows" that were not perfect, but were damaged through having ADD / ADHD. These negative feelings and the perception of having an "imperfect" child had an effect on the primary relationship established between mother and child, which can be envisioned as a skewed relationship between the "bow and arrow". The primary relationship formed between mother and child is essential in the later involvement, experience and meaning attribution of the child in respect to all subsequent relationship formation on the child's journey towards his ultimate target, namely self-actualisation.

It was felt that there was a need for parents to be trained to bond, communicate with and relate to their children without experiencing negative feelings or feeling ashamed or inadequate. There was also a need for the parents to realize that they were not alone and that their feelings and experiences were shared by others. The writer was becoming increasingly aware of these difficulties when she attended a course on Filial Therapy presented by Reyhana Ravat (1995). Subsequent courses presented by Dr. Sue Bratten (1997), Emily Oë (1997) and Garreth Landreth (1997) were also attended. This proved to be a turning point as the writer felt that this therapy could be used within the Educational - Psychological framework to assist parents in enjoying their ADD / ADHD children and at the same time enhancing the relationship with them. For then, the bow could successfully accommodate the arrow so that it could "fly swift and far on life's journey."

Group Filial Therapy, which joins two important strategies, non-directive play therapy for children and parent education through direct involvement in the change process, was felt to be the ideal means of doing this. The professional therapist served as the archer who directed the intervention, serving as both teacher and an empathic support person for the parents. Using the group format provided the forum in which knowledge could be increased and experiences could be shared.
6.3 PURPOSE OF THE STUDY

The present study sought to determine the effects of a group Filial Therapy programme on the mothers' acceptance of their children with ADD / ADHD through knowledge, empowerment and sharing by means of active involvement through the medium of child-centred play therapy. The general and specific aims were as follows:

6.3.1 General Aims

The aims of the study were:

- To undertake an in depth literature research on the phenomena, which for the purpose of the study, have two components:
  
  a) Filial Therapy: tracing the concept of play therapy and how it evolved to produce the concept of Filial Therapy based on child-centred play therapy.
  
  b) ADD / ADHD: what it is and how a child with ADD affects the family and in particular the mother-child relationship. This effect is usually caused by the way the mother reacts to the problem.

- To undertake an empirical study, using Filial Therapy as a means of allowing mothers to become aware, explore and personalize the effects of the child's learning problem on their relationship with the child within the framework of Educational Psychology with particular reference to Relations Theory (Jacobs 1997).

- To provide specific guidelines, a step-by-step programme and the necessary worksheets so that Educational Psychologists could implement Filial Therapy in educational settings or in private practice.

Table 32: General Aims of the Study
6.3.2 Specific Aims

The specific aims of the study were:

- To empower mothers with information so that they could move through the awareness period to an in depth exploration of ADD so as to reach acceptance through personalization.
- To allow mothers to enjoy their children and accept their uniqueness through the medium of child-centred play.
- To provide the mothers with a forum for sharing their feelings, frustrations and experiences with other mothers who have similar problems.
- To encourage greater interest and a better quality of involvement of the mothers in the child's learning process. This was done through teaching better communication skills, setting of limits, the giving of choices and helping the children to accept the consequences of their actions.
- To improve the relationship between mother and child initially and eventually to bring about a personal growth of each mother and child. This should lead to the child forming a more positive relationship with the self, so assisting him on his road to self-actualisation.

Table 33: Specific Aims of the study

6.3 METHOD OF RESEARCH

In order to meet the aims of the study, it was considered essential to perform a literature as well as an idiographic study. The literature study encompassed two phenomena. Chapter two detailed Filial Therapy as a development of play therapy. This chapter was concluded with a comparison between non-directive play therapy and Relations Theory. The second phenomenon researched
consisted of a historical background, definition, etiology and characteristics of ADD / ADHD and was discussed in chapter three. The planning of the study was outlined in chapter four. The actual idiographic study was detailed in chapter five.

6.4.1 Findings from the Literature Study

The purpose of the literature study was to research the phenomena, which for the purpose of the study had two components:

- Filial Therapy formed the first component of the study. To understand the concept of Filial Therapy, the history of play therapy and how child-centred play therapy evolved to produce the concept of Filial Therapy had to be explored.

- The second component consisted of an in depth discussion of ADD / ADHD, what it was and how a child with ADD, affected the family and in particular the mother-child relationship. This effect was usually caused by the way the mother reacted to child with this problem. This discussion was essential as the ADD / ADHD child became the focus of this study as a result of the demarcation for the application of Filial Therapy.

In chapter two the writer presented a description of client-centred play therapy, a historical overview of play therapy as a precursor to Filial Therapy. This was followed by a definition of Filial Therapy. The task of mothers as primary educators was also addressed during the comparison between non-directive play therapy and the Relations Theory of Jacobs (1981: 150). Referring back to figure 1 and the quotation from "The Prophet" (Gibran, 1991), this chapter thus focused on the relationship of the bow to the arrow. The different requirements for this relationship, namely the educational climate, involvement, experience and meaning attribution also received attention from a client-centred perspective.
as compared to the Relations Theory model. The area covering the distance between the bow and the target, namely the lifeworld of the child was also explained. The final focus was the target, the bull's eye being self-actualisation, the outer circles depicted the intrapsychic structure. The literature study presented in chapter two demonstrated the fact that during the early years the parents, especially the mother, exert a tremendous influence on the growth of the child to adulthood and self-actualization, affecting intellectual, emotional and social aspects. McWhirter (1976:27) accepts that the attitudes, beliefs and knowledge of parents play a critical role in the child's development of feelings about himself and in the subsequent achievement in school and adulthood.

This writer feels that the quotation about children, from "The Prophet" encompasses the Educational Psychological aim of education which is to accompany the child on his journey to self-actualization. Kahil Gibran (1991) also stresses the mutual dependency of both the bow and the arrow.

The present writer has tried to correlate the cornerstones of child-centred play therapy with the Relations Theory as presented by Unisa. This correlation formed the foundation upon which the present writer has based her empirical study. Kirk and Gallagher (1989: 8) acknowledge that the improvements in parent-child relationships which are brought about by early intervention aimed at changing the family environment through parent training are of the utmost importance. Tuttle and Panquette (1993:48) have found that invaluable advice and comfort can be obtained from other parents who have been through the system and who have learnt how to experience success. They offer advice on mistakes to be avoided and can help parents to develop trust in themselves.

The writer feels that the concept of Filial Therapy which is based on child-centred play therapy, is a wonderful intervention technique. Van Fleet (1994) felt that Filial Therapy was an intervention with wide applicability for children
with social, emotional, and behaviour problems stemming from a variety of sources.

It used a psycho-educational intervention model which was based on client-centred, dynamic, behavioural and family systems principles. In Filial Therapy, therapists teach, supervise and empower parents to conduct of child-centred play sessions with their children. For the purpose of this study the writer used the process of Filial Therapy to train mothers, whose children have been diagnosed as having Attention Deficit Disorder, to conduct play sessions with the child so as to eliminate presenting problems and strengthen their relationship. At this stage it was felt to be important to look at ADD / ADHD and the effect that it has on the family. In terms of the analogy from "The Prophet" the ADD / ADHD child can be considered to be the arrow which has to be understood, so that it can be accommodated by the bow from which it is to be shot so as to reach the "bull's eye" of self actualization.

Chapter three consisted of a study of ADD / ADHD: the background, primary behaviour problems, effect on the families, prevalence, etiology, developmental course and treatment of ADD / ADHD. It became clear that children suffering from Attention Deficit Hyperactivity Disorder may vary widely from one another in the symptoms they display. However, in general, hyperactivity, attention deficit and impulsiveness are the most common behaviours and the ones which show up most in structured environments. (Tables 18, 19, 20, 21, 22, 23, 24) It does seem that ADHD children are both unable to focus their attention selectively on a task and have difficulty in sustaining attention. Having said that, it is important to acknowledge that conceptualizing and measuring of all the manifestations of ADHD have been problematic. Children with ADHD, although often impulsive and unfocused, are within the normal range of intelligence. They often are unable to utilize this intellectual potential and are sometimes several grades or standards below children of the same chronological age group. (Figure 5). Although there is often a major reduction in ADHD by
adolescence, academic and social difficulties, which need to be addressed, often persist.

Garguilo's (1985) phases of acceptance also received a great deal of attention, as it is essential for the parents, and therapists working with parents to understand which phase the parent is experiencing. This provides insight and a starting point for therapy.

ADHD is a disorder which may lead to tremendous stress for the family, and/or teachers of the child, it is therefore, vital that they are not only given support and encouragement, but practical techniques as well. Medication, while not an ideal long-term solution, might well be a help if it enables the child to achieve better levels of concentration and improved family and social relationships. The need for parental knowledge, support and coping strategies became clear. These parents generally seemed to feel isolated and inadequate and harbour intense feelings of guilt.

6.4.2 Results and Findings of The Empirical Study

A step-by-step description of the programme, with relevant exercises and worksheets, was detailed in chapter five. This was done in an attempt to prove the hypotheses which were posed in chapter one. The hypotheses have been re-iterated below to serve as the basis for summarizing the results of the research.

6.4.2.1 Hypothesis

1) Filial Therapy, within the Educational Psychological framework, can be used as a tool to help ADD children in their journey towards self-actualization by improving the mother-child relationship.
Results of the research supported this hypothesis.

The mothers all reported an improvement in their relationships with their ADD / ADHD children. They felt that they had a better understanding of their children through knowledge gained, which in turn resulted in a more realistic acceptance. They felt empowered by the use of choices and the setting of limits. The gradual structured teaching programme led from awareness to exploration and finally to personalization.

2) Filial Therapy will help mothers to accept and love their learning disabled children unconditionally.

Results of the research supported this hypothesis.

The mothers expressed awareness of their child’s difficulties and came to realize that negative behaviour was not always manifested deliberately. As they came to "know" their children through reflective listening, they realised that much of the negative behaviour was a means of expressing dissatisfaction, a cry for understanding. They became aware that they could not take away their children's problems, but they could support them through being able to reflect their feelings and project their confidence in the child’s ability to solve his own problems. This in turn strengthened the child's self-concept which is essential for self-actualisation.

3) Filial therapy will improve the self-concept of mothers as they realize that they are being the best mothers that they are capable of being.

Results of the research supported this hypothesis.
The mothers reported that greater understanding led to decreased frustration with the child and more realistic expectations. They were better able to listen to and talk with their children, to assess problem situations, and to identify and reflect feelings. This led to a decrease in the feelings of blaming, guilt and inadequacy, which improved their self-concept as mothers. They were able to improve their relationship with their children as they learnt to enjoy their children during the play sessions.

4) Filial Therapy, because it takes place within a group, will help provide a support system for the parents.

Results of the research supported this hypothesis.

Mothers found enormous comfort in the presence of a number of parents who experienced similar stresses and, therefore, understood the frustrations and anxieties present in a family that has an ADD / ADHD child. They expressed the opinion that their parenting skills had been improved through the sharing of ideas and discussing of issues. When mothers discovered that they were not the only ones experiencing particular problems, they no longer saw themselves as inadequate.

6.4.2.2 Results of the Empirical Study

Feedback from the Filial Therapy was very positive. Favourable comments were made to the facilitator, staff members and to other parents. The mothers felt that they had gained a better understanding of their child as a unique individual. They felt empowered by the information received, and were more in control as a result of limit setting and the provision of choices, which resulted in them being able to cope with their child's demands. The group support allowed for them to
feel more competent as parents and they no longer felt isolated. They all expressed great enjoyment during the play sessions. The mothers all felt that their relationships with their children had improved resulting in improved behaviour, family dynamics and interaction.

The parents were taught to engage in a quality relationship during the weekly play sessions. They were empowered through reflective listening, encouraging, providing choices and setting limits. They learnt to follow their children rather than lead the way according to their own needs and feelings. This resulted in better communication between parent and child. Filial Therapy proved to be the ideal means of encompassing the Educational Psychological philosophy while empowering the mothers through knowledge of their children's problems and, in the supportive climate of the group, teaching them how to relate better to their children.

Three mothers missed one session each as a result of work or family commitments, otherwise attendance was excellent. Monthly follow-up sessions have taken place three times. They are still all enthusiastic and are continuing with the play sessions. Two mothers had stopped with the play and the children's behaviour showed a deterioration. They realised that the children needed this quality sharing time and quickly resumed the sessions.

The mothers did not report any criticism of the programme. They felt that the length of the course had been sufficient. They enjoyed all the sessions and always felt that they had learnt something.

The need to include the fathers was a recurrent theme. Many of the mothers were prepared to co-facilitate groups. All of them reported that they would be prepared to share their experiences with other mothers, and assist them wherever necessary. Nine of the ten mothers were prepared to video tape their play sessions for future use.
6.4.2.3 Results of The Parental Acceptance Scale

The results of the Blaine Porter Parents Acceptance Scale of 1954 indicated increased acceptance of their ADD / ADHD child, for all the mothers. The range of improvement in acceptance scores was from 8 to 21.

