

**Adapting a western model of filial therapy to a  
locally specific form through a participatory  
process with kinship carers**

**Ann Petty**

**Submitted in partial fulfilment of the requirements for the  
Degree of Master of Social Work (Clinical Practice)  
in the Faculty of Community and Development Disciplines,  
Centre for Social Work, University of Natal, Durban,  
January 2002.**

## Declaration of Originality

I hereby declare that this dissertation, unless specifically indicated to the contrary in the text, is my own work.

Ann Petty  
University of Natal, Durban.  
January 2002

Submitted with the approval of the supervisor, Professor Vishanthie Sewpaul.

  
.....  
Professor Vishanthie Sewpaul

.....  
Date

## ABSTRACT

As social workers are challenged to move away from a preoccupation with direct, clinical practice and move toward developmental interventions, there is concern that vulnerable members of society will be abandoned. It is feared that these members are likely to become the responsibility of their family, friends and neighbours, who themselves may be struggling for their own survival.

Kinship carers are left to care for children whose parents are unable to fulfil their parental responsibilities because of illness, death, poverty, or other debilitating social factors. In many instances the children arrive into these placements as a result of tragic circumstances and are thus in need of remedial intervention. The rapid growth of this phenomenon has superseded the development of relevant services for kinship carers and their wards.

Filial therapy is an effective method for helping families in distress as it combines treatment and prevention. It incorporates didactic and dynamic principles where parents are trained to act as therapeutic agents in their children's lives. It is a strength-based intervention that recognises parents' abilities to provide emotional support for their children. Parents are empowered to do this by participating in professionally facilitated group sessions where they learn to develop healthy relationship skills, which may lead to the alleviation of psychosocial difficulties.

This study was an exploratory study to establish whether the western model of filial therapy could be adapted for a locally specific group of kinship carers through a participatory process. Using a qualitative research design a group was formed to explore ways in which the model needed to be adapted to meet locally specific needs. There were two phases in this study. The first phase was concerned with identifying the problem. The second phase was the formation of the filial group and the evaluation of members' experiences. The participatory research methodology which underpinned the study is consistent with the person-centred approach and with participatory learning experiences. Over a ten-week period the research participants familiarised themselves with the techniques and assumptions of this intervention, and made recommendations for the adaptation of the model to a locally specific one. The data were collected via semi-structured interviews, focus groups, researcher assisted questionnaires, and video recordings of the group sessions.

The outcome of this study revealed that filial therapy, as adapted to locally specific needs by participants, provided them with valuable support, enhanced their relationships with the children in their care, provided them opportunities to address unresolved issues from their pasts, and in some cases, resulted in positive behavioural changes in their children. Whilst these findings are tentative in view of the limitations identified in the study, the workbook that evolved from this participatory process is a consolidated outcome which may be used by other practitioners. Recommendations for further research are detailed.

# ACKNOWLEDGEMENTS

I extend my sincere appreciation to the following:

The participants, for their bravery and for sharing so much of their realities with me. Their enthusiasm sustained me.

My supervisor, Professor Vishanthie Sewpaul, for her careful review, insightful criticisms and encouraging comments.

Rehana Ravat, for introducing me to the magic of play.

My colleagues, for their ideas, suggestions, and support.

The social workers of the Durban Children's Society for their cooperation.

The sponsors for their generous donations of toys that were needed for this study. Special acknowledgement should be given to Broadway Pharmacy, Classic Cash Wholesale, Gina Cossavella, East Coast Medical CC, Osmans, Toys R Us (Pavilion), The Toy Shop (Pavilion), and the Walsh family.

Berkley, my husband. Thank you for the sacrifices you made so that I could have the time and space to complete this study. Your endless reassurance and belief in my ability motivated me.

Kai and Yorke, my children. Your endless love inspires me to find creative ways to assist the children of our country.

My parents, for constantly being there for my family.

Anita, my friend, for her loyal friendship and technical support.

# Contents

<b>Chapter One : Context and Purpose of the Study .....</b>	<b>1</b>
Context of the study .....	3
Rationale for the study .....	4
Purposes of the study .....	7
Critical Questions .....	7
Theoretical Framework .....	7
Research Approach .....	10
Assumptions of the study .....	10
Value of the study .....	11
Presentation of contents .....	12
<b>Chapter Two: Literature Review: Kinship Care .....</b>	<b>14</b>
Definitions .....	16
Characteristics of Kinship Carers .....	18
Reasons for the increase in Kinship Care Placements .....	19
The Advantages and Disadvantages of Kinship Care Placements .....	23
Common Concerns of Kinship Carers and Services proposed to strengthen these families .....	26
<b>Chapter Three: Literature Review: Filial Therapy .....</b>	<b>33</b>
Definitions .....	34
Play Therapy .....	37
The History and Development of Filial Therapy .....	41
The Logistics of Filial Therapy Groups .....	43
Outcome Studies .....	50
Filial Therapy with other Nationalities .....	54
<b>Chapter Four: Methodology .....</b>	<b>58</b>
Introduction .....	58
Research Design .....	58
The Research Process .....	61
Phase One: Problem identification .....	63
Sampling .....	65
Data Gathering .....	65
Phase Two: The Research Group .....	67
Sampling .....	70
Data Collection Tools .....	71
Data Analysis .....	76
Limitations of Design and Methodology .....	79
Validity .....	81
Reliability .....	82
Ethical Considerations .....	82

<b>Chapter Five: Analysis and Discussion: Part One</b> .....	<b>85</b>
Phase One: Problem Identification .....	85
Phase Two: Filial Sessions with the research group .....	89
Conclusions drawn from the analysis of the six case studies .....	106
<b>Chapter Six: Analysis and Discussion: Part Two</b> .....	<b>111</b>
The role of facilitator .....	111
A session-by-session outline of the filial group sessions .....	112
Focus group discussion .....	128
Conclusions drawn from the analysis of the ten-group sessions .....	133
Themes that emerged during the study .....	137
Limitations of this programme .....	142
<b>Chapter Seven: Recommendations and Conclusions</b> .....	<b>145</b>
Rationale and Context .....	145
Theoretical Framework .....	147
Research Approach .....	148
Overview of the Findings .....	149
Contributions of the study .....	153
Recommendations of the study .....	154
Conclusion .....	156
<b>References</b> .....	<b>158</b>
<b>Appendices</b> .....	<b>164</b>

164 ✓

# Appendices

## Appendix I :

<b>Landreth's 10-week model as adapted by Ravat .....</b>	<b>164</b>
---	------------

## Appendix II :

<b>Focus group discussion of the kinship care relationship enhancement programme .....</b>	<b>174</b>
--	------------

## Appendix III :

<b>A personal review of the kinship care relationship enhancement programme .....</b>	<b>175</b>
---	------------

## Appendix IV :

<b>Workbook .....</b>	<b>175</b>
-----------------------	------------

# Tables

## **Table One :**

Outcome research .....	53
------------------------	----

## **Table Two :**

Overview of the differences and similarities between the Landreth model and the locally specific model .....	135
---	-----

## **Table Three :**

Differences and similarities in the programmes .....	136
--	-----

# Chapter One

## CONTEXT AND PURPOSE OF THE STUDY

### Introduction

For some time, warning bells have been sounding for social workers, and the shape of the services they render in the mental health field. The necessity for them to affirm their commitment to addressing the needs of the poor and of revisiting their intervention strategies, to include community development on a much wider scale has been indicated (Gray, 1996; Ferguson Brown and Partab, 1999).

The recent developments in welfare in South Africa have raised interesting debates. The Social Welfare Action Plan (SWAP) has indicated that the current South African government is unwilling to support remedial services and are demanding that social workers, “engage themselves in wider socioeconomic, environment and geopolitical arenas in order to change the circumstances under which the poor, the unemployed and the marginalised find themselves” (Ferguson Brown and Partab, 1999, p.138). The concern for many is that as welfare shifts from a clinical/ direct practice paradigm to a developmental one, there may be serious consequences. The support of vulnerable members in this society is shifted back to families, friends and neighbours at tremendous physical, emotional and economic costs to these carers. Nowhere is this more evident than in the growing phenomenon of kinship care. A paradigm shift is demanded at a time when social workers are hard pressed to meet the needs of the victims of poverty, violence, AIDS and many other social “ills”. A major concern for social workers is finding new ways to facilitate the healing of the ever-growing number of psychologically traumatised children.

Robertson (1999) who referred to working with children who have been physically or sexually abused, neglected, or exposed to extreme violence said, “Each child’s particular circumstances differ and the psychological trauma associated with these circumstances manifests in a variety of physical and psychological symptoms. Beneath the various

symptoms a pattern may be observed – the core experience of psychological trauma are seen as being disempowerment and disconnection” (p.30). These patterns can impair their lives forever. Social workers may ask the question, “How do we create opportunities for traumatised children to process and integrate their experiences through using a developmental paradigm?”

The second debate being waged is that welfare, in South Africa, is too reliant on European and American models of mental health. Joubert (1995) asked, “Can these models be applied in a society as diverse as South Africa?” (p.169). For more than thirty years, the northern hemisphere has been offering international aid to the southern hemisphere. Collins (1999) remarked that these people were no better off after receiving the aid because the methods suggested often did not take local conditions into account. These attempts were often humiliating for the people as they perceived them to be “a rejection of their own ways which were treated as inferior to the perceived superior ways of the north” (p.5). Furthermore, in view of the high levels of poverty, and the over-reliance on clinical paradigms of the Northern hemisphere (which the researcher-facilitator contends has been over emphasised in the training of social workers in South Africa for far too long) one has to ask whether the casework method should be the method of choice? “In a society that is well-developed, fair in its processes, and in general working well, the need will be more for clinical social work to help individuals adjust to the society and less on community work” (Orten 1987, p.76). Because of South Africa’s history and the oppression of many of her people, it would appear that a locally specific approach that is developmental in nature would be more relevant.

These two debates were paramount in the researcher-facilitator’s consciousness when considering new methods to address the unique needs and, the growing numbers of kinship care placements, which social agencies have been expected to address, with minimal resources at their disposal.

In this study the researcher-facilitator used a participatory research design which “responds more directly and appropriately to the ethic of participation – an ethic central to the

context of widespread democracy and participation” (Van Rooyen, 1998, p.77). As indicated by Van Rooyen (1998) participatory research is a way of solving problems and developing knowledge. It engages principles of collective action and empowerment, and goes beyond the acquisition of knowledge as it exposes problems and achieves social change. The participants, a group of kinship carers in Umlazi, were actively engaged in adapting a Western model of play therapy to create their own indigenous one which could be used by other kinship carers in the Umlazi area to facilitate the psychosocial adjustment of the children placed in their care.

### **Context of the study**

Umlazi is a township south of the city of Durban. It is located close to an airport and an industrial area. There are no accurate statistics available for the population of Umlazi, however the population estimates randomly given for the township is two million (Urban Strategy Unit, Durban Metropolitan Council). It consists of formal and informal housing units. The Durban Children’s Society reported that a large number of the clients they service in the formal housing area have an income level of between R300-R599, which is below the poverty datum line. The clients who are drawn from the informal settlements fall in the 0- R 299 income, which is well below the poverty datum line (Rampersad, 2002). Social work agencies reflect an increase in the number of cases referred in this area. There are few welfare organisations that have permanent fulltime offices there. The most active welfare services are provided by the Department of Welfare KwaZulu-Natal, Durban Children’s Society, and Mzamo Child Guidance Clinic. Other specialised agencies have satellite offices that service the community a few days a week such as the Family and Marriage Society of South Africa (FAMSA) and the South African National Council for Alcoholism and Drug Abuse (SANCA).

The Durban Children’s Society under whose auspices the study was conducted aims to “provide protection to the most vulnerable viz. children, youth and women using a developmental approach and services to the poorest of poor to improve their quality of life”

(Rampersad, 2002, p.4). The society addresses needs in three special development areas: children requiring special protection due to age, abuse and/or wilful neglect, children and families affected by HIV/AIDS, children and families living in poverty. Over the past two years the number of referrals in Umlazi has grown, necessitating the deployment of more social workers. There are seventeen social work, and two and a half managerial posts that have been allocated by the society to this district (Rampersad, 2002). An increasing number of children serviced are orphaned as a result of the death of their parents from HIV/AIDS. The agency has implemented a non-discriminatory placement policy and simplified formal foster and adoption processes. They have experienced tremendous growth in the formalisation of kinship care placements, but this has placed the agency under greater pressure to screen and monitor these arrangements. Because of the high number of requests for kinship care placements, the society has undertaken to train volunteers to assist the social workers in intake and screening of these cases. One hundred and thirty one foster parents were involved in foster parent support groups during the past year (Durban Children's Society Annual report, 2000/2001). There remains a significant backlog of families awaiting services and the agency continues to search for ways to support to this group of vulnerable children and carers. This background serves to explain the reasons for the researcher-facilitator choosing to conduct the study within this context.

## **Rationale for the study**

The rate of violence in South Africa, together with the alarming incidence of AIDS, has caused many children to experience psychological trauma. After these tragic incidents, many children find themselves living with members of their extended families, as their parents have died, or are not able to accept or exercise parental responsibility. Joubert (1995) pointed out that in many instances, a grandparent, aunt or older sibling becomes the most significant caregiver of a particular child. In a sense this person becomes the "informal" custodian or foster parent. Barrett, McKerrow and Strode (1999) said, "In many cases, an orphaned child or child in need, does not go through the children's court enquiry, but is simply absorbed into the extended family system. This means that the caregivers of

the child are not officially appointed custodians, foster parents, and are therefore unable to access foster-care grants for a child” (p.40). A child in this type of placement is not afforded much protection. There is no agency that formally supervises and monitors the quality of the “care” he or she receives. Because of the economic burden placed on kinship carers (Barrett et al 1999), some children become victims of neglect, or abuse and suffer secondary trauma.

There is little formal research on kinship care in South Africa. Welfare agencies consulted in the first phase of the study identified that these carers were typically a group of single women of colour who are struggling themselves with limited incomes. The high statistics of kinship care placements are incongruent with the services and resources developed to assist these families. More than ever before, mental health practitioners need to find ways to strengthen the coping strategies of these families, whilst at the same time assisting the children to deal with their losses and traumas.

“Filial therapy is a unique form of parent training that incorporates training in play therapy skills, parent-child play sessions, and supervision experiences. The objective is to help parents become therapeutic agents in their children’s lives” (Rennie and Landreth, 2000, p.19). Filial therapy involves training parents in groups of six or eight, to conduct sessions with their emotionally troubled young children, using the philosophy and methodology based on client-centred play therapy. After being trained in the philosophy and skills of filial therapy, parents contract to conduct the play sessions with their own children as the basis for discussion and learning in the group sessions. Whilst filial therapy usually involves parents as the therapeutic agents in their children’s lives, it has been used effectively to strengthen custodial grandparents’ relationships with the grandchildren in the United States of America (Bratton, Ray and Moffit, 1998). There is no evidence that filial therapy has been used to strengthen relationships between kinship carers and the children left in their care within the South African context. No recommendations exist on how the model should be adapted to ensure that it is a culturally sensitive intervention for Zulu families.

The researcher-facilitator believed that filial therapy would be an effective approach to assist children in kinship care. This approach seemed to have merit in that it relies on the group as a context for change. This suggests that it could be an effective method of increasing leverage of the scarce professional resources in South Africa. Filial therapy is regarded as a cost effective intervention strategy that could be used to treat emotionally distressed children from different families at the same time (Guerney, 2000). Filial therapy appears to be an uncomplicated parent education programme that was designed to increase the capacity of a family, so that the parents would retain their position as the primary change agents in their children's lives. The parenting techniques taught in filial therapy could be generalised to enhance the parenting of the other children in the home, thereby strengthening family relationships all round. Filial therapy has been successfully used in many different contexts with different ethnic groups (Guerney, 2000). It has been described as a culturally sensitive intervention (Jang, 2000; Glover and Landreth, 2000). Guerney (2000) described filial therapy as "a treatment that rests on good research, with results that show its efficacy, one that can be replicated by practitioners who can achieve comparable positive effects using it" (p.1). These factors prompted the researcher-facilitator to conduct a participatory study with a group of kinship carers and a volunteer.

The researcher-facilitator's intention was to assess whether filial therapy might be a possible solution to ensuring that psychosocially distressed children, left in the care of kinship carers in the Umlazi area, could receive therapy that would be accessible, affordable and effective. The second intention was to explore whether filial therapy could be a possible means of providing support to kinship carers who have, as described by Gibson (1999), "gone through a role shift". (p.331).

The researcher-facilitator believed that this research would narrow the inappropriate polarisation of the clinical and developmental paradigms. It was assumed that whilst the children and the kinship carers participated in the study, they would benefit from the clinical intervention of filial therapy as well as the empowering group process of participatory research. The participatory nature of the study and the person-centred approach that is integral to filial therapy, would empower the participants, strengthen their families and, even possibly, the community in which they live.

## **Purposes of the study**

- To explore the usefulness of filial therapy as an intervention to engage kinship carers from the Umlazi area in providing support for the children in their care, who were experiencing behavioural or emotional difficulties.
- To adapt a Western model of filial therapy to a locally specific form through a participatory approach.

## **Critical questions**

- Would the participants in the study consider filial therapy to be a worthwhile parenting education service that strengthened their custodial relationship with the children in their care?
- Would the participants in the study benefit from the support from other filial therapy group members and would this support empower them to cope with the challenges of parenting the children of their deceased or absent relatives?
- Is it possible to adapt a Western model of filial therapy to an indigenous one and what role would the participants in the study play in developing this model?

## **Theoretical Framework**

The study was guided by the following theories: person-centred approach and participatory learning. The person-centred approach is the primary theory on which filial therapy is based. Many of the assumptions underpinning filial therapy and client-centred play therapy are based on the nineteen propositions of this approach. Participatory learning is a people centred way of working in community development and provided the researcher-facilitator with valuable pointers on how to combine a clinical paradigm with a developmental one. The central tenets of these theories are summarised as follows:

- **The person-centred approach.** This approach is a humanistic phenomenological approach that involves trying to understand the client in an ever-changing context. Through the skilful creation of a facilitative therapeutic relationship, based on core conditions of respect, empathic understanding, and the genuineness of the helper/facilitator, the client system is helped to examine him or herself and his or her life. The client system gains a deeper awareness of the unsymbolised experiences in his or her life. This insight enables him or her to use his or her personal power to decide what changes he or she will address in his or her life. “We have come to recognise that if we can provide understanding of the way the client sees himself at this moment, he can do the rest” (Rogers in DuToit, Grobler and Schenck, 1998, p.ix). The helper is required to be highly reflective and opposed to directing the client system in any way. The relationship between the helper and the client system is democratic and collaborative. The helper and client system carefully explore meanings of the past, present and future, as experienced by the client system. Attention is given to the feelings of the client system because these are seen to reflect his or her needs. Behaviour is recognised as the client system’s goal directed efforts to satisfy his or her needs. The client system is seen to have an innate desire to grow and actualise and is regarded as a rational being who will move towards self-sustaining actions, especially when the right context, or atmosphere is created. This approach recognises that all clients are unique and have unique strengths and emphasises unconditional positive regard for all client systems. It assumes that all people are to be trusted and respected. “Everybody’s needs, initiatives, creative abilities, skills and knowledge are regarded as important and valued” (Schenck and Louw, 1995, p.9).

The person-centred approach can be used with individuals, families, groups and communities (DuToit et al, 1998). In working with groups and communities the people are to be trusted and respected. The group members and the facilitator or helper are involved as equal participants in the learning process. Members are recognised as capable of deciding for themselves what is to be learned. New knowledge is developed with them (Schenck and Louw, 1995) rather than for them.

- **The participatory learning approach.** “How we think about and facilitate skill and knowledge acquisition rests on whether we can or can’t trust the learner” (Rogers in Schenck and Louw, 1995, p.9). Participatory learning must be based on a felt need of a community. The people should be alert to the need, have an idea of its extent and implications, and ideas about the changes that need to be introduced to alleviate the problem. They must want change (Schenk and Louw, 1995). It builds on what people know. It recognises that every group should be regarded as a source of knowledge as they have unique experiences about their world, experiences and perceptions. Pooling diverse ideas deepens our knowledge base. Groups have their own solutions, ideas, strategies for resolving problems. Groups have unique resources for dealing with problems. Participatory learning is a mutual learning process between the facilitator and the participants. It depends on active sharing, discovering new ideas together, sharing the responsibility for learning. Participants are actively involved in deciding about the content, presentation and evaluation of learning experiences. Chambers (as referred to by Schenk and Louw, 1995) stressed that the knowledge of the community should be seen to compliment that of the “expert” facilitator. Participatory research stresses dialoguing. The facilitator acts as a resource of specialised or expert knowledge and resources for the group, when they call for assistance. The theory stresses the need for a facilitative climate where participants receive support and encouragement from one another and the facilitator. Participatory research relies on an experiential process of learning. It is recognised that adult learners benefit most from discovering their own answers. The circular process of doing, reviewing, analysing and generalising shapes lasting learning. The facilitator encourages sharing, showing and experimenting. Feedback is encouraged. This learning takes place through interactive group experiences. The facilitator needs to be skilled in working with groups. Participatory learning is a cumulative process. It consists of a series of steps. Each step consists of action, reflection on the preceding actions and planning for further action.

Schenck and Louw (1995) identified the following advantages of using this approach: it is about making the knowledge and skills people have visible, appreciated and useful; it strengthens the community's initiative and creative abilities; it promotes relationships and practices that promote the group's ability to problem solve, accept responsibility, acquire skills and knowledge.

## **Research Approach**

A detailed description of the research methodology is outlined in Chapter Four. A qualitative research approach was used. The researcher-facilitator chose to use a field focused study where she met with kinship carers in Umlazi, she was interested in perceiving and interpreting the kinship carers responses to the filial therapy programme, and she hoped to make sense of their experiences of the filial therapy programme. The study was an exploratory study. The researcher-facilitator's intention was to explore ways in which the Western model of filial therapy could be developed into a locally specific one by engaging the kinship carers as co-researchers. The research strategy that was chosen was in keeping with the theoretical approaches of person-centredness and participatory learning. These theories were used throughout the study. A participatory research strategy was used. There were two phases in this project: phase one involved defining the problem of inadequate services for kinship carers and the children in their care, and exploring possible ways to deal with these; phase two involved a group of five kinship carers, a volunteer and the researcher-facilitator in a participatory learning experience of filial therapy and kinship care.

## **Assumptions of the study**

The study had several underlying assumptions. These were:

- By engaging the participants of the study in deciding on the information they wanted to discuss during group sessions, they would be instrumental in developing

a model of filial therapy more relevant to their circumstances.

- By making the research process a democratic one, and emphasising listening to the kinship carers' unique concerns and validating their attempts to deal with them, the group process would be an empowering one and participants would feel more confident about addressing the challenges of being kinship carers.
- In order to develop a locally specific model of filial therapy, individual perspectives needed to be made explicit. These meanings would help the researcher-facilitator to gain a truer picture of what issues they wanted to learn about and what issues were relevant to their circumstances.
- The participants had to have control over the content to be presented and ways this information would be presented. Their active participation in this study was crucial to refining the filial therapy approach, making it more culturally sensitive and appropriate for the socioeconomic and political context in which they found themselves. The knowledge generated by their participation would be invaluable for the service providers serving kinship carers in the Umlazi area.
- The application of a person-centred approach would restore their dignity and freedom that had historically been ignored for many decades.

## **Value of the study**

It would be inappropriate to make premature conclusions about the outcomes of any study as the outcomes of qualitative research are only uncovered during the process of conducting the study. However, the researcher-facilitator anticipated that the study would assist kinship carers in the following ways:

- They would be given an opportunity to review their parenting styles and learn new parenting behaviours to replace those that they perceived as ineffective.
- They would benefit from the support from other kinship carers, thereby broadening their resource and knowledge bases as they exchanged ideas of how to deal with their problems in parenting.
- They would be empowered to share their contextual realities and through this

process of sharing, influence the development of an appropriate model of filial therapy for kinship carers.

- Their relationships with the children in their care would improve. They would integrate the newly acquired relationship enhancement skills into their relationships with others in the home so that their families would be strengthened.

It was hoped that the Durban Children's Society would benefit in the following ways:

- It would have a model that could be used to strengthen kinship care placements.
- It would render some intervention to children who had lost a parent in order to enable them to deal with their losses and traumas and facilitate their adjustment to these placements.
- It could lead to the undertaking of similar studies, developing filial therapy as an intervention for other target groups such as childminders and residents of children's homes.

The values of this study for the field of social work include:

- A deeper understanding of the contextual realities of kinship carers.
- An opportunity to prove that direct practice and development are not separate dichotomies, and that social workers can and should adopt integrated methods in helping client systems.
- It will demonstrate how principles of collective action, participation and empowerment assist social workers to expose social problems and achieve social change.
- It will be an example of a study that combines research with therapeutic action.

## **Presentation of contents**

The researcher-facilitator provided a broad overview of the study in this chapter. The rationale, purpose, theoretical framework, research approach, assumptions and value of the study have been briefly discussed.

Chapter Two is the literature review on kinship care. It covers: definitions of kinship care, reasons highlighted in the literature for the increase in kinship care placements, common characteristics of kinship carers, common problem areas experienced by kinship carers, the advantages and disadvantages of kinship care as cited in the literature, the services recommended for kinship carers and filial therapy as a possible intervention for kinship cases.

The theory on filial therapy is discussed in Chapter Three. This chapter covers: the definitions of filial therapy, play therapy and the value of play in children's lives, the history of the development of filial therapy, outcome studies, the structure and content of filial therapy groups, outcome studies of filial therapy with different nationalities.

Issues concerning the research design and findings are covered in Chapters Four and Five. Chapter Four details the research strategy, the sampling strategy used in the study, methods of data collection, the analysis of data, issues of validity and reliability, ethical consideration and the limitations of this study. Chapters Five and Six discuss the analysis of the collected data. The findings are discussed in terms of the critical questions raised in this chapter and the literature reviewed in Chapters Two and Three. The final conclusions and recommendations are outlined in Chapter Seven.

In conclusion, this report highlights the reasons this intervention was selected as a possible intervention for kinship carers and the children in their care, the steps that were taken to prepare for a participatory action research study with kinship carers as co researchers, and the meanings that the co researchers gave to this intervention.

## Chapter Two

### LITERATURE REVIEW: KINSHIP CARE

#### Introduction

Mental health professionals are becoming increasingly aware of the staggering growth in the number of relatives providing residential care for the children of their kin. Sadly, research in this area has not kept pace with its development as a placement alternative. As indicated by Roe and Minkler (1998) one would expect professionals to address the dearth of research in this area because these carers are left to raise some of society's most vulnerable children. Sadly, the researcher-facilitator's experience suggested that this group of carers are given little assistance to deal with the children left in their care, despite the evidence that many of these children had been exposed to various forms of child abuse and neglect, or loss and trauma, even though there are indicators that these result in major incapacitating problems, not only during their childhood, but throughout their lives. Rittner and Sacks (1995) identified the typical problems they encounter. Abused and neglected children are more socially immature, have more maladaptive social skills, are more aggressive, and are more prone to temper tantrums and delinquency, more easily distracted, more likely to be enuretic than non-abused children. Maltreated children are less ready to take on the tasks of school and have lower academic performance. As was suggested by Burton (1992, p.744), in discussing grandparents as kinship carers, "Grandparents are beset with a myriad of problems related to the care of this special population of children and that social service interventions on behalf of the grandparents are in order".

Kinship care offers a significant challenge to social work in terms of: the growing numbers of these placements; the complexities of the relationships among the kinship carers, the children in their care, and other family members; the economic consequences of caring for a child or children that were not planned; the economic consequences for the welfare system; the social consequences to what often is a "three generation" scenario (Gibson, 1999). The

development of relevant services for these placements is often overlooked because of the complexity of these issues and the scarcity of resources to address them. The nature of these placements are varied and complex, and, as described by Gleeson, O' Donnell and Johnson Bonecutter (1997, p.803) "not currently well understood."

The researcher-facilitator was unable to locate any published findings that reflected the extent of the growth of these placements in South Africa, but her discourse with welfare agencies revealed that an overwhelming amount of social workers' time was spent processing applications for foster care by kinship carers. It can be assumed that we are merely seeing the tip of the iceberg as many of these arrangements take place informally (Barrett et al, 1999), especially in the rural areas. This is not just an African phenomenon, but is experienced in other continents as well. Roe and Minkler (1998) reported a forty-four percent increase in the number of children living with grandparents and other relatives between 1980 and 1990 in the United States of America. They revealed that by 1997, close to four million children lived in a household headed by a grandparent, and in approximately one-third of the homes neither of the child's biological parents was present. Ten percent of these grandparents raised these children for a period of six months or longer. In another study it was estimated that over a quarter of the approximately 500 000 American children in care, many of whom were young, lived with relatives other than their parents (Leslie, Landsverk, Horton, Ganger, and Newton, 2000).

As stated by Rogers and Bouey (1993), "The literature review is a key tool for providing information on what is new, important, believable, and useful" (p.388). Leedy (1993) emphasised how critical it is for researchers to review the related literature because, "when you know what others have done, you are better prepared to attack the problem you have chosen with deeper insight and more complete knowledge" (p.87). This chapter will outline a review of related literature to the study. The themes covered highlight information from the literature that helped the researcher-facilitator to immerse herself in the issues of kinship care. This chapter covers definitions of kinship care and reviews the reasons for the growth in these placements. Following the discussion of the advantages and disadvantages of these placements, the researcher- facilitator shares common areas of concern identified

by carers as found in the literature. Services that have been suggested for kinship carers and the children in their care will be summarised.

It must be noted that there have been no studies on kinship care published in South Africa. Furthermore, most of the literature focuses on grandmothers as kinship carers. The researcher-facilitator believes that much of what has been written on grandmothers as kinship carers has a direct bearing on most other kinship carers in South Africa.

## **Definitions**

Whilst scanning the literature it becomes evident that authors do not use a single term to refer to kinship carers. There are many terms given to carers who are related to the children they care for when the parents of the children can no longer do so. Some definitions place emphasis on the relationship between the carer and the child such as “grandparents as caregivers to grandchildren” (Burton, 1992; Jendrek, 1993; Roe and Minkler, 1998), and Gibson’s (1999) term, “grandmothers as ‘mothers’ again”. But the most widely used term in the literature appears to be kinship carers.

There do not appear to be universal definitions of kinship care, but rather descriptions of what kinship care is. Berrick (1997) described kinship care as, “a developing phenomenon, falling somewhere between family preservation and foster care” (p.286). Grogan-Kaylor (2000) defined kinship care as “a particular form of family foster care in which children are placed with foster parents who are biologically related to them – most often, these kinship foster parents are grandparents of the child or an aunt or uncle” (p.133).

These descriptions have two commonalities. Firstly, the authors suggest that kinship carers fulfil the role obligations of “foster parents”. When the parents of a child can no longer care for him or her, then a close relative takes over the responsibility for that child. The relative may be related by blood or marriage, or be a person with close family ties. Hegar and Scannapieco (1995) quoted Billingsley who indicated that “people can become part of a

family unit or, indeed, form a family unit simply by deciding to live and act toward each other as family” (p.201). Secondly, kinship care performs a family preservation function. Scannapieco and Hegar (1996) even described kinship care as a “strategy for family preservation” (p.567). These placements enable children to live with people they know and trust, support the transmission of the child’s family identity, support the child’s cultural and ethnic identity, help the child stay connected to siblings, and help the child build and retain connections to the extended family (Scannapieco and Hegar, 1996).

The Child Welfare League of America as cited by Hegar and Scannapieco (1995, p.201) and Ingram (1996, p.554) defined kinship care as “the full-time nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with a child, when they become separated from their parents.” This is a broad definition that is inclusive of all the people who may be classified as kinship carers, but it does little to explain why these people should be responsible for these children, and fails to define their authority and roles.

Kinship care becomes even more confusing because it may be formal or informal. In other words it may be provided by “kinship caregivers” who provide care that is not formally recognised by the foster care system, or “kinship foster parents” who are recognised by the foster care system (Wilhelmus, 1998, p.118). Leslie et al (2000) expanded upon this distinction, referring to them as formal and informal kinship carers respectively. Formal kinship care is regarded as custody that has been legally transferred by the court to the caregiver or the state child welfare agency. Informal kinship care is when an informal arrangement, without legal involvement has been facilitated by the child welfare system or family members themselves. The literature tends to focus on formal kinship care placements (Dubowitz, 1994). Little is known about the families who arrange the care of the children among themselves. This distinction has serious ramifications because the formal kinship carers are given more assistance than the informal ones. In South Africa informal kinship carers are not eligible for foster-care grants, which pays out substantially more than child support grants for which the informal carers are eligible, provided that the children in their care are under the age of seven years. For informal kinship carers, caring

for children over the age of seven years, there is no relief. In addition to this, informal kinship carers do not qualify for exemption of school fees because they are not considered legal guardians of the child (Barrett et al, 1999). This means that although informal kinship carers assume the functions of foster parents “without formal appointment of custody or guardianship they are unable to access necessary forms of assistance” (Barrett et al, 1999, p.47).

It can be concluded from the discussion on definitions that kinship care, if dealt with properly, has enormous potential as a placement option. A summary of the common characteristics of kinship carers follows, alerting the reader to the number of kinship carers who are expected to care for children, who are at risk themselves.

### **Characteristics of kinship carers**

Grandmothers and aunts are the predominant kinship carers (Grogan-Kaylor, 2000; Hegar and Scannapieco, 1995). The literature on kinship carer focuses on grandmothers as kinship carers. Perhaps this is because grandparents are more motivated by a sense of familial responsibility to provide care for their grandchildren in a time of stress (Wilhelmus, 1998).

Research conducted in the United States of America has suggested that kinship carers are likely to be single women, of colour, with low-incomes, less education and an average age of approximately fifty years (Berrick, 1997; Gibson, 1999; Gleeson et al, 1997; Hegar and Scannapieco, 1995; Ingram, 1996). These findings have been disputed by Roe and Minkler (1998) because, according to them, the national findings in America revealed that just over half of grandparent kinship carers were married white women, living above the poverty line. However, they agreed that the socioeconomic realities of being poor and the long history of care giving across generations in black families, were seen to increase the chances of an African-American grandmother caring for her grandchildren. The kinship carers who most pressingly require the services of welfare agencies are most likely to be

those, with poor support systems and lower incomes.

Kelly, as quoted in Berrick (1997) suggested that grandparent kinship carers often experienced poor health and depression. It was found that seventy-eight percent of the caregivers in a study had between five and twelve persons living in their homes (Gleeson et al, 1997). More than half (fifty-six percent) had between four and nine children under the age of eighteen years living with them. Many of the grandmothers in Berrick's (1997) study expressed concerns about their abilities to continue parenting young children into adolescence due to their advancing age. Almost three-quarters of children who came into the care of their grandparents in Roe and Minkler's (1998) study did so when they were infants or preschoolers with over forty percent remaining for a period of five or more years.

It can be seen that although kinship care is such a prevalent phenomenon, more research needs to be conducted to develop a common definition of kinship care. This section also suggests gaps in knowledge about who the typical kinship carers are. This may be because many of these placements are arranged informally, and the cases that become known to social workers are more likely to be those that require services, especially social assistance in the form of grants or social relief. The literature creates a sense that the cases that are known about are older women, with fewer resources, living in over crowded circumstances and experiencing poor health as a result of the responsibility for caring for children for long periods at a time. The reasons given in the literature for the growth in kinship care placements helps to deepen one's understanding of this area so these are discussed in the next section.

### **Reasons for the increase in kinship care placements**

Anthropologists have followed the life course of extended black families over the last century and have suggested that grandmothers have served as surrogate parents to their grandchildren for many years in response to cultural precedence, historical events, and the needs of their families (Burton, 1992; Gibson, 1999; Gleeson et al, 1997; Hegar and

Scannapieco, 1995; Mills and Usher, 1996). This suggests that kinship care is not a new phenomenon but rather a growing phenomenon, as social pressures impact greatly on the life cycle of families, and the reasons for these arrangements have changed. The literature suggests three main reasons for this growing trend: legal; demographic; and value-based changes (Berrick, 1997; Grogan-Kaylor, 2000; Leslie et al, 2000; Roe and Minkler, 1998).

- **Legal reasons.** Legislative and policy initiatives over the last two decades have favoured family preservation and emphasised the importance of family ties. Efforts are made to avoid institutionalising children, and placements for children are sought that provide permanency, in family-like settings. There has been legal acknowledgement that kin should not be excluded from the definition of foster parents. In South Africa, however, welfare allocations are being curtailed and many kinship carers struggle to qualify for social grants to enable them to care for their relative's children.
- **Demographic factors.** There is a growing crisis between supply and demand for placements in child-welfare. The number of children needing placements is increasing concurrent with the decline in the number of non-kinship foster parents offering to foster children in need. Placements with kinship carers may thus represent a way of finding more foster homes. There has been a wide range of social factors that have had a major impact on the increasing need for placements for children. Most of these factors are linked to the continued problem of poverty. Some of the factors rendering parents incapable of caring for their offspring have been identified and will be discussed.

The increase in drug abuse, particularly the cocaine epidemic in the United States of America, has been cited as the most dramatic and causal factor in kinship care placements in America. Discussions with social workers in South Africa indicate that they too are concerned about the rising incidence of alcohol abuse among women and this often necessitates the removal of children when there are few suitable placements available for them. Inadequate housing, high unemployment

rates and financial problems contribute to circumstances of neglect and abuse. Historically, black mothers and children were separated when their mothers had to find employment, often in another town. This remains an issue today. Welfare agencies are often asked to intervene when the mothers who have gone into the city to find employment fail to return to care for their children. Many just disappear, resulting in a high number of children being abandoned with relatives.

Grandparents are said to parent well over half the children of imprisoned mothers in the United States, which has had a dramatic increase in the number of women incarcerated. This rate has grown six-fold over the last fifteen years (Roe and Minkler, 1998). Statistics of mothers in prison in South Africa were not available, but it can be assumed that where poverty rates are high, criminal activities are also likely to be high.

In the event of a child being born with physical or mental disabilities, it is often the grandmother who is left with the burden of caring for the child, to enable the parent to work. Grandparents become the primary caregivers of grandchildren born to developmentally immature children as adoption and abortions are not considered as solutions to unwanted pregnancies. AIDS is recognised as the leading cause of death among South Africans and orphaned children are usually left in the care of relatives (Barrett et al 1999).

Factors such as unemployment, poverty and alcohol and drug abuse often result in the neglect, physical, sexual and or emotional abuse of children, before the parents acknowledge that they are unable to fulfil their parenting role. Kin attempt to intervene to preserve family ties. Often by the time they start caring for their relatives' children, the children have already experienced some trauma, necessitating professional intervention. Unfortunately, many abused children do not receive services to offset the effects of their abuse (Daro and McCurdy, 1994). In a study conducted by Grogan-Kaylor (2000) sixty-seven percent of the children were placed with a grandparent as a result of neglect, sixteen percent as a result of

physical abuse, nine percent reported sexual abuse as the primary reason, and eight percent mentioned other forms of ill treatment. Leslie et al (2000) conducted a smaller study of children placed with kinship carers and found that fifteen percent had been placed with the kinship carers because of physical abuse, seven percent because of sexual abuse, forty-seven percent because of parental absence, or neglect, eight percent because of emotional abuse, seven percent because of multiple types of abuse, and sixteen percent for other reasons. These studies did not give death as a reason for placement, perhaps because kinship placements related to death, especially with the escalation of AIDS related deaths, are more common in South Africa than in America.

- **Value based changes.** Research over the last decade has indicated that kinship placements provide advantages for children in need of care. The factors that are considered as advantages will be discussed in greater detail in the next section but are named in this paragraph. In brief they are: kinship care placements offer continuity, familiarity, less disruption, greater permanency, and ethnic and cultural continuity. Practitioners have realised that those family members who share a common background, rather than strangers can better serve children.

The reasons outlined suggest that kinship placements are fast becoming entrenched. The social problems necessitating these placements are ever increasing and remain harmful to these children. It can be anticipated that this phenomenon is likely to demand the attention of social workers for a long time. It can also be surmised that many kinship carers care for children who have been emotionally or socially damaged by their circumstances. Kinship carers are expected to care for these traumatised children independently, with little professional assistance. Social workers should be developing relevant services to address these reconstructed families who need support to deal with the traumatised children. Social workers need to accept the challenge of strengthening kinship care arrangements as best they can. As a result of the prevalence of these placements, social workers should be aware of the advantages and disadvantages of kinship care placements. These will be reviewed in the next section.

## **The advantages and disadvantages of kinship care placements**

Research undertaken suggests that there are many positives to be gained from placing children in need of care with relatives, as well as some risks. An understanding of the advantages and disadvantages of kinship placements will help us to capitalise on the positive aspects of these placements and to address some of the possible negative effects. The advantages are that they offer stability/permanency, support, and a sense of emotional security, and they preserve cultural and ethnic identities.

The first advantage highlighted in the literature is that these placements appear to offer more stability and permanency. Research points to the fact that the children benefit from this increased stability (Berrick, 1997; Ingram, 1996; Leslie et al, 2000). These children are less likely to have their foster placement arrangements altered or changed (Berrick, 1997; Dubowitz, 1994). Leslie et al (2000) provide a simple explanation for this. The finding of their study revealed that children in kinship care placements experience less maltreatment than children in non-kin care placements, so social workers are happy to leave them where they appear settled. The children in kinship placements are more likely to retain some form of contact with their biological parents, and relative caregivers tend to be committed to working with biological parents towards family reunification (Dubowitz, 1994). Dubowitz (1994) stated, however, that when kinship carers were in receipt of social grants they were disinclined to relinquish their status as foster parents because of the implications of losing these grants. Thus social grants may serve to promote the stability of these placements.

The second advantage stressed in the literature is that kinship care placements offer more support to children than traditional foster care placements. At a time of crisis the child receives the support and care, not just from the kinship carer, but a group of caring individuals who are related to and associated with the child and the kinship carer in some way. These existing, established relationships provide the child with a large, familiar network of support that can be relied on in various situations (Berrick, 1997; Leslie et al, 2000). Because the members of this network of support are familiar to the child, they lessen the trauma associated with separation and placement (Dubowitz, 1994; Hegar and

Scannapieco, 1995; Ingram, 1996; Wilhelmus, 1998). The members of this support network are familiar with the child's history and tend to be more willing to focus on the separations and losses that the child has experienced, especially when the child has been removed from his or her parental home (Leslie et al, 2000). Dubowitz (1994) explained that relatives tend to have a special investment in one of their kin as illustrated in the saying "Blood is thicker than water", and so will be more committed to seeing to the welfare of one of their member's offspring than a stranger.

