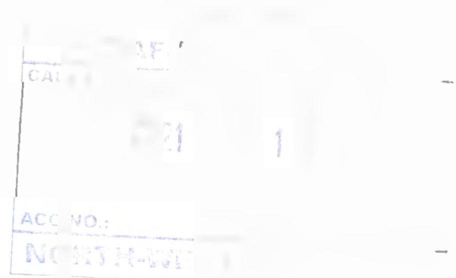
SOCIAL WORK, PLAY THERAPY AND CHILDREN WITH LEARNING DISABILITIES.



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SOCIAL WORK, PLAY THERAPY AND CHILDREN WITH LEARNING DISABILITIES.

By

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Submitted in accordance with the requirements for the degree of

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"I declare that the dissertation for the degree of Master of Social science in Social work at the University of North West hereby submitted, is my own work and that the sources I have used herein have been duly acknowledge."

Janda Maria de Kock

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"If we were to allow the wonder of the life of a child to reach us fully and truly and to be our teacher, we would have to say: "thank you, child of man...for reminding me about the joy and excitement of being human. Thank you for letting me grow together with you, that I can learn again of what I have forgotten about simplicity, intensity, totality, wonder and love and learn to respect my own life in its uniqueness. Thank you for allowing me to learn from your tears about the pain of growing up and the sufferings of the world. Thank you for showing me that to love another person and to be with people, big or small, is the most natural of gifts that grows like a flower when we live in the wonder of life."

By Peccei

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CHAPTER ONE

1 ORIENTATION

1.1 Introduction

Why is it necessary for a social worker to give professional support to a child who fails in school? Why is it necessary for a social worker to give professional attention in the field of education? What will her objectives be and how can she use play therapy in dealing with this child? It goes without saying that unattended learning problems may cause serious or even permanent damage to a child's social, emotional and intellectual development. The child with learning disabilities, who experiences difficulties to learning, may fall behind and eventually drop out of school. This may even lead to involvement in dubious activities such as crime, and he may become another social burden. To prevent this child from becoming a social drop-out, he requires specialised support services to assist him throughout his school career.

The social worker may render a professional service, aiming at enhancing the social and emotional coping skills of the client, ensuring optimal functioning, in order to prevent and restore dysfunction, and help him become the child he is meant to be. This support service could be accomplished amongst others through the use of play therapy. The social worker may act as a source of expertise and advice for the learning disabled child, his parents, and the teachers who work with this particular child.

According to Gambrill (1983:12) life is not always easy for learners with special needs. The audience they meet is not always sympathetic. It is the responsibility of the social worker to help the client, in this case, the child with a learning disability, to make a match between his handicapping abilities and the professional resources offering solutions:

> "Getting along in the world poses problems in living. For all of us there are discrepancies between how things are and how we would like them to be. In trying to find solutions or a sympathetic audience

we often consult friends, family members, or even strangers. Often, such helping sources together with our own resources provide sufficient aid. At other times, however, the match between our own resources and the particular environment we find ourselves in, does not offer solutions, and help may be sought from a social worker who will try to improve this match."(Gambrill 1983:12).

The social worker is faced with the fact that the spectrum of the professional support she has to provide is extensive, because of the complexity of learning disabilities. The goal of the social worker could thus be seen as:

- One who guides the child with a learning disability to develop problem-solving skills, to enable him to cope effectively and to enhance his emotional and social functioning.
- Informative, to provide professional guidance to teachers for handling specific emotional and social problems of the child with a learning disability in the inclusive environment.
- Give guidance to the parent in learning how to cope with their child with a learning disability with more understanding and less frustration.

The challenge is to actualise the potential of the child with a learning disability by identifying the emotional problems when they arise and then to plan a support program to aid his total capacities and needs with dedicated patience and understanding.

With the ongoing debate in the field of education based on Curriculum 2005, regarding the higher student teacher ratio, problems arising out of inclusion and so forth, the specific needs of pupils with learning disabilities may be overlooked. In order to progress satisfactorily in school the child with a learning disability needs remedial education as well as social and emotional guidance. Without these support services the learning process may be seriously disrupted. The child with a learning disability will then not be able to cope academically. Without professional

help, he will most likely become an underachiever, emotionally handicapped, a social outcast, and a drifter through life.

Transley and Gulliford (1962:49) have already stressed in 1962, the close correlation between the emotional state and mathematical performance of a child:

> "Children whose basic needs have been inadequately satisfied may be difficult to motivate. It is difficult to interest children in Arithmetic if they are continually pre-occupied with the relationship with their parents. They cannot organise their emotional energies for learning in school if they are continually being upset by feelings of hostility and jealousy, or riddled with anxieties about their own failures..."

The Department of Education in Curriculum 2005, Lifelong Learning for the 21st century (1997:1) stipulates that the learner needs emotional, social, intellectual and physical support. This type of child suffers from one of the most disabilitating types of experience possible. He needs to develop life-skills, to listen and co-operate with others and be able to solve problems. The learning disabled child struggles to listen and co-operate because he has a short attention span, is easily distracted making it very difficult, and almost impossible to cope in a big group.
The child with learning disabilities:

- Is easily distracted and cannot work in a big group.
- Has a short attention span and finds it impossible to focus, on that which is relevant, in an auditory environment.
- Has a short memory span.
- Is often hyperactive.
- Is emotional labile.
- Does not integrate information spontaneously and cannot form generalisations. (Kephart, 1968: 14-15).

He sees himself as not capable of performing on a level with his peers (which in itself is frightening) but even more fear producing, is the thought that he is not performing on the level where he himself feels and expects he should be. He feels

trapped within a situation that he is not able to control. He believes that these conditions are insurmountable. It is this defeatist attitude that must be overcome, because it builds an invisible fence around him, and without the support of the professional team the learner will never emerge from its boundaries.

The child with a learning disability places limits on his accomplishments, because he believes that he is incapable and cannot perform adequately. He typically begins to have doubts about his own capability. Feeling powerless, he becomes frustrated and sometimes adopts violent behaviour. He is aggressive and hostile, not only to those in authority but also to his peers. Alternatively he may retreat by withdrawing into a passive protective shield, failure is accomplished by refusing to try. The child is frightened, insecure, frustrated and he focuses his attention on his failures and shortcomings. This reaction is often caused by the attitudes of those who have authority over his life. Teachers or parents learn to expect certain behavioural patterns from learners. If they have labelled the learner as "slow or bad", almost any type of behaviour will be judged from within the framework of that opinion. (Johnson, 1979:10)

It is clear that the child with learning disabilities has specific needs. He needs to overcome emotional and social barriers. He needs to form and maintain positive relationships, to overcome and prevent serious negative emotional problems. He needs quality support to reverse his low self-esteem, his self-contempt, and his feelings of powerlessness, his frustrations and need of acting out behaviour. It follows that educational presentation for the learner with learning difficulties, must be designed to match his individual learning style. The child with learning disabilities presents an educational challenge.

Curriculum 2005 demands that education re-evaluates its procedures and practices and adapts its activities to the requirement of quality education for all pupils so as to empower them to participate as active citizens. (National Department of Education, 1997:1-3)

The social worker can:

- Enable the child towards a problem-solving way of thinking.
- Help him develop capacities within himself so that he will be able to cope in a group situation and to control and understand his emotions.
- Help the child break away from the negative mental image that he holds of himself.
- Help him build a positive attitude towards himself.

As a child communicates through play, the social worker can make use of play therapy in supporting the child with a learning disability. Play is to the child what verbalisation is to the adult. It is a medium for expressing feelings, exploring relationships and self-fulfilment. Through play she can reconstruct the self-image of the learner, and construct a solid foundation of what the learner can expect from life. She can help him get rid from the invisible barriers composed of self-doubts.

1.2 Objectives

The learning disabled child experiences so much frustration and disappointment in his school accomplishments that his interest and motivation drops. His learning becomes impossible, and his patience shortens with resulting displays of temper and poor emotional control. He becomes a loner, a troublemaker and an underachiever. The social worker is qualified to address these forms of crying out-behaviour and can act as a supporting system. The objective of this study is therefore aimed at:

- Determining the role of the social worker in dealing with the child with a learning disability, who may experience social, emotional and behavioral problems in an inclusive school situation.
- Determining how play therapy as a therapeutic aid can help the child cope at all levels of his existence when interacting with other individuals, situations and the environment.

To accomplish this, the following steps were taken:

- A review of available literature central to this study.

- A literature survey that determines how the educational environment where inclusion is practised, will affect the child with learning disabilities.
- The relationship between learning disabilities and social/ emotional problems that may lead to underachievement, a low self-esteem and cry-out behaviour were determined.
- A description and evaluation of the role of the social worker in dealing with the learning disabled child who experiences social and emotional problems.
- Suggestions were formulated of how the social worker can use play therapy as a therapeutic aid in helping the learning-disabled child cope at all levels when interacting with other individuals and various situations in his environment.
- The community was informed about the typical problems of children with a learning disability functioning in the community.

1.3 Statement of the problem

Learning-disabled children have been part of public schools for many years. Kephart (1968:5-6) found in his survey as far back as 1966, that 17% of the normal school population displayed symptoms characteristic of learning disorders. These problems caused significant reductions in school achievement. Kephart found with further research that learning disorders affect at least 15-20% of the school population. This means that in a typical classroom of 30 children there will be 5 or 6 struggling to achieve academic success.

Sapir (1973:660) states that a review of literature suggested that 7% to 25% of all school children are in trouble academically. The reasons for their failure include emotional disorders, neurological dysfunctions, environmental stress, developmental lags and genetic factors. Heideman (1973:1) states that about 15% to 20% of the children in any heterogeneous class have difficulty in learning the basic school subjects. He explains that these figures do not include children who have a lower intellectual capacity or emotional problems. These children may experience emotional problems as a result of learning problems.

According to Lerner (1997:17-20) there has been an increase in the number of children with a learning disability. This can be contributed to the fact that educationists now have a better awareness of what to look for in a child and have improved methods of testing for learning disabilities. The number of boys with a learning disability occupying the classroom is four times more than the girls with a learning disability. Lerner (1997:17) states that there are three reasons for this situation:

- "**Biological causes**- males may be more vulnerable to learning disabilities;
- **cultural factors**- more boys may be referred because boys tend to exhibit more disruptive behaviour that are troublesome to adults;
- **expectation pressures-** the pressure to succeed in school may be greater for boys than for girls, making boys more vulnerable to the efforts of stress".

According to researchers there is a definite correlation between the emotional state of a child and his academic performance. If the emotional needs of a child are not fulfilled, he might develop feelings of failure and insecurity, because he thinks of himself as a 'loser'. These emotions will handicap him in such a way that he will not be able to cope with the daily challenges. Bently, Washington and Young (in Mowbray and Salisbury, 1975:109) stress the fact that if a child experiences emotional security he will feel comfortable to engage in new learning experiences:

> "If children's emotional needs have not been met, any attempt to provide learning experiences to foster their cognitive development could be futile. When a child is emotionally secure and stable, he is then ready to engage in a variety of learning experiences."

A child with a learning disability in an inclusive environment without support systems in the classroom of 2005 is definitely at risk. Because of continued failure, his poor performance at school will have a profound effect on his life. His self-esteem

and emotional state is at risk. If this is not followed up, this child may react with cry-out behaviour and become one of the many "educational casualties". If such a child is seen in therapy by a social worker just after a learning disability has been identified, preventive measures may be implemented. This could eliminate self-destructive conditions that may lead to emotional maladjustment and/or intellectual deprivation, which result in serious underachievement, social dysfunction and despair.

The social worker is confronted with a learning disabled child in the inclusive environment, who needs strength within to dispel this sense of inadequacy, to reassure a healthy self-esteem and emotional state that will help him live up to his full potential in this lifetime, despite his hidden handicap. The social worker can attempt to address these problems through play therapy and help a child with learning disabilities to control and manage his life successfully.

1.4 The significance of research

Curriculum 2005 (Department of Education, 1997:2) calls for an open classroom where no learner is excluded from the right to unbiased education. The learning disabled child needs special support within the inclusive situation. The social worker, educators, community and peer groups are to join hands to support and guide the learning disabled child.

There has not been empirical research conducted in South Africa with regards to the role of the social worker and the child with learning disabilities in the classroom of 2005. With problems arising from inclusion, now facing education in the country, the researcher considers the study justified and necessary. This study attempts to identify various problem areas, and suggests positive guidelines on how the social worker as part of the support team can deal with a child with learning problems in the new inclusive situation.

Educators maintain that the means through which the child communicates best is play. The social worker can therefore use play therapy as a therapeutic aid in lead-

ing the child with a learning disability to cope and function optimally in life. The researcher hopes that through this study:

- Parents and educators will acknowledge the importance of a social work practitioner as member of the support team.
- That play therapy will be recognised as an important therapeutic tool to help the child with serious emotional and social problems, caused by learning disabilities to cope optimally in the inclusive environment

The researcher believes that effective intervention, where the therapy is focused on prevention and coping skills, will ensure a richer more fulfilling existence for the learning disabled child, and help him to cope successfully in the inclusive educational environment.

1.5 Assumptions

Assumptions according to Grinnell (1988:103) are formulated on the basis of our own values, the values of our profession and as a result of reading literature and discussions. He stresses the importance of assumptions when formulating a particular research problem:

> "The variables we decide to focus on are thus determined by the assumptions underlying the particular study. It is important that our assumptions are stated clearly, such statements help set limits to our study and allow further deductive analyses to be carried out on the theory itself." (Grinnell, 1988:104)

The focus of this specific research is:

"Children with unattended learning disabilities in an inclusive educational environment may develop serious emotional, social and behavioral problems. The teacher, parent and community may form a team together with the social worker, and guide the child with a learning disability to optimal functioning.

Social workers may apply play therapy in supporting the child to enable him to cope and function optimally in his life environment."

The following was assumed relating to the focus of research:

- The emotional status of the child with a learning disability and academic performance influence each other directly. Children with unattended learning disabilities in an inclusive educational environment may develop serious emotional and behavioral problems.
- Learning disabilities may lead to emotional problems; low-self esteem and cry out behaviour.
- Prevention of emotional problems and low-self esteem by a child with learning disabilities may ensure optimal performance in the school environment.
- Various techniques of Play therapy used skilfully may ensure that the child with a learning disability functions optimally.
- Curriculum 2005 calls for a social worker as part of the multi-professional team to help all children with learning disabilities to cope within a normal situation.
- By means of a workshop the community may be informed in how to support the child with a learning disability, to enable him to cope and function optimally in his life environment.

1.6 Limitations

1.6.1 Representation

A research project of this nature inevitably has certain limitations. Although the study consisted of only ten respondents from the Stella - Vryburg area in the North West Province, the intervention strategy could be used with any grade 1 to grade 4 learning disabled child in any region in the RSA. The researcher only used ten cases to prove the intervention strategy due to the in-depth study method.

1.6.2 Lack of objectivity

The researcher had to constantly be objective when observing the child with a learning disability. She was confronted with the problem of a lack of objectivity during the interviews with the parent and teacher. The researcher had to define ex-

actly what was observed and measured, to assure objective observation for valid knowledge. This meant that information gained, were double checked, which was time consuming.

1.6.3 Availability of literature

Literature on play therapy, learning disabilities and inclusion are available, but literature on the combination of these three topics in relation with social work is limited.

1.7 Definitions of concepts

In the context of this research the following concepts will be defined:

- Social work and social worker
- Child
- Normal, disability, learning disabilities, and learning disabled
- Inclusion, co-operative learning, and outcomes-based education (OBE)
- Directive therapy, non-directive therapy, play and play therapy

1.7.1 Social Work

Barker (1991:237) in "The Social Work Dictionary" defines social work as:

> "The professional activity of helping individuals, groups or communities enhance or restore their capacity for social functioning and creating societal conditions favourable to this goal."

According to the New Dictionary of Social Work (1995:60), social work is that:

> "Professional services by a social worker aimed at the promotion of the social functioning of people."

and social functioning (New Dictionary of Social Work,1995:58) implies the:

> "Individuals role performance in its entirety at all levels of existence in interaction with other individuals, families, groups, communities and situations."

One of the classical definitions of social work published in 1958 by Werner Boehm (Compton and Galaway, 1979:6) stated:

> "Social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused upon their social relationships which constitute interaction between individuals and their environments. These activities can be grouped into three functions: restoration of impaired capacity, provision of individual and social resources, and prevention of social dysfunction."

Social work can thus be seen as a professional service rendered by a social worker aimed to enhance the problem solving, coping, and developmental capacities of the client so that he will function optimally in his environment, and that dysfunction could be prevented.

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1.7.2 Social workers

According to Barker (1991:222) in "The Social Work Dictionary" social workers can be defined as:

> "Graduates of schools of social work (with either bachelor's or master's degrees), who use their knowledge and skills to provide social services for clients (who may be individuals, families, groups, communities, or society in general). Social workers help people increase their capacities for problem solving and coping, and they help them obtain needed resources, facilitate interaction between individuals and between people and their environments, make organizations responsible to people, and influence social policies."

1.7.3 Child

A child according to the New Dictionary of Social Work (1995:8) is:

> "A person under the age of 18 in terms of the Child Care Act, 1983 (Act 74 of 1983).

For the purpose of this study the focus will be on children between the ages of 6 and 10.

1.7.4 Normal

Barker (1991:157) in "The Social Work Dictionary" defines normal as:

> "A term denoting a culturally defined concept of behaviors or phenomena that are not markedly different from the average, usual, or expected."

1.7.5 Disability

Barker (1991:63) in "The Social Work Dictionary" defines disability as:

> "Temporary or permanent inability to perform "normal" activities, usually as a result of a physical or mental condition or infirmity."

1.7.6 Learning Disabilities

As a reflection of its ambiguous nature, the definition of learning disabilities has been continually revised over the years. In 1969 the Division for Children with Learning Disabilities of the Council for Exceptional Children patterned one definition namely:

> "A child with learning disabilities is one with adequate mental ability, sensory processes, and emotional stability who has specific deficits in perceptual, integrative, or expressive processes which severely impair learning efficiency." (Westman, 1990:22)

The National Joint Committee for Learning Disabilities in Westman (1990:22-23) proposed a more realistic definition in 1981:

> "Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifesting by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g., cultural differences, insufficient or inappropriate instruction, psychogenic factors), it is not the direct result of those conditions or influences."

The most common definition for learning disability according to Lerner (1997:9) is their federal definition taken from the individuals with Disabilities Education Act (IDEA). It states:

> "The term 'specific learning disability' means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include a learning problem which is primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage."

Learning disabilities can therefore be seen as a group of disorders manifesting by significant difficulties in the use of listening, speaking, reading, writing or mathematical abilities. The child with a learning disability therefore needs specific support to cope in life. A learning disabled child is also different from a child with a learning problem. Westman (1990:23-24) assumed that the causes of learning problems were entirely emotional.

1.7.7 Learning disabled

According to Barker in The Social work Dictionary (1991:129) learning disabled can be defined as:

> "A descriptive term for children of normal or above – average intelligence who experience a specific difficulty in school, such as dyslexia (reading difficulty); dysgraphia (writing difficulty); or dyscalculia (math or calculation difficulty)."

1.7.8 Inclusion

According to Forest and Pearpoint (1997:1) inclusion in the educational environment means:

> "affiliation, combination, enclosure, involvement, surrounding. It means WITH... inclusion means BEING WITH one another and caring for one another. It means inviting parents, students and community members to be part of a new culture, a new reality.
> Inclusion means joining with new and exiting educational concepts (co-operative education, adult education, whole language, computer technology, critical thinking). Inclusion means inviting those who have been left out (in any way) to come in, and asking them to help design new systems that encourage every person to participate to the fullness of their capacity - as partners and as members."

According to Smith (1997:2) inclusion is not just about placing a child with a disability in a classroom or a school but inclusion is how to deal with diversity and with difference. It means to build a better society with more acceptances, more love, more care, and more compassion.

> "Inclusion means:
> - providing all students enhanced opportunities to learn from each other's contribution,
> - having all learners follow the same schedule,
> - encouraging friendship between all students,
> - teaching learners to understand and accept human differences,
> - placing pupils with special needs in the same schools they would attend if they did not have disabilities,
> - providing an appropriate individualised program."
>
> (Smith, 1997:2)

1.7.9 Cooperative learning

Vygotsky (1979:90) stresses that 'learning awakens a variety of internal developmental processes that are able to operate only when the child is interacting with people in his environment and in co-operating with his peers. Once these processes are internalised, they become part of the child's independent developmental achievement." For Vygotsky, a child's potential for learning is revealed and realised in interactions with more knowledgeable others.

1.7.10 Outcomes-based Education (OBE)

According to the Department of Education (1997:8-9) Outcomes based Education or OBE, is the approach in education, that aims not only to increase the general knowledge of the learners, but also to develop their skills, critical thinking, attitudes and understanding. The OBE approach focuses not only on **what** you learn, but **how** you learn, so that the process of learning becomes just as important as what you learn.

1.7.11 Directive therapy

According to Barker in The Social work Dictionary (1991:63) directive therapy can be defined as:

> "An approach in counselling in which the social worker or other mental health care provider offers advice, suggestions, information about resources, and prescriptions for more effective behavior."

1.7.12 Non-directive therapy

According to Barker in The Social work Dictionary (1991:156) non-directive therapy can be defined as:

> "A term applied to an approach in counselling or therapy that emphasizes a warm, permissive, accepting atmosphere to encourage the client to discuss problems freely. In the non-directive approach to therapy, called client-centered therapy by some professionals, the social worker or therapist asks very little questions and offers few, if any, suggestions or advice. Rather, the social worker prompts and encourages the client to initiate, explore and follow ideas and feelings."

1.7.13 Play and Play Therapy

According to Singh (1991:24) play can be seen as a

> "...serious activity which is pursued by children, which helps them relieve tension, develop intellectually, physically, socially and emotionally."

Faure (1966:22) sees play as the communication of a young child who has not yet mastered the ability to express himself verbally. Play can therefore be seen as an enjoyable, non-threatening fun experience in a relaxed environment in which the child feels safe. Axline (1996:16) describes play therapy as:

"...an opportunity that is offered to the child to experience growth under the most favourable conditions. Since play is the natural medium for self-expression the child is given the opportunity to play out his accumulated feelings of tensions, frustrations, insecurity, aggression, fear, bewilderment and confusion. By playing out these feelings he brings them to the surface, gets them out in the open, faces them, learns to control them or abandons them."

According to Barker in The Social work Dictionary (1991:120) play therapy can be defined as:

" A form of psychotherapy used by social workers and other professionals to facilitate communication. The client uses toys to act out conflicts or to demonstrate situations that cannot be verbalized. Play therapy is most commonly used in work with children but is also affective and useful with adults in certain circumstances."

Thompson and Rudolph (2000:87) also mentions that play therapy is not only for the child, but it is an universal activity for people of all ages that can be used most effectively:

" Play is an universal activity that people of all ages need. Play provides needed change from our daily routines. It provides opportunities to work through emotional problems and release pent-up emotions. Play has also been identified as preparation for adulthood and that it provides children with a medium in which to act out their lives."

Play is the means through which children communicate; play therapy creates an opportunity to help the child experience growth and to shed unwanted feelings. . Play therapy is most commonly used in work with children but is also affective and useful with adults in certain circumstances. The type of play therapy used by the

social worker will vary according to the specific needs and level of response of the child under treatment.

1.8 Methodology

The Social work Dictionary (Barker, 1991:143) defines methodology as:

> "The systematic and specified procedures by which a social worker or other investigator develops hypotheses, gather relevant data, analyzes data acquired and communicates the conclusions."

The methodology section in the research process according to Rubbin and Babbie (1989:73) delineates in very precise terms the design of the study, including the logical arrangements, sampling and data collection procedures, and the measurement approached used. The next step was to select an appropriate research design to serve as a basis for this study.

1.8.1 Research designs

The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible. De Vaus (2001:1) states that before types of research can be examined, it is important to be clear about the role and the purpose of the research design:

> "We need to understand what research design is and what it is not. We need to know where design fits into the whole research process from framing a question to finally analysing and reporting data ......
> Social researchers ask two fundamental types of research questions:
> 1 What is going on (descriptive research)?
> 2 Why is it going on (explanatory research)?"

De Vaus (2001:1-3) feels that some people dismiss descriptive research as mere description, but good description is fundamental to the research enterprise and it has added immeasurably to our knowledge of the shape and nature of our society.

It can both be concrete or abstract. Good description provokes the "why" questions needed for explanatory research. Explanatory research according to him (De Vaus, 2001:2) focuses on "why" questions. The way in which the researchers develop research designs is fundamentally affected by whether the research question is descriptive or explanatory.

According to De Vaus (2001:48) it is helpful to think in terms of our broad types of design to impose some order on this range of possibilities, namely:

- Experimental
- Longitudinal
- Cross-sectional
- Case study.