6.4.2.4 Results of Bloomquist's Ratings

The results of Bloomquist's rating of self, family and child in ten areas of focus also showed improvement in most areas. (Lower scores were obtained during the second filling out of the questionnaire). These areas were not worked on specifically so it was interesting to note the improvement.

6.5 LIMITATIONS OF THE STUDY

It was felt that this study was best conducted in a practical, personalised situation. However, it must be borne in mind that only 10 mothers represented the group. The writer is aware that the results cannot be generalized to a wider population. All the participants in the study had previously expressed a need for further knowledge, help and support. Thus the study included parents who were genuinely interested in their children, who showed a need to improve the relationship with their children and so were ready to grow or move towards self-actualization. Different results may have been obtained if parents were not totally committed to improving the relationship with their children. Furthermore, as pointed out by Porter (1954:179), questionnaire type of research is subject to limitations. The responses may be affected by needs or feelings, or the desire to disclose only certain facts. However, the fact that the mothers perceived changes, was very positive.
6.6 CONTRIBUTIONS OF THE STUDY

- The greatest contribution of the study was that because the programme was highly structured and adapted to the needs of the ADD / ADHD child, it could easily be used by other Educational Psychologists. The programme was set out in weekly sessions and all the worksheets and information were included. Thus there is no need for further research or input by future users. The programme was implemented by other psychologists at the school by merely following the format provided. They reported great success with the programme. The fifth group of parents at the school is now involved in the programme. Use has been made of parents who had completed the programme and they are providing valuable input. Hopefully Educational Psychologists will also make use of the programme in their private practices which will lead to greater support for all the parents of ADD / ADHD children who still feel isolated and alone.

- Filial Therapy can be used by Educational Psychologists to assist parents in coping with the needs of their children.

- Filial Therapy can be used to prevent behavioural problems in children.

- Filial Therapy can be used to improve parent-child relationships.

- The structured programme can be used as is, or it can be adapted for use with any children, or with any type of behaviour problem.

- Worksheets and exercises are included in the programme.

- Relations Theory is included in the programme and can be used to empower parents to become the best parents that they are able to be.
The programme teaches parenting skills by using the step-by-step programme.

The programme helps parents to become aware of parenting skills that they may be using, which may be detrimental to the self-actualization of their children.

Parents may become aware of "extra baggage" that they are still carrying as a result of circumstances they experienced during their own childhoods.

Specific guidelines given in the programme provide a foundation for psychologists who may not be experienced in group work.

6.7 RECOMMENDATIONS FOR FURTHER RESEARCH

6.7.1 Proposed Research based on the present study

The research carried out in this study has led to the awareness of a number of problems which merit further investigation. It is recommended that research take place in the following areas with specific reference to this study of the parents of ADD / ADHD children.

Since it might be difficult to recruit parents who are considered to be experiencing difficulty with acceptance of their child's problem and who appear uninvolved in their child's education, it is considered to be worthwhile to devise ways of involving such parents without antagonizing them.
The mothers expressed a need for their husbands to attend such a group. It is felt that the fathers might benefit a great deal if a Filial Therapy group exclusively for fathers was initiated. The present writer feels that they might experience different needs which need to be expressed.

Since the advice of many trained teachers is sometimes unsound and leads to further confusion for parents, teacher training should be investigated. The teachers themselves do not always understand the ADD / ADHD child and thus label them as being naughty. The present writer feels that it might be beneficial for teachers to attend a Filial Therapy group. It could be suggested that they use as their subject, one of the children from their class, who is felt to be a behaviour problem.

Since early intervention is considered to be imperative if the impact of the ADD / ADHD is not to have a detrimental effect on the whole family, Filial Therapy groups should be introduced in all schools enrolling children with ADD / ADHD. This would enable the parents to meet other parents and thus not feel so isolated.

These groups should be further extended so that all families, throughout South Africa, who are dealing with problem children could be encouraged to become part of a Filial Therapy group.

Since many parents of older children feel inadequate as they have never received support or guidance, the principles of Filial Therapy should be adapted to suit the needs of these parents and their children, who are already too old to participate in play therapy.
6.7.2 Proposed Research on a Wider Basis

- Filial Therapy for couples, hypothesizing improvement in the marriage relationship, as many marital conflicts appear to arise through conflict in child rearing skills.

- A study assessing the growth of the children after a course of Filial Therapy may yield interesting results.

- Studies assessing the use of Filial Therapy with single or divorced parents may be meaningful, as these parents often feel very isolated and have no support system.

- Filial Therapy with grandparents could be useful. Many children are being brought up by grandparents because the mothers are working. The traditional role of the grandparents has thus shifted. They often replace mothers as the primary caregivers.

- The concepts of Filial Therapy can be adapted to working with older children, especially the adolescent. In a study of this type the concepts would be taught but play therapy would have to be replaced by some other type of quality intervention, like art or music therapy.

- Filial Therapy can be adapted for use with any children as a preventive measure for later conflict situations.

- Filial Therapy can be adapted for use in support groups of parents with children experiencing various types of problems.
Parents of children who have suffered a loss might also benefit. Often children who have lost a sibling have many unresolved feelings that may emerge during the play sessions.

Filial Therapy can be used to improve the communication skills of both children and parents.

Filial Therapy can be used to help parents with disciplining and providing structure for their children.

Filial Therapy would be useful for foster or adoptive parents to help establish a better relationship with their children.

Filial Therapy could be used to teach parenting skills to parents who have grown up in orphanages or foster homes.

Filial Therapy can be taught to other professionals working with children so that they are able to assist parents with problems that they may become aware of while dealing with the children.

Filial Therapy might be a valuable tool in the hands of caregivers at orphanages or places of safety.

6.8 CONCLUSION

The impact of the mother on the child's development towards adulthood is great. When parents do not understand the reason for their handicapped child's behaviour and inability to achieve success, they may experience feelings of rejection, helplessness, isolation, frustration, anxiety and overprotectiveness to name but a few. These feelings may negatively affect the mother-child
relationship which is one of the prerequisites for the eventual self-actualisation of the child (Figure 5).

An overview of the literature clearly indicates that parents of ADD / ADHD children feel very insecure, incompetent and isolated when having to deal with their handicapped children. The present writer felt that support groups, although playing a very important role, seemed only to facilitate awareness and exploration. This writer felt that more was needed in that the experiences should be personalized so as to become automatic. She felt that Filial Therapy, by using the play therapy format, taught important techniques that could be practised in a novel and exciting way. This setting provided for greater involvement and new experiences which resulted in a new way of attributing meaning. It was felt that if new techniques were taught with the aim of implementation in the everyday environment these would soon fall by the way, as the old behaviour patterns were so deeply entrenched in the functioning of the mother.

Results of the idiographic study undertaken confirm that Filial Therapy is a useful tool to help ADD / ADHD children in their journey towards self-actualisation by improving the mother-child relationship. The mothers learnt to accept, love and enjoy their unique children unconditionally and in totality, through learning better ways of communicating such as reflective listening and the usage of "I-messages." They learnt the value of setting limits and providing choices where their children came to accept the consequences of their behaviour which is important for self-actualisation. This learning took place in a group setting where the group dynamics enhanced and intensified the acquisition of these skills. The mothers all came to realize that they were not guilty of causing their children's problems and that they were being the best mothers that they could be. In the words of "The Prophet":

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"You are the bows from which your children as living arrows are sent forth. The Archer sees the mark upon the path of the infinite, and He bends you with His might that his arrows may go swift and far. Let your bending in the Archer's hand be for gladness; For even as he loves the arrow that flies, so He loves also the bow that is stable" (Gibran 1991: 25).
FILIAL THERAPY GROUP

Dear Mrs

Thank you for being willing to join the group. I hope that you will benefit from this time that we spend together. Your input and feedback will be appreciated. Confidentiality will be respected.

VENUE AND TIME

The group will meet every Friday between 12:00 and 14:00. There will be a total of 10 sessions. The first session will commence on Friday 30 January, 1998. Tea will be served at 11:45. The group will meet in the old Paired Reading room or Audio-room (C 16) in the C-corridor at School of Achievement.

REQUIREMENTS

1. Total commitment.
2. File, preferably with plastic folders to store your notes, homework and handouts.
3. Notebook, pen, pencil and eraser.

A-i
APPENDIX A

4. A list of required toys that need to be acquired will be provided during the second session.

THE DISCUSSION GROUPS SHOULD PROVIDE THE FOLLOWING:

- To gain information about ADD / ADHD and the implications of being mothers of these children.
- To improve our understanding of the terms which are used to explain learning and remediation.
- To share with others our feelings about and experiences of being parents of ADD / ADHD children.
- To benefit from the support of other parents who are faced with similar problems.
- To discover ways of assisting our children on their paths to adulthood.

WHAT HAPPENS IN FILIAL THERAPY:

The parent-child relationships are strengthened through the medium of non-directive play therapy, guidance and group support. Parents will be taught skills through demonstration, role play and practise. An educational psychological perspective will form the foundation.

AIMS:

1. Establishing an educative or pedagogic climate through knowledge, care and love, respect, trust and honesty.
2. Improving relationships.
3. Understanding and giving meaning to the life-world of the child.

These are the presuppositions, which together with the attribution of meaning, experience, involvement and self-actualisation form the foundation whereupon the intrapsychic structure, namely, "I", "Self", "Identity", and "Self concept" rest. The intrapsychic mutual interaction of these components is responsible for the person's eventual behaviour or self-actualisation.

Thank you

Mandy Amott
(INTERN PSYCHOLOGIST - SCHOOL OF ACHIEVEMENT)
APPENDIX B

QUESTIONNAIRE
Adapted from Clark (1995)

Name: 
Occupation: 
Date of Birth: 
Date of Marriage: 
Number of Children: 
Sex and Birthdates of Children: 

1 Name and standard of child with ADD / ADHD: 
2 School attended: 
3 Position of child with ADD / ADHD in the family (e.g. 1st, 2nd) 
4 When did you first discover your child had ADD / ADHD? 
5 What specific behavioural manifestations does your ADD / ADHD child exhibit? 
   e.g. hyperactivity, language problems, motor problems, etc. 
6 Who made the discovery? 
7 How did you initially react to this information? 
8 What action was taken once the discovery had been made? 
9 From whom did you get the most support regarding this knowledge? 
10 How do you feel about your child's problem now? 
11 How do the siblings relate to your ADD / ADHD child? 
12 Do you and your spouse agree on the way to handle the situation? 
13 Do you and your spouse agree with regard to discipline? 
14 How does your experience of parenthood in reality differ from that for which you had hoped? 
15 What aspirations for your child did you have prior to the discovery that he / she has 
   ADD / ADHD that he / she will be unlikely to meet? 
16 How do you feel about the fact that your child may not aspire to a level at which you had 
   hoped he / she would aspire? 
17 What expectations do you have for your child now? 
   ☐ immediate goals: 
   ☐ long term goals: 
18 Do you consider your expectations of your child's success to be realistic in the light of his / her strengths 
   and weaknesses? 
19 How do you relate to your ADD / ADHD child? 
20 What things about your ADD / ADHD child annoy / disappoint you? 
21 What things about your ADD / ADHD child please you? 
22 When is your ADD / ADHD child most annoying? 
23 How frequently do you become annoyed with your ADD / ADHD child? 
24 When is your ADD / ADHD child least annoying? 
25 What do you know about ADD / ADHD? 
26 How do you describe your ADD / ADHD child to people whom he / she first comes into 
   contact? 
27 How do you feel about your child attending a remedial school? 
28 What medication is administered to your child? 
29 What is your opinion of medication being administered to children to bring about more 
   effective learning? 
30 What are your specific needs as the parent of a ADD / ADHD child that are currently 
   not being accommodated? 
31 How do you feel about attending group sessions for the following ten weeks? 
32 What goals do you wish to achieve by attending the group sessions? 
33 As a parent of a ADD / ADHD child, do you consider it necessary to have knowledge 
   of learning disabilities? 
34 How would you evaluate yourself as a parent? - Give a rating from 1-10 and explain why 
   you gave yourself this rating. 
35 How does your ADD / ADHD child effect your self esteem as a parent? 
36 How do your friends and relatives relate to your ADD / ADHD child in general? 
37 How has your ADD / ADHD child changed the way in which you socialise, if at all? 
38 How much support have you received from others regarding the problems of your 
   ADD / ADHD child and in what form? 
39 Write a paragraph about what you think the picture above is all about.