The third advantage pertains to the emotional security experienced by children in kinship placements as a result of the greater likelihood of being placed with siblings, than those in non-kinship placements (Dubowitz, 1994; Hegar and Scannapieco, 1995; Leslie et al, 2000). The continuity of relationships between siblings and the support they receive from one another protect these children from feeling that the family has disintegrated totally, and allows them to have a greater sense that they will not be abandoned.

In conclusion, a tremendous advantage of these placements is that they preserve the racial and ethnic identities of children. Hegar and Scannapieco (1995) stated that, "kinship care takes advantage of historical patterns of family care giving in specific communities" which is regarded as critical for identity formation. The researcher-facilitator believes that this is particularly important in the Zulu culture, as a direct link with blood relatives is seen to "please the spirits of the ancestors".

Whilst there are many positive reasons documented for kinship care placements, there are also drawbacks. A careful analysis of the drawbacks provides social workers with valuable indicators of what intervention strategies are needed to strengthen these reconstructed families. These disadvantages can be broadly grouped into: less stringent screening and monitoring criteria and procedures, limited access to knowledge and resources to meet the demands of their newly acquired parenting role, the more penetrable boundaries between the children and the biological parents who were responsible for their neglect and abuse, and limited resources.

Mention is made of kinship placements not receiving adequate professional services for the screening and/or monitoring of the quality of care that the children receive. Services provided are fewer compared to those provided to non-kin placements (Berrick, 1997; Dubowitz, 1994). This is a concern because children needing foster care have more than average health, educational, social and emotional problems. Many kinship carers lack the resources to refer the children in their care for specialised treatment, and sadly, they seem to be left on their own to just get on with the responsibility for caring for these children. Furthermore, they are not expected to undergo training before the children come into their care, which is of concern because as indicated, kinship carers are often older than non-kin foster parents and report difficulties in parenting and dealing with the psychosocial problems of grandchildren (Berrick, 1997; Wilhelmus, 1998). Kinship carers were also reported to be reluctant to accept supervision from welfare agencies, believing that they are in the best position to know what is in the child's interests (Ingram, 1996).

A few authors have suggested that children in kinship care placements are not adequately protected because the care givers have greater difficulty restraining the parents of these children from having contact with their offspring. There is significantly more biological parent-child contact in these situations than in non-kin placements (Berrick, 1997; Wilhelmus, 1998). This may be detrimental when there has been a history of severe abuse or neglect. These families are sometimes described as dysfunctional families because the abusive or neglectful parent was raised in the same kinship network that is left to care for their offspring (Dubowitz, 1994; Ingram, 1996; Scannapieco and Hegar, 1996). The references quoted remind the reader that many practitioners believe that the dynamics of physical and sexual abuse continue from one generation to another. Critics of kinship care question how relatives, who failed with their own children, can provide the offspring of these children with a more positive context to grow up in.

Sadly, kinship homes are more likely to be compromised than non-kin homes. Financial constraints, inadequate housing, unemployment, drugs and alcohol, violence and/or threatened violence are problems that are often reported by kinship carers as problems experienced in their homes (Berrick, 1997; Grogan-Kaylor, 2000; Ingram, 1996). These

concerns create excessive psychological stress for the caregivers, which in turn impacts on the children in their care, and may create an increased risk of abuse and neglect (Whitley, White, Kelly and Yorke, 1999). Grandparents as kinship carers may experience further constraints as their age affects their level of physical activity. Low levels of energy and lack of knowledge about current child rearing practices, are commonly experienced issues associated with the wide age difference between the older kinship carers and children in their care.

A detailed review of kinship carers' common concerns is necessary before social workers can begin to shape and develop appropriate services. These two topics will be discussed in the next section. This section concludes with a review of a study by Bratton et al (1998) who used filial therapy to strengthen the relationships between grandparents and the grandchildren in their care.

### **Common concerns of kinship carers and services proposed to strengthen these families**

The literature suggests that kinship carers love the children in their care, are committed to them, and at times experience this “newly acquired” parenting role as gratifying. Whilst the role of “parent” is foisted on them at a time when they may feel least prepared for the enormous responsibilities associated with this, they often report acquiring a sense of purpose in their lives again (Burton 1992; Gibson, 1999; Jendrek, 1993). In referring to grandparents as kinship carers Roe and Minkler (1998) stated, “Intergenerational households headed by grandparents exhibit many strengths, with many of the grandparents who assume care giving, doing so willingly, glad that they can ‘be there for the children’. A renewed sense of purpose, and the sheer fun that children can bring into a household, are among the benefits cited by grandparent caregivers” (p.27). These positive attitudes should not allow social workers to become complacent in their quest to assist these families as kinship carers, as they face a number of problems and challenges.

Burton (1992) investigated the life situations of black grandparents and great-grandparents who acted as caregivers to children. She identified three levels of stressors that impacted on their lives. These are contextual stressors, familial stressors, and individual stressors. The research facilitator of this study believes that many of these stressors are equally relevant to kinship carers who are not the grandparents. Each of these stressors will be explored separately. Whilst Burton (1992) refers to American kinship carers, the stressors appear to be equally relevant within the South African context.

The contextual stressors refer to the stressors caused by the contexts the kinship carers find themselves in. Many live in poverty. The housing available to them is often in crime-infested areas. The participants in Burton's study (1992) verbalised their fears of burglaries, drive-by shootings, increased criminal presence and gangsters. These fears for their safety impacted on their tasks and routines such as grocery shopping, paying accounts, leaving their homes and allowing the children to play outside. South African kinship carers experience similar concerns, as the township areas lack adequate policing and security. The high level of unemployment has contributed to a high crime rate. In the absence of child minders, the grandparents are forced to leave the children locked inside their homes when they attend to shopping, collect pensions, or, in some instances, go to work. These observations were reported by student social workers who were doing their practical work in townships in and around the Durban area.

The kinship carer's family has to be rearranged, or reshaped, when a child is suddenly placed in their midst. There are many role shifts to be made and new responsibilities to honour. These changes place new demands on all concerned. The demands often create considerable strain. Grandparents in Burton's study (1992) were quoted as saying that "there are just too many things that we have to deal with".

Gibson (1999) referred to the specific stresses faced by grandparents parenting younger children. The grandparents in this study reported that they did not feel adequately prepared for "parenting" because there were tremendous differences between their care giving styles and those the children were used to; they were overwhelmed by the extent of the children's

needs as a result of their previous abuse or neglect; the changes in the rules and regulations that govern their lives differed from those of another generation and this was confusing; the long length of time since they had been the primary caregivers of young children had minimised their confidence in their parenting abilities; and the numerous adjustments they had to make in their daily activities such as house rules, space available, and routines were quite frustrating.

Many kinship carers report being overwhelmed by the numerous logistical and physical demands placed on them. They struggle to keep up with the school, social and physical demands of these children, at the same time as struggling to meet the financial costs of caring for them (Burton, 1992; Grogan-Kaylor, 2000). Because of the severe financial constraints, carers are often unable to ensure that the children in their care, who have easily identifiable health problems, receive the necessary treatment. Many of these children have long-term problems requiring some form of remediation as a result of their traumatic pasts. Grogan-Kaylor (2000) mentioned that kinship carers struggle to understand and deal with the special needs of children diagnosed with developmental delays or hyperactivity. Some kinship carers find themselves being responsible for multiple kin such as an elderly parent, an alcoholic spouse or adult child, or an unemployed and financially dependent adult child who place further demands on them.

Kinship carers are left to struggle with other difficult issues, such as how to protect children in their care from the “stigma” associated with the parents’ shameful pasts (Grogan-Kaylor, 2000; Roe and Minkler, 1998), and how to provide positive role models for the children to identify with. In some instances the kinship carer may be criticised by other members in the family for the time or money she invests in the child who is placed in the home as this limits the attention or resources that those members would have benefited from had the child not been there.

Handling so many stressors impacts on the personal lives of the kinship carers. Jendrek (1993) found that grandmothers who were carers for their grandchildren complained of being physically tired. A high percentage, eighty-six percent, reported feeling depressed or

anxious most of the time, sixty-one percent noted that they smoked more heavily than they had done prior to the placements, thirty-six percent mentioned drinking more heavily, thirty-five percent complained of heightened medical problems with diabetes and arthritis, eight percent reported having had a stroke and five percent had a mild heart attack within the year they had participated in the study.

These carers are left with little or no time to do the things they should do for themselves (Burton, 1992; Gibson, 1999; Jendrek, 1993; Grogan-Kaylor, 2000; Roe and Minkler, 1998). They tend to delay seeking formal help for themselves, particularly with mental or emotional problems (Roe and Minkler, 1998). The demands placed on them tend to prevent them from socialising; leaving them feeling socially isolated and alienated (Burton, 1992; Gibson, 1999; Jendrek, 1993; Roe and Minkler, 1998). “Intergenerational households formed as a result of parental AIDS or drug addiction may experience special feelings of alienation” (Burnette cited in Roe and Minkler, 1998, p.28). They may forfeit their own aspirations to meet the responsibilities demanded of them as a result of caring for the children living with them. Roe and Minkler (1998) provided examples of the kinds of forfeits they tend to make: resigning from employment, cutting back on hours so as to be able to care for the child, or even giving up work altogether.

The role shift of kinship carers requires an adjustment for all involved. Often there are no structural supports to enable them to adjust to their new, unplanned-for role. The researcher-facilitator felt that it was essential to find out what services were considered to be important for kinship carers. Services that were recommended in the literature can be sub-divided into two broad categories. The first stresses standardising screening and monitoring practices. The second stresses finding interventions that will assist kinship carers to deal with their unique tensions. This study is more interested in the second category. The suggestions listed in the literature alerted the researcher-facilitator to the gaps that exist in these services and became a motivating factor in selecting this research design.

Suggestions made by Bratton et al (1998), Berrick (1997), Dubowitz (1994), Gibson

(1999), and Roe and Minkler (1998) are briefly summarised. Standardising screening and monitoring practices includes establishing guidelines concerning the caregiver, housing and security measures, and neighbourhood, in order to provide more uniform standards for social workers in their selection of kinship carers. Special assessment tools should be used for kinship carers rather than relying on the assessment tools used for non-kin foster placements.

Kinship carers need practical information that will assist them to gain access to practical resources such as financial support, housing, medical care, day and respite care, legal advice. Kinship carers are often overwhelmed by the lack of resources and knowledge at a time when they are most needed to address the many problems that lie before them. Knowledge is a critical resource. Kinship care may necessitate that the carer has to review his or her knowledge on parenting. They may need to learn about more current techniques used in raising children, gain information about the developmental phases of children, learn about special needs of children, and methods of dealing with the special needs (Bratton et al, 1998; Berrick, 1997). Pointers on basic health and safety measures, as well as economic resources or services available to kinship carers are considered as useful.

Finally, support groups are considered an invaluable source for providing short-term emotional, informational and material support for carers. In these support groups, they may socialise with others who have similar experiences. In a supportive context they are able to share, learn, and benefit from feedback and suggestions from one another. This form of learning is more participatory in nature, and provides an empowering process, far superior than being reliant on the instruction from experts (Schenck and Louw, 1995).

The study conducted by Bratton et al (1998) found that filial therapy offered significant possibilities for promoting the well-being of grandparents and their grandchildren who lived in their care. Filial therapy provided the grandparents in this study with healthy parenting and relational skills, and the grandchildren with necessary emotional support.

## Summary

The literature review has attempted to define kinship care. The distinct advantages associated with kinship placements and some of the disadvantages were discussed. The advantages out-weigh the disadvantages, but this should not allow social workers to become complacent about developing meaningful services for these families.

Kinship care raises many challenges for the carers and the professionals who serve them. A multitude of factors makes it difficult for kinship carers to positively contribute to the healthy development of children in their care. Social workers have an obligation to find new methods of addressing their needs. Whilst economic support is a most pressing need for many kinship carers, support and parenting skills are likely to empower, restore their self-confidence in their roles as carers, and enable them to address these challenges. Support and parenting skills are likely to lessen the potential of secondary abuse of children by their carers (Whitely et al, 1999).

There are few, if any, locally specific studies published on kinship care in South Africa. Whilst most of the studies reviewed in this chapter have been American based, their findings appear to be relevant to kinship carers and professionals in South Africa. However, more is to be gained from testing this knowledge against the experiences of the kinship carers in the local context. It is the researcher-facilitator's contention that services that acknowledge the strengths and resources of kinship placements, that involve kinship carers in developing relevant intervention strategies, that offer kinship carers support, and build on their competencies, are likely to provide social workers, and kinship carers, with the best way forward. Rather than be daunted by the lack of simple solutions to the complex problem of kinship care, social workers should create opportunities for kinship carers to discover their own solutions.

Reference has been made to the benefits of using filial therapy as an intervention for custodial grandparents and children in their care. The literature reviewed indicated that kinship carers need educational and support services. Filial therapy is seen to have

potential as a valuable intervention for kinship carers and the children in their care as it combines support and education. The kinship carers develop new skills that strengthen the relational ties between themselves and children in their care. Carers are taught to create opportunities for children, through play, to work through some of their emotional pain. This enables the children to regain a sense of power and control over their difficult circumstances. Filial therapy, and the possibilities of adapting it for use with kinship carers are addressed in Chapter Three.

## Chapter Three

### LITERATURE REVIEW: FILIAL THERAPY

#### Introduction

Many innovations have been made in the quest for efficient and effective ways of helping families in distress. Some of them involve parents directly in the treatment of their children's emotional and behavioural problems. The need to find methods to combat emotional problems in the young has been stressed, because, "once these problems become relatively fixed, even massive expenditures of professional time often later fail to be of use" (Guernsey, 1964, p.304). The involvement of parents in treating their children is a most credible way to address change because it utilises the parents' continual and natural contact with their children. The therapist's role becomes one of consultant, teaching the parent the basic principles of the treatment approach being used. Athanasiou and Gunning (1999) captured a popular sentiment most profoundly when they said: "Parents constitute a force in children's lives that cannot be rivalled by others" (p.587). The parent's relationship with the child is a dynamic vessel to use to engineer change in the child's life. The use of parents as therapists is viewed as consistent with the growth of the community mental health movement and the concept of dealing with the total context in which the child resides (Ginsberg, 1976). This also increases the leverage of professionals' time as the therapist can work with more than one family at a time.

Filial therapy is an approach that engages parents directly in the treatment of their children's problems. It treats developmental and emotional dysfunctions in children by making direct use of the parent-child relationship. The parent is trained to carry out client-centred play therapy with his or her own child by a professional who has been trained to instruct parents in this kind of therapy.

This chapter contributes to a clearer understanding of filial therapy and the possibility of using this as a treatment approach for kinship carers. It covers definitions of kinship care as a process that fulfils the dual function of intervention and prevention. It details its application to specific problem areas. It outlines the history and development of training parents in therapeutic play and demonstrates how this is linked to client centred play principles. A broad overview of filial therapy as group intervention is included. The chapter ends with a discussion of several outcome studies relevant to this study.

## **Definitions**

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, 1994, p.414). This definition would suggest that filial therapy is therapy that takes place between blood relatives.

Andronico, Fidler, Guerney and Guerney (1967) described filial therapy, as developed by Guerney and Guerney in 1964, as a method of teaching parents of emotionally disturbed children to relate empathically to their children for prescribed periods of time. The children are not seen in therapy, but rather have “play periods” at home with one or both parents. The goal of the play periods is to enable the child to work through his or her emotional problems via play in the atmosphere of parental empathy. The parents meet with a therapist for one and a half to two hour sessions on a weekly basis. In these sessions the therapist helps the parents to develop empathic and reflective listening, as well as limit-setting skills. The parents conduct weekly play sessions with their children at home to practice these skills. Johnson (1995) explained that these play sessions are special times, intentionally different from “normal” time and it is this difference that fosters the development of the nurturing parent-child relationship. Because the parent-child interaction becomes less conflicted, the family is more likely to start addressing other family issues.

Van Fleet (1994) defined filial therapy as: “a psycho educational intervention model that is based on client centred, dynamic, behavioural and family system principles” (p.65). The preceding discussion highlights that “Filial therapy joins two important strategies, non-directive play therapy for children, and parent education through direct involvement in the change process” (Arnott, 1998, p.3). It offers significant possibilities for enhancing and strengthening parent-child relationships in troubled families.

The three important principles that are central to filial therapy are: the recognition of the importance of play in child-development, the belief in parents’ ability to learn the skills necessary to conduct the child-centred play sessions, and the belief that social, emotional, and behavioural difficulties of children are environmentally based adjustment problems arising primarily from a lack of knowledge or skill (Van Fleet, 1994). In view of these principles, the therapist believes that play is a primary way to gain understanding of children.

Filial therapy is based on the premise that parents who are considered the most significant adults in children’s lives have a greater impact on children than any therapist, and that an educational model is preferable when working with parents and children. The article by Guerney, Guerney and Stover (1972) best explains these premises by introducing readers to three assumptions on which filial therapy rests. Firstly, filial therapy abandons the historical diagnostic orientation by avoiding discussions of what parents may have done wrong in the past that may have led to their children’s problems and concentrating instead on parents learning and practicing new beneficial behaviours. Secondly, it believes that whatever happened in the past is best remedied by attempting to create a favourable set of circumstances for an unhappy family. This can be done by imparting knowledge and interpersonal skills which will strengthen the family and create more favourable circumstances. Thirdly, by denouncing the need to uncover parental inadequacies in treating their children, the filial therapist convinces parents that they are capable psychotherapeutic agents. Parental defences are lowered, together with their guilt, and they tend to explore what keeps them from behaving in the way they choose to towards their children. They explore their emotions, needs, and personal conflicts that prevent them from fulfilling a more positive parenting role. As described by Johnson, Bruhn, Winek, Krepps

and Wiley (1999), they become sensitised and conscious of their roles in the problems of their children. The focus shifts from the child as the identified patient to the family.

Filial therapy takes place typically in a support group format. Parents are taught the basic child-centred play therapy principles and skills and are expected to use these with their children in special weekly play sessions at home. Didactic instruction is combined with supervision in a supportive atmosphere (Bratton and Landreth, 1995). Through viewing video tapes, receiving supportive feedback from the facilitator and other parents, role playing and a variety of didactic experiences, the parents learn to convey acceptance, empathy and encouragement to their children, as well as to master the skills of effective limit-setting. According to Landreth (1991) "This new creative dynamic of empathic responding by parents becomes the creative process through which change occurs within parent and child and between parent and child" (p.339).

This approach is suitable for children between the ages of three and twelve years of age. It has much diversity and has been found useful with all socio- economic groupings and a variety of childhood problems (Ginsberg, 1976; Johnson et al, 1999; Van Fleet, 1994). Amongst those problems and range of circumstances mentioned by these authors were: anxiety, depression, reactions to trauma, timidity, difficulties in relationships with peer and/or siblings, separation anxiety, school refusal, speech disturbance, children of alcoholics, mentally retarded children, multiple disabled children, reducing aggressive behaviour, enuresis, abused and neglected children, children with chronic illnesses, children of divorced parents, children of incarcerated fathers and adopted children. A study conducted by Bratton et al (1998) indicated that this was a useful approach to implement with American custodial grandparents and their grandchildren.

To fully understand the theoretical underpinnings of filial therapy, it is suggested that the principles and assumptions on which child-centred play therapy is based be revisited. The next section discusses important theoretical constructs of play therapy, creates an awareness of the underlying person-centred foundation on which filial therapy was built, and traces the development of filial therapy.

## **Play therapy and the history and development of filial therapy**

The rationale for using filial therapy is deeply rooted in client or person centred play therapy. Play therapy has been in use since the 1930s. Play is the natural means of expression for a young child and Erikson, as quoted by Guerney (1990, p. 79) said, “that to ‘play it out’ is the most natural and self-healing process in childhood”. “Play has been called the primary precursor of creativity with the capacity to moderate affect and anxiety – a rehearsal for life, through which the child discovers self, potentials and limitations. It has been said that play is the ‘essence of therapy’, the common thread which runs through all types of therapeutic interaction” (Johnson, 1995, p.55).

Play is not considered as a frivolous activity, with no purpose, but rather an activity that involves problem solving, learning new social, language and physical skills. It provides the child with a safe context to test out new ideas, experiment with new behaviours, and resolve emotional issues.

Johnson et al (1999) stated that whilst play is a general term used to describe a variety of interventions, the common elements of these interventions are: that play is considered as the child’s communication and work, and that toys are the media he or she uses to express him/herself, or accomplish his or her work. Through play, the child may act out perceptions of self, family and others in ways that would not be revealed in the everyday world. The child uses his or her imaginary expressions to help him or her cope with the insecurities created by his or her real world (Moustakas, 1997).

Landreth (1991) detailed the purposes of play as: teaching children self-control and self respect, helping children to accept, express and deal with their feelings effectively and responsibly, empowering children to be creative and resourceful when confronting problems, freeing children to move in self-directing ways, and in making responsible choices, and enabling children to accept themselves at a feeling level. These purposes highlight the importance of creating opportunities for meaningful play for children to facilitate their adjustment into adulthood.

## **Client centred/Child centred play therapy**

Carl Rogers (1951) believed that counselling is a way of helping the individual to help him or herself. The function of the counsellor is to make it possible for the client to gain release from his or her emotional problems, and as a consequence, to think more clearly and more deeply about him or herself and the situation that he or she is in. The counsellor provides an atmosphere in which the client, through his or her exploration of his or her situation, gains insight about him or herself and his or her reactions to situations. On the basis of this insight he or she is able to meet his or her life problems more adequately. A central task of the counsellor is to understand and empathise with the client. A relationship must exist for this sharing and understanding to take place. The therapist displays unconditional positive regard for the client, which then lowers the client's defences, allowing the client to see him/herself more accurately. Child centred play therapy is based on these theoretical assumptions.

It is believed that children thrive in a relationship of unconditional positive regard. The therapist demonstrates genuine interest and unqualified acceptance of children. The children are free to explore and express themselves completely without any judgement or control from the therapist. The therapist shows sensitivity to the child's feelings by gently reflecting those feelings, demonstrating a belief in the child's capacity to act responsibly, and sets appropriate therapeutic limits.

Virginia Axline (1971) was the main pioneer of client centred play therapy. Her work has remained a valuable reference for people choosing to work with children. She proposed eight basic principles for conducting play sessions with children.

- The therapist must develop a warm friendly relationship with the child, in which good rapport is established as soon as possible.
- The therapist accepts the child exactly as he or she is.
- The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his or her feelings completely.
- Limitations are few and are set only on behaviour, not on verbal or other affective

expressions. The therapist only sets limits that are necessary to anchor the therapy to the world of reality, and to make the child aware of his or her responsibility in the relationship.

- Responsibility for direction and change are left to the child, with no hurrying. The child takes the initiative and the therapist follows.
- Feelings are identified, labelled and accepted. The therapist states those feelings to the child, or reflects them back (preferably in different words) in order to convey understanding and acceptance of the child's feelings and point of view.
- The therapist does not attempt to change the child's perceptions directly but adheres to the belief that the child will change in the direction of increased self-understanding and self-acceptance, as well as increased pro-social behaviours when he or she feels fully accepted by the therapist.
- The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.

These eight principles are critical to client centred play therapy and filial therapy and form the basis of this form of therapeutic activity. The principles are well demonstrated in this excerpt from a training manual. "The play therapist is a unique adult in the children's lives, unique because the therapist responds out of his or her own humanness to the person of the child, while controlling any desire to direct, probe, or teach and instead provides responses that are freeing to the child's natural urge towards self direction" (Ravat, 2001a, p.5).

Before Axline published the first edition of *Play Therapy* in 1947, studies had already been conducted on therapist and child sessions (Landisberg and Snyder, in Guerney, 1990). Moustakas and Schalock (in Guerney, 1990) later found that when the therapist responded empathically, the child responded by releasing significant feelings through his or her actions. Reif and Stollak, in Guerney (1990), found that trained therapists were able to elicit high levels of fantasy related to the child's expression of internal emotional states through demonstrating acceptance and permissiveness.

Guerney (in Guerney, 1990) identified that when parents became more empathic and encouraged the child to use more self-direction, the child's aggression and dependency decreased and appropriate assertiveness increased.

It would seem that when a child believes that he or she is accepted, it minimises the need for him or her to behave in socially inappropriate ways. Through play the child can talk, emote, fantasise, master and resolve conflicts via the play objects, within a unique relationship with the therapist. Children often play out feelings of anger, depression, aggression, dependence and the need for approval and nurturing. The child tends to feel safe to reveal hidden emotional and interpersonal needs, experiment with new more mature behaviours and feels safe to make mistakes whilst learning new actions. The child uses the language that he is most comfortable with to express this "play".

Although the child is free to verbalise, play nonverbally, and be "original" in his or her behaviour and expressions, he or she is also limited to some degree. Limits are set to protect the therapist, property and the child from damage and possible later guilt. In the event of the child refusing to stick to the limits, it is advisable for the child to be given the choice of accepting the restriction or accepting a consequence. An example of this is, if the child persists in kicking the therapist, the child is warned that he can choose between ending the session for the day or refraining from hurting the therapist. Two warnings are given, followed by the statement of the restriction. If the behaviour continues, the child then experiences the consequence. The therapist explains the rule in a firm way and empathises with the child's desire to do otherwise. The therapist accepts the child's feelings but remains calmly assertive at the same time.

A slow, persistent metamorphic change transpires. "Mastery of motor tasks, speech challenges, asking for affection in an appropriate way, and attempting to be appropriately assertive are all seen frequently in later sessions" (Guerney, 1990, p.80). The new experiences with the therapist are generalised to other relationships and situations outside sessions.

## **The history and development of filial therapy**

“For decades, practitioners have been seeking ways to engage parents meaningfully when children are in therapy or in need of support, when a divorce has taken place, or when a blended family has formed” (Guernsey in Van Fleet, 1994, ix). The concept of training parents to become therapeutic agents in their child’s life can be traced to the early 1900s when Freud involved a father in treating his five-year old son’s phobia (Bratton et al, 1998). Further therapists, Jacobs (1949) and Bonnard (1950) successfully engaged parents in intervening in their children’s problems after receiving training (in Bratton et al, 1998). In 1957, Carl Rogers helped his daughter, Fuchs, to use play therapy methods to overcome her anxiety related to toilet training. Fuchs was quoted as saying that she experienced positive changes within herself as a result of the sessions (in Guernsey). Moutsakas (1997) continued to build on theory pertaining to involving parents in conducting play sessions in their homes and recorded that these sessions had great benefits for children.

In 1964 Bernard Guernsey developed the idea that parents could serve as client-centred play therapists. For some time he challenged psychotherapists that individual psychotherapy had to be replaced, or at least be augmented with more community-based methods to increase professional leverage. He published the first report on the systematic training of parents to serve as change agents for their children. Guernsey provided five major arguments for this development. He believed that the problems children experienced were not as a result of parent pathology, but rather a lack of parenting knowledge and skills. By helping children to communicate thoughts, feelings and needs in play, the parents would become more aware of the stresses that their children experienced and become more understanding towards them as a result of this awareness. Direct intervention by a therapist offered few, if any, advantages compared with intervention by parents who had been systematically trained and supervised by a therapist. By engaging parents directly in the treatment of their children, the therapist would reduce their resistance and encourage them to collaborate in the treatment plan. Unconditional positive regard and empathy within the child-parent relationship are more rewarding than when encountered in a therapeutic relationship with a professional.

Guernsey and colleagues trained parents in the skills and attitudes of non-directiveness. During the 1960s they spent time refining the method and publishing articles about it. They developed a structured small-group training format. Parents were taught in groups of between six and eight to apply the principles and skills of child-centred play therapy in special weekly play sessions, whilst receiving weekly supervision from the professionals. The programmes lasted between six and twelve months. Guernsey and Guernsey shortened the number of sessions and groups met for between five and six months, yet still demonstrated comparable gains (Guernsey, 2000). Filial therapy was later relabelled Child Relationship Enhancement Therapy, in 1985, as they believed that it was more descriptive. The term filial therapy, or filial family therapy, continues to be widely used (Guernsey, 2000). Landreth (1991) preferred to use the term Child-Parent-Relationship Training (CPR for parents).

Landreth (1991) shortened the programme to last for a ten-week period so that families with financial and time constraints could be helped. The ten-week model sparked greater interest and expanded for applications with many populations: chronically ill children, prisoners, and single parents. “The brevity and success of this model have made it seem more manageable to practitioners pressed for time and looking to improve their effectiveness” (Guernsey, 2000, p.11).

In the last fifteen years the interest in play therapy and filial therapy has grown. The writings of Landreth (1991) and Van Fleet (1994) have sparked academic and practitioner interest. Furthermore, many of the former filial therapy supporters have moved into positions of leadership in academic settings and have continued to publish their original work. Their teaching is developing a third generation of filial therapy students and utilisers (Guernsey, 2000). It seems as though the model Guernsey proposed, which was at the time seen as radical, is now commonplace when working with families.

The new wave of interest in this approach may be attributed to several factors. Some of the important reasons for the popularity of filial therapy, as given by Guernsey (2000) are in keeping with the theoretical assumptions of this study. The post-modern emphasis which

stresses utilising client strengths and building on them during the therapeutic alliance seems to be “the flavour of the day”. The researcher-facilitator welcomes this trend, believing that more is to be achieved by engaging clients positively in treating their problems rather than labelling them as dysfunctional. The prevailing philosophy embraces empowering people to address their concerns. The advantages of working with families in a systemic way, rather than focussing on individuals, are being given preference because of the results these efforts yield. The family is recognised for the collaborative role it can play in assisting its members, be it in social work, mental health or ancillary medical services. Parents are seen to want to do well by their children. Recent approaches to helping families stress communication and social skills training, as these are believed to have a positive outcome for individuals and families. These are central themes throughout filial group sessions.

Sadly, filial therapy has not been applied that widely in South Africa. Whilst Ravat continues to conduct numerous training groups in filial therapy in South Africa, there is to date only one published research, Arnott’s study with mothers of children diagnosed as having Attention Deficit Disorder (1998). Ravat in her personal communication with the researcher-facilitator reported that several post-graduate students were working on different research topics using filial therapy as the main intervention.

### **The logistics of filial therapy groups**

This section details the “how to” of running filial therapy groups and provides the specifics of the structure of filial therapy sessions and the equipment used. A detailed description is given of the four conditions taught to parents in filial therapy groups. These conditions prepare the parents for the parent/child play sessions and later are used as relationship skills in the parents’ interaction with the child. To conclude this section, an overview of Landreth’s ten-week group filial session programme is described. It is hoped that this will enable the reader to compare and contrast the structure of the Western model of filial therapy with the locally specific model that emerged from this study.

### **Getting started**

The play therapist screens each family. The play therapist arranges to meet the parent alone to obtain a clear understanding of what the parent's reasons are for coming, the difficulties he or she is experiencing with the child, and to take full developmental and social histories of the child and family. If filial therapy is advocated, the therapist discusses the advantages of play therapy and how these relate to the concerns that the parent presented. The purpose of play is explained and the process of filial therapy is described. Specific goals for therapy are defined. The role of parents as partners in this therapeutic venture is stressed.

A group of six to eight parents are brought together by the play therapist. The literature suggests creating groups that have parents of children who have a variety of problems. This diversity is said to enrich the group (Guernsey, 1990; Landreth, 1991; Van Fleet, 1994). A pre-group session is arranged to clarify any misconceptions, plan for meeting times, arrange a venue, and introduce members to one another.

The parents contract to attend weekly sessions, which last between one and a half to two hours each, and agree to conduct weekly play sessions with their children at home. During the group session, the first half-hour consists of a play therapy session conducted by the play therapist with one of the parents' children whilst the rest of the group observes. The next hour and a half are spent discussing what the parents observed and experienced. In the early stages of the group the parents discuss their parenting problems and how play sessions will help them to deal with these problems. The parents practise conducting sessions through making use of role-playing. When the parents appear to have mastered the skills sufficiently, they are asked to assemble a toy kit and then conduct weekly half-hour play sessions at home with the child. They provide weekly reports of their play sessions at the group sessions. Members are encouraged to raise additional concerns about their children, families and themselves.

### **The four conditions for parent/child play sessions**

The conditions are translated into skills which the parents learn and practise throughout the therapeutic process. Some of these skills become generalised and the parents begin to use

them in appropriate areas of family life.

- The child should be completely free to determine the use he or she makes of the time and materials. The child leads and the parent follows without making suggestions or asking questions. Whilst Moustakas (1997) referred to this as “structuring the relationship” (p.44), Van Fleet (1994) referred to it as “child-centred imaginary play”(p.17). Through reinforcing the child’s power to direct the play sessions, the child is able to understand freedom and autonomy and rely upon his or her own powers to discover, explore, and actualise interests and potentials (Moustakas, 1997). This skill enables the parent to become more sensitive to the child’s “inner world” and helps the parent to further the child’s expression of themes in play (Van Fleet, 1994).
- The parent’s major task is to empathise with the child and to understand the intent of his or her actions, thoughts and feelings without judgement. It is a way of demonstrating a deep regard for the child without dominating or leading. Van Fleet (1994) suggested that when teaching parents to reflect feelings one can liken the reflective comments to the play-by-play commentary of a sport broadcast.
- The parent learns to reflect the child’s emotions in a brief, accurate, and natural sounding way. Moutsakas (1997) stressed that this was a way of affirming the child’s uniqueness and encouraging his or her disclosures and self-actualisation. Through this verbalised reflection the parent’s interest in the child is demonstrated. The child is able to clarify any misunderstandings the parent has of the child’s intentions or feelings. The child is taught to label feelings which later enables him or her to learn to express these feelings as a matter of course. Finally, it helps the child gain self-acceptance as he or she experiences this acceptance by the parent (Van Fleet, 1994).
- The parent is instructed to be clear and firm about the few “limits” that are placed on the child in play sessions. Later, as the parent demonstrates competency in applying this skill in play sessions, he or she is taught to generalise it for use outside the play sessions. The limits are usually simple. They may include limits about the duration of the session, not breaking the toys, not harming the parent or him or herself, not leaving the session prematurely. Limit setting informs children of

general boundaries without jeopardising the atmosphere (Van Fleet, 1994). The children gain the message that they are relatively free to do as they please during play sessions, but the parent has the authority if the boundary is not respected. Moutsakas (1997) argued that these limits connect the relationship during the session to the realities of the everyday world. They remind children of their responsibilities to the parent, the playroom and to themselves.

### **The play sessions at home**

The parents are asked to identify a physical space suitable for “playing” at home. This area does not remain set as a playroom between sessions. Every effort should be made to create a free environment so the room should be arranged in such a way to provide this (Ginsberg, 1976). Several factors are considered when choosing the area: the area should be large enough to permit punch bag play and two people and the other toys, it should be cleared of breakable items, it should withstand rough and tumble play without the need for many additional limits, it should be suitable for water play and spills (Van Fleet, 1994).

The therapist helps the parent select toys that allow for mastery, fantasy and action-aggression play (Van Fleet, 1994). Each toy selected has a specific purpose. Dart guns, plastic knives and rope allow the child to express angry feelings. Water and bowls, baby bottles and dolls are included to facilitate nurturing themes. A dollhouse, furniture and a doll family are provided to enable the child to play out family issues. Construction toys and games allow the child expression of mastery, competition and cooperation themes. Items representing other interests of children are included such as medical kits, masks, and dress up clothes. Expressive materials such as play dough, sand, paper, crayons and paints are also provided. Moutsakas (1997) refers to the toys as “unstructured media” (p.210). He cautioned that parents should always be alerted to the fact that the play materials have different meanings to different children and that “their use should never be directed by social definitions” (p.211).

Van Fleet (1994) and Landreth (1991) involved the parents in assembling their own set of toys to be used for the “at home” sessions. Jang (2000) and Glover and Landreth (2000)

provided the parents with toys in their studies. Parents are urged to keep these toys separate from the child's regular toys so as to communicate the "specialness" of the play therapy sessions at home. Van Fleet (2001) made suggestions for low or no-cost toy substitutions for indigent families. Some of these were used in this study.

When it is time for the "at home" play session, the parent scatters the toys around the chosen play area in an inviting way before the structured playtime begins. The child is brought into the room and is given thirty minutes to play with the toys in as many of the ways that he or she chooses to.

Precautions are taken to ensure that the parent and child will not be disturbed by others during this time. A five-minute warning is given to the child in the last remaining five minutes in the session. When the time is up, the child is led out of the room. It is the parent's responsibility to clean up and pack the toys away for the next session.

Filial therapists continue to meet with the parents on a regular basis to discuss the home play sessions and to facilitate the generalisation of the skills to daily life. As progress is made toward therapy goals the therapist and group members start planning for termination. Often there is a reduction in the children's interest in the play sessions coupled with a decrease in the intensity of the play and these may be indicators that the sessions should be terminated. Therapy is phased out and parents are encouraged continue play sessions on their own. Usually, the parents have conducted a minimum of ten play sessions with their children when these signals appear suggesting that the group are nearing termination. The therapist and parents evaluate the progress made and identify remaining problems (Van Fleet, 1994). If the feedback is that the problems are resolving well then the parents are asked to complete any questionnaires, skill measures, or behaviour rating scales administered during the assessment phase to provide additional evidence of progress. The therapist emphasises the desirability of continuing the play sessions at home until the children grow tired of them.

A review of Landreth's ten-week model will be presented to conclude this section. It provides the therapist with a tentative plan to guide the group through ten sessions.

## **Landreth's ten-week programme**

Landreth's (1991) shortened model of filial therapy is a practical model. It provides the group facilitator/play therapist with clear guidelines of topics and exercises to be covered in the group sessions, and at home. Much of the information was adapted from the work of Louise Guerney, PhD. Modifications were made by Bratton and Ravat (Arnott, 1998). The ten sessions and their primary purposes and contents are summarised. (For a more detailed outline of the contents of each session refer to Appendix I).

**Session one:** Parents are helped to be more sensitive to the children and respond to their emotional expressions with empathy. The therapist uses role-plays to teach this skill. The discussion centres around the importance of focusing on children's needs and emotions. Homework assignments are given to the parents, requiring them to identify the four feelings, anger, happiness, sadness, and surprise in the child and make reflective responses to each of these. Another assignment is to notice some physical characteristic about their child that they had not previously seen.

**Session two:** Parents are helped to experience reflecting feelings in a play session. Group discussion centres around obstacles to reflecting children's feelings. A videotaped play session is shown to the group. Parents take it in turns role-playing being a parent and a child in a play session. A list of toys needed for the play sessions at home is allocated to each parent and they are encouraged to buy or borrow the listed items so that the toy kit is available for the next session. Play is presented as a meaningful activity and the non-directiveness of child-centred play therapy is stressed.

**Session three:** Plans are finalised for beginning the home play sessions. Parent/child sessions are portrayed as special times that should not be interrupted. The parents are taught the basic limit-setting skill to remind them that they need to remain in control even though their children are given the lead. The parents role-play setting limits in simulated situations. Parents share their fears about play sessions and brainstorm ways to prevent problems. Their homework is to make a videotape of a play session, as each parent is

expected to present one such recording for discussion at a group session. Parents are asked to start a journal to record the themes and reactions to the child's play. They are encouraged to write down any positive moments in the sessions. A parent volunteers to bring a video recording of the first play session.

**Sessions four to nine:** During these meetings the members talk about their play sessions and share their reactions with one another. The therapist facilitates discussions between members, ensuring that they become empowered to find their own answers to their difficulties. Parents are encouraged to start to examine their own feelings and to provide support for one another. Parents take it in turns to provide a videotape for discussion. Positive feedback is provided, rather than corrective advice. Parents are encouraged to generalise their newly acquired skills beyond the parent/child play session into other aspects of their daily living. Training and role-playing of play session principles and skills are continued in each session.

**Session ten:** The goal of this session is to bring closure to the experience and to plan for future "special time" with the children. Parents evaluate their experience and the changes that have occurred in their children and their parent/child relationship. Members are encouraged to provide one another with feedback.

Ginsberg (1976) conducted a filial therapy group where it was not possible for the members to videotape sessions. Group members took turns to bring a child for a live demonstration of a play session so that there was a different child for each group session. Some groups include information about specific problem areas with children such as coping with illness, single parent issues etc. "The interesting factor is that whilst this intervention was waiting to gain broader recognition and acceptance by practitioners, advocates in academic settings were testing its efficacy" (Guernsey, 2000, p.1). Reference is made to outcome studies conducted and filial therapy with other nationalities in the next section.

## **Outcome studies**

Outcome studies found in the literature reflected that filial therapy obtains desirable effects for children and their parents. Parents were found to be good learners and felt empowered by being actively involved in their children's remediation (Guerney, 1990). The findings are consistent. They continue to suggest that filial therapy is a highly effective means of producing positive changes in parent/child interactions, as it increases parents' empathy and acceptance towards their children. As parents become more proficient in dealing with their children's feelings, reports of problem behaviours decrease (Johnson, 1995). Filial therapy dropout rates are low, parental stress levels decline, and follow up studies conducted five years later found that these gains were maintained. For the purpose of this literature review, the discussion of outcome research will be subdivided into four subsections: improved relationships between parents and children; lowered parental stress; a reduction in the problematic behaviours manifested by children; and therapeutic benefits of participating in a filial therapy group.

### **Improved relationships between parents and children**

Andronico et al (1967) proposed that the improvements noted in relationships between parents and children could be explained because parents in their study tended to accept the initial task orientation aspect of the programme and then as a result of their lowered defences started working gradually on areas requiring personal exploration. This view is shared by Bratton et al (1998) who used filial therapy to work with custodial grandparents. Their findings suggested that the grandparents in their study were willing to address the emotional concerns and adjustments that were required as a result of their difficult life transitions from grandparents to parents again, resulting in closer relationships with their custodial grandchildren.