1.8.2 Choice of research design

The researcher's choice of research design for this study is the **case study design** in combination with the **descriptive design.**

1.8.2.1 The case study design

The views portrayed by De Vaus on the subject of the case study design, formed the basis for this study. He states that for many years the case study has been seen as the ugly duckling of research design:

> "Most research methods text either ignore case studies or confuse them with other types of social research. When case study designs have been discussed they have generally been seen – from a methodological point of view - as 'soft' options. Some commentators believe case studies should be used only for exploratory research: to generate hypotheses for future testing with more rigorous designs." (De Vaus; 2001:219)

A distinguishing characteristic of case studies is that contextual information is collected about a case so that we have a context within which to understand causal processes. According to De Vaus (2001:51) case study designs might consist of a

single case study or a series of case studies with each case testing a theory from a different angle. Case study designs constitute a major design for social research, because they offer a flexible approach, which can result in an extensive variety of particular designs. It is particularly suited to situations involving a small number of cases with a large number of variables. This approach is appropriate for the investigation of cases when it is necessary to understand parts of a case within the context of the whole.

A case is the object of study or the unit of analysis about which information is collected. The unit of analysis may be a person about whom we try to build up an understanding that is informed by the context in which the whole case exists. Case studies are **not restricted to individuals**. A case might also be **an event** such as divorce rather than a person, **a decision** on downsizing an organization or **time periods.** Each of these can be the "thing" about which we collect data.

For purpose of this study, the object of study or cases of analyses is the study population consisting of ten children with a learning disability, with emotional, social and behavioural problems, in an inclusive educational environment. Some of the many levels from which information was gathered to examine the study population, were the teachers, the parents as well as the children with a learning disability. The collecting and analysing of information from case studies were guided by theory.

De Vaus (2001:221-228) distinguished between the following types of case studies:

- **Explanatory case studies**: seeks to achieve more complex and fuller explanations of the phenomena. This approach begins with a theory, or a set of rival theories, regarding a particular phenomenon. On the basis of a theory the researcher will predict that a case with a particular set of characteristics will have a particular outcome.

- **Theory building case studies**: the researcher selects cases to help develop and refine propositions and to develop a theory that fits the case studied. In the

theory building the research begins with only a question or a basic proposition, looks at real cases and ends up with a more specific theory or a set of propositions as a result of examining actual cases.

- **Clinical case studies:** in contrast with the above two case study approaches that are theory centered, clinical case studies are case centered. The goal is to use the case to test, refine and develop theoretical generalizations. **This approach uses theory to understand a case.**

- **Descriptive case studies**: may consist of single or multiple cases. A case study deals with the whole case, but it is impossible to describe everything; there must be a focus. The researcher must select and organize that which he wants to describe and this is done by using theory.

For purpose of this study the clinical case study method was used. It was assumed that children with unattended learning disabilities might develop serious emotional, social and behavioural problems. If social workers applied play therapy in supporting this child, she could enable him to cope and function optimally in his life environment. The goal was to use the case (the study population in play therapy) to test, refine and develop theoretical generalizations (learning disabled children need intervention from social workers to prevent emotional, social and behavioural problems). This approach uses theory (thorough literature study) to understand a case.

1.8.2.2 The descriptive design

This method, also known as normative survey, is employed to process data derived from simple observation situations, which may be observed physically or through means of interviewing and questionnaires. A clear definition of the study population is needed, as well as the safeguarding of data from the influence of bias, so that the data can be presented in a systematically and organised manner. Finstone and Kahn (1975:62) state that the general purpose of the descriptive survey is to describe the characteristics of a population or phenomenon when the characteristics

of interest are known. Furthermore, there are no prior hypotheses about casual relationships between the variables, or testing of such relationships but:

> "... there may be simultaneous consideration of two or more variables for more precise description. The design requires carefully defined populations and representative samples. Data may be gathered from questionnaires, interviews, observation, or available statistical reports."

According to Leedy (1989:140) this method of research "looks with intense accuracy at the phenomena of the moment and then describes precisely what the researcher sees." This method of research is simple in design, but it is not without problems. It is not less demanding in its design requirements or any easier for the researcher to conduct than any other method of research.

The researcher described the characteristics of the phenomenon of children with learning disabilities leading to emotional and behavioral problems through gathering data by means of interviews, and the use of questionnaires with children with a learning disability, their parents and their teachers. Data obtained through the technique of observation by means of play therapy with the learning disabled children was correlated with the data gathered from the observation and experiences of their parents and teachers. Data was obtained through a comprehensive literature study.

1.8.3 Methods of data collection

Research design differs from the method by which data is collected. Many research methods text according to De Vaus (2001:9) confuse research designs with methods of data collection. He states that it is not uncommon to see research design treated as a mode of data collection.

Methods used to process data may derive from simple observation situations. Data may be observed physically or through means of interviewing and questionnaires or

statistical reports. The researcher described the characteristics of the phenomenon of children with learning disabilities leading to social, emotional and behavioral problems by means of data gathered through :

- **a literature survey**,
- **personal interviews** with the teacher and parent of the learning disabled child,
- **completing questionnaires** with the learning disabled child,
- **open-ended sentences, social skill board games and projective-choice cards,**
- **observation** by means of play therapy with the learning disabled child.

1.8.3.1 Literature survey

To serve as a theoretical basis for the study, a literature search on local and overseas data was done. Data was gathered from Internet reviews and articles, books, magazine articles, reviews, and reports from the academic fields of social work, sociology, psychology, education, and medicine. This procedure was necessary to become acquainted with the various opinions regarding:

- Children with learning disabilities and related emotional problems.
- Play therapy as an aid to the social worker in helping the learning disabled child cope with emotional and social behavioural problems.
- Curriculum 2005 focussing on inclusion and the child with a learning disability, supported by the multi-professional team and the community.

1.8.3.2 Personal interviews

The use of personal interviews as an appropriate data-collecting instrument for the current study, finds support in Grinnell (1988:267) who states,

> "The advantages of interviewing as a data collection method is primarily related to naturalness and spontaneity, flexibility and control of the environment. Combined with a high response rate, these advantages provide

good argument for the use of interviews as opposed to mailed surveys and questionnaires."

For purpose of this study, the researcher interviewed the parents and teachers of the respondents and collected data concerning their social, emotional and behavioural performance in the educational environment. The teachers/parents were interviewed before, and after the play therapy sessions. The teachers were consulted on a regular base and the information observed concerning the respondents were analysed.

1.8.3.3 Questionnaires

Standardised questionnaires were used as measuring instruments. Grinnell (1988:111) states that:

> "Validity is the degree to which a measuring instrument is measuring what it is supposed to measure."

To make sure that the data collected through a measuring instrument is valid, the standard Psychosocial Functioning Inventory for Primary School Children (PFI-PRIMARY-C) were used for measuring self-esteem, social and peer group relations, as well as emotional functioning of learning disabled children. The PFI-PRIM-C questionnaire is for children in primary schools between the ages of six and twelve. The questionnaire measures sixteen different sub-scales or problem areas, of children's psychosocial functioning namely:

- **Perseverance**: measures the inability of the child to act with determination. This is important because the learning disabled child may not act with determination towards a goal in life, because of repetitive failure.
- **Satisfaction**: measures problems a child may have with regard to the experience that he is satisfied with his life in general.
- **Future perspective**: measures problems the child experiences with regards to the orientation he has towards his own future. Children experiencing problems in

this area normally have no future perspective or an unrealistic future perspective in order to escape from the unpleasant circumstances they find themselves in.

- **Self-image**: a troubled child normally has a low self-image. Children with a learning disability may feel inadequate, and different from their peers and may have a low self-image. This subscale measures the problems the child may have with regard to the image the child has of himself.
- **Responsible for others' happiness**: troubled children normally feel they are responsible for other people's happiness.
- **Memory loss**: measures problems that the child may have to remember basic things.
- **Frustration**: measures the child's reaction to the problems he experiences in himself and his environment that prevent him from achieving his goals and desires in life.
- **Anxiety**: measures feelings of insecurity and fear the child may experience. The child with a learning disability may experience feelings of insecurity in the school set-up. Troubled children will experience excessive anxiety levels. Anxiety is often perceived to be a problem with young primary-school children, due to their stage of development.
- **Helplessness**: this subscale measures the child's feelings of the exhaustion of his coping abilities and his helplessness to do something about his life situation.
- **Attitudes towards adults**: a troubled child who was the victim of some kind of trauma where adults were involved has a negative attitude towards adults and do not trust them. This subscale measures the child's attitude towards adults in general.
- **Stigma**: measures the feelings that the child has with regards to him being different than other children. The child with a learning disability may experience his "being different" in a negative way.
- **Problems with school**: measures the problems the child may have in school.
- **Problems with friends**: measures the problems a child may experience in his relationships with friends. Children with a learning disability may experience problems because of their lack of social skills and impulsivity.
- **Problems with mother**: measures the relationship with his mother.

- **Problems with father**: measures the relationship with his father.
- **Family problems**: measure the problems that a child may experience with regard to his own family.

The PFI-PRIM-C questionnaire contains 91 items that require an average of 20-30 minutes to complete. It is a paper-and-pencil self-report measure. Children respond to each item via a three-point category-partition scale. The different subscales range in length from four to eight items, with each subscale producing its own score. The different subscales are scored on a scale of 0 to 100, with a lower score indicating little or no problem in the specific area being measured. A higher score indicates a greater degree of problem in the area being measured.

To score the different subscales on the PFI-PRIM-C, one must first reverse all the positively worded items that are marked with an asterisk (PFI-PRIM-C questionnaire - Addendum 1) by changing a score of one to three. The researcher did this by marking the negatively worded items with bold. These scores were reversed and then calculated. (See Addendum 1).

The scoring formula is S=(Sum (Y)-N (100)/[(N)(k-1)], where Y is the score for an item, N is the total number of items correctly completed by the respondent; omitted items are ignored and K is the largest item response permitted. A score obtained from the respondent who fails to answer 80% of the subscale items should not be used. These sub scores are used to develop a graphical profile that can be employed in assessment and treatment planning of the child. (Faul and Van Niekerk, 1999:95-97).

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The principle aim of this questionnaire is to serve as a tool for assessing diverse problems of children during intake or early phases of treatment or service delivery. This, together with the specific 16 problem areas, covered in the questionnaire, were the reasons for using this questionnaire for this specific research.

1.8.3.4 Play therapy sessions, open-ended sentences, social board games and projective-choice cards

Structured play therapy sessions focused on the pupil's feelings and emotions, self-awareness and self-esteem, as well as their peer-group relations. The information obtained in three play therapy sessions was confirmed with the teachers and/or parents by means of an interview.

Open-ended sentences, where the respondent had to respond to open-ended questions were used to gather information related to: the self-esteem, social and peer group relations, and the emotional functioning of the child with a learning disability. According to Grinnell (1988:314) open-ended sentences are designed to permit free responses to our questions and do not suggest any particular structure for replies.

Social skill board games as well as **projective-choice cards** invented by the researcher were used to obtain information in connection with self-esteem, anxiety and emotional functioning, social skills and behaviour.

1.8.4 Sampling

Sampling can be defined as the process of selecting variables. According to Rubin and Babbie (1989:229) purposive sampling is the means the researcher uses to select the sample for research on the basis of his own knowledge of a population, its elements, and the nature of his research that is based in the researcher's judgement and purpose of study. Grinnell (1988:253) relies on the closest typical subject to constitute the sample for purposive sampling:

> "We can only use purposive sampling when we have sufficient knowledge related to the research problem to allow selection of "typical" persons for inclusion in the sample".

The purposive sampling method is appropriate for this study. Because of the costs and time factor it is impossible to deal with every learning disabled child in the RSA or North West province. A selection of learning-disabled children in the Vryburg - Stella region were made through means of purposive sampling. After a remedial therapist tested 25 children, a purposive sampling and a pilot study followed. The study population consisted of ten learning disabled children.

Children, between the ages of six and ten years diagnosed with learning disabilities in an inclusive educational environment, were selected for the purpose of this study. Because of the case-study method used, the study population only consisted of ten respondents.

1.8.4.1 Selection of the ten suitable respondents

The ten respondents for more in depth research, were selected as follow:

1. The respondents came from three different schools in the Stella-Vryburg region.
2. The reason for research was discussed with the Grade one to Grade three schoolteachers. The teachers were requested to make a selection of 25 children in the grade one to three classes, which struggled academically and might have learning disabilities and not learning problems stemming from emotional or social problems. This was based on the view of Hosterman (Chapter 3, par. 3.4.2). Kramer's problematic behaviour that commonly occurs in the classroom (Chapter 3.7.2 p67), formed the framework of reference.
3. A remedial therapist tested the 25 children for specific learning disabilities. 20 were identified as children with learning disabilities. They all fitted the characteristics, the literature showed out in chapter 3: 3.6 p 62-65.
4. Two respondents, with specific learning disabilities, came from the researchers caseload. They where referred because of their emotional and behavioral problems they experience at school.

5. A further 8 respondents were to be selected from the group of 20 children, who were tested by the remedial therapist.
6. The researcher decided to do the standardised, PFI-Prim–C, questionnaire next with the group of twenty children, so that a further eight respondents could be selected. This was not done individually but in a group situation.
7. Due to the distractibility of the respondents, the findings gathered out of the questionnaire done in the group setting, could not be used for means of selection. As shown in Chapter 6, table 6.1, p127, the only positive outcome of the big group doing the questionnaire, was the observation of their behaviour, which corespond with the literature on the characteristics of the learning disabled child, gathered through the literature survey. The children therefore had to do the PFI-Prim-C, questionnaire on an individual basis.
8. The researcher decided to ask the teachers which children were the most in need of therapy so that the selection of eight could be made on that basis.
9. The selection of ten learners was finalized. Two came from the researchers caseload and eight from the group of twenty. They seemed to be the most desperate in need of therapy. All of the respondents showed signs of low self-esteem, problems with relationship structures, and problems in schoolwork performances, which again lead to stress and anxiety.

1.8.5 Data analysis

Arkava and Lane (1983:203) emphasised that the data analysed should be consistent with the objectives of the study, the research design, the measurement level of the data, and the assumptions underlying the use of a particular statistical test. In order to culminate a study properly, it is necessary to analyse the data so that the results can be presented in an understandable and convincing format.

The data gained through methods of data collecting was analysed and is presented in chapter six.

1.9 Conclusions and recommendations

The obtained data in this study enabled the researcher to formulate recommendations related to the definite role and task of the social worker in working with the learning disabled child in the educational environment. The focus was on using play therapy when dealing with the learning disabled child. For the purpose of this study only, recommendations related to the importance of the multi professional team, consisting of the social worker, educators and the parents (as consultants of their child) in supporting him through his scholastic years, were formulated.

1.10 Presentation of contents

The field of study is very broad. The researcher focused on the following:

- Curriculum 2005 as a guide necessitating the inclusion of the social worker as resource person in a multi-professional team when dealing with the learning disabled learner presenting emotional, social and behaviour problems within the main stream (inclusion).
- The use of play therapy as therapeutic aid when dealing with the emotional, social and behavioural problems of learning disabled children.
- The role of the social worker when dealing with the learning disabled child, his parents and his teacher.
- Presentation and analysis of data
- Conclusions and recommendations

CHAPTER TWO

2 INCLUSION, THE CHILD WITH A LEARNING DISABILITY AND SOCIAL WORK

2.1 Introduction

Learning problems in school are not as simple as one might think. In order to learn in school, a child (the learner) must accept the authority of a teacher and be motivated to pay attention to, and concentrate on a given task. The child must be able to see, hear and correctly integrate, and interpret stimuli presented by the teacher in order to correctly perform the given task. To succeed, the child must know how, and where to begin the task, carry it out step by step and complete it successfully. He must be able to co-ordinate and communicate ideas about the task either verbally or in writing. He must also recognise when errors are made and have the desire to correct them. This must all be remembered and carried through to the next day, when something new will be added to the store of knowledge. The child's schoolwork is also influenced and affected by his attitude, emotional state and personality. Repeated experiences of failure in school negatively affect his character. The child with learning disabilities should be aided in acquiring and applying self-discipline, acceptable interpersonal skills and self-confidence in a highly taxing environment.

We need a sensible approach to the puzzling and frustrating problem of children who do not learn as expected in schools. An approach that integrates all, and concurrently improves educational outcomes for all is needed. An educational programme that uses the same schedules, same curriculum and provide improved educational outcomes for all should be the focus point. A classroom where everyone accepts the challenging difference amongst pupils with respect and gratitude is greatly encouraged. It is up to the teacher and parent as adult to act responsible and accountable, and to adapt new approaches with an open mind, in order to make a success of this great challenge. Is curriculum 2005 the solution? Can teachers, parents and professionals cope with the new challenge of Inclusive education?

The underlying rationale for inclusion is commendable. There is a need for de-emphasis on isolation and labelling, increased protection of human rights; individualisation in all phases of education; and increased attention to the development of the total child including his social and emotional well being. From an administrative point of view, greater cost efficiency in the delivery of services, which inclusion advocates claim as a significant strength. Most professionals working in programmes for handicapped children agree that to create an isolating environment, where significant deviations from the norm are not encountered is unwise. The task of self-acceptance and societal integration is not enhanced by permanent existence in a protective environment.

Unlocking the mystery of how a child with a learning disability learns is a tremendous challenge. To succeed, the child needs changes that may include curriculum adjustments, alternative classroom organisation and management, specialised teaching techniques and study skills, counselling in behaviour management and increased parent/ teacher/team collaboration.

This chapter will focus on:

- Inclusion as concept.
- Inclusion and the child with a learning disability.
- Inclusion and the social worker as part of the multi-professional team

2.2 Inclusion as concept

Inclusion means helping children with various needs within the regular classroom setting. According to Forest and Pearpoint (1997:1) inclusion in the educational environment means:

> "...affiliation, combination, comprisal, enclosure, involvement, surrounding. It means WITH... inclusion means BEING WITH one another and caring for one another. It means inviting parents, students and community members to be part of a new culture, a new reality.

> Inclusion means joining with new and exiting educational concepts (co-operative education, adult education, whole language, computer technology, critical thinking). Inclusion means inviting those who have been left out (in any way) to come in and asking them to help design new systems that encourage every person to participate to the fullness of their capacity as partners and as members."

According to Smith (1997:2) inclusion is not just about placing a child with a disability in a classroom or a school, but inclusion is how to deal with diversity and with difference. It means to build a better society with more acceptance, more love, more care, and more compassion, one in which the human rights of all children are protected.

> "Inclusion means:
> - providing all students with enhanced opportunities to learn from each other's contribution,
> - having all learners follow the same schedule,
> - encouraging friendship amongst all students,
> - teaching learners to understand and accept human differences,
> - placing pupils with special needs in the same schools they would attend if they did not have disabilities,
> - providing an appropriate individualised program." (Smith, 1997:2)

The researcher is aware that a new educational philosophy has emerged. Educators and parents are facing a complete educational reversal. Educators, parents and the community are co-dependent on contributions of others to succeed when an inclusive model is followed. The key to successful inclusive education (educating the learner with special needs within the regular classroom) is a co-operative process, involving a number of people sharing specialised knowledge. To succeed, the teachers must work with a support team that makes it possible for all learners to learn co-operatively, individually and independently.

2.3 Inclusion and the child with a learning disability

Since 1994 the whole education system in South Africa has been transformed. This includes transformation of the curriculum as well as the policy on learners with special educational needs or learners who experience barriers to learning. The term "learners with special educational needs" refers to those learners whose education requires more time, planning and effort in order to help them to learn. According to Landsberg (1997:1) there are various forms of barriers to learning and they can be divided into the following groups:

- learning problems;
- behavioural problems;
- emotional problems;
- developmental problems;
- disabilities (sensory, physical and intellectual disability) and
- aspects of the system (e.g. poorly trained teachers, inaccessible curriculum, poor school facilities).

Landsberg (1997:1) stresses the fact that when learners with disabilities do not get special assistance from an early age, they may fall behind in their development or even develop additional problems. She feels that the parents also need guidance on how to care for and educate their disabled learner.

The new education policy on learners with special needs or who experience barriers to learning is one of integrating these children within the general classroom setting. This policy has been influenced by the following international and national trends:

- A growing awareness that one should not discriminate against any person who may, in some way, be different from others but that all learners should receive equal educational opportunities in the same environment.
- The realisation that by separating people who is different, you are not promoting an attitude of acceptance of differences in people but rather an atti-

tude of stigmatisation. To build accommodating societies, learners at school should already learn to accept all people.

- The realisation that it is financially totally impossible to provide specialised education in separate schools for all learners who have special educational needs. (Lansberg, 1997:1-2)

The White Paper on Education and Training in a Democratic South Africa: First Steps to the Development of a New System, February 1995 provided the framework for the provision of education in this country. This white paper specifies the following:

- The education of learners with special educational needs (LSEN) and the educational services should form an integral part of education and should not be viewed as a separate section.
- The provinces should assume responsibility for the provision and organisation of the education of learners with special educational needs.
- Representatives of the educational staff of learners with special educational needs and of the learners themselves should serve on all legal and consultative bodies when special educational need issues are being discussed.
- There shall be an inclusive and integrated approach to the provision of services to learners with special educational needs. Government departments involved with learners with special educational needs such as Education, Welfare, Health and Labour, will have to co-operate with one another much more closely (Lansberg, 1997:1-2).

The South African Schools Act, no 84 of 1996, makes provision for compulsory education for every one and for admission to public schools. The Member of the Executive Council (for each province) must, where reasonably practical, provide education for learners with special educational needs at ordinary public schools and provide relevant educational support services for such learners. The South African policy on learners with special educational needs is in accordance with modern international trends and specifies that they should be accommodated within the gen-

eral educational system and assisted in an integrated, community based manner. The overarching goal of this national education policy is to enable all learners to value, have access to and succeed in lifelong education and training of good quality that is a flexible system (Landsberg, 1997:2-3).

To conclude:

- The whole educational system in South Africa has been transformed. Learning disabled children should be accommodated within the general education system.
- These learners should be assisted in an integrated, flexible community based manner. Differences in people should be accepted and honoured; there should be no stigmatisation.
- The White Paper on Education and Training in a Democratic South Africa provides a framework for the provision of education in this country.
- Integration and inclusion of children with a learning disability are more in accordance with modern international trends.

2.4 The utilisation of cooperative learning for the learning disabled child

"Co-operative learning" (i.e., jigsaw, learning together, group investigation, student teams-achievement divisions, and team-games-tournaments) is a generic term that is used to describe an instructional arrangement for teaching academic and collaborative skills to small, heterogeneous groups of students within a bigger group setting. Co-operative learning is deemed highly desirable because of its tendency to reduce peer competition and isolation. It promotes academic achievement and positive interrelationships. A benefit of co-operative learning is to provide students (with learning disabilities and social interaction difficulties) with an instructional arrangement that fosters the application and practice of learning skills within a natural setting.

The learning environment should be created in such a manner that it promotes active learning and teaching, classroom talk, individual learning, small group and whole-group learning. Co-operative learning is one example of an instructional organisation that can be used to foster active learning, for students with different needs in one classroom. Students can be given graded tasks to discuss, and problems could be set on various levels of difficulty, to solve and complete. Co-operative learning activities can be used to supplement textbook instruction by providing students with opportunities to practice or apply relevant skills and concepts. Teachers can use co-operative learning activities to help students make connections between the concrete and abstract level of instruction through peer interactions and carefully designed activities. Finally, co-operative learning can be used to promote classroom discourse and oral language development. (Riveral, 1996:1)

According to Riveral (1996:1-3) research supports co-operative learning as an effective approach where students, with learning disabilities, are included in doing group work to promote peer acceptance in the classroom. Students with learning disabilities can benefit from peer interactions in co-operative learning groups and learn specific learning skills and concepts with proper instruction and preparation (i.e., previous direct instruction on skills).

According to Johnson (Riveral, 1996:3) there are five basic elements of co-operative learning namely:

- **Positive interdependence** – it means that students see the importance of working as a team and realize that they are responsible for contributing to the group's effort.
- **Face-to-face interaction** - this interaction involves students working in environmental situations that promote eye contact and social space so that students can engage in discussions.
- **Individual accountability** - it suggests that each person is responsible to the group and must be a contributing member, not just someone who lets others do all of the work.

- **Group behaviours** – it refer to those interpersonal, social, collaborative skills needed to work with others successfully and
- **Group processing** – it is the time after the co-operative learning task is finished when team members analyse their own and their group's abilities to work collaboratively.

These five elements can be structured to promote team- work and collaborative skills. They can be facilitated in various ways, for example:

- asking students to be responsible for certain duties (e.g., record keeper, spokesperson, encourager);
- providing limited materials thus necessitating sharing;
- providing bonus points for demonstrating collaborative behaviours;
- asking students to self-evaluate after-task completion;
- assigning a group grade to the math activity, and
- arranging the environment so students interact in small groups.