A- iii
APPENDIX C

BLOOMQUIST'S RATING SCALE

Rate the following statements

<table>
<thead>
<tr>
<th>WHERE:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

PARENTS' STRESS

1. I feel overwhelmed with responsibilities.
2. I feel depressed and unhappy.
3. I am physically unhealthy.
4. It seems like I am not taking care of myself.
5. I use drugs and/or alcohol too often.
6. I have recently experienced stressful life events (e.g., loss of job, death of significant person, divorce, etc.)
7. My spouse/partner and I don't communicate (if applicable).
8. My child is very difficult to discipline.
9. My spouse/partner and I don't agree on parenting issues (if applicable).
10. I feel like I have no support and I am all alone.

Total score

PARENTS' THOUGHTS

11. I often have the thought, "My child is behaving like a brat."
12. I often have the thought, "My child does it on purpose."
13. I often have the thought, "My child is the cause of all our family problems."
14. I often have the thought, "If I wasn't such a poor parent, my child would be better off."
15. I often have the thought, "It is his/her fault (other parent/guardian) that my child is this way."
16. I often have the thought, "My child's future is bleak; he/she will probably be irresponsible criminal, a highschool dropout (etc) when grown up."
17. I often have the thought, "My child should behave like other children; I shouldn't have to teach my child how to behave."
18. I often have the thought, "Our family is a mess."
19. I often have the thought, "I give up; there is nothing more I can do for my child."
20. I often have the thought, "I have no control over my child, I've tried everything, nothing seems to work."

Total score

PARENTAL INVOLVEMENT AND POSITIVE REINFORCEMENT

21. I don't pay much attention to my child's good behaviour.
22. I don't praise my child as much as I could.
23. I have more negative interactions than positive interactions with my child.
24. I probably give my child more attention when he/she acts negatively than when he/she acts positively.
25. I'm too busy and spend little time with my child.

A - iv
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>APPENDIX C</strong></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>When I'm with my child, I'm usually doing things (e.g., cleaning, running errands, shopping, etc.) and not really paying attention to him/her.</td>
</tr>
<tr>
<td>27.</td>
<td>I'm not involved in my child's activities (e.g., school, athletics, scouts etc.).</td>
</tr>
<tr>
<td>28.</td>
<td>My child and I are not very close to each other.</td>
</tr>
<tr>
<td>29.</td>
<td>My child and I are emotionally disconnected.</td>
</tr>
<tr>
<td>30.</td>
<td>I'm too stressed out and tired to spend &quot;quality&quot; time with my child.</td>
</tr>
</tbody>
</table>

**Total score**

<table>
<thead>
<tr>
<th><strong>FAMILY INTERACTIONS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>31.</td>
<td>We are seldom aware of when we are having communication problems.</td>
</tr>
<tr>
<td>32.</td>
<td>We express ourselves in &quot;unhelpful&quot; ways (e.g., put-downs, blaming, interrupting, talking on and on, etc.).</td>
</tr>
<tr>
<td>33.</td>
<td>We are not good at listening to each other (e.g., making poor eye contact, daydreaming, thinking about what one is going to say without listening to the other person, etc.).</td>
</tr>
<tr>
<td>34.</td>
<td>We often communicate different messages on verbal and nonverbal levels (e.g., saying, &quot;I love you,&quot; in a loud, screaming voice while pounding one's fist on a table).</td>
</tr>
<tr>
<td>35.</td>
<td>We have difficulty recognizing and defining family problems.</td>
</tr>
<tr>
<td>36.</td>
<td>Our family uses the same solutions over and over, and we don't think of new ways to solve our problems.</td>
</tr>
<tr>
<td>37.</td>
<td>We don't think ahead about whether a solution to a problem might work.</td>
</tr>
<tr>
<td>38.</td>
<td>We figure out a good solution to a family problem, but we usually don't follow through and use it.</td>
</tr>
<tr>
<td>39.</td>
<td>We usually don't recognize when anger and conflict are becoming destructive.</td>
</tr>
<tr>
<td>40.</td>
<td>We rarely know how to control anger and conflict, and it gets out of hand in our family.</td>
</tr>
</tbody>
</table>

**Total score**

<table>
<thead>
<tr>
<th><strong>DISCIPLINE RELATED TO COMPLIANCE AND RULE FOLLOWING IN CHILDREN</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>41.</td>
<td>I give in and allow my child to &quot;get his/her way&quot; because he/she is so difficult and belligerent.</td>
</tr>
<tr>
<td>42.</td>
<td>It's easier to do things myself rather than ask my child to do them.</td>
</tr>
<tr>
<td>43.</td>
<td>I have to yell, threaten, and so forth to get my child to do anything.</td>
</tr>
<tr>
<td>44.</td>
<td>My child and I have power struggles.</td>
</tr>
<tr>
<td>45.</td>
<td>I am inconsistent in disciplining approaches.</td>
</tr>
<tr>
<td>46.</td>
<td>My spouse/partner and I don't agree on discipline approaches (if applicable).</td>
</tr>
<tr>
<td>47.</td>
<td>I seem to &quot;tune into&quot; my child the most when he/she is acting negatively.</td>
</tr>
<tr>
<td>48.</td>
<td>I often don't know where my child is or what he/she is doing.</td>
</tr>
<tr>
<td>49.</td>
<td>I have no clear rules established at my home.</td>
</tr>
<tr>
<td>50.</td>
<td>There is no set time for curfew, bedtime, homework, and so forth.</td>
</tr>
</tbody>
</table>

**Total score**

<table>
<thead>
<tr>
<th><strong>CHILDREN'S SOCIAL BEHAVIOUR SKILLS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>My child doesn't have good eye contact with other children.</td>
</tr>
<tr>
<td>52.</td>
<td>My child has difficulty expressing feelings appropriately to other children.</td>
</tr>
<tr>
<td>53.</td>
<td>My child doesn't share with other children.</td>
</tr>
<tr>
<td>54.</td>
<td>My child doesn't know how to cooperate very well with other children.</td>
</tr>
<tr>
<td>55.</td>
<td>My child doesn't know how to start conversations with other children.</td>
</tr>
</tbody>
</table>

A - v
56. My child is passive with other children.
57. My child is aggressive with other children.
58. My child doesn’t ask questions of other children.
59. My child doesn’t listen to other children.
60. My child doesn’t ignore other children when he / she should.

**Total score**

**CHILDREN’S SOCIAL AND GENERAL PROBLEM-SOLVING SKILLS**

61. My child doesn’t think about what he / she is doing.
62. My child gets into trouble because of not thinking ahead about consequences of behaviour.
63. My child doesn’t work toward a goal.
64. My child seems unaware when he / she is having a problem.
65. My child does the same thing over and over, even though it doesn’t work to solve problems.
66. My child doesn’t use good strategies to solve problems.
67. My child doesn’t know when he / she is having a social problem.
68. My child is unaware of his / her effect on others.
69. My child doesn’t use good strategies to solve interpersonal difficulties.
70. My child uses primarily aggressive solutions to solve disagreements with others.

**Total score**

**CHILDREN’S ABILITY TO COPE WITH ANGER**

71. My child has an anger problem.
72. My child gets upset very easily.
73. My child is unaware when he / she is getting angry or frustrated.
74. My child destroys or damages personal or others’ belongings / property.
75. My child is violent towards others.
76. My child blows up and has anger outbursts.
77. My child is easily frustrated.
78. My child tends to be irritable and cranky.
79. I get angry at my child too much.
80. I have an anger problem.

**Total score**

**CHILDREN’S ABILITY TO ENGAGE IN SELF-DIRECTED ACADEMIC BEHAVIOURS**

81. My child is unable to organize school materials.
82. My child doesn’t effectively budget his / her time.
83. My child often doesn’t know what homework is supposed to be done.
84. My child is usually off-task and doesn’t get work done at school.
85. My child is usually off-task and doesn’t get homework done at home.
86. My child has poor study skills and habits.
87. My child doesn’t have a routine time and place set up for homework in our home.
88. I don’t really know why my child is having problems at school.
89. I am uninvolved in my child’s schooling.
90. I don’t work closely with my child’s teacher.

**Total score**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDREN'S EMOTIONAL WELL-BEING AND LEVEL OF SELF-ESTEEM</strong></td>
<td></td>
</tr>
<tr>
<td>91.</td>
<td>My child doesn't understand his / her own emotional experience.</td>
</tr>
<tr>
<td>92.</td>
<td>My child tends to deny his / her feelings.</td>
</tr>
<tr>
<td>93.</td>
<td>My child doesn't express feelings very well.</td>
</tr>
<tr>
<td>94.</td>
<td>My child doesn't tell anyone about his / her troubles.</td>
</tr>
<tr>
<td>95.</td>
<td>My child tends to think negative thoughts.</td>
</tr>
<tr>
<td>96.</td>
<td>My child doesn't like him / herself.</td>
</tr>
<tr>
<td>97.</td>
<td>My child tends to think things are awful.</td>
</tr>
<tr>
<td>98.</td>
<td>My child focuses on the negative and loses sight of the positive.</td>
</tr>
<tr>
<td>99.</td>
<td>My child tends to blame him / herself for too many problems.</td>
</tr>
<tr>
<td>100.</td>
<td>My child puts him / herself down a lot (e.g., says negative things about him / herself).</td>
</tr>
</tbody>
</table>

Review your answers to the above questions carefully. Total up the score within each of the ten areas of focus and indicate the total score where designated above. Those areas of focus with higher scores may indicate problem areas for yourself, your family, and / or your child. Those questions that were rated as a 3, 4, or 5 may indicate specific problems.
PARENTAL ACCEPTANCE SCALE

Information About Your Child

Many parents say that their feeling of affection toward or for their child varies with his behaviour and with circumstances. Will you please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

<table>
<thead>
<tr>
<th>TICK ONE COLUMN FOR EACH ITEM BELOW</th>
<th>MUCH MORE THAN USUAL</th>
<th>A LITTLE MORE THAN USUAL</th>
<th>THE SAME</th>
<th>A LITTLE LESS THAN USUAL</th>
<th>MUCH LESS THAN USUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>When he is obedient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he is with me</td>
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<td></td>
<td></td>
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<tr>
<td>When he misbehaves in front of special guests</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>When he expresses unsolicited affection. “You’re my nicest mommy (daddy) in the whole world”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he is away from me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he shows off in public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he behaves according to my highest expectations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he expresses angry and hateful things to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When he does things I have hoped he would not do.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

Read each statement carefully and then place a circle around the letter in front of the one response which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things.

It is possible that you may find a few statements which describe a type of behaviour which you have not yet experienced with your child. In such cases, mark the responses which nearly describe how you think you would feel or what you think you would do.

Be sure that you answer every statement and mark only one response for each statement.

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, it:
   a. Makes me feel annoyed
   b. Makes me want to know more about what excites him

   A - viii
APPENDIX D

c. Makes me feel like pushing him

d. Makes me feel that I will be glad when he is past this stage

e. Makes me feel like telling him to stop

12. When my child misbehaves while others in the group he is with are behaving well, I:
   a. See to it that he behaves as the others
   b. Tell him it is important to behave well when he is in a group
   c. Let him alone if he isn't disturbing the others too much
   d. Ask him to tell me what he would like to do
   e. Help him find some activity that he can enjoy and at the same time not disturb the group

13. When my child is unable to do something which I think is important for him, it:
   a. Makes me want to help him find success in the things he can do
   b. Makes me feel disappointed in him
   c. Makes me wish he could do it
   d. Makes me relise that he can't do everything
   e. Makes me want to know more about the things he can do

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:
   a. Makes me realise that he is growing up
   b. Pleases me to see his interest widening to other people
   c. Makes me feel resentful
   d. Makes me feel that he doesn't appreciate what I have done for him
   e. Makes me wish he liked me more

15. When my child is faced with two or more choices and has to choose only one, I:
   a. Tell him which choice to make and why
   b. Think it through with him
   c. Point out the advantages and disadvantages of each, but let him decide for himself
   d. Tell him that I am sure he can make a wise choice and help him foresee the consequences
   e. Make the decision for him

16. When my child makes decisions without consulting me, I:
   a. Punish him for not consulting me
   b. Encourage him to make his own decisions if he can foresee the consequences
   c. Allow him to make many of his own decisions
   d. Suggest that we talk it over before he makes his decision
   e. Tell him he must consult me first before making a decision

17. When my child kicks, hits or knocks his things about, it:
   a. Makes me feel like telling him to stop
   b. Makes me feel like punishing him
   c. Pleases me that he feels free to express himself
   d. Makes me feel that I will be glad when he is past this stage
   e. Makes me feel annoyed

18. When my child is not interested in some of the usual activities of his age group, it:
   a. Makes me realize that each child is different
   b. Makes me wish he were interested in the same activities
   c. Makes me feel disappointed in him
   d. Makes me want to help him find ways to make the most of his interests
   e. Makes me want to know more about the activities in which he is interested

19. When my child acts silly and giggly, I:
   a. Tell him I know how he feels
   b. Pay no attention to him
   c. Tell him he shouldn't act that way
   d. Make him quit
   e. Tell him it is alright to feel that way, but help him to find other ways of expressing himself