The didactic component of filial therapy equips parents with a range of relationship enhancement skills. Studies indicate that filial therapy assists parents to develop skills in reflecting feelings, learning to express acceptance of their child's feelings, and in setting limits in a caring non punitive fashion (Bratton and Landreth, 1995; Glazer and Kottman,

1994; Glover and Landreth, 2000; Johnson, 1995). The skills of setting limits and offering children choices was found to introduce significant attitudinal shifts from authoritarian views to more egalitarian views (Bratton and Landreth, 1995; Bratton et al, 1998). This is considered significant as it helps parents and custodians to recognise children's need for independence and autonomy, thereby reducing unnecessary conflicts. Parents were reported as using the skills they had learned in training sessions outside sessions (Anthanasio and Gunning, 1999).

Studies reported increases in parental acceptance of children (Bratton and Landreth, 1995; Glazer and Kottman, 1994; Glover and Landreth, 2000; Johnson, 1995). Parents in these studies noted growth in their acceptance of their children's unique make-up, acceptance of their children's feelings and their right to express them, and their acceptance of their children's activities in a non-evaluative fashion.

#### **Lowered parental stress**

The improved relationships were recognised as reducing parental stress considerably (Anthanasio and Gunning, 1999; Bratton and Landreth, 1995; Johnson, 1995). The reduction of stress related to their improved belief in their abilities to parent, the children's improved behaviour, and the parents reporting feeling calmer and more in control.

#### **Improved behaviour manifested by children**

Improvements in problematic behaviour of children were reported in several studies (Anthanasio and Gunning, 1999; Bratton and Landreth, 1995; Glover and Landreth, 2000; and Johnson, 1995). Improvements in the children who participated in these studies demonstrated positive gains in their affect and verbal expressions. Improvements in desirable play behaviours in children were also noted. Bratton and Landreth (1995) found that the children in their study were more independent, demonstrated more self-control and took more appropriate risks.

#### **The therapeutic benefits of participating in a filial therapy group**

Whilst Andronico et al (1967) elaborated on the lowering of parental defences and the

benefits of doing so in terms of parents being more willing to examine their personal needs, feelings and experiences and how these impact on their parenting styles, they did not attribute these benefits to the dynamic influences that result from being part of a group. Bratton and Landreth (1995), in working with a group of single-parents, found that the group context provided members with support that helped to alleviate their stress. The cohesiveness between the members during their group discussions helped them to form significant friendships outside sessions. Members in the study seemed to readily identify with each other and find similarities in the situations that were overwhelming them. They reported that it was helpful for them to learn that others were dealing with similar struggles and problems as it gave them hope.

### **The versatility of filial therapy**

Filial therapy may be used with individual families, single parents, or it can be adapted for use in other formats such as groups of parents or home-based intervention programmes. It may be used, in conjunction with other forms of therapy such as behaviour therapy or crisis intervention and/or as a prevention programme (Van Fleet, 1994).

The applications of filial therapy to specialised populations have yielded positive results. Some of these outcome studies include the following: attention deficit disorder (Arnott 1998; Blackman, Westervelt, Steven and Welch, 2000), children with emotional problems (Andronico et al, 1967), custodial grandparents and their grandchildren (Bratton et al, 1998), single parents (Bratton, Landreth, 1995), adolescents and their families (Ginsberg, 1995), children and divorce (Glazer, Kottman, 1994), chronically ill children and their families (Glazer-Waldman, Zimmerman, Landreth, Norton, 1992; Van Fleet, 2000), retarded children and their families (Ginsburg, 1984), problems in Early Childhood Settings (Guerney, 1991), Head Start families (Johnson et al, 1999), and incarcerated fathers (Landreth and Lobaugh, 1998). It can be concluded that the efficacy of filial therapy has been well proven. The studies referred to used quantitative and qualitative research methods. None of these studies have used a participatory research design.

**Table One : Outcome research**

Focus of research	Date	Author	Outcome
Attention deficit disorder	1999	Arnott, A M	Mothers formed better relationships with their children, were empowered with knowledge and coping mechanisms
Custodial grandparents and their grandchildren	1998	Bratton, S Ray, D Moffit, K	Improved relationships between grandparents and grandchildren. Provided children with assistance to adjust to changes in their environment. Equipped grandparents with healthy parenting skills.
Single parents	1995	Bratton, S Landreth, G	Single parents significantly increased both their attitudes of acceptance and their empathic behaviour toward their children. Their level of stress related to parenting issues decreased. They reported fewer problems with their children's behaviour.
Children of divorced parents	1994	Glazer, H Kottman, T	There was evidence of enhanced relationships between the access parents and children. They were equipped with skills in communication, discipline, and methods to enhance the children's self esteem. The children were helped to cope with the transitions of divorce.
Chronically ill children and their families	1992	Glazer-Waldman, H Zimmerman, J Landreth, G Norton, D	Parents were better able to judge their child's level of anxiety. The course had a positive impact on their relationships with their children.
Early childhood settings	1990	Guerney, L	Parents were empowered with the understanding and skills to facilitate their child's behavioural improvement at home and school. Teachers, college students, social workers can learn to conduct play therapy and teach parents to do so.
Head start families	1999	Johnson, L Bruhn, R Winek, J Krepps, J Wiley, K	Parents acquired reflective listening skills. They allowed their children self-direction. The parents were involved in their children's emotional expression and behaviour. The parents demonstrated increased empathic skills towards their children.
Incarcerated fathers	1998	Landreth, G Lobaugh, A	Fathers demonstrated increased attitudes of acceptance towards their children. Their empathic behaviours towards their children increased. Their levels of stress relating to parenting and identified problem behaviours decreased. They increased the self-concepts of their children.
Parent child behaviours: a review of outcome studies	2000	Rennie, R Landreth, G	Reports of increased parental empathy, parental acceptance, reduced parental stress, increased child adjustment, reduced behavioural problems, increased self-concept among the children.

## **Filial therapy with different nationalities**

Filial therapists have researched the outcome of this intervention on different nationalities such as Chinese families, Korean families and Native Americans (Rennie and Landreth, 2000). The research by Chau and Landreth (1997) tested the efficacy of using filial therapy with Chinese families. The study reported sufficient gains in improvement between the parents and their offspring.

Jang (2000), a Korean, used filial therapy to enhance parent-child relationships with a group of Korean preschoolers and their parents. Results of the quantitative and qualitative analyses suggested that Korean parents learned and applied the basic skills of play therapy which then resulted in positive changes in the quality of their relationships with their children. A reason given for the effectiveness of the intervention was that it was not only psycho-therapeutic, but also educational. This educational aspect served to reduce the parents' resistance to psychotherapy. Jang (2000) suggested that because Korean parents are traditionally educated in a way that emphasises the academic and social success of their children and downplays the importance of developing warm and empathic relationships with them, many Korean children have developed anxiety and adjustment problems.

It is the researcher-facilitator's belief that this study may be significant to the current study because the Zulu people that she has encountered in practice have placed little emphasis on the psychological issues of their children. They appear to be interested in learning skills rather than engaging in discussions about their problems.

Glover and Landreth (2000) conducted a study on the effectiveness of filial therapy with Native Americans on the Flathead Reservation. This study has specific relevance for the researcher, as the plights of the Native Americans and the South African Zulus are similar. Both groups have been historically discriminated against and relocated to geographical areas where their bio-psychosocial needs were not adequately addressed. Western domination undermined their customs and traditions. The functioning of their traditional families disintegrated giving rise to a myriad of social problems often associated with poverty. The following extract can be equally applied to the Blacks in South Africa:

“While Native Americans suffer from the same types of mental disorders as other Americans, the prevalence and severity of these disorders appear to be greater, the availability of services lower, the cultural relevance of treatment plans more challenging, and the social context more disintegrated than in almost any segment of American society. Failure to address these issues will result in more severe emotional problems for future generations of individuals, families, and communities” (a National Plan for Native American Mental Health Services, 1990 as quoted in Glover and Landreth, 2000, p.58).

Glover and Landreth (2000) believed that a training programme for Native Americans would be effective if it respected and supported the cultural style of parenting rather than promoted dominant Western approaches to parenting. The rationale for using filial therapy with Native American parents was based on the congruence between filial therapy and traditional Native American values. These values include a deep respect for individuals, involvement of the extended family, a liberal child-rearing ideology, and independence. Whilst these researchers identified the values of the dominant culture of the United States as competition, wealth, conformity, and power, they described the traditional Native American values as including cooperation, generosity, individuality, and community.

Afrocentric culture is permeated by the philosophy of *ubuntu*. The essence of *ubuntu* is that a person can only be a person through others. Values such as morality and personhood are important. Elements of group solidarity, conformity, compassion, respect, human dignity and empathy are stressed. Individual behaviour is only valued in terms of its effect on the group (Collins, 1998). The outcome of Glover and Landreth’s study was relevant to this research project because of the similarities between the two cultures.

The results indicated that filial therapy was an effective method for enhancing empathic responsiveness in parents and increasing desirable play behaviours in children, but that the improvement in parental acceptance and parental stress was not as high as predicted. This was attributed in part to the sporadic participation of members in the group meetings. Glover and Landreth (2000) suggested that some modification of the programme is

necessary when working with Native Americans in future. They proposed longer training segments with fewer training sessions, and on sight practice play sessions.

Ravat (2001) has been active in conducting filial therapy with families in Jakarta. Her experience suggests that filial therapy is an effective intervention as it is culturally sensitive. Whilst the outcome of her work in Jakarta has not been published, she shared that her experience has taught her that filial therapy, far from being a purely clinical approach for children in distress, combines a treatment paradigm with a developmental one. This intervention increases professional leverage. The families who benefit from intervention are strengthened, and this in turn strengthens the communities in which they live.

## **Summary**

The premise of filial therapy is “that despite some psychological shortcomings, most parents have within them the psychological and emotional wherewithal to make a major contribution to the positive development of their children, given knowledge and practice and emotional support to do so” (Guernsey, 2000, p.7). The literature suggests that filial therapy could be an effective intervention to use to strengthen kinship care families. This review defined filial therapy, described the historical development of this intervention, detailed a filial therapy group programme, and made reference to successful outcome studies in different specialised areas. Its application to different nationalities has been considered.

Because filial therapy is effective in a group format, it can be offered to six to eight families simultaneously. Hence, it may be seen as an effective method of increasing therapeutic leverage of scarce mental health services, which might otherwise never reach the indigent kinship families in the Umlazi area. Filial therapy appears to be an empowering strategy that acknowledges the family’s strengths and resources and involves them directly in the treatment of their children. The democratic helping alliance, typical of this intervention is

more preferable to the “expert” hierarchical one, and therefore less patronising than traditional social work interventions. The experiential, participatory nature of acquiring relationship skills suggests that filial therapy may be an effective method of improving relationships between kinship carers and the children in their care, early on in the newly assembled family’s life together. This may reduce the intensity of the adjustment problems of the children, who may bring into the new placement context unresolved traumas relating to their pasts.

The dearth of literature on filial therapy in the South African context suggests that practitioners may not be keeping up with developments in family counselling. They have an obligation to ensure that clients benefit from any scientifically validated approach, providing that attempts are made to ensure that the approach is adapted to meet locally specific needs. It is a combination of these factors that has motivated the facilitator to conduct a participatory research study, adapting a Western model of filial therapy, to develop a locally specific one for kinship carers in the Umlazi area. The methodology that was used in this study is outlined in Chapter Four.

## **Chapter Four**

### **METHODOLOGY**

#### **Introduction**

“The emergence of a holistic, pluralistic and egalitarian world view which accepts human beings as the creators of their own reality through participation, experience, imagination, intuition, thinking and action” (Ván Rooyen and Gray, 1995, p.88) was central to the selection of the study’s research design and the formulation of the primary research questions. In summary, the study was designed to adapt a Western model of filial therapy into a locally specific form through participatory action with a group of kinship carers in the Umlazi area. This chapter outlines the methodology used during the study and focuses on: the research design, the sampling strategies and data collection tools used during phases one and two of the study of identifying the problem and the filial therapy group process, and data analysis. It also elucidates the ethical considerations and concludes with a discussion of the limitations of design and methodology.

#### **Research Design**

The researcher-facilitator used a qualitative research paradigm. This paradigm was consistent with the theoretical framework guiding the study, namely a person centred and participatory learning approach. Eisner (in Leedy 1993) identified six characteristics of qualitative research. Qualitative research tends to be field focused, uses the researcher’s experiences and observations as a research instrument, is interpretive in character, utilises expressive language and the presence of voice in the text, is attentive to details and particulars, and becomes believable because of its coherence, insight and instrumental utility.

The researcher-facilitator was less preoccupied with studying quantities, intensity, and frequencies and more interested in identifying processes and meanings (Denscombe, 1998; Pernice, 1996). This study was more a “process of discovery”(Grinnell, 1993, p.54) rather than a structured, experimental approach of hypothesis testing. The researcher-facilitator was interested in recording the “meanings” kinship carers attached to filial therapy. It was meant to be “more sensitive to holistic and ecological issues, rather than exerting scientific control over the contextual complexities of the project” (Grinnell, 1993, p.54). Less emphasis was given to monitoring and controlling different variables. The researcher-facilitator’s main aim was to directly involve kinship carers in capturing their experiences and suggestions regarding filial therapy as an intervention approach. The kinship carers were considered to be the best determiners of the utility of this service. They were given a “voice” to highlight details and particulars of their experiences that may have been overlooked if the researcher had used a quantitative research paradigm. The researcher-facilitator was interested in the research participants’ adaptations and functions, their inner experiences, their descriptions and generalisations, rather than scientific qualifications and statistical analysis (Grinnell, 1993).

This study was intended to be exploratory in nature. Exploratory research is described as “breaking new ground and generating exciting insights into the nature of an issue when we know little about the problem area” (Marlow, 1993, p.24). In this instance it was decided to explore, with a small group of kinship carers, whether filial therapy was an appropriate intervention for kinship carers in the Umlazi area, and if considered so, the researcher-facilitator would enable the kinship carers to modify the Western model and create their own indigenous model. This would determine the feasibility of conducting further research into the topic (Collins, 1999).

The researcher-facilitator felt that a participatory research methodology would be an appropriate methodology for several reasons. Collins (1999) defined participatory research as, “the collective generation of knowledge which leads to the planning and achievement of jointly set objectives. The objectives are often for political ends, but may also be for organisational change, project management, community development and personal growth, or any other objectives the participants decide upon.” (p.2). The emphasis of this study was

on developing a programme for and with kinship carers that would promote their personal growth to enable them to fulfil their potential as supportive kinship carers. “Participatory action research is a way of creating knowledge to effect necessary action and change, and the people on whose behalf the investigation action cycle is carried out, get directly involved in the research process from problem formulation, to inquiry to action” (Lindsey and McGuinness, 1998, p.1106). When research methods fully involve the people who are faced with the problem being studied at every step of the research process, and they are collectively involved on an equal basis in collective action, developing knowledge, educating, and generating social change and their own empowerment, then it should be regarded as participatory research (Van Rooyen and Gray, 1995, Van Rooyen 1998).

There are two important aspects to participatory research, according to Collins (1999). The first is, it entails a group of people planning together what they are going to research and how they will uncover the information that they are looking for. Secondly, it involves the group going about the business of discovering the knowledge. The knowledge discovered is used in action.

In this study, it was hoped that the participants would review the value of developing a locally specific model of filial therapy. The intention was that this would lead to welfare organisations finding a more comprehensive service that could be developed for kinship carers and the children in their care. Also, it was hoped that the participant’s involvement would empower them to find ways to improve their parenting skills, thereby, strengthening their own families, and, indirectly, the community in which they live.

Van Rooyen and Gray (1995) listed three distinguishing features of participatory research. Participatory research involves the people, themselves, as researchers, in seeking solutions to the problems which confront them; it offers a way for the researcher and the people to join in solidarity, and to take collective action for social action; it combines three activities – research, education, and action. Each of these features was regarded as an objective of this research. The researcher-facilitator believed that if services were to be developed for kinship carers, then the kinship carers should be actively engaged in developing and evaluating those services. This research method placed a higher value on their personal

knowledge and experiences, rather than that of the experts, dealing with them. Sadly, as consumers of welfare services, they had historically been denied the opportunity to participate democratically in the development of services. The researcher-facilitator and the kinship carers collaborated in deciding what research questions should be formulated, what data should be analysed to determine whether filial therapy was a useful approach to addressing their problems with the children placed in their care, and how the findings should be used to shape future services for kinship carers in the Umlazi area. The kinship carers were directly involved in helping to decide what tools, processes and methods of filial therapy needed to be adapted for their context. Van Rooyen and Gray (1995) also stressed that participatory research has a practical orientation, as the researcher combines research with intervention. This was relevant to this study, as the researcher-facilitator was able to address treatment issues, parallel to collecting information for the study, whilst also engaging the research group in an educative process regarding parenting issues in kinship care. It was hoped that the Durban Children's Society would benefit directly from these three joint functions.

## **The Research Process**

Mulenga as quoted by Van Rooyen and Gray (1995) said, "there is no evidence of methodological orthodoxies, and no cook-book approaches to follow" when using participatory research. It seems as though specific methodological guidelines for participatory research are hard to find (Reason, 1994, Van Rooyen, 1998).

Different authors have proposed frameworks which set out and sequence the steps involved in participatory research. These steps emphasise the similarities between the participatory action research process and more traditional research processes, following the sequence of problem solving theories. They utilise a combination of quantitative and qualitative research techniques. The stages are "used merely as a system for articulating and representing an otherwise abstract and non-linear process" (Van Rooyen 1998, p.84). The steps tend to overlap in practice and it is often difficult to differentiate between one phase and the next. Van Rooyen (1998) proposed that a methodological framework was

necessary, provided that it could be used flexibly to guide social workers to “reframe some of their research and practice activities in order to respond more appropriately to a context where democratic participation, empowerment and social justice are central issues” (p.82).

Reason (1994) identified four phases of participatory research: co-researchers agree on an area for inquiry and identify some initial research propositions, and agree to some set of procedures by which they will observe and record their own and each others’ experiences; they initiate their agreed actions and observe and record the outcomes, paying attention to their own experiences during the process; they become immersed in this activity to the extent that they can put aside prior beliefs and pre conceptions and become more open to new experiences; and then, they amend and develop their research procedures, in order to uncover new insights and discoveries, almost in a continuous, circular way. Collins (1999) and Van Rooyen (1998) proposed slightly different models. They both considered the first step to be problem formulation. An area for investigation is defined. Literature and informal sources are consulted to obtain up-to-date information on the problem. Gathering information should involve those “affected by the problem” such as kinship carers and those who “want to solve the problem”, in this instance, the service providers (Rubin and Rubin in Van Rooyen 1998, p.83). Collins’ (1999) and Van Rooyen’s (1998) second steps concur with Reason’s, although Collins (1999) refers to this stage as “designing the study” and Van Rooyen as “planning” the study. In this step the participants review the environment, or sociopolitical reality in which the problem arises as well as their skills and strengths in the community (Van Rooyen 1998, p. 84). The participants decide on the research questions and refine them. They select data collection procedures and/or evaluation tools. Van Rooyen (1998) detailed the third step as “implementation”. Here, Collins (1998) offered more specificity to this step by subdividing it into data collection and data processing. The final step discussed by Collins is, writing the research report. Whilst the researcher-facilitator did not follow or adhere to any specific model, the stages identified by these authors helped to shape the research design.

There were two distinct phases in this study. Phase one involved collecting information about the problem and defining the services needed by kinship carers and the children in their care. The researcher-facilitator relied on the feedback she received from students

doing their practical work in the Umlazi area who had direct contact with kinship carers and her interviews with professionals who were active in rendering services to these families. Phase two involved the formation of a group of interested research participants, kinship carers and one volunteer, and the research facilitator who participated in ten filial group sessions and recorded their findings.

### **Phase One: Problem identification**

Rubin and Rubin in Van Rooyen (1998) state that this phase involves systematic gathering of information by the people who are affected by the problem, on the one hand, and those who want to solve the problem, on the other hand. The researcher-facilitator, in her capacity as a supervisor at UNISA, became aware of the growing problem of kinship carers struggling to manage the children left in their care, when monitoring the students' practical work. Most of the students' interventions involved investigating the suitability of these placements in order to meet the statutory process of finalising placements with kinship carers. Little, if any, intervention dealt with the emotional trauma of the children, or the adjustments required by the kinship carers, as the growing requests for services gave the social workers little opportunity to address these deeper issues. Instead, most professional activity involved investigating and finalising the applications for kinship care. Social workers reported their frustrations at not being able to direct their professional interventions to strengthen these families, but instead were required to fulfil enormous statutory requirements regarding these placements. After supervision sessions, the students who were dealing with kinship carers began asking them about their realities. They learned that many kinship carers had difficulty managing the additional children placed in their care and that many of these children presented with emotional and/or behavioural problems. Sadly, no one seemed to address these issues because there were few, if any, resources to help these children adjust and so they were just managing as best they could.

The researcher-facilitator conferred with colleagues from different welfare agencies about finding ways to address the needs of traumatised children in the community. She addressed social workers and psychologists whom she knew were rendering services to these children

and their families in and around the Umlazi area and exchanged ideas about these observations. (A synopsis of these discussions is presented in Chapters Five and Six, the findings). These discussions with “people who wanted to solve the problem” broadened the researcher-facilitator’s understanding of the remedial services that would benefit these newly reconstructed families. A group programme that would enable kinship carers to help the children in their care deal with their emotional traumas, enhance their parenting skills and provide support for one another was indicated. The researcher-facilitator investigated possible interventions and identified filial therapy as a possible option. The interviews with service providers also helped her to gain entry into the Umlazi community. The Durban Children’s Society linked the research-facilitator with fifteen kinship carers who had applied to foster their relatives’ children.

Discussions with social workers from Childline, Durban Children’s Society, Howick Hospice, Lifeline, Mzamo Child Guidance Clinic, and a play therapist in private practice, encouraged the researcher-facilitator to engage kinship carers in an exploratory study to assess the effectiveness of filial therapy as an intervention for carers and children in the Umlazi area. It was decided to conduct the research under the auspices of the Durban Children’s Society as this organisation reported having to deal with one hundred and twenty new kinship care placements a month. Most of the kinship carer applicants were grandmothers, maternal aunts, or older siblings.

The researcher-facilitator attended workshops on play therapy and filial therapy, presented by Rehana Ravat, a social worker in private practice and an accredited trainer in play therapy. On completion of these courses she conducted ten filial therapy play sessions, with her daughter of seven years, under the supervision of Rehana Ravat. Once familiar with the process and techniques of filial therapy, she contacted Durban Children’s Society to identify a suitable volunteer who would act as a co-leader and translator during the group sessions and research process. This volunteer received a basic orientation programme to filial therapy, adapted from the one day training course presented by Ravat.

## **Sampling**

A non-probability sampling method was used for both steps in this phase. During step one of this phase, collecting information from social work students working with kinship carers in the Umlazi area, the research facilitator used an availability sample. The students' insights and experiences of dealing with kinship carers were conveniently available to the research facilitator. They were a close and available source of information (Grinnell, 1993).

The service provider interviewees were purposively selected because of their expert knowledge and experience in dealing with kinship carers or the children in their care, or their knowledge of play therapy. Denscombe (1998) defined a purposive sample as one that is "handpicked". The researcher-facilitator used her knowledge of the service providers in and around Durban who, in her judgement, best represented the range of those persons in the best position to know the needs of kinship carers, or the children in their care, and then interviewed them as to their estimates of those needs and their suggestions for the development of new services to meet those needs. They were all known to the worker, with the exception of the psychologist involved with Lifeline and Childline in Pietermaritzburg. Within the already established relationships existed trust, which enabled the interviewees to speak openly and honestly about the issues of kinship carers, children in need, and the services that needed to be developed. These contacts highlighted the researcher's understanding of the issues affecting the lives of the Umlazi residents. Eight professionals were interviewed.

## **Data Gathering**

### **Students' reports and discussions:**

Grinnell (1993, p.425) described informal or unpublished sources of information as "fugitive data" indicating that these forms of data are vital to social work research. In this stage of the research, the researcher-facilitator used information from students' reports and their discussions about their cases during supervision sessions to identify the possible research topic.

**Interviews with service providers:**

Denscombe (1998) stressed that if one wishes to investigate emotions, experiences and straightforward factual matters, then the researcher may be justified in preferring interviews to the use of questionnaires. The interviews with “those who wanted to solve the problem” were relatively informal face-to-face interviews. Face to face interviews are useful when the researcher needs respondents to provide more thoughtful answers, and when, longer, more open-ended responses are needed (Grinnell, 1993). Lindsey and McGuinness (1998, p.1108) referred to these interviews as “in depth interviews with key informants”. Whilst the interviews were not “unplanned and unanticipated”(Rubin and Babbie, 1997, p.388) as in informal conversational interviews, the researcher-facilitator tried to keep them flexible, and relatively relaxed so as to be able to pursue relevant information in whatever direction seemed appropriate. The interviews were telephonically arranged at the key informants’ convenience.

The researcher-facilitator had certain goals in mind before she conducted the interviews and therefore kept a semi-structured guide to refer to. The semi-structured guide helped to keep the interviews focused on the predetermined issues, while at the same time remained conversational and allowed her to probe unanticipated circumstances and responses (Rubin and Babbie, 1997). The semi-structured guide was developed using the following questions: (a) What do you consider to be the main issues that kinship carers struggle with? (b) What services do you believe children in kinship care need? (c) What are your feelings about using play therapy with children in kinship care? (d) Please tell me of any remediation you know of that reaches children in kinship care placements in the townships? These were all open-ended questions. “Open ended questions are designed to permit free responses to questions; they do not incorporate any particular structure for replies” (Grinnell, 1993, p.228). The purpose of using open-ended questions during these interviews was to increase the researcher-facilitator’s understanding of the challenges facing kinship carers and the children in their care, as well as possible resources that would grant entry into a complicated research process.

Six interviews, each lasting for approximately an hour, were conducted. The informality of these contacts had several benefits for this stage of the research process: they were

sensitive to capturing the nuances of attitudes and behaviours of service providers towards the kinship carers and/or children; they conscientised the researcher-facilitator to the issues affecting kinship carers; this was a flexible tool to use early in the research process which allowed the researcher-facilitator an opportunity to modify the research design accordingly, because at this stage, the researcher-facilitator was only uncovering tentative findings. These interviews were critical in terms of strengthening the rationale of this study.

## **Phase Two: The Research Group**

This phase can be partialised into smaller steps: the formation of a research group, the planning of the study with the co-researchers, the ten filial therapy sessions, and the evaluation of their experiences at termination. The first three steps concurred with the five steps of Van Rooyen's planning phase (1998). Research activity was directed at: linking the participants' immediate individual interpretations of the problem to the broader sociostructural reality within which these problems arose, affirming the participants' strengths and validating the efforts they had made and/or were still making to contain or manage the problems themselves, refining questions for the study, collectively identifying and agreeing upon strategies and procedures for data collection and analysis, and, finally agreeing upon evaluation methods.

### **Step one: the formation of a research group**

The researcher-facilitator had two meetings with two Umlazi area managers of the Durban Children's Society and two social workers working in B and C sections. She was asked to make an official request to the research committee at the agency to conduct the study under the auspices of the agency. When permission was granted, the social workers provided the researcher-facilitator with names and addresses of fifteen kinship carers who had applied to foster a relative's child or children whom they thought might be available to participate in the study. One of the agency's trained volunteers was assigned to work with the researcher-facilitator as a research participant and interpreter. The researcher-facilitator and volunteer met on two occasions prior to the orientation meeting, once to become acquainted with one another, to establish whether the volunteer was interested in being

involved as a participant and interpreter in the study, and share basic information about filial therapy as a method of intervention. The second time was to orientate the researcher-facilitator to the Umlazi area and conduct home visits to the fifteen carers to invite them to an orientation meeting. The researcher-facilitator and volunteer traced eleven of the fifteen applicants through home visits or telephone contacts. The interested kinship carers agreed to attend an orientation meeting about filial therapy.

### **Step two: the planning of the study with the research participants**

Six of the eleven women, the volunteer and researcher-facilitator were present at the orientation meeting. A talk was given about the use of play therapy as a means of helping children with emotional and/or behavioural difficulties. The women were told about a research project that had been done in a township, using the non-directive play therapy approach (Masilo, 2000). A ten minute video, "Children's Emotions", was shown to demonstrate the importance of unconditional positive interaction with babies and how this may be used to enhance children's emotional security. A general explanation of the purpose of the study was given as the researcher-facilitator's interest in establishing a filial group for kinship carers to assess whether filial therapy should be developed into a locally specific intervention to strengthen kinship care families. A request was made for interested persons to volunteer as participants in the study. The voluntary nature of the study was considered as a central premise of the participatory research design chosen. Five of the six kinship carers present, and the volunteer agreed to participate in the study. The sixth member stated that she would have liked to participate, but could not because of work commitments.

The participants were informed that the objectives of the study would be specified by themselves once they had decided that the study should proceed. They were alerted to their roles as participant co-researchers in this study. They were reminded that their roles were invaluable as their immediate experiences in sessions could provide the researcher-facilitator with a link with the broader sociostructural reality as experienced by kinship carers in Umlazi, something which the researcher-facilitator could only gain from their participation. Whilst the researcher-facilitator had specialised knowledge of filial therapy, the purpose of the research was to engage the participants in adapting the theory to ensure

that it would be suited to their locally specific context and they were considered the “experts” of this process.

Each research member identified one child in her care who was between the ages of four to nine years, that she could do play sessions with in her home. The research group agreed to make sacrifices in their normal routine to attend the group sessions on a weekly basis and conduct play sessions at home. The group decided to meet at the Umlazi library, as this venue was available, accessible and offered a television and/or video machine for sessions when these were required.

The researcher-facilitator intended to conduct individual pre-group interviews with the members as suggested by Landreth (1991) and Van Fleet (1994). The motivation behind conducting pre-group interviews was to explain the purpose of filial therapy again, clarify members’ expectations of group sessions, collect information about the children they would be working with and identify their management problems, if any, in caring for these children. Reasons for this not happening are discussed in Chapter Six.

### **Step three: the ten filial group sessions**

Ten group sessions were conducted with the members. The themes presented for discussions were adapted for use with this group from Landreth’s (1991) ten-week programme (as adapted and modified by Ravat, 2001b). This model was presented as a basic guideline for the sessions and the group was encouraged to modify the model in any way the members deemed necessary, according to their perceived needs. The participants remained active determiners of the themes discussed, deciding whether to include, modify or exclude themes in the programme. Each of the ten sessions was video recorded with the participant’s permission. The central topics dealt with in each session will be detailed in Chapter Six. Each participant, with the exception of one, arranged to bring a child to a group session for a live demonstration of play therapy.

Each session lasted between two and a half and three hours. Sessions were opened by the participants with singing and a prayer. Refreshments were served mid-way through sessions. The sessions were generally divided into three parts: talking about and teaching

concepts relevant to filial therapy in an experiential learning fashion, discussing the relevance/irrelevance of the new concepts that had been introduced in terms of the participants' experiences, live demonstrations and video recordings of the play sessions conducted by the members and feedback and evaluations of these sessions. Handouts used for the discussions were translated into Zulu. Members were requested to practice skills and complete take-home assignments in between sessions. Each participant was provided with a tote bag containing the toys needed for the play sessions for the duration of the ten-week period.

#### **Step four: evaluation on termination**

During this step the participants were invited to consolidate their experiences of filial therapy, re-look at the research questions, and formulate answers to these. Van Rooyen (1998) suggested that at this stage of a research process the participants should evaluate the extent to which their goals have been achieved, their level of skills development and empowerment, and the potential benefits of the project for the community.

### **Sampling**

A non-probability availability sample was used. The researcher-facilitator and volunteer, with the assistance of the social workers from the Durban Children's Society, identified kinship carers who were conveniently available. Rubin and Babbie (1997) described the relevance of using this sampling method when evaluating practice effectiveness. Participants are chosen because they happen to be around needing intervention at the time of the study. This overcomes the practical limitations of choosing a randomised sample, and yet, enables the researcher to collect important information that has been previously lacking. The two distinct advantages of using this sampling method for the researcher-facilitator were that firstly, the participants were not difficult to find and, secondly, they were enthusiastic about and committed to conducting the study. The researcher-facilitator believed that the voluntary nature of participatory research was important and therefore favoured this sampling strategy. However, Leedy (1993) cautioned, "all research data need not be sterile, highly refined, and controlled by criteria, but without these safeguards,

the research may not be trustworthy” (p.200). The major limitation of using this sampling technique was that it was not representative of all kinship carers in the Umlazi area, thus the inability and the opportunity to generalise the study’s findings (Grinnell, 1993).

The sample size of this study was six. The literature on filial therapy advocates between six and eight members as the ideal size for a filial therapy group (Landreth, 1991; Van Fleet, 1994). The small sample size was suited to this study because it was intended as a study of limited scope and the researcher-facilitator wanted to use “the richness of the interview material to trace connections between the individuals who participated in the study” (Pinder, 1995, p.611).

The participants in this study were all Zulu speaking residents of Umlazi who were either kinship carers, or in the case of the volunteer, involved with kinship carers through an association to an organisation servicing kinship carers. The first volunteer withdrew after one group session and a second volunteer was recruited. This volunteer was not a kinship carer, but a single mother of twins who was happy to participate in the filial therapy programme with her children. Being a fulltime social work student doing her practical training at Mzamo Child Guidance Clinic, she already had some understanding of issues affecting kinship carers and client centred play therapy.

## **Data collection tools**

A variety of data gathering techniques were used in this protracted phase of the study. The purpose of the data collection plan was to obtain detailed descriptions of the participants’ experiences of the filial therapy programme and their perceptions of developing a locally specific model. The primary research tool was the dialogue that took place between the research participants during the ten sessions. Interaction in groups is often deepened through the facilitator’s skilful ability to process participants’ contributions within the group context. This “facilitating” prompted members to share their experiences and observations regarding filial therapy and kinship care quite spontaneously. The members’ experiences and observations were captured on video. Group techniques such as the

nominal group technique, focus group discussion, and researcher assisted self administered questionnaires were used to uncover specific data needed during the different steps of this study. The use of these data collection techniques is briefly reviewed.

The sources of data in this phase were the five kinship carers and the volunteer. The data were collected during group sessions.

### **Case Studies**

The case study is not actually a data-gathering technique, but a methodological approach that incorporates a number of data-gathering methods (Berg, 2001). The researcher-facilitator has included it here as a data-gathering tool to reflect that each individual group member was monitored throughout the ten week period to record the changes in behaviour and attitudes that they reported. The findings compiled from the study of the individual members were not meant to be generalised, but rather provide a deeper understanding of their unique experiences of kinship care and filial therapy for the purposes of this exploratory study. The data-gathering measures that were used were: the researcher-facilitator's observations of each member's participation in the group over the ten week period, the video recordings of sessions, and the researcher administered questionnaire at the end of the group meetings.

### **Video recordings**

The video recordings allowed the researcher- facilitator to record themes that the participants had chosen to discuss, the subtle changes in their behaviour and attitudes over the ten sessions, and their suggestions about making the model locally specific. The video recordings captured the participants' inner experiences, descriptions and generalisations and were more pertinent to this study than quantitative techniques would have been (Reason, 1994). Berger (2001) describes video recordings as a useful tool for building grounded theory. The greatest disadvantage of using this as a data collection tool is that technical equipment is not always reliable because they may fail because of power failures, faulty equipment etc. The video camera should not be the only data collection tool and the researcher-facilitator should have back up equipment such as a notebook and pen (Rubin

and Babbie, 1997). A lesser disadvantage of using the video camera could be the threat it imposes to those who are unfamiliar with this form of technical equipment. Their permission to use the video camera as a data-capturing device was obtained at the first group session. The researcher-facilitator demonstrated how the camera worked at session three and invited any interested members to film one another before the session began.

### **The nominal group technique**

The nominal group technique was used at the start of session two to assist the members to define the research questions for the study and the objectives for their group. Participants were asked to develop research questions that they considered important and relevant for the study. Secondly, they were asked to clarify objectives for this filial therapy programme that would shape the contents to be covered in the sessions. It was considered most important that the programme should have maximum utility for them and they were reminded that they were the best determiners of their needs. A half hour was spent on each of the two questions.

Zuber-Skerrit's guideline (in Collins, 1999) was adapted for this purpose. Members were given five minutes to brainstorm their own ideas. A round robin collection of ideas involving the whole group was initiated. The ideas were recorded on newsprint. The sharing continued until their ideas ran out. The ideas presented were clarified. Overlapping ideas were combined and the items on the list were edited and numbered. Each group member was allowed to select three items from the list that they considered to be most important. The rankings were discussed with the group allowing a collective weighting of items to take place. The results were summarised and confirmed with the group. The advantage of using this technique for a group such as this is that it engages each member in the action and planning of this research stage (Van Rooyen, 1998). This sets the tone for democratising the research process and encourages equal participation between members, which is pertinent to facilitating the communication process in the early stage of the group process. Another advantage is that it prevents dominant members from monopolising the communication process in the group.

A disadvantage of using the nominal group technique could be that discussion may become too controlled and the group too focused, and may disallow individuals to freely express the breadth of their ideas. This technique may also put shy, reticent members under pressure to participate before they are ready to do so and thereby increase their discomfort levels. The advantages of using this data collection tool for this study outweighed the disadvantages.

### **The focus group**

One focus group session of approximately one and a half hours in length was conducted at termination. The purpose was to consolidate the individual participant's experiences of the ten filial group sessions and answer the research questions collectively that they had decided to explore at the outset of the group. To generate the data six questions were asked in the focus group (See Appendix II).

The focus group is suitable for use with small groups of between eight to twelve members who have been drawn together to discuss their knowledge, experience and expertise to a specific problem (Van Rooyen, 1998). The relatively homogenous group reflect on a few questions asked by the interviewer. The number of questions is limited because the response time increases according to the size of the group. The group facilitator processes each response. The members are given an opportunity to consider their own views in the context of the views of others. As a qualitative data-collection technique, this is highly efficient because it takes less time than it would if one conducted individual interviews, participants provide checks and balances on each other and 'weed out' extreme or false views, and there is high face validity of the collected data (Van Rooyen, 1998).

A focus group is "a useful tool for the dynamic exploration of differing experiences and perceptions" (Lindsey and McGuinness, 1998, p.1108). It is appropriate for collecting programme evaluation data (Rubin and Babbie, 1997). "The distinguishing feature of this type of interview tool is the explicit use of group interaction to produce data and insights that would otherwise be difficult to obtain" (Grinnell, 1993, p.72). The focus group offered specific advantages for data collection in this study, it provided rich data, it generated speedy results, the group interaction provided a feel for the range and diversity of perceptions of the members and pulled out issues that would not have emerged in

individual interviews, the researcher-facilitator learned how the group constructed and defined its reality (Grinnell, 1993; Rubin and Babbie, 1997).

Focus groups are known to have inherent weaknesses. There were limitations that impacted on this study. The number of questions that were asked was limited as the response time was increased by the number of participants (Marlow, 1993). This meant that the researcher-facilitator could have lost valuable interpretations, meanings, beliefs, thoughts and feelings of individuals because of adhering to the limited number of topics for discussion. Secondly, it is possible that when the group participants' responses differed from an individual's, the individual may have been more reticent about expressing the differences of opinions and these differences would not have been recorded or noted. Thirdly, the presence of the researcher-facilitator could have influenced the participants to voice opinions that they thought the researcher-facilitator wanted to hear. The focus group offered no opportunity for anonymous feedback.

These limitations prompted the researcher-facilitator to include a researcher administered interview schedule that would be administered to the whole group after the focus group discussion to ensure that data lost here would be obtained by another tool.

#### **The researcher administered interview schedule**

The data gathering method in this phase of the study was a researcher administered interview schedule that was completed by five participants in the study (See Appendix III). This schedule took approximately one hour to complete. Broadly, the researcher administered interview schedule was used to build on data collected in the focus group. The participants filled in the schedule. The two members who could not write were assisted by the researcher-facilitator and the volunteer who recorded their answers on the questionnaires.

A group administered questionnaire is used in a situation where respondents can be brought together for the purpose of completing a survey (Grinnell, 1993). Grinnell stated that this is a useful instrument to use with groups who meet on a regular basis. The advantages of including the research administered interview schedule in the last session were that the

researcher-facilitator would find out as much as possible in a limited amount of time (Grinnell, 1993), it would yield a higher response rate than if surveys had been given to the participants and they had to return them (Grinnell, 1993; Rubin and Babbie, 1997), it would reduce the numbers of “don’t knows” and “no answers” (Rubin and Babbie, 1997) as members would have an opportunity to clarify confusing questionnaire items, it would provide the literate members anonymity. The disadvantage that needed to be considered was that it would be difficult to determine the extent to which the presence of the researcher-facilitator influenced the participants, especially the two illiterate members who needed assistance in filling in their questionnaires.

Because of wanting to elicit deeper insights and meanings the researcher-facilitator included open-ended questions that are appropriate to exploratory studies. “Open ended questions are used when all of the possible issues and responses involved in a question are not known, or when the researcher is interested in exploring basic issues and processes” (Grinnell, 1993, p.228). The drawback of using open-ended questions is that people who find it difficult to articulate their ideas, or find it difficult to write, may be discouraged and may fail to record their full answers.

## **Data analysis**

Data analysis is the important step in research that uncovers the findings. Grinnell (1993) stated that “nobody is interested in reading unorganised rambling notes – the researcher must somehow boil down the raw text, summarise it, and emerge with a clear description of the findings and their implications” (p.63). There does not appear to be consensus for the analysis of the forms of qualitative data (Creswell, 1998). Because there are so many ways of analysing data, this part of the research process becomes quite trying as it requires time, effort and expertise.

Creswell (1998) identified common features of analysing data espoused by Bogdan and Biklen (1992), Huberman and Miles (1994) and Wolcott (1994). These data analysis authors recommended, first, a general review of all information. This may be achieved by

jotting down notes in the margins of text. Then writing findings in the form of memos and reflective notes. This enables the researcher to do an initial sorting-out process. At this point the researcher might obtain feedback on the initial notes, by taking this information back to informants. The researcher looks closely at the words used by participants in the study, such as their use of metaphors. The process of reducing data begins. It is followed by creating displays of information such as diagrams, tables or graphs – means for visualising the information and representing it by case, subject, or theme.