To promote co-operative learning through group work, roles with specific responsibilities can be assigned to each group member. Examples of roles may include amongst others, spokesperson, writer, encourager and timekeeper. Roles should be taught and practiced prior to placing students in co-operative learning groups; since learners need a good understanding of the responsibilities associated with each role. Limiting group size to four to six students, afford each member an opportunity to actively participate. (Riveral, 1996:2-3)

To conclude:

- Co-operative learning is a generic term that is used to describe an instructional arrangement for teaching academic and collaborative skills to small, heterogeneous groups of students with in a bigger group.
- Co-operative learning is therefore desirable because of its tendency to reduce peer competition and isolation. It promotes academic achievement at the individuals' tempo of development within a positive environment focussed on the value of human dignity within developing interrelationships.

- A benefit of co-operative learning is to provide students with learning disabilities, burdened with social interaction difficulties, an instructional arrangement that fosters the application and practice of learning skills within a natural setting.

2.5 Inclusion and the social worker as part of the multi-professional team

Social work is a profession that focuses on helping people to solve their personal, family, and community problems through enhancing social functioning. According to Skidmore, Thackeray and Farley (1994:12) a social worker is particularly effective in developing and using a team approach and in bringing about coordination of services and activities:

> " Many professional workers regard the social worker as the catalyst who has the ability and responsibility to help the professional team work together and function in optimal fashion. The social worker often acts as coordinator and integrator for the team effort."

Professional helpers such as counsellors, psychologists and social workers offer their services under specified conditions. Counselling, according to Brammer and Shostrom (1977:8), stresses rational planning, problem solving, decision-making, and support for situational pressures arising in the everyday lives of the individual. Psychotherapy, in contrast, is defined as more inclusive re-education of the individual, where the individual is assisted in gaining perceptual reorganisation, so that he can integrate consequent insight into his every day behaviour. The social worker can help the teacher and parent in guiding the learning disabled child to be a self-fulfilled human being, one who is in touch with his "bodily-self".

The researcher believes that the social worker is equipped to render services in specified ways to the child with a learning disability. The social worker can be part of the support team to guide the child with emotional and social problems, to rid himself of these handicapping conditions. The child with a learning disability needs a support team that will teach him to develop specific skills to help him function

optimally socially, emotionally and intellectually in an inclusive environment. A well-equipped support team should comprise out of the following professionals and non-professionals:

- teacher/ remedial teacher,
- occupational therapist,
- speech therapist,
- social worker,
- psychologist,
- parents, family and friends.

Each member of the team has a very important role to play in leading the child to optimal functioning. According to Dubois and Miley (1996:433) the social workers in schools often work with children who have special educational needs such as learning disabilities, attention deficit disorders, problematic behaviour and immature social skills. According to them social work services include:

- "Preparing social histories for the special education assessment
- Consulting with teachers and other school personnel
- Providing in–service training
- Facilitating observations, conferences and re-evaluations
- Providing individual and group counselling for special education students and their parents
- Assisting in referral to other necessary resources." (Dubois and Miley, 1996:433)

Social workers, as part of the team are trained in doing community work, group counselling and individual counselling. According to Dubois and Miley (1996:433) school social work has changed from clinical-case work approach to an approach that reflects home-school-community liaisons, and "this underscores the importance of partnerships between schools, families, and communities and emphasizes the role of social workers as collaborative partners.

The social worker may apply her skills and knowledge in helping the school, and the community to support the learning disabled child and his family by means of group discussions and informative workshops.

LIBRARY

2.6 Conclusion

The researcher believes that a new and exciting educational philosophy has emerged as a result of the introduction of curriculum 2005 into our schools. Learners, educators and parents are facing a complete educational paradigm shift. Educators, parents and community are co-dependent on contributions of each in his own way, to succeed when an inclusive model is followed. It is clear that the whole educational system in South Africa has been transformed. For the researcher, the educator, and the parent it is important to remember that the learning disabled child in the inclusive environment, who is referred to as a learner, needs an education programme that requires more time, more individualised planning and specialised effort in order to help him learn successfully, according to his individual learning style. This learner will need the support of a multi-professional team.

The researcher believes that the integration of the child with a learning disability into the regular classroom setting ensures and promotes the acceptance of differences in people and removes an attitude of stigmatisation. This in turn will only lead to an emotionally healthier community. Integration and inclusion of children with a learning disability are more in accordance with modern international trends. The social worker can play a prominent role when guiding the learner with a learning disability to be a self-fulfilled human being.

CHAPTER THREE

3 THE CHILD WITH LEARNING DISABILITIES

3.1 Introduction

Imagine having important ideas and the need to communicate, but being unable to express them. Perhaps feeling bombarded by sights and sounds, unable to focus your attention or just trying to read or add but not being able to make sense of the letters or numbers. Thousands of elementary school children, otherwise normally developing and growing individuals are deprived of the joy and elation accompanying successful school achievement. This is due to their having handicapping learning disabilities. According to some estimates, learning disabilities represent the single largest category of exceptionality even when including such other common problems as mental retardation, speech handicaps, and crippling diseases. (Johnson, 1979:5)

Many different estimates of the number of children with learning disabilities have appeared in the literature ranging from 1% to 30% of the general population. Myklebust and Boshes in Johnson (1979:5) indicated in 1969 that a typical school population might have as many as 15% teaching disabled children, a much more conservative cut-off point would be as much as 7%. The Family Education Network (1999:2) gave the following statistics in their article "About Learning Disabilities":

- In 1987 the Interagency Committee on Learning Disabilities concluded that 5 – 10% is a reasonable estimate of the percentage of persons affected by learning disabilities.
- The U.S. Department of Education (1995) reported that more than 4% of all school-aged children received special education services for learning disabilities and that in the 1993-1994 school year over 2.4 million children with learning disabilities were served. (Differences in estimates perhaps reflect variations in the definition.)

Learning disabilities are hidden disabilities that affect many intelligent children and leave them unable to achieve their full potential. They experience their life-world differently from that of their peers. They move on the developmental track more

slowly than others, some may even stand still - but they are all on the same track, leading to adulthood. The outward characteristics of many learning disabled children are frequently mistaken for those of mental retardation or emotional disturbance, but learning disabilities are neither of these. The pervasive problems of learning disabled children usually are multifaceted influencing educational, psychological and social development. The effects extend beyond the confines of the classroom to influence also family and peer relationships.

This chapter will focus on:

- background information on the definition of learning disabilities,
- labelling,
- criteria of learning disabilities,
- common signs of learning disabilities,
- causes of learning disabilities,
- the characteristics of learning disabilities,
- characteristics of the children with learning disabilities,
- related problems of learning disabilities.

3.2 Background information on the definition of learning disabilities

In 1963 parents in Canada embraced the term "learning disabilities" when they attempted to organise on a national basis, an association for a group of adults and children who suffered reading, writing, memory, attention, communicating, or mathematical problems, due to identifiable or inferred central nervous system dysfunction. These were children who eluded traditional categories of exceptionality. For the parents this was a term that focussed on what seemed to be the primary problem of their children, and which would hopefully catapult the education community into solving their problem. (LDAC, 1999:1)

In Britain, an eye surgeon, Dr. James Hinshelwood (LDAC, 1999:1) attempted to correlate his knowledge of patients who had received cerebral insult through disease or trauma, with similar symptoms he saw in children with reading problems.

He published his monograph “Congenital Word Blindness”, in 1917 and today "Word Blindness" is still used in England to refer to Dyslexia or children with severe reading problems.

In the early 1930's the current belief was that emotional maladjustment was at the root of learning problems. The American psychiatrist Dr. Samuel Orten (LDAC, 1999:1) refused to accept this believe. He believed that children with learning problems often displayed "mixed laterality" (laterality is the process by which a person develops an awareness of the existence of two sides of the body, and ability to recognise these two sides as right and left). Dr. Orten suggested that the failure of one hemisphere of the brain to become dominant caused this disorder. Factors around hemispheric dominance are today still considered important in the field of learning disabilities. After World War I, an encephalitis epidemic followed, that led to the description of “disorganised and erratic behaviour associated with hyperkinesis or hyperactivity”. In 1947, Alfred Strauss, (LDAC, 1999:1) the German neurologist and psychiatrist, described this syndrome in children, noting both perceptual and abstract reasoning deficits. For a time hyperactivity was described as "Strauss Syndrome", but the terms "brain damaged" and "brain injured", became prevalent in the literature.

In 1959 researchers who noted perceptual and learning similarities in patients with cerebral palsy and other neurological handicaps proposed the term "cerebral dysfunction" to embrace the following syndromes:

- cerebral palsy (basically a neuromotor disorder),
- mental retardation (primarily an intellectual disorder), and
- the "hyperkinetic behaviour disorder" (ADD) characterised by irritability, short attention span, purposeless activity, and poor school work in reading, arithmetic, and handwriting. Another term used synonymous with learning disability at that time was “perceptually handicapped". (LDAC, 1999:2).

During 1963, under the chairmanship of American neurologist Dr. Richmond Paine (LDAC, 1999:2) the planning began for the establishment of a series of task forces to investigate learning disabilities. This field attained particular prominence in education, medicine, psychology, and the language specialties, in the United States.

The term "Minimal Brain Dysfunction" (disturbance or impairment of function) was then accepted as representing what was seen as a milder or sub-clinical degree of organic brain dysfunction on the continuum of other cerebral dysfunctions such as cerebral palsy, epilepsy, autism and mental retardation. "Minimal Brain Dysfunction syndrome" according to the definition accepted at that time, referred to children of near average, average, or above average general intelligence with certain learning or behavioural disabilities ranging from mild to severe, which are associated with deviations of function of the central nervous system. These deviations manifest themselves by various combinations of impairment in perception, conceptualisation, language, memory, and control of attention, impulse, or motor function. These aberrations again may arise from genetic variations, biochemical irregularities, prenatal brain insults or other illnesses or injuries sustained during the years that are critical for the development and maturation of the central nervous system, or from unknown causes (LDCA, 1999:2).

In 1967 the National Advisory Council on Handicapped Children (NACHC) developed the following definition, which became part of the United States Public Law mandating Special Education in the United States:

> " Children with specific learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or using spoken or written languages. These can be manifested in disorders of listening, thinking, talking, reading, writing, spelling or arithmetic. They include conditions which have been referred to as perceptual handicaps ~ brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems basicallly due to visual, hearing, or motor handicaps, to mental

retardation, emotional disturbance, or to environmental disadvantage." (LDCA, 1999:3).

The NACHC definition generated a great deal of activity in the field, but it did not promote consensus, because it only referred indirectly to etiological factors. Children with learning disabilities who have come from disadvantaged backgrounds, often would be diagnosed only in terms of their deprived environment, and not looked at in the real context of physiological causes. Learning disabilities tended to become a middle-class phenomenon (the child of the middle class would be diagnosed as having a learning disability, while a child of the slums would automatically be considered deprived). Learning disabilities unfortunately at that time were solely an educational problem and not a medical or social problem.

The need for more precision was becoming apparent to the Canadian Association for Children and Adults with Learning Disabilities (CACLD). In 1979, the CACLD Sub-Committee on the Definition was directed to further the definitional issue. In their report they recommended that the following statement of principles needed to define the term "Learning Disabilities" should:

- represent children and youth of potentially average, average, or above average intelligence;
- distinguish this sub-set of the learning impaired population from others with other types of learning difficulties;
- delineate the known/implied etiological basis for learning disabilities;
- describe in general terms the major signs and symptoms observed, with special emphasis to early life;
- focus attention toward prevention, identification, and understanding of their specific needs;
- encourage research in medicine, paediatrics, biochemistry, genetics, the neuroscience, education and social work (LDAC, 1999:4).

In 1981 the National Joint Committee for Learning Disabilities (NJCLD) composed of five major and concerned organisations in the United States, prepared a paper on the defining of the term "Learning Disabilities". They urged that this disorder represented by the collective term "Learning Disabilities" must be understood as intrinsic to the individual, and that the basis of the disorder presumed to be due to central nervous system dysfunction. This definition of the NJCLD met many of the criteria adopted by the CACLD.

The CACLD modified this definition by including the effects of such dysfunction's on behaviour as well as upon learning. They added attention, memory, coordination, social competence, and emotional maturation to the list of areas of possible difficulty or delay; a statement about possible causes based on present knowledge; and recognition that central nervous system dysfunction can be demonstrated in many cases.

On October 18, 1981, the former Canadian Association for Children and Adults with Learning Disabilities – (CACLD) now known officially as the Learning Disabilities Association of Canada (LDAC) adopted the following official definition of learning disabilities:

- "Learning disabilities are a generic term that refers to a heterogeneous group of disorders due to identifiable or inferred central nervous system dysfunction. Such disorders may be manifested by delays in early development and / or difficulties in any of the following areas: attention, memory, reasoning, co-ordination, communicating, reading, writing, spelling, calculating, social competence and emotional maturation.
- Learning disabilities is intrinsic to the individual, and may affect learning and behaviour in any individual, including those with potentially average, average, or above average intelligence.
- Learning disabilities is not due primarily to visual, hearing, or motor handicaps; to mental retardation, emotional disturbance, or environ-

mental disadvantage; although they may occur concurrently with any of these.

- Learning disabilities may arise from genetic variations, biochemical factors, events in the pre-to parental period, or any other subsequent events resulting in neurological impairment." (LDAC, 1999:1)

In 1990 the National Joint Committee on Learning Disabilities (NJCLD) developed the following definition of learning disabilities:

> "Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the life span. Problems in self-regulatory behaviours, social perception, and social interaction may exist with learning disabilities, but do not by themselves constitute a learning disability. Although learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, serious emotional disturbance), or with extrinsic influences (such as cultural differences, inappropriate or insufficient instruction), they are not the result of those influences or conditions." (NCLD, 1999:1)

The National Institute of Mental Health (NIMH) described learning disabilities in 1993 as follows:

> " Learning Disabilities (LD) is a disorder that affects people's ability to either interpret what they see and hear or to link information from different parts of the brain. These limitations can show up in many ways – as specific difficulties with spoken and written language, co-ordination, self-control, or attention. Such difficulties extend to schoolwork and can impede learning to read or write, or to do maths.

Learning disabilities can be lifelong conditions that, in some cases, affect many parts of a person's life: school or work, daily routines, family life, and sometimes even friendships and play. In some people, many overlapping learning disabilities may be apparent. Other people may have a single, isolated learning problem that has little impact on other areas of their lives." (NCLD, 1999:1-2)

The most common definition for learning disability according to Lerner (1997:9) is the federal definition taken from the individuals with Disabilities Education Act (IDEA), of the USA. It states:

> "The term 'specific learning disability' means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include a learning problem which is primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage."

The researcher comes to the following conclusion:

- Efforts to find a suitable name for the conditions of learning disabilities have been as many and as various as the opinions on the symptoms that should be included in it. It is clear that there is no single explanation to this massive problem.
- Defining the term learning disabilities has been a complex and ongoing issue since the early nineteenth century. Regardless of professional opinion, learning disabilities are serious afflictions that limit every aspect of a learning disabled

person's life. Whether emotional or pathological, the need for treatment is undisputed.

- The term "learning disabilities" is a generic term that refers to a heterogeneous group of disorders. These disorders are due to identifiable or inferred central nervous system dysfunction.
- Learning disabilities are neurological in origin; it affects a person's ability to either interpret what he sees and hears, or the integration of information coming from different parts of the brain (storing, processing, and or production of information). A variety of central nervous systems impairments appear to be associated with learning disabilities at present.
- Learning disabilities are specific limitations that can affect one's ability to read, write, speak, or compute mathematics, and can impair socialisation skills, coordination, self-control or attention.
- The term learning disabilities includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.
- The term learning disability does not include a learning problem, which is primarily the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or of environmental, cultural, or economic disadvantage.
- Learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, and serious emotional disturbance), or with extrinsic influences (such as cultural differences, inappropriate or insufficient instruction), but they are not the result of those influences or conditions.
- Learning disabilities can be lifelong conditions that may affect many parts of a person's life, his school or work, his daily routines, his family life, his relationships with friends or strangers and various other facets of his life. Children with learning disabilities learn different than other people.

This conclusion forms the basis of what is meant by learning disabilities for this specific research.

3.3 Labelling

"Confusion in organising a specific terminology is readily apparent. The myriad of available nomenclatures used to categorise the learning disabled child adds to this semantic chaos."(Marvin and Gottlieb, 1979:232)

Labels are sensitive controversial professional issues, because they may:

- Prematurely terminate additional investigation,
- Focus on an isolated area of a multifaceted problem and thus represent an incomplete diagnosis,
- Brand a child cruelly as being uneducable, lazy, backward, defective or even emotionally disturbed,
- Erroneously regarded as irreversible.

Labelling is necessary for precise conceptualisation of data. Labels can assist learning disabled children or serve inappropriately to stereotype their potential. In some instances the need of the child is denied because the "proper label" has not been determined and assigned.

Controversies in terminology and classification may be the resultant manifestation of professional communication gaps, which often characterise ineffectual multi-disciplinary interactions. Labels can mean different things to different specialists! The necessity for "correct " labelling cannot be under estimated, because a meaningful classification is of critical importance when designing educational or other support programmes. (Griffith, 1979:3).

Controversy still seems to rage over what the condition of learning disability should be called. The researcher will refer to it as a learning disability.

3.4 Learning disabilities

In the previous headings the researcher showed that the efforts to find a suitable name for the conditions of learning disabilities have been as many as the opinions on what symptoms should be included in it. The conclusion the researcher came to

was that the term learning disability does not include a learning problem, which is primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage. Learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, and serious emotional disturbance), or with extrinsic influences (such as cultural differences, inappropriate or insufficient instruction), but they are not the result of those influences or conditions.

It is now necessary to focus on:

- the major types of learning disabilities,
- the criteria of learning disabilities, and
- the common signs of learning disabilities.

3.4.1 Major types of learning disabilities

Not all learning problems are necessarily learning disabilities. Some children are simply slower in developing certain skills. As said before, children show natural differences in their rate of development. What sometimes seems to be a learning disability may simply be a delay in maturation. Specific criteria must be met to be able to diagnose a learning disability. The criteria and characteristic for diagnosing learning disabilities appear in a reference book called the Diagnostic and Statistical Manual of Mental Disorders (DSM).

According to the DSM learning disabilities can be divided into three broad categories:

- Developmental speech and language disorders
- Academic skills disorders
- "Other", a catch-all that includes certain co-ordination disorders and learning handicaps not covered by the other terms.
- Each of these categories includes a number of more specific disorders. (NIMH, 1993:1)

3.4.2 Criteria of learning disabilities

A learning disability is a condition that can affect anybody, regardless of age, ethnicity, or gender. Learning disabilities are hidden disabilities that affect many individuals who usually have average or above intelligence, but are unable to achieve at their potential. A learning disability is a lifelong disorder, which affects the manner in which individuals with normal or above average intelligence select, retain, and express information. Incoming or outgoing information may become scrambled as it travels between the senses and the brain. Hosterman (1999:1) diagnoses learning disabilities according to the following four criteria:

- Firstly, there must be a significant discrepancy between overall cognitive ability and achievement.
- The second criterion for a learning disability is a processing deficit. The brain must process all information that it receives from the senses systematically and sequentially (like hearing and vision).
- Thirdly, the processing deficit(s) must be shown to be directly contributing to underachievement.
- The fourth criterion for diagnosing a learning disability is that the underachievement cannot be primarily due to factors other than a processing deficit, such as a head injury or epilepsy, physical disability, sensory impairment (vision and hearing), mental retardation, lack of appropriate instruction or severe psychological disturbance.

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Hosterman (1999:1) believes that many learning disabled children have other problems in addition to their learning disability, such as low self-esteem and test-anxiety. However, these other concerns are not the primary cause of the underachievement, they are secondary to the learning disability.

From the information obtained to this point in the research, the researcher comes to the following conclusion:

- There is a difference between a learning problem and a learning disability.

- Socio-cultural - and educational factors may cause learning problems, which may have an effect on learning, but are not a disability.
- A learning disability is caused by impairment in the central nervous system that affects the receiving, processing or communicating of information.
- Learning disabilities are disorders that affect people's ability to either interpret what they see and hear, or to interpret information from various parts of the brain. Learning disabilities can affect a person's ability to speak, listen, read, write, spell, reason, recall, organise information, and do mathematics.
- A learning disability can't be cured or fixed; it is a lifelong issue. With the right support and intervention, however, children with learning disabilities can succeed in school and go on to have successful, often distinguished careers later in life.
- Parents can help children with learning disabilities achieve success by encouraging their strengths, knowing their weaknesses, understanding the educational system, working with professionals and learning about strategies for dealing with specific difficulties.

3.4.3 Common signs of learning disabilities

Parents are often the first to notice, "Something doesn't seem right." If parents, teachers, and other professionals discover a child's learning disability early and provide the right kind of help, it can give the child a chance to develop skills needed to lead a successful and productive life.

If you are aware of the common signs of learning disabilities, you will be able to recognise potential problems early. A recent National Institute of Health's study showed that 67% of young students who were at risk with reading difficulties became average or above average readers after receiving help in the early grades (CCLD, 1999:1-2).

The following is a checklist of common behavioural warning signs that may point to a learning disability. Most people will, from time to time, see one or more of these warning signs in their children (NCLD, 1999:1-2):

Table 3.1 Behavioral Warning Signs of Learning Disabilities, What to Look For.

Some First Signs of Trouble: Keeping up with the Flow of Expectations				
PRESCHOOL				
Language	**Memory**	**Attention**	**Fine Motor Skill**	**Other Functions**
Pronunciation problems. Slow vocabulary growth. Lack of interest in story telling .	Trouble learning numbers, alphabet, days of week. Poor memory for routines	Trouble sitting still. Extreme restlessness. Impersistence at tasks.	Trouble learning self-help skills. (e.g. Tying shoe laces). Clumsiness. Reluctance to draw or trace.	Trouble interacting (weak social skills). Trouble learning left from right. (possible visual spatial confusion).
LOWER GRADES				
Language	**Memory**	**Attention**	**Fine Motor Skill**	**Other Functions**
Delayed decoding abilities for reading. Trouble following directions. Poor spelling.	Slow recall of facts. Organisational problems. Slow acquisition of new skills. Poor spelling.	Impulsivity, lack of planning. Careless errors. Insatiability. Distractibility.	Unstable pencil grip. Trouble with letter formation.	Trouble learning about time. (temporal-sequential disorganization) Poor grasp of math concepts.
MIDDLE GRADES				
Language	**Memory**	**Attention**	**Fine Motor Skill**	**Other Functions**
Poor reading comprehension. Lack of verbal participation in class. Trouble with word problems.	Poor illegible writing. Slow or poor recall of math facts. Failure of automatic recall .	Inconsistency. Poor self-monitoring. Great knowledge of trivia. Distaste for fine detail.	Fist-like or tight pencil. Illegible, slow or inconsistent writing. Reluctance to write.	Poor learning strategies. Disorganization in time or space. Peer rejection.

UPPER GRADES				
Language	**Memory**	**Attention**	**Fine Motor Skill**	**Other Functions**
Weak grasp of explanations. Foreign language problems. Poor written expression. Trouble summarizing.	Trouble studying for tests. Weak cumulative memory. Slow work pace.	Memory problems due to weak attention. Mental fatigue.	(Lessening relevance of fine motor skills)	Poor grasp of abstract concepts. Failure to elaborate. Trouble taking tests, multiple choice (e.g. SAT's)
From "Learning Disorders and the Flow of Expectations", by Melvin D. Levine, M.D., F.A.A.P., published in <u>*THEIR WORLD, 1990*</u>. These lists are guideposts for parents, teachers and others involved. They should not be used in isolation, but may lead you to seek further assessment. Many children will, from time to time, have difficulty with one or more of these items. They should always be reviewed in a broader context of understanding about a child.				

Important guideposts for teachers, parents and social workers in identifying early warning signals of learning disabilities are table 3.1 together with Thompson's (1997:1-2) "Common ability characteristics or Classic symptoms List":

- **auditory perceptual skills** - understanding what we hear and processing it correctly,
- **visual perceptual skills** - understanding what we see and processing it correctly,
- **processing speed** - the time it takes to process information,
- **organisation** - storing information in correct order, in the right place,
- **memory** - short term and long-term storage and retrieval of information,
- **fine motor skills** - legible and effective written communication including copying what is seen,
- **gross motor skills** - control of body parts in walking, working and playing,
- **attention** - focusing on one thing for the required length of time,
- **abstractions** - interpreting symbolism,
- **social competence** - effective interactions with others.

If a problem is experienced in one or more of the common ability areas it may lead to learning disabilities.

The researcher believes that the above lists can be used as guideposts by the parents, teachers and others involved in early screening of a possible problem that may lead to learning disabilities, however, they are not to be used in isolation. Many children may experience difficulty with some of these items, because of emotional or environmental factors or those who are simply slower in developing certain skills, and not because of a neurological problem. The child should always be reviewed in a broader context.

The researcher came to the conclusion that "learning disability" is not a diagnosis in the same sense as "chickenpox" or "measles". Chickenpox and measles imply a single known cause with a predictable set of symptoms, but learning disabilities is a very broad term that covers more than one possible cause, symptom, treatment and outcome. Learning disabilities can show up in so many forms making it very difficult to diagnose or pinpoint the cause.