20. When my child prefers to do things with his friends rather than with his family, I:
   a. Encourage him to do things with his friends
   b. Accept this is part of growing up
   c. Plan special activities so that he will want to be with his family
   d. Try to minimize his association with his friends
   e. Make him stay with his family
APPENDIX D

21. When my child disagrees with me about something which I think is important, it:
   a. Makes me feel like punishing him
   b. Pleases me that he feels free to express himself
   c. Makes me feel like persuading him that I am right
   d. Makes me realize he has ideas of his own
   e. Makes me feel annoyed

22. When my child misbehaves while others in the group he is with are behaving well, it:
   a. Makes me realize that he does not always behave as others in his group
   b. Makes me feel embarrassed
   c. Makes me want to help him find the best ways to express his feelings
   d. Makes me wish he would behave like the others
   e. Makes me want to know more about his feelings

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
   a. Give him something quiet to do
   b. Tell him that I wish he would stop
   c. Make him be quiet
   d. Let him tell me about what excites him
   e. Send him somewhere else

24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
   a. Try to minimize his association with that person
   b. Let him have such associations when I think he is ready for them
   c. Do some special things for him to remind him how nice I am
   d. Point out the weaknesses and faults of that other person
   e. Encourage him to create and maintain such associations

25. When my child says angry and hateful things about me to my face, it:
   a. Makes me feel annoyed
   b. Makes me feel that I will be glad when he is past this stage
   c. Pleases me that he feels free to express himself
   d. Makes me feel like punishing him
   e. Makes me feel like telling him not to talk that way to me

26. When my child shows a deep interest in something I don't think is important, it:
   a. Makes me realize he has interests of his own
   b. Makes me want to help him find ways to make the most of his interest
   c. Makes me feel disappointed in him
   d. Makes me want to know more about his interests
   e. Makes me wish he were more interested in the things I think are important

27. When my child is unable to do some things as well as his others in his group, I:
   a. Tell him he must try to do as well as the others
   b. Encourage him to keep trying
   c. Tell him that no one can do everything well
   d. Call his attention to the things he does well
   e. Help him make the most of the activities which he can do

28. When my child wants to do something which I am sure will lead to disappointment for him, I:
   a. Occasionally let him carry such an activity to its conclusion
   b. Don't let him do it
   c. Advise him not to do it
   d. Help him with it in order to ease the disappointment
   e. Point out what is likely to happen

29. When my child acts silly and giggly:
   a. Makes me feel that I will be glad when he is past this stage
   b. Pleases me that he feels free to express himself
   c. Makes me feel like punishing him
   d. Makes me feel like telling him to stop
   e. Makes me feel annoyed

30. When my child is faced with two or more choices and has to choose only one, it:
   a. Makes me feel that I should tell him which choice to make and why
   b. Makes me feel that I should point out the advantages and disadvantages
APPENDIX D

c. Makes me hope that I have prepared him to choose wisely
d. Makes me want to encourage him to make his own choice
e. Makes me want to make the decision for him

31. When my child is unable to do something which I think is important for him, I
a. Tell him he must do better
b. Help him make the most of things which he can do
c. Ask him to tell me more about the things he can do
d. Tell him that no one can do everything
e. Encourage him to keep trying

32. When my child disagrees with me about something which I think is important, I:
a. Tell him he shouldn't disagree with me
b. Make him quit
c. Listen to his side of the problem and change my mind if I am wrong
d. Tell him maybe we can do it his way another time
e. Explain that I am doing what is best for him

33. When my child is unable to do some things as well as others in his group, it:
a. Makes me realize that he can't be best in everything
b. Makes me wish he could do as well
c. Makes me feel embarrassed
d. Makes me want to help him find success in the things he can do
e. Makes me want to know more about the things he can do well

34. When my child makes decisions without consulting me, it:
a. Makes me hope that I have prepared him adequately to make his decisions
b. Makes me wish he would consult me
c. Makes me feel disturbed
d. Makes me want to restrict his freedom
e. Pleases me to see that as he grows he needs me less

35. When my child says angry and hateful things about me to my face, I: Tell him it's alright to feel that way, but help him find other ways of expressing himself
a. Tell him I know how he feels
b. Pay no attention to him
c. Tell him he shouldn't say such things to me
d. Make him quit

36. When my child kicks, hits and knocks his things about, I:
a. Make him quit
b. Tell him it is all right to feel that way, but help him find other ways of expressing himself
c. Tell him he shouldn't do such things
d. Tell him I know how he feels
e. Pay no attention to him

37. When my child prefers to do things with his friends rather than with his family, it:
a. Makes me wish he would spend more time with us
b. Makes me feel resentful
c. Pleases me to see his interests widening to other people
d. Makes me feel he doesn't appreciate us
e. Makes me realize that he is growing up

38. When my child wants to do something which I am sure will lead to disappointment for him, it:
a. Makes me hope that I have prepared him to meet disappointment
b. Makes me wish he didn't have to meet unpleasant experiences
c. Makes me want to keep him from doing it
d. Makes me realize that occasionally such an experience will be good for him
e. Makes me want to postpone these experiences

39. When my child is not interested in some of the usual activities of his age group, I:
a. Try to help him realize that it is important to be interested in the same things as others in his group
b. Call his attention to the activities in which he is interested
c. Tell him it is alright if he isn't interested in the same things
d. See to it that he does the same things as others in his group
e. Help him find ways of making the most of his interests
APPENDIX D & E

40. When my child shows a deep interest in something I don't think is important, I:
   a. Let him go ahead with his interest
   b. Ask him to tell me more about this interest
   c. Help him find ways to make the most of this interest
   d. Do everything I can to discourage his interest in it
   e. Try to interest him in more worthwhile things

THANK YOU VERY MUCH FOR YOUR CO-OPERATION

APPENDIX E:

REVIEW OF THE PARENT SUPPORT GROUP FILIAL THERAPY PROGRAMME
Adapted from Clark (1995)

Please answer the questions below as honestly as possible.

Name:

What were your goals in attending the session?
Were your goals met?
What goals were not met?
In what way was the information provided useful to you?
What needs do you still have that were not met by your participation in the group sessions?
What do you feel about the discussions which took place between group members?
What quality of support did you receive from the other group members?
In what way were you of support to other group members?
In what way did you most benefit from attending the group sessions?
Which session was the most meaningful to you? Why?
Which session was the least meaningful to you? Why?
In what way do you think you're better equipped to cope with your ADD / ADHD child?
What awareness of yourself, as a parent of an ADD / ADHD child which you would consider most significant, did you reach during the ten week period?
What changes have you noted in other group members with regard to their child's ADD / ADHD over the ten week period?
In what way has attending the group sessions influenced your relationship with your ADD / ADHD child?
What did you learn about your child during the play sessions?
What did you enjoy the most about the play sessions?
Describe your most significant play session and how did you feel?
In what way have the family dynamics changed over the past ten weeks, if at all?
In which particular stage of reaction would you have placed yourself at the start of the sessions?
In which particular stage would you place yourself now?

STAGES OF PARENTAL ACCEPTANCE

<table>
<thead>
<tr>
<th>Primary Phase</th>
<th>Secondary Phase</th>
<th>Tertiary Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock</td>
<td>Ambivalence (e.g. love / hate)</td>
<td>Bargaining</td>
</tr>
<tr>
<td>Denial</td>
<td>Guilt</td>
<td>Adaptation and Organisation</td>
</tr>
<tr>
<td>Grief</td>
<td>Shame and embarrassment</td>
<td>Acceptance</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Adjustment</td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E (CONTINUED)

What would you consider to be the most important aspect of guiding an ADD / ADHD child towards adulthood?
Would you recommend group sessions for other parents of ADD / ADHD children?
How many sessions would you consider ideal?
What suggestions can you make for improving the programme? Why?
Do you wish to keep in contact with other group members?
If so, how regularly would you want to meet?
Would you be prepared to be the group coordinator should the general wish of the group members be to continue sessions of support and discussion on an infrequent basis?

APPENDIX F:

SESSION 1:1

WHAT IS A CHILD?

A Child is someone with the energy of an atom, the subtlety of a bulldozer, and an imagination that would challenge the creative effort of the most able science-fiction writer.

A Child, unless he is asleep, is in constant motion. He is a noisy, restless, squirming bundle of energy. But for all his exuberance, a child is the most sensitive of God’s creations.

A Child thrives when time is taken to answer his many questions, when he is encouraged to develop his own special talents, and, most important, when an untiring effort is made to help him broaden his own reasoning powers. But each time that he is brushed aside, or ignored, as if grown-ups, he wilts a little.

A Child is notorious for being inattentive, forgetful, and -- that most grievous fault -- a dreamer. If allowed to use his imagination, he will explore and travel a universe of concepts, which will enrich and become a part of his life. If squelched repeatedly reminded to be "practical" he will eventually retire to a prosaic little world.

A Child can consume much of your time, he can try your patience. He can exhaust your energy. But what greater reward for all your effort than to see his face radiant with a sense of accomplishment... the discovery that he has it in his power to manipulate a whole new world of knowledge and ideas.

Matthew Orlando
LISTENING

Listening is a magnetic and strange thing, a creative force... The friends that listen to us are the ones we move toward, and we want to sit in their radius as though it did us good, like ultra-violet rays... When we are listened to, it creates us, makes us unfold and expand. Ideas actually begin to grow within us and come to life... It makes people happy and free when they are listened to... When we listen to people there is an alternating current, and this recharges us so that we never get tired of each other. We are constantly being recreated.

Now there are brilliant people who cannot listen much. They have no ingoing wires on their apparatus. They are entertaining but exhausting too. I think it is because these lecturers, these brilliant performers, by not giving us a chance to talk, do not let us express our thoughts and expand; and it is this expressing and expanding that makes the little creative fountain inside us begin to spring and ease up new thoughts and unexpected laughter and wisdom.

I discovered all this about three years ago, and truly it made a revolutionary change in my life. Before that, when I went to a party, I would think anxiously: "Now try hard, Be lively. Say bright things. Talk, don’t let down." And when tired, I would have to drink lots of coffee to keep this up. But now before going to a party, I just tell myself to listen with affection to anyone who talks to me, to be in their shoes when they talk; to try to know them without my mind pressing against theirs, or arguing, or changing the subject. Now my attitude is: "Tell me more. This person is showing me his soul. It is a little dry and meagre and full of grinding talk now, but presently he will think, not just automatically to talk. He will show his true self. Then he will be wonderfully alive..."


SESSION 1:3

Adapted by Sue Bratton, Ph.D.

THE FOUR BASIC FEELINGS

1.  

2.  

3.  

4.  

A - xiv
Briefly describe what happened and/or what your child said. Then write down your reflection of feeling response.

Child:
Parent:
Child:
Parent:

SESSION 1:4

A NEW DAY

This is the beginning of a new day
God has given me this day to use as I will.
I can waste it or grow in its light
and be of service to others
But what I do with this day
is important because I have
exchanged a day of my life for it
when tomorrow comes
today will be gone forever.
I hope I will not regret
the price I paid for it.
[anon.]
And a woman who held a babe against her bosom said, Speak to us of children.

And he said:

Your children are not your children.
They are the sons and daughters of Life’s longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.

You may give them your love but not your thoughts,
For they have their own thoughts.

You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow,
which you cannot visit, not even in your dreams.

You may strive to be like them, but seek not to make them like you.
For life goes not backward nor tarries with yesterday.

You are the bows from which your children as living arrows are sent forth.
The Archer sees the mark upon the path of the infinite, and He bends you with His might that His arrows may go swift and far.

Let your bending in the Archer’s hand be for gladness;
For even as he loves the arrow that flies, so He Loves also the bow that is stable.

BELIEVE YOU CAN

You have the power of which you have not dreamed
You can do things you never thought you could do
There are no limitations to what you can do -
Except the limitations of the mind.

Don’t think you can’t - believe that you can!
Believe in yourself.

If you believe you are beaten - you are
If you think you dare not - you don’t
If you’d like to win but think you can’t
It’s almost a cinch you won’t
If you think you’ll lose you’re lost.

For out in the world we find
Success begins with a fellow’s will
It’s all a state of mind.

If you think you are outclassed - you are
You’ve got to think high to rise
You’ve got to be sure of yourself before
You can ever win a prize!

Life’s battles don’t always
Go to the stronger or faster man
But sooner or later, the man who wins
Is the one who thinks he CAN.

CONSTRUCTING THERAPEUTIC RESPONSES IN THERAPY

Early Exploratory Stage

1) Description of Content.
"I see you are crashing the cars together?"

Later Exploratory Stage

2) Affect expressed by therapist in role play, or labelling child’s affect, attributing it to the toy taken within the context of the child’s play.

Label affect consistently:
a) to see if in touch with the child
b) to enhance the child’s affective vocabulary.
"The blue car feels hurt when it gets hit."