These steps were followed in a general way during the study. “In all social science research methods, there is a large gap between understanding the skills of data analysis and actually using those skills effectively. Typically, experience is the only effective bridge across the gap” (Rubin and Babbie, 1997, p. 397). The researcher-facilitator obtained a broad overview of the experiences of the kinship carers during group sessions. There were a few comments that were made by individual participants that alerted her to a poor fit between the Western model of filial therapy and the participants’ experiences. Memos were kept to remind the researcher-facilitator of these differences. The differences were raised with the group as a whole in the next session or sessions to allow participants to confirm or refute the researcher-facilitator’s observations about the differences. This led to a deepening of understanding of the participants’ “lived” experience. The descriptions given by the participants were recorded.

Memoing involved writing memos or notes to remind the researcher of possible areas that need to be explored in more depth, or any leads that may have provided a greater understanding of the phenomenon being studied. Memos were recoded during sessions, or after sessions when the researcher-facilitator replayed the video recordings. The memos included both the research facilitator’s observations and her interpretations of these. They were then filed in the research file.

Not all information is used in a qualitative study. That which is not used is discarded. An approach useful for reducing data is the development of codes or categories and the sorting of data into these categories. Categories can be determined inductively, deductively, or by some combination of both (Berg, 2001). The inductive approach begins with the researcher

immersing him/herself in the various messages of the participants, in order to identify the dimensions or themes that seem meaningful to the participants. In other words, induction involves collecting data to enable the researcher to make generalisations from his or her specific observations. Deductive analysis requires the use of some structure suggested by a theoretical perspective or documents to refine and shape the emerging hypotheses. Berg (2001) explained that it is reasonable to suggest that insights and general questions about research derive from previous experience with the phenomenon being studied. This experience may be personal experience, scholarly experience, or previous research undertaken to examine the matter. It is these experiences that lead to the development of tentative comparisons that assist in creating various deductions.

Three themes were identified through inductive analysis. In accordance with Glaser and Strauss' (in Grinnell, 1993) recommendation, "The process of ponder and check continues until the conclusions seem to be firm", the researcher-facilitator would record interesting observations, check these out and discuss these in greater depth with the group members and then refine her observations (p.67). The consensual discussion of themes contributed to the participatory research aspects of the study.

From focussing on the interplay of experience, induction and deduction, Glaser and Strauss formulated their description of grounded theory (Babbie, 2001). This approach begins with observations rather than hypotheses and seeks to discover patterns and develop theories from the ground up, with no preconceptions. This general strategy to analyse data was relevant to this study because the intention was to concentrate on the rich meanings that could only be obtained from the participants themselves. It placed responsibility on the researcher-facilitator to realistically interpret what she observed and present the findings in the form of a final theoretical analysis or framework. It also involved generating theory and doing social research as two parts of the same process (Strauss and Corbin, 1998).

In conclusion, grounded theory was selected because of the number of parallels between the grounded theory method and what social workers do in direct practice (Gilgun in Rubin and Babbie, 1997). Both methods start where the client or informant is and focus on his or her perceptions. Both try to understand the case in a wider environmental context. Both

combine induction and deduction and the constant comparison method in formulating working hypotheses based on observations and then modifying those hypotheses in the light of further observations. Both try to avoid imposing preconceived ideas on ideas or theories or cases. Both rely heavily on open-ended interviewing and use largely the same interviewing skills. The process of using notes and memos in grounded theory resembles the social worker's use of process recording and case record keeping. Both attempt to "keep a balance between being in tune with clients and maintaining an analytic stance." Both like to conduct observations in a natural setting, such as in the home or community.

The grounded theory method employs the constant comparative method. Grinnell (1993) outlined the four stages of the grounded method strategy as: firstly, comparing incidents applicable to each category. The researcher-facilitator specified the nature and dimensions of the issues arising from the data. These incidents were compared from things said between the members during sessions. Secondly, the researcher-facilitator noted the pattern, themes or categories emerging within the data. Emphasis was given to circular rather than linear causality, thereby deepening the focus. Thirdly, decisions were taken to ignore some of the concepts or issues in order to concentrate on a limited number of salient ones. Finally, the researcher-facilitator put the findings into words, which were then shared with others. The process of sharing the findings allowed the researcher-facilitator to modify and improve her grasp of the topic. This information resulting from the analysis is presented in Chapters Five and Six.

### **Limitations of design and methodology**

The chief strength of this study lies in the depth of information about the experiences of the research participants during the filial therapy group programme. This depth was possible because the number of participants was limited to ensure that the study would be conducted in a practical and personalised manner. There were six research participants at the start of the study. This group size was recommended for filial therapy groups (Landreth 1991; Ravat, 2001b) but the use of the availability sampling method, and the small group size, suggests that the results cannot be generalised to a wider population. Participation was on a

voluntary basis and one may conclude that the participants of the study were those who were eager to work on their relationships with children placed in their care. They may not have been most representative of kinship carers who most needed parenting education.

The groups were conducted in English despite this not being the home language of the participants. It must be concluded that some meanings may have been lost in the translation of participants' ideas and experiences into English. Even the presence of an interpreter could not avoid this happening.

The absence of quantitative data to evaluate improvements in relationships between kinship carers and the children in their care placed more emphasis on participants' self reports of changes in parenting styles and behaviours of the children in their care. Subjective accounts have limitations because the participants may not have disclosed all the facts, the presence of the researcher-facilitator may have inhibited them from telling it like it was, and their investment of time and energy into the study may have influenced their evaluations of filial therapy more favourably.

No control group was used in the study. In view of this, one cannot reach categorical conclusions that the changes were the result of the intervention. Extraneous variables were not controlled for two reasons. Firstly, the researcher-facilitator considered it ethically unacceptable to have a control group in a study of this nature. Secondly, evaluation per se was not the main aim of the study. The aim was to adapt the Western model of filial therapy into a locally specific form using a participatory approach.

Participatory research is time consuming because the design places emphasis on staying with and facilitating the research process. Whilst this design was most suited to the study undertaken it was difficult to work within the time constraints imposed. The final planning for action phase could not take place within the time frame allowed for the study.

## Validity

Internal validity addresses the accuracy of the information and whether it matches reality (Creswell, 1994). In an effort to minimise the limitations of observational work, the researcher facilitator used multiple sources of data-collection, within the methodology. The cautionary comment made by Garfinkel and Bloor in Silverman (1993) about using triangulation was observed. They stated that, “the major problem with triangulation as a test of validity is that, by counterposing different contexts, it ignores the context-bound and skilful character of social interaction and assumes that members are ‘cultural dopes’, who need a sociologist to dispel their illusions” (p.158). To counteract this criticism, the researcher-facilitator used methods of research that were consistent with person centred approach and participatory research, and used data-gathering tools and methods that concentrated on the research participants’ realities. Involving the participants in a constant review of their experiences of filial therapy and checking the research facilitator’s understanding of their experiences on a regular basis helped to ensure that the findings reported were true and valid reflections of the outcomes of this study. The semi-structured interviews used after the focus group confirmed the accuracy of the collective responses generated in the last session. This process of checking and rechecking helped to strengthen the credibility of the results.

The external validity of research refers to the generalisability of findings from the study (Creswell, 1994). As previously stated in the limitations of this study, by choosing to work with a smaller sample to ensure a greater depth of information, the findings of the study should not be generalised for the broader community. However, “being there is a powerful technique for gaining insights into the nature of human affairs in all their rich complexity” (Babbie, 2001, p.298). The small sample size allowed the researcher-facilitator to establish close rapport with all the participants and to bring her in touch with their subjective experiences. These experiences would not easily have been captured by quantitative measures. The depth of information gained was vital to conceptualising the changes needed in the Western model of filial therapy to develop a locally specific one. In this study, the research facilitator regarded the shared experiences of the participants as more powerful than statistics or outcome scores.

## **Reliability**

Reliability deals with the accuracy of the findings. Qualitative research has a greater problem with reliability than validity (Babbie, 2001) because the measurements it uses are very personal. The researcher may easily introduce his/her own biases and points of view into the findings. The interpretive nature of qualitative research reduces the possibility of a replicated study attaining the same results. However, the careful documentation of a study's design, tools and processes helped to keep the research endeavour objective (Berg, 2001). This chapter attempted to be as specific as possible about the tools and procedures used in this study for this reason. The sensitivity to, and an awareness of, possible research bias may also have provided a safeguard because awareness of bias is the first step to be taken to avoid it (Rubin and Babbie, 1997).

## **Ethical Considerations**

The National Association for Social Workers identified six specific guidelines for scholarships and research (Grinnell, 1993). These were considered during the planning and implementation of the research project.

The consequences for human beings participating in the study were considered. Prior to the pre group session, the researcher-facilitator conducted a comprehensive review of the literature to ascertain what contexts or problems were not suited to filial therapy. Several consultations were held with colleagues experienced in working with township families, to discuss the implications and dangers of the research. It was anticipated that filial therapy would do no harm.

The consent of the individuals participating in the study had to be voluntary and informed, to meet the criteria as outlined in Grinnell (1993): participants should be competent to give consent, participants should be provided with sufficient information to enable them to make a reasoned decision whether their involvement would be favourable to them, and to ensure that participation should be voluntary and un-coerced. In view of the foregoing factors the

researcher-facilitator undertook the following: possible participants were invited to a pre-group session to learn about filial therapy, the research project, the role of the researcher-facilitator and the Durban Children's Society. It was stressed that their participation in the project should be voluntary as their involvement, or lack of involvement, would not influence their applications to foster the children in their care, in any way. The prospective participants were informed of the research project's demand in terms of time, activities and disclosure of private information. During the pre-group session, the researcher-facilitator explained that there had been no documented evidence of filial therapy research with Umlazi carers and children. The application of Non-Directive Play Therapy with township children exposed to violence (Masilo, 2000) was discussed, and the positive outcomes as well as the limitations that had been identified in that project were highlighted. At the first session members who chose to participate in the study gave informed consent to their involvement, and permission for the researcher to videotape the sessions.

Efforts were made to protect participants from physical or mental harm. The researcher-facilitator conducted a thorough literature review on filial therapy and kinship care. She underwent training and ongoing supervision in non-directive play therapy and filial therapy, before and during the project, to safeguard the interests of the participants at all times. A play therapist was available to provide free consultations for the children of any of the participants who needed more intensive therapy than the filial therapy offered. When it was necessary to provide feedback to the Durban Children's Society, the researcher-facilitator did this on an aggregated or non-specific basis so that members would not experience any breach of confidentiality.

The discussion and evaluation of kinship carers and the children in their care was only done for the professional purposes of this research. Their identities were protected by using nom-de-plumes, as stated earlier. They were referred to on an aggregated or non-specific basis when liaising with other professionals about the research process. Data gathering was limited to information that was essential for the study.

Collegial consultations were used to tentatively select the research problem and questions, the study population and sample, the research method, and review relevant racial and

cultural perspectives. At a later stage in the research process it was decided to use a Zulu social work student, who was familiar with the Person Centred Approach and Non-Directive Play Therapy theory, and who was a resident in Umlazi, who would serve as a volunteer. Her role was to be a participant observer who would assist the researcher-facilitator as an interpreter to ensure that any cultural issues that emerged in the study would not be overlooked or misrepresented. Individuals and organisations consulted during the research process were acknowledged in the research report. Findings were honestly and accurately reported.

The kinship carers who participated in the study will be consulted about how the findings of the research should be used. Plans have been made to distribute the findings to Durban Children's Society and other interested welfare agencies who deal with kinship carers.

## **Summary**

In this chapter the research facilitator described the methodology that was used in this study. The sampling procedures were consistent with the exploratory nature of the study and the theoretical frame of reference that was used throughout. More than one method of data collection was used to improve the validity of the findings. Even though the researcher-facilitator relied on triangulation to enhance the validity of the outcome, the research tools were chosen because of their compatibility with person centred and participatory learning theories. Participative research principles were central to this study and were implemented to increase the accuracy of data collection, analysis and interpretation. The results obtained are detailed in the next two chapters.

## **Chapter Five**

### **ANALYSIS AND DISCUSSION: Part One**

#### **Introduction**

In this chapter the researcher-facilitator provides a synopsis of the findings from the interviews conducted with professionals, during the problem identification phase and a case-oriented analysis of the six individuals who participated in the study. The six individuals who participated in the ten sessions are discussed separately to capture their individual realities of kinship care and their personal experiences of filial therapy as fully as possible. A combination of observation, interviews, analysis of video recordings and the researcher administered interview schedule generated the findings presented in this chapter. The data within this chapter should substantiate the interpretations and conclusions presented in Chapter Seven.

In summary, this study set out to establish, firstly, whether participants would consider filial therapy to be a worthwhile parenting education service that strengthened their relationship with the children in their care, and secondly, whether they would benefit from the support from other group members who were part of the study and whether this support would empower them to cope with the challenges of parenting children of their absent or deceased relatives. Finally, the research group wanted to establish whether a Western model of filial therapy could be adapted to a locally specific form through a participatory process.

#### **Phase One: Problem identification**

##### **The researcher-facilitator is alerted to the problem**

Whilst monitoring the social work students' practical work, the researcher-facilitator became aware of the growing problem of kinship carers struggling to manage the children

left in their care. Most of the students' interventions involved investigating the suitability of these placements in order to meet the statutory process of finalising placements with kinship carers. Little, if any, intervention dealt with the emotional trauma of the children, or the adjustments required by the kinship carers, as the growing requests for services gave the social workers little opportunity to address these deeper issues. Instead, most professional activity involved investigating and finalising the applications for kinship care. Social workers reported their frustrations at not being able to direct their professional interventions to strengthen these families, but instead were required to fulfil enormous statutory requirements regarding these placements. After supervision sessions, the students who were dealing with kinship carers began asking them about their realities. They learned that many kinship carers had difficulty managing the additional children placed in their care and many of these children presented with emotional and/or behavioural problems. Sadly, no one seemed to address these issues because there were few, if any resources, to help these children adjust and so they were managing as best they could.

#### **The researcher-facilitator checks out her observations with professionals**

Six interviews were conducted with eight professionals who "wanted to solve the problem". These were conducted with professionals from Childline, Durban Children's Society, Howick Hospice, Lifeline, Mzamo Child Guidance Clinic and a play therapist in private practice. Seven were experienced social workers, and one a psychologist.

Each interviewee identified that there was a tremendous need for troubled children in the Umlazi area to receive some form of therapy. Service providers were described as overworked, caught up in the heavy demands of fulfilling the statutory requirements of placing children, and unable to cope with the remedial needs of the kinship care families. Lengthy delays between the referral of child abuse cases and the actual rendering of services to these families were reported. One interviewee stated that in some instances child abuse cases were not even being followed up once reported. Social workers were described as struggling to manage extremely high caseloads that could not be addressed through casework alone. Confusion reigned about combining developmental paradigms and direct service models. The funding crisis in welfare was impacting on the morale of the professional staff.

It was stated that children who experienced trauma should receive services as soon as possible after a traumatic event in order to promote the chances of recovery. Few children were receiving the benefits of play therapy. They all agreed that play therapy was indicated for many of the cases that were referred to them. Staff of the Child Guidance Clinic stressed that counselling services were not reaching the people most in need of them. Many of the treatment facilities that render specialised services to emotionally disturbed children were centralised. Because the travelling costs involved in taking children to the centres were high, many appointments were not kept beyond the assessment interviews.

The Durban Children's Society was active in dealing with kinship care placements. There had been a marked increase in the number of cases being referred in the Umlazi area, especially children orphaned as a result of the death of parents from HIV/AIDS. Because the demand for applications to foster kinship children were exceeding the human resources available to assess these applications, the concern was raised that inadequate attention was being given to screening and the early identification of problems. Whilst this society offered an orientation programme for fostering, the programme focussed on the legal issues and processes of fostering, and less on equipping the new kinship carers with adequate skills to manage and develop the children in their care. None of the interviewees were aware of published research on services to kinship carers within the South African context but stressed the need for this. The problem of accessing financial assistance was given as the biggest problem facing the carers. Other problems cited were inadequate parenting skills, limited support systems, and for many, an inability to deal with the emotional and behavioural repercussions of children experiencing trauma. Many of the kinship carers were described as unemployed, single parents who scarcely had the resources to provide for their biological children. This description is consistent with the literature (Berrick, 1997; Grogan-Kaylor, 2000; Ingram, 1996).

One practitioner working with terminally ill patients and their families expressed her growing concern about the number of children orphaned on account of AIDS who were experiencing problems with bereavement. She stated that there were few services that ever reached these children. Because of the enormity of the problem she envisaged a community-based programme, engaging groups to learn about play.

Another interviewee reported having had success in working with volunteers at a State hospital, involving them in providing basic play therapy with children who had been hospitalised. This project had given her hope that one could work with volunteers to do play therapy with children. Programmes to train volunteers to do play therapy with children in need were suggested as a way of providing some care to children and decentralising services. However, a concern was raised that unless the volunteers were directly responsible to a service provider, secondary abuse of children could occur.

The general feeling was that group programmes designed for kinship carers would increase professional leverage. Furthermore, they felt that there was ample evidence that groups were effective means of providing support to client systems. Group programmes that simultaneously alerted the carers to children's emotional trauma and enhanced parenting skills were needed. A suggestion was made by the social worker in private practice who was an accredited trainer in play and filial therapy, that filial therapy could be used to address these needs. Although a Western model, she believed that it had enormous potential for use in developing countries.

These discussions broadened the researcher-facilitator's understanding of the remedial services that would benefit kinship carers and the children in their care. Group programmes that enable kinship carers to assist their children deal with their emotional traumas, enhance their parenting skills, and provide support for one another was indicated. The programme suggested by Bratton et al (1998) appeared to address these issues. The researcher-facilitator conducted a literature study on filial therapy and selected this intervention as a possible option. A decision was taken to engage kinship carers in an exploratory study to assess the effectiveness of filial therapy as an intervention for carers and children in the Umlazi area.

## **Phase Two: The research participants' experiences of the filial sessions**

In this section participants' life worlds and experiences as kinship carers and members of the filial group are explored. These were regarded as important to "bring the research effort to its destined conclusion so that the findings may be shared with others" (Leedy, 1993, p.315).

### **Case studies**

This section deals with the experiences of the six women who participated in the study. The information presented was compiled from the issues they shared during their participation in the ten group sessions that were video recorded. Their responses to the researcher-administered questionnaire are included within these discussions.

## **Kinship carer: Makhosi Mhlongo**

### **Personal details**

Makhosi was a seventy-two-year-old, retired domestic worker who had eight people living with her. They were her two adult unemployed daughters, four grandchildren between the ages of nine and twenty-two years, and two great grandchildren – one of four years and one nine months of age. Her only set income was a State Old Age Pension of R570 per month. Makhosi worked as a fruit vendor in order to supplement the family income. She had experienced a life of hardship. Only six of her twelve children were alive. She was widowed at an early age and was left to raise her children on her own. For several years she suffered with arthritis and high blood pressure.

### **Details of kinship care issues and how they affected her**

Makhosi's daughter had died three years ago after suffering a long and undiagnosed illness. Makhosi had to care for her then eleven-year old granddaughter and six -year-old grandson. She had approached the agency a year ago for financial assistance to assist her to care for her two orphaned grandchildren but had not had further contact with them before the sessions commenced. Because she had been unable to provide the social worker with the children's father's death certificate, she had given up hope of ever qualifying for a Foster Care Grant. The status of "foster parent" was important to her as it would entitle her to a Foster Care Grant for the two younger grandchildren and their school fees would be waived (Barrett et al, 1999).

She reported no problems managing her two grandchildren and described them as respectful and helpful. It was evident that she was a warm grandmother who avoided shouting at her grandchildren. She spoke of herself as "soft" and "kind". Somewhat light heartedly she stated, "the only problem is that M (the now nine-year-old grandson) eats too much. He's always hungry and there's never enough food to satisfy him!" Her specific needs were clearly financial assistance. Her aspirations were that the children would grow up respecting her and move outside of the poverty they were currently experiencing. She stated on more than one occasion, "I want them to have a better future and they need to study." A deep concern that was expressed towards the end of the sessions was the

uncertain future her grandchildren would face when she died as she was totally responsible for them and there was no-one else reliable in their lives. Kinship care had placed additional burdens on her such as having to do extra work in order to support them. The extra responsibility of caring for them resulted in her neglecting herself, and there were little time and resources for her to do the things she wanted to, like involving herself in some of the programmes offered by her church.

Makhosi chose to work with her nine-year-old grandson during the filial sessions.

### **Makhosi's response to filial therapy**

Makhosi benefited most from the support received from the other group members. She stated, "I'm always pleased to come to sessions because I get to be with my new friends" and "I liked to listen to their ideas". During the first two sessions she clarified her misconceptions about the process to be followed when applying to foster and through the encouragement of the other members, she contacted the agency to reapply to foster the children. The social worker paid a home visit and Makhosi had started the process of obtaining necessary affidavits as suggested by the group.

Whilst she recognised the benefits of filial therapy, "it's good for the child because it allows him a time to be free and express feelings", it was clearly not a useful intervention for her. She found it difficult to set aside regular time to play. The concept of playing with the child was rather uncomfortable for her as indicated in her statement, "they must just get on with it. I can't play. I'm too old." She was the only member who chose not to do a demonstration of play therapy. She found it difficult to do the exercises and often joked that she hoped that she would not be given a turn to share, as she felt she had little to contribute. This member missed three sessions, which can be understood because her attendance at sessions prevented her from selling fruit.

The group gave Makhosi an opportunity to talk about her losses in life. Her sharing helped her to identify her personal strengths of courage, resourcefulness, and a deep commitment to providing the children in her care a loving home. The group encouraged her to verbalise

her deep fears of dying without having arranged alternative care for the children and she resolved to pursue this matter with the Durban Children's Society.

She reported playing with the boy only twice. There was no evidence of the child having benefited from filial therapy. He would not have responded directly from play therapy after such limited exposure to the intervention. The members accepted that Makhosi attended meetings for the support and friendship she received from the others. As this was one of the objectives that had been set by the group they did not see it as a problem. It is possible that the children may have benefited indirectly from their grandmother's sense of having support and an opportunity to interact with other carers.

On reviewing the objectives set at the outset of the group, Makhosi stated that most of the objectives had been met.

## **Kinship carer: Lindiwe Nzuza**

### **Personal details**

Lindiwe was a bright, articulate thirty-two-year-old who was the “informal” carer of her nine-year-old niece. She was an unmarried, unemployed secretary who supported herself and the child in her care by doing temporary work and selling tablecloths that she crocheted in her spare time. She was frustrated by her inability to find permanent employment. Her income seldom exceeded R800 a month. Her family, who lived in another town, assisted her with money for the child’s expenses.

### **Details of kinship care issues and how they affected her**

Her niece had lived with her for about two years. The niece was the daughter of her eldest brother. The child’s mother died in childbirth and the brother, who was “in a lot of trouble”, had disappeared. Whilst she suspected that the mother of the child had died of AIDS, the family chose not to discuss it. At the time of the group, she and the child shared a close relationship and the child was old enough to share some of the household responsibilities and so she did not consider herself as burdened as some of the other members. Lindiwe was mostly concerned about the fact that she had not been adequately prepared for a child in her life. No financial plans had been taken to secure the child a good education and this worried her. She said, “some days I just worry about what steps I should be taking to give her a good life.” Her dreams for this girl were, “I want her to grow up thinking that she is a princess.” The issue that she most wanted to address in the group was how to explain death and the details of the child’s mother’s death to her niece. No-one had ever done this and the child was told that her mother had gone away. She said, “It is all wrong, we never tell our children the truth about serious matters such as this.” Lindiwe elected to work with her niece during the ten sessions.

### **Lindiwe’s response to filial therapy**

Lindiwe attended the first four sessions. She withdrew when she received an offer of temporary employment. She was saddened about missing the sessions and indicated that she hoped that she could be included in another programme. Her contributions during the four sessions were greatly valued by the members. She was thoughtful about her parenting

role, eager to learn new skills, and insightful about some of the poor parenting techniques she was using. When role-playing setting limits, she said “ we often use techniques to get the child to stop nagging, that are quite dishonest, like telling them that we will buy something for them later when we have no intention to do so.” She began to appreciate the power of play, “This is powerful. I didn’t choose the pictures. They chose me.” She was supportive of the idea of using filial therapy because she believed that it would create opportunities to strengthen relationships between kinship carers and children in their care, “during play time you are showing the child that you are there for her and that will make the child feel important.”

Whilst Lindiwe missed the sessions on death, she was given an opportunity to talk about her sister’s death and the unpleasant consequences of keeping secrets from children. She resolved to talk more honestly about the death of the child’s mother, as she believed that breaking the silence would enable the girl to “move on in her life.”

There was no mention of the child’s response to filial therapy. The only record was that Lindiwe felt that reflecting feelings seemed to diffuse tense situations in the home.

## **Kinship carer: Zodwa Khumalo**

### **Personal details**

Zodwa was an unemployed single parent who was the “informal” carer of two children and the “formal” foster parent of two children. She lived with two of her own children – one of four years and the other of eleven months, and two younger siblings. She was thirty-two years old. She was estranged from the father of her children who paid R150 per month child support. She received three Child Care Grants that amounted to R300 per month. Her parents, who were teachers, subsidised her expenses to provide some relief as she was finding it difficult to meet the high living expenses incurred by caring for so many children. It was taken for granted that she could not work as the family had appointed her as the carer of the children. She attained a matriculation certificate but had never been employed. It was evident that she loved the children in her care.

### **Details of kinship care issues and how they affected her**

Zodwa’s sister had died of AIDS a few weeks after her youngest child was born at the start of the year 2000. Her sister had been unwell for an extended period and had prepared Zodwa for her death and requested that her children be raised by her. Zodwa was so distraught at the time about her sister’s diagnosis that she did not consider the fearsome responsibility that had been placed before her.

Her brother’s two children, born out of wedlock, were cared for by their maternal grandmother who abused alcohol. They were brought to stay with her. The grandmother was abusive towards the children and often beat them whilst under the influence of alcohol. The children’s mother died in 1999 and their father disappeared. The young girl of nine witnessed her uncle being stabbed to death by robbers in front of their home. Because of her distress and poor school performance the family decided that both children should live with Zodwa. The child manifested poor social skills at school and was involved in many fights. Zodwa reported that the child was often bullied.

There were no serious problems of parenting reported by Zodwa. The issues in the home were the general parenting issues such as the children failing to do their chores when asked

to, or the two older children not applying themselves at school. The issues which troubled her most were, “Who’s going to look after them when my parents and I die?”, “I want them to respect me”, and “I need money to raise them. It’s so hard because they are so many when it comes to financial needs. They need clothes, books for school, school fees.” She expressed a need for group support. She worried about her brother’s children growing up with a sense of abandonment and hoped that she could counteract the negative effects of her brother’s lack of commitment to his children.

Zodwa concentrated on working with her nine-year-old niece during sessions and presented one live demonstration for the group with this child.

### **Zodwa’s response to filial therapy**

Zodwa attended every session. She was very enthusiastic about the process and often related generalising the skills learned in different contexts. She loved the play sessions with the children and found it difficult to end these. The things she found most useful were the listening and reflecting skills, the skills for praising and encouraging, and the limit setting skills. At termination she reported, “I have learned so much about the child. It has deepened my understanding of her experiences”, “I feel closer to this child”, and “I think I have mastered the art of setting limits.” Apart from benefiting from the new content learned, she related her positive experiences of being a member of a group. She also reported learning new ideas from others as a valuable experience and stated that she enjoyed the friendships she had formed with the other members.

Her niece developed themes during her play sessions. Many seemed to be the enactment of the violent scene that she had witnessed. She later used the medical equipment to treat the victims who had been attacked in the dollhouse and this seemed to lead to some resolution of her issues as much of her play towards the end of the sessions was constructive and creative. Themes relating to the home became more predominant. Zodwa reported very definite improvements in the child’s behaviour that were validated by others in the home and teachers at the school. The child was more assertive and less fractious in her interactions with peers. She was a happier family member who was more cooperative, resulting in fewer fights in the home.

Zodwa reported that the group had achieved most of the objectives they had set at the outset. She was pleased about the experience and indicated that she would be available as a volunteer for similar programmes should they be developed for the community.

## **Kinship carer: Thembi Mkhize**

### **Personal details**

Thembi was an unemployed single woman of forty-three years. She was responsible for an elderly, severely diabetic, and mentally disabled mother, two nephews and one niece. She was the “formal” foster parent of the three children and therefore in receipt of Foster Care Grants which amounted to R990 per month. She was depressed and anxious. She suffered with high blood pressure and an ulcer. She did not disclose her level of education and spoke little English. Her religious convictions were described as her main source of support and comfort.

### **Details of kinship care and how these issues affected her**

At the start of the group Thembi was depressed and overwhelmed by her responsibilities. She appeared to have many issues in her life that she had not been able to resolve. She was left to care for her nephews, niece and mother as a result of tragic circumstances. The practical issues of caring for these members meant that she had made several sacrifices and she was left feeling resentful.

Her problems began in January 1995 when she heard over a radio broadcast that nine members of a family had been killed in an incident of political violence. The members had been shot in their home. Later that day she was contacted by the police who informed her that her parents, siblings, their partners and their children had been shot. All had died instantly, with the exception of her mother who had been airlifted to Wentworth Hospital for specialist treatment for severe head injuries. Her two nephews and one niece were the only surviving relatives. They had been visiting friends at the time of the attack. Her personal life had been put on hold. Whilst her mother had survived, she required much nursing. The children never spoke about their parents but she suspected that the two nephews were angry and resentful about the crime that had been committed against their parents and took their frustrations out on her. She merely went through the motions of meeting the children’s physical needs. The relationships in the home were strained. Thembi seemed to be unable to communicate with the children. Her confidence as a parent was low and she was filled with self-doubt.

It became evident that she had not been able to deal with the shock of losing her entire family at once. She was merely going through the rituals of living. Her only explicit requests about changes that she wanted in the family were, "I want them to respect me" and "I want to learn how to try to make things better in the home." She complained of her neighbours being critical of the way she dealt with the children and felt threatened by her nephews' remarks that she did not count because she was not their real parent.

She chose to work with her eight-year-old niece. The niece participated for one demonstration of play therapy.

### **Thembi's response to filial therapy**

Thembi missed three sessions because of health problems. She struggled with the concepts of filial therapy as her style of relating to others was passive and unresponsive. It was difficult at first to establish whether she understood the concepts being taught because she spoke little English and seldom volunteered her opinions. In the early sessions she seemed unable to empathise with the other group members and only responded when asked direct questions. It was only in session six that she began to open up and express a willingness to learn new behaviours and experiment with the skills that were being taught.

The live demonstration of her filial therapy session with her niece in session seven suggested that she still had much to learn. She presented as quite unresponsive to the child's play but reported that she had been having more success in playing with her niece at home and was starting to recognise the child's feelings. The child's play was unfocused. She moved around the room spending brief moments with the play mediums. Thembi said, "Even at home she plays all over the show. I don't know what's wrong." Despite her poor performance, the group offered positive feedback and this encouragement seemed to be a turning point. She approached the volunteer to assist her to supervise her play sessions and help her to integrate the content covered in the handouts. The volunteer worked closely with the researcher-facilitator.

The group's positive response towards Thembi seemed to make some difference. When they empathised with her, it enabled her to talk about her losses, especially during the session on death. During session eight, when talking about the play sessions with her niece at home, she reported that she liked to play and looked forward to the sessions. Whilst Thembi was not particularly active in terms of reflective listening and tended to ask too many questions, there had been a major breakthrough. She had begun to establish a relationship with the child that went beyond the routine chores that she was accustomed to performing. In session eight she reflected that she was beginning to recognise the child's emotional content, even though she did not reflect the feelings appropriately. It was too soon to identify any specific changes in the child's behaviour, but Thembi requested to keep the tote bag of toys for an extended month because she believed that it would have been premature to terminate the sessions at that point.

At termination she indicated that she believed that the group had achieved most of the objectives it had set out to.

## **Kinship carer: Sibenzile Ndlovu**

### **Personal details**

Sibenzile was a fifty-seven-year-old retired schoolteacher. She was widowed in 1990. She lived in a rented house with her three children and two grandchildren. None of the adults in the home were employed. She supported her family on her Civil Servant's Pension of R 1400 per month. Sibenzile was an active member of her church. She often remarked about the inadequate housing available to her and her family and she was most concerned about the lack of security in their neighbourhood. Her story of the previous New Year holiday that had been marred by gangsters shooting innocent people in her street illustrated her point. She had applied to be the "formal" foster parent of her nine-year-old granddaughter. She was receiving treatment for hypertension and arthritis.

### **Details of kinship care and how these issues affected her**

Her daughter died of AIDS in May 2000. She had been ill for an extended period and Sibenzile nursed her until her death. The child's father had died the previous year. There were no major problems that Sibenzile had in terms of raising her grand daughter. She stated that she was very proud of her granddaughter's scholarly achievements and described her as "gifted". Her concerns about raising the child were at first everyday issues of parenting, such as struggling to get the child to respond to her requests to tackle her chores and studies. She was displeased by her granddaughter's attempts to play in the street. She argued that she would not be able to protect her safety there.

Later, some deeper issues emerged that she shared during group sessions. She believed that the child needed someone younger to look up to. She could not identify anyone in the child's life who would serve as a good role model for her. She shared her deep sadness about her adult children's life choices, revealing that they had problems related to alcohol abuse. She also expressed, "My age is against us. When I die, there will be no-one to take care of her." When talking about becoming a kinship carer she said, "This has affected my finances. I now have the burden of raising a child at the age of fifty-seven. What is more painful is that I had not budgeted for this." She also worried about the family not having been honest about her daughter's death and their decision not to discuss the matter openly.

Her aspirations for the child were, “I will be happy if she can be highly educated and be a Christian.”

### **Sibenzile’s response to filial therapy**

This member was a core member of the group. She never missed a session. She was interested in the other members and volunteered to attempt group exercises. Her evaluation of the process was very positive. She noted that, “I have learned to be observant of the child’s feelings. By being observant, I understand her better.”

Her granddaughter appeared to have set themes in her play times. She played with the doctor’s equipment and this enabled Sibenzile to raise her own issues about her denial about her late husband’s death, her daughter’s death and her deep sadness about losing her own mother at eight years of age. It became apparent that Sibenzile had experienced many losses in her life, which she had never managed to resolve. She spoke of “being robbed of the opportunity of ever knowing anything” about her mother who died when she was eight years old and said, “I have no memories of her, not even something small like a hankie. No one ever thought of telling me about her.” She discussed how she had used denial to protect her from the harsh realities of her husband’s death and then her daughter’s death a few years later. Talking about these losses enabled her to connect with her sense of having lost her dreams for a bright future and her efforts to “just get by” without having a definite focus in her life.

Her sense of disappointment in her children and their drinking behaviour had left her with a sense of failure. The group helped her to challenge this perception and see that their behaviour had also been shaped by the broader socioeconomic realities. They gave her hope about the positive role that she was playing in her grandchild’s life.

There were several changes that she reported in the child’s behaviour. Her granddaughter was more responsive to her requests, more respectful towards her maternal aunt living in the home, and able to resolve her conflicts with her peers more independently. The family members verified Sibenzile’s observations. She clearly felt empowered by the group as

illustrated in her saying, “It is so good to learn something useful. I feel I want to spread the gospel. We must share our experiences of this therapy with others.” She stated that, according to her assessment, the group had achieved all of the objectives they had set out to. She volunteered to assist with future groups of this nature.

### **Volunteer: Noxolo Myeni**

Noxolo was the volunteer who joined the group in the third session to replace the first volunteer who had withdrawn from the study because she had found the group sessions too demanding in terms of the time that she had to invest and she did not believe that she had a role to play in the group. The researcher-facilitator discussed the volunteer's resignation with the group in the second session. Whilst the group believed that they could manage without an interpreter they decided that it would be useful to have another person to translate the handouts into Zulu before they were distributed to the members. It was important to choose someone who was committed and familiar with the principles of play therapy, so that the group process would not be affected. The researcher-facilitator approached a student social worker, placed at Mzamo Child Guidance Clinic, who was interested in developing her skills in play therapy.

### **Personal details**

Noxolo was a single mother of twins. She had completed her third year of social work. She lived with her parents and siblings in a four-roomed house. Seventeen people lived in the dwelling. The father of her twins paid R150 Child Support per month. She was in receipt of a study loan of R6 000 per year. Her father was a state pensioner and her mother a songoma. Her parents and siblings assisted her with pocket money.

### **Details of kinship care and how these affected Noxolo**

Working as a student social worker at the Mzamo Child Guidance Clinic had alerted her to the number of children who had limited access to counselling for emotional or behavioural difficulties. The agency where she had been placed had expressed its concern about the growing numbers of kinship carers and the lack of parenting programmes in the community to strengthen these families. Noxolo hoped that by being involved in the study she would be able to share the knowledge gained with the agency personnel and establish a similar project there the following year.

### **Details of how Noxolo experienced the sessions as a single parent of twins**

Noxolo was concerned about being a single parent. She wanted to create a future for her

children that would take them out of the township. She placed a high emphasis on education and wanted them to succeed in life. Living with her parents was stressful. There were conflicts in the home about her independence and the parenting of her children. Her daughter was quiet and reticent and her son aggressive and boisterous. The school had raised a concern that her son may be hyperactive. He was finding it difficult to apply himself in the classroom. He had high needs for recognition. The twins were seven years old and were completing grade one.

Noxolo was concerned about the children growing up without a father. She felt that her son needed to have a father figure, but did not state whether any of her relatives in the home fulfilled that function. She was unhappy about the siblings fighting with one another. She worked with her children on an individual basis, playing with them on different days. The group met her daughter when she presented a live demonstration of filial therapy.

#### **Noxolo's response to filial therapy**

The most striking aspect of the filial therapy, according to Noxolo, was that it had provided her with a window to view what was happening in her children's lives. The daughter appeared to enact the conflict between her grandmother and mother in the dollhouse in her sessions at home and the live demonstration in front of the group. She also commented that she could see the value of being less directive in playing with children as it allowed them to find their own solutions to problems. She also began to recognise how astute children were in terms of finding creative solutions to issues in their lives when encouraged to do so.

She noted a change in her relationship with her children. She felt that the filial therapy sessions had brought her closer to them. She reflected on her over reliance on her mother's approval and her inability to make value decisions independently. The play sessions had given her children more quality time with her and they had verbalised their enjoyment of this. Her daughter responded more favourably to the sessions than her son. She believed that ongoing sessions would have a more positive impact on his behaviour. Noxolo reported that her daughter had become more confident in her interaction with others, was more mature, and she independently resolved minor issues in her life.

## Conclusions drawn from the six case studies

It was evident in this study that the kinship carers fulfilled the two role obligations that Hegar and Scannapieco (1995) had suggested were typical of kinship carers: those of foster parents and preservers of their family units. Participants expressed their efforts to feed, clothe, educate, and protect their children. Each had high aspirations of creating a positive future for their wards. They had regarded it as a matter of duty that they assume the parental responsibilities in the absence of the biological parents because they were close relatives of the children and believed that children should remain within the extended families.

The research participants were females, between twenty-six and seventy-two years of age. The children in their care were between eighteen months and seventeen years. Each carer was responsible for more than one child. Their incomes ranged between R470 and R1 400 per month.

The five kinship carers were grandmothers and aunts as described by Grogan-Kaylor (2000) and Hegar and Scannapieco (1995). They were single women, of colour, with low incomes, and limited opportunities for employment. Death had been the main reason for these placements. AIDS was positively confirmed as the reason for two of the five placements. Two sets of children had lost relatives as a result of violent crimes. Whilst four of the kinship carers spoke of loving the children and wanting the best for their wards, as typified in the literature (Dubowitz, 1994; Hegar and Scannapieco, 1995; Leslie et al, 2000), they were struggling to provide them with the basic resources they required. It was surprising that these women supported so many people on their limited incomes. Collins (1999) proposed that *ubuntu*, being an integral part of African culture, may explain how these women managed to survive. *Ubuntu* ensures that those in need are helped by others, with the understanding that when the helpers fall on hard times, they in turn would be assisted by those in the community who were able to provide help. The cramped living conditions provided additional stresses as highlighted in the literature by Gleeson et al (1997). The members all lived in four roomed houses. The lowest number of people reported by the

group living in a house was five and the highest seventeen. Suitable housing was difficult for members to obtain and they had resigned themselves to this. Space to conduct play sessions in their houses was limited. Lack of privacy presented further difficulties. Members expressed grave concerns about the safety of the neighbourhood. As residents of an area that was inadequately policed, they felt they had no protection from gangsters, as identified in Burton's study (1992).

### **Therapeutic benefits of participating in group sessions**

All members described benefiting from the support of the group which suggested that they had perceived their existing networks to be insufficient for supporting them to deal with the issues they needed to address. Members enjoyed the opportunity to talk to one another about their problems, exchanged ideas on how to deal with these, and gained the sense that others understood their concerns.

The filial groups provided much needed support and relief from aloneness. The researcher-facilitator relied on this supportive climate of the group to provide members with suggestions and feedback by capitalising on the different strengths each member offered (Johnson, 1995). The support and encouragement between the members appeared to have a direct impact on Makhosi and Thembi. Makhosi was encouraged to be more assertive and proactive in applying for financial assistance to raise her two younger grandchildren.

The support they shared seemed to alleviate some of their stress. The cohesiveness which developed within sessions prompted them to their make contact with one another outside of the group sessions. Members referred to these new relationships as significant friendships. They made contact with and offered assistance to each other in between group sessions. These changes were also reported in the study by Bratton and Landreth (1995).

### **Lowered stress**

Their unresolved feelings relating to the deaths of their loved ones emerged as factors which may have been obstacles to their providing support to the children in their care (Linidwe, Thembi, and Sibenzile demonstrated this clearly). Makhosi's lack of information

regarding the necessary documentation and process to follow to foster her grandchildren clearly demonstrated the need for basic information for kinship carers. Lack of knowledge had denied her the financial assistance she was entitled to. Members' accounts of how they had tackled the hurdles during their applications gave Makhosi new hope. Members reported feeling calmer and more in control in their dealings with their children. They felt more confident in their abilities to deal with their situations. Professional services to enable the women to deal with issues such as drawing up a will, nominating a guardian for the children in the event of their dying, obtaining financial support, dealing with grief, and, in the case of Thembi, depression, were all indicated. The opportunity to talk about these issues helped them to recognise their own potential to address them.