3.5 Causes of Learning Disabilities

"Why? What went wrong?" is some of the first questions parents ask when they learn that their child has a learning disability. Professionals in the mental health field stress the fact that since no one knows what causes learning disabilities, it doesn't help parents to look backward to search for possible reasons. There are too many possibilities to pin down the cause of the disability with certainty and it is far more important for the family to move forward in finding ways to get the right help.

Scientists need to study causes in an effort to identify ways to prevent learning disabilities. At first, scientists thought that all learning disabilities were caused by a single neurological problem. Research supported by NIMH has shown that the causes are more diverse and complex. New evidence show that most learning disabilities do not stem from a single, specific area of the brain, but from difficulties in

bringing together information from various brain regions. A leading theory today is that learning disabilities stem from subtle disturbances in brain structures and functions. Some scientists believe that in many cases the disturbance begins even before birth. (NIHM, 1993:6-7).

3.5.1 Errors in Fetal Brain Development

The fetal brain develops throughout pregnancy from a few all-purpose cells into a complex organ made of billions of specialised, interconnected nerve cells called neurons. During this evolution of cells, things can go wrong that may alter how the neurons form or interconnect. The brain stem is formed in the early stages of pregnancy and it controls the basic life functions such as breathing and digestion. A deep ridge is then formed dividing the cerebrum (the thinking part of the brain) into two halves, a right and left hemisphere. Finally all the senses develop together with the areas associated with attention, thinking and emotions and the areas involved with processing sight and sound. As new cells form they move into place to create various brain structures and the nerve cells rapidly grow to form networks with other parts of the brain. These networks allow information to be shared among various regions of the brain. Throughout the pregnancy this brain development is extremely vulnerable to disruptions. Disruption occurring early in the developing stages may lead to the death of the fetus, or the infant being born with widespread disabilities and possibly mental retardation. If the disruption occurs later, when the cells are becoming specialized and moving into place, it may leave errors in the cell makeup, location, or connections. It is the belief of some scientists that these errors may later show up as learning disorders. (NIMH, 1993:7).

3.5.2 Other Factors That Affect Brain Development

Scientists at NIMH and other research facilities are tracking clues to determine what disrupts brain development. Through experiments with animals, scientists study the normal processes of brain development, so that they can better understand what can go wrong. These studies are used for examining how genes, substance abuse, pregnancy problems, and toxins may affect the developing brain. The researcher

will now focus on genetic factors; tobacco, alcohol, and other drug use; problems during pregnancy and delivery; and toxins in the child's environment.

3.5.2.1 Genetic Factors

Learning disabilities tend to run in families. This fact indicates that there may be a genetic link. Children who, for example, lack some of the skills needed for reading, such as hearing the separate sounds of words, are likely to have a parent with a related problem. The parent's learning disability might however take a slightly different form in the child. A parent who has a writing disorder may have a child with an expressive language disorder. For this reason, it seems unlikely that specific learning disorders are inherited directly. What could possibly be inherited, is a subtle brain dysfunction that can, in turn, lead to a learning disability. Another alternative explanation for why learning disabilities might seem to run in families is that some learning difficulties may actually stem from the family environment. For example, parents who have expressive language disorders might talk less to their children, or the language they use may be distorted. In such cases, the child lacks a good model for acquiring language and therefore, may seem to be learning disabled (NIMH, 1993:7-8).

3.5.2.2 Tobacco, Alcohol, and Other Drug Use

During pregnancy many kinds of drugs, which can be taken by the mother, pass directly to the fetus. Research shows that a mother's use of cigarettes, alcohol, or other drugs during pregnancy may have damaging effects on the unborn child. Scientists have found that mothers who smoke during pregnancy may be more likely to bear smaller babies. The concern is that small newborns, usually those weighing less than 5 pounds, tend to be at risk for a variety of problems, including learning disorders. Alcohol may also be dangerous to the fetus' developing brain and it appears that alcohol may distort the developing neurons. Heavy alcohol use during pregnancy has been linked to fetal alcohol syndrome, conditions that can lead to low birth weight, intellectual impairment, hyperactivity, and certain physical defects. Any alcohol use during pregnancy may influence the child's development and lead to problems with learning, attention, memory, or problem solving. Women

who are pregnant or who may soon become pregnant (because scientists have not yet identified "safe" levels of alcohol use during pregnancy) should use alcohol cautiously (NIMH, 1993:8).

Drugs such as cocaine (especially in its smokable form known as crack) seem to affect the normal development of brain receptors. These brain cell parts help to transmit incoming signals from our skin, eyes, and ears, and help regulate our physical response to the environment. Children with certain learning disabilities have difficulty understanding speech sounds or letters, and therefore some researchers believe that learning disabilities, as well as ADHD, may be related to faulty receptors. Current research points to drug abuse as a possible cause of receptor damage (NIMH, 1993:8).

3.5.2.3 Problems during pregnancy or delivery

Other possible causes of learning disabilities involve complications during pregnancy. In some cases, the mother's immune system reacts to the fetus and attacks it as if it was an infection. This type of disruption seems to cause newly formed brain cells to settle in the wrong part of the brain. During delivery, the umbilical cord may become twisted and temporarily cut off oxygen to the fetus and this can impair brain functions and lead to learning disabilities (NIMH, 1993:8).

3.5.2.4 Toxins in the Child's Environment

New brain cells and neural networks continue to be produced for approximately year after the child is born. These cells are also vulnerable to certain disruptions. Researchers are looking into environmental toxins that may lead to learning disabilities, possibly by disrupting childhood brain development or brain processes. Cadmium and lead are becoming a leading focus of neurological research. Cadmium, used in making some steel products, can get into the soil, and then into the food we eat. Lead was once common in paint and gasoline, and is still present in some water pipes. (Cadmium and lead are both prevalent in the environment).

A study of animals sponsored by the National Institutes of Health showed a connection between exposure to lead and learning difficulties. In this study rats were exposed to lead and afterwards the rats experienced changes in their brainwaves, slowing their ability to learn. The learning problems lasted for weeks, long after the rats were no longer exposed to lead. In addition, there is growing evidence that learning problems may develop in children with cancer who had been treated with chemotherapy or radiation at an early age. For children with brain tumours who received radiation to the skull, this seemed particularly true (NIMH, 1993:8-9).

The question, what causes learning disabilities, is not easily answered. As stated previously, there are too many possibilities to pin down a single cause of learning disability with certainty. Scientists do need to study causes in an effort to identify ways to prevent learning disabilities. At first they thought that all learning disabilities were caused by a single neurological problem. Research supported by NIMH has shown that the causes are more diverse and complex. Sophisticated brain imaging technology is now making it possible to directly observe the brain at work and to detect subtle malfunctions that could never be seen before. Other techniques allow scientists to study the points of contact among brain cells and the ways signals are transmitted from cell to cell. With this array of technology, NIMH is conducting research to identify which parts of the brain are used during certain activities, such as reading. For example, researchers are comparing the brain processes of people with and without dyslexia as they read. Research of this kind may eventually associate portions of the brain with different reading problems (NIMH, 1999:17).

Clinical research also continues to amass data on the causes of learning disorders. NIMH grantees at Yale are examining the brain structures of children with different combinations of learning disabilities. Such research will help identify differences in the nervous system of children with these related disorders. Eventually, scientists will know, for example, whether children who have both dyslexia and an attention disorder will benefit from the same treatment as dyslexic children without an attention disorder (NIMH, 1993:17-18).

The researcher came to the following conclusions:

- There is no definite answer too exactly what causes learning disabilities. There are too many possibilities to pin down the exact cause of disability.
- The following may cause learning disabilities namely errors in fetal brain development, genetic factors; tobacco, alcohol, and other drug use; problems during pregnancy or delivery and toxins in the child's environment.
- Scientists continue to do research to determine the causes of learning disabilities, hoping to identify ways to prevent learning disabilities. At first they thought that all learning disabilities were caused by a single neurological problem, now they know that the causes are more diverse and complex.

3.6 Characteristics of the child with a learning disability

When a child is identified as having a learning disability, according to Thompson (1997:1) we know two things:

- he or she has at least average intelligence, and possibly above average;
- and he or she learns in a different way.

For Thompson (1997:1) this means that this child is whom researchers call an "exceptional student," and that the exceptionality is in the area of communications. This area covers the ability to process information. The mystery of how an individual child with a learning disability learns is a tremendous challenge to researchers. Thompson tries to explain it as follows:

> " Think of the circuitry of a computer. As complex as it may be, all the bits and pieces are labelled and, if there is a malfunction, a trained technician can find the problem and fix it. The human brain, on the other hand, is infinitely more complex than a computer. Even the best neurosurgeons cannot repair the malfunctions in a person's ability to process information" (Thompson, 1997:1).

The following are the characteristics of young learning disabled students as tabled by Seldin (The Lab School of Washington, 1998:1-2):

Table 3.2 Characteristics of young disabled students

Characteristics Related to General Functioning and Social-Emotional Development
• Immature emotionally and socially. • "Spacey": Look of disorientation. • Can't make choices. • Can't stay with an activity. • Distractible. Impulsive. • Knows rules but do not apply. • Labile emotions; excessive silliness; catastrophic reactions; angry; shy or withdrawn. • Shifts blame? • Academic skills very slow in developing. • Strong discrepancies in skills and knowledge. • Socially off-base. Unaccepted by group. • Poor memory. • Easily frustrated. Won't take risks. • Doesn't take pride in work or accept compliments. • Excessively rigid: cannot abide change. • Artistic. Sensitive. Mechanically inclined. • Non-verbal reasoning is highly developed

Characteristics Related to Speech – Language Development
• Avoids talking or focuses mainly on adults. • Uses pat phrases to communicate. • Excellent vocabulary but poor production. • Hesitate constantly, uses filler words stammers. • Make off-topic comments? Raises hand but have no words. • Wants to tell but cannot retrieve words. • Tells stories in random order without references. • Mishears or doesn't hear. • Articulation weak with substitutions of sounds. • Uses incomplete sentences. Mumbles. Slurs. • Poor pragmatic: eye contact, turn taking. • Loses focus in-group activities. • Hyper vigilant. Watches others to see what to do. • Word order or syllable order frequently mixed. • Cannot rhyme. • Cannot segment sounds in words, or blend them together to make words
Characteristics Related to Sensory – Motor Development
• Avoids tasks. Colouring, drawing, cutting. • Excessively physical. Touching, pushing, wrestling. • Generally not upright. Leaning, lying, drooping. • Gets into trouble when he/she has free time or space. • Bumps into things and people without awareness. • Lasting egocentricity. • Avoids or is uncomfortable on play equipment. • Falls often and easily. Slides out of chairs. • Large and fine motor skills immature. • Can't blow nose or tie shoes. • Very disorganized. Can't get ready. Clean up. • Constantly losing things. Can't remember how to go where to put things. What its time for. • Pencil grip awkward. Puzzles challenging. • Fussy eater. Messy eater. Over or under reacts to stimuli. Treats a light touch as he/she does a punch. Frightened by loud noises. Overwhelmed by strong smells and bright lights."

Thompson (1997:2) is correct in stating that the frustrations and anxieties children with learning disabilities experience are beyond the comprehension of people who learn and get along with others satisfactorily. The most devastating result for these children is the gradual deterioration of their self-esteem, and everything possible must be done to help these children maintain it. The common side effects of having a learning disability may include:

- distractibility,
- impulsiveness,
- mood changes,
- inconsistencies,
- work-avoidance behaviour, and
- attention-seeking behaviours.

These behaviours often develop to mask the real problems that learning disabled children face on a daily basis, but with the right support and an individualised learning program they can be successful!

The researcher came to the following conclusions:

- It is important to remember that although one child's learning disability may have a lot in common with another child's learning disability, there are no grounds for assuming that they are both associated with identical conditions or events.
- The learning disabled child is not mentally retarded, he is not physically impaired, he is not emotionally disturbed and he is not culturally disadvantaged.
- The learning disabled child can be seen as a child of at least average intelligence, whose academic performance is impaired by a developmental lag in the ability to sustain selective attention. He requires specialised instructions in order to permit use of this full intellectual potential.

3.7 Related problems of learning disabilities

3.7.1 Learning disabilities and emotional problems

Distinguishing between learning disabilities and emotional disturbances is sometimes difficult. According to Johnson (1979:15) it is particularly evident in those cases where a child has experienced so much long-term frustration and failure, he then develops emotional reaction patterns towards them. Johnson believes that these emotional problems in reaction to learning disabilities are seldom neurotic-psychotic syndromes. He believes that the learning frustrations can well be powerful, long lasting and permeating the personality structure, but such problems tend to be specific related to the learning context. For him, emotional problems, which emerge from learning disabilities, are commonly decreased relatively quickly and easily once the learning difficulty is alleviated.

If the child's emotional needs, on the other hand, are not attended to, it may lead to fear of failure and feelings of inadequacy and he might not be able to cope in and organise his life-world. According to research there seems to be a correlation between the child's emotional needs and his academic performance.

Transley and Gulliford (1962:49) believes that if the basic needs of the child are not adequately satisfied, he may be difficult to motivate and will lack interest in what he is doing. He will not be able to organise his emotional energy needed for learning in school. He will continually be upset by feelings of hostility and jealousy towards the teacher and peer group, and experience anxiety about his own failures. This may have a devastating effect on his self-esteem.

The emotional needs of the child must be met in an attempt to provide positive learning experience to him. He must feel emotionally secure and stable to be able to engage in a variety of learning experiences. He needs to develop cognitively so that he will be able to handle the "frustration-failure lowered self-concept experience".

3.7.2 Learning disabilities and behavioural problems

If children were computers programmed with infallible software there would not have been a single behavioural problem. All children display inappropriate or unexpected behaviour from time to time, but it does not mean that the behaviour is problematic. According to Kramer (1992:1) behaviour can be regarded as problematic if it:

- occurs to a serious extent and over a period of time;
- becomes worse;
- interferes significantly with learning and teaching;
- is inappropriate to the child's chronological age and level of development;
- endangers the student or others;
- results in or could result in damage to property, equipment, materials, etc;
- is contrary to acceptable social norms.

Kramer (1992:1-2) also listed some problematic behaviour that commonly occur in classrooms:

Table 3.3 Problematic behaviour that commonly occur in classrooms

Disruptive behaviour	Poor attitudes and work habits	Withdrawal
•attention–seeking behaviour (clowning around, general naughtiness, rowdiness, etc.); •harassing fellow-students; •aggressive behaviours; •talking out of turn; •making unnecessary noises; •hyperactivity; •impulsive behaviours; •emotional outburst – these behaviours indicate a lack of self-control.	•inability to concentrate for long periods of time; •distractibility; •negativism; •lack of motivation; •lack of interest; •idleness/work avoidance; •ineffective use of time; •losing things; •inability to remember instructions; •inability to work co-operatively; •not accepting responsibility for own acts; •cheating –these behaviours have	•excessive shyness; •disobedience, refusal to work, or co-operate; •daydreaming – withdrawal is the opposite of disruptive behaviour

	a negative impact on the child's individual performance.	

Behaviour deviations, which occur most commonly in children with learning disabilities, are:

- Poor self-concept, attempts to manipulate the environment, frustration and aggression as a consequence of the wounding of the ego,
- Error-avoiding behaviour, which is marked by attempts to change the subject or sick attempts to draw attention such as clowning,
- A denial of the existence of the problem and a tendency to project the cause on to other non-relevant sources outside him e.g. "I cannot write because this pencil is too blunt."
- Very marked is the poor impulse control, which is manifested in disinhibition, hyperactivity, hyperkinesis, low frustration tolerance level, lability or explosive emotionality. (Lerner, 1978:387-389)

The child with a learning disability may react in any of the above ways.

3.7.3 Learning disabilities and low self-esteem

According to Mowbry and Salisbury (1975:114) children with healthy feelings of self-esteem, including a positive self-image tends to have few anxieties and knows concrete ways to work through them. They feel worthy of themselves, and are therefore well received and capable. They do not likely have experiences that anticipate unpleasant outcomes and they do not need to allay anxious feelings with behaviours that tend to alienate others. They continue to behave in ways that have proved effective in meeting their needs in the past, keeping in motion a positive cycle of emotional growth.

Children, who continuously meet with failure, are more apt to anticipate unpleasant outcomes. In dealing with these uncomfortable feelings, they tend to behave in less socially acceptable ways.

According to Shelton (1971:19) the child who lacks the necessary courage and ability to master certain situations his peers have already mastered, can very quickly appear frightened, confused and resentful. If the child keeps on failing, his self-esteem gets so low that he sees himself as worthless and has an inferiority complex. He begins to hate school because he is always in trouble and is punished for his "failures". His teachers are viewed as oppressors instead of friends and he develops a negative attitude towards the learning situation.

According to Kissel (1990:vii) there are more and more children showing dysfunctional reactions and having greater difficulties learning in school. Behaviour problems, academic difficulties, and an inability to relate to authority figures are either the result of emotional difficulties or the cause thereof. He feels that it makes little difference if a child's problems stem from socio-cultural differences, education-based deficiencies, or fractured families, because despite their origins, they leave scars, which impact a child's self-esteem. However, if we take the time to talk to these children, they will say that they only want to learn and to have friends like everyone else.

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3.7.4 Learning disabilities and relationship structures

The family is the core of the young child's life and he desperately needs the satisfaction and assurance of relationships in the primary family. However, because of the child's numerous problems in social behaviour, language and temperament, their relationships are hard to establish and the child does not receive satisfaction, even within the family circle.

Singh (1991:5) states that when a child feels incompetent he cannot progress according to his own potential:

> "When a child is feeling inferior and incompetent he will be attributing unrealistic meaning to school, teachers and peers, consequently his true potential will be masked. He will not be able to progress in accordance with his actual potential. His progress to-

> wards self actualisation has been arrested both in his emotional world and his scholastic world."

The greatest contribution parents can give a child with learning disabilities is to accept this fact, and to support him in the process of growing to accept himself. The child will need the understanding and encouragement of the parent in order to cope with frustrations he will experience, and to meet the extra demands, which will be made of him. Lawrence (1988:87-88) states that:

> "No child who is considered to have a specific learning disability should be excused on the grounds that there are good reasons for his failure, and he can, therefore, be allowed to slack. On the contrary, he has to get the message early that he has to work harder than others to keep up or even to move at a reasonable space... Some parents of these children appear to behave as though achieving on admission that their child is learning-disabled is a solution in itself. But at best this is only the beginning of what could be a long hard haul for the child and his teachers."

One of the most important skills to be taught, both at home and in school, is how to get along with others. Lerner (1993:512) defines social skills as the ability to organize ones thinking and behaviour into an integrated course of action, which is directed towards culturally acceptable social or interpersonal goals. Social skills include what a person thinks and how a person behaves in the social environment. Kronick in Lerner (1978:390) postulates that the development of social perception is similar to the development of academic skills such as reading or mathematics. Pupils with social disabilities have difficulty in perceiving the affective status of others, and they are less able to perceive how others feel. They may use inappropriate behaviour, or they may be insensitive to the general atmosphere of a social situation.

3.8 Conclusion

In this chapter the researcher firstly focused on the history of the development of the definition on learning disability. The researcher came to the following conclusions:

- The efforts made to find a suitable name for the conditions of learning disabilities have been as many as the various opinions on what symptoms should be included in it.
- Learning disabilities are neurological in origin, and it affects a person's ability to either interpret what they see and hear, or to integrate information from different parts of the brain.
- The term learning disability does not include a learning problem, which is primarily the result of visual, hearing, or motor handicaps, or of mental retardation, or of emotional disturbance, or of environmental, cultural, or economic disadvantage.
- Learning disabilities may occur concomitantly with other handicapping conditions or with extrinsic influences, but they are not the result of those influences or conditions.
- Labels are sensitive and controversial professional issues, because they may focus on an isolated area of a multifaceted problem and thus represent an incomplete diagnosis, or brand a child cruelly as being uneducable, lazy, backward, defective or even emotionally disturbed.

The researcher further focused on the criteria, the causes and common signs of learning disabilities, the characteristics of the child with learning disabilities and the related problems. The following conclusions were made:

- There is no definite answer as to what exactly causes learning disabilities, but that the causes are more complex and diverse than a single neurological problem.
- The learning disabled child is one of at least average intelligence and whose academic performance is impaired by a developmental lag in the ability to sustain selective attention.

- Related problems of learning disabilities are emotional-, behavioural- and low-self esteem problems. Children, who continuously meet with failure, are more apt to anticipate unpleasant outcomes.
- In dealing with these uncomfortable feelings, they tend to behave in less socially acceptable ways. These children also have difficulty in their relationship structures.
- The researcher believes that these children need specialised instructions, a safe life-world where they feel loved and especially unique in order to permit their full potential.

CHAPTER FOUR

4 PLAY THERAPY

4.1 Introduction

The researcher believes that some of the most frequently asked questions when working with children are the following:

- Why do children play?
- What is it in play that provides the child with means of coping with extremely difficult situations?
- Why do children use play as a form of language to make their own personal statement?
- What elements in play trigger the path of healing?

The knowledge of play and especially how play is used in therapy is essential for any therapist working with children. It is important that children are approached and understood from a developmental perspective. Children are not miniature adults. Their world is one of concrete realities where their experiences and feelings are communicated through play. Play cannot be seen as a mindless filling of time or a rest from work. Play is work and work is play! Play is a child's life. It is the means by which he comes to understand the world he lives in.

For Gordon and Brown (1989:323) play is how children reconstruct their world in order to understand and master it. According to McMahon (1993:1) play can be seen as a way of assimilating new information and making it part of ourselves through a process in which we can change ourselves and our view of the world without our autonomy being challenged or threatened. Landreth (1991:8) believes that play is the singular central activity of childhood that occurs at all times and in all places. Play is a form of spare-time behaviour that is selective, directed, persistent, and self-rewarding. Play is usually spontaneous, voluntarily, pleasurable and enjoyable. Play has no extrinsic goals and it requires active involvement on the part of the participant. Play can be considered a learning process.

Florey (1979:62-64) states that play is one of the most common phenomena of childhood and that it is a biological, psychological and socio-cultural phenomenon, which is singularly difficult to define, describe and delimit. Oaklander (in West, 1996:13) maintains that play for the child is a very serious and purposeful business:

> "Play is the child's form of self-therapy through which confusions, anxieties and conflicts are often worked through. Through the safety of play children can try out their own ways of being. Play performs a vital function for the child. It is far more than just the frivolous, light hearted, pleasurable activity than adults make of it. Play also serves as a symbolic language.... Children experience much that they cannot as yet express in language, and so they use play to formulate and assimilate what they experience."

Play can thus be seen as a means through which the child develops emotionally, socially, intellectually, and physically. Children do not need to be taught how to play nor must they be made to play. Young children's play, can be accepted as their attempt to try out their world, and in so doing, they learn to live in a community. Play supports the child's everyday learning about the people and objects in his environment as well as the relationships with them.

Because of the inability of the child to express himself adequately in a verbal way; and because play is the natural medium of communication of the chid, play as form of therapy evolved. This chapter will focus on:

- The understanding of children's play.
- The development of play as a form of therapy.
- Play therapy: non-directive/client-centered therapy and short-term/structured play therapy.
- Play therapy resources: the play therapy environment, materials and media, methods/ techniques used in treatment.

4.2 Understanding children's play

The dichotomy between, play as a child's activity and work as an adult activity originated out of the nineteenth century. It was accentuated in the twentieth century by reactions to the abuse of child labour. Play is such an accepted part of life today that few people stop to consider its role in the child's development. What is known about play is found in the different theories of play, personality and cognition. These theories are derived from such fields as education, philosophy, psychology, medicine, sociology and anthropology. In 1964 Slobin (1964:1) wrote that when we examine a set of behaviours as outstanding as play, we find ourselves face-to-face with hundreds of years of attempts to understand human behaviour.

Initially, children's play consists of recollection and re-enactments of real situations. Through the recognition of implicit rules governing their games, children achieve an elementary mastery of abstract concepts. Vygotsky (in Cattanach, 1993:33) suggested as early as 1933 in his book "Play and its Role in the Mental Development of Children" that children's play is a transitional stage in learning to separate the meaning of an object from its presence. For example, the child plays with a stick, (an object), and he calls it a horse. Because he uses the stick to present a horse, he perceives the meaning of the concept horse even though the real horse is not present. The child then separates the meaning of stick horse from the real horse and he now learns to "think" horse. The stick acts as a pivot and the meaning of "horse" is established for the child while playing with the stick. The stick and the play are pivots to recall and understand the concept and the action of the object. In this way the child learns that every object has a meaning. Vygotsky (in Cattanach, 1993:33) calls this feature of human perception, reality perception. He postulates that the child does not only see the world in colour and shape, but also as a world with sense and meaning.