(Revat, 1995)
APPENDIX F

Limit Setting

3) Recognise the feeling behind the testing of the limits first, then set the limit.
"I know you are angry at me and that's okay, but I still won't let you throw the toys."

Early Therapeutic

4) Pair the affect or motivation with the observed Growth Stage to what happens outside the session.
"I've noticed that whenever you feel hurt, you like to crash the cars, shoot the guns and boss me around."

Later Therapeutic

5) Connect the emotion and behaviour pattern Growth Stage to what happens outside the session.
"The blue car feels hurt when it gets hit just like you feel hurt when Dad says he'll come get you for visitation and doesn't show up."

TRACKING THE IMPACT OF RESPONSES TO CHILDREN

When Responses are Accurate:

1. The child will intensify the play activity.
2. The child will make an additive play response.
3. The child will reduce the distance between self and therapist.
4. The child will have an instant "pause" response.
5. The child will include the therapist in the play (Ask the therapist to join the play depending upon the meaning of play and capacity to participate).
6. None of the above responses, but with none of the following responses.

When Responses are Inaccurate:

1. The child will diffuse from the play focus.
2. The child will change the play focus to another activity.
3. The child will distance him/herself from the therapist.
4. The child will exclude the therapist for the play activity.
5. The child will stop play completely.

SESSION 2:3

CHILD-PARENT-RELATIONSHIP TRAINING (CPR for PARENTS)

BASIC PRINCIPLES OF THE PLAY SESSION

1. The child should be completely free to determine how he will use the time. The child leads and the parent follows without making suggestions or asking questions.
2. The parent's major task is to empathize with the child, to understand the intent of the child's actions, and the child's thoughts and feelings.
3. The parent's next task is to communicate this understanding to the child by appropriate comments, particularly, whenever possible, by verbalising the feelings that the child is actively experiencing.
4. The parent is to be clear and firm about the few "limits" that are placed on the child. Limits to be set are time limits, not breaking specified toys, and not physical hurting the parent.
Goals for the Play Session

1. To help the child change his/her perceptions of the parent's feelings, attitudes, and behaviour.
2. To allow the child - through the medium of play - to communicate thoughts, needs, and feelings to the parents.
3. To help the child to develop more positive feelings of self-respect, self-worth, and confidence.

Reminder

These play sessions and the techniques you use are relatively meaningless if they are applied only mechanically and not as an attempt to be genuinely empathic and to truly understand your child.

Toys for the Play Sessions

Play Doh, crayons, paper, blunt scissors, nursing bottles (plastic), rubber knife, dart gun, a family of small bendable dolls, toy soldiers, small plastic car, Lone Ranger type mask, Tinkertoys, doll house furniture (kitchen, bedroom, bathroom), doctor kit, play money, a 3-5' piece rope, a Bobo, ring toss game, box of bandaids, Scotch tape, hand cuffs, pacifier, pipe cleaners, checkers and small cardboard box to store toys in. A hand puppet toy would be a special asset. Feel free to discuss with us the addition of other items.

Place for the Play Session

Whatever room you feel offers the fewest distractions to the child and the greatest freedom from worry about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed - no phone calls or interruptions by other children. You may wish to explain to your child that you are having these sessions because you are interested in learning how to play with them in a different, "special" way than you usually do.

Process

Let the child use the bathroom prior to the play session. Tell the child, "we will have thirty minutes of special play time and you may choose to play with the toys in many of the ways you like to." Let the child lead from this point. Play actively with the child if the child requests your participation. Set limits on behaviours that make you feel uncomfortable. Track your child's behaviour and feelings verbally. Do not identify toys by their normal names: call them "it," "that," "her," "him," and so forth. Give the child a five minute advance notice before terminating the session. Do not exceed the time limit by more than two to three minutes.

(Ravat, 1995)

Education

Unlimited.
FACILITATING REFLECTIVE COMMUNICATION
(Session #2 Handout)

What response would you make to the following situations if you were practising reflecting the child’s feelings:

1. Joe: (With wrinkled brow, red face, and tears in his eyes) “We lost. That team didn’t play fair!”
   Parent:

2. Jill: (Enters with C-test paper in hand) “I tried so hard but it didn’t do any good.”
   Parent:

3. Janet: (Rummaging through her drawer wildly, looking for a particular sweater she wanted to wear to the party she had been looking forward to for a long time) “I can never find anything I want.” (Begins to cry.)
   Parent:

4. John: (Undressing Barbie doll) “Wow! Look at her butt!”
   Parent:

5. Carol: (Looking through the doorway to a dark room) “What’s in there? Will you come with me?”
   Parent:

6. Charlie: (Showing you his torn, smudged painting from school) “Look, MOM! Isn’t it neat! My teacher said I was a good artist!”
   Parent:

SESSION 2:5

APPOINTMENT CARD

DATE: AT AM
PLACE:

FILIAL THERAPY CONTRACT

I, ... do, hereby agree to continue Special Play Time sessions at home with my child...
I agree to continue for at least ... weeks after the end of this course. I understand that
by following the agreement stipulated in this contract that I may significantly enhance
the relationship I have with my child.

Signature: Date
Witness: Date

I’M HERE  I HEAR YOU  I CARE

Education
Unlimited

A - xx
PICTORIAL EXPRESSION OF FEELINGS

- Aggressive
- Anxious
- Bored
- Cautious
- Cold
- Concentrating
- Confident
- Curious
- Determined
- Ecstatic
- Enraged
- Exhausted
- Frightened
- Frustrated
- Happy
- Hot
- Hungover
- Indifferent
- Interested
- Lonely
- Meditative
- Mischief
- Negative
- Optimistic
- Relieved
- Sad
- Sheepish
- Surprised
- Suspicious
- Thoughtful
SESSION 3.2

BASIC RULES FOR FILIAL THERAPY

DON'T
1. Don't criticize any behaviour.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach.
7. Don't imitate new behaviour.
8. Don't be passive, quiet.

DO
1. Do set the stage.
2. Do let the child lead.
3. Do track behaviour.
4. Do reflect the child's feelings.
5. Do set limits.
6. Do salute the child's power and effort.
7. Do join in the play as follower.
8. Do be verbally active.

CHECK YOUR RESPONSES TO YOUR CHILDREN

Your responses should convey:
1. "You are not alone. I am here with you."
2. "I understand how you feel and I hear/see you."
3. "I care."

Your responses should not convey:
1. "I will solve your problems for you."
2. "I am responsible for making you happy."
3. "Because I understand you, that means I automatically agree with you."

SESSION 3.3

RULES FOR PLAY SESSION

1. The therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely.
4. The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.
6. The therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship and resists any urge to direct the child's play or conversation.
7. The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The therapist establishes only those therapeutic limits which help the child accept personal and appropriate relationship responsibility.

SESSION 3:4

TECHNIQUES OF LIMIT SETTING

1. **Acknowledge** your child's feeling or want. This lets the child that you do understand.
   
   I know you would like to watch TV.  
   I know you would like to spend a long time eating cereal.  
   I can tell you don't want to leave now.  
   I can tell you are really angry at Johnny.

2. **Communicate** the limit. State the rule or tell what needs to be done.
   
   But the TV time is over.  
   But it’s time to go to school now.  
   But it’s time to leave now.  
   But Johnny is not for hitting.

3. **Target** the alternative.
   
   You can go turn the TV off or you can have me turn it off.  
   You can finish the cereal in 1 minute or you can have me take it away in 1 minute.  
   You can hold my hand and walk out with me or you can walk on your own.  
   You can tell him that you are angry.

When limits need to be set it is time to **ACT**.

   I’m here I hear you I understand I care

SETTING THE LIMITS: EXAMPLES

1. Susan picks up the dart gun, aims it at your head. Respond.
2. John is anxious to play with friends and insists on leaving the room before your session is over. Respond.
3. Linda picks up a crayon, announces she is going to draw the outline of her hand on the wall. Respond.
4. Paul is very angry with you, curses you, and hits and kicks you. Respond.
5. Jennifer starts to pull the head off a $80.00 doll. Respond.
6. Jim wants to play doctor with you and asks you to take off your clothes. Respond.

SESSION 4.1

THE SCIENCE OF CONTROL

Many proud parents spend a lot of time trying to take control of the actions of children. This is natural. It is easy to feel like bad parents when we see our children out of control.

There is nothing more pathetic to see than a child out of control. This scares parents and children alike. A child who knows that he is out of control feels insecure. He puts on a tough exterior. His actions are easy to misread because they appear to be attempts to show that he cannot and will not be controlled. He needs limits, but often fights having them.

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Parents can place limits in these situations by giving away some of their control. At the same time they will be gaining more control. This small miracle comes about when children are given choices rather than orders.

It is also refreshing to know that the same technique reduces stress in families while preparing children to make decisions that affect them as they go through their lives. It provides wonderful preparation for the real world in which they will live.

Consider this situation in which a parent gives some control to the child while gaining more for himself. A youngster is making too much noise in the family room. A typical parental response might be, "Quit making so much noise. You're making me mad!"

This usually does not work since it gives the child the wrong kind of control. He feels that he now has the power to make his parent mad.

This parent gives the child some positive control over his own life by offering choices, "You can either stay here with us being quiet, or go somewhere else to make your noise."

A determined youngster might fight this by saying, "I'm staying here! I have just as many rights as you do!"

The parent's calm reply is simply, "That's not one of the choices. But feel welcome back with us when the noises are finished."

Providing choices is based upon the fact that most people cannot make decisions about themselves and fight with others at the same time. Parents can easily set the limits children need by taking good care of themselves at the same time they offer the choices. The parent in this last example sets limits regarding the child's behaviour around others without putting the child down.

The youngster's dignity was maintained as he was left with the decision regarding his behaviour. The parent's dignity was maintained as he handled the situation in a calm, controlled manner.

Dealing with choices and being held responsible for decisions is wonderful practice for youngsters. It prepares them for the lifetime of decision making required of all responsible people.

Effective parents offer choices only when they are willing to make sure the child will have to live with the consequences of this choice.

These parents know that children need to learn from their mistakes. Mistakes are often better teachers that parents who lecture.

From Cline/Facy Institute, Inc. 1985.
An Information Sheet for Parents

Parents, you can use what researchers have found to be the most effective approaches by following these ‘Five ! “C”s of Effective Discipline’.

1. **Clarity**

   Be clear in stating rights, rules and limits.
   - Children need to know what the rules are, what the discipline will be for breaking a rule and what that discipline is intended to achieve.
   - Make this rule unmistakable: use of alcohol, cigarettes or any other drug by children will not be tolerated.
   - Be direct and honest in establishing rights, rules and limits. Never be secretive or try to manipulate. If your child is confused about a rule (“But you smoke...”) answer questions as honestly as you can.
   - Some families write out rules about homework, TV viewing, curfews, friends, spending money and responsibilities.

2. **Consistency**

   Be consistent in rules and discipline or reward, but be flexible, too, to encourage growth.
   - There are times when an exception can be made to a curfew or some other rule.
   - Whenever possible, make this exception beforehand. This helps develop the child’s sense of responsibility.
   - Avoid adding new disciplines that were not discussed before the rules were broken.

3. **Communication**

   Talk often about rights, rules and limits and the reasons for them.
   - Help your child learn to talk openly and honestly about feelings and needs - including the need for help.
   - Talk about expanding rights and changing limits as your child grows. This shows respect for children’s need to explore, take risks and become more independent.
   - Be willing to discuss the fairness of any rule.

4. **Caring**

   Show affection and love often without being overly protective. Children who have close, affectionate ties with their parents are most likely to obey family rules: this is more important than how strict or permissive you are.
   - Criticize the action, not the child. Instead of saying, "How could you be so stupid?" say, "Do you know why that was dangerous?"
   - When rules are broken, act in a calm way and carry out the discipline your child expects.
   - Show respect for your child’s rights, such as the right to privacy.

5. **Create**
Create a sense of social responsibility. Give your children regular duties to help them develop self-discipline and a sense of accomplishment.

- Hold your children accountable for their actions.
- Help your children develop a sense of self-respect so that they think about how an action will make them feel about themselves.

SESSION 4.3

Let's Not Forget How to Play

Once two boys who were already into their second and third year of Little League baseball, respectively, came home with friends from the park on a summer morning planning a neighborhood baseball game.

All of us were baseball-ed up to here, what with driving car pools, buying uniforms, practising batting with daddy in the back yard, memorizing rules over dinner, arguing over who got which number, taking ice chests and scheduling who brought drinks, and so the boys, profiting from our benign neglect, managed to spend three weeks planning their own summer morning baseball game. They formed and reformed the teams, they help practices, they fired each other as coaches, they commandeered equipment, filched cold drinks, "borrowed" an ice chest.

Finally, one morning, the kids all went down to the park and played The Game. It lasted three, maybe four innings, they lost count. Nobody remembered the score, but that didn't matter any way because they rearranged the team halfway through; they gave Mikey an extra turn at the bat because he always struck out, and big John agreed to run only as far as second base on his powerhouse hits.