### **Improved relationships between carers and children**

Five of the six members of the research group provided evidence of positive changes in their relationships with the children in their care which occurred during their involvement in the programme. Five of the six members stated that the relationship skills taught in sessions had strengthened the relationships between themselves and their children. Carers reported feeling more accepting towards their children and more aware of their unique abilities. This finding confers with those of Bratton and Landreth (1995) and Glover and Landreth (2000). The carers believed that they were more understanding as carers, and were trying to set limits in a non-punitive fashion. This reported outcome is in keeping with the outcomes reported by Glazer and Kottman (1994) and Johnson (1995). The carers described themselves as less autocratic. This attitudinal shift was reported in Bratton and Landreth's study of single parents (1995). The programme prompted four members to address unresolved personal issues such as their own bereavement, conflicts with members of their families, and their unrealistic expectations of themselves. Andronico et al (1969) explained that the didactic components of sessions often provide an entry for members to venture into emotionally and dynamically significant areas. The opportunities for group problem solving led to more positive actions being taken on the part of members.

### **Improvements observed in the child participants**

Three kinship carers reported positive changes in their children. The changes they noted

were validated by significant others in the children's lives. Lindiwe was unable to evaluate her child as she withdrew from the group before she had started the individual sessions at home. Makhosi failed to conduct the minimum number of sessions and Thembi had only begun to note general improvements at the time of termination. Both Makhosi and Thembi suggested that their children may have benefited from their improved sense of well being as they were more congenial when less stressed.

The children were reported as enjoying the play sessions at home and the carers recognised these times as quality time, different from their usual interaction with their children. The improvements noted in the children's behaviour were: increased independence, assertiveness, creative problem solving, and cooperation within the home. Three carers identified that their children were re-enacting personal issues in their play and over time observed signs of these issues leading to some resolution in the play sessions.

The group's initial belief that play was a superficial activity that children engaged in for pleasure alone was clearly refuted. The members recognised play as a medium for understanding their children and the issues that they were dealing with subconsciously, a way to strengthen their relationships with their children, an opportunity to validate the impressionable young people in their care, and a testing ground for these children to find creative solutions to their problems.

### **Suggestions regarding the adaptation of the Western model to a locally specific one**

Some issues about the structure of filial therapy emerged as needing to be readdressed as illustrated in the cases of Makhosi, Lindiwe and Thembi. Filial therapy is time consuming and women who are already burdened with responsibilities may not be able to meet the requirements unless the structure is modified. As in the study of Native Americans on the Flathead Reserve, the members' first priorities were to their families, not the group sessions (Glover and Landreth, 2000). Secondly, change as a result of filial therapy can only occur if members are able to conduct the play sessions at home in between the group sessions. Makhosi and Thembi found this difficult to do because of limited space and time available to them. The relationship between level of education and outcome success should be

explored further, as the members with higher levels of education seemed to benefit more than those who were less educated, such as Makhosi and Thembi.

## **Summary**

This chapter has served to detail the empirical findings of the members who participated in the study and the interviews with the professionals. Whilst no definite conclusions may be reached from the limited number of cases studied, there is sufficient evidence to suggest that the women considered filial therapy to be a useful model that fulfilled some of their pressing needs. Compromised circumstances such as inadequate housing, unemployment and alcohol abuse in the home had created psychological stress for these caregivers (Whitley et al, 1999) and the group had given them some relief, enabling them to cope better with these issues. Many of the themes outlined in the literature about kinship carers were identified in the lives of the five women. Adequate assistance in the form of support from the group, information, basic skills of play therapy and parenting were seen to enhance their coping strategies.

A review of the group sessions as they unfolded over the ten-week period will be presented in the next chapter, together with the analyses of the three themes that emerged that were relevant to modifying the Western model into a more locally specific form.

## **Chapter Six**

### **ANALYSIS AND DISCUSSION: Part Two**

#### **Introduction**

In summary, Phase Two of this study involved forming a research group of five kinship carers, a volunteer and the researcher-facilitator. The previous chapter presented an analysis of the interviews that were held with the professionals and a discussion of the six individuals who participated in the study and self-reports of the impact that the filial sessions had on them. This chapter provides a collective analysis of the orientation meeting and ten group sessions that the group members were involved in. A detailed account will be given of the group sessions and the outcome of the focus group discussion held at termination. Reference will be made to the researcher-facilitator's role within the sessions. Some difficulties and imperfections in the implementation of the filial therapy sessions that the researcher-facilitator believes should be noted are highlighted. Finally, whilst facilitating the group sessions, three themes emerged that were relevant to adapting the filial therapy model to a locally specific form and so the chapter concludes with an analysis of these three themes.

#### **The role of facilitator**

The researcher-facilitator worked in close collaboration with the participants. In order to do this she had to be a "facilitator of human interaction" because participation is based on the cooperation of the group participants (Collins, 1999, p.52). The facilitator listened, responded and reflectively related to others in order to encourage a dynamic process (Collins, 1999). A wide repertoire of group work skills was required. These skills have been outlined by many social and psychological group workers and will not be examined here as they form a study of their own (Konopka, 1972; Glasser, Sarri and Vinter, 1974; Douglas, 1976; Corey, 1990; Corey and Corey, 1992; DuToit et al, 1998). The role played

by the researcher-facilitator typified the criteria defined by Kickett, McCauley, and Stringer (in Stringer, 1996). Apart from sharing some didactic content, the researcher-facilitator was there as a catalyst for group discussion, her role was not to impose but to stimulate the need for the members to consider the need for changes in themselves and the intervention model. She directed the group's attention to the way they were tackling issues rather than the results they achieved. She began where the group was, helped the members analyse their experiences, consider their findings, plan how to keep what they wanted to, change what they did not like, and she kept the group focused on their development.

### **A session-by-session outline of the filial group sessions**

The programme content was largely based on the Landreth ten-week programme that had been adapted by Bratton and Ravat and presented in Ravat's training course (2001b). Permission was granted by Ravat to use the materials for the purposes of the study. The material was adapted to suit the needs of the members. The researcher-facilitator followed the communication process in the group, rather than the set programme. This flexibility was in keeping with the participatory learning approach characteristic of this study and ensured that the members had a direct say in developing the programme to meet their needs as they had perceived them (Schenck and Louw, 1995). This was an empowering process for the members as evident in a member's statement, "We were treated with respect and given the responsibility for choosing the topics and told that we would be learning from one another. It was great to realise that we were able to help one another and soon we felt that we weren't so bad as parents after all".

There were four main parts to every session: welcome, teaching of new content, exercises to provide practice opportunities to group members, and the live demonstration of a play session by one of the group members. The welcome and opening started with the singing of choruses and prayers by the members and were followed by a general exchange about the week's events. The chorus singing and prayers seemed to increase the sense of group solidarity and was characteristic of working within the *ubuntu* philosophy. These rituals were never pre-planned but rather occurred spontaneously, creating a unique dimension to

the sessions. The content to be discussed was determined democratically and then presented by the researcher-facilitator, with handouts that had been translated into Zulu. Most sessions involved experiential exercises which were followed by discussions of the relevance of content for the context that the members found themselves in. The activities were consistent with person-centred groups (DuToit et al, 1998). The live demonstrations were video recorded in the presence of the other members who benefited from observing the training lessons of others. This dimension of observational learning is regarded as beneficial for all (Van Fleet, 1994). Each video recording was played back in the next session to provide members with an opportunity to offer more detailed feedback to one another (Glover and Landreth, 2000). Many take-home exercises were set for members to complete between sessions. These were discussed at each group session on their completion.

#### **Pre group /orientation meeting**

Eleven kinship carers were invited to an orientation meeting to learn about filial therapy. Six of the eleven women who were invited attended the session. The researcher-facilitator described play therapy and the importance of play in the lives of children. A video "Children's Emotions" was shown to illustrate the importance of developing relationships of acceptance and respect with children. A brief explanation of filial therapy was presented and at their request a video of the researcher-facilitator's session with her daughter was shown. The kinship carers were informed that the researcher-facilitator was interested in forming a group to research the possibility of adapting the Western model into a locally specific form using a participatory approach. Five of the six women present volunteered to be part of the group. The logistics of time, venue, and dates were discussed and decided upon. The first volunteer was present at the group and interpreted the researcher-facilitator's talk into Zulu. A few queries were raised about applications to foster as some of the women present had encountered difficulties.

The atmosphere was quite formal. Members revealed little about their personal lives. The researcher-facilitator and volunteer did much of the talking. The kinship carers merely participated in the discussion when they had to make decisions regarding the formation of and planning for the group. The volunteer translated their suggestions into Zulu.

### **Session one**

The purpose of the session was to enable the members to introduce themselves to one another and make decisions about the structure of the group. The five principles of play therapy were briefly introduced: time for children, reflection of their feelings, limits during play sessions, structure of play sessions and problem solving to orient the new members to the basic language and concepts of play therapy. The members were asked to make individual collages from magazines provided depicting their realities as kinship carers. They were reminded of the objectives of filial therapy as outlined in their handout and the researcher-facilitator's expectations which were: they were to have set play times with the "child of focus" lasting thirty minutes, once or twice a week; do one live demonstration of a play session with their child; have the demonstration taped to be shown to the group for discussion and feedback; and have patience as filial therapy was a slow process. The last part of the session was spent establishing group norms such as confidentiality, attendance, experimenting with new behaviour and participation.

The group process was slow. Members' responses were quite guarded as they attempted to check out whether they would be accepted by the group. The members spoke of the suddenness of the kinship care arrangements. Few had been prepared for these placements. The overwhelming sense of responsibility to feed, nurture, and provide the children with a sense of hope for their futures, were central themes. The two older group members shared that their ages were against them and they worried about who would be there for the children in their care when they died. Members were able to identify commonalities in their life experiences. The volunteer was absent and this was the group's first effort to speak directly to the researcher-facilitator in English. The absence of the interpreter seemed to help the group process as the members and researcher-facilitator were drawn closer by their efforts to understand one another. The expectations which they defined were: to regain a sense of control in their lives, increase the closer and happier times with the children, and develop a deeper understanding of their children.

The two homework tasks set were to identify one physical characteristic of their child that they had not previously noticed, and complete the "Four Faces Feelings Chart" (the handouts are contained in the work book, refer to Appendix IV).

## **Session two**

The group offered feedback on the two tasks that they had been expected to do at home. They accomplished the first task, to identify a physical characteristic of the child that they had not previously noticed, but not the “Four Faces Feeling Chart”. The first exercise had been helpful because it had sharpened their awareness of the children in their care. They had realised that they had much to learn about these children. Dealing with feelings was more difficult and confusing. There was a general sense that the members were not accustomed to singling out emotions. The exercise was completed in the group with the researcher-facilitator encouraging members to think of their own examples when they were angry, sad, surprised and happy. They found it easier to talk about the pleasant emotions but could, with encouragement, identify situations where they had been angry and sad. The “Listening” handout was read aloud by the volunteer. The group discussed the difference between listening and reflective listening as presented in a role-play between the volunteer and the researcher-facilitator. Reflective listening was identified as the more supportive style. It was seen to be an understanding form of listening that reflected the listener’s full presence and therefore communicated a sense of care and respect. The members were asked to read over the “Facilitating Reflective Communication” worksheet and the “Listening” handout at home and practice the “Four Faces Feeling Chart” again.

The second part of this session was set aside to deal with research issues. A nominal group technique was used to define the research questions and the objectives that the members planned for the group. The research questions which emerged from this procedure were: to establish whether the programme would have a positive influence on their roles as kinship carers, result in positive changes in their children’s behaviour, and determine whether filial therapy was a suitable intervention for their community. The objectives they defined were: to “learn new ideas to deal with old problems”. These “old problems” were seen as: the need to gain information about raising children, giving special attention to issues such as disciplining children and managing their difficult behaviour, and learn ways to assist children to cope with the loss of their parents and deal with their grief so that they would come to accept these placements. They also identified the need for group support to deal with their new responsibilities.

Time was devoted to addressing the technical aspects of applying to foster the children in their care. Practical advice was given to members by the volunteer about steps that could be taken to prove that attempts to trace the missing parent had been made, approaching the police station for affidavits, and requesting letters for the schools advising the principal of the application for fostering so that the school fees could be adjusted.

The group remained in the initial stage of the group process (Corey, 1990). Members revealed little personal information. Their interaction with one another was courteous and socially appropriate. They chose to deal with the “safe” issues such as dealing with foster care applications, rather than issues that were generating emotional content. Their difficulty of focussing on feelings in their interactions in the home was identified at first as a cultural issue. “We just don’t talk about feelings in our culture,” said one member. The researcher-facilitator suspected that the presence of the first volunteer had a negative impact on the group communication process. The volunteer was didactic and authoritarian. She preferred telling the members what to do. She disrupted the session by arriving late and taking calls. The roles she had played in imparting information about foster care placements were useful. She seemed surprised that the group had chosen to communicate directly with the researcher-facilitator in English and at the end of the session informed the researcher-facilitator of her intention to withdraw from the study as she was “no longer needed”. When this was discussed with the group, they stated that they could manage without an interpreter, but that another Zulu-speaking volunteer would be useful to assist the researcher-facilitator with the translations of handouts. The researcher-facilitator proposed using a social work student who was more familiar with the person-centred approach. The group were in agreement with this.

### **Session three**

The objectives for the group were to emphasise the value of play when working with children, and discuss the five principles of filial therapy in greater detail to check that they were culturally appropriate for the group members. The new volunteer was introduced to the group and members’ attempts to complete the “Four Faces Feeling Chart” at home were discussed in the group context. The list of play materials required for sessions was handed out for discussion. Members were asked to identify any culturally inappropriate objects on the list, and were given an opportunity to amend the list as they felt appropriate.

Whilst the members recognised their improvement in identifying their children's feelings, they struggled with verbalising them. The difficulties they encountered were common listening mistakes of being patronising, trying to solve the children's problems, and judging these emotions. Time was spent checking out whether they considered this form of listening to be a culturally inappropriate exercise. To this, one member replied, "it's just something new. It is going to take time and practice." Lindiwe said, "I think we're getting better because at least we think about the mistakes we're making." They recognised that the listening they needed to engage in should be active, on the one hand, in that they had to hear, understand and reflect, but non-directive on the other, in that the children had to be given time to deal with their feelings without interference from the kinship carers. They chose to do the "Facilitating Reflective Communication" exercise in the group. They laughed at their inappropriate responses and applauded spontaneously when they were accurate.

The "Five Principles of Child-Kinship Relationship Training" handout was read aloud and discussed in detail. Whilst the members were puzzled that their children did not have to tidy up after the sessions, they recognised that the freedom allowed in sessions enabled the children to deal with inner struggles, and encouraged them to be more congruent. They were relieved to learn that they did not need a big vocabulary of feeling words, and could use simple phrases such as "you like that" and "you don't like that". They shared that there were not that many feeling words in Zulu and that feelings were often reflected using metaphors. They recognised that much of their interaction with children involved instructing them to do or not do something, or was a communication of expectations rather than a supportive, understanding, and non-directive stance on their part. The use of choices to enforce limits was received with curiosity as there seemed to be a tendency to use threats such as, "if your mother were alive she would punish you severely for these actions", or corporal punishment as reflected in, "I get so mad that I just give her a smack".

The chosen places for all the kinship carers to do the "at-home" play sessions were their bedrooms. Small dwellings with little space and privacy were common issues highlighted. They foresaw that they would have to find ways to restrict their children from playing with the toys in between sessions. They pooled their ideas of how the toys could be stored and what the children should be told. They added a balaclava, scarf and baby blanket to the list

of toys for the tote bags. The bop bags would be constructed from rubbish bags and rags (Van Fleet, 2001). They planned the construction of the dollhouses from the cardboard boxes that the researcher-facilitator provided.

Members challenged the researcher-facilitator that they did not like the term homework and preferred the term “practice”. It was decided to use the term “practice” from that point onwards. The members agreed to repeat the “Four Faces Feeling Chart” for practice and read the “Child Kinship Care Relationship Enhancement” and the “Five Principles of Child Kinship Relationship Training” handouts at home in preparation for the play sessions with their children.

It was evident that the members were starting to relax in the group. The new volunteer joined the group, expressing her need to be a participant who would use the opportunity to strengthen her relationship with her twins. The group members started to challenge the researcher-facilitator by voicing their dissatisfaction with the term “homework”. They were more vocal about the things they disagreed about, such as not expecting the children to tidy up. These responses are characteristic of the transition, or middle phase of the group process (Corey, 1990) and if handled appropriately in open discussion, promote members’ ownership of the group process and deepen their participation. They asked more questions, demonstrating their willingness to assume more responsibility for the group.

#### **Session four**

The objectives of the session were to check out their experiences of reflecting feelings and prepare members for their play sessions at home. A video of a filial session was shown to demonstrate the Five Principles on which Child Kinship Relationship Training is based. The principles as were evident or absent in the video were identified. Members practised the principles in their role-plays. At the end of the session they were introduced to the theme: Setting Limits and the handout “Three Steps in Limit Setting” was discussed briefly.

As the group was more relaxed and members were directing their communication to one another, rather than through the researcher-facilitator, they engaged in more meaningful

discussion about reflecting feelings. “In the Zulu culture, it isn’t easy to talk about feelings. Horrible things may happen and you have to keep your thoughts and feelings about the issues to yourself.” “Respecting your elders is so important and any negative feelings towards them are seen as disrespect and so you learn not to show anger or disappointment.” “It seems as though we’re allowed to express joy or happiness, but never anger and so one just stops focussing on feelings.” Members felt that they had taken great strides in identifying their children’s feelings and were beginning to reflect their basic feelings. Each member had a positive example to offer. They concluded, “Reflection of feelings does not go against our culture. It’s just a different way of doing things and that is okay.” They recognised the improvement in the quality of their relationships which they attributed to reflecting feelings. It was decided that they needed a feeling chart that could help them to be more attuned to the variety of feelings experienced by people.

Members became deeply involved in the role-plays. They took turns to play and facilitate a play session. Their own excitement of playing became evident. “It was great to have someone who was focussing on me”, “The undivided attention seemed to allow me to become more involved in my play”, and “the play allowed me to relax”. Only when reviewing the video recording did the researcher-facilitator take note of how long it had taken members to sufficiently relax to be able to play. One member remarked that the toys that she had chosen had been relevant to issues in her life. It was recognised that play in the presence of the carer could also be a powerful stimulus to uncovering “threatening” family related conflicts or issues (Guerney, 1964). The role-play indicated the kinship carers ability to track the content and respond to very basic feelings.

Each kinship carer was allocated toys they would need for their sessions at home. This is referred to as a tote bag (Landreth, 1991). They expressed concern that the communal nature of the *ubuntu* philosophy would present problems for them. They feared that they would not be able to use the toys for the benefit of a few individuals in the family, and would have to give all the children in the home a time to play. The group could find no solution to this problem and three of the members ended up creating time for the other enthusiastic children in the home to play. Two members could not spare the time and reserved playing with the “child of focus”. The sixth member was Lindiwe who had

advised the group of the change in her circumstances and expressed a request to be released from the group because of temporary employment.

The communication was direct, honest and members revealed more of their personal realities. They were keen to tackle the group exercises and provided one another with supportive encouragement and constructive suggestions. Corey (1990) refers to this stage in the group process as the working phase. The researcher-facilitator's role was far less active. Zodwa was a great help as she grasped concepts quickly and was eager to practice and often volunteered to demonstrate the exercises. The group turned to Sebenzile for translations. The members had a definite sense of purpose and directed the group at the pace that they wanted to move at. The group had chosen to develop its own model of filial therapy.

#### **Session five**

The researcher-facilitator shared her observation of the members' initial discomfort of "playing" in the previous session and asked for clarity about the role of play in the lives of their children. The researcher-facilitator proposed an exercise for the members, playing with play dough as a means of allowing them to understand the experience of play from the children's frame of reference. The members were asked to report back on their sessions at home. A handout on "The Magic of Play" was prepared to provide members with more information about the value of play in the lives of the children. Sebenzile conducted a live demonstration of play with her granddaughter.

The members chose to start with the play dough exercise. At the outset, members giggled and glanced at their neighbours to see what they were doing. They stopped and started their modelling and later seemed to become absorbed in the activity and oblivious to one another. Members identified a sense of accomplishment and satisfaction at having been given an opportunity to be creative. One member said, "It was nice to feel the play dough and be able to shape it just for fun." Their comments were linked to issues relevant to play therapy and they were once again questioned about play and children in the Zulu culture.

One member explained that “children must just get on with playing by themselves, or with their friends, and usually this happens in the street”. Because of the demands placed on the kinship carers they reported that they had no time to play with the children in their care. On reflection, they could not remember the significant adults in their lives playing with them as children. The large families presented as a difficulty and siblings were often left to care for one another. They concluded that too little emphasis was given to using play as a conscious activity with children to enhance creativity, relaxation and emotional adjustment. Play in the township meant letting their children play football or cricket in the streets, imaginary games as teachers or mothers in the home, drawing, climbing trees or swinging on branches, and skipping. The toys that their children were familiar with were the guns, knives, cars, and blocks. The puppets, mask, plastic animals and soldiers, bop bag, dollhouse and furniture, play dough were things they thought they would be unfamiliar with. The purpose of including specific toys in the tote bag was discussed. The group read the handout “The Magic of Play” together. The members identified the need for children to be allowed to play in a relaxed, free atmosphere and acknowledged the purpose of setting as few limits in play sessions as possible.

Zodwa, Sebenzile and Noxolo were most enthusiastic about their play sessions in the home. Zodwa commented, “she wanted to play everyday” and “she even invited her friends to join us”. Limit-setting was suggested by group members as a means of dealing with these problems. The researcher-facilitator modelled their application. The session ended with Sebenzile’s demonstration of a play session. The members were encouraging and praised her for limiting the questions she asked, reflecting feelings and being firm about the “time up” call. The demonstration highlighted that when the child’s feelings are accurately reflected, it deepens the child’s focus in play, providing more clues about the thematic content of the child’s play.

The group members were warm and supportive towards one another. Members disclosed personal experiences of violence in their neighbourhoods and the political violence that they had encountered ten years earlier. Their stories were stories of struggle for survival. They identified themselves as women of courage and demonstrated genuine interest in one another. The group was cohesive. They directed the flow of the communication in the

group, problem-solved and offered feedback. These actions are typical of the working phase of the group (Corey, 1990).

### **Session six**

Members had requested a “Feeling Chart” in the previous session. They were handed a sheet of faces with different facial expressions and had to identify the emotions that the expressions typified. Because of the difficulties experienced by the members in terms of setting limits in play sessions at home, they chose to review the “Three Steps for Setting Limits” and complete the worksheet “Lets Practice Setting Limits” within the session. Zodwa was asked to do the live demonstration

The video of Sibenzile’s demonstration of a play session was reviewed. The members used the “Five Principles of Child Kinship Relationship training” to evaluate the play session. Glover and Landreth (2000) referred to this as observational learning. This form of learning reduces participants’ resistance to change as they become active participants in the treatment of their children (Andronico et al, 1969). The didactic and dynamic principles of learning are merged by doing this, providing the members with an opportunity to deal with their emotionally and dynamically significant areas at the same time. The supportive group climate tends to promote significant sharing.

Members asked questions about thematic play. The session with Sibenzile’s granddaughter had helped to make them aware of themes emerging in their play sessions at home. The researcher-facilitator dealt with the queries. Members identified that it was difficult to refrain from directing the play. Their role as “controllers of behaviour” was more deeply engrained than their roles as “containers for emotional release”. Whilst they were struggling to avoid the urge to curtail rough play in sessions, or messy play, they were having better success in reflecting feelings. Three members gave perfect examples of attending fully to their children in different situations. They succeeded in commenting on their children’s feelings with acceptance. One member asked what she should do as her son kept asking her to name the toys. The members referred her to the handout: “Child Kinship Carer Relationship Training” that included “Key Sentences” that could be used in play sessions. The children’s natural abilities to problem solve were recognised in their

sessions. A child needed a stove in her play and she drew one, another needed a big vehicle to transport her doll family in and so she constructed one from blocks. It was noted that professionals would not be able to form the same relationships with the children in as short a space of time as the carers had.

The handout “Lets Practice Setting Limits” highlighted the members’ tendency to control their children rather than offering them choices and making them responsible for those choices. There was much humour but through the laughter members appeared to gain an insight into this aspect of parenting. The handout “Five C’s of Effective Discipline” seemed an appropriate place to end the didactic section of this session.

The session concluded with the live demonstration of a play session by Zodwa. Her niece demonstrated extremely violent scenes shooting and stabbing the members of the dollhouse family and the soft toys. Zodwa was visibly shocked by this vicious display of anger. It was inappropriate to discuss this in front of the child and so the discussion was to be carried forward to the next session. Members were asked to practise setting limits.

### **Session seven**

The members reported finding the sessions helpful. At this point the only member who was not having regular play sessions was Makhosi. She seemed to attend sessions for social and emotional reasons rather than learn about play therapy. The group recognised her need for support and made no demands of her. Thenbi was asked to do a live session. The researcher-facilitator suggested reviewing the handout “Rules for Child Kingship Relationship Training” if the group had time.

The group evaluated Zodwa’s play session with her niece. Members thought that because children were often denied opportunities to express angry feelings, these feelings build up in the child, and when given a safe context such as the one Zodwa had created for her niece, they “spill” out. Zodwa shared with the group her niece’s unhappy past and suggested that the feelings towards the grandmother were issues the child was struggling with as the same angry demonstrations also manifested in her play at home. Sibenzile related her experience as a young girl being raised by a stepmother who abused her

physically at eight years. An intimate bond between the members was evident as they each began sharing the deep losses they had suffered through losing loved ones as a result of death. Each member gave a detailed account of how the children they were caring for lost their natural parents and the losses they suffered as a result. They identified the denial mechanisms that they had used to enable them to fulfil their daily responsibilities, but not their responsibilities to themselves. The loss of loved ones through AIDS, violence and disappearance were recounted one by one. Their inability to deal with these issues suggested to the carers that their children would also be struggling with similar issues and that they needed to acquire skills to help them.

Thembi bravely presented her demonstration of play with her niece. She was very anxious and froze into lengthy periods of silence and inactivity during the session. Her niece moved from one set of toys to the next, finding it difficult to focus. Thembi remarked at the end of the session that the times when she had questioned the child about her actions, the child moved on to the next activity. She had learned that it was not helpful to ask questions. The group, sensing her discomfort, praised her efforts to create an opportunity for the child to play when her own emotional issues were weighing so heavily on her shoulders. She responded to this feedback by breaking into a smile; something she had never done in any of the previous sessions.

The content that the group had learned about filial therapy seemed to be internalised by the members and slowly and deliberately members began to address their own unresolved emotional issues. This was largely possible as a result of the supportive climate that prevailed in the group. Whilst some of the problems experienced by the members could not be resolved through action, their talking about them helped to ease their tension (Andronico et al, 1969; Anthanasiou and Gunning, 1999). A general sense prevailed that given their circumstances, they were doing the best they could to parent their children. This marked the increase in their self-confidence as carers that had been noted in the study by Landreth and Lobaugh (1998).

### **Session eight**

Much of this session was taken discussing ways to help children cope with death, the

genogram and memory box as tools for helping children whose parents have died to retain a sense of identity, and bibliotherapy as a tool for discussing sensitive issues. Handouts were made available for members. Noxolo did a demonstration of play therapy at the close of the session.

The feedback from members about their play sessions in the home was positive. Thembi volunteered that she was making progress as she was playing with the child on a regular basis and could often identify the child's feelings although she was not always able to put her understanding in words. Her greatest concern was "She plays all over, quick, quick." This clearly described the behaviour the group had witnessed in the demonstration and Thembi requested that the volunteer assist her by continuing to supervise her sessions with the child after the group ended. Noxolo was surprised that her daughter's play reflected many of her own conflicts with her mother and discussed the punishment she had received from her mother since she had fallen pregnant seven years ago. Noxolo also mentioned that her daughter often acted out the teacher's harsh remarks about her son whom they suspected was hyperactive. The other members supported her observations and one added "this has become a window through which we can view the issues that our children have to deal with".

The general consensus was that the children had not been told the truth about their parents' deaths. Sibenzile shared, "there are so many customs about death that we don't understand so how are we supposed to explain these to our children?" Members debated the value of "showing the person" before the funeral. Some felt that this was too traumatic for the children, others felt that it was a way of helping the children accept the finality of death. A few members shared their experiences of adult children refusing to view the body at the funeral and that these people were often judged, rather than efforts made to understand their pain. The group accepted that there were no hard and fast rules to deal with death and it was more important to provide a warm and understanding climate for people who are grieving.

There were two members whose children were too young to understand their mother's death. This provided a natural way to introduce the Memory Box and Genogram to the

members. Sibenzile remarked that the information contained in those tools would have meant much to her when she entered the teenage years. Noxolo remarked that much of a person's belief about him/herself was taken on from their knowledge of his/her parents. This insight gave new meaning to the custom of "honouring the dead". The discussion of the memory box prompted Zodwa to start making notes about her deceased sister. She beamed about being given an opportunity to honour her sister's memory.

The demonstration by Noxolo reflected that she had grasped the basic concepts of filial therapy. She reflected the child's feelings, tracked the child's movements and sounds, and was totally available to her for that half hour. The child played in the dollhouse trying to find solutions to appease a grumpy grandmother. Noxolo received positive recognition from the group and once the child had left the session explained some of the dynamics that she had identified in the child's play.

The group were attentive when discussing the handouts "Helping Children Cope With Death" and "Making Your Story Book About Death". They were satisfied that the group had achieved this objective. Plans were made for the penultimate session. The members chose to discuss the theme on praise and encouragement that had not yet been dealt with. Makhosi was not present to be approached to do the last demonstration. It was decided that the group had enough to discuss without the demonstration, should Makhosi fail to arrive with her grandson.

### **Session nine**

Makhosi was present but did not want to do a live demonstration. As the group had chosen topics for discussion, this was not a problem. The handouts "Giving Recognition or Reinforcement" and "Praise Versus Encouragement" were read and discussed. A work sheet was used to provide members with an opportunity to practice the content covered in the handouts.

Members acknowledged that they tended to concentrate on shaping negative behaviour, at the expense of acknowledging the positive behaviour. They agreed that even though recognition was a basic human need, life was so busy that they failed to provide the people

around them with the necessary recognition. Praise was not a totally desirable activity, as it could also be used to manipulate others to internalise other people's values. Sibenzile questioned whether this wasn't why peer pressure was more powerful than parental pressure during adolescence. The discussion led the group to decide that the second handout, "Praise Versus Encouragement" was more helpful. Zodwa stated that when a person reflects another's feelings, that person is actually validating the other. Noxolo reflected that constant complaining and nagging could result in the person internalising the negative messages and result in their behaving according to the label they had been assigned. The group strayed off the topic as Sibenzile and Zodwa spoke of the need to protect children from the negative things that had been said about their deceased or missing parents. They struggled with trying to prevent the problems that had affected their children's parents' lives from affecting the children in their care. Members identified that they needed to concentrate on offering children more encouragement, but felt that insight was the first step towards change. Makhosi was more verbal in this session.

Arrangements were made for the last session. The group were asked to recall all that had been covered in the group up to this stage. The researcher-facilitator reminded the members of the research questions that had formed the basis for the study and the objectives that they had set for themselves at the outset of the group. They were asked to reflect on these before the next session. Arrangements were made for the tote bags that had been lent to them for their home play sessions to be returned at the next session. It was agreed that Thembi would keep the tote bag for an extra month as to terminate the sessions at that point would be premature. Members expressed their disappointment that their play sessions would be coming to an end, but agreed that the group had contracted to conduct ten play sessions and they had achieved that. An offer was made for members to keep the toys for an extra month and return them at the post group meeting, but eventually this suggestion was turned down as many members were going away for the holiday period or were having visitors to stay and the home play sessions would be impractical.

The group participation had become more impersonal. Members were withdrawing from one another and the researcher-facilitator was more active in processing and facilitating the group discussion. The regression of the group is characteristic of the ending or termination

stage of groups (Corey, 1990). Whilst some sadness was evident, the members reflected that the group had met most of their expectations and they were ready to generalise the skills they had learned in play sessions in their everyday functioning. The termination time had been pre-planned and members felt prepared for it. Whilst the members had enjoyed their sessions, they had taken up much time and members could return to meeting some of their other obligations. The group commented once again on the richness of the support that they had received from one another and hoped that these friendships would be maintained into the future.

### **Session ten**

Time was spent on reflecting on the changes that the members had observed in the eleven weeks that they had been together. Members provided one another with positive feedback. The researcher-administered questionnaire was read out and members completed these in the group. The final evaluation involved all the members in a focus group discussion. The topics for discussion were circulated amongst the members and they were asked to comment on whether they felt that the topics were suited to collecting data to answer the research questions that they had selected for this study. When members were in agreement about these, the focus group discussion commenced.

The findings were summarised on newsprint and verified with the members. Presentations of certificates of competence in Child Kinship Care Relationship Training were made. The session ended with a luncheon for the members. Arrangements were made for the follow up meeting which was scheduled for a month later. It was hoped that at this meeting the group would plan for the third stage of the project: the planning for marketing and implementing the project in the broader community.

### **Focus group discussion**

Seven topics were discussed, and the members' responses to the topics were noted:

**1. What information presented in the programme was relevant?**

The five members identified the magic of play, reflecting feelings, setting limits, and encouraging and reinforcing children as most relevant to their situations. No one mentioned the information on helping children to cope with death. When this was brought to their attention they explained that whilst the information had been interesting and helpful, it would not be incorporated into their daily interactions with their children to the same extent that the other four topics would. The general feeling was that all the information had been relevant to helping kinship carers enhance their relationships with the children in their care. Noxolo considered the principle of play therapy to be helpful as it facilitated the need for carers to be more accepting of the children in their care so that these children would believe in their potential and move towards self actualisation. The members concluded that they had struggled with reflecting feelings but this relationship skill had been instrumental in bringing about most of the positive changes that they had witnessed in their relationships with their children. The content covered was described as “useful”.

**2. What information was not useful for the purpose of this programme?**

The members did not identify any information presented during the sessions as unhelpful. The group concluded that all the information had been helpful, some more than others. Thembi reflected that the information on helping children to cope with death would have been more relevant had she had access to it soon after the deaths of her family members. Talking to the children in her care about death at this point seemed less relevant to her. Zodwa challenged that the genogram and memory box were relevant and that the information on helping children to deal with death served to help carers to become more aware of how children were affected by death, and how their unresolved feelings would manifest in their behaviour. They concluded that none of the information should be excluded.

**3. Was the content covered relevant to their culture?**

The members stated that the content was culturally relevant. The explanation given was that the concepts taught were different to those that they had internalised from

their families, but different did not suggest that they were irrelevant. At the outset of the group an objective set was to find new solutions to old problems. The content presented in the course did just that. The new concepts that they had learned had not interfered with their personal value systems, quite the contrary, there were similarities between the principles of the approach and the *ubuntu* philosophy. Compassion, respect, recognition of human dignity and empathy were regarded as core elements in both *ubuntu* and child-kinship care relationship enhancement training. The group sessions were suited to *ubuntu* as the training sessions placed more emphasis on the group than the individuals within the group, and created opportunities for collective responsibility which had been a major attraction that was responsible for bringing the group to where they were at termination.

The presentation of the new knowledge had been done in a respectful way. The group members felt that they had been included in determining the relevance of the content throughout the programme. The participatory nature of the learning approach adopted during the study encouraged them to rework concepts to suit their experiences rather than being taught concepts in a “top down” way. Members felt that by having reworked some of the concepts they could now be considered as relevant to each of them.

**4. Can you suggest further modifications to the programme that will ensure that it may continue to be regarded as suitable for locally specific kinship carers?**

There were five main suggestions made. The first was that the toy list needed to be amended to include more culturally relevant items. Those identified by these members were: a clay pot, a sjambok, a knob kierrie, a truck or mini bus car. Prior to the allocation of toys the members suggested the inclusion of a baby blanket and balaclava to preserve the cultural identity of their children. The items listed here are a part of the children of Umlazi’s everyday realities.

The second suggestion was more research should be undertaken into the importance of play and reflecting feelings in the Zulu culture. Whilst the members could see the parallels between play therapy and *ubuntu*, culturally specific information could have strengthened support for this approach even further. Members remarked that many of the people were moving away from their cultural heritage and information such as this could help to strengthen cultural ties. They anticipated that research of this nature would need to be conducted with the assistance of one of the universities.

The third suggestion related to the experience that their group had gained. They had amended the programme to spend more time on reflecting feelings and play and they believed that this was recommended for other groups in Umlazi.

The fourth suggestion was that in view of the busy realities of kinship carers, the format of the group needed to be changed so that the programme would not preclude people from attending. By altering the format to a two full-day programme and then having eight support sessions of one hour each in the late afternoons, they believed that more kinship carers would be reached without compromising the therapeutic benefits of the programme.

Finally, the term Child Kinship Care Relationship Training should be changed to a Zulu name. The group suggested *Indawo Yethemba*. The direct translation is “place of hope”. They felt that the programme provides kinship carers with hope for a better future. This was what they were all striving for.

#### **5. What did you enjoy most about sessions?**

Members stated that they had experienced the sessions as enjoyable as there had been a balance of information, practical exercises, and opportunities for interaction with one another. The communal nature of the sessions was seen to be an important element that led to the success of the programme. Comments such as “the togetherness and sharing made this experience meaningful”, “learning new ideas from others was nice”, and “we have developed special friendships with one another” provide evidence of the members’ sentiments. Members, with the

exception of Makhosi, enjoyed the opportunities to play with their children in their homes. Zodwa enjoyed the sessions because she found them to be practical. She said, “We learned, practised and then were sent away to do. The information was easy to follow and we felt as though we were making the world a better place for our children by using our new skills.” These sessions were seen to strengthen their relationships. They reported that their confidence as kinship carers had been restored, enabling them to deal with their pressures differently.

**6. What did you enjoy least about the sessions?**

Members found it difficult to conduct the live demonstrations directly in the presence of the others. The group remarked that this had impacted on their children’s play as most of the children had ended up playing silently, which was not characteristic of the play they had witnessed in the home sessions. Members reported that it was difficult to sit still for thirty minutes at a time in total silence. They suggested that by using the new format, members could arrange turns to be video taped by the group facilitator after the one-hour session. These tapes could then be played at the eight support meetings and serve the purpose of creating opportunities for observational learning. Members reported that much was to be gained from observing others.

**7. What suggestions do you have for improving the programme?**

Some of the changes suggested were discussed in other questions. In summary they were: to change the format to a two-day workshop and eight hourly support groups, to change the name to *Indawo Yethemba*, to include more information about Zulu culture regarding play, respecting others and empathising, to do away with live demonstrations of play sessions with children and use video recordings made after sessions, and include culturally specific items identified by the members. Further to these, the group proposed that the handouts and worksheets be compiled in a workbook form as working with loose sheets in a folder had been awkward.

**8. Other comments and decisions taken.**

The group agreed to meet in a month’s time to plan ways to market the programme. Members were enthusiastic about their experiences of filial therapy and wanted to

plan ways to create opportunities for kinship carers in the area to benefit from the programme. Firstly, they needed to tell the community of their experiences and the meeting planned would be used to decide how they would conduct the awareness campaign. Three of the members, Zodwa, Sibenzile and Noxolo indicated that they would like to assist in similar programmes as volunteers. The members expressed that they knew of no programmes on parenting issues that were available to members of their community and they felt that filial therapy had much to offer in this regard.

### **Conclusions drawn from the analysis of the ten group sessions**

The analysis of data suggests that members' experiences of filial therapy were similar to those outlined in the outcome of studies highlighted in Chapter Three. Four of the five members regarded filial therapy as a useful intervention for strengthening their relationships with the children in their care. Four of the five members reported significant changes as a result of participating in the study. Recognising the positive changes in themselves, they recommended the need to train other parents in the use of filial therapy. The five members learned that it was important to add play to their children's lives. The specific changes noted in their relationships were: members displayed a greater sensitivity to the children in their care and there was increased communication between the kinship carers and their children (Anthanasio and Gunning, 1999; Jang, 2000; Landreth and Lobaugh, 1998), the sessions provided members with greater confidence in themselves as "parents" (Anthanasio and Gunning, 1999; Rennie and Landreth, 2000); they began generalising the skills learned in the groups in their daily interactions with their children, and they reported a reduction in "parental" stress (Glazer and Kottman, 1994; Rennie and Landreth, 2000).

Because of the combination of didactic and dynamic elements of the programme, members discussed their own feelings and experiences pertaining to their emotionally and dynamically significant areas. This was a surprising finding because the sharing of the members had been so intense that the researcher-facilitator had only read about the

therapeutic benefits for parents briefly in two articles (Andronico et al, 1969; Bratton and Landreth, 1995). Many of the women had issues that they needed to work through and used the context of the group to address these. One can surmise that this form of emotional expression led to greater personal growth of members.

Three of the five members identified specific behavioural changes in their children that they regarded as positive and attributed to the play sessions. These kinship carers felt that they had been empowered to provide therapeutic help for their children. As indicated by Johnson (1995), filial therapy is a stepping-stone to family treatment. It appears that the kinship carers had been provided with basic child-centred play therapy skills that equipped them to become active in helping the children in their care (Rennie and Landreth, 2000).

There were distinct advantages of engaging members directly in shaping the model. They determined the content and therefore equipped themselves with skills that they considered as most relevant to their circumstances. Through involving them as active participants, they determined the pace at which the group worked. The researcher-facilitator could not “lose” them through following a structured programme. The members were actively engaged, thus making this a dynamic process rather than one that was too didactic. There was much repetition which is typical of an experiential learning model – a circular process of doing, reviewing, analysing, and generalising results in lasting learning (Schenk and Louw, 1995). As a result, several themes of Landreth’s adapted ten-week model (Ravat, 2001) were not covered. Some handouts had been excluded because they were too Americanised and did not translate easily into Zulu. These topics that were excluded were: “Dealing with Aggression”, “Structured Doll Play”, “When Discipline Doesn’t Work”, “Learning to be Perfectionistic”, “Let’s Not Forget to Play”. There were several topics that were included at the request of the members: they were “Feelings”, “The Feeling Chart”, “The Five Principles of Child-Kinship-Relationship Training”, “The Memory Box” “Helping Children Cope With Death” “The Magic of Play”, “Making your Story Book About Death”. All the handouts and exercises were translated into Zulu.