Piaget (in Cattanach, 1993:34-35) regards play as an assimilation of new experiences. He examines play as part of the whole intellectual development of the child and relates play to the process of assimilation and accommodation. Assimilation occurs whenever the individual, as a result of his past experience, is able to recog-

nise and give meaning to new elements encountered in the environment. Accommodation occurs when the individual is changed by the environmental circumstances in which he finds himself. Piaget (in Cattanach, 1993:33) classifies play into three types: practice, symbol and rule:

- **Practice games** - which are used when a new skill is acquired - these begin during the first month of life.
- **Symbolic games** – which involve the use of make-believe, and is a specifically dramatic form of play that starts at the age of two.
- **Social play** – which involves rules and regulations imposed by the group. This form of play occurs in the seven to eleven year old age group.

The researcher believes that both Vygotsky and Piaget's research are very significant in understanding children's play. These principles should be kept in mind when working with the child. The child's play must be observed in the context of where the child is at that stage on the developmental track. Play and child development should not be seen as two different entities The researcher agrees with Frank (1979:51) where she states that play is a revealing process of personality development, whereby the child learns and rehearses varied transformations The child explores, manipulates and utilises objects, animals, people and events as occasions for creating his own life space while living in the consensual world.

Children project themselves into adult activities and rehearse their future roles and values in play. Through role-playing they learn who they are, who others are, and what it feels like to be them. Play helps them to express their emotions and get rid of pent-up energy in a manner that will win social approval. They acquire these social motivations, skills, and attitudes more effectively through imitation in play than in training. Play provides children the opportunity to learn, develop and perfect new skills that build competence. Play is essential for communicating and mastering feelings. (Westman, 1990:312-313).

Frank (in Landreth, 1991:8) suggests that play is the way through which children learn what no one can teach them - they explore and orientate themselves to the actual world of space and time, of things, animals, structures, and people. By engaging in the process of play, children learn to live in our symbolic world of meanings and values. At the same time they explore, learn and experiment in their own individual way. For Oaklander (1978:160) play is the young child's form of improvisational dramatics. As for Frank, she also sees play as how the child tries out this world, and at the same time, learns about his world. Play is therefore essential to the healthy development of the child. She postulates that play for the child is a serious, purposeful business through which he develops mentally, physically, and socially. Play can therefore be seen as the child's form of self-therapy, by which confusions, anxieties, and conflicts are often worked through. Through the safety of play, every child can try out his own new ways of being.

Landreth (1982:ix) feels that play is to the child what verbalisation is to the adult. Play is a medium for expressing their feelings, exploring their relationships, describing their experiences, disclosing their wishes and self-fulfilment. Children communicate through play. They express themselves more fully and more directly through self initiated spontaneous play than they do verbally. The process of play is viewed as the child's effort to gain control over his world and the environment in which he finds himself. Children can master frightening feelings through make believe. Through play they practice the social skills that they will need when they are older. The most natural dynamic and self-healing process in which children can engage, is to "play out" their experiences and feelings (Landreth, 1991:10).

The researcher came to the following conclusions:

- Children develop mentally, physically and socially through play.
- Children master important skills and learn facts about relationships through play. They learn to create their own life space and learn about themselves and their relationships with others

- Play is essential for learning skills such as concentration, memory, thinking, language, communication, self-awareness, self-regulation, social sensitivity and interpersonal skills.
- Play is an assimilation of new experiences, as through play the child gains control over his environment and life - world.
- The child learns what his abilities are and how these abilities compare with those of others.
- Play is the child's natural medium of communication.
- Play provides pleasure and learning and a minimum of risks and penalties for mistakes. Errors do not have serious consequences - the play matters more than the outcome of his plans.
- In play children devise and solve problems without relying on adult approval. They find pleasure in completing tasks. Development of imagination through play, is a central aspect of overall character development.
- These skills enable him to establish a more definite and realistic impression of himself and, in addition, he learns about his problems and how to face them.

The researcher believes that:

- Once the child learns that creating something new and different is satisfying, he will be prepared to transfer his creative interest to situations outside the play world.
- Play provides an outlet for needs and desires which cannot be met in any other way. If these needs and desires are met satisfactorily in play or through identification with fictional characters, the frustrations of daily life will be lessened.
- Play helps the child to comprehend and control the world in which he lives and to distinguish between reality and fantasy. Through play reality loses its seriousness and it becomes the means by which the child truly comes to know and understand the world he lives in.
- Through play the child communicates his fears and his feelings and by pretending he gains control over his environment.

- As the child plays, he discharges energy, prepares for life's duties, achieves difficult goals, and relives frustrations. Play is the child's symbolic language of self-expression.
- An understanding of child's play behaviour provides cues to help the therapist to enter more fully into the inner life of the child.

4.3 The development of play as a form of therapy

The first recorded use of play in therapy was the case of "Little Hans" by Sigmund Freud in 1909. Freud applied the principles of adult therapy in his work with "Little Hans", a 5-year old boy with a phobia. Freud acted mostly through Hans's father, where his thinking was directed along purposeful lines (Landreth, 1993:1-2).

In 1921 Von Hug-Hellmuth (in Rutter et al, 1994:936) observed children's play and was aware that play was a means of expression. This led to a specific technique for gaining understanding of children through the medium of play. Play developed from efforts to apply psychoanalytic therapy to children. Because child analysis was distinct and different from psychoanalysis, only a few psychoanalysts were capable of child analysis before the early 1920's, According to Landreth (1991:26-29 and 1997:26) Anna Freud used play to win children's friendship and Melanie Klein developed "Play Analysis", which in principle was true to the psychoanalytic tradition. Considering how little was known about children in the early 1900's, it is surprising to realise that the formal and often highly structured approach utilised in adult analysis to obtain material for interpretation, primarily through the process of recall and recollections of the client, was quickly recognised by these early therapists as being inadequate and inappropriate for child analysis.

Solomon, Levy and Conn (in Lebo, 1982:69-70) developed forms of active play therapy. Solomon and John Levy stressed the relationship between the child and therapist. For them the relationship was considered to be diagnostically indicative of the child's relationship with others. They followed the formulations of Anna Freud while Conn and Levy did not consider the need to build up a feeling of rap-

port between the child and the therapist as essential. Their work resembled the play techniques of Melanie Klein. Psychoanalysts found the standard techniques and approaches used in diagnosing and treating emotionally disturbed children insufficient. It had to be modified. The child cannot become an adult, just to be treated effectively.

A method of child treatment developed from relationship therapy, which emphasized the present rather than the past and stressed the importance of a dynamic relationship between the therapist and the child. These postulates of the relationship therapy were absorbed into the non-directive therapy where the therapeutic reliance was placed upon the person himself. Non-directive therapy, a more "passive" form of therapy developed concurrently with active therapy. In non-directive play therapy the therapist does not restrict the child's play and the child is allowed to direct the play. The passive play therapist believes that the child can work out his anxiety, hostility or insecurity at his own speed through a process of play. There is no restriction placed on the toys used during play sessions (Lebo 1982:71-72). The client-centered approach developed out of the non-directive approach. The child is in charge of the play in a child–centered play session. He is given an opportunity to learn about himself in relation to the therapist. This is long-term therapy.

Levy (Hambridge, 1982:105) worked out a series of play forms, which he found useful in the treatment of children. He essentially devised a series of specific stimulus situations, which the child could then freely play out. This over-all technique was the beginning of structured play therapy.

Structured play therapy is short-term therapy. According to Hambridge (1982:105 - 110) the structured play situation is used as a stimulus to facilitate the independent free play of the child in treatment. The child should be acquainted with the playroom. The playroom must be equipped with the necessary play materials that have clinical value.

The difference between short-term therapy and long term-therapy is more than a matter of time. According to Shapiro (1994:5) they are two distinct models of psychotherapy, with some similarities but more differences:

> "The aim of short-term therapy is not to "cure" children, but rather to simultaneously stimulate their internal resources for growth and development and make their environment more responsive to their needs... Long-term therapy is usually open-ended and deliberately ambiguous about its purpose, short-term therapy seeks to define the child's problem in terms as concrete as possible."

Short-term therapy is time-limited and the techniques chosen by the therapist to achieve each goal contain as much therapeutic power as possible. Long-term therapists typically use non-directive and reflective techniques, which allow children to reveal their conflicts, and their solutions at their own rate. According to Shapiro (1994:6) no form of therapy is so powerful that it can change a child in ways that are incompatible with his basic needs. The goal of psychotherapy is to give children choices where before they had none.

The researcher came to the conclusion that:

- The development of child therapy where the use of play as therapeutic medium, was an unavoidable process through which a platform was created for the child to be approached by a therapist.
- The techniques of play therapy evolved because the child cannot express himself adequately on a verbal level and play seems to help the child to verbalise his feelings.
- Therapeutic play behaviour enables the child to reveal his emotions, wishes, attitudes and fantasies. It also releases socially unacceptable impulses and aggressive behaviour without fear of being censured or punished. The child can move safely into therapeutic experiences through which his anxiety level is reduced.

- Client-centered child therapy is long-term therapy and developed out of the non-directive approach. The child is in charge of the play process and is given an opportunity to learn about himself in relation to the therapist.
- Short-term therapy is time-limited and the techniques chosen by the therapist to achieve each goal contain as much therapeutic power as possible.
- Long-term therapists use non-directive and reflective techniques, which allow children to reveal their conflicts, and their solutions at their own rate

4.4 Play used in the treatment of children

The word "play" carries for most people a meaning synonymous with pleasure or having a good time. Allen (1947:124-125) was concerned that the word "play" in connection with therapeutic work with children, may give the impression that the child is just "having a good time". For a child, play is much more than only pleasurable activity and children quickly sense this in the therapeutic hour. Play is the child's most natural medium for the expression of feelings; it is a language that brings him into a communicating relationship with others and with the world in which he lives.

Research has shown that play in treating children can be used in different ways. According to Amster (in Landreth et al, 1982:34-42) play in treating children can be used as follows:

- Play can be used for diagnostic understanding of the child. The child's capacity to relate himself to others, his distractibility, his rigidity, his areas of preoccupation, his areas of inhibition, the direction of his aggression, his perception of people, his wishes, and his perception of himself can be observed.
- Through play, the child's behaviour, ideas, feelings and expressions helps the therapist to "understand" the problem and how the child sees it.
- Play can be used to establish a working relationship.
- Play can be used to break through a child's way of playing in his daily life and his defences against anxiety.
- Play can be used to help a child verbalise certain conscious material and the associated feelings.

- Play can be used to help a child act out unconscious material and to relieve the accompanying tension.
- Play can be used to develop a child's play interest, which he can carry over into his daily life and which will strengthen him for his future life.

Schaefer (1985:107) believes that play therapy has the following curative powers:

- it releases tension and pent up emotions,
- it allows for compensation in fantasy for loss, hurt and failures,
- it facilitates self-discovery of more adaptive behaviour,
- it promotes awareness of conflicts which may be revealed only symbolically or through displacement,
- it offers the opportunity to re-educate children to alternate behaviours through role-playing and story telling.

Children do not possess the developmental or intellectual sophistication to participate in adult verbally based therapies, because the very nature of childhood is incompatible with the formal operations of adult counselling. Homeyer and Sweeney (1998:2) believe that if the child is required to participate in traditional communicative adult therapy, the following message is sent to them very clearly: "We are the experts. We expect you to come up to our level of communication. We are unwilling to enter your world." This approach could be very harmful to the child. A trained play therapist therefore must understand the metaphorical content of a child's play, and strive to help the child express his needs and discover solutions in a safe, therapeutic environment. The awareness of the therapeutic usefulness of play is essential in working with children.

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The researcher came to the following conclusions:

- The therapeutic usefulness of play is based on the fact that the child uses play as means of self-expression, just as verbal communication is natural for the adult.

- A child lacks the cognitive maturity to benefit talking through personal problems. That is why adult controlled activities cannot give a child the needed feeling of empowerment, which can be achieved through voluntary play.
- Play gives the child an opportunity to search for and experiment with alternative solutions to his problems.
- Through play, the child in the play therapy session, creates a world he himself can master, where he can practice social skills, overcome frightening feelings, and symbolically triumph over the upsets and traumas that destroyed his sense of well being.
- Play offers the child in a therapy situation the opportunity to use the power of his natural creativity and imagination to heal and grow.
- Play is an essential medium to be used when working with children.

4.5 Play therapy

Play therapy is a dynamic interpersonal relationship between a child and a therapist. Play is voluntary. It is motivated from the child within, and involves the child in totality - physically, emotionally and mentally. The involvement of the total child in play leads to the creative expression of the physical, mental and emotional self of the child and it can involve social interaction (Landreth,1991:13).

Play therapy takes place in a playroom that has been specially designed, decorated and furnished with the toys and equipment needed to use as tools for the dramatic scenes they direct with the therapy. The therapist provide selected play material and facilitates the development of a safe relationship for the child in which he can fully express and explore his feelings, thoughts, experiences and behaviours. Through play, the child can physically demonstrate, rather than talk about his problems. The therapist listens, observes and comments to the child in an atmosphere of emotional safety.

Landreth (1991:14) believes that the therapist needs to strive to see, hear, feel, and experience the child's world, unconditionally. This could be accomplished through

the therapist's non-evaluative relationship with the child. The therapist should, as far as possible, avoid interpretations. The therapist communicates the messages "I am here, I hear you, I understand you and I care about you". The therapist does not offer any help, advice, or suggestions, unless it is on an emergency basis, or the child repeatedly requests assistance.

The therapist strives to guide the child to:

- express his thoughts and feelings in a constructive way,
- practice self-control,
- develop self-respect,
- develop self-direction,
- make choices and accept responsibility for the choices.

Issues such as behavioural problems, acting out of anger, adjusting to a disorder, poor peer relationships, low self-esteem and depression are effectively addressed through play activities.

Parents are important allies in the play therapy process and can do much to support and expand the work their child does in play therapy sessions. The therapist regularly meets with the parents and discusses the work the child does in play therapy sessions. During these meetings the therapist increases her awareness of sources of stress in the child's life, by sharing important observations about the child's behaviour, thoughts and feelings. The therapist gives useful advise on how parents can support their child's therapy, and develop ways of resolving problems experienced by the entire family to enable them to cope more effectively with everyday life.

The researcher will now focus on:

- Non-directive or client-centered therapy
- Structured therapy

4.5.1 Non-directive and client-centered play therapy

This approach was elected for its emphasis on self-esteem and its use of the environment to form a safe outlet for the child to express his or her feelings, fears, and conflicts. Virginia Axline (1969), paralleling the adult client-centered approach offered by Carl Rogers (1951), created non-directive play therapy. The non-directive therapy is based upon the assumption that the individual has within himself the ability to solve his own problems satisfactorily, together with a growth impulse that makes mature behaviour more satisfying than immature behaviour.

> "Non-directive therapy grants the individual the permissiveness to be himself; it accepts that self completely, without evaluation or pressure to change; it recognizes and clarifies the expressed emotionalized attitudes by a reflection of what the client has expressed; and, by the very process of non-directive therapy, it offers the individual the opportunity to be himself, to learn to know himself, to chart his own course openly and aboveboard - to rotate the kaleidoscope, so to speak, so that he may form a more satisfactory design for living" (Axline, 1996:14).

Since play is a child's natural medium for self-expression, non-directive play therapy offers him an opportunity to experience growth under the most favourable conditions. The child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion. According to Axline (1979:16) the child, through play, brings these negative feelings to the surface, gets them in the open, faces them, learns to control them, or to abandon them. After he has achieved emotional relaxation, he begins to realise the power within himself to be an individual in his own right. He learns to think for himself, to make his own decisions, to become psychologically more mature, and eventually he establishes his own identity.

According to Axline (1979:73 and 1996:69-70) when working with children, there are eight essential basic principles that should guide the therapist in all non-directive therapeutic contacts, namely:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognise the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour.
5. The therapist maintains a deep respect for the child's ability to solve his own problems, if given an opportunity to do so. The responsibility to make choices and to institute change is that of the child.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

During play therapy, the child is free to be himself in a safe and non-judgemental environment. The basic theory behind this approach is that all individuals, including children, have a powerful force within themselves that strives for growth, independence, and self-direction or self-actualisation. People, therefore, have within themselves the ability to improve, and solve their own problems. They are able to correct their psychological disturbances. This is done with the assistance of an accepting environment, which facilitates and encourages the clients to be themselves (Axline, 1969:preface).

Child-centered play therapy allows the child to direct the play at his own pace. He is given an opportunity to learn about himself in relation to the therapist. The role of the child-centered therapist is to empathise, and to respond by reflecting the feel-

ings and the thoughts of the child. The therapist behaves in a way that provides the security and opportunity to the child to explore the room and the toys. He should also have the opportunity, during this experience, to measure himself against himself. The relationship between the child and the therapist is the most potent force in healing. Landreth (1991:58) suggested that the child-centered therapist should focus on the following: the child and the child's feelings, the present, an effort to be understanding and accepting, the child's direction, and the child's knowledge.

The child is allowed to select the toys he wants to play with, as well as the manner of play. The therapist continually shows acceptance of the child's actions and feelings through empathic listening. In order to create an open atmosphere in which the child feels comfortable to express his true feelings, the therapist imposes only a few rules or limitations. Only when necessary, will the therapist set and enforce the limitations in a defined, effective manner. This is done in order to ensure that the child understands the boundaries and learns to take responsibility for his actions. The therapist engages in play with the child, only at his request, and then does so in the manner desired by the child (Van Fleet, 1994:5).

The researcher came to the following conclusions:

- Individuals have within themselves a powerful force that strives for growth, independence, and self-direction or self-actualisation.
- Non-directive play therapy offers the child an opportunity to experience growth under the most favourable conditions, since play is his natural medium for self-expression.
- Client-centered therapy developed out of the non-directive approach.
- The eight basic principles of Virginia Axline that guide the therapist in all non-directive therapeutic contacts in working with children are essential.
- Child-centered play therapy allows the child to direct the play at his own pace. He is given an opportunity to learn about himself in relation to the therapist.

4.5.2 Structured or short-term play therapy

Structured play therapy can be used in the larger framework of psychotherapy. Psychotherapy according to Axline (1982:121) is an experience where many different psychological rationales and methods are used with the overall objective to provide a relationship with the client. This experience will enable him to utilize the capacities that are within him for a more constructive and happier life as an individual and a member of society. Psychotherapy is a learning experience, a very complex, integrative, cumulative, complex personal involvement.

Levy (Hambridge, 1982:105) worked out a series of play forms, which he found useful in the treatment of children. He essentially devised a series of specific stimulus situations, which the child could then freely play out. This over-all technique was the beginning of "structured play therapy". Levy was firstly interested in this technique as a research method and also as a psychotherapeutic procedure.

According to Hambridge (1982,105-110) the area of direct psychotherapy with children has at its disposal a number of techniques that can be used by the therapist during the therapeutic session. The structured play situation is used as a stimulus to facilitate the independent free play of the child in treatment. The child should be acquainted to the playroom that must be equipped with the necessary play materials with clinical value. The child will have the opportunity to choose other play materials aside from those given to him at the outset of structured play. The child's own selection of toys is a very important and a significant element in the treatment process. The therapy session should not be conducted with limited materials. Structured play therapy according to Hambridge (1982:110) saves time by not indulging in "hours of diffuse, therapeutically unremunative activity" and simultaneously increases the specificity of treatment method in direct psychotherapy with children.

According to Sloves and Peterlin (1997:302-303) structured or time-limited therapy emphasizes the use of a single, overriding central theme or core conflict to guide the therapy throughout its course. The therapist follows a directive, focused ap-

proach to each session, and structures and restructures the play, as he/she helps the child to maintain a positive transference in the face of growing frustration and anxiety. The therapist also uses time as a metaphor to encapsulate the past, present and future of the child. At the onset of the treatment the time-limited therapist can tell the child when to expect the disappointment of termination. The child then has no basis for fear of betrayal of sudden abandonment.

According to Sloves and Peterlin (1997:304) the structured play therapist designs specific scenarios, selects the materials, controls the major parameters and constructs the introductory narrative to each session. The play materials are selected for their ability to recreate, in reasonably concrete, literal ways, the child's core conflict. Any material resistant to psychological regression is acceptable. Some of the primary tools of treatment are puppets, dolls, action figures, toy animals, dollhouses and furniture, building blocks, and drawing materials.

The researcher came to the following conclusions:

- In contrast with client-centred therapy where the child directs the therapy at his own pace, the therapist in structured therapy, has an active role to fulfil and decides on the theme, course of treatment and choice of play materials.
- The therapist pre-plans each play session to optimise time. She follows a directive, focused approach to each session and makes use of a single, overriding central theme or core conflict to guide the therapy throughout its course.
- The therapist structures and restructures the play, as she helps the child to maintain a positive transference in the face of growing frustration and anxiety.

4.6 Play therapy resources

Child therapists of different orientations make use of toys and play materials in the diagnosis of treatment of emotionally disturbed children. According to Ginott (in Landreth, 1982:145) the rationale for this practice is the belief that play is the child can state more adequately than in words how he feels about himself, the child's symbolic language of self-expression. Through the manipulation of toys the significant people and events of his life. He (Ginott, in Landreth, 1982:145-146) assumes

that because this is true, the kind of toys and materials used in the playroom is an important therapeutic variable:

> "The aim of child therapy.... is to effect basic changes in the intrapsychic equilibrium of the child. Through relationships, catharsis, insight, reality testing, and sublimation, therapy brings new balance in the structure of the personality, with a strengthened ego, modified superego, and improved self-image. The value of any toy, object, or activity in child therapy depends on its contribution to the realization of these objectives. In evaluating activities and materials, one should consider their effect on the inner process of therapy" (Ginott, in Landreth, 1982:145-146).

The researcher feels that this assumption of Ginott is of cardinal importance when working with the child with a learning disability. Choosing the right kind of material and activities is a very important process of the play therapy. The researcher will now focus on:

- The play therapy environment, materials and media.
- Methods and techniques used in play therapy

4.6.1 The play therapy environment, materials and media

A playroom with a variety of selected toys is more conducive to therapeutic communication than one filled with odds and ends of junk. Many therapists find it easier to structure therapy and to make contact with the child when the playroom contains materials that reflect permissiveness. According to Ginott (in Landreth,1982: 146) there are five criteria for selecting and rejecting materials for child therapy. A treatment toy should:

1. facilitate the establishment of contact with the child,
2. evoke and encourage catharsis,
3. aid in developing insight,

4. furnish opportunities for reality testing,
5. provide media for sublimation.

The therapy setting must provide materials that allow growth in the repertoire of self-expression. Landreth (1982:153-154) gave the following list of materials found to be useful in facilitating a wide range of children's expressions in a fully equipped playroom:

small table and two chairs	rubber knife	balls (large/small)
dollhouse and furniture	handcuffs	telephone (two)
bendable doll family	toy pistol	nursing bottles
ironing board	toy machine gun	blunt scissors
colour chalk and eraser	construction paper	dart board
chalkboard	crayons, pencil, paper	scotch tape, paste
suction throwing darts	rubber snake	alligator
stove (wooden)	toy watch	building blocks
dishes, pans silverware	egg cartons	tempera paints
empty fruit and vegetable cans	egg cartons	newsprint, easel
brooms	dolls	brushes, finger paint
dolls bed, clothes, etc	purse and jewellery	pipe cleaners
Bobo	trucks, cars, airplane	medical kit
Long ranger type mask	tractor, boat, bus	xylophone
drum	straw hat	fireman's hat
sandbox	miniature farm animals	play money
cash register	hand puppets	pine log and hammer
toy soldiers/army equipment		

According to Ginott (in Landreth,1982:149) toys do not contribute directly to the achievement of insight, but ii is gained through growth in inner security:

> "Toys do facilitate interpretations that help children become more aware of themselves and their relationships with significant people. It is through this awareness that insight is attained."

The frustrations and satisfactions encountered in handling playroom materials and the sense of power acquired in mastering them, have direct bearing on the child's ego strength and self-image. Ginott (in Landreth, 1982:150) feels that children should be provided with situations and materials that demand exploration of others as well as themselves, in order for play therapy to be an experience in social learning.

Children should have the opportunity to express their needs symbolically in a great variety of ways according to their changing capacities. They should for instance be led to express their feelings of anger by punching dolls and destroying clay figures. Not all acting out behaviour has therapeutic value. Catharsis in children mostly involves motility and acting out, but acting out per se has no curative effects beyond pleasure and release. According to Ginott (in Landreth, 1982:148-149) the therapist, for therapeutic catharsis, should furnish materials that elicit acting out related to the child's fundamental problems and should avoid materials that evoke diffuse hyperactivity:

> "Thus hyperkinetic, overactive, and brain damaged children should not find finger paints or running water in the playroom. Such materials over stimulate them and invite smearing of the walls... such behavior may be highly pleasurable for children, it is psychonoxious in effect and leads to weakened inner controls and disorganization of personality. These children need materials and activities that will focus rather than diffuse their flow of energy. Pounding pegboards, building block houses, shooting rifles, driving nails, sawing wood, or constructing boxes may give form and direction to the disorganized urges of these children" (Ginott in Landreth, 1982:148-149).

Fearful and fragile children should again find materials in the playroom that can be handled without the aid of tools, such as water, paint, sand, play-dough, dolls, crayons, etc. According to Ginott (in Landreth, 1982:149) they need materials that will enable them to conceal what they do not want to reveal, and to do and undo acts without detection and embarrassment. They can use clay for sculpturing/scalping; sand for building/burying and paint for decorating/dirtying. These media enable children to change identity of their symbolic revelations at will and makes it safe for them to explore their inner and outer worlds.