This, in short, was a game truly "played" out in response to the needs and desires of the group as they arose. Each rule and nuance was worked out by the children as it came along, and their control of it was supreme.

It remains the best game in memory; and nobody knew the score.

What does all this mean, you may grump.

Heck, if I know.

But somewhere back in some small, niggling, irrepressible part of my unstructured instinct, I suspect that in our pursuit of games, in our insistence for performance, our idolization of skill, even our infatuation with oxymorons like "educational toys" and "good sports", we have discarded "play" and discouraging most of us from trying to participate in games ourselves. And so we become a nation of passive fans, watching the few, the able, play out our games, our music, our fantasies.

No wonder we have to pay them so much.

They don't do it for the fun, you know.
SELF-CONCEPT

MOVEMENT OF THE SELF-CONCEPT BETWEEN THE POSITIVE AND NEGATIVE POLES

NEGATIVE  \(\rightarrow\)  POSITIVE

A realistic self-concept
A realistic positive self-concept
A realistic negative self-concept
An unrealistic positive self-concept
An unrealistic negative self-concept

THE SELF-CONCEPT IN NEGATIVE POSITION

NEGATIVE  \(\rightarrow\)  POSITIVE

SELF TALK
Identity Formation = "who am I".
Self-actualization - to become what I can, want to and ought to become.

Physical Self: the self in relation to the awareness of the body.
Personal self: the self in his own psychic relationships
Family self: the self in relation to the family.
Social self: the self in social relationships
Moral self: the self in relation to moral norms
Intellectual self: the self in relation to intellectual abilities.
Self-criticism:
SESSION 5:3

ARE YOU AN ENSLAVED PARENT?

While many parents are indentured to kids who control the household and demand the moon, psychologists are writing a Parental Emancipation Proclamation.

By Lewis Vaughn

PREVENTION - January 1985

Sixteen-year-old Robbie Jones is lord of all that he surveys - which includes a house in suburbia, two cars, one motorcycle, a roomful of electronic playthings and two subversive parents. Because he throws well-timed tantrums, he's allowed unlimited use of both cars, all the late-night partying he can stand and meals at any hour, compliments of his mother. Because he disdains household chores, his parents end up cleaning his room, doing his laundry and fetching whatever he says fetch. And because he threatens to leave home, he's granted veto power over every family decision.

SLAVERY LIVES IN THE HEARTLAND

Indeed, the people whom this fictional family represents dot the social landscape. Family psychologists report that their practices are cluttered with parents indentured to their own sons and daughters, parents who spend every waking hour trying to gratify children never gratified, parents whose decisions are countermanded by children too young to make decisions, parents trying to wrest control from children out of control. And out of the strained relationships often boil family anger, fear and guilt - or worse.

Joseph R Novello, MD, a child psychiatrist is Washington, DC, and author of "Bringing Up Kids American Style" (A and W Publishers, Inc. 1981), has seen such families many times. "The most common problem, he told PREVENTION. "is the behaviourally disordered youngster who is out of control in terms of both his own internal self-control and his parents' efforts to discipline him. Such a youngster may be excessively impulsive or destructive or demanding. He may refuse to keep rules or respect family relationships. He may whine or cry repeatedly to get his own way. And his parents acquiesce. They may be too scared and intimidated to change the situation. They have lost their position of leadership in the family, and the child is in charge."

ROOT OF SLAVERY

But why? Why are so many parents in bondage?

Many experts blame the era of parental permissiveness. "Permissive parenting," says Dr Novello, "which was so stylish in the late 40s, the 50s and the 60s. Unfortunately lives on today. Initially, it was based on the erroneous concept that if kids were freed from neurosis-producing parental control, they would develop their natural talents and realise their greatest potential in life. Later, I'm afraid it became simply a handy cop-out for individuals who lacked the confidence and will to provide parental leadership."
This laissez-faire approach and the theories that spawned it are now on the wane, say some psychologists. And the biggest argument in favour of the decline is not the recent scientific studies that contradict the permissive parenting mode. It's the mode's negative consequences that family therapists say they see every day.

"I am convinced that these (permissive) theories have brought much sorrow to American families," says Victor B Cline, PhD, professor of psychology at the University of Utah and author of "How to Make Your Child a Winner" (Walker and Company, 1980). "Again and again I've seen in parents a paralysis of will and an uncertainty about what to do when their children become abusive, destructive and manipulative. I've repeatedly seen parents function as servants and children as masters."

But according to child psychologists the let-the-kid-do-his-own-thing ethic isn't the only factor in the servant-master syndrome. Parents, they say, often overreact to their own oppressive mother or father by giving their own children free rein. Or they become so confused that they do nothing. Or they're too busy to address the problems that arise. Or they're just a little mixed up about love.

(Ravat, 1995)
Education Unlimited
FOR ALL CHILDREN
just to let them know that parents have limitations!

I gave you life
but cannot live it for you
I can teach you things
but I cannot make you learn
I can give you directions
But I cannot always be there to lead you
I can allow you freedom
but I cannot account for it
I can take you to church
but I cannot make you believe
I can teach you right from wrong
but I cannot always decide for you
I can buy you beautiful clothes
but I cannot make you beautiful inside
I can offer you advise
but I cannot accept it for you
I can give you love
but I cannot force it upon you
I can teach you to share
but I cannot make you unselfish
I can teach you respect
but I cannot force you to show honour
I can advise you about friends
but I cannot choose them for you
I can advise you about sex
but I cannot keep you pure
I can tell you the facts of life
but I cannot build your reputation
I can tell you about drink
but I cannot say NO for you
I can warn you about drugs
but I cannot prevent you from using it
I can tell you about lofty goals
but I cannot achieve them for you
I can teach you about kindness
but I cannot force you to be gracious
I can warn you about sins
but I cannot make your morals
I can love you as a child
but I cannot place you in God’s family
I can pray for you
but I cannot make Jesus your Lord
I can tell you how to live
but I cannot give you eternal life.

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ONLY YOU CAN MAKE THE DIFFERENCE

- You alone can bring magic - and humour, and joy - to the people you encounter.
- Anything you dream, by the very nature that you can dream it, makes it possible.
- The purpose of life is to help others. And if you can't help them, would you at least not hurt them?
- You CAN make things happen that you never thought you could!
- The greatest risk in life is to risk nothing. The person who risks nothing does nothing, has nothing and is nothing.
- To be is to do - and to do is to do NOW because tomorrow might not be there.
- You have everything you need to be so much ... don't settle for less!
- There is no end to human potential - and there's so much more to learn.
- The time for action is NOW - and only YOU can make the difference

Leo Buscaglia

MY PERSONAL STRENGTHS SHEET

Place a check mark next to each strength that you think you have. You might also have your parents or grandparents go over the list and tell you which ones they think you have, too. Sometimes other people see our strengths more than we do.

- able to give orders
- able to take orders
- able to take care of self
- accepts advice
- admires others
- affectionate
- alive
- appreciative
- articulate
- artistic
- assertive
- athletic
- attractive
- bright
- brave
- businesslike
- calm
- can be firm if necessary
- caring
- clean
- committed
- common sense
- communicates well
- compassionate
- considerate
- cooperative
- courteous
- creative
- daring
- dedicated
- dependable
- diligent
- discipline
- do what needs to be done
- don't give up
- eater to get along with others
- eager to please
- effective
- efficient
- elegant
- encourages
- others
- enjoys taking care of others
- fair feeling
- forceful
- frank and honest
- friendly funny
- generous
- gets along with others
- gets things done

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## APPENDIX F:

**session 5:6**

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<td>good dancer</td>
<td>often admired</td>
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A - xxxiv
WHERE AM I GOING?

After studying successful people in all walks of life, we discovered that most of them have practiced ten specific steps to success. We also learned that these steps and skills associated with them are teachable to any age student. Some of these skills have been introduced already and others are incorporated in this and later sections.

This repetition is deliberate on our part because we feel that these principles skills need to be taught and retaught many times; for example, the strategies. visualization and affirmations are suggested in several of the activities throughout the book.

THE 10 STEPS TO SUCCESS

1. Acknowledge the Positive Past.
   • Let go of your past hurts. (Feel it . . . Forgive . . . and Forget)
   • Do the mirror exercises every morning and night.
   • Keep a “Victory Log.” Write down all of your successes everyday.

2. Positive Self-Talk:
   • Use only positive self-talk (“I can . . .” and “I will . .
   • Do not use “I can’t . . .,” “I’ll never, or, They made me
   • If you think a negative thought, whack the vulture!
   • If someone puts you down, say

   "NO MATTER WHAT YOU SAY OR DO TO ME,
   I'M STILL A WORTHWHILE PERSON."

3. Acknowledge and Affirm Your Strengths:
   • Write down all of your personal strengths
   • Ask others to tell you what they see as your strengths
   • Review the “My Strengths,” sheet every week.

4. Clarify Your Vision and Your Values:
   • Decide what is important to you.
   • Notice whom you admire and what you admire about them; then create a plan to become more like them.

5. Plan Your Future:
   • Set goals
   • Write your goals down . . . make them specific and measurable

6. Visualize and Affirm Your Success:

   A - xxxv
APPENDIX F:

- Say your affirmations. Close your eyes and see yourself as a winner. Do this every day when you wake up, at lunch time, and before you go to bed.

7. Act to Create It:
   - TAKE ACTION... DO IT NOW.
   - Act as if you have already reached your goal.
   - ASK, ASK, ASK, ASK, for what you need and want UNTIL YOU GET IT!

8. Respond to Feedback:
   - Look for feedback and ask for feedback
   - When you are “off course,” get back “on course.”
   - Remember: It’s O.K. to make mistakes. Just learn from them.

9. Persevere
   - Never give up your dream
   - Keep on keepin’ on.
   - Remember: There is no such thing as failure. Failure means a second chance to reach your goal.

10. Reap the Rewards:
    - When you reach your goal, give yourself a reward.
    - Thank other people who have helped you reach your goal.

SESSION 6.2

SOME THOUGHTS ON AGGRESSION

Ralph Kantor describes aggression as a process whereby the child (and many times a parent) feels more and more helpless. This helplessness builds through a four stage process as follows:

1. Irritant & Inability to remove = Frustration (Awareness)
2. Frustration & Inability to remove = Anger (Focused Action)
3. Anger & Inability to remove = Rage (Beginning Distortion of Action)
4. Anger & Inability to remove = Fury (Complete Distortion of Action)

After fury is reached, Kantor continues, exhaustion occurs and both child and parent are left feeling temporarily overwhelmed and powerless. The increased powerlessness/helplessness felt by a child and often a parent only must be eliminated. A key to this shifted circle is an understanding by both parent and child that power is not something held over someone else but is, instead, power over self. The final thrust then, in learning to manage a child’s aggression is, in fact, managing our own aggression.

Following is a list of techniques found effective in increasing the power of both parent and child.

3. Lower one’s voice and talk softly.
4. Use the child’s name over and over in a reassuring voice.
5. Refer to the child’s last success and compliance.
6. Use silence for thirty-sixty seconds as the child’s aggression builds.

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APPENDIX F:

6. Use silence for thirty-sixty seconds as the child's aggression builds.
7. Leave the room giving the child time to gain self-control and thus, "save face".
8. Switch the subjects of conflict to some topic of non-threatening nature for a few minutes.
9. Give permission to be angry.
10. Exaggerate the conflict to humorous proportions.
11. Interpret the aggression to the child - determine and discuss the true origin of the aggressive behaviour.

Through an understanding of aggression and the use of techniques stated above, one can go beyond simple "child control" to more complex and challenging task of "child development", Kantor concludes.

SESSION 6:2

STRUCTURED PLAY SESSION

Parents can use structured play sessions to teach children how to work through anxiety about specific events.

Special Materials: Besides your regular play session materials, make sure you have enough dolls and stuffed toys to represent you, the child, and any other relevant family members or significant others.

Process: Act out with the child a Story sequence that parallels the anticipated anxiety producing situation (i.e. visiting a divorced parent, going to kindergarten, visiting the doctor, etc. Eventually, if the event is habitual, the child may decide to tell you the story... By depicting the expected sequence of events, you show the child that you believe they will make it through okay, and that you are aware of them and their upcoming experience. It can also be helpful to let the child act out the event after they return.

LET'S NOT FORGET HOW TO PLAY'

Once two boys who were already into their second and third year of Little League baseball, respectively, came home with friends from the park on a summer morning planning a neighbourhood baseball game.

All of us were baseballled up to here, what with driving car pools, buying uniforms, practising batting with daddy in the back yard, memorizing rules over dinner, arguing over who got which number, taking ice chests and scheduling who brought drinks, and so the boys, profiting from our benign neglect, managed to spend three weeks planning their own summer morning baseball game. They formed and reformed the teams, they helped practices, they fired each other as coaches, they commandeered equipment, filched cold drinks, "borrowed" an ice chest.