The sessions were longer than the one and a half to two hours that were recommended (Landreth, 1991; Ravat, 2001; Van Fleet, 1994). More time was allocated for two reasons: firstly, all the members were Zulu speaking, and secondly, the group had to address

research matters. Land and Hudson (1997) made a valid observation. They pointed out that apart from language differences, cultural issues also increase interview time. The oral traditions of a culture encourage members to respond to questions in a non-linear style, through dialogue and story telling. This was the researcher-facilitator's experience of working with this group.

**Table Two : Overview of the differences and similarities between the Landreth model and the locally specific model**

	Landreth model	Locally specific model
<b>Name of the group</b>	Filial Therapy	Indawo Yethemba
<b>Pre group contact</b>	Pre group interviews	Pre group session
<b>Number of sessions</b>	10	10
<b>Rituals</b>	Refreshments	Chorus singing. Prayers Refreshments
<b>Toys</b>	As per handout.	As per handout plus: clay pot, sjambok, knobkierrie, truck/minibus, baby blanket, balaclava.
<b>Type of group</b>	Closed.	Open, other members of the community come to observe.
<b>Video</b>	Parents film at home and bring to session	Filmed at the session.
<b>Exercises</b>	Written and oral	Oral
<b>Take home exercises</b>	Homework set	Practice sessions set.
<b>Duration of sessions</b>	1 ½ to 2 hours	2 ½ to 3 hours
<b>Evaluation</b>	Standardised measures and evaluation schedules	Focus group discussion and researcher administered questionnaire.

Similar to the study by Glover and Landreth (2000), the need to amend the programme to best suit the specific context in which it is presented was noted. Several recommendations to modify the programme were made by the members. These were discussed in the section detailing the outcome of the focus group discussion. Table Two details some of the similarities and differences of the Landreth model and the locally specific one. It reflects

the ways in which the Western model was adapted to suit the kinship carers in who participated in the study. The consolidated outcome of their efforts was the workbook with adapted exercises and handouts (Appendix IV).

**Table Three : Differences and similarities in the programmes**

	<b>Landreth Model</b>	<b>Locally specific model</b>
<b>Session One</b>	Overview of filial therapy. Group introductions. Video: Children's emotions. Listening. Reflective listening.	Introductions. Kinship carer collage. Five principles of child-kinship relationship training. Expectations of the group. Group norms.
<b>Session Two</b>	Child parent relationship training. Constructing therapeutic responses. Video demonstration.	Defining group objectives. Foster care applications. Listening. Reflective listening. Four Faces Feeling Chart.
<b>Session Three</b>	Basic rules for filial therapy. Three steps to setting limits. Let's practice setting limits. Parent demonstration tape.	Five principles of child-kinship relationship training. Four Faces Feeling Chart. Toy materials. Facilitating reflective communication.
<b>Session Four</b>	Let's practice setting limits. Giving choices. Structured doll play. Parent demonstration tape.	Five principles of child-kinship relationship training. Child parent relationship training. Three steps in setting limits.
<b>Session Five</b>	Thoughts on aggression. When discipline doesn't work. Parent demonstration tape.	Play exercise - dough. The magic of play. Role-play playing. Parent demonstration.
<b>Session Six</b>	Common problems in sessions. Practising : Reflective listening; setting limits; giving choices. Building self-esteem. Parent demonstration tape.	Feelings chart. Three steps for setting limits. Let's practice setting limits. Five C's of effective discipline. Parent demonstration.
<b>Session Seven</b>	Positive reinforcement. Let's not forget how to play. Learning to be perfectionistic. Parent demonstration tape.	Rules for child-kinship relationship training. Personal reflections on loss. Parent demonstration.
<b>Session Eight</b>	Explaining death to children. Parent demonstration tape.	Helping children cope with death. Genogram. Memory box. Making a story book of death. Parent demonstration.
<b>Session Nine</b>	Evaluating change. Parent demonstration tape.	Giving recognition and reinforcement. Praise vs. Encouragement. Let's practice giving encouragement. Preparation for termination.
<b>Session Ten</b>	Collect evaluations. Handout diplomas.	Dealing with unfinished issues. Feedback to members. Focus group evaluation. Return tote bags.

## **Themes that emerged during the study**

The researcher-facilitator identified three themes during the study. They were: the impact of cultural influence on participants' abilities to reflect feelings, to engage in direct play with their children, and help children cope with death. The fourth theme was adapting the programme to make it locally specific. The themes have been raised in the recordings of the case studies and the report of the focus group discussion and so will receive brief mention in this section.

Filial therapy is an approach to helping which was developed in the United States of America. Whilst several studies have been conducted with other cultural groups (Chau and Landreth, 1997; Glover and Landreth, 2000; Jang, 2000), it must be acknowledged that it is Eurocentric in origin. The study that was conducted was situated in a culture that was more collective in nature and cognisance had to be taken of the differences of the individual and collective paradigms when working with this group of kinship carers. The differences in individualism and collectivism may offer a possible explanation for the different emphases that the group members placed on reflecting feelings, engaging in direct play with children and helping children cope with death than those suggested in the literature. Individualism is described as placing more emphasis on the individual than the wider community, whilst collectivism is seen to recognise the individual more in terms of his or her contribution to society (Collins, 1999). This may translate into major differences when people of different cultures deal with or view the life crises and developmental stages of their families.

It was not possible in a study of limited scope such as this to address these deeply seated differences in paradigms. Further research into this area is indicated. The researcher-facilitator suggests that the three themes identified may have presented as different because of the differences in the collective versus the individual paradigms. Filial therapy has developed within a culture representative of individualism and the research participants have grown up within a collective paradigm. The researcher-facilitator and group recognised the differences but did not believe that they were problematic. Collins (1999) made a salient comment, "In South Africa, the transfer of knowledge and diffusion of values between cultures is occurring as a fast rate" (p.11) and in order for people of

different cultures to work together they have to acknowledge their differences. This may result in blending the strengths of each culture in order to create a high standard product.

### **Reflection of feelings**

At first, members found this a difficult concept to learn, especially within their interactions with the children in their care. Their style of communicating with children tended to be more authoritarian, characterised by many questions being asked and just as many instructions being issued. Because respecting elders was regarded as so important in their culture, any sign of negative expression by a child was interpreted as a sign of disrespect. Children in these homes soon learned that it was inappropriate to show anger and disappointment. As early as in session two members remarked that dealing with feelings was difficult and confusing and they were not accustomed to singling out feelings and labelling them. Careful review over the next few sessions revealed that the reflection of feelings was permissible when the feelings experienced were positive such as happiness or surprise, but became less appropriate when negative emotions such as anger or disappointment were ventilated. “Because we’re only allowed to express feelings such as joy or happiness, and never feelings like anger, we just stop focussing on our feelings and submit”, was the explanation given by a member in session four.

With time the members indicated that the expression of feelings was not “inappropriate” but different and they were willing to experiment with using reflection in their interactions with their children. Because the technique appeared new to them it was said, “this is something new that is going to take time and practice.” At first they were frustrated by the limited number of Zulu feeling words in their vocabulary and with time were relieved to learn that they could use simple phrases such as “you like that” and “you don’t like that”. Then it occurred to them that it was easier to use metaphors to describe feelings and that this was fairly characteristic of their conversations with others. This seemed to bring about change. Good progress was reported. As members practised, they realised that reflecting a child’s feelings did not necessarily imply agreeing with the child, or giving into the child, but merely accepting the child’s interpretation of his or her emotional state and mirroring this back to the child, so that the child would feel understood.

At termination members commented that they had taken great strides in identifying their children's feelings, and were competent at reflecting basic feelings. It was concluded that "reflecting feelings does not go against our culture, but is just a different way of doing things" and that the improvement in the quality of their relationships could be largely attributed to this relationship technique.

An area related to the reflective listening was members' limited opportunities to deal with their own feelings. The tragedies that they had experienced often lay deeply buried inside them. As explained by one member, "In Zulu culture, it isn't easy to talk about your feelings. Even when horrible things happen to you, you have to keep your thoughts and feelings about these issues to yourself." It seemed that as the members became more in touch with the feelings of their children, they slowly opened the door to the secrets that they had been harbouring within themselves. Each member spent time reflecting on previously denied inner experiences. This opportunity for personal growth had not been anticipated.

### **Play**

The realities of the kinship carers were that they were burdened with responsibilities, had limited resources and had not reflected on the benefits of play for children. At the start of sessions Makhosi, who had been told that the intervention to be learned involved learning to play with their children, said, "they must get on with it. I can't play. I'm too old." Also, when the group was asked to describe the play opportunities for children in the township they said, "children must just get on with playing by themselves or their friends, and usually this happens in the street."

Members did not recall play as a form of interaction between significant adults in their lives and themselves whilst growing up. They rationalised that they had come from big families and their parents could never have had the time to play with them. Play was described as a superficial activity that children engaged in for pleasure alone. Unstructured play activities that they described as characteristic of the play of township children involved playing cricket or football in the street, imaginary games such as teachers and mothers in the home, drawing, climbing and swinging in trees, skipping, or wrestling. Toys that the children

were familiar with were guns, knives, cars and blocks. Mostly, children relied on their own imaginations.

The play sessions and discussions alerted members to a totally different dimension of play. To assist them in their understanding of the subconscious element involved in play, the researcher-facilitator created opportunities for the kinship carers to play. Simple exercises using pictures from magazines, play dough, handling the toys from the tote bag and having their own play sessions facilitated by another member alerted them to the power of play. One member remarked, “This is powerful. I didn’t choose the pictures. They chose me.” They became aware of the emotional release, opportunities for creative expression, mastery and problem solving that are intrinsic in play. Once they had learned to overcome their inhibitions they became fully immersed in the world of play.

When the sessions with children began and they witnessed thematic play representing the life struggles of their children, recognised the children’s abilities to resolve these issues using only their inner strength and ingenuity, the mediums provided in the tote bag and the supportive relationships with their carers, they started to acknowledge the “magic” of play. Suddenly play became much more: a non-threatening medium for understanding their children, an opportunity to validate them, a tool to use to strengthen their relationships, an arena for them to find their own solutions to their problems, a place for free expression.

There are several realities that cannot be escaped when working in this community. The homes are very small and are not conducive to creating the right context for home sessions. Because of the communal nature of living arrangements, it was difficult for members to create privacy and freedom from interruptions. The large numbers of children living in the homes of kinship carers meant that it was difficult for the carers to provide every child a turn to play, and when they failed to do this, they feared that it would be interpreted as putting the needs of some family members above others. These are issues of filial therapy that need to be addressed if this model is to be used more widely in this context. However, the researcher-facilitator contends that the benefits of the play sessions far outweighed the limitations of their settings.

## **Death**

The researcher-facilitator found this to be a perplexing area. Even the members were confused. “There are so many customs about death that we don’t understand. How are we supposed to explain these to our children?”

The experience of working with these women revealed that death was a visible force against which they seemed to have to constantly and unrelentlessly struggle. Members frequently recounted incidents involving the loss of family and friends through AIDS, crime and political violence during sessions. Whilst they had requested skills to help children cope with death, it became apparent that they had few to help themselves. Mostly, the members dealt with death by denying the awful realities. They continued to struggle with meeting the demands of the daily lives in their attempts to avoid acknowledging the harsh realities and complications created in their lives by the loss of loved ones. Several members were forced to put their personal lives on hold to meet the needs of the children left behind. Usually, this was done with kindness and love, but other times, as experienced by Thembi there were moments of resentment and regret. The members had a need to talk about their losses in the group and whilst this did not lead to positive action it seemed to ease their pain. Members frequently commented on the benefits of the support provided by the members in the group.

Death seemed to be a closed topic in these families. “It’s all wrong, we never tell our children the truth about serious matters such as death”, “we do not talk about the children’s deceased parents”, and, “I’m worried about the family not having been honest about the death of the mother of the child” were common laments recorded during sessions. Members were confused as to whether to continue with the conspiracy of silence or force disclosure. They could not reach a consensus on the matter.

The benefits of disclosing were that the children would be brought closer to finding out about their parents. One member stated that by breaking the silence the children would be helped to move on with their lives, as the keeping of secrets was likely to lead to unpleasant consequences. A member who had lost her mother at the age of eight shared that not talking about her mother’s death had robbed her of the opportunity of ever knowing

anything about her mother. She was saddened that no one had thought of telling her about her mother, as she believed that this would have eased some of the dilemmas she faced during her teenage years.

The group resolved that there were “no hard and fast rules of how to deal with death” and that as far as their experiences had taught them, providing a warm, understanding climate for those who were grieving was the best action they could recommend. The suggestions of the memory box and genogram were regarded as helpful in that they could be used to restore the child’s sense of identity at a later stage in his or her life. The insight that they gained from discussing death was that as much of a person’s belief about himself or herself was taken on from the knowledge of his or her parents, children needed to be told about their parents. A member suggested that this could explain why “honouring the dead” was considered as so important.

## **Limitations**

There are limitations within any study. The limitations identified in a study should not detract from the benefits of the study. Rather, they should help to shape further endeavours in similar research or practice attempts. The limitations that were identified by the researcher-facilitator will be discussed.

The greatest limitation of the study was the process used to recruit the research participants. The agency provided the researcher-facilitator and volunteer with a list of names of cases who they felt might benefit from the programme. The researcher-facilitator and volunteer contacted these carers without any introduction from social workers. This amounted to little more than cold-canvassing. It can be assumed that the researcher-facilitator was regarded with suspicion and uncertainty and this may explain why only six of the eleven members arrived for the orientation meeting. In other words, it may have influenced the group size. The social workers had not taken heed of the criteria for membership and many of the names provided were unsuitable in that the children were too old, the kinship carers

were working and could not attend meetings, or, as in the case of Makhosi, too old to want to learn new skills.

Because there had been limited time to establish a personalised and trusting rapport with members before the orientation meeting, members were reluctant to participate in pre group interviews and elected to deal with pre group interviews at an open meeting. It is difficult to say whether the benefits of pre-group interviews would have influenced the outcome of the group in any way, but they were recommended in the literature (Landreth, 1991; Van Fleet, 1994).

Whilst six to eight members is the recommended group size for filial groups, starting with six members definitely impacted on the group. It became problematic when one member was forced to withdraw from the group for personal reasons. The interaction between members remained high, but more members provide more diversity of ideas and more live demonstrations.

A smaller limitation was the language problem. The researcher-facilitator spoke no Zulu. Whilst members made a concerted effort to understand her and make themselves understood, and there were always members who were willing to interpret, it can be expected that some of their meanings may not have been captured fully.

At first, the researcher-facilitator relied on the agency to provide one of their volunteers for the project. The volunteer's authoritarian style was not suited to the nature of the group. She lacked commitment to the programme. By recruiting a second volunteer who was genuinely interested in the programme, had been trained in person centred intervention, the problem was obviated. This volunteer helped to screen materials for the programme and checked the translations into Zulu before they were allocated to members.

Sadly, the toys lent to the members had to be returned at the end of the sessions. It would have been more beneficial for members to retain the tote bags and continue with the "home sessions" until the children indicate that they no longer have a need for them (Van Fleet,

1994). This problem should be addressed in future filial therapy projects to ensure that the therapeutic process is not terminated prematurely.

Finally, as noted by the members, the sessions were too long and cut across members' time making it difficult for them to meet some of their other commitments.

## **Summary**

This chapter has served to detail the empirical findings of this study. The interpretation of findings relied on qualitative methods. Triangulation was used to obtain several different perspectives on the use of filial therapy with kinship carers. It was hoped that by combining case studies, video recordings, semi-structured interviews, a focus group discussion and researcher administered questionnaires, the findings would provide readers with "a more substantive picture of reality; a richer, more complete array of symbols and theoretical concepts, and a means of verifying many of these elements" (Berger, 2001, p.4).

As a participatory research design was used and the analysis of data was based on grounded theory, no quantitative analysis was necessary. The methods used to analyse the findings were consistent with the theoretical framework that guided the study.

The findings of this study suggest that filial therapy was an effective means of strengthening the relationships of the kinship carers who had participated in this study with the children in their care. These carers had benefited from the group support and had succeeded in adapting the Western model to make it more locally specific. The efforts of the research participants were consolidated into a workbook (Appendix IV). The findings and principal recommendations of the members and the researcher-facilitator are consolidated in Chapter Seven.

## **Chapter Seven**

### **RECOMMENDATIONS AND CONCLUSIONS**

#### **Introduction**

This chapter reintroduces the study's rationale and the central issues that stimulated the research process. A broad overview of the main findings are presented and linked to the study's theoretical framework. Finally, the principal recommendations from the participants, as well as those of the researcher, are discussed.

#### **Rationale and Context**

Violence, poverty, social disintegration and AIDS are common factors that rob children of their parents. The number of children living with their extended families is rapidly growing (Joubert, 1995). Many of these arrangements are informal placements that secure limited services and protection for both carers and children. Whilst social workers recognise the need to develop specialised services for this sector, the demand exceeds the supply. The heavy emphasis placed on the statutory requirements of these placements curtail social workers' initiatives to provide the much needed remedial and preventive services to these families.

Many of the children in kinship care have experienced some trauma by the time they reach their kinship carers. The core experiences of trauma reported are disempowerment and disconnection (Robertson, 1999; Van Dyk, 2000). Unless they are able to resolve the psychological harm caused by their circumstances, the psychological and physical symptoms they experience can impair their lives forever (Robertson, 1999).

There were two topical issues that were given consideration when the researcher-facilitator contemplated methods for developing services for this group. The first was the call for social workers to “engage themselves in wider socioeconomic, environment and geopolitical arenas in order to change the circumstances under which the poor, the unemployed and the marginalised find themselves” (Ferguson Brown and Partab, 1999, p.138) rather than developing remedial services. The second was that traditionally social workers were reliant on European and American models of mental health without evidence that these models were suited to the diversity of South Africans (Joubert, 1995). The researcher-facilitator hoped to address both these issues in her selection of an intervention method for kinship care. The intervention needed to combine the developmental and clinical paradigms to provide victims of trauma with therapeutic intervention but at the same time empower families to develop healthy lifestyles. Secondly, the researcher-facilitator wanted those in need of the service to be actively engaged in developing a model for helping that they considered relevant and meaningful.

The literature indicated that filial therapy is a unique form of training that combines instruction in play therapy and parenting skills with the main purpose of helping parents to become therapeutic agents in their children’s lives, whilst at the same time strengthening their families. Filial therapy fulfilled the first criterion of the researcher-facilitator’s requirements for an intervention method as it combined treatment and prevention. The literature reviewed suggested that successful results had been gained when using this intervention with different cultural groups: Chinese families, Korean families, Native Americans, and middle class South Africans (Arnott, 1998; Chau and Landreth, 1997; Jang, 2000; Rennie and Landreth, 2000). Unfortunately, these studies failed to provide information regarding the processes followed to adapt the model for the unique and diverse needs of communities that were studied. It was decided that if filial therapy was a possible intervention for kinship carers in the Umlazi area, then in order to meet her second criterion, kinship carers should be directly involved in developing and evaluating the locally specific version to ensure that it would be culturally specific.

A participatory research design was used to engage a group of kinship carers from the Umlazi area to adapt the Western model of filial therapy to create a locally specific model that could be used by other kinship carers in the Umlazi area to improve the quality of care that they would receive in the future.

## **Theoretical Framework**

As noted in Chapter One, the study was guided by two theoretical approaches; the person-centred approach, and participatory learning. These theories helped the researcher-facilitator organise her observations and make sense of things as was suggested by Rubin and Babbie (1997).

The person-centred approach guided the researcher-facilitator to place high regard on the research participant's unique perceptions and experiences of kinship care and filial therapy. In keeping with the principles of person centred theory, the research process was kept democratic and collaborative. The research participants were consulted about any decisions that had to be taken. The research participants determined the pace at which their group progressed. They were active in making decisions about the contents of the filial therapy, determined the research questions and evaluated the programme. The researcher-facilitator communicated her belief in the group's ability to move towards self-sustaining actions and underplayed her "expert" knowledge of filial therapy. Person-centred theory defined the researcher-facilitator's role throughout the study as facilitator rather than expert. The researcher-facilitator emphasised creating the right climate for members to deal with their symbolised and unsymbolised experiences. The conditions of unconditional positive regard, empathic understanding and the researcher-facilitator's congruence were central to developing this positive climate for members to critically examine their lives. As a result of the unconditional acceptance demonstrated to each member, they lowered their defences and recognised their innate strengths and abilities to deal with kinship care issues. It was hoped that as the members became more accepting of themselves they would become more accepting of the children in their care.

Participatory learning influenced the researcher-facilitator to build on the knowledge that the research participants already had. The members were recognised as having unique experiences and perceptions that could contribute to the knowledge that the researcher-facilitator needed to develop. The process throughout the research process involved uncovering the group's own solutions, ideas and strategies for resolving their problems as kinship carers. The members were directly involved in deciding on the content, presentation and evaluation of the group sessions. The rich dialogue that transpired in the sessions was encouraged. The specialised knowledge of filial therapy was shared as and when the members requested it. The experiential approach of doing, analysing and generalising was used throughout the study.

## **The Research Approach**

The researcher-facilitator used a qualitative research paradigm which was consistent with the theoretical framework that guided the study. It was a field focused, exploratory study with kinship carers in Umlazi to explore whether filial therapy was an appropriate intervention for kinship carers in order that they could adapt it to create a locally specific model. The outcome would determine the feasibility of conducting further research into the topic (Collins, 1999). The researcher-facilitator selected a participatory research strategy for the study as it was regarded as most suited to the study's aims and objectives and was in keeping with the theoretical framework that underpinned the study. The researcher-facilitator planned on using the kinship carers in every step of the research process. The research participants were involved in collective action, developing knowledge, educating, generating their own change and empowerment (Van Rooyen and Gray, 1995). The research approach was not directed by the formation of hypotheses but research questions that the research participants determined themselves. Careful attention was given throughout the research process to gathering data that were rich in detail to answer these questions.

## **An overview of findings**

At the outset of the formation of the research group, the research participants were advised that the group was formed to explore the usefulness of filial therapy as an intervention to engage kinship carers from the Umlazi area in providing support for the children in their care. The second tentative purpose they were given was to ascertain whether they could adapt a Western model of filial therapy to a locally specific intervention through their direct participation.

The research participants refined these two purposes into three critical research questions:

- Would the participants in the study consider filial therapy to be a worthwhile parenting education service, which strengthened their custodial relationship with the children in their care?
- Would the participants in the study benefit from the support from other filial therapy group members and would this support empower them to cope with the challenges of parenting the children of their deceased or absent relatives?
- Was it possible to adapt a Western model of filial therapy to a locally specific form and what role would the participants play in developing this model?

Chapters Five and Six discussed the data collected to investigate these questions. This section will present a summary of the major findings.

### **Filial therapy as a parenting education service designed to strengthen custodial relationships of kinship carers**

In general the research participants stated that filial therapy had been successful in strengthening their custodial relationships with their children. This outcome was consistent with results of studies discussed in the literature review (Bratton et al, 1998; Arnott, 1999; Glazer and Kottman, 1994; Glazer-Waldman et al, 1992). The specific changes identified by the participants in this study were:

- A greater sensitivity to the feelings experienced by their children as was indicated in similar studies reviewed in the literature (Bratton et al, 1998; Bratton and Landreth, 1995; Glazer and Kottman, 1994; Glazer-Waldman et al, 1992; Johnson et al, 1999; Landreth and Lobaugh, 1998; Rennie and Landreth, 2000).
- Increased communication between themselves and their children as reported in the literature by Glazer and Kottman (1994) and Guerney (2000).
- The reduction in stress associated with having acquired improved parenting skills, such as techniques for disciplining their children. This outcome was consistent with the findings of other outcome research (Bratton et al, 1998; Bratton and Landreth, 1995; Glazer and Kottman, 1994; Landreth and Lobaugh, 1998; Rennie and Landreth, 2000).

Central to the participants' improved relationships with their children was their increased understanding of the value of play in their children's lives. They reported a major shift in their attitudes about play. The value of play had been highlighted in the literature study and references were made to the writings of Ginsberg (1976), Guerney (1990), Johnson (1995), Landreth (1991) and Moustakas (1997). From their former description of play as a superficial activity that children engaged in for pleasure, they had come to regard it as a more meaningful activity. They recognised play as:

- A medium for understanding their children.
- A technique that alerted them to the issues that their children were dealing with, but unable to express in language.
- A means of strengthening their relationships with children.
- An opportunity for validating children.
- Provided a safe place for children to experiment with problem solving skills and creative endeavours.

Most members described themselves as more confident in their custodial role by the time the group sessions were nearing termination. The skills they learned were generalised in their daily interaction with their children. They felt empowered to provide help for their children and concluded that filial therapy had been a worthwhile parenting education

service.

### **Filial therapy as support for kinship carers**

The literature in Chapter Two highlighted kinship carers' need for support (Bratton et al, 1998; Burton, 1992; Jendrek, 1993). In the attempts of kinship carers to satisfy the needs of those they are responsible for, they overlook their own personal needs. Supportive understanding is a common need kinship carers express. As many of their earlier support networks become disrupted by their "parenting" role they may experience loneliness and isolation (Bratton et al, 1998). Filial therapy combines educational input and dynamic interaction with other group members and the support it offers members acts as a powerful catalyst for change (Andronico et al, 1967; Bratton et al, 1998; Bratton and Landreth, 1995; Burton, 1992; Jendrek, 1993). There were conclusive findings in this study that indicated that group members had benefited from the support that members received from one another. All members commented that the support of the group had been a satisfying experience. The group had provided members with:

- An opportunity to talk about their problems
- An opportunity to exchange ideas of how to manage their problems
- Relief of knowing that others had experienced similar concerns and had dealt with their problems successfully
- Encouragement to tackle their problems
- Information
- Friendship

These factors increased their confidence and decreased their stress levels. The research participants concluded that the support that they received from one another had helped them to cope with the challenges of their roles as kinship carers.

### **Research participants' experiences of developing a locally specific filial therapy model**

The group met for ten weeks. In their roles as research participants and filial group members they constantly reviewed the content, tools and techniques central to filial therapy. Their personal experiences during the ten-week course presented evidence that the locally specific model that they had developed for themselves had strengthened their roles as kinship carers and increased their sense of well being. They believed that their adapted model would benefit other kinship carers in the Umlazi area. Whilst group members addressed some cultural issues in adapting their model, they suggested that it needed to be continually reworked and modified to ensure that it would evolve into an even more culturally specific intervention. Whilst they believed expert knowledge from a training institution would help in this regard, they also believed that the model would evolve into a culturally relevant format as different kinship carers added their “expertise” of Zulu culture with time.

There were similarities between the person-centred philosophy on which filial therapy is based and the *ubuntu* philosophy such as compassion, respect, recognition of human dignity, and empathy (Mbigi, 1997). The benefits of collective responsibility typical of *ubuntu* seemed to strengthen the supportive role members of the filial group fulfilled for one another. The research participants included rituals of singing and praying at the start of sessions which increased group solidarity. They developed a Zulu name for the programme. The members developed the content to be more culturally relevant. They identified some concepts central to filial therapy as “different”. Through open dialoguing and the participatory approach adopted during the group process, members reworked the concepts until they felt that they were consistent with their values and beliefs.

There were three areas that the group identified as culturally different. These were reflecting feelings, dealing with death, and play. The knowledge of the group was seen to compliment that of the “expert” facilitator (Schenck and Louw, 1995). Just as the members had been affected by the knowledge that the researcher-facilitator had shared, so she became affected by their values and insights. Collins (1999) referred to this process as a process of mutual transformation. Dialoguing was an essential aspect to the mutual

transformation. The process of mutual transformation was evident throughout the adaptation of the model. The direct and active involvement of the research participants was therefore critical to the development of the knowledge which resulted in the planning and achievement of the locally specific adapted version.

The differences and similarities of the Western model and the group's own locally specific one were discussed in Chapter Six in the section that detailed the conclusions reached at the termination of the ten group sessions. The consolidated adapted model is presented as a workbook (Appendix IV).

The research participants developed clear recommendations for the future use of filial therapy with kinship carers in the Umlazi area. These evolved during the study and were based on their own experiences. These are referred to in the next section briefly.

### **Contributions of the study**

The model was developed for use by the Durban Children's Society to increase social work leverage to strengthen kinship care placements. It combines a parent education programme with therapeutic intervention for children which is offered by the kinship carers themselves. The workbook (Appendix IV) has been completed with sufficient depth and detail for the model to be replicated by other interested practitioners. The possibilities of developing this model to service other target groups such as childminders and non-kinship foster placements are enormous.

Social workers are at the forefront of addressing the break down of families. Whilst kinship care is not a new phenomenon, it is an ever-increasing one that this profession has to tackle. When kinship care placements are orchestrated with care, they help to strengthen the quality of life for the children and carers involved. The model developed in this study provides social workers with a service that offers kinship care families opportunities to strengthen their reconstructed families and support to enable them to cope with the

challenging issues intrinsic to these placements. There are two distinct advantages which emerged from this study. Firstly, this locally specific model of filial therapy provides social workers with an opportunity to combine direct, remedial practice and preventive practice in keeping with the recommendations of the White Paper for Social Work (1997) and integrated practice as typified in the tradition of the profession. Secondly, it used principles of collective action, participation and empowerment which are critical to challenging social problems and social change in our context.

### **Recommendations of the study**

Through the meaningful interaction between research participants and the researcher-facilitator, valuable recommendations for further endeavours to use filial therapy as an intervention for kinship carers in their township were identified. These are discussed in this section.

#### **Recommendations of the group participants**

The main recommendations formulated by the members are briefly summarised.

- In order for the programme to be sensitive to the demands placed on kinship carers' time, they suggested that the format be modified. They recommended that the programme be presented in two full days and be followed by eight weekly support group sessions of one hour each in the late afternoons.
- The list of toys needed to be modified to include specific culturally appropriate items.
- Ethnographic research into the concepts of play, reflection of feelings and death should be conducted to explore and obtain a deeper understanding of these issues.
- The model should evolve with time and be influenced by fellow kinship carers who have unique contributions to offer.
- That a workbook be compiled from the handouts and exercises for future use with other groups.
- That a follow-up meeting be arranged to plan ways to market the programme in

their community.

### **The researcher-facilitator's recommendations**

Emerging from the researcher-facilitator's own experience of working with kinship carers are additional suggestions. These suggestions are discussed in three categories: research, policy and practice.

#### **Research**

The study indicates that there are several possibilities for further research into the use of filial therapy. The research topics proposed should increase professional leverage and lead to effective efficient practice. These opportunities include the following:

- A quantitative study measuring the benefits of filial therapy for carers and children.
- Comparative studies between kinship carers who have completed the programme and those who have not.
- The development of a similar model for child care workers working with children in children's homes.
- The development of a similar model for nurses, teachers and child care workers working in townships.

#### **Policy**

The development of direct and preventive services for kinship carers should not blind practitioners to the broader influences that impact on the lives of kinship carers. Further issues which social workers should constantly reflect upon and challenge include:

- The need to attend to women's personal issues within the broader context of gender, culture and socioeconomic status instead of trying solely to provide a template approach to kinship care service provision.
- Social workers should be asking whether kinship carers are satisfied with the access

to services, the sufficiency of service delivery, and what their needs are in order to lobby for change.

## **Practice**

The experience of facilitating this group has alerted the researcher-facilitator to a number of issues. These are discussed.

- A third phase of the project needs attention. The locally specific model has been developed and the research participants are poised to move into the “action” phase. It is envisaged that the research group will continue to meet to plan ways to launch the adapted model in their community.
- The timing for the next filial group for kinship carers should coincide with the orientation meeting for foster care applications. This will provide the social worker with a public platform to discuss the nature of the group and recruit members. It is envisaged that three of the research participants will be involved in this.
- More social workers should be trained in the use of this didactic and dynamic model for assisting and empowering families in distress.
- The participatory approach used in this study is a powerful model which needs to be given a greater platform especially in our country where the diversity of people necessitates the evolution of locally specific practice.

## **Conclusion**

Kinship care presents social work with new challenges. Whilst the benefits of placing children with relatives are substantial, there are several risks involved. In the context where the study took place, the carers who participated in the study described themselves as living in compromised circumstances. They were unprepared for the suddenness of the changes resulting in having extra children to fend for. Their need for support and educational services, as highlighted in the literature, was most evident.

A multitude of factors associated with kinship care have been identified that make it

especially difficult for carers to maintain healthy relationships with the children in their care and make positive contributions to their development. Filial therapy offers significant possibilities for promoting the well being of these families by equipping carers with healthy parenting and relationship skills, whilst providing them and their children with emotional support.

An overview of the literature clearly indicates the efficacy of using filial therapy with a broad range of specialised groups. Only one study referred to its application with custodial grandparents suggesting that further research in this area was indicated (Bratton et al, 1998). Rather than replicate the Eurocentric model for use with kinship carers, the researcher-facilitator engaged a group of kinship carers in participatory action to develop and evaluate their own adapted version.

Speaking eloquently to the experience of facilitating Participatory Research, Lindsey and McGuinness (1998) said,

“It’s like trying to describe how to paint a Picasso. You can teach people about colour, you can teach them about form, you can teach them about structure, and the paintbrush and what its bristles are like. And you can talk about different kinds of paper, and you can talk about what kind of music they can play to inspire them, and you can talk about all sorts of other things. But the bottom line is that when the image unfolds on the paper there is a flowing of creativity from the wholeness of the person” (p.1113).

With the participative nature of this study, kinship carers were invited to allow their “wholeness” to flow and create a new service that could benefit others in similar circumstances. It is hoped that in some way this study will benefit other kinship carers and children in their care.

## REFERENCES

- Arnott, A.N. (1998). **An educational psychological perspective on the use of filial therapy in mother - child relationships**. Pretoria: Unpublished Master's Dissertation.
- Andronico, M.P., Fidler J., Guerney, B., Guerney, L. (1967). The combination of didactic and dynamic elements in filial therapy. **International journal of group psychotherapy**. Vol 17(1): 10-17.
- Anthanasiou, M.S., Gunning, M.P. (1999). Filial therapy : effects on two childrens' behaviour and mothers' stress. **Psychological reports**. Vol 84(2): 587-590.
- Axline, V. (1971). **Play therapy**. New York: Ballantine Books.
- Babbie, E. (2001). **The practice of social research** (9th edition). Belmont: Wadsworth/Thomson Learning.
- Barrett, C., McKerrow, N., Strode A. (1999). Consultative paper on children living with HIV/AIDS. **The South African Law Commission**. Pretoria: Government Press.
- Berg, B.L. (2001). **Qualitative research methods for the social sciences** (4th edition). Long Beach: Allyn & Bacon.
- Berrick, J.D. (1997). Assessing quality of care in kinship and foster family care. **Family Relations**. Vol 46(3): 273-281.
- Blackman, J.A., Westervelt, van D., Stevenson, R., Welch, A. (1991). Management of preschool children with attention deficit-hyperactivity disorder. **Topics in early childhood special education**. Vol 11(2): 91-105.
- Bratton, S., Landreth, G. (1995). Filial therapy with single parents: effects on parental acceptance, empathy and stress. **Journal of play therapy**. Vol 4(1): 61-80.
- Bratton, S., Ray, D., Moffit, K. (1998). Filial/family play therapy : an intervention for custodial grandparents and their grandchildren. **Educational Gerontology**. Vol 24(4): 391-407.
- Burton, L. (1992). Black grandparents rearing children of drug addicted parents: stressors, outcomes and social service needs. **The gerontologist**. Vol 32(6): 744-751.
- Chau, I., Landreth, G. (1997). Filial play therapy with Chinese parents. **International journal of play therapy**. Vol 6(2): 75-92.
- Collins Sons and Co. Ltd (1994). **The New Collins Concise Dictionary**. London: Guild Publishing.

- Collins, K.J. (1999). **Participatory research : a primer**. Cape Town : Prentice Hall.
- Corey, G (1990). **Theory and practice of group counselling** (3rd edition). Pacific Grove: Brooks/Cole Publishing Co.
- Corey, G., Corey, M.S. (1992). **Groups : process and practice** (4th edition). Pacific Grove: Brooks/Cole Publishing Co.
- Creswell, J.W. (1994). **Research design : qualitative and quantitative approach**. London: Sage Publishers.
- Cresswell, J.W. (1998). **Qualitative inquiry and research design : choosing among five traditions**. London: Sage Publishers.
- Daro, D., McCurdy, K. (1994). Preventing child abuse and neglect : programmatic interventions. **Child Welfare**. Vol 73(5): 405-431.
- Denscombe, M. (1998). **The good research guide**. Buckingham: Open University Press.
- Dinkmeyer, D., McKay, G.D. (1982). **The parent's handbook**. Circle Pines, Minn: American Guidance Service.
- Douglas, T. (1976). **Groupwork practice**. London: Tavistock Publishers Ltd.
- Dubowitz, H. (1994). Kinship care : suggestions for future research. **Child Welfare** .Vol 73(5): 553-565.
- Durban Children's Society. 2001. Unpublished **Annual Report 2000/2001**. Durban.
- DuToit, A., Grobler, H., Schenck, A. (1998). **Person centred communication: theory and practice**. Johannesburg: Thomson Publishing.
- Ferguson Brown, H., Partab, R. (1999). Social work in the new South Africa : which way for justice and development? **Social work / maatskaplike werk**. Vol 35(2): 138-151.
- Gibson, P.A. (1999). African American grandmothers: new mothers again. **Affilia : Journal of woman and social work**. Vol 14(3): 329-344.
- Ginsberg, B.G. (1976). Parents as therapeutic agents: the usefulness of filial therapy in a community mental health centre. **American Journal of community psychology**. Vol 4(1): 47-54.
- Ginsberg, B.G. (1984). Filial therapy with retarded children and their families. **American psychology bulletin**. Vol 6: 332-334.
- Glasser, P., Sarri, R., Vinter, R. (1974). **Individual change through small groups**. New

York: Free Press.

Glazer, H.R., Kottman, T. (1994). Filial therapy : rebuilding the relationship between parents and children of divorce. **Journal of humanistic counseling, education and development.** Vol 33(1): p. 4-13.

Glazer-Waldman, H., Zimmerman, J.E., Landreth, G.L., Norton D. (1992). Filial therapy: an intervention for parents of children with chronic illness. **International journal of play therapy.** Vol 1: 31-42.

Gleeson, J.P., O'Donnell, J., Johnson Bonecutter, F. (1997). Understanding the complexity of practice in kinship foster care. **Child Welfare.** Vol 76(6): 801-826.

Glover, G.J., Landreth, G.L. (2000). Filial therapy with Native Americans on the Flathead Reservation. **International journal of play therapy.** Vol 9(2): 57-75.

Gray, M. (1996). The role of social workers in developmental social welfare. Is there a place for them? **Social work practice.** Vol 2(96): 8-13.

Grinnell, R.M. (1993). **Social work research and evaluation** (4th edition). Illinois : F.E. Peacock.

Grogan-Kaylor, A. (2000). Who goes into kinship care? The relationship of child and family characteristics to placement into kinship foster care. **Social work research.** Vol 24(3): 132-142.

Guerney, B.G. (1964). Filial therapy: description and rationale. **Journal of consulting and clinical psychology.** Vol 28(4): 303-310.

Guerney, B.G., Guerney, L., Stover, L. (1972). Facilitative therapist attitudes in training parents as psychotherapeutic agents. **The family co-ordinator.** Vol 21(3): 275-278.

Guerney, L.F. (1987). **A clinician's and group leader's manual for parenting: a skills training programme.** Silver Springs: Ideals.

Guerney, L.F. (1990). Parents as partners in treating behaviour problems in early childhood settings. **Topics in early childhood special education.** Vol 11(2): 74-90.

Guerney, L.F. (2000). Filial therapy into the 21st century. **International journal of play therapy.** Vol 9(2): 1-18.

Hegar, R., Scannapieco, M. (1995). From family duty to family policy: the evolution of kinship care. **Child Welfare.** Vol 74(1): 200-217.

Ingram, C. (1996). Kinship care : from last resort to first choice. **Child Welfare.** Vol 75(5): 550-566.

- Jang, M. (2000). Effectiveness of filial therapy for Korean parents. **International journal of play therapy**. Vol 9(2): 39-56.
- Jendrek, M.P. (1993). Grandparents who parent their grandchildren: effects on lifestyle. **Journal of marriage and the family**. Vol 55: 609-621.
- Johnson, L. (1995). Filial therapy: a bridge between individual child therapy and family therapy. **Journal of family psychotherapy**. Vol 6(3): 55-70.
- Johnson, L., Bruhn, R., Winek, J., Krepps, J., Wiley, K. (1999). The use of child-centred play therapy and filial therapy with head start families: a brief report. **Journal of marital and family therapy**. Vol 25(2): 169-176.
- Joubert, M.F. (1995). De facto family structures in Bosmont: therapeutic and conceptual considerations. **The social work practitioner - researcher**. Vol 8(3): 169-185.
- Kaliba, N., Kadowe, J.N., Kalinaki, D., Williams, G. (2000). **Open Secret**. London: Actionaid.
- Keech, R. (1984). **Education for living: a program for developing self-knowledge and personal relationships**. Johannesburg: Divaris Stein.
- Konopka, G. (1972). **Social group work: a helping process**. New Jersey: Prentice-Hall Inc.
- Landreth, G. (1991). **Playtherapy: the art of the relationship**. United States of America: Accelerated Dev. Inc.
- Landreth, G., Lobaugh, A.F. (1998). Filial therapy with incarcerated fathers: effects on parental acceptance of child, parental stress and child adjustment. **Journal of counselling and development**. Vol 76(3):157-166.
- Leedy, P.D. (1993) **Practical research planning and design** (5th edition). New York: Macmillan publishing.
- Leslie, L.K., Landsverk, J., Horton, M.B., Ganger, W., Newton, R.R. (2000). The heterogeneity of children and their experiences in kinship care. **Child Welfare**. Vol 79(3): 315-335.
- Lindsey, E., McGuinness, L. (1998). Significant elements of community involvement in participatory action research. Evidence from a community project. **Journal of advanced nursing**. Vol 28(5): 1106-1114.
- Marlow, C. (1993). **Methods for generalist social work**. Pacific Grove: Brooks/Cole Publishers.