One of the important objectives of play therapy is to help the child develop sublimations that are compatible with society's demands and mores. Fire setters should have cap guns; enuretic children should be given paint and running water, encopretic children, mud or brown clay. There should be miniature utensils for cooking and serving meals to sublimate oral and nurturing needs, punching bags and target guns to sublimate aggressive drives.

A therapeutic relationship can only be established and maintained if the therapist understands the child's communication. Some materials are superior for the use in therapy because they give therapists tools for understanding the child, without diminishing the fluidity of his play or conversation. Noise-making toys such as drums, pegboards, xylophones, air rifles and cap guns will only communicate loud and clear the adult's basic spirit of tolerance.

4.6.2 Methods and techniques used in play therapy

In helping children to gain an understanding of and come to grips with many stressful situations, therapists have been making use of different methods and techniques in play therapy. According to Shapiro (1994:1) there are many ways to do therapy with children, from reading books, playing games, drawing, and listening to music, to using sophisticated behavioural techniques and even electronic technology. Some of these techniques require both natural ability and specialized training. Others require only that the therapist working with children be sensitive, caring, and know the basic principles of helping children learn to help themselves. He (Shapiro,

1994:36) believes that one of the most difficult jobs for the therapists is to choose the right combination of techniques for each child.

According to Schaefer (1979:309) play techniques and materials most often used are: art, clay, drawing activities, water and sand play, dramatic play and puppet productions, free play as used by nondirective therapists and doll play. Other methods and techniques used amongst other are:

- "paraverbal therapy" technique
- therapeutic- and mutual story telling technique, (further development of the regular sentence completion technique)
- game play therapy, and
- bibliotherapy.

The researcher will for the purpose of this research focus on the above four methods and techniques.

4.6.2.1 "Paraverbal therapy" technique

Heimlich (in Gardner, 1993:28) uses a technique, which she refers to as "paraverbal therapy". She attempts to unite the therapeutic aspects of music (listening, singing, playing instruments, mime, dance, and finger painting) as a therapeutic modality. In her technique she sings with the child a song that is likely to touch upon issues relevant to his or her pathology:

> "Her purpose is not only to provide strong and dramatic cathartic release but to use the issues in the song as points of departure for therapeutic discussions. There is no question that music, properly utilized, can be an extremely useful therapeutic modality. The most resistant and withdrawn children are likely to be engaged in musical activities, both verbal and along with musical instruments. It touches something

primitive in all of us. If one adds words to the music, there is a greater likelihood that the words will be heard ...."

Heimlich (in Gardner, 1993:28) adds to these mime, dance, and other elements of physical movement, all of which attempt to enhance the efficacy of the therapeutic communication. In this way he endeavours to enhance the efficacy of the therapeutic communication.

The researcher came to the following conclusion:

- Therapists can enhance the efficacy of the therapeutic communication by means of uniting the therapeutic aspects of music.
- The child's inner conflicts, frustrations, and defences can be extremely well addressed by engaging the child in musical activities.

4.6.3 Therapeutic story telling and mutual story telling technique

Children enjoy both listening to and telling of stories. Most children can initiate the most useful story telling spontaneously, through which they give the therapist a peep into their inner worlds. According to Boyd-Webb (Ravat, 1999:8) all story telling techniques, whether they are told, read, or watched, involve distancing, identification and projection. As children listen to stories, they learn to exercise the power of their imagination while they envision animal or human characters coping with situations which are similar in some respect to those in their own everyday lives.

Therapeutic story telling can be very effective in addressing the child's underlying concerns. From the stories that the child tells, the therapist can gain invaluable insight into the child's inner conflicts, frustrations, and defences. Story telling can be used in a manner that does not provoke resistance and non-cooperation. Richard Gardner (1979:313) developed the mutual story telling technique as a proposed solution to the question of how to utilise the child's story therapeutically.

The therapeutic value of stories lies in the fact that stories provide children with the opportunity to remain safe and anonymous while they project their worries, con-

cerns, or questions into the story lines. Children can identify with objects or persons in their stories. In this way they provide clinical information about their identity, their hopes and their fears on a basis of anonymity. The therapist therefore has to stay "with the story," and not interrupt the story with references to the real world or real situations. Children often make these connections by themselves, and even more so when they are emotionally ready to do so. To interpret to them too quickly or too explicitly may cause them to shut down (Ravat, 1999:8).

According to Ravat (1999:8-9) the following ten steps are important when telling a therapeutic story:

1. Decide ahead of time what your focus point is. Limit yourself to one or two focus points at the most. Don't get complicated or abstract in what you're trying to convey.
2. Prepare the story ahead of time and know where you are going.
3. Develop a character that the child can identify with, for example a child of the same gender or similar situation.
4. Also give the child a character that he will accept wisdom or authority from for example, a grandparent, a fairy godmother, a wise owl, an angel, etc.
5. Get the child's attention right away. Present him with an issue that he is interested in.
6. Structure your story so that it has a beginning, middle, and end. The middle introduces the issue, problem, or question. The end includes a healthy or adaptive resolution, lesson or moral of the story. Be sure to offer new choices and the potential of mastery and control.
7. Use your tone and pitch of voice in such a way as to emphasize what you are trying to get across or what you want the child to remember.
8. Make sure you have introduced the concept of resolution into the future.
9. Don't use a monotone tone of voice. Try to be interesting and entertaining.
10. Most of the time, children will listen to the story with interest. After the story is told, you can ask the child what he or she thought about your story, the characters, and the problem they faced. You can ask other questions to elicit a dialogue. The therapeutic dialogue must stay within the story metaphor.

A very important technique used together with storytelling is the use of metaphors. According to Ravat (1999:9) metaphors can have many different forms: "They can be allegories, analogies, similes, proverbs, anecdotes, stories, parables, art, objects (for example puppets, toy animals, toy trucks), cartoons, poetry, music, and games." She believes that the significant difference between the use of metaphors in therapy and the use of metaphors in other settings lies in the goal(s). Outside the therapeutic setting metaphors, such as stories told by grandparents, or fairy tales, aim to teach specific messages and make definite points. The therapeutic metaphors in contrast offer new choices, show new ways of perceiving a situation, and tap a variety of dormant beliefs, attitudes and values of the child.

The researcher came to the following conclusions:

- Therapists can get valuable insight from the stories children tell with regard to the child's inner conflicts, frustrations, and defences.
- Children can identify with objects and persons in their stories, providing clinical information about identity, hopes, and fears.
- Stories have the potential to be therapeutic because they provide children with opportunities to remain safe and anonymous while projecting worries, concerns, or questions into story lines.

4.6.3.1 Game play therapy

Reid (1997:527) believes that games are frequently used in child psychotherapy. He has found that traditional play therapy material and methods often fail to attract or hold the interest of many children, especially in the latency period of development. The preference of games by children of this age, matches their developmental interests and orientation toward their social world. They often reject playing with dolls, puppets, and miniatures as being too babyish.

The difference between games and play is important, for the understanding of the theoretical basis for the use of games in therapy. Reid (1997:528) believes that play at first glance appears to be more in line with the goals of therapy, which usu-

ally include relaxation of defences and expression of thoughts, emotions, and conflicts. Furthermore, play with its open-ended nature and freedom from the restrictions of rules, often becomes a medium or a substitute for verbalisation, fantasy expression, and free association. According to Reid (1997:528) the therapeutic values of games are:

- eliciting emotional expression,
- a medium for expressing of resistance and oppositional attitudes,
- the projection of the relationship of the players (projective tool).

Games have a definite therapeutic function in play therapy. The games typically being referred to in the play therapy literature include board games, fine and gross motor games, card games, and street games. Video games, organised sports, maths and logic games, as well as recreational games have not yet found a place in play therapy.

Game playing forms a definite part of human development. According to Reid (1997:528) the major theories of play are consistent in placing the emergence of game play in normal development between the ages of 5 and 8 years. He listed the following important therapeutic elements of game play:

- **Therapeutic Alliance**: - games are a natural and enjoyable part of children's lives. They are even intriguing to resistant children. Games usually involve interaction between two players. The therapist becomes a player and does not remain the passive observer. Through this situation the adult-child boundary is blurred because the child now experiences the adult joining his world and not vice versa.
- **Pleasure**: - game playing, even without therapeutic intervention, promotes emotional growth, especially for withdrawn or emotionally constricted children. In this informal group situation the child feels needed and wanted.
- **Diagnosis**: - games are useful as projective tools for exploring a child's self-esteem, helplessness, and general ego strength. General diagnostic information about the child's personality can be gathered through game play. For example an obsessive-compulsive child may insist upon the rigidity of the rules

and have trouble accepting defeat. The child's intellectual strengths, weaknesses and coping style will be revealed through his responses during game play.

- **Communication**:- the rules and goal striving of game play tend to promote communication between players.
- **Mastery of Anxiety**:- games bring into play the child's ego processes. The competitive nature of games demand concentration, impulse control, and the motivation to win. Playing games frequently arouses anxiety regarding self-esteem, power, and risk taking. Games also offer opportunities for the child to confront and master these anxieties.
- **Socialization**:- games are particularly useful for socialisation. They offer opportunities to experience depersonalised sources of authority in the form of rules, a structure that defines the game, and positive peer pressure for socialised behaviour. Games require children to compete and assert themselves (by trying to best the other player) within limited boundaries, thus allowing for practice of controlled expression of aggression (Reid,1997: 530-532).

According to Shapiro (1994:41) games provide an opportunity to observe and experience the child's conflicts or concerns and to create therapeutic experiences. He (Shapiro, 1994:41-42) believes that psychotherapeutic games allow us to step inside a child's world and see exactly why he is having difficulty:

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> "The game experience will reflect affective problems (e.g., low frustration tolerance, depressed affect), behavioral problems (e.g., difficulties taking turns, staying seated, or following rules), cognitive problems (e.g. poor impulse control, difficulty in following directions), ...And if the child does not exhibit a particular problem, the therapist can choose a particular game or manipulate the situation to create that experience in order to observe it and hopefully change it."

Shapiro (1994:41-42) believes that game play is a technique that also has a metaphorical level; the unspoken message that the child receives while a therapeutic

game is played. The therapist gives the message that she will take the time to work with the child on his problem; will respect his rights and limits as defined by the rules; and he will be rewarded for the new things he learn and the behaviour changed in the form of tokens won in the game.

According to Shapiro (1994:43-46) games can:

- be helpful in motivating the child towards the therapeutic goal,
- allow for the repetition necessary to learning and behavioral change,
- allow for the transfer or generalizing of psychological principles,
- allow for communication and controlled disclosure by the therapist,
- allow for the learning and reinforcement of social skills.

According to Shapiro (1994:86) games provide a unique opportunity to work on behavioural problems. Games provide "corrective experiences" for children, which can immediately be reinforced. Certain behaviours are required to play any game for example taking turns, follow the rules, being a good sport, etc. Some games are also specifically designed to deal with behavioural issues.

Games can be used to teach a hierarchy of skills related to having children express and understand feelings. According to Shapiro (1994:62-63) feeling games can teach the child to:

- "Identify feelings words.
- Learning to appropriately express feelings in different situations.
- Learning to handle two different feelings at the same time.
- Identify the feelings of others.
- Empathizing with the feelings of others. "

Games can act as a magnet for the therapist to invite children into therapy, or foster particular interactions between children outside therapy.

The researcher came to the following conclusion:

- Game play therapy can be seen as a useful therapeutic method that helps relieve the emotional distress of children. Game play therapy involves much more than only playing a game with the child.
- The therapist can integrate her given theoretical orientation together with the therapeutic game materials in order to help the-child move systematically toward mental health.
- Game play is theoretically impossible to tell apart from the traditional play therapy. It is not an alternative to traditional play therapy. It can be seen as an extension and broadening of play therapy to better meet the developmental needs of children in the latency age group.

4.6.4 Bibliotherapy

Bibliotherapy arose from the concept that reading can affect an individual's attitude and behaviour, and is thus an important influence in shaping, moulding and altering values. Bibliotherapy first emerged in medical settings. Literature was used to support the healing process. According to Hynes and Hynes-Berry (1986:10) bibliotherapy uses literature to bring about a therapeutic interaction between the participant and facilitator. Literature is used in a broad context, which includes the use of print, video material, and creative writing. Clients may be asked to consume literature (e.g., reading, viewing, observing) as well as create literature for example writing. The benefits of these techniques are similar regardless of the medium used.

According to Myers (1998:243) bibliotherapy is the dynamic process of interaction between the individual and literature, which emphasizes the reader's emotional response to what has been read. The effectiveness of bibliotherapy is therefore based on its use to help therapists understand the client's moral imperatives and constructions of meaning. Therapeutic reading promotes the conscious recognition of client's ways of knowing and experiencing so that both emotional and cognitive understanding of problems is enhanced.

Pardeck in Myers (1998:243-244) listed six major goals of bibliotherapy namely:

- to provide information,

- to gain insight,
- to provide solutions,
- to stimulate discussion on problems,
- to communicate new values and attitudes, and
- to help clients understand that others have dealt with similar problems.

Bibliotherapy provides metaphors for life experiences that help the client to verbalize his thoughts and feelings so that he can learn new ways to cope with problems.

Individuals can also use bibliotherapy to promote personal growth, but it is most effective when viewed as an interactive process in which guided discussion is used to achieve therapeutic goals. Interactive bibliotherapy has been used successfully in conjunction with other techniques, such as play therapy. Myers (1998:244) advocates bibliotherapy as a therapeutic intervention and feels that it is best used in conjunction with other counselling approaches. Well-articulated treatment goals; the selection of books based on the reading ability of the client; the theme; format and believability of characters are essential when bibliotherapy is used. Myers (1998:244-245) is correct in stating that it is essential that the counsellor be familiar with any resource or book used before providing the assignment to the client. Also that bibliotherapy may be viewed as a projective assessment technique - clients project their internal representations on the characters and stories in the book.

The researcher came to the following conclusions:

- Bibliotherapy is a dynamic emotional process of interaction between the individual and literature where the emphases is placed on the emotional response of the reader.
- The literature used in bibliotherapy is used in a broad context, which includes the use of print, video material, and creative writing.
- Bibliotherapy provides metaphors for life experiences. This helps the client to verbalize his thoughts and feelings so that he can learn new ways to cope with problems.
- Bibliotherapy can be used to promote individual, and personal growth.

- Bibliotherapy is most effective when viewed as an interactive process through which guided discussion is used to achieve therapeutic goals.
- Interactive bibliotherapy has been used successfully in conjunction with other techniques, such as play therapy, in the treatment of children.

4.7 Conclusion

Most of the earlier works on theory and practice of child psychotherapy and play therapy were theoretical in orientation and directed intervention from a singular point of view. The modern–day child therapist, according to Kissel (1990:5-6) tends to be more eclectic in orientation. The current renaissance in play therapy can be attributed to the following socio-cultural developments:

- high divorce rates,
- blended families,
- socio-economic pressures requiring both parents to work, and
- greater pressures to show academic proficiencies at younger ages.

These events according to Kissel (1990:5), have been consistently shown to place children "at risk" for the development of emotional difficulties and adjustment problems. Within the setting of "play" the child with learning disabilities can forget his fears about performance. Through the mastery of new social skills, hidden in well-designed games, the mastery of social and emotional competence almost sneaks up on him. In verbalising and displaying his fears when playing, he consciously formulates successful strategies. The various forms of games provide a safe, structured way of trying out new skills. Games provide the learning disabled child with the motivation and medium for upgrading his performance. He can approach a new task with confidence, and find that life can be fun. The key to a game's success is the therapist. With experience the therapist develops guidelines that best suit the child in need. This, in addition, has been a need in the professional community for increased understanding of treating children therapeutically.

The next chapter will focus on how the social worker as part of this professional community has a definite role to play in treating the child with a learning disability.

CHAPTER FIVE

5 SOCIAL WORK, PLAY THERAPY AND LEARNING DISABILITIES

5.1 Introduction

The moment an individual begins to live, unsupported by the physiological connection to the mother, new and significant influences and factors become operative. The consciousness of a separate self is awakened, and the infant then gains his first awareness that not only is he an individual in himself, but he is also closely related and associated with others. Allen (1947:23) states as early as 1947 that the actual living reality of the child at birth consists of two fused and inseparable realities:

- the reality with which he is born (genetic and biological) and
- the reality into which he is born (the social).

These two realities can never exist apart from each other but constitute a totality from which growth always proceed.

Social workers who work with children, work with living, human beings continuously confronted with change, who need and seek guidance towards optimal functioning. When working with the child with a learning disability the focus of social work is on the improvement of the social functioning of this individual interacting with his specific environment. According to Potgieter (1998:27) social work deals with the needs and problems people experience in their efforts to cope with the demands of their environment. He emphasises the idea of ubuntu, "namely that people will always need other people to realise their humanness and individual potential".

Social work, according to Potgieter (1998:27) takes into consideration both the developmental characteristics and the needs of the person and places them in the context of specific forces in a particular environment. Bearing this in mind, the so-

cial worker working with the child with a learning disability, in an inclusive environment, must take into consideration that this child needs a different support system to prevent negative cry out behaviour, underachievement and emotional insecurity to secure optimal social functioning.

Problems in family life, school performance and peer relations, self-image and self-growth call for intervention. The researcher believes that the child with a learning problem adapting to the classroom, the teacher, peers and family life, needs the assistance of a trained skilled social worker to guide him to adjust harmoniously.

The social worker must equip her with specialized knowledge of play therapy. Together with her basic background training and acquired skills, she can now use play effectively to communicate with children in a therapeutic situation (McMahon, 1993:xiii). If social workers are concerned with the healthy development of the children on their caseloads they are bound to be concerned with the opportunities for play (Crompton, 1980:49). The researcher has shown in the previous chapter that children communicate through play. The social worker concerned with the child on her caseload must be equipped with the correct skills to render child centered therapeutic opportunities. Through therapeutic play, and not adult centered therapy, the child as a client should be addressed. If we as social workers accept that every child has as much right as an adult to be a client, we must be capable to offer, work and communicate directly with every child who has the need of and the right to social-work services. After all we are the engineers of a healthy society.

In the previous chapters the researcher focused on the child with learning disabilities (chapter 3) and play therapy (chapter 4). This chapter will now focus on:

- The purpose and function of social work.
- Values, skills, goals and techniques used in social work.
- Play therapy techniques, which may be used successfully in the treatment of children with a learning disability.
- The child as a client versus the adult as a client.

- The social worker as therapist in dealing with a child with learning disabilities.
- The use of play therapy in dealing with the emotional, behavioral and self-esteem problems children with learning disabilities experience.

5.2 The purpose and function of social work

Every profession has a particular function to perform in society and it has received a certain job assignment for which it is held accountable. Traditionally, social workers have thought of themselves as caseworkers, group workers, and community organisers. That later changed, to the quest for a unitary approach of integrating these methods (Specht and Vickery, 1979:15-16). The social worker has emerged as an expert in human relationships, whose primary function is to provide assistance in this area, helping individuals solve their difficulties and enhance their capacity for self-management.

According to Skidmore, Thackeray and Farley (1994:53) social work practice, has the purpose of preventing or curing the breakdown of a healthy relationship between an individual and his or her family or other associates. Social work, seeks to strengthen the maximum potential in individuals, groups and communities. The basic aim of social work is to help the clients to help themselves or to help a community to help itself. The social worker operates under the premise that most people have the ego strength to solve their own problems when they bring them out into the open and understand what they are:

> "The social worker does not listen to a client and then prescribe a "social-psychological pill"....the social worker endeavours to help a person to improve his or her understanding of oneself and relationships with others and to tap his or her own community resources in solving personal problems" (Skidmore, Thackeray and Farley, 1994:11).

The distinctive purpose and function of social work from its social purpose, namely, to strengthen coping patterns of people and to improve their environment, to ensure that the people's adaptive needs, potential and the qualities of their impinging envi-

ronment are met. According to McMahon (1996:6-7) social workers strive to eliminate discrimination and to create just social environments.

5.3 Values, skills and goals of social work

Social work has specific values that must be met in working with the child with a learning disability. These values assume that:

- The inherent worth (value) and importance of the individual, more specific the child with a learning disability, and the interdependence between him/her and the society, is respected.
- Man (the child with a learning disability) and society are dependent upon each other, and have a social responsibility for one another.
- Emphasis is placed on the importance of respect for the dignity of the individual (the child with a learning disability) and on his or her ability to make important decisions.
- Although each individual (the child with a learning disability) remains essentially different and unique, he/she still has needs in common with all others.
- In a democratic society, the potential of each person (the child with a learning disability) is realized, and it is assumed that he/she will accept social responsibility by actively participating in society.
- When an individual (the child with a learning disability) is unable to function, society has the responsibility to remove the obstacles that prevent achievement (Skidmore, Thackeray and Farley, 1994:53).

If the social worker wants to help the child with a learning disability in an inclusive environment, she has to apply her knowledge and skills from within the framework of the above values. According to Gibelman (1995:xxi) the functions performed by social workers often overlap with the functions carried out by other helping disciplines. She believes that the ability to carry out these functions is predicated on the use of social work knowledge and skills in ways that are consistent with social work values. Our claim is not to a monopoly of functions, but to a uniqueness and distinctiveness in our view about human problems, their solutions and in our particular value and practice orientation.

All social workers are trained initially in a broad variety of basic skills. According to Gibelman (1995:17-18) the National Associations of Social Welfare (NASW) identified twelve essential skill areas in the performance of social work roles, namely:

"1. listen to others with understanding and purpose,

2. elicit information and assemble relevant facts to prepare a social history, assessment and report,

3. create and maintain professional helping relationships,

4. observe and interpret verbal and non-verbal behaviour and use knowledge of personality theory and diagnostic methods,

5. engage clients, including individuals, families, groups and communities, in efforts to resolve their own problems and to gain trust,

6. discuss sensitive emotional subjects supportively and without being threatening,

7. create innovative solutions to "clients" needs,

8. determine the need to terminate the therapeutic relationship,

9. conduct research or interpret the findings of research and professional literature,

10. mediate and negotiate between conflicting parties,

11. provide inter organizational liaison service,

12. interpret and communicate social needs to finding sources, the public, or legislators."

McMahon (1996:13-14) feels that the foundation skills for social work can be divided in four main areas namely: relationship skills, problem-solving skills, political skills and professional skills, and tabled it as follows:

Table 5.1 Foundation Skills for Social Work

SOCIAL WORK PERSON IN ENVIRONMENT		
Relationship skills	Problem-solving skills	Political skills
Listening Responding Feeling/sensing Paraphrasing Clarifying Information giving Referring	Problem identifying Data collecting Assessing/goal setting Planning/task defining Selecting and implementing intervention Evaluating Terminating	Advocating Taking legal action Providing evidence Bargaining Organizing Publicizing Demonstrating
Professional Skills Recording research, time-management, teamwork		

The social work profession has a commitment to child welfare. According to Frederickson and Mulligan (1972:384) the work of child welfare from many different countries have been guided by the principles of the "Declaration of the Rights of the Child". The Save the Children International Union, of Geneva, drew up this declaration in 1923. It states that men and women of all nations, recognizing that mankind, owe to the child the best that it has to give. It declares and accepts that mankind must see the following as its duty, beyond and above all considerations of race, nationality, or creed:

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"1. The child should be given the means for its normal development, both materially and spiritually.
2. The child that is hungry should be fed; the child that is sick should be helped; the erring child should be reclaimed; and the orphan and the homeless child should be sheltered and succoured.
3. The child should be first to receive relief in times of distress.
4. The child should be put in a position to earn a livelihood, and should be protected against every form of exploitation.

5. The child should be brought up in the consciousness that its best qualities are to be used in the service of its fellow men" (Frederickson and Mulligan, 1972:384).

The researcher believes that if we, as social workers, live up to the above principles, we can and will make a difference in the life of every child that come in to our office. The fourth principle is especially true for social workers working with the child with a learning disability. This child should equally enjoy his livelihood!

5.4 Play therapy techniques which may be used successfully in the context of children with learning disabilities with social and emotional problems

Children are not adults. They need to be treated differently and cannot be treated in an adult centred way. The social worker needs to take in account that the child as client differs from the adult as client. Children explore their world through play, for that is their natural medium of communication. The researcher believes that through means of play children relive routine, they relive enjoyable as well as traumatic experiences, they entertain themselves and express themselves in relation to their world. Through play they gain insight into their inner world and through repetitive play gain mastery over traumatic experiences. Through the process of play the child grows into being an adult.