Finally, one morning, the kids all went down to the park and played The Game. It lasted three, maybe four innings, they lost count. Nobody remembered the score, but that didn't matter any way because they rearranged the team halfway through; they gave Mikey an extra turn at the bat because he always struck out, and big John agreed to run only as far as second base on his powerhouse hits.

This, in short, was a game truly "played" out in response to the needs and desires of the group as they arose. Each rule and nuance was worked out by the children as it came along, and their control of it was supreme.
APPENDIX F:

It remains the best game in memory; and nobody knew the score.

What does all this mean, you may grump.

Heck, if I know.

But somewhere back in some small, niggling, irrepressible part of my unstructured instinct, I suspect that in our pursuit of games, in our insistence for performance, our idolation of skill, even our infatuation with oxymorons like "educational toys" and "good sports", we have discarded "play" and discouraging most of us from trying to participate in games ourselves. And so we become a nation of passive fans, watching the few, the able, play out our games, our music, our fantasies.

No wonder we have to pay them so much.

They don't do it for the fun, you know.

Reprinted from the article in The Dallas Morning News March 8, 1987 by Ann Melvin

SESSION 6:3

STRUCTURED DOLL PLAY

What is structured doll Play?

Structured doll play is a lively way of story telling. It provides a brief and specific experience for the children to prepare them for anxiety provoking experiences such as parents' divorce, going over to the babysitter, etc. It has a specific purpose and a clear message (e.g. Mom is going to come back at the end of the day to pick Lucy up).

Can my child benefit from structured doll play?

If your child is showing anxiety or fear, or has been through a traumatic experience, he/she can probably benefit from this special experience. Structured doll play works best with children from ages 2-6. However, older or younger children can also benefit from it.

Can I do structured doll play with my child?

Yes, you as a parent are the most appropriate person to do this for your child.

How do I do structured doll Play?

1. Structured doll play is basically creative story telling about specific real life happenings. It is similar to reading a story from a story book to your child, the major differences are:


b. The story involves real life characters such as Mom, Dad, Lucy (your child), babysitter Jane, Grandma, school-teacher, etc.

c. The story is about real life happenings, usually about future events that are coming up in the next day or two. It can also be a story of routine daily happenings.

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APPENDIX F:

d. You have a specific purpose and a clear message. For example: Lucy is reluctant to go to a day care centre. She would not let you leave when you dropped her off at day care. Your purpose is helping Lucy to feel more comfortable about going to day care. Your message may be "Mom is going to return at the end of the day."

e. You use dolls to enhance the dramatic effect and help your child remember. You can also use sound effects to enrich the story and make it more powerful. Remember, young children understand concrete things like dolls and scenes better than promises and reasons.

2. The Making of Story

A story includes a beginning, a middle, and an end.

Beginning - Don't start off by saying Lucy is going to the babysitter. Start off by giving some background for the story. (E.g.: waking up in the morning).

Middle - Give content to the story by putting in details (e.g.: putting on shoes, buckling seat belt).

End - Remember to end the story. Don't leave your child hanging. End the story with a big kiss. "Mom drives to the babysitter's (Jane) house and rings the bell (Ding-dong). Jane opens the door and Lucy sees Mom. Lucy jumps into Mom's lap. Mom gives Lucy a big hug and a big kiss (make kissing sound). Mom and Lucy drive home together. They talk about the day on the way home."

Steps

a. Start with a title sentence (e.g. This is a story about Lucy going to the babysitter).

b. Introduce the characters by using real names of people.

c. Tell the story.

d. Do not use "you" to refer to the doll representing your child. Use your child's name to stay objective (e.g.: Lucy is saying goodbye to Mom, rather than "you are saying goodbye to Mom").
APPENDIX F:

SESSION 6:4

CHILDREN LEARN WHAT THEY LIVE

Dorothy Law Nolte

If a child lives with criticism,
he learns to condemn.
If a child lives with hostility,
he learns to fight.
If a child lives with fear,
he learns to be apprehensive.
If a child lives with pity,
he learns to feel sorry for himself.
If a child lives with ridicule,
he learns to be shy.
If a child lives with jealousy,
he learns what envy is.
If a child lives with shame,
he learns to feel guilty.
If a child lives with encouragement,
he learns to be confident.
If a child lives with tolerance,
he learns to be patient.
If a child lives with praise,
he learns to be appreciative.
If a child lives with acceptance,
he learns to love.

If a child lives with approval,
he learns to like himself.
If a child lives with recognition,
he learns that it is good to have a goal.
If a child lives with sharing,
he learns about generosity.
If a child lives with honesty and fairness,
he learns what truth and justice are.
If a child lives with security,
he learns to have faith in himself and in those about him.
If a child lives with friendliness,
he learns that the world is a nice place in which to live.
If you live with serenity,
your child will live with peace of mind.

(Ravat, 1995)
And a woman spoke, saying, *Tell us of Pain.*

And he said:

Your pain is the breaking of the shell that encloses your understanding.

Even as the stone of the fruit must break, that its heart may stand in the sun, so must you know pain.

And could you keep your heart in wonder at the daily miracles of your life, your pain would not seem less wondrous than your joy:

And you should accept the seasons of your heart; even as you have accepted the seasons that pass over your fields.

And you would watch with serenity through the winters of your grief.

Much of your pain is self-chosen. It is the bitter potion by which the physician within you heals your sick self. Therefore trust the physician, and drink his remedy in silence and tranquillity. For his hand, though heavy and hard, is guided by the tender hand of the Unseen.

And the cup he brings, though it burn your lips, has been fashioned of the clay which the potter has moistened with His own sacred tears.

THE PROFIT: Kahlil Gibran.
BUTTERFLY

A family in my neighbourhood once brought in two cocoons that were just about to hatch. They watched as the first one began to open and the butterfly inside squeezed very slowly and painfully through a tiny hole, that it had chewed in one end of the cocoon. After lying exhausted for about ten minutes, following its agonising emergence, the butterfly finally flew out the open window on its beautiful wings.

The family decided to help the second butterfly so that it would not have to go through such an excruciating ordeal. So, as it began to emerge, they carefully sliced open the cocoon with a razor blade, doing the equivalent of a Caesarean section. The second butterfly never did sprout wings, and in about ten minutes, instead of flying away, it quietly died.

The family asked a biologist friend to explain what had happened. The scientist said that the difficult struggle to emerge from the small hole, actually pushed liquids from deep inside the butterfly's body cavity into the tiny capillaries in the wings, where they harden to complete the healthy and beautiful adult butterfly.

A TRUE STORY - WITHOUT THE STRUGGLE, THERE ARE NO WINGS!

(Ravat, 1995)
APPENDIX F:

PRAISE VERSUS ENCOURAGEMENT

Although praise and encouragement both focus on positive behaviours and appear to be the same process, praise actually fosters dependence in children by teaching them to rely on an external source of control rather than self-control. Praise in an attempt to motivate children with external rewards. In effect, the parent who praises is saying, "If you do something I consider good, you will have the reward of being recognised and valued by me." Over-reliance on praise can produce crippling effects. Children come to believe that their worth depends upon the opinions of others. Praise employs words which place value judgements on children and focuses on external evaluation.

Examples:

"You're such a good boy (girl)." The child may wonder, "Am I accepted only when I'm good?"

"You got an A. That's great!" Are children to infer that they are worthwhile only when they make As?

"You did a good job." "I'm so proud of you." The message sent is that the parent's evaluation is more important than the child's.

Encouragement focuses on internal evaluation, and the contribution children make. Encouraging parents teach their children to accept their own inadequacies, to have confidence in themselves, and to feel useful through contribution. When comments about children's efforts are to be made, we must be careful not to place our value judgements on what they have done. Be alert to eliminate value-laden words (good, great, excellent, etc.) From your vocabulary at these times. Instead, substitute words of encouragement which help children believe in themselves.

Encouraging Phrases that Demonstrate Acceptance:

"I like the way you tackle a problem."
"I'm glad you're pleased with it."
"It looks as if you enjoyed that."
"How do you feel about it?"

Encouraging Phrases that Show Confidence:

"I have confidence in your judgement."
"You'll figure it out."
"That's a rough one, but I'm sure you'll figure it out."
"Knowing you, I'm sure you will do fine."
"You'll make it."

Encouraging Phrases that Focus on Contributions, Assets and Appreciation:

"Thanks, that helped a lot."
"It was thoughtful of you to ....."
"I need your help on ....."
"You have skill in ..... Would you do that for the family?"

Encouraging Phrases that Recognise Effort and Improvement:

"It looks as if you really worked hard on that."
"Look at the progress you've made." (Be specific)
"You're improving in ....." (Be specific)

In summary, encouragement is: (1) valuing and accepting children as they are (not putting conditions on acceptance), (2) pointing out the positive aspects of behaviour, (3) showing faith in children so that they can come to believe in themselves, (4) recognizing effort and improvement (rather than requiring achievement), and (5) showing appreciation for contributions.


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I believe that perfectionism may be in part learned from a child's interactions with perfectionistic parents. This is the way I see the process working: a child is regularly rewarded with love and approval for outstanding performance. When the parents react to one child's mistakes and failures with anxiety and disappointment, the child is likely to interpret that as punishment or rejection. The perfectionistic parent often feels frustrated and threatened when a child is having difficulties in school work or in relationships with peers. Because the parent is unrealistically self-critical, he or she personalizes the child's difficulties by thinking, "This shows what a bad mother (or father) I am". Because the parent's self-esteem is contingent on the child's success, the parent puts great pressure on the child to avoid failure. Consequently, when the troubled child turns to the parent for reassurance or guidance, the parent reacts with irritation, not love, and the child is flooded with shame.

The child begins to anticipate that mistakes will lead to loss of acceptance. Because the child bases a sense of self-esteem on the parent's approval, the child begins to fear mistakes and to avoid failure. This leads to emotional constriction and fear of any experience or adventure in which the outcome is not guaranteed. The child becomes anxious and upset about making mistakes, which further reinforces the perfectionistic parent's belief that failure is dangerous and undesirable. Essentially, the parent and child are locked into a kind of folie-a-deux.

"The Perfectionist's Script for Self-Defeat"
by David D. Burns
Psychology Today, November, 1980

SESSION 7:3

WHAT OF MARRIAGE

Then almitra spoke again and said, and what of marriage master?

And he answered saying:

You were born together you shall be for evermore.
You shall be together when the white wings of death scatter your days.
Aye, you shall be together even in the silent memory of God.

But let there be spaces in your togetherness.
And let the winds of the heavens dance between you.

Love one another, but make not a bond of love:
Let it rather be a moving sea between the shores of your souls.
Fill each other's cup but drink not from one cup.
Give one another of your bread but eat not from the same loaf.
Sing and dance together and be joyous, but let each one of you be alone,
even as the strings of a lute are alone
though they quiver with the same music.

Give your hearts, but not into each other's keeping.
For only the hand of Life can contain your hearts.
And stand together yet not too near together:
For the pillars of the temple stand apart,
And the oak tree and cypress grow not in each other's shadow.

THE PROFIT: *Kahlil Gibran*

SESSION 8:1

**COMMUNICATION SKILLS**

*(Clark. 1995)* gave the following talk and handout on communication skills.

**HOW TO LISTEN TO YOUR CHILD**

(Adapted from van Niekerk, 1990)

Communication comes in many forms. What may start out as communication may wind up as a lecture, argument, or worse.

**ROLES WE PLAY WHEN CHILDREN EXPRESS THEIR FEELINGS**

**Commander in Chief**
Orders, commands, and threats are the tools the Commander uses to keep the upper hand.

**Moralist**
The moralist is a "shouldist!" He preaches.

**Know-It-All**
These parents lecture, advise, make appeals to the child's reason, and try to show how superior they themselves are.

**Judge**
They are interested in proving that they are always right.

**Critic**
They critic relies on ridicule, name-calling, sarcasm, or jokes to put the child down.

**Psychologist**
The psychologist diagnoses, analyses and questions.

**Consoler**
Simple reassurance, a pat on the back and the pretence that all is well when it isn't are this parent's answer to a child's worries and anxieties.

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BECOMING AN EFFECTIVE LISTENER

Becoming an effective listener requires concentration. It involves establishing eye contact and a posture which says, ‘I’m listening’. Sometimes good listening requires us to be silent. Sometimes it requires us to respond.

REFLECTIVE LISTENING

Listening to our children requires letting them know that we recognise the feelings behind what they are saying and what they are not saying.

Reflect and clarify the child’s feelings.

Communication between persons can be described in terms of closed and open responses. The child may wish to tell you more. The communication process is always non-verbal. Our actions, facial expressions, and tone of voice communication whether or not we are listening.

RESPONDING TO NON-VERBAL MESSAGES

One must learn to catch the meaning of a child’s behaviour by "tuning in" to more than his or her words. "When your face lights up that way, you look very happy".