- Masilo, N. (2000). Non-directive play therapy with township children exposed to violence. Unpublished paper. **Creative Rescue: counselling and assistance for the children of our country**. UNISA (Faculty of Education). August 2000.
- Mbigi, L. (1997). **Ubuntu : the African dream in managment**. Pretoria: Knowledge Resources.
- Mellonie, B., Ingpen, R. (1983). **Lifetimes : the beautiful way to explain death to children**. New York: Bantam Books.
- Mills, C.S., Usher, D. (1996). A kinshare care case management approach. **Child Welfare**. Vol 75(5): 600-618.
- Moustakas, C. (1997). **Relationship play therapy**. New Jersey: Jason Aronson.
- Orten, J. (1987). The role of clinical social work in a developing society. **Social work/ maatskaplike werk**. Vol 23: 75-78.
- Pernice, R. (1996). Methodological issues in unemployment research: quantitative and/or qualitative? **Journal of occupational and organisational psychology**. Vol 69:339-349.
- Pinder, R. (1995). Bringing back the body without the blame? The experience of ill and disabled people at work. **Sociological health and illness**. Vol 17(5): 605-631.
- Rampersad, S. (2002). **Social work manager's programme proposal: 2002-2003**. Durban Children's Society Community Services.
- Ravat, R. (2001 a). **Play therapy learningshop course notes**. Durban: Education Unlimited.
- Ravat, R. (2001 b). **Filial therapy workshop course notes**. Durban: Education Unlimited.
- Reason, P. (1994). Three approaches to participative inquiry in Denzin, N., and Lincoln, Y. (Ed.) **Handbook in qualitative research**. California: Sage publications.
- Rennie, R., Landreth, G.L. (2000). Effect of filial therapy on parent and child behaviour. **International journal of play therapy**. Vol 9(2):19-38.
- Rittner, B., Sacks, A. (1995). Children in protective services : the missing educational link for children in kinship networks. **Social work in education**. Vol 17(1): 7-18.
- Robertson, G. (1999). Leaving trauma on a mountain top. **Children first**. Oct/Nov 1999:30-31.

- Roe, R., Minkler, M. (1998/1999). Grandparents raising grandchildren: challenges and responses. **Generations**. Vol 22(4): 25-38.
- Rogers, C.R. (1951). **Client - centred therapy**. Boston: Houghton Mifflin.
- Rubin, A., Babbie, E. (1997). **Research methods for social work** (3rd edition). Pacific Grove: Brooks/Cole publishing co.
- Scannapieco, M., Hegar, R.L. (1996). A non traditional assessment framework for formal kinship homes. **Child Welfare**. Vol 75(5): 567-582.
- Schenck, A., Louw, H. (1995). Participatory Learning: a people centred way of working in community development. **The social work practitioner-researcher**. Vol 8(1): 8-18.
- Silverman, D. (1993). **Interpreting qualitative data : methods for analysing talk, text and interaction**. London: Sage publications.
- Strauss, A., Corbin, J. (1998). **Basics of qualitative research : techniques and procedures for developing grounded theory**. Thousand Oak: Sage publications.
- Stringer, E.T. (1996). **Action research: a handbook for practitioners**. Thousand Oaks: Sage publications.
- Van Dyk, G.A.J. (2000). Psychological debriefing: An adjusted model for community workers to heal traumatised children in South Africa. Unpublished paper. **Creative Rescue: counselling and assistance for the children of our country**. UNISA (Faculty of Education). August 2000.
- Van Fleet, R. (1994). **Filial therapy: strengthening parent - child relationships through play**. Harrisburg: Professional Resource Press.
- Van Fleet, R. (2001). **Play therapy ideas: helping parents develop their own toy lab in filial play therapy**. <http://www.play-therapy.com/ideas-2htm>.
- Van Rooyen, C.A.J., Gray, M.M.A (1995). Participatory research and its compatibility to social work. **Social work researcher - practitioner**. Vol 8(2):3-8.
- Van Rooyen, C.A.J. (1998). Democratizing social work research in Gray, M.(Ed) **Developmental social work in South Africa**. Cape Town: David Philip Publishers.
- White Paper for Social Work** (1997). Pretoria:Government Press.
- Whitley, D.M., White, K.R., Kelley, S.J., Yorke, B. (1999). Strengths - based case management: the application to grandparents raising grandchildren. **Families in society: the journal of contemporary human services**. Vol 80(2): 110-119.
- Wilhelmus, M. (1998). Mediation in kinship care: another step in the provision of

## **APPENDICES**

## LANDRETH'S 10-WEEK MODEL AS ADAPTED BY RAVAT

### FILIAL SESSION 1

- I Introduce self, welcome group, give name tags and booklets to all members.  
(Forms signed first)
- II Overview of Filial Training :
- Play is the child's language
  - Based on actions, not words
  - Way of preventing problems because adults become more aware of child's needs
  - "In nine weeks, you are going to be different, and your relationship with your child will be different"
- Techniques from play therapy will :
- Return control to you
  - Provide closer, happier times with your child
  - Give key to your child's inner world
- III Group introductions :
- Describe entire family – help pick child of focus
  - Tell concerns about this child (take notes)
  - Make generalizing comments to other parents
  - "Anyone else feel angry with their child?"
- IV Provide Basic Agenda :
- One half hour play sessions
  - Everyone will be video taped here once for replay. **(Bring your own tape to keep)**
  - We will see demonstrations before starting
  - Patience is important in learning a new language
- V Show video tape of "Children's Emotions."
- VI Reflective listening :

- Ways to following, rather than leading
- Don't ask questions
- Reflect behaviours, patterns and **feelings**

Responses say :

I am **here**; I **hear** you

I understand

I care

Not :

I always agree

I must make you happy

I will solve your problems

I love you

VII Toys

VIII Demo

IX Keep focus on positive. Stroke their concerns.

X Mention "Listening" and "Self-Care"

- "I don't have all the answers, but I know some things that will be helpful."
- Take notes on each family/child
- What shows on parents' faces affects the child possibly more than the words. The child's facial expressions also say more than their words; therefore, ask parents to listen to their child with their eyes rather than their ears.
- Have parents role-play with partners. Let's practice:  
"I would like you to share with your partner what happened to your child this week and listeners will be a mirror. Reflect back on what your partners say."  
Then have them switch roles. Point out that it takes energy to listen.

#### HOMEWORK

- (1) Notice some physical characteristic about your child you haven't seen before.
- (2) Practice reflective listening this week (4 faces sheet). Keep yourselves out of the response and concentrate on how your child is feeling.
- (3) Begin to buy toys for special play session.
- (4) Listening sheet.

## FILIAL SESSION 2

- I Review Homework : (1) Physical Characteristic  
(2) 4 faces Sheet.
- II Handout : “Filial Therapy Parent Group”
- Go over entire sheet, especially list of toys. (Demonstration Box).  
“How to” for play sessions.
- III Show video tape of session or do live demonstration.
- IV Tour of play room, have them pair off and role play to practice reflective responding. Encourage tracking what they see and hear. Forbid them to ask questions, point out tone of voice making a difference. Have them give each other feedback then switch partners.
- V Things to remember :
- Children have needs and they will do whatever they can to get their needs met.
  - If parents claim it doesn't/won't work, ask them “Is what you've been doing working?” Then, “Would you be willing to try something different?” Let them know that you hear the discouragement.
  - Forbid them to use techniques any other time besides the schedule 30” playtime.
  - Tell parents to introduce play session in this way: “I'm going to a special class to learn to play with you. My teacher told me to get toys on this list. Let's go find what we have and we'll buy the rest.”
  - Encourage parents to be firm when shopping for these toys – these are the only toys that will be bought. Similarly, these toys will only be played with during the 30” sessions.
  - Introduce concept that patience is necessary when learning a new language.

### HOMEWORK

- (1) Buy toys for special play sessions.
- (2) “Facilitating Reflective Communication” handout.
- (3) Pick out spot and time for sessions – report back next week (may not be child's room and timers are forbidden).
- (4) Make a “Do not Disturb” sign together and give child a “special play time” appointment card.

### FILIAL SESSION 3

#### I Review homework

- (1) Toys bought, sign made, appointment card given.
- (2) "Facilitating reflective Communication".
- (3) Time and Place for Play Sessions.

#### II Handout in Class : "Basic Rules ..."

- Use to review rules for play session.
- Basic limits "I'm not for shooting".
- Intro to play session. "This is our special playtime where you can play with the toys in many of the ways that you want to."

#### Handout : "3 Steps to Setting Limits"

- 3 Step = ACT
  - Acknowledge feeling
  - Communicate limit
  - Target alternatives
- Go over importance of using this as first step in discipline process.
- Once choice is given and made, parents should be a brickwall. The goal is for children to live with their own choices.
- Do not O.D. on choice giving. Work on one thing at a time
- Do not use choice giving with **feelings** – **only behaviours** need discipline, not children's personality, i.e. who they are. Their behaviours may be bad – they are not.

#### III Go over first parent tape, or other demonstration tape

#### IV Arrange for parent to do video taping this week.

#### V Role-play – have parents practice choice giving. Give each other feedback and switch.

#### VI Go over "empathic grunts" – Um / Ohh / Ahh.

#### HOMEWORK

- (1) Play sessions at home begin this week.
- (2) "Setting Limits" worksheet.

## FILIAL SESSION 4

- I Debriefing. How did their play session go. (Be aware of time --- keep group process moving!).
- II As reporting is occurring, use their examples to illustrate rules of filial therapy. Also focus on how they were able to reflect their child's **feelings**.
- III Go over homework : "Setting the Limits"
- IV Handout : "Giving Choices" as a way of discipline. Go over examples of this technique (Oreo Cookie Story)
- V Arrange for next parent to video tape.
- VI Show video from parent-child session.
- VII Introduce Structured Doll Play
  - Parents tell a story with dolls/stuffed animals.
  - "I want to tell you a special story and we need some people/dolls. Pick one to be you, pick one to be me, pick one to be the teacher, father, etc ...
  - Tell story 2 - 3 times per week. Exaggerate movements and sounds.

### HOMEWORK

- (1) Notice one intense feeling in yourself this week.
- (2) Practice giving **one** choice.

## FILIAL SESSION 5

- I Debriefing, combined with report on one intense feeling they had. Focus on importance of awareness of themselves in the play sessions. Be specific : “Did you track?” “What did you notice about yourself/child?” “How do you think your child felt?”
- II Handout : “Some Thoughts on Aggression”  
  
Emphasis on them **not** escalating along with their child  
  
Child’s feelings **are not** their feelings  
  
“Be a thermostat, not a thermometer”
- III Handout : “Common Problems in Filial Therapy”
- IV Go over “When Discipline Doesn’t Work” handout briefly
- V Set up next parent to come in and tape
- VI Review video of parent-child session

### HOMEWORK

- (1) Sandwich hugs – explain.
- (2) Continue play session.

## FILIAL SESSION 6

- I Debriefing on play sessions and giving one choice.
- II Review “Common Problems ...”
  - Use as chance to review reflective listening, setting limits, giving choices, etc.
  - Identify responses to build self-esteem. Use words to describe their child in this way. Examples : creative, caring, loving, friendly, helpful, considerate, etc...
- III Arrange for nest taping.
- IV Show video of play session.

### HOMEWORK

- (1) Write a note to child each week for 3 weeks, pointing out a positive character quality you appreciate. Save these notes. Example:

Dear -----

I was just thinking about you and what I was thinking is “You are so .....  
(something you appreciate about your child).

Love Mom and/or Dad.

- (2) Notice the number of times during the week you touch your child.
- (3) Continue play sessions – notice patterns of play that are showing up.

## FILIAL SESSION 7

- I Debriefing on play sessions with focus on patterns and number of times they physically touched their child.
- II Go over handout on "Positive Reinforcement"
- III Handout : "Let's Not Forget How to Play"
- IV Show videotape of session.
- V Handout : "Learning to be Perfectionistic"
- VI Arrange for taping of next parent

### HOMEWORK

- (1) Write down any unanswered questions and bring next time.
- (2) Continue play sessions.

## **FILIAL SESSION 8**

- I Debriefing on play sessions.
- II Handout : “Explaining Death to Children”
- III Arrange last taping session.
- IV Mention filial follow-up meetings.
- V Show videotape.
- VI Arrange for next parent.

### HOMEWORK

- (1) Continue play sessions.
- (2) “Evaluation.”

## FILIAL SESSION 9

- I Debriefing on play sessions. Give time for questions on various topics.
- II Show last videotape.
- III Closing process.

Focus on looking at differences in child and parent --- then and now.  
Encourage feedback within a group on positive changes made.

(Praise them, they may be scared about leaving the safety of the group!)

- IV Emphasize monthly meetings.
- V Encourage them to continue play sessions.

“If you stop now, the message is that you were playing with your child, because you had to, not because you wanted to.”

## FILIAL SESSION 10

- I Collect evaluations.
- II Hand out diplomas.
- III Exchange names, addresses and phone numbers.

## **FOCUS GROUP DISCUSSION OF THE KINSHIP CARE RELATIONSHIP ENHANCEMENT PROGRAMME**

We have reached the end of our programme. These are possible topics for discussion but the group is urged to add to or modify this agenda in any way. Each of these topics is for discussion in the group. Remember your views are essential for strengthening the findings of this study.

### **Question 1.**

What information presented in the programme was relevant?

### **Question 2.**

What information presented in the programme was not useful?

### **Question 3.**

Was the content covered culturally relevant?

### **Question 4.**

Please suggest further modifications to the programme that will ensure that the programme may be regarded as suitable for locally specific kinship carers.

### **Question 5.**

What did you enjoy most about the sessions?

### **Question 6.**

What did you enjoy least about the sessions?

### **Question 7.**

What suggestions do you have for improving the programme?

**Other questions for discussion in the group.**

## **A PERSONAL REVIEW OF THE KINSHIP CARE RELATIONSHIP ENHANCEMENT PROGRAMME**

Remember that you are a fellow researcher. Your honest feedback is essential to the development of an appropriate model for helping kinship carers and the children in their care. These answers will assist the research facilitator to compile the findings of this study. You do not need to disclose your name on the sheet.

### **Instructions**

Each question will be read aloud in the group. If you are unsure of the meaning of the question please ask for more clarity. Assistance will be offered to group members who do not wish to write their answers. You will be given the time you need to answer each question and so you must not rush. Your full answers will provide the study with the rich information it needs to reach solid conclusions.

### **Question 1.**

What are your reactions to the kinship care relationship enhancement programme now?

### **Question 2.**

Do you believe that you have benefitted in any way from attending this programme? Please substantiate your answer.

### **Question 3.**

Do you believe the child in your care has benefitted from the programme in any way? Please specify.

### **Question 4.**

Describe the quality of support that you have experienced in this group.

### **Question 5.**

Describe your experiences of the play sessions.

### **Question 6.**

How do you feel the child in your care experienced the play sessions?

**Question 7.**

Discuss the difficulties you experienced as a result of participating in this course, if any.

**Question 8.**

Have you learned anything new about the child in your care since you started the programme? Please discuss your observations.

**Question 9.**

Discuss any negative consequences that you may have experienced as a result of participating in this programme.

**Question 10.**

Please rank the extent to which you believe the group achieved the objectives it set for itself at the outset. The goals that were set in session two were to

- obtain information about raising children
- learn about death and dying and the effects on children
- learn about disciplining children
- learn new ways to manage children's behaviour
- enhance the relationship between yourself and the child in your care
- obtain support from other kinship carers

none	some	half	most	all
1	2	3	4	5

**Question 11.**

Would you recommend this programme to other kinship carers? Explain your answer.

**Question 12.**

Would you be prepared to assist as a volunteer in future kinship care relationship enhancement programmes?

Thank you for helping us to evaluate this programme.

# **INDAWO YETHEMBA**

**CHILD KINSHIP RELATIONSHIP TRAINING**

# **WORKBOOK**

## **Introduction to the programme**

Research has shown that some ways of dealing with children are more successful and beneficial than others. The methods that we have chosen to work with have been found to promote open, warm, supportive relationships between kinship carers and the children they look after. These methods should help to strengthen your family.

Much of the learning takes place through sharing and communicating ideas with others in the group. People working in groups are likely to find more solutions to old problems than people addressing these problems on their own. Remember, you may have good ideas that the others have not thought about. The success of the group therefore relies on everyone participating and being open-minded enough to consider different opinions. At the end of the day members choose solutions that they believe best suit their circumstances.

The programme is designed to provide you with opportunities to try out parenting skills that we have found to work. Some of these may be new to you. You will be given exercises to do during the sessions and at home. Remind yourself that these skills are likely to be unfamiliar and it will take time to master them. As a human being you are entitled to make mistakes whilst you are learning. It is important that you try. Be sensitive to the efforts of your fellow group mates and encourage them in their efforts.

The content that we considered as helpful has been divided into different themes. This does not suggest that members should follow the workbook like a recipe. Your group will need to decide on themes that are most relevant to their needs. You may even add extra themes to ensure that the specific issues relevant to your members are addressed. The group must pace itself. Our group found that we needed to spend more time on some themes and less on others. It is better to work at a slower pace and leave out some themes than to rush through the book without having mastered the skills and concepts. It is important that you talk about your experiences and attitudes during the sessions to ensure that at the end of the sessions you can own them. You need to feel that they are consistent with your values and cultural heritage.

## **What is a kinship carer?**

Because of a number of social factors children may find themselves abandoned, deserted, orphaned, abused or neglected by their parents. When the parents are unable to care for these children, other members in society have to step in to do so. There are many advantages to a child's relative stepping in to assume this role. Some of the benefits are:

- Relatives offer the child comfort and a measure of stability at an emotionally distressing time.
- The child seems to settle better and more quickly with people he or she knows than strangers.
- The extended family becomes an enormous help as they lessen the child's trauma associated with separation or loss. They are more likely to understand what he or she has been through and can answer more questions about the child's past than strangers.
- They are likely to preserve the child's cultural identity, which in turn strengthens the child's idea of whom he or she is.

In order for the placement to be finalised the relatives have to apply to foster the child. Foster care provides a child with another family when the child's own parents have died or are unable to provide him/her with a caring home environment. The foster parents can apply for a Foster Care Grant to assist them with providing for the child's material needs.

## **Who qualifies to foster a child?**

Any person who is Single or Married and:

- Can provide the child with a stable home environment.
- Is financially secure.
- Loves children and is capable of providing them with discipline and control
- Can provide for the child's educational, moral and spiritual needs.
- Can provide children with love, safety and security.

## Screening procedure

1. Contact your local Child Welfare Society
2. Arrange an appointment to see the Intake Worker. You must take several documents with:
  - Copies of identity documents (one for each spouse).
  - A marriage certificate (if married).
  - Death certificates of the deceased parents, and your spouse if he or she has died.
  - Your Divorce Order (if you are divorced).
  - Proof of Income (salary advice slips, pension card).
  - References from at least two non-related persons (e.g. Priest, doctor, school principal).
  - Medicals
3. You will be invited to attend a Foster Care Orientation Programme that will explain all the procedures to be followed.
4. The foster parents have to sign a contract which specifies their responsibilities, and those of the child, and his/her parents (if their whereabouts are known).
5. The social workers investigate your application. They may visit you at home, check your references to make sure that the child's needs are protected. They will conduct discussions with you and your family to make sure that everyone is in agreement with the arrangement and are clear about their roles.
6. The social worker prepares a report for the Commissioner of Child Welfare. The report is read before the Commissioner at Court. Statutory requirements regarding the extension of the court Order and the implication for the Foster Child Grant will be conveyed to you. If the application is approved a Foster Care Grant may be approved at the same time. You will be assisted to obtain the grant by the social worker.
7. The foster parents and the child are expected to attend support groups when arranged by the agency.

If you do not apply to foster, the arrangement to care for the child remains informal and you do not qualify for any assistance for schooling or the Foster Care Grant.

#### EXERCISE:

- Discuss any problems you may have experienced in your application.
- Let us brainstorm ways that these obstacles can be removed.

### **What is child kinship care relationship enhancement?**

This is a programme developed by and for kinship carers. It was based on an American model that suggests that play is the primary method adults can use to understand children. Through play, children express their feelings, master new skills, begin to work through their experiences of their world, develop social judgement, and sharpen their problem solving and coping abilities. In other words we believe that play is very important for children. Our experience in developing this model has taught us this.

The model suggests that carers are able to learn the skills necessary to conduct child-centred play sessions with the children in their care. In fact our experiences have taught us that kinship carers may have a greater impact on their children's lives than any social worker or psychologist. Kinship carers can be taught effective ways to strengthen their relationships with their children, and find ways to help them adjust to their circumstances.

We believe that education and skill development can alleviate many problems in families.

### **The Objectives of the programme**

This programme has benefits for both children and kinship carers. It aims to eliminate parenting problems as soon as possible, develop positive relationships between kinship carers and their children, and increase families' communication, coping, and problem-

solving skills so they are better able to handle future problems using their own strengths.

### **Benefits for children**

This programme helps children to

- Recognise and express their feelings constructively.
- Develop problem-solving and coping skills.
- Increase their confidence and self-esteem.
- Be in control of their behaviour.
- Develop trusting relationships with their carers.
- Feel understood and accepted.

### **Benefits for carers**

The sessions help carers to

- Increase their understanding of their children.
- Decrease their feelings of frustration with their children.
- Enhance effective parenting skills.
- Develop a network of support as they meet other kinship carers.
- Increase their confidence in their ability to parent.
- Develop good communication skills that other family members benefit from too.
- Develop warm relationships with their children.
- Deal with their own issues as they relate to their children and parenting.

### **GROUP EXERCISE:**

- Discuss the reasons why this programme could benefit kinship carers.

### **SELF REFLECTION EXERCISE:**

Try to answer these questions on your own. This will help you to decide whether you are able to commit to the programme, and whether it is what you need right now.

1. What benefits would there be for you in joining this programme?
2. Identify the family issues you would like to focus on during the sessions.

3. What are your concerns about being part of this programme?
4. What actions can you take to address your concerns?

#### HANDOUTS FOR DISCUSSION:

1. Play therapy: more than just play
2. The five principles on which child-kinship relationship training is based.

### **Theme One : Getting started**

The purpose of this exercise is for us to introduce ourselves to one another. Kinship care has many realities and by sharing experiences we will be able to discover similarities and differences in your situations. You may share as much or as little about your reality as you choose to. It must be stated at the outset that the success of the group depends on members' willingness to work together. Feel free to ask members questions, but remember they always have the right to "pass", in other words they can decide that they are not ready to talk about certain issues yet.

#### EXERCISE: COLLAGE

There are several magazines for you to look at. Select any pictures that you believe reflect your experiences as a kinship carer. You can choose as many pictures as you like. It is important that you choose the pictures rather than allow others to help or guide you. You can choose to do whatever you like with the pictures: stick them on paper, draw on them, tear them in different shapes, cut them out, display them in any way you choose. There are no right or wrong ways of doing this exercise. You have twenty minutes to do this.

1. Each member has a turn to discuss their selection of pictures.
2. Are there any themes that you notice in the stories told by the members?
3. Are there any issues that you as a group would like to discuss in the sessions to come?

The facilitator discusses the Five Principles of Child-Kinship Relationship Training and asks the group to identify whether they were aware of any of these principles being present during the exercise. The facilitator stresses that members do not have to tidy up, that they stick to the time allocated for selecting the pictures, and that they relax so that the pictures “choose them”.

#### EXERCISE TWO: DEVELOPING NORMS FOR THE GROUP

Because we will be working in a group, it is important for you to identify what rules you feel should be developed for the group that will ensure that it achieves the objectives it has set out to. To encourage participation the group can be introduced to the brain storming method.

#### PRACTICE EXERCISES FOR HOME:

1. Try to notice one physical characteristic of the child you will be working within the sessions that you have never noticed before.
2. Look at the Four Faces Feeling Chart and try to note whether your child displays these feelings during the week.

### **Theme Two : Listening, and reflective listening**

Some of these questions may need to be discussed before you move on to the theme of Listening.

1. Exchange news about any significant events you experienced during the week, or topics you would like to raise for discussion today.
2. Discuss the physical characteristics that you may or may not have noticed. Tell us what you learned about yourself from doing this exercise. Tell us what you learned about your child.
3. Were you able to identify your child’s expression of the four feelings on the Four Faces Feeling Chart? Can you identify your personal experiences of these four feelings this week?

4. Let us view the video of Children's Emotions and then we can share opinions about the way children express their emotions and adult responses to these expressions.
5. It is important that the group set clear goals for the remaining sessions. The facilitator introduces the group to the Nominal Group Technique. The goals must be recorded for the group to see.
6. Decide on ways that the group can measure whether they achieve these goals at the end of the sessions.
7. Are there any issues that you wish to clarify regarding foster care?

### **Listening and reflective listening**

1. Let us read the handout on Listening together.
2. Why is listening such an important communication skill?
3. What does this handout have to do with identifying feelings?
4. A role play of reflective feelings using a group member who relates an experience and the facilitator who reflects these feelings.
5. What are the differences and similarities between listening and reflective listening?
6. Let us discuss Facilitating Reflective Communication together.

#### **PRACTICE EXERCISES FOR HOME:**

1. Repeat the Four Faces Feeling Chart. Identify your child's expressions of these feelings.
2. Review the Facilitating Reflective Communication Handout.
3. Attempt reflecting your child's feelings if the opportunity arises.

### **Theme Three : Preparing for play sessions**

Some of the following topics may need to be discussed before you commence with the next theme.

1. Discuss any significant happenings or experiences of the past week.
2. Discuss the Practice Exercises that were attempted.
3. Discuss rules for constructive feedback. Put these rules into practice by providing your fellow members with feedback regarding their completed Practice Exercises.

## **Play sessions**

Look at the handout on Child-Kinship Relationship Training.

1. Are there any issues that you would like more clarity on?
2. View a video demonstration of a filial session.
3. Identify which of the five principles the carer integrated in the play session. Refer to the Five Principles of Child-Kinship Relationship Training Handout.
4. Discuss what space you will allocate for your play sessions at home. Plan ways to maximise privacy for these sessions. Plan ways to minimise the other children in the home feeling left out and excluded.
5. You may find the Key Sentences helpful to get you started.
6. Why do you believe some rules are set for the playroom? Do the rules relate to the Five Principles of Child-Kinship Relationship Training in any way?
7. Look at the list of toys and decide if there are items you feel need to be added.
8. Discuss the construction of the dollhouse from a cardboard box.
9. Can you provide a beer box, black rubbish bags and rags before the next session?
10. Check the Tote Bag to see whether all the items are there.

### **PRACTICE EXERCISES FOR HOME:**

1. Collect one beer box, three rubbish bags and rags.
2. Start preparing your dollhouse.
3. Inform your child about your doing this course and the play sessions that will follow.

## **Theme Four : The principles structure and limits**

Discuss any of the following topics before you start the new theme.

1. Are there any significant experiences or happenings during the past week that you would like to share?
2. What progress are you making in terms of being able to identify your child's emotions?
3. What progress are you making in reflecting feelings?
4. Can you identify any concepts that we have discussed that go against your values or cultural practices?
5. Are you ready for the play sessions at home?
6. Let us draw up a roster for videoing each member and her child once. We need to have our first volunteer next week.

### **Structure and limits**

#### **EXERCISES:**

1. Watch a video of a filial therapy session. Try to identify whether the child has complete freedom in the session.
2. What limits are appropriate in sessions and how could you enforce them?
3. What methods do you normally use to limit your child's behaviour?
4. Discuss whether the limits imposed are always necessary, or whether they stifle the child's autonomy?
5. How do you relate to too many instructions and restrictions in your life?
6. Let us discuss the Three Steps in Limit Setting.
7. Let us practice. Refer to the exercise Let's Practice Setting Limits.
8. Identify ways in which you can maintain the structure of the play sessions.
9. Role play setting limits and imposing the structure in play sessions.

**PRACTICE EXERCISES FOR HOME:**

1. Conduct your first play session at home.
2. Identify areas where you could be giving your child more autonomy.

**Theme Five : The magic of play**

Discuss any of the following topics if relevant to members' needs before addressing the new theme.

1. Discuss your experience of your play session.
2. Discuss autonomy versus restrictions and instructions.
3. Review reflecting feelings, setting limits and structuring sessions.

**EXERCISES:**

1. Each member is given a generous helping of play dough. They are told that they can play with the dough in as many of the ways they choose to. They are given ten minutes to do this. A two-minute warning is given before their time is up.  
Discuss the physical sensations of playing.  
Discuss their satisfaction of playing.  
Discuss the "parent" within each member that inhibits the childlike behaviour.  
Review the personal needs of members that were met through this simple activity.  
Discuss the items that members modelled and see whether they can identify whether the items were symbolic of issues in their lives.
2. Read the handout *The Magic of Play* together.
3. Look at the items in the Tote Bag and identify which toys are "real life toys", "acting out aggression toys", "emotional expression toys", "creative expression toys".
4. Discuss members' own experiences of play as a child and as an adult.
5. Discuss the role of play in the lives of children in the township.
6. Get members to take turns in role playing facilitating a play session.
7. Watch the video of the first group member playing with her child.

Concentrate on highlighting the positive behaviours she exhibited during the sessions.

Allow her to talk about any issues relating to her child.

Ask members to identify the toys the child used, the emotional expressions the child exhibited whilst playing, the carer's use of the Five Principles of Child-Kinship Relationship Training.

#### PRACTICE EXERCISES FOR HOME:

1. Read over The Magic of Play.
2. Conduct your second play session at home.
3. Treat yourself to one childlike activity during the week, e.g. walking in the rain with no shoes, sitting on a swing, licking the bowl after cooking.

### **Theme Six : Feelings**

Discuss the following topics before proceeding with the new theme:

1. Your experience of your play session.
2. Feedback on your childlike activity and the impact it had on you.
3. Identify any issues that you need to clarify about this intervention.

### **Feelings**

All human beings have potentially the same feelings. Our feelings are part of our humanness. We need to understand our feelings and the feelings of others. When we deny our feelings, it often leads to an escalation of tension in our lives.

#### EXERCISES:

1. Read the handout Feelings and Their Expression.
2. Look at the Feelings Chart and fill in as many feeling words as you can.

3. Complete the exercises on the Feelings and Their Expression handout.
4. Are feeling words absolutely necessary to demonstrate your understanding of another?
5. Think of idioms or metaphors that one may use to convey feelings.
6. Discuss ways of increasing happiness in your life.
7. Watch the members' video taped play session. Pay extra attention to the child's expression of emotion and the carer's reflective comments.

#### PRACTICE EXERCISES FOR HOME:

1. Conduct your third play session at home.
2. Make a point of doing two activities this week purely for your pleasure.
3. Concentrate on reflecting feelings within and outside play sessions.

### **Theme Seven : Limit setting and discipline**

Discuss the following topics before proceeding with the new theme.

1. Feedback on play session. Can you identify any themes in your child's play?  
What do you enjoy about the sessions and what don't you enjoy?
2. Feedback on the activities you completed for your own pleasure. Did your doing these activities for your benefit have negative or positive effects on the family?

#### **Limit setting and discipline**

Many parents spend a lot of time trying to take control of the actions of their children. This is natural. Always taking control of their actions can have disastrous outcomes. Children never learn that there are natural consequences to the choices they make and they fail to learn to function independently and maturely. This is summed up in the handout "The Science of Control".

**EXERCISES:**

1. Refer to the handouts Three Steps for Setting Limits, Let's Practise Setting Limits, The Five C's of Effective Discipline.
2. What methods of discipline work for you?
3. Have you thought of offering choices as a means of regulating your child's behaviour?
4. Let's Practise Offering Choices. See the handout.
5. View the carer's video recording of a play session. Concentrate on providing positive feedback.

**PRACTICE EXERCISES FOR HOME:**

1. Practise offering choices and setting limits outside of the play sessions.
2. Conduct the fifth play session.

**Theme Eight : Death: Helping children to cope**

Discuss the following topics before proceeding with the new theme.

1. Feedback on your fifth play session.
2. Feedback on discipline and choices.
3. Start identifying whether you can pin point any changes in the quality of your relationship with your child, your stress, the child's behaviour, and the group.

**Death: Helping children to cope**

There are numerous reasons for the constant and unrelentless struggle you may have had to face against death until now. Our experience in our group taught us that it is difficult to help children deal with the many issues of death if we, the adults in their lives, fail to confront these issues ourselves. Death is usually a topic people avoid talking about. There

are no hard and fast rules of how to deal with death but we would like to share some ideas of the things we found useful in dealing with this issue.

#### EXERCISES:

1. Listen to an excerpt from the story “The Lion King”. Try to identify the young lion cub’s feelings about the death of his father. Could his feelings be generalised to describe children’s reactions to a parent’s death? Read, *Helping Children Cope With Death*.
2. Brainstorm ways to assist children through their grief.
3. Suggestions for assisting children in their grief such as: making your storybook about death, compiling a family tree, creating a memory box.
4. Examine the role that culture plays in dictating the way you help your child come to terms with what has happened.
5. Examine the extent to which you have allowed yourself to mourn your losses.
6. One carer presents a video recording of her session with her child.

#### PRACTICE EXERCISES FOR HOME:

1. Start any of the projects that were discussed, or create your own to share with the group.
2. Conduct your sixth play session.

### **Theme Nine : Giving recognition**

Discuss the following topics before proceeding with the new theme:

1. Termination
2. Feedback about play sessions
3. Any unfinished business that needs to be dealt with before the session ends.

## **Giving recognition**

One assumption we often make is that others know when we appreciate them. We take it for granted that they know when we are pleased with their efforts, and don't bother voicing these in the form of recognition. All people need recognition of some sort.

We can work through the handouts, Giving Recognition or Reinforcement and Praise Versus Encouragement and discuss these as they apply to you.

### **EXERCISE:**

2. Let's Practise Giving Recognition, see the handout.
2. Video presentation by a carer.

### **PRACTICE EXERCISES FOR HOME:**

1. Make a point of offering each family member some recognition three times a week to begin with.
2. Conduct your seventh play session at home.
3. Start asking others in the home for feedback about changes that have taken place.

## **Theme Ten : Termination and evaluation**

We have reached the end of the formal part of this programme. You are expected to continue with your play sessions at home for another month. The group will meet for a follow-up discussion where you will be asked to return the Tote Bags at that meeting. This session is very important. It provides us with an opportunity to assess the extent to which the group brought about the desired changes. Your views are essential for adapting this model for the benefit of other kinship carers in the community.

EXERCISES:

1. Provide each member with some recognition and reinforcement for being part of the group. Remember to make sure that the feedback is specific, identifies the member's efforts or strengths, and emphasises their own opinions as suggested last week.
2. Identify any unfinished issues.
3. Complete the focus group evaluation.
4. Plan a follow-up meeting (in a month's time).
5. Members must continue to play with their children until they attend the follow-up meeting.
6. Handout Certificates of Recognition to each member.

# **CERTIFICATE**

## **OF**

# **COMPETENCE**

**THIS IS TO CERTIFY THAT**

---

***Has Satisfactorily Completed 20 Hours of Training in  
Kinship Care Relationship Enhancement.***

\_\_\_\_\_ **IS TO BE ADMIRER FOR:**

---

---

---

---

\_\_\_\_\_  
**FACILITATOR**

\_\_\_\_\_  
**DATE**

## **HANDOUTS**

**BASIC RULES FOR FILIAL THERAPY****Don't**

1. Don't criticize any behaviour.
2. Don't praise the child or the child's actions.
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 suggest new behaviour.
8. Don't be passive, quiet.

**Do**

1. Do create the atmosphere of permissiveness.
2. Do allow the child to lead.
3. Do track the child's behaviour.
4. Do follow the child's feelings.
5. Do set limits.
6. Do acknowledge the child's power and effort.
7. Do join in the play as a follower.
8. Do be verbally active.

## **Child-Kinship-Relationship Training**

Adapted from Garry Landreth

### **Basic Principles of the Play Sessions**

1. The child should be completely free to determine how he/she will use the time. The child leads and the kinship carer follows without making suggestions or asking questions.
2. The kinship carer's most important task is to follow the child's expressions and understand them. The kinship carer enters the child's world by trying to understand the child's intentions behind the child's actions, together with his/her thoughts and feelings.
3. The kinship carer must communicate this understanding of the child by making appropriate comments, and whenever possible verbalising the feelings that the child is actively experiencing.
4. The kinship carer should be clear and firm about the few "limits" that are placed on the child.  
These are: time limits, not breaking toys, and not physically hurting the kinship carer or him/herself.

### **Goals for the Play Session**

1. To help the child change his perceptions of the kinship carer's feelings, attitudes, and behaviour.
2. To allow the child through the medium of play - to communicate thoughts, needs, and feelings to the kinship carer.
3. To help the child to develop more positive feelings of self-respect, self-worth, and confidence.

### **REMINDER**

These play sessions and the techniques become meaningless if you apply them mechanically, without trying to understand and follow the child's experiences with care and concern.

### **Toys for the Play Sessions**

You will need a special toy kit for these sessions. A list has been provided. Should you not have some of the items, you may borrow them from us. It is important to remember that these toys must be used for the special play times only. When you have completed the sessions planned, we will ask for our toys to be returned as they will be used for similar groups with kinship carers. Store the toys away in a safe place in between sessions so that the child only uses them for your "special time".

### **Place for the Play Session**

Try to find a place where there will be as few distractions and interruptions as possible. The space should be big enough for the two of you to sit on the floor and a little space to display the toys. The area should be cleared of breakable and valuable items. You can mark off an area in a larger space

or room by using masking tape. The child should not have to worry about making a mess there as spills are quite likely to happen.

Pre-warn other family members that you may not be disturbed during this time. Set aside a regular time in advance. Explain to the child that you are having these sessions because you are interested in learning how to play with him/her in a different, "special" way than you usually do.

### **Process**

Try to ensure that the child will not interrupt the session by needing the toilet or something to eat or drink. 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 with the child when requested to do so. Remember to set limits when you need to. Keep following the child's actions and showing the child that you understand his/her behaviour and feelings by making short statements labelling the expressions and actions you observe. Do not identify toys by their usual names; call them "it", "that", "her", "him", etc. Allow the child to correct your comments to ensure that you remain in step with his emotional world. When there are only five minutes remaining, remind the child, "you have five minutes left". Do not exceed the time limit by more than two or three minutes. Do not ask the child to tidy up before he/she leaves. You can quickly do this and store the toys in the box for the next session.

## COMMON PROBLEMS IN RELATIONSHIP ENHANCEMENT

1. My child notices that I talk differently in the play sessions, and wants me to talk normally. What should I do?
  
2. My child asks many questions during play sessions and resents my not answering them. What should I do?
  
3. My child just plays and has fun. What am I doing wrong?
  
4. I am bored. What is the value of this?
  
5. My child does not respond to my comments. How do I know I'm on target?
  
6. When is it okay for me to ask questions, and when is it not okay?
  
7. My child hates the play sessions. Should I discontinue them?
  
8. My child wants the playtime to be longer. Should I extend the session?

## **EIGHT BASIC PRINCIPLES OF CHILD-CENTRED PLAY THERAPY**

1. The helper cares deeply for the child and so develops a warm, supportive relationship.
2. The helper shows that she accepts and respects the child, and does not try to change the child in any way or wish for them to be different.
3. The helper creates a feeling of safety and permissiveness in the relationship. This frees the child to explore and express self completely.
4. The helper is always sensitive to the child's feelings and gently reflects those feelings so that the child develops self-understanding.
5. The helper believes in the child's ability to act responsibly, solve personal problems, and so creates the time and place for the child to do so.
6. The helper trusts the child's ability to make healthy personal choices and so allows the child to lead in all areas of the relationship. The helper resists any urge to direct the child's play or conversation.
7. The helper is patient and knows that this healing process cannot be rushed.
8. The helper only establishes limits that will help the child to accept personal and relationship responsibility.

Adapted from  
Landreth, G (1991). **Play Therapy: The Art of the Relationship**. Muncie, IN: Accelerated  
Development, Inc.

## FACILITATING REFLECTIVE COMMUNICATION

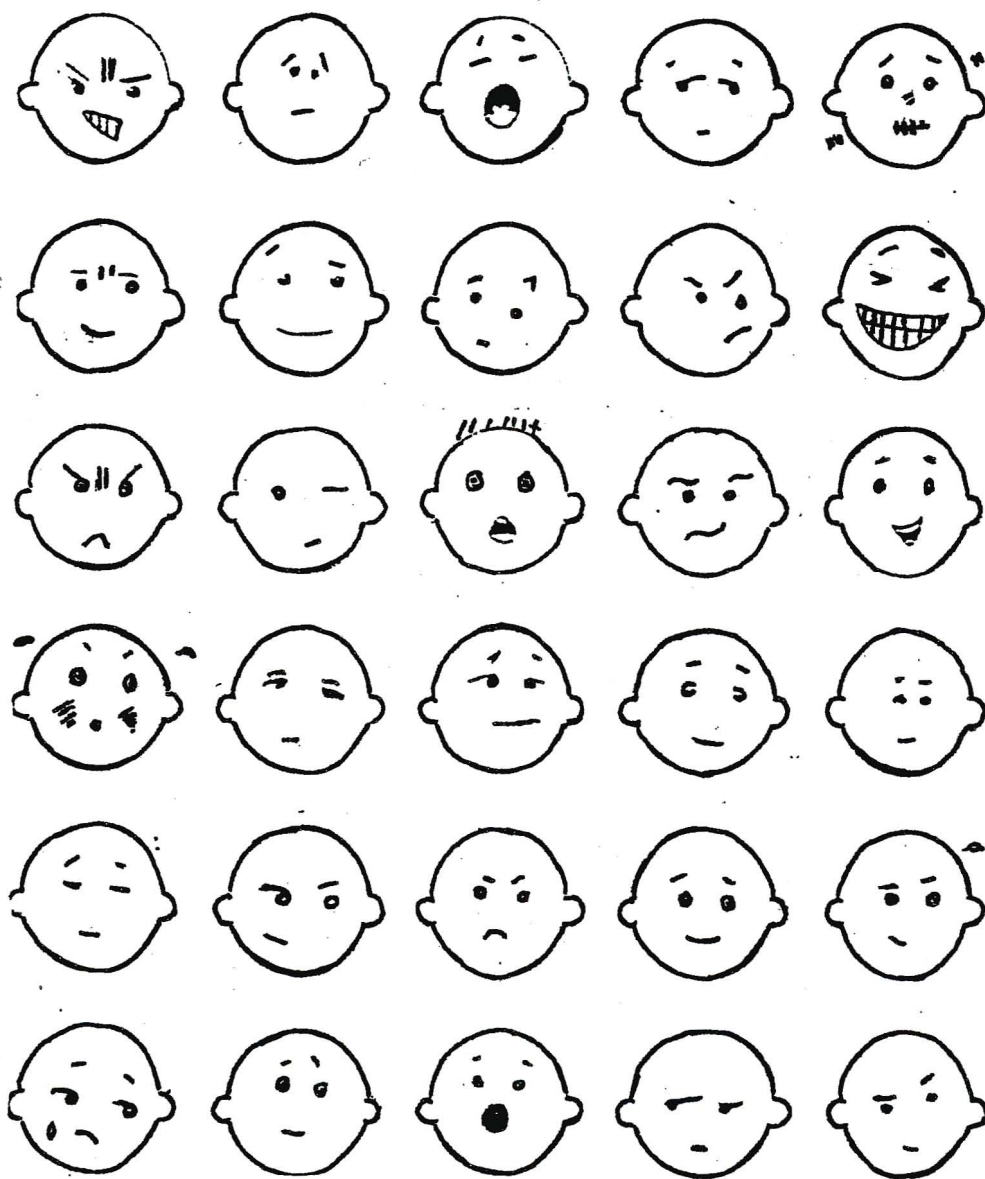
Choose the most helpful response. Explain why you think it is the best response.