As social workers dealing with the child as client, we need to recognize the developmental level which the child is at if we want to use play appropriately to help. According to Mc Mahon (1993:5) the development of children's play follows a predictable pattern, which again is linked to aspects of physical, intellectual, social and emotional development. McMahon (1993:5) tabled it as follow:

Table 5.3 The development of play

THE DEVELOPMENT OF PLAY					
Approx. age	**Sensory /Creative Play**	**Physical play**	**Exploratory play**	**Social play**	**Symbolic play**
0-12 months	Using whole body and all senses - smelling, feeling, tasting, sight and sound Using senses to experience world	Sensory-motor play Practice play Manipulative play, repetitive and ritual play	Own and mother's body Pleasure at 'being a cause' – What is this object? What can I do with this object?	Baby and mother turn-taking games- Peep-boo, Pat-a-cake imitation of mother's actions and sounds Solitary play	First words Transitional object
1 and 2 years	Play with food and own waist prod-ucts Play with sounds and words Using all senses	Large muscle play— walking and climbing Small muscle skills-building	Exploring physical world: in/out, push/pull, hide/seek up/down	Baby and mother— hide and seek Baby and father— rough and tumble Baby and siblings Solitary play, and watching parallel play with peers	Enactive naming, imitative play, self-pretend, doll pre-tend, role play. and situation or sequence pretend
3 and 4 years	Sand, water, play dough, painting words, stories and music	Running, jumping, trike riding, dancing, ball skills drawing and cutting	Problem-solving construction and puzzles	Associative play or cooperative paral-lel play	Solitary elaborated sym-bolic play: complex and sustained themes in-creasing symbolism in use of objects in pre-tend, imaginary companions, dressing-
5 – 12 years	Creative art, mu-sic, books and stories, and pets	Games with rules, gym and sports, bike riding, sewing and construc-tion, writing	Making things using domestic, technical and scientific skills	Co-operative play-domestic themes and chase games Cooperation, competition elabo-rate social organi-zation	Co-operative socio-dramatic play: actions and roles coordinated (weddings, school, camps, shows, hunter and hunted, continued from day to day)
Over 12 years and adults	Creative art, mu-sic, writing and books, sex and loving, cooking and eat-ing, children and pets	Sports and games, hobbies and skills	Science and tech-nology	Formal games with rules	Elaborate 'small world' play, books stories and television Playing with ideas, think-ing, daydreaming, writ-ing and role playing in living

The researcher suggests that this table can be used as a guideline by social workers when choosing suitable activities for play therapy sessions. For example, it would be appropriate to use a therapeutic board game or therapeutic stories with a child in the age group 5-12 years of age, because it fits in with their stage of play development. In the practical research done for purpose of this study, bibliotherapy and games were included in the therapeutic sessions of the learners that fell in the age group 6 – 10. This is because it matches with their stage of play development.

5.5 The child as client versus the adult as a client

- The child as client is different from the adult client. The social worker must bear in mind that people at different chronological ages are likely to have different ways of conceptualising, so that it may not lead to uncertainty as how to respond to the child. Research done by Porter (1983:110-120) give a picture of the following specific characteristics of the child as client:
- The child is still incapable to see himself as a client.
- The child's behaviour is still immature.
- Formalities for the child are irrelevant
- The problem of the child is directly linked to the behaviour of his parents.
- The communication level of the child differs from that of the adult. The child uses different words and his behaviour is much more spontaneously.
- The child's insight is limited.
- The child's knowledge of feelings and how to express these feelings are limited.
- The child is much more dependent on the therapist. (Dependency by the child is stronger.)
- The child cannot decide realistically when it is time to quit therapy.

It goes without saying that these characteristics play an important role in dealing with the child as client. The social worker must feel comfortable with these characteristics of the child, for only then can she help the child effectively.

The researcher has tabled the distinguishing characteristics of the child client opposed to the adult client from information gained from Porter (1983:114), Brammer and Shostrom (1968:374-376) and Van Dyk (1994:49) as follows:

Table 5.4 Different characteristics of the child as client versus the adult as client

Different characteristics of the child as client versus the adult as client	
Child as client	**Adult as client**
Differences related to developmental age • Children's behaviour is immature. They act according to their developmental age. • The means of communication differs. Children communicate more effectively on the non-verbal level. • Children find it difficult to verbalize their feelings. They experience feelings without naming them. • The child's language developmental level influences his communication. • Children cannot concentrate very long. • Children don't like formalities. • Children's intellectual abilities are not yet fully developed. • Formulating goals are more difficult to come by.	**Differences related to developmental age** • Adults have already mastered the levels of development and act accordingly. • Adults communicate effectively on a verbal level. • Adults can verbalise their emotions and feelings. They don't just experience them. • The adult communicates on a matured level. • Adults can concentrate for longer periods. • Most adults prefer formalities. • Adults have the ability to integrate and think on an abstract level. • Adult can formulate goals more easily because of their verbal skills.
The child role • Children do not understand the client role and are dependant on the therapist/ social worker. • Children lack the ability to decide when it is time for termination of therapy. (The parent or teacher may insist that therapy continue until certain unacceptable behaviours are changed.) • The environment of the child forms part of the therapeutic process – e.g. his parents,	**The adult role** • The adult can differentiate between the role of client and therapist. • Adults can decide when they want to terminate therapy. • The environment of the adult not necessarily forms part of the therapeutic process

school.	ily forms part of the therapeutic process.
The therapeutic relationship	**The therapeutic relationship**
• Children are more demonstrative in their relation with others and have a strong need for individualising.	• Adults are more reserved and less demonstrative in their relation with others.
• Children are honest and sincere in their communication.	• Adults tend to be more reserved.
• The child sometimes sees the therapy as a goal in itself.	• The adult usually sees the therapy as a means towards a goal.

Table 5.4 clearly shows that the child as client differs from the adult as client because of the differences in their developmental age, as well as their different perceptions of the client role and therapeutic relationship. Landreth (1982:124) states that children are far more accepting of others – are far more understanding and tolerant than their elders. Children are quick to respond to the attitudes of respect and love that are offered to them – not imposed upon them.

The researcher came to the following conclusions:

- The child as client is different from the adult client.
- The different characteristics of the child client must be taken into consideration when the child comes in to therapy.
- The development of a child's play normally follows a predictable pattern.
- Child's play can be linked to aspects of physical, intellectual, social and emotional development.
- The child and adult client differ according to their developmental age and perceptions of the client role and therapeutic relationship.

5.6 The social worker as therapeutic adult in dealing with a child with learning disabilities

The normal child-adult relationship differs from that of the social worker as therapeutic adult. To the child coming for therapy, the social worker is just another adult. His past experiences with adults, negative or positive, may influence the therapeutic

relationship. According to Landreth (1982:124) and Axline (1996:62-65) the following basic requirements for all therapists working with children are essential:

- the therapist should have a genuine interest and respect in the child as total person,
- the therapist should treat the child with sincerity and honesty,
- the therapist should have patience and understanding of the complexities of a child's inner world,
- the therapist should know herself well enough to be willing to serve the child without emotional involvement,
- the therapist should have sufficient objectivity and sufficient intellectual freedom to set up tentative hypotheses to check,
- the therapist should have sensitivity, empathy and a sense of humour,
- the therapist should be a matured person who recognizes the responsibility that is entrusted to her when she undertakes to work with children,
- the therapist must like children and really know them,
- the therapist must develop self-discipline, restraint, and a deep respect for the personality of the child.

The social worker as the therapeutic adult must meet these basic requirements. The researcher believes that the social worker must provide an "emotional safe space" for the child so that he can learn about himself in relation to the adult therapist. The social worker must react in ways that will convey to the child the sense of security and opportunity to explore himself.

One task of the social worker as the therapeutic adult is to help the child discover himself, to have greater confidence and therefore more capacity to accept responsibility for him. "Sometimes the social worker may be the only person in the world to believe in the worth of the child" (Crompton, 1980:29).

McMahon (1993:22) states that the social worker as the therapeutic adult worker provides containment, "a space where the child's feelings can be borne and thought about". The social worker has a vital role in helping the child learn about his past

and present, discover who he is and think realistically about his future. Crompton (1980:29) states that the social workers must help children to remain in contact with themselves, and maintain a sense of their own unique identity and worth in relation to other people. According to Crompton (1980:33) children must learn to take responsibility for them and learn not to blame others for their own problems. These help them to become stronger and have increasing energy to spend on growth in other directions. She feels that nothing is more exhausting than anxiety, bewilderment and anger.

Axline, Smith, Donley and Berliner, in Porter (1980:120-126) identified important principles that the social worker, as therapeutic adult, must bear in mind when working with children. The researcher tabled them as follows:

Table 5.5 Guiding principles for social workers in working with children according to Axline, Donley, Berliner and Smith

Guiding principles for social workers in working with children according to Axline, Donley, Berliner and Smith			
Axline	**Donley**	**Berliner**	**Smith**
• develop a warm, friendly relationship with the child, • accepts the child exactly as he is, • establishes a feeling of permissiveness- child feels free to ex- press his feelings, • recognise feelings the child express, reflects feelings back to him (can gain insight into his behaviour), • maintains a deep respect for child's	• don't use cliché's, • show child that you really care, • child has been "hurt" emotionally damaged, handle unattended feelings, • verbal communication not enough, play techniques essential • be a trust worthy consistent, and responsible person in child's life.	• child's feelings are important, • child must have part in forming the solution, • focus on child's feelings, • focus on information gained through verbal and non-verbal communication, • use simple and understandable words.	• has a responsibility to wards the child, • focus on emotional growth of the child, • element of friendship more important than formal professionalism • knowledge of child's developmental stages are es sential, • child must play an active role in therapeutic process • therapy must focus on stabilizing child's life

ability to solve his own problems, • don't rush therapy, • establishes only limitations necessary to anchor therapy in reality.			

These principles are very important guidelines for the social worker as therapeutic adult to use in working with children. The child must experience that *this* adult is genuine, sensitive for his feelings, sincere and trust worthy. He must feel safe in this child-adult relationship. In 1953, Moustakas, said that techniques, tools and methods play a large role in therapy, **but the particular values of the therapist pervade the relationship, to a large degree, determine its therapeutic effectiveness**. "What the therapist says and does is important." (Moustakas, 1953:1) Today, this principle is still just as important as in 1953, when working with children.

Sometimes social workers may find it difficult to communicate with children. McMahon (1993:13-24) suggest possible sources of difficulty in communication between children and adults. She states the following possible reasons:

- The adult is afraid of looking silly and feeling rejected.
- The child feels hostile and suspicious towards the adult.
- The adult can get bored (e.g. young children want to listen to the same story time after time).
- Some adults cannot face the crudeness of comments made by children; they feel embarrassed.
- Some adults struggle with the concept of "play as work".
- Social workers may sometimes find it difficult to communicate with children because they need to maintain distance from and boundaries between themselves and their clients – fear for loss of authority.
- Exposure to the feelings and pains of children may bring the danger of recognizing similarities to their own past experiences and memories

The researcher believes that problems in communication can be overcome if the social worker *as an adult;* acknowledge, accept and respect the client *as a child.* To conclude, the following statement made by McMahon (1993:24) bears reference:

> "So perhaps one of the greatest inhibitors to *really* communicating with children, to open oneself to the embarrassment and non-successes and boredom and irritation and sadness and commitment and confrontation with pain is this: that no one is prepared to offer the social worker what she is required to offer the children; respect, understanding, the opportunity to communicate, help to achieve change, support to acknowledge and becomes reconciled to frustration and disappointment, encouragement, recognition of all these, the love of one person concerned for the welfare of another. Where agencies and establishments offer this to their social workers I believe that the children on their caseloads too are respected and loved" (McMahon 1993:25).

The researcher strongly believes that social workers can make a difference in the communication process by offering the child the necessary respect and understanding in a therapeutic situation where in he can grow and heal. The researcher will now focus specifically on the relationship between the learning disabled child and the social worker.

5.7 The social worker in dealing with a child with learning disabilities

Malone, McKinsey, Thyer and Straka (2000:169-181) states that social workers' awareness of and formal involvement in family-centered early intervention for infants and toddlers who are at risk of or who have developmental disabilities (this includes learning disabilities) has increased considerably during the past 15 years. The social workers' role expansion in early intervention parallels the expanded focus on early intervention in the social services system. They feel that opportunities abound for social workers as service coordinators, counsellors, consultants, and

family trainers carrying out services through home visits, early identification, screening and assessment services.

> " Given the increased vulnerability of some families of children with developmental disabilities to a number of issues that may require professional intervention (for example, social isolation, child abuse, marital distress, fatigue, financial stress, and lack of stable employment) it is imperative that social workers understand the potential effect of a disability on a family system...individuals should develop an understanding of the nature of developmental concerns, early intervention policy and service guidelines, family systems and empowerment, and the competence needed to fill early intervention roles that they might assume adequately. Individuals who equip themselves with knowledge and skill in these areas ...will be in a position to provide more effective services and supports to...(children) with developmental disabilities and their families" (Malone, McKinsey, Thyer and Straka, 2000:169-181).

Learning disabilities usually come with related emotional-, behavioural-, low-self esteem and relationship structure problems, which may affect the family as a system. Goldberg (1974:13) believes as social workers we mostly meet families in trouble. These families therefore do need the support of social workers.

Social workers according to McMahon (1993:55-57) has a role in relation to the child in the real world, as well as roles in relation to other members of the child's real world. The social worker forms a bridge between the outside world and the child's feelings. In chapter 3 the researcher focused on the relationship between emotional problems, behavioural problems, low self-esteem and learning difficulties. The researcher came to the conclusion that children who continuously meet failure are more apt to anticipate unpleasant outcomes. In dealing with these uncomfortable feelings they tend to behave in less socially acceptable ways and have difficulty in their relationship structures. This situation calls for intervention!

The social worker can create a safe life-world for the child with a learning disability where he feels accepted, uniquely understood, and through the means of play therapy realises his full potential, and comes to meet his own inner-self. Axline's (1979:73-74) eight basic principles are an essential guidance for the social worker working with the learning disabled child, in a non-directive way. The researcher believes that when working with the learning disabled child through structured therapy, the following principles are applicable:

- The development of a warm and friendly relationship with the learning disabled child, so that a good rapport is established as soon as possible.
- Total acceptance of the learning disabled child exactly as he is.
- Establish a feeling of permissiveness in the relationship so that the learning-disabled child feels free to express his feelings completely.
- Be alert to recognise the feelings that the learning disabled child is expressing. Reflect those feelings to him in such a manner that he gains insight into his behaviour.
- Maintain a deep respect for the learning disabled child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is that of the child.

The social worker who works with a learning disabled child must be fully informed about the concept 'learning disability'. Children with learning disabilities must be assured that they are not dumb or lazy. They are intelligent children who have trouble learning because their minds process information differently. According to Crompton (1980:129) the fundamental aim of any activity the social worker and child engage into, is always to enhance communication between the participants.

The researcher came to the following conclusions:

- It is crucial that the social worker who works with a learning disabled child, is fully informed about learning disabilities and its affect on the child's emotions, behaviour, self-esteem and relationship structures.

- The social worker uses therapy to create a safe life world for the learning disabled child where he feels accepted and uniquely understood. Through the means of play therapy the child realises his full potential, and comes to meet his own inner-self.
- The basic principles of Axline (1979:73-74) are an essential guide for the social worker, when working with the learning disabled child.
- Children who continuously meet failure tend to behave in less socially acceptable ways in dealing with these uncomfortable feelings. They experience problems in their relationship structures and this situation calls for social work intervention.

5.8 The use of play therapy in dealing with the emotional, behavioral and self-esteem problems children with learning disabilities experience

Children with learning disabilities are unique individuals, but they also share certain characteristics. The primary one is a gap between apparent intellectual functioning and actual performance and productivity. According to Evans and Smith (1977:427) the incidence of sensitivity to criticism and easy discouragement supports the frequently stated assumption that , with continued school failure experiences, these children tend to become anxious and generally emotionally disturbed, further handicapping them in regard to school learning.

Children with learning disabilities are at higher risk for social skill deficits and children with poor social skills are at higher risk for social, emotional, and academic problems. This according to Utay and Lampe (1995:117-121) makes children with learning disabilities candidates for group counselling intervention. As indicated in chapter 5.4 of this study, social workers need to make use of play therapy to address the behavioural, emotional and self-esteem problems these children may experience.

In this regard McMahon (1980:54) states that social workers may use therapeutic play in different ways, depending on their perceptions of a child's needs and the

demands and constraints of the context in which they work. In chapter 4 the researcher focused on play therapy. The researcher has shown that play is the child's natural medium of communication and therefore is essential for therapy with learning disabled children. The researcher will now focus on how the social worker may deal with the emotional-, behavioural-, self-esteem- and the relationship structure problems these children experience through the use of play therapy.

5.8.1 Emotional-, behavioural-, relationship- and self-esteem problems the child with a learning disability may experience and play therapy

The child who is experiencing learning problems is continuously struggling with a deteriorating self-esteem. In the school environment he begins to notice that he is different from other children and begins to attribute unrealistic meaning to the self. If the child is continuously struggling with tasks, facing recurrent failure he soon begins to have negative feelings of self-worth. According to Pietrofesa (1978:22) the major part of the self-concept is how the person sees himself and this perception will affect the individual's behaviour. When the child with a learning disability, sees himself as less adequate, inferior and different, he begins to behave accordingly. The outcome is a lowered self-esteem, and a child who loses his confidence.

As far back as 1965, Schonnel (1965:viii) has said in this regard, that there is a correlation between school performance and emotional attitudes. He said that academically backward children experience rapid deterioration in personality and this is particularly noticeable in children who have reading disabilities. These children manifest loss of confidence, apathy, sense of frustration, and anxiety, that influence their entire attitude towards school. Negative experiences within the school situation may not only influence their self-esteem, but also their relationship structures. Children with learning disabilities may harbour subtly hostile feelings towards their peers who they see as academically able and successful. More recently Gibelman (1995:175), wrote that social workers can help students overcome barriers to school attendance and academic achievement, promote responsible behaviour, and intervene in problem situations to prevent the development of more serious difficulties.

Children can play alone, but the therapist must take an active role in providing a proper environment for the child with a learning disability to succeed and feel important. There is no effective technique for teaching ' feeling good' that does not guide the child to ' do well'. Feelings of a positive self-esteem develop as the side effects of mastering challenges, working successfully and overcoming one's frustrations. Suitable games, skilfully applied and developed can add a social dimension to play. As it allows the development, of an appreciation of his own worth, and importance within the context of an organised social group.

Playing board games as a specific play therapy technique to improve social skills has been suggested for children with learning disabilities. According to Kaduson (1997:20) the playing of a game offers the player an opportunity to deal with the rules of the game, as an analogy to living acceptable societal norms. This aspect is useful in helping children with learning disabilities to accept the reality of social rules and the consequent need for self-control. Low expectations and low self-esteem may result in a lack of motivation to succeed. Kaduson (1997:220) further states playing a game offers the child an opportunity to deal with the rules of the game as an analogy to living acceptable societal norms. This is useful in helping children with ADHD to accept the reality of social rules and the consequent need for self-control. For example, children with ADHD might oppose the rules governing behaviour that they typically find so difficult, but might comply with the rules of the game because they are presented in a fun-like manner. What Kaduson has said from the ADHD child is also true for the child with a learning disability.

5.9 Conclusion

Through means of a literature study the researcher has up to this point shown that the social worker has a definite role to play in the life world of the child with a learning disability. The child with a learning problem adapting to the classroom, the teacher, peers and family, needs the assistance of a trained and skilled social worker. She has the skills to help him, and assist his parents and teachers, so that he may develop optimally. Through therapeutic play, and not adult centered ther-

apy, the child as client, the problems he experiences in family life, school performance and peer relations, self-image and self-growth, can be addressed. The social worker is skilled to support and guide this child as well as his family in modifying the home situation, so that the learning disabled child can function as smoothly as possible within the family.

The social worker, through the use of play therapy, can assist the teacher and parents of the child with a learning disability, in an inclusive situation, in leading him to self-fulfilment, and to seek optimal functioning.

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CHAPTER SIX

6 PRESENTATION OF DATA

6.1 Introduction

The purpose of this chapter is to present data in such a way that findings can be discussed. The information obtained through the literature study, questionnaires, and the therapy sessions with the children, as well as the parent- and teacher sessions will be assessed, evaluated, compared and merged together. This exercise will help with formulating the definite role the social worker needs to fulfil in working with the child with a learning disability, as well as, in an inclusive environment, as emphasised in Curriculum 2005.

The researcher has up to now used literature to show the important role the social worker fulfils in the life world of the child with a learning disability in an inclusive school environment. The process of collecting data by means of literature study has formed an important part of the study. This research focussed on data concerning:

- **Inclusion**: information was gathered through a literature survey. This was important because inclusion according to Curriculum 2005, now spells out a definite role for the social worker, in an educational environment. Because of this, the researcher could organize a workshop concerning the teacher, and parents of the learning disabled child within the school context. The relationship between the multi-professional team consisting of the teacher, school, parent and social worker (researcher) could be evaluated. This relationship is based on the framework of inclusiveness, as spelled out in curriculum 2005, where the social worker and parent now have the right to intervene on behalf of the learner, who now forms the focus point. In this chapter the outcome of the workshop held will be discussed.
- **The learning disabled child:** a very thorough literature study was done, by gathering data by means of internet articles, books and articles. This was nec-

essary to construct a clear picture of the learning disabled child and the whole concept of a learning disability. To be able to work with the child with a learning disability, it is important to know what causes a learning disability, what is the characteristics of such a child. This information will enable the supporting team to act appropriately when dealing with the child with a learning disability. This information is necessary to help the child function optimally in sociable accepted ways. For this chapter the data collected through means of the literature study formed the basis from which the researcher worked with the respondents. In this chapter, whenever the researcher refers to a child with a learning disability, it is done within the framework of chapter three.

- **Play therapy:** play therapy as a therapeutic method was explored by the researcher. This information was applied by the researcher as a tool when working with a child with a learning disability, suffering of low-self esteem, and poorly developed social and emotional skills. The study focused on the origins of play therapy, but, of importance for this research, is the literature done on the methods and techniques used with the respondent. In this chapter, the findings gathered through the play therapy done with the respondents, will be presented through means of case studies.

- **Social work:** the next step was gathering literature about social work and the role of the social worker in assisting the child with a learning disability. This chapter will now especially focus on the information the researcher gathered by means of practical research.

This chapter will present the information gathered for the means of the practical research as follow:

- The application of tables, graphs and other figures will be used to depict and simplify the information gathered.
- Tables and figures will be followed by a brief description or reflections of its content.
- Interpretations and implications will be compared to formulate findings.

Facts gathered from this chapter will also be used in the next chapter when conclusions and recommendations are formulated.

6.2 Presentation of practical research

The practical research done for means of this study will be presented under the following headings:

- Inclusion and social work.
- Selecting the ten respondents.
- Pilot study.
- Case studies.
- Combined outcomes.

6.2.1 Inclusion and social work

One of the main objectives of this study was to determine and demonstrate the role of the social worker in dealing with the child with a learning disability who is experiencing social, emotional and behavioral problems in an inclusive school situation. According to curriculum 2005 the education policy on learners with special needs, or who experience barriers to learning, is one of integrating these children within the general classroom. Through means of a literature study (chapter two and five of this study) the researcher came to the conclusion that the social worker has a definite role to play, in the life-world of the child with a learning disability. The social worker has the appropriate skills to help this child and his family.

Furthermore, inclusion as seen in chapter two demands that all children must be treated equally and that Curriculum 2005 gives an open invitation to specific skilled and trained professionals, as well as the parents, to fulfil a more participative and supportive role, in the educational process of the child. This means that the social worker has a role to play in the life world of the child in the school environment and, even more so, with the child with a learning disability who experiences social and emotional problems (Chapter 2, par. 2.3). Taking this into account, the researcher

saw the need of educating the community in understanding children with learning disabilities.

As support measurement of the research done, of the whole concept of inclusiveness, where the school, parents, community and professionals, must work together as a supportive team for the child with a learning disability, a workshop (at one of the schools) was organised for the grade one to grade three teachers, parents and members of the community.

6.2.1.1 The aim of the workshop

The aim of the morning workshop was the following:

- To help the parents of the learning disabled child as well as other parents in the community, to gain insight into the behaviour of the learning disabled child, and the various individual learning styles.
- To show parents of a learning disabled child, that there are other parents who experience the same frustrations and anxieties as they do. These are normal children with different individual learning styles, who need support and not rejection.
- Looking at the possibility of forming a support group for parents of children with learning disabilities.

6.2.1.2 Workshop attended

The grade one to grade three teachers, 25 parents and four persons out of the community attended the workshop. These parents all had children in school in the grade one to grade three phases. 20 of the 25 parents had children with definite learning disabilities. They all acknowledged experiencing feelings of frustration, and failure in reaction to their children's problems. They were misinformed and the need of someone understanding them and their situation was obvious.

Counselling can be very helpful to children with learning disabilities and their families. Counselling can help the child develop greater self-control and a more positive attitude towards his abilities and the family can assist and support the child in this

regard. Talking to a social worker or any other professional who has the knowledge of learning disabilities allows family members to air their feelings as well as get support and reassurance.

Many parents felt that joining a support group could make a difference. Support groups can be a source of information, practical suggestions, and mutual understanding.