EFFECTIVE LISTENING

(Adapted from Van Niekerk 1990)

Closed Response: Denies children a right to their feelings by demonstrating listener’s unwillingness to accept and understand.

Open Response: Acknowledges children’s right to their feelings by demonstrating that the listener accepts what they feel as what they say, indicates that the listener understands.

<table>
<thead>
<tr>
<th>Child’s Remark:</th>
<th>Closed Response:</th>
<th>Open Response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m never going to play with her again!</td>
<td>Why don’t you forget it; she probably didn’t mean it.</td>
<td>You’re really angry with her.</td>
</tr>
<tr>
<td>I can’t do it!</td>
<td>now, don’t talk like that! you just got started!</td>
<td>It seems very difficult to you.</td>
</tr>
<tr>
<td>I wish I could go along. He always gets to go everywhere.</td>
<td>We’ve discussed this before- so, stop fussing.</td>
<td>It seems unfair to you.</td>
</tr>
<tr>
<td>Look at my new model!</td>
<td>That’s nice...now will you please go...</td>
<td>You’re pleased with your work on it.</td>
</tr>
<tr>
<td>I don’t want to go to school today. Billy is mean!</td>
<td>Everyone has to go to school. It’s the law.</td>
<td>You’re afraid Billy will pick on you.</td>
</tr>
<tr>
<td>You’re the meanest mother in the whole world!</td>
<td>Don’t you ever talk to me that way!</td>
<td>You’re very angry with me.</td>
</tr>
</tbody>
</table>
POINTS TO REMEMBER

COMMUNICATION: LISTENING

1. Communication begins by listening and indicating you hear the child's feelings and meanings.
2. Effective listening involves establishing eye contact and posture which clearly indicates you are listening.
3. Avoid nagging, criticizing, threatening, lecturing, probing, and ridiculing.
4. Treat your children the way you would treat your best friend.
5. Mutual respect involves accepting the child's feelings.
6. Reflective listening hearing the child's feelings and meanings and stating this so the child feels understood. It provides a mirror for the child to see himself or herself more clearly.
7. Learn to give open responses that accurately state what the other person feels and means.
8. Avoid closed responses which ignore the child's feelings, relaying that we have not heard or understood.
9. Let the child learn. Resist the impulse to impose your solutions.

COMMUNICATION

EXPLORING ALTERNATIVES AND EXPRESSING YOUR IDEAS AND FEELINGS TO CHILDREN (Adapted from Gordon 1970)

Through your reflective listening, children can clarify their feelings and consider a problem more rationally. Sometimes they can discover their own solutions simply by being heard by an understanding adult. There are other times when children need help in considering various courses of action. The process of exploring alternatives should not be confused giving advise. Giving advise, such as “Do this...” or “I think you should.....” is not helpful, for the following reasons:

1. Advice does not help children learn to solve their own problems.
3. If your advice doesn't work, guess who is held responsible.

To help a child explore alternatives means to help the child evaluate each course of action and then to obtain a commitment to action. The steps in exploring alternatives are:

1. **USE REFLECTIVE LISTENING TO UNDERSTAND AND CLARIFY THE CHILD'S FEELINGS.**
2. **EXPLORE ALTERNATIVES THROUGH BRAINSTORMING.**
   Get as many ideas from the child as possible.
3. **ASSIST THE CHILD TO CHOOSE A SOLUTION**
   Help the child evaluate the various possibilities.
4. **DISCUSS THE PROBABLE RESULTS OF THE DECISION.**
5. **OBTAIN A COMMITMENT.**
6. **PLAN A TIME FOR EVALUATION.**

Be careful not to enter into exploring alternatives too soon. Offer suggestions to a minimum. Appropriate timing is essential.

**CONCEPT OF PROBLEM OWNERSHIP**

The techniques of reflective listening and exploring alternatives are especially helpful when the child is the one experiencing the problem. There remains a question of what to do when you are the one experiencing a problem with your children. To determine problem ownership, simply ask, whose problem is it? Dr Thomas Gorden defines problem ownership in the following manner:

**SESSION 8:2**

**EXPLAINING DEATH TO CHILDREN**

BY ELIZABETH HORMANN

November 22, 1963 - the kind of crisp fall day New England is famous for. I spent the day with my little sister enjoying her chatter about her upcoming birthday and Thanksgiving just a few days away. She was outlining her plans for a birthday party when our background music was interrupted. John Kennedy had been shot - and killed. Stunned by the vulnerability of even so well - guarded a man as the president, grieved by his loss, I could hardly speak. My sister took it all in, wide - eyed, swallowing over and over, gripping her chair. Finally, her voice no more than a whisper, she asked, "Can I still have a birthday party?" "How can you think about that now?" I chided. Today I'd know better. Children can't take large doses of grief. They need familiar people and events to stay balanced.

When Robert Kennedy was assassinated five years later, Mister Rogers was there to help. The day after the shooting, on a special programme for children and their parents, he talked about how scary it is for someone's daddy to be shot, to die, to leave behind children who love him. He helped his viewers confront their own vulnerability but reassured them that it is very unusual to have a shooting in the family. Most children can feel secure that their daddies will be alive until they grow up. Parents were reassured that a wide range of behaviour is normal when children are grieving and were encouraged to talk with their children about it. "Any thing human is mentionable, and anything mentionable can be manageable.

Knowing what to say to our children is easier if we understand their concept of death. Most young children don't understand its permanence. In the magic world they inhabit, wishing does make it so. They can create or transform or destroy their interior world and the world outside. The phenomenon of television only reinforces this magic thinking. Week after week they see people killed on one programme, only to turn up alive on another - or even the same programme with a new name. Is it any wonder that when someone they know dies, they believe it is only temporary, that in time, that person will return?

Magic thinking in the young child is coupled with egocentricity. Everything that happens not only has a direct bearing on her. She believes, but is probably caused by her - and she may have the power to
undo it all. Developmentally, this is a normal stage in mastering the world, but when there has been a death, egocentricity can be a fearsome source of presumed power and guilt. Children often blame themselves for the death of someone close. Believing that they are at the centre of all activity and trying to make sense of an overpowering and painful event, they make tenuous connections and draw their own conclusions. "If I wouldn't have sneezed in front of him. Grandpa wouldn't have caught pneumonia and died." "Mom always said we'd be the death her. Why didn't we behave?"

Even older children, in the face of grief can be thrown back on thought processes appropriate to much younger children. I was 11 when my cousin and life-long playmate, was accidentally shot by his best friend. Like many pre-adolescents of mixed gender, we'd been a little on the outs at the time. I'd even stuck out my tongue at his picture just the day before he died. I was well into my teens before I really believed that I had no responsibility for his death. Magic thinking and egocentricity explain, in part, why our children are some times puzzled by the way we behave. How can we be so preoccupied with our grieving that we forget our children are sad, too (even a temporary separation is painful), that we don't listen to what they say, that we are not interested as usual in their projects?

But much of their puzzlement is simple ignorance of the customs surrounding death. Why do we "lay-out" our dead, dress them in their best (or buy a new outfit), put them in a box and bury it in the ground? Why do we go to church when someone dies, and why do so many people try to keep children away from the proceedings? Why indeed?

When my mother was dying, my 5-year old wanted to see her. The nurses in intensive care, already aghast that our doctor had permitted all children to see her together, tried to dissuade me. My mother might slip away at any moment. She didn't know us. What good would it do her? My explanation that Eli, Who had asked for the visit, was the one who would benefit, fell on deaf ears. The hysteria mounted when Eli arrived - just a few minutes after his grandmother died. "You can't let him in now!" they chorused. The choice I told them, would be his. He chose to go in. For a few seconds he stood still, taking it all in. "The line monitor is flat," he told me gently, "That means she is dead." He sat down beside her, and for the last time, held her hand. A minute to two later, he was finished. Five-year-old's have short attention spans even for important moments. As he stood up to go he asked me, "Why didn't the nurses want me here? It's not scary. Ouma just looks like she's sleeping." I had no answer for him.

SESSION 9:1

RISKING IN LOVE : BUSCAGLIA, 1995

I have heard it said that there is nothing wrong with allowing yourself to get into hot water as long as you emerge cleaner for it. Risk is always worth the effort.

I was told that if I left a good job to travel around the world, I'd be sorry and I'd certainly never be tenured as a professor. I took off anyway. And when I returned, I found an even better job and was tenured in spite of my decision. I was told that if I taught a Love Class at University, which I felt was strongly needed, I'd be considered a nut. I taught the Love Class anyway, was indeed considered a nut, and the class changed my entire life for the better.

When I was small, I was informed often enough that dreams don't come true for people who live on the wrong side of the tracks. I was told that I'd never get to college and would do better to lower my sights
toward more realistic goals. But I continued to dream and set my goals anyway. I not only went to college, but graduated with a doctorate. I've never given up a single dream.

Everything worthwhile is a risk. To play it safe is to miss the point of the game. Certainly, risk brings with it the possibility of pain, but there is more profound pain that comes from the emptiness of never having been risked at all. Certainly, no one who has ever succeeded in love has ever played it safe.

I'f's kind of fun to do the impossible - WALT DISNEY

SESSION 9:2

IF YOU WANT JOY : (JOHNSON B, 1997)

If you want JOY for half an hour, take a bubble bath.

If you want JOY for an afternoon, go shopping.

If you want JOY for an evening, go out to dinner.

If you want JOY for a day, go on a picnic.

If you want JOY for a week, go on a vacation (or send the kids to camp).

If you want JOY for a month, spend within your budget.

If you want JOY for life, invest time in others.
SESSION 10:1

FILIAL THERAPY CONTRACT

I, _________________, do hereby agree to continue Special Play Time sessions at home with my child _________________. I agree to continue for at least ________ weeks after the end of this course. I understand that by following the agreement stipulated in this contract that I may significantly enhance the relationship I have with my child.

Signature ___________________________ Date ___________________________
Witness ___________________________ Date ___________________________

I'M HERE  I HEAR YOU  I UNDERSTAND  I CARE

SESSION 10:2

RULES OF THUMB AND OTHER THINGS TO REMEMBER

Rules of Thumb

1. You can't give away what you do not possess. You can't extend patience and acceptance to your child if you can't first offer it to yourself.

2. When a child is drowning, don't try to teach him to swim. If a child is feeling upset, that is not the moment to impart a rule or value.

3. Be a thermostat, not a thermometer. Reflect rather than react. The child's feelings are not your feeling and needn't escalate with him/her.

4. Good things come in small packages. Don't wait for the big events in our child's life to enter their world. The little ways are always with us.

A - li
5. The most important thing may not be what you do, but what you do after what you have done. We are certain to make mistakes, but how we handle our mistakes will make all the difference.

6. Grant in fantasy what you can’t grant in reality. In a play session it is okay to act out feelings and wishes that may require limits in reality.

7. Praise the effort, not the product. This circumvents feelings of failure and fear of rejection.

8. If you draw your gun, shoot. When you don’t “follow through” you lose credibility and harm your relationship with your child.

9. Don’t answer questions that haven’t been asked. Look beyond the question for the deeper question.

10. If you can’t say it in 10 words or less, don’t say it.

Other Things to Remember

1. Reflective responses can diffuse anger.
2. What’s important is not what a child knows, but what s/he believes.
3. “We’re about to institute a new and significant policy immediately effective within the confines of this domicile.”
4. When you’re just trying to solve the problem you lose sight of the child.
5. Give children credit for making decisions: “Oh, you’ve decided to do ________
6. Today is enough. Don’t push your child toward the future.
7. One of the best things we can communicate to our children is that they are competent. Tell a child he is capable and he will think he is capable. Tell him enough times he can’t do it and sure enough, he can’t.
8. Don’t try to change everything at once.
9. In the play session, the parent is not the source of answers. Reflect questions back to child.
10. Free the child. With freedom comes responsibility.
11. Noticing the child is a powerful builder of self-esteem.
12. Support the child’s intent even if you can’t support his behaviour.
13. When we are flexible in our stance we can handle anger much more easily. When we are rigid, we and the child can end up hurt. (Remember the stiff arm!)
15. Where there are no limits, there is no security.
16. In the play session, praise limits creativity and freedom.
17. In play, children express what their lives are like now, what their needs are, or how they wish things could be.
18. What a child doesn’t do is as important as what he does do

A - lii
My gift to you is a Butterfly

A butterfly is an extremely fragile creature, with gossamer wings and gentle legs, capable of landing on the most delicate of petals without moving it.

I give you this butterfly, so that when you handle it with all the tenderness it deserves, you reveal to others the sensitive, tender side of you; a side I believe you keep well hidden from others most of the time.
CERTIFICATE OF COMPELENCE

THIS IS TO CERTIFY THAT:

has satisfactorily completed 20 hours of training in Filial Therapy.

__________ is competent in doing Play Therapy with: ___________.

__________ is to be admired for her:


A.M. ARNOTT

DATE
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