1. Siphso : (with wrinkled brow, crumpled face and tears in his eyes) “We lost. That team didn’t play fair!”  
Kinship carer:
  - a. Big boys don’t cry. You’ll do better next time.
  - b. It really hurts to lose. You wanted so much to win.
  - c. Why do you think they didn’t play fair?
  
2. Thembi: (enters with her test paper in her hand) “I tried so hard but it didn’t do any good!”  
Kinship carer:
  - a. You’ll do better next time.
  - b. Well if you had studied harder, you might have done better.
  - c. It’s really frustrating not to do as well as you like, especially when you tried so hard.
  - d. You can’t expect to do as well as your sister.
  
3. Thandiwe: (scratching through her drawer wildly, looking for a particular jersey she wanted to wear to Church. She had been looking forward to this function for a long time.) “I can never find anything I want” (and begins to cry).  
Kinship carer:
  - a. Well, if you’d learn to be more organised, you wouldn’t lose things.
  - b. You’re so excited because you want to look just perfect and you can’t seem to make things go just right.
  - c. Here, let me find it.

What responses would you make in the following situations if you were practising reflecting the child’s feeling:

1. Siphso: (with wrinkled brow, crumpled up face, and tears in his eyes) “We lost. That team didn’t play fair!”  
Kinship carer:
  
2. Thembi: (enters with test paper in hand) “I tried so hard but it didn’t do any good”.  
Kinship carer:
  
3. Thandiwe: (scratching through her drawer wildly, looking for her jersey she wanted to wear to the Church function she had been looking forward to for a long time) “I can never find anything I want” (begins to cry).  
Kinship carer:
  
4. Vusi: (undressing a female doll) “Wow! Look at her bum!”  
Kinship carer:
  
5. Lindiwe: (looking through the doorway to a dark room) “What’s in there? Will you come with me?”  
Kinship carer:
  
6. Siphwiwe: (showing his torn, smudged, painting from school) “Look, Goggo! Isn’t it great! My teacher said I was a good artist!”  
Kinship carer:

# FEELINGS CHART



## FEELINGS AND THEIR EXPRESSION

All human beings have potentially the same feelings. Feelings are part of our humanness. Although they are instinctive it does not mean that we cannot control them. When we ignore or deny our feelings they do not go away, instead they seem to create more pressure and tension.

By learning to express or at least label our feelings it becomes easier for us to understand the issues that cause problems in our lives, as well as those that create joy and pleasure. This awareness helps us to be alert and responsive to problem areas and more active in seeking pleasurable moments. We cannot tell ourselves that we should snap out of feeling a particular feeling, but we can change the unpleasant feelings by trying to see things in a different light, or reacting to them differently.

How many different feelings can you think of?

Let's look at the feeling chart and try to fill in as many feeling words as we can.

Which of these feelings have you experienced this week, this month, this year?

Discuss any of the following feelings: anger, sadness, loneliness, fear.

When did you experience that feeling?

How did you react?

Did your reaction make you feel better or worse?

Happiness is a feeling that presents no difficulty. It is when we are not happy that we complain. The question therefore is: How can we achieve as much happiness as possible? Happiness is not a tangible object that we can lay our hands on. It seems to come to us when we feel we are doing something we enjoy or something that is important to us. Quite unusual things can bring us happiness, for example, when we listen to a thunderstorm, clean our cupboards, accomplish a difficult task.

### List of feelings

Admiration	Confidence	Sexiness
Ambition	Desperation	Shame
Amusement	Defiance	Enthusiastic
Anger	Doubt	Surprise
Anxiety	Excitement	Tenderness
Appreciation	Love	Wishful
Boredom	Power	Confusion
Joy	Sadness	Jealousy
Loneliness	Worry	Cheerfulness
Nervousness	Fear	Irritation
Regret	Frustration	Humiliation
Sympathy	Guilt	Tension

(Ruth Keech, 1984)

## GIVING RECOGNITION OR REINFORCEMENT

Once you have mastered the art of limit setting, reinforcement or recognition can help to motivate the child to engage in positive actions, as a matter of choice. What recognition or reinforcement means is: “rewarding or giving approval to the child for something he/she does that pleases you.”

Examples:

- 1) “Simphiwe, I’m so glad you washed your hands before you came to the table.”
- 2) “Lindiwe, you have taken great care to tidy your room. It looks great.”
- 3) “Zandile, you are the first one dressed this morning!”

Everyone likes to be praised for their efforts or deeds, e.g. you like to be recognised for cooking a good meal, making a nice dress. Consider how you feel when no one notices your efforts? Just as adults need recognition, so do children. It is important for the following reasons:

- recognition helps children to appreciate their unique talents and abilities.
- recognition keeps children’s will to improve alive.
- recognition encourages children to achieve their potential.
- recognition increases desired behaviours.

An atmosphere of recognition and reinforcement is more beneficial to both children and adults than an atmosphere of disapproval, criticism, and punishment. Criticism teaches children to lie and be afraid of you. It lowers their motivation for improving. It kills the desire for them to achieve their potential.

Reinforcement stamps in the behaviour you desire so that it becomes second nature to the child. The child starts to make connections between the behaviour and the rewards, and starts to increase his/her good behaviour because he/she enjoys the praise and reinforcement. The end result is that the child learns self- control.

### Ways of recognising good behaviour or giving approval

#### 1. Give attention to the child

Remind yourself about the importance of having a good relationship with the child. Make sure that he/she knows that you are fully aware of his /her presence and are interested in his/her experiences. Be prepared to listen and show that you understand.

#### 2. Admiring and praising

Example:

“Nonhlanhle, you got nine out of ten sums right in the test. That means you only made one mistake. Very good!”

“Nozipho, I’m really happy to see you share with your sister. That was very nice of you.”

#### 3. Giving affection

Remember to put your arm around the child, or pat his/her arm, or stroke his/her back from time to time. The need for affection is a basic human need.

**4. Giving treats**

Example: "Thanks for washing the dishes. You must be hungry now - how about the biscuit that I saved for you?"

**5. Giving special time to the child**

Time together to read a story, to play a game, or to go to the park or library, reminds the child that he/she is important.

It takes time to learn new behaviour. A child cannot be expected to change overnight and so one should not wait to reward him/her when he/she has completely mastered the task. Reward efforts, moves in the right direction. Acknowledge small successes and remind the child that you believe that he/she will finally master the change that he/she is working towards. Help to make the learning process easier by "shaping" the desirable behaviour.

Try to:

1. Structure situations to maximise the chances of some success. Help the child define manageable steps towards the desired change.
2. Reward the child's efforts in the right direction, however incomplete, and don't expect a perfect result in the beginning.
3. Select the proper rewards. They should not be too big or too small.

Recognition must be:

1. Specific, accurate and factual
2. Frequent
3. Immediate
4. Encouraging and motivating

## Helping Children Cope with Death

Death – a difficult topic for all of us – is especially hard to discuss with children. When someone close to a child dies, he/she needs to be able to talk about his/her normal fears and anxieties about dying, with the people who are close to him/her.

Death is a natural part of life. Death is not temporary, as many children tend to believe.

There are many feelings that a child has to work through, when someone he/she loves dies. It is scary for him/her to find that someone he/she loves will not be there for him/her anymore. Children react to death in many different ways. We as adults should talk with the children about the loss of the people they love. Much of their confusion is because they have not been prepared about death, nor do they understand the customs we practice when someone dies. Why do we “lay out” our dead, dress them in their best, put them in a box and bury the box in the ground? Why do we go to church when someone dies? Most importantly, why do we talk in whispers so the child doesn’t hear what we are saying when someone dies and why do we try to “protect” him/her from finding out what is going on?

Children grieve when someone near to them dies. Their grief is often difficult to understand because it is often seen as “inappropriate behaviour”. Their grief is often more intense because they do not understand what is happening and don’t know how to express what they feel and think. They feel afraid, angry, guilty – all the feelings adults go through without having the maturity and experience to help them to put things into the right perspective. This is why they express these feelings in their behaviour.

Knowing what to say to our children is easier if we understand their concept of death. Most young children do not understand its permanence. In the “magic” world they live in, they believe that wishing makes anything possible. In their imaginations they can change the world. They believe that when someone they love dies, it is only temporary, and in time, that person will return. It is common for children to deny their intense feelings when they lose someone they love. They often only cope with those feelings at a much later stage.

Children also see themselves as the centre of the world. Everything that happens not only affects the child directly, but he/she believes is probably caused by him/her, and he/she thinks that he/she has the power to undo it all. This is a normal part of the child’s development. Yet when someone dies, this can result in a child feeling responsible and guilty. Children often blame themselves for the death of someone close. Believing that they are at the centre of all that happens, and trying to make sense of this overpowering and painful event, they make dangerous connections between the parent’s death and their actions, and draw their own conclusions. “If only we had listened, Mum wouldn’t have died.”

Bargaining is a routine tool children use to control a world that is run by other people. When someone close dies, they may try to make elaborate bargains with God to get the situation reversed. It never works, and gradually they realise that they can’t control the universe, that their powers are very limited, and that the person they love is gone forever.

Once children begin to realise that death is permanent and that nothing they can do will alter it, they often go into a cycle of anger and depression. They may be openly angry with the person who dies, or the person, who they believe, allowed the death. Even God may be the target of this anger. But more often, the anger is not direct. Their anger is expressed in their behaviour. The

children may misbehave, have tantrums, and demonstrate all kinds of behaviour that releases the anger and sadness that they are unable to put into words.

Depression often follows anger. Children may feel guilty about the way they behave, or feel hopeless about the loss of someone so special, knowing that they cannot change things. Their sadness may be obvious, or subtle.

Acceptance comes with time and support. Children whose grieving is recognised and respected, who can talk to grown ups who are willing to listen, and are tolerant of the outbursts described, who offer comfort to the children at these times, come to accept death and move on with their lives.

Children need grieving cut in small portions. Their feelings can be so overwhelming that they need to deal with death over a period of time. It is important to give them a chance to play, to be with friends, to pursue normal activities.

Let us make a conscious decision to “be there for children when they lose someone they love”.

- Tell the truth in terms the child can understand.
- Help the child to see that death is a part of living. All things eventually die.
- Death is permanent.
- Speak about his/her feelings – pain, frustration, anger, and loneliness. Let him/her know that it is safe to be angry, that you understand why he/she is angry, but at the same time put limits on his acting out. Don’t mistake depression for good behaviour.
- Remind him/her about the wonderful times he/she spent with the person he/she loved.
- Help him/her to create a memory box to keep his/her wonderful memories of his/her parent alive.
- Remind him/her that he/she was not responsible for the parent’s death in any way.
- Funerals and other grieving rituals are useful for children too. Don’t exclude him/her.
- Give the child loving support. Hold and hug him/her, rock and listen to him/her.
- Expect some delays and regressions in his/her behaviour. A child may take longer than a year to grieve for someone close.

**KEY SENTENCES**

1.     Beginning:  
This is our special time. You can play with the toys in a lot of ways you want to.
2.     Ending:  
We have five more minutes for today. (After five minutes have passed.) Our time is up.  
It's time to go. I will pick up the toys.
3.     Child: Do this / Draw / Put it together.  
Show me what you want me to do / Show me how you want me to do it.
4.     Child: What is this?  
It can be anything you want it to be.
5.     Child: Is this pretty?  
So you think it is pretty.  
Child: But what do you think?  
In here it's not what I think, but what you think, that is important.
6.     Child: Guess what I am making.  
You want me to guess.  
Child: Yes, I want you to guess.  
In here you can tell me.

**RULES FOR THE PLAYROOM**

1.     The sand is for staying in the sand box.
2.     The rule in the room is half a bottle of water for every time.
3.     The rule in the room is the paper is for drawing on.
4.     I'm not for hitting / hurting.

Others:

**ACCIDENTS**

If sand or water spill accidentally, its O.K. Just say: "Sometimes accidents happen. And I know that this is an accident."

If the spill is major and immediate action is required, say: "I will come over and help you clean up." If the spill is small, just leave it.

If the child gets hurt, comfort him.

## LET'S PRACTISE GIVING CHOICES

1. You want your child to bath but he/she is too busy playing outside.
2. You want your son/daughter to do his/her homework but he/she is watching TV.
3. Your child is nagging and crying and you know he/she is tired and needs to go to bed.
4. Your son is supposed to take the rubbish out but doesn't, saying that it's unfair that he always gets the dirty jobs around the house.
5. Your daughter is teasing the youngest child who is crying. You can't bear the noise.
6. Your child has just left his/her clothes lying on the bathroom floor.
7. Your son/daughter is crying at the shops because he/she wants you to buy him/her chips.
8. Your child is making such a noise that you can't think properly.

## LET'S PRACTISE GIVING RECOGNITION

1. Nonhlanhle has tidied her room.
2. Simphiwe was very quiet in Church.
3. Thokoza prepared the breakfast and tidied up the kitchen.
4. Vusi stopped himself from hitting his sister who ran off with his bike.
5. Precious has taken great care with her picture.
6. Zodwa demonstrated good manners at the party.

## 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 midst. In the same way we want to sit in the sun when it's winter. When we are listened to, it creates meaning in our lives, we unfold and grow. New ideas develop and come to life. It makes people happy and free when they are listened to. When we listen to people it is like a gentle dance, with each of us having a turn to express our worlds and neither of us tire. Instead new energy is released.

Now there are brilliant people who cannot listen much. Their ears are just there as decorations. 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 grow; and it is this expressing, listening and expressing pattern that makes the little creative stream within us begin to grow into a healthy river of new thoughts, wisdom and pleasure.

I discovered all this about three years ago, and truly it made a big difference in my life. Before that, when I went to any social event, I would think anxiously: "Now try hard. Look lively. Think of clever things to say." When I tried, I found it hard and often my hands would sweat and my face would ache from trying to smile all the time. Then I learned that all I had to do was to listen to anyone who spoke to me with care, to be in their shoes when they were speaking; to try to know them in such a way that I would see what it was like to be in their position. This was a different kind of listening than the kind I had previously used. I did not judge them, try to change their minds, argue or even change the topic. I just listened. It was magic!

Now my attitude is: "Tell me more. This person is sharing his/her soul with me. The more I listen, the more lively he/she will get and he/she will start to move from just talking to showing me his/her true self. It will be like a dance and both of us will feel wonderfully alive."

Adapted from Ueland, B. (1974). Tell me more. The Ladies' Home Journal. November, 51,53 by Ann Petty (2001)



## Making your story book about death (based on *Lifetimes* by Mellonie and Ingpen)

Take time to find appropriate pictures. The kinds of pictures needed are nests and eggs, broken shells, fish, birds, animals, young and old, seeds, plants, fruit on trees, vegetables, bones, insects, crabs, butterflies, fish, and people, young and old. I suggest that you use the text from "Lifetimes" to help you to shape your story.

There is a beginning  
and an ending for everything  
that is alive.  
In between is living.

All around us, everywhere,  
beginnings and endings  
are going on all the time.

With living in between.

This is true for all living things.  
For plants.  
For people.  
For birds.  
For fish.  
For trees.  
For animals.  
Even for the tiniest insect.

Nothing that is alive goes on living forever.  
How long it lives, depends upon what it is  
and what happens while it is living.

Sometimes, living things become ill or they  
get hurt.  
Mostly, of course, they get better again.  
But there are times when they are so badly  
hurt, or they are so ill, that they die because  
they can no longer stay alive.

This can happen when they are young,  
or old, or anywhere in between.

It may be sad, but it is the way of all things,  
and it is true for everything that is alive.

For plants.  
For people.  
For birds.  
For fish.  
For trees.  
For animals.  
Even for the tiniest insect.

There are lots of living things in our world.  
Each one has its own special lifetime.

Trees that are tall and strong grow slowly,  
standing in the sunshine and in the rain.  
Some of them live for a very long time  
indeed, as long as a hundred years or more.  
That is their lifetime.

Rabbits and mice grow up in only a few  
weeks. Then they go on to live for a year or  
two, crunching up carrots and nibbling  
cheese until they grow old and very tired  
and it is their time to die.

That is how it happens to be for rabbits and  
mice.  
It is the way they live, and it is their lifetime.

Flowers and vegetables, planted as seeds at  
the beginning of spring, when the earth is  
warm, grow quickly to live through the heat  
of summer. The days pass, and they become  
old during autumn, when it is cooler. Then  
when winter comes, and it is cold, they die.  
It is the way they live. That is their lifetime.

Butterflies live as butterflies for only a few weeks. Once they have dried their wings, they flutter and flit from leaf to flower. At first, they are bright and quick, but as time passes they begin to slow down until finally they can go no further. They rest for a while, and then they die.  
That is the way butterflies live, and that is their lifetime.

Birds grow up quite quickly, too. It is often no more than a few months from the time they hatch until they are strong enough to fly and feed themselves. How long they live after that seems to depend upon their size. Mostly, the bigger they are, the longer they will be alive. That is the way birds live: some for as long as fifty years, others no more than two or three.  
But, however long, it is their lifetime for each one.

Fish, swimming in lakes and rivers or in the sea, can be so tiny it is hard to tell that they are there at all, or so big that the only way to describe them is enormous. Again, as far as we know, it seems that the smaller they are, the shorter will be their lifetime, but that is how it is for fish. Their lives can be as little as a day or so, or as long as eighty or ninety years.  
It is the way they live, and those are their lifetimes.

And people?

Well, like everything else that is alive, people have lifetimes, too.  
They live for about sixty or seventy years, sometimes even longer, doing all the things that people do like growing up and being grown up.

It can happen, though, just as it does with all other living things that people become ill or they get hurt.  
Mostly, of course, they get better again, but there are times when they are so badly hurt or they are so ill that they die because they can no longer stay alive.  
It may be sad, but that is how it is for people. It is the way they live and it is their lifetime.

So no matter how long they are, or how short, lifetimes are really all the same.  
They have beginnings, and endings, and there is living in between.

That is how things are for plants.  
For people.  
For birds.  
For fish.  
For animals.  
Even for the tiniest insects.

EVERYWHERE!

## TECHNIQUES OF DISCIPLINE THAT WORK

### Firm Limit-setting

There are three steps:

1. Recognise the feeling:

“I know you’d really like to.....”, or “I can tell you’re really feeling....”, etc.

2. Set the limit:

“...but you may not \_\_\_\_\_(because...)”, or “but the answer is no”, or “but the cupboard door is not for kicking.”

3. Provide an alternative:

“You can \_\_\_\_\_ if you like” or “What you can do is \_\_\_\_\_”.

- After the three steps do not discuss the matter any further.  
“I can tell you’d like to discuss this some more, but I’ve already answered that question”.
- If you are not prepared to answer the question (want to talk it over with someone, want to get more information, want to think about it),  
“I can’t answer that question now because...”  
“I’ll let you know (specific time)”.
- If nagging begins:  
“If you must have an answer now, the answer will have to be no.”
- If asked the same question again:  
Calmly-“I’ve already answered that question.”  
or  
“Do you remember the answer I gave you a few minutes ago when you asked me the same question?” (Child answers that he doesn’t remember). “Go and sit down in a quiet place and think and I know you’ll remember.”  
or  
“I’ve answered that question once (twice) and that’s enough.”
- If you think the child does not understand:  
“I’ve already answered that question. You must have some question about the answer.”
- If you are undecided and open to persuasion:  
“I don’t know. Let us sit down and discuss it.”

### **Tenets for Relating to Children**

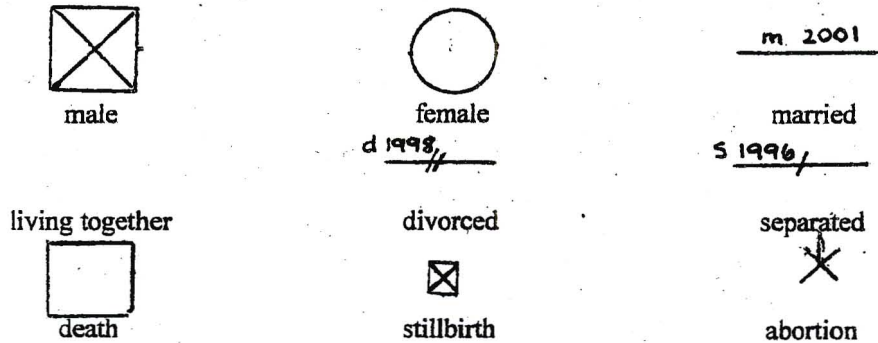
1. **Children are not miniature adults** and the therapist does not respond to them as if they were.
2. **Children are people.** They are capable of experiencing deep emotional pain and joy.
3. **Children are unique and worthy of respect.** The therapist prizes the uniqueness of each child and respects the person they are.
4. **Children are resilient.** Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.
5. **Children have an inherent tendency toward growth and maturity.** They possess an inner intuitive wisdom.
6. **Children are capable of positive self-direction.** They are capable of dealing with their world in creative ways.
7. **Children's natural language is play.** This is the medium of self-expression with which they are most comfortable.
8. **Children have a right to remain silent.** The therapist respects a child's decision not to talk.
9. **Children will take the therapeutic experience to where they need to be.** The therapist does not attempt to determine when or how a child should play.
10. **Children's growth cannot be speeded up.** The therapist recognises this and is patient with the child's developmental process.

**(Garry Landreth, 1991)**

### THE FAMILY TREE

The family tree helps one to picture a family through time. It is a kind of record of the significant features of a family through different generations. It can contain a wealth of information if family members are able to collect information. Finding out information from different family members can be fun.

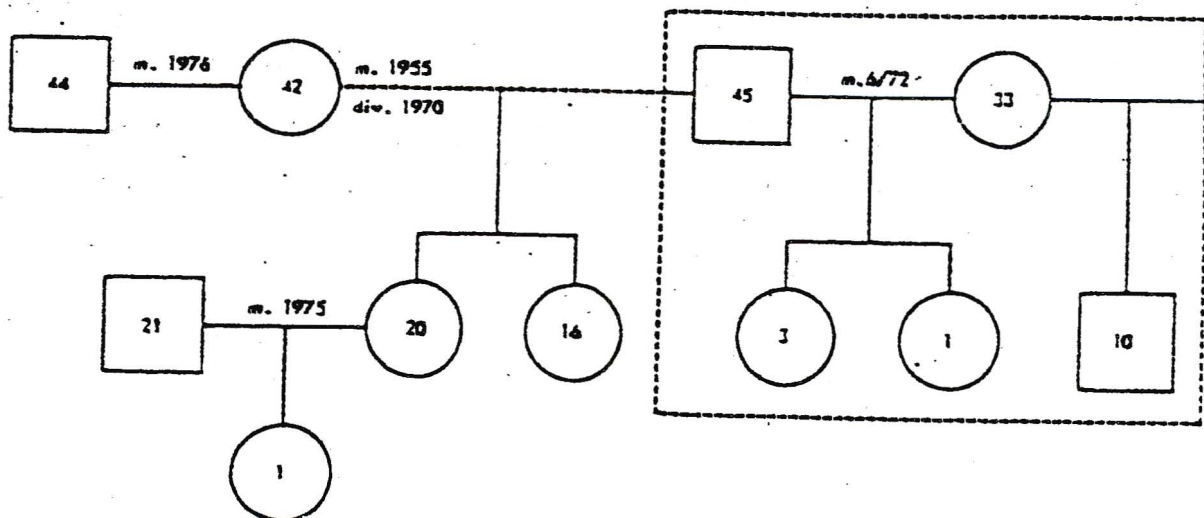
Symbols are used to describe basic family membership and structure. Significant members who lived with or cared for family members can be included. Some of the common symbols are:



Information of special importance may be noted:

- Medical history
- Religion
- Occupation
- Education
- Sporting achievements
- Special awards

### An Example



## **THE FIVE PRINCIPLES ON WHICH CHILD-KINSHIP-RELATIONSHIP TRAINING IS BASED**

### **1. Time - take time to build relationships and trust**

Children need a relaxed time with a carer. This time needs to be different from the daily routine where the messages often involve instructions, cross-questioning, lecturing or tasks. This time should be a time when the child is free to take the lead, and the carer follows. It should be a time for either laughter and fun, or serious play. The child should decide what to do. The child may choose to play alone or include the carer. The child may even just choose to sit. The play may be active or quite calm. The carer's role is to be fully present for the child during this session. The carer shows this by never judging the child, but accepting and following the child's actions without interpreting them. Because life is so busy, carers need to plan for this time and book it in advance with the child.

In this time the child will experience the carer as a genuine, honest, and respectful person. The child will feel that the carer understands, and believes in the child's personal power and so the child will start to feel free to explore his or her feelings within this relationship. It takes time for this kind of relationship to develop and so the carer must be patient and not try to rush it.

### **2. Feelings - identify and understand the child's feelings**

Feelings are the basis for actions. Show the child that you understand (or want to understand) the feelings, thoughts and motives that underlie his or her actions. The carer needs to show the child that feelings are part of his or her "humanness" and these feelings should never be judged as good or bad.

When the child complains or shows anxiety or fear do not tell the child that these feelings are stupid or unreasonable-even if you believe they are. Rather, you help the child to identify, label and accept the feelings so that he can deal with them effectively. Mirror the feelings back to the child and let him or her talk about the feelings and why he or she feels that way. A simple statement such as, "You didn't like that" or "That hurt" can make the child sense that you know what it is like to be in his or her shoes. This is one of the most important ways of showing a person that you accept them.

When children are allowed to talk about the way they feel, they bring these feelings out into the open - this allows them to decide for themselves whether the feelings are reasonable or not. They will start to explore the reasons for their behaviour and try to find new ways of coping with their situations.

Feelings are often felt and expressed as physical discomfort- headaches, nausea, tension, tiredness. Learning to cope with feelings and working through them, will help relieve these symptoms.

Often in play therapy, children work through some of their anxieties in silence. This must be accepted and the carer must resist the urge to question or break the silence.

### 3. **Problem-solving and challenges**

Play is a wonderful time for a child to find solutions to his or her problems. During sessions the carer creates space for the child to discover his or her own solutions to problems. The child is allowed to experiment with, and find solutions without adult input. For this reason, the carer never gives answers to questions unless the questions are about the carer. If asked by the child "What is this?" simply answer, "In here you can decide. It can be anything you want it to be." Or when asked, "How does this work?" reply, "Mmm, you're wondering how it goes. How do you think it works?"

Even when actions require the adult's physical strength or co-ordination, the child should be engaged in deciding just how he or she wants to involve the adult in completing the task, e.g. the child wants to open a jar that is too tight and asks for help. The carer says, "Show me what you want me to do and how you want me to do it. Is this how?" The carer asks the child to keep her fingers on the jar and exerts the necessary pressure, but gives credit to the child for solving the problem.

Play therapy helps children to gain a sense of mastery over their world. It is a very empowering experience.

### 4. **Limit setting - is reality based**

The child needs to learn that limits are an important part of life. Limits are applied to protect the child, and others. The child learns that complete freedom is unrealistic. He or she has to limit his or her wishes to prevent detrimental consequences. The child needs to know that the carer has the final authority if boundaries are not respected. The child learns the difference between impulsive actions that have unpleasant consequences, later, and carefully chosen alternative actions. When the child behaves in a way that is harmful to himself, the carer, others or objects, then he is reminded of the limit. The feeling behind the intended action is acknowledged. The limit is specified and a suggestion is made about an alternative behaviour that has more rewarding long-term consequences. The child is given the choice and if need be the carer enforces the consequence.

In other words, the child is reminded of the rule. Rules should be clearly defined and consistent. If the rule is broken, there is a predictable outcome. Some people call this a penalty. If the child does not keep the rule, there is no shouting or anger. The penalty is automatic, and the carer can reflect the child's feelings. "You feel angry that you have to miss TV tonight, because you did not do your homework - how can you make sure that this does not happen again?"

### 5. **Structure**

The sessions need to happen regularly. The toys are always the same and are laid out before the session in the same way. The child is reminded on entering the session that he has thirty minutes to play with the toys in as many of the ways as he chooses to. The space for the sessions needs to be big enough for some rough play and should be cleared of breakable and valuable items beforehand. No one is allowed to interrupt the sessions. A five-minute warning is given before the session ends. At the end of the session the child is told that the time is up. The child is told that he does not need to tidy up.

The child is never allowed to play with the toys between play sessions. After the session the carer stores the toys away in their box.

## The Five Tips of Effective Discipline

### An Information Sheet for Carers

#### 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.
- Decide which rules may never be broken: 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.
- There may be rules about homework, TV viewing, playtime, spending money, and responsibilities.

#### 2. Consistency

Be consistent in rules and discipline or reward, but be flexible, too, to encourage growth and independence.

- Whenever possible, make this exception before the rule is broken. This helps develop the child's sense of reasoning, problem solving and compromise.
- Warn the child of new disciplines that will be taken before the rules are broken.

#### 3. Communication

Talk about rights, rules and limits and the reasons for them.

- Help your child learn to talk about feelings and needs - and make sure that he/she knows that he/she is allowed to ask for help.
- Talk about how rights and limits change as the child grows. Children need space to take risks, explore and become more independent.
- Be willing to discuss the fairness of any rule.

#### 4. Caring

Make sure that discipline only happens in the context of a caring relationship. Remind the child that he/she is loved and respected. Children who have close, affectionate ties with their carers are most likely to obey family rules.

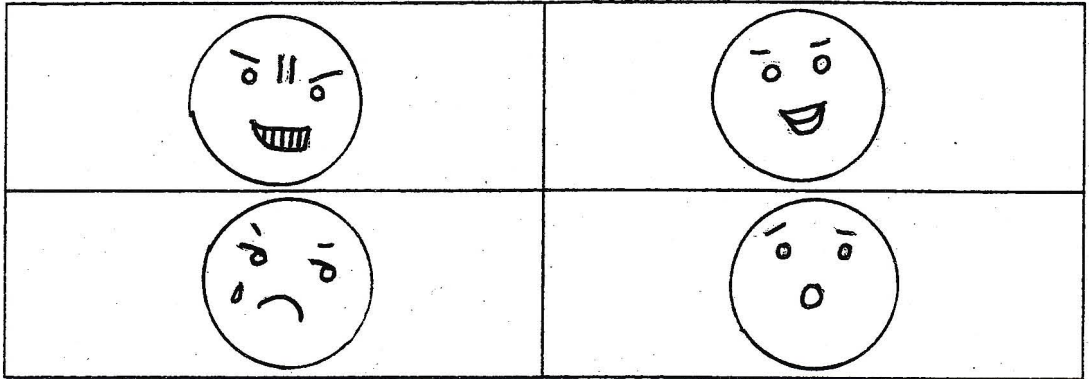
- Criticise the action, not the child. Instead of saying, "How could you be so stupid?" say, "Do you know why that was so dangerous?"
- When rules are broken try to keep your emotions in check. Act as though you are calm and carry out the discipline in a matter of fact way.
- Recognise the child's needs and rights, such as the right to privacy.

#### 5. Communalism

Help the child recognise that he/she is part of a bigger picture and that he/she has a responsibility towards others too. Give your child regular chores to help him/her develop self-discipline and a sense of accomplishment.

- Help your child see how his/her actions impact on others.
- Ensure that they are accountable for their actions.
- Help your child develop a sense of self-respect so that they think about how an action will make them feel about themselves.

### THE FOUR BASIC FEELINGS



Active listening responses this week

1.

2.

3.

4.

## THE MAGIC OF PLAY

“Play” can mean different things to different people. Usually, when used to refer to an adult activity, it means taking part in a game requiring physical or mental skills, or using a musical instrument. Sadly, when used to refer to a child’s activity, adults often take it to mean something that has no serious point to it. Something that is senseless or frivolous.

Studies of children’s play have shown that this is not the case at all. For the child, play is an enjoyable, voluntary, purposeful and spontaneously chosen activity. It is often creative as well. It involves problem solving, learning new social, language and physical skills. Far from being an activity with no purpose, it is important to the young child. It provides him/her with a place to test out new ideas, experiment with new behaviour, adapt socially and overcome emotional problems.

One seldom has to do anything to get the child to play. The child possesses an innate sense of what needs to be “played” in order to facilitate the self-healing or self-mastery process. The adult’s role is simply to create the right atmosphere for this important activity to take place.

### Guidelines

1. Treat the child with respect. It is a privilege to be allowed to witness the child at work. Believe in his/her ability to choose activities that will allow him/her to work through the issues that are most pressing in his/her life. Curtail any urge to direct or control the play.
2. Create a permissive atmosphere that will allow the child to engage in free-form play, i.e. play that has no rules or roles for the child to adhere to.
3. Remember that the most meaningful forms of play are those that are self-invented. This kind of play frees the child’s sense of creativity, his/her problem-solving abilities, and empowers him/her to make sense of the world he/she finds him/herself in.
4. Recognise this activity as serious and so do not joke, or tease the child. Also do not talk to others about what you observe, unless it is a trained professional who will respect the child’s right to confidentiality.
5. Wait to be invited to join in the play. Remember to ask the child what he/she would like you to do and how he/she would like you to do it.
6. Provide a collection of items that will allow the child to express a range of emotions and inner experiences.
7. Create a safe environment for the child to work through feelings - a place where the child will not harm him/herself, or face negative consequences as a result of his/her actions.
8. Believe in the child’s ability to work through his/her personal issues on his own. Your role is merely to support him/her through this.
9. Don’t assume that you know what the play is about. Rather than rely on your own interpretations, wait for the child to explain what is going on. He/she will disclose this when he/she feels safe to do so.
10. Your role is not to cross-examine the child about the meanings of the play, but rather to follow or track his/her actions and responses in play, with sensitivity and care.

## THE MEANEST MOTHER IN THE WORLD

I had the meanest mother in the world.  
While the other children had sweets for breakfast, I had to eat porridge.  
While other children had Cokes and sweets for lunch I had a sandwich.  
As you can guess, my dinner was different from other children's dinners, too.  
My mother insisted on knowing where we were at all times.  
You'd think we were on parole.  
She had to know who our friends were and what we were doing.  
I am ashamed to admit it, but she actually had the nerve to break the child labour law.  
She made us work. We had to wash dishes, make the beds, and learn how to cook.  
That woman must have stayed awake nights thinking up things for us kids to do.  
And she always insisted that we tell the truth.  
By the time we were teenagers, our life became even more unbearable.  
No boy was allowed to whistle for us to come running; she embarrassed us to no end by insisting that the boys come to visit us at home.  
Our friends were allowed out at the mature ages of 12 and 13, but our old-fashioned mother expected us to wait until we were 17.  
She really raised ordinary people.  
None of us were ever arrested for shoplifting or caught with drugs.  
And whom do we have to thank for this?  
You're right, our mean mother.  
I'm trying to raise my children to stand a little straighter and taller, and I smile to myself when my children call me mean.  
I thank God for giving me the meanest mother in the world.  
Our country doesn't need anything other than more mothers like mine!

## THE MEMORY BOX

Death is a sensitive issue that many people don't like to talk about. In some cultures subjects such as illness, death and sex are never discussed with children. In modern societies where there is a prevalence of AIDS and violent deaths, it may no longer be appropriate to continue the conspiracy of silence as this silence seems to trap children in their grief, allowing them to have strong feelings of fear, panic and loss of identity.

A memory box or book is an attempt to help a child retain a sense of whom his/her parents were, what their aspirations for him/her were and it serves as an ongoing reminder of his parents' love for him/her once the parents die. When a parent learns that they are suffering of a terminal illness, the parent compiles a memory box for the child to refer to after their death. In this box or book the parent captures information about their own early lives, their families' origins and who their relatives were. The memory box also allows them to express their own beliefs and values, and their aspirations for their children's future lives. Whilst the children in your care do not have the memory box to fall back on, there is nothing stopping you from helping them to compile one.

Much of what you have learned in this course will help you to assist the child through his/her grief. You have learned and practised the art of listening and showing understanding. You also have learned that the child's needs are often reflected in his/her behaviour and you are now quite adept at finding ways to assist the child to cope with or manage feelings. You are now ready to start preparing a memory box. These are some suggestions of what you may choose to put in that box:

- compile a family tree
- highlight significant aspects of the family history
- describe the family's way of life, culture and beliefs
- keep a copy of the parents' birth certificates, marriage certificate and death certificates in there
- have a section on the people who are significant in the child's life that the child can turn to for assistance at different times in their lives
- have a section on the things that the parents would have wanted the children to know about life
- highlight the parents' hopes for the child's future
- the child's birth
- the child as a baby
- the parents' interests
- the parents' achievements
- a few mementos such as a purse or scarf
- photographs

(Based on the Memory Project, Kaleeba, Kadowe, Kalinaki and Williams, 2000, p.70-73)

## 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 he or she is out of control feels insecure. He/she puts on a tough exterior. His/her actions are easy to misread because they appear to be attempts to show that he/she cannot and will not be controlled. Children need limits but often fight about having them.

Parents can place limits in these situations by giving away some of their control. At the same time they gain more control. This small miracle comes about when children are given choices rather than orders.

It's 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 the situation in which a parent gives some control to the child while gaining more for him/herself. A youngster is making too much noise in the kitchen. A typical response would be, "Stop making so much noise. You're making me cross!"

This usually does not work because it gives the child the wrong kind of control. The child knows how to make the parent angry.

By giving a child choices, the parent offers the child some positive control over his or her own life. "You can either stay here with us being quiet, or go somewhere else to make your noise."

A determined child might fight this by saying, "I'm staying here! I have just as many rights as you!"

The parent replies calmly, "That's not one of the choices, but feel welcome back with us when the noises are finished."

Providing choices is based on 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. It is important to set limits without insulting the child.

The child's dignity and the parent's dignity were maintained. The child was left with the decision regarding his behaviour. The parent's dignity was maintained by him/her remaining calm and controlled.

Dealing with choices and being held responsible for decisions prepares children for a lifetime of decision-making that is 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 than the parents who lecture.

From Cline/Facy Institute, Inc. 1985  
and Ravat (2001)(b).

## TOYS FOR PLAY SESSIONS

Please go over the list and check what you have at home and what you can borrow. Do not go shopping for the toys. Wait till we have discussed it in the first session.

Toy	Have it at home	Have to borrow
Play dough		
Crayons (6-8)		
Paper		
Blunt Scissors		
Baby Bottle		
Rubber Knife		
Dart Gun		
A Family of Small Dolls		
Toy Soldiers		
Small Cars, Aeroplanes, Boats, Truck		
Mask/Balaclava		
Doctor Set		
Play Money		
Rope- 1 to 2 metres		
Punch Bag		
Hand Puppets		
Baby Blanket		
Knobkierrie		
Cardboard Box to make a doll house		
Dollhouse Furniture		
Toy Telephone		
Hand Cuffs		
Baby's Bottle		
Sjambok		
Farm Animals, Wild Animals		
Sand		
Water Basin/ Bowl/Clay Cooking Pot		
Blocks		
Musical Instrument		
Tennis Ball and Bat		
Tea set, pots and pans		
Other		

## WHEN "SETTING THE LIMITS" DOES NOT WORK

You have been careful several times to (1) reflect the child's feelings, (2) set clear, fair limits, and (3) give the child an alternate way to express his/her feelings. Now the child continues to deliberately disobey. What do you do?

1. **Look for normal causes for rebellion:** fatigue, sickness, hunger, extreme stress, abuse/neglect, etc. Physical needs and crises need to be attended to first before one expects cooperation.
2. **Remain in control, respecting yourself and the child:** you are not a failure if your child rebels, and your child is not bad. All children act out at some time. It is a way of learning to stand up for themselves.
3. **Set reasonable consequences for disobedience:** let the child choose to obey or disobey, but set reasonable consequences for disobedience and enforce the consequences, e.g. "If you choose to watch TV instead of going to bed, then you choose to give up TV all day tomorrow".
4. **Never tolerate violence:** physically restrain the child who becomes violent, without becoming aggressive yourself. Continue to reflect the child's anger and loneliness; provide compassionate control and alternatives.
5. **If the child refuses to choose, you choose for him:** the child's refusal to choose is also a choice. Set the consequences, e.g. "If you don't choose between bathing now and watching TV later, or not watching TV at all, then you have chosen for me to pick the one that is most convenient for me."
6. **Enforce the consequences:** "Don't draw your gun unless you intend to shoot". If you give in to your child's anger or tears, you have given up your role as a parent and lost your power. Get tough, try again.
6. **Recognise signs of depression:** the very angry or rebellious child is in emotional trouble and may need professional help. Share your concern with the child, e.g. "Lindiwe, I've noticed that you seem to be angry and unhappy most of the time. I love you, and I'm worried about you. We're going to get help so we can all be happier."