6.2.1.3 Conclusions made as result of the workshop

- The researcher believes that most problems do not stem from the learning disability itself, but from the way people respond to the learning disability.
- Negative attitudes, stigma, discrimination and prejudice are all factors that can affect the child with a learning disability and his family.
- If the community, school and family have insight into how the learning-disabled child functions, the environment doesn't have to be part of the "problem". Instead they can all be part of the solution helping to put the child in a position to earn a livelihood, without exploitation.
- The learning disabled child must be empowered so that his best qualities can be developed to the full.
- The social worker has a definite role to play in the empowering of the learning disabled child. She could act as a consultant or mediate between the academic and the home environment, guiding the social, and emotional support of the various parties concerned.

6.2.2 Important findings made in the process of selecting children needed for research

Children from grade one to grade four in three different schools in the Vryburg-Stella region were selected - see chapter 1 par. 1.8.4.1. As mentioned in chapter 1, the researcher selected children with a learning disability who experienced emotional and social problems, resulting from learning problems encountered in the school situation. Kramer's problematic behaviour that commonly occurs in the classroom (chapter 3, par. 3.7.2), formed the framework of reference.

In chapter 1 paragraph 1.8.4 the researcher showed the process followed to select the study population, and mentioned that a selection of 20 suitable children were identified after doing the standardised, Psychosocial Functioning Inventory for Primary School Children, (PFI-PRIM-C) questionnaire in a group setting. The findings will now be discussed.

6.2.2.1 Findings of the group of 20

The researcher wanted to use the questionnaire with the group of 20 children to help with the selecting of ten children for the purpose of further in-depth therapy. This was not effectively done in a group situation due to the severe distractibility, characteristic of the child with learning disabilities.

The positive outcome of this group session was the observations done by the researcher in connection with the behaviour of the group of 20 children. Some of the behavioural characteristics of a child with learning disabilities (in the introduction p13 and chapter 3, par. 3.6 of this study) according to Kephart (1968:14-15), Johnson (1979:10) and Seldin (1998:1-2) were beautifully demonstrated in the large group situation. The researcher compiled the following table of findings in connection with this situation:

Table 6.1 Table of findings

Characteristics of a learning disabled child	Behaviour of children with a learning disability in a big group situation
Characteristic	**Reaction of the group of 20 children**
• Is easily distracted, and cannot work in a large group	• Every child in the large group was easily distracted. The classroom noise, (writing sounds of paper and pencils) fidgeting of neighbours, all had a negative affect on the attention span.
• Has a short attention span and finds it impossible to focus on the relevant, in an auditory environment	• Every child in the large group found it impossible to focus on the relevant. They repeated the same question nu-

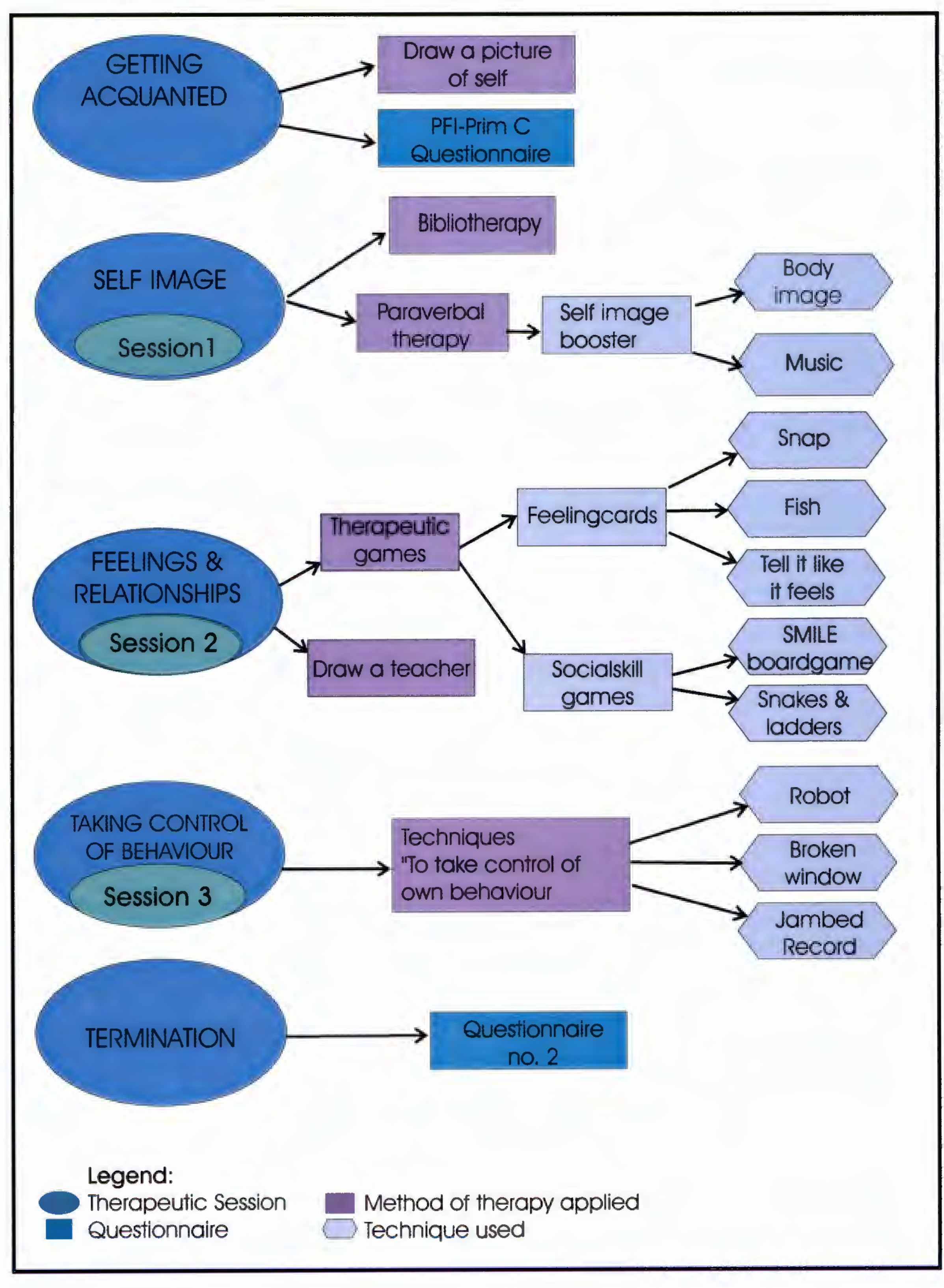
	merous times, asked irrelevant questions, or just answered the questions by random
• Has a short memory span	• The same task was repeated several times to most of the children before they did it
• Is often hyperactive	• 50 % of the group were hyperactive. They fidgeted a lot, wanted to move around the whole time and found it difficult to sit still.
• Does not integrate information spontaneously and cannot form generalisations	• From questions asked it was clear that the children struggled to integrate auditory information spontaneously. For example, one child responded as follows: "Do I have to circle the answer I choose?", after he had completed 15 similar questions with exactly the same procedure.

6.3 Pilot study

The choice of the specific respondent for the pilot study was done after the child's mother requested therapy. The child's teacher complained of negative behaviour in the school and the child's attitude towards school became very negative since the new term started. He was a grade one pupil and a slow learner. As the work became more difficult, he began to struggle. He started picking fights with his peer group and became a troubled and quarrelsome child, with a self-image, which deteriorated daily. The mother agreed to him being part of the study for purpose of research and the pilot study began.

Figure 6.1 shows the framework of the pilot study. It will be discussed in detail.

Figure 6.1 Framework for pilot study



6.3.1 Getting acquainted

6.3.1.1 Draw a picture of myself

The session started with informing the child of being part of the research for the next three sessions, which he agreed to. He was then asked to draw a picture of himself and was asked the following questions:

- How old is he and in which school grade?
- Which thing does he like/dislike?
- What makes him sad/glad?
- What makes him cross/shy?
- If he could take one person to the moon/doctor/picnic, who would it be?
- Three wishes.

The respondent was told that this was done so that the researcher could get a clear picture of how he sees himself.

6.3.1.2 Doing the questionnaire

Doing the Psychosocial Functioning Inventory for Primary School Children (PFI-Prim-C) questionnaire followed. This was done on a one to one basis and this proved to be more effective than the large group situation, due to the distractibility and short attention span (see Chapter 6, table 6.1).

6.3.2 Therapeutic Session One: Building the self-image

6.3.2.1 Bibliotherapy

A bibliotherapy activity followed the completion of the questionnaire. The book "Van kop tot toontjie", a book about a journey across a child's body, was read. The respondent had to identify with the main character in the story and imitate some of his actions taken from the content of the book:

- Firstly the respondent had to look in a mirror. He then had to reveal what and whom he saw.

- The book was read and the respondent was drawn into the story, through dramatising certain parts in the book.
- The respondent had to show his own hands; touch his own eyes and say which colour they are, and so forth. He quickly became absorbed in the story and identified successfully with the main character.

6.3.2.2 Body image

Making a life-size body picture of the respondent followed:

- He was instructed to lie down on a huge sheet of paper.
- His body outline was drawn.
- He then had to draw his own face and fill in the detail.

While working on the body-image picture the respondent had to tell what his own body parts were capable of doing.

6.3.2.3 Self-image booster-song

The next step was very important. The researcher focused on how special the respondent is. It is important for the researcher to remain honest and optimistic during this stage. Explain to the child that he may struggle with learning, but that he has a different learning style and that he can learn. Focus on the child's talents and strengths. Assure him that he can meet realistic challenges and succeed. The next step was to teach the child the following song about how special he is. A well-known melody was chosen, so that the child could easily learn the song.

EK IS SPESIAAL	**I AM SPECIAL**
(Wysie: Vader Jakob)	(Melody: Brother John)
"ek is spesiaal x2	"I am special x2
God het my gemaak x2	God made me x2
Hy maak nie gemors nie x2	He doesn't make junk x2
Ek is 'n wenner hiep–hiep hoera!"	I am a winner hip-hip hurray!"

This song can be sung at any time that he is upset as a reminder that he is special! For example: his teacher scolds him in the class for something he couldn't help, he then can sing his special song softly in his mind to remind him of how special he really is! The session ended after the researcher again gave positive feedback on the respondents' body image.

6.3.3 Therapeutic Session Two: Developing insight into feelings and skills for healthy relationships

This session focused on:

- Developing insight into the feelings one experiences daily.
- Social skills needed for keeping relationships with the family, teacher and peer-group sociably acceptable.

Out of the literature study done (chapter 4, par. 4.6.2) the researcher came to the conclusion that game play, as a therapeutic method, for relieving the emotional stress of children, need to form an essential part of this session.

As the play therapy literature includes board games and card games as a medium for expressing of resistance and oppositional attitudes (chapter 4, par. 4.6.2) the researcher's choice in therapeutically games therefore fell on both card and board games.

6.3.3.1 Feeling card games

Children with a learning disability need to be aware of their feelings, and how their behaviour can influence their peer relations. The child with a learning disability is usually out of touch with his feelings and also experiences problems in differentiating between these feelings. The researcher made a set of play cards depicting different emotions. These cards were used in different card games. The aim of these cards was to make the child aware of various emotions that one may experience in different situations. These cards were used to play the following games:

• **"Snap"**

The cards are dealt equally, face down between the researcher and child. When a similar card is placed on top of the other "Snap" is shouted. The person who shouts, "Snap", first, "wins" the cards and tells when he felt like that specific feeling-card, and then the other person may respond.

• **"Fish"**

The aim is to collect two similar cards to make a set. Each person is dealt five cards. He then asks the other player if has a specific card that matches the one he has. If not, he has to pick up a card from the pile. The person with the most sets wins. After collecting a set, the person tells, in one sentence, when he experienced that specific emotion. The aim of this game is to let the child know that he can have different feelings in different situations.

• **"Tell-it-like-it-feels"**

The researcher starts by asking specific questions and then the child has to respond by selecting a card to show how he would feel. Some of the questions were:

- When someone makes fun of you, how do you feel?
- When someone pushes you in the line, how do you feel?
- If you win a million rand, how would you feel?
- When you forget to do your homework, how do you feel?
- When you see a stranger, how do you feel?
- When you do your homework well, how do you feel?
- When you wear a pretty new dress/shirt and your friend says you look ugly, how do you feel?

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The researcher and child both get a chance to draw a card, to play "Tell it as it is." Each player shares when he felt like the face on the card, what made him feel that way and how did he react. The aim of this game is to let the child realize the different feelings a person can experience, as well as the different intensities of a feeling.

For instance just being cross is different from being furious. He then had to show and tell on the feeling chart how he felt at that stage.

6.3.3.2 Social skills – board game

The next game played was a choice between the social skill-board game from Smile educational toys, and a therapeutic snakes and ladders game (Addendum 2) designed by the researcher.

6.3.3.2.1 Social skill - Snakes and ladders game

The researcher developed the social skill snakes and ladders game (Addendum 2) especially for this research because of the age group of respondents. Snakes and Ladders is a game most children in this age group enjoy playing. The researcher used the "ladder" to present a positive, and socially acceptable behaviour or action, while the "snake" presented a negative, and socially unacceptable behaviour or action. For example:

- **One of the ladders:** at the foot of the ladder is printed, "I listen to my teacher in class" and at the top end of this specific ladder is printed "I feel glad because my teacher praises me". While respondent is moving up the ladder the researcher could easily use this time and just reaffirm this positive action by saying, "See, this is what happens if you do the things in the way your teacher expects you to."

- **One of the snakes:** at the top of the snake is written "I lied to my friends", the snake now swallows him. At the end of the tale is printed, "Always be honest, otherwise you feel bad." Again the researcher could respond by saying "It is not worth it to be dishonest, you can loose friends this way!"

As the literature study showed in chapter 4 (table 4.1) playing games, in play therapy, include a sense of enjoyment and pretend, focus on rules, mimic "real life" and are supposed to be fun. The focus of this game, as well as the card games, was on

the feelings that one might experience in various situations, especially the school setting, that could be addressed in a "fun" way. This respondent experienced a lot of anxiety in the school setting, and this fun experience of learning new skills had a positive effect.

6.3.3.2.2 The Smile social skill board game

The Smile board game is a game that focuses on teaching children the right social skills and positive behaviour. It is a game that is played by throwing a dice and picking up a card. On the card is printed either a positive or negative situation. For the negative action a penalty is build in and for the positive action an award. For example:

- **A negative situation**: the card reads that a child bullies a friend by pushing her from the swing, because she did not want to wait her turn. Penalty: Move back four spaces.
- **A positive situation:** the boy helps his father to clean up the garage out of his own. Award: Move forward three spaces.

The cards are specific for four different age groups, namely:

- pre-primary
- primary
- junior-high and
- high school.

For research purposes only the pre-primary and primary group cards were used. These cards correlated with the age group of the respondents. The situations described on the cards fitted the age group of the study population. The respondent could easily identify with these situations. The Smile board game also helped to create an atmosphere, which felt safe for the respondent to test out certain scary life situations. This lead the respondent to realize and accept behaviour that is so-

cially acceptable, and experience what may go wrong if he did things that are not socially correct.

Again the information gained through the literature study was taken into account. Playing games include a sense of enjoyment and pretend, focus on rules, mimic "real life" and are supposed to be fun (chapter 4, table 4.1). On the board itself were two different icons namely a singing child, and a person telling a joke. Every time you landed on one of them you had to perform the action. This again contributed to the growing of the self-image.

The focus of the board games, as well as the card games, was on the feelings that one might experience in various situations, especially the school setting, that could be addressed in a "fun" way. This respondent experienced a lot of anxiety in the school setting, and the fun experience of learning new skills had a positive effect.

6.3.3.2.3 Draw a teacher (DAT)

The literature survey on children with a learning disability (see chapter 3, table 3.3) showed some problematic behaviour that commonly occurs in the classroom. Taking this into account it is obvious that the child might get into trouble frequently, because of this behaviour. Learners, who distract the other learners and shows disruptive class behaviour like clowning around, talking out of turn, and harassing other fellow students, often irritate teachers. The grade one to three teachers that took part in research confirmed this. This may lead to children disliking their teachers, because they are scolded quite often for this negative behaviour. The relationship between the child and teacher may be negative because of the child interpreting the teacher's reprimanding, as the teacher dislikes him. The literature did show that these children mostly struggle with relationships (see chapter 3, par 3.7.4).

The teacher–learner (child) relationship is important in the child's life.
The researcher wanted to observe the interaction in this relationship from the respondents view. At this point in the research, the respondent is requested to draw a picture of a teacher (DAT) and some of the following questions, table 6.2, were asked:

Table 6.2 Questions for evaluating the child-teacher relationship

QUESTIONS	Yes	No
Is this a nice teacher?	Y	N
Is the teacher helpful?	Y	N
Do you like this teacher?	Y	N
Are you afraid of this teacher?	Y	N
If you ask this teacher a question, does she help you?	Y	N
Would you go to the movies with this teacher?	Y	N
Do you think this teacher likes children?	Y	N
Do children sometimes get very anxious in this teachers class?	Y	N
Would you like to be in this teacher's class next year?	Y	N
Is this teacher concerned about children?	Y	N

Information gathered at this point by the researcher, could be useful in helping the respondent understand the negative feelings he experiences towards his teacher, and lead him to understand that the teacher disapproves of his behaviour and not him as a person.

6.3.4 Session Three: Taking control of your own behaviour.

This session focused on leading the respondent to realize that he himself is responsible for the choices he makes in life. He has to take control of his own behaviour, for he is responsible for the outcome of his actions. He must take control of his emotions and face the frustration and the feelings of failure he experiences. The literature study (chapter 3, par. 3.7) showed that it is evident where a child has experienced long-term frustration and failure; he tends to develop emotional reaction patterns, which can permeate the personality structure. Such problems tend to be specifically related to the learning context.

This was true of the respondent. The frequent failure, he began to experience in the learning context (school), led to negative behaviour (harassing his fellow classmates) as well as him starting to withdraw at school. Out of the information gathered from the literature study, (chapter 3, par. 3.7) the researcher knew that this

session had to address this problem in the life world of the learning disabled child, because:

- The emotional problems, which emerge from learning disabilities, are commonly remitted relatively quickly and easily once the learning difficulty is alleviated.
- If the child's emotional needs are not attended to, it may lead to fear for failure and feelings of inadequacy which freezes his coping skills and his life-world falls apart.
- There seems to be a correlation between the child's emotional needs and his academic performance.

If this problem was not addressed the respondent would carry on being unhappy in school and his negative behaviour would continue. The respondent therefore needed to realise that the way he chose to behave, would have an impact on his whole life world.

6.3.4.1 The Psychosocial Functioning questionnaire two

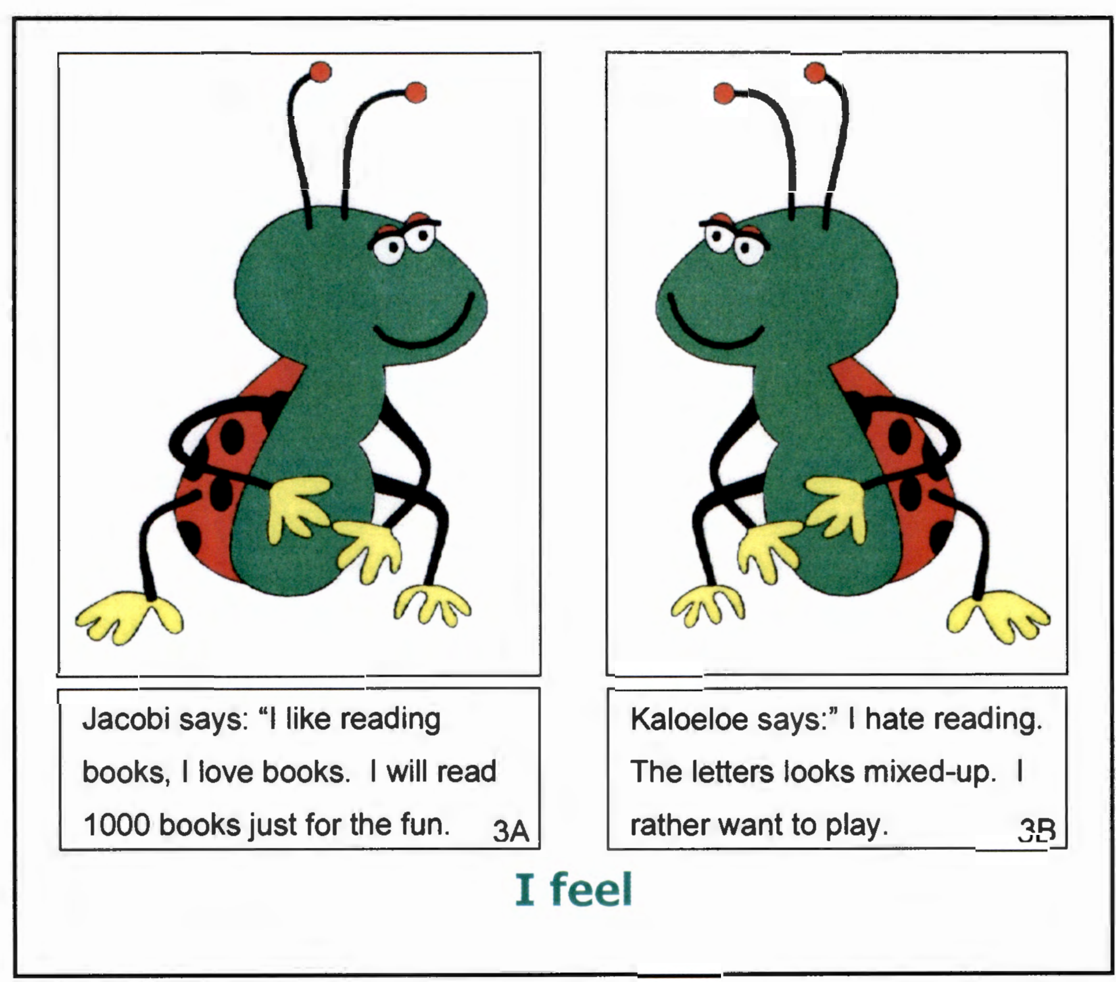
This session started with a questionnaire, compiled by the researcher, that focused on particular areas that may cause problems in the life world of the learning disabled child. This questionnaire correlated with the questionnaire the respondent did during the first session. The researcher compiled thirty questions that could help the researcher get a view of the respondent's progress in dealing with his problem situation with regard to the following:

- **Trauma Dynamics:** To what extent does his forgetfulness (memory loss), frustration, helplessness, attitude towards adults (teachers specific), and school problems influence his behaviour.
- **Scholastic performance (School environment and learning problems):** To what extent does the child experience anxiety and frustration, because of his reading, writing, and mathematic performance. Does the child still feel capable of wanting to achieve scholastically?

- **Positive Functioning Areas:** To what extend is the child still determined to do things (perseverance), is the child still satisfied with his circumstances and is his future expectations realistic?
- **Self-perception (Anxiety, tummy and head aches, mild depression, self-image and Sleeplessness):** To what extend does the child suffer from feelings of fear and anxiety, guilt, worthlessness/ lack of self-worth, isolation, and lack of assertiveness. What are the frustration, stress and helplessness, which again affect the self-image, the child experience?
- **Relationships (Socialising with Peer group and Peer group relations and Parent-child relationship and home environment):** What is the strength of the child's relationship with friends or peer group, mother or stepmother, father or stepfather, family, and teachers?

After the two previous sessions, the researcher wanted to find out if the child experienced any positive growth in any of the above areas. The questions asked could only be answered positively or negatively. The researcher showed the respondent a card with two bugs, the one named Kaloeloe and the other Jacobi.

Figure 6.2 An example of one of the questionnaire questions



Each one of them made a statement, the one positive and the other negative. The respondent then had to chose the one that matched his feelings (see figure 6.2).

The questions asked where more specific than the first questionnaire. The respondent could use the card to project his feelings. The researcher wanted to know how the respondent himself felt about his school performance, and included questions that were related to specific school performance problems. Figure 6.2 is an example.

The questionnaire was done with the respondent. The researcher observed that the respondent decided which bug he prefers and that he made his choice of the

bug according to appearance and not by listening to the question. The researcher then asked him to listen to the questions without looking at the bugs and to decide on his answer. This worked well. After this session the researcher changed the pictures to the extent that the two bugs looked the same. The answers to these questions were constructed in such a way that in some instances the positive statement was the "A" option and in some the "B" option. The answers were tabled (See Addendum 3) and negative questions answers were reversed to compute the scores on the following five testing areas:

- Socialising with Peer group and Peer group relations
- Parent-child relationship and home environment
- Anxiety, tummy and head aches, mild depression, low self-image
- Sleeplessness
- School environment and learning problems

The different subscales range in length from three to eight items, as indicated in table 6.3, with each subscale producing its own score.

Table 6.3 Subscales in questionnaire 2

Description of subscales	No of items
Socialising with Peer group and Peer group relations	8
Parent-child relationship and home environment	3
Anxiety, tummy and head aches, mild depression, self-image	8
Sleeplessness	3
School environment and learning problems	8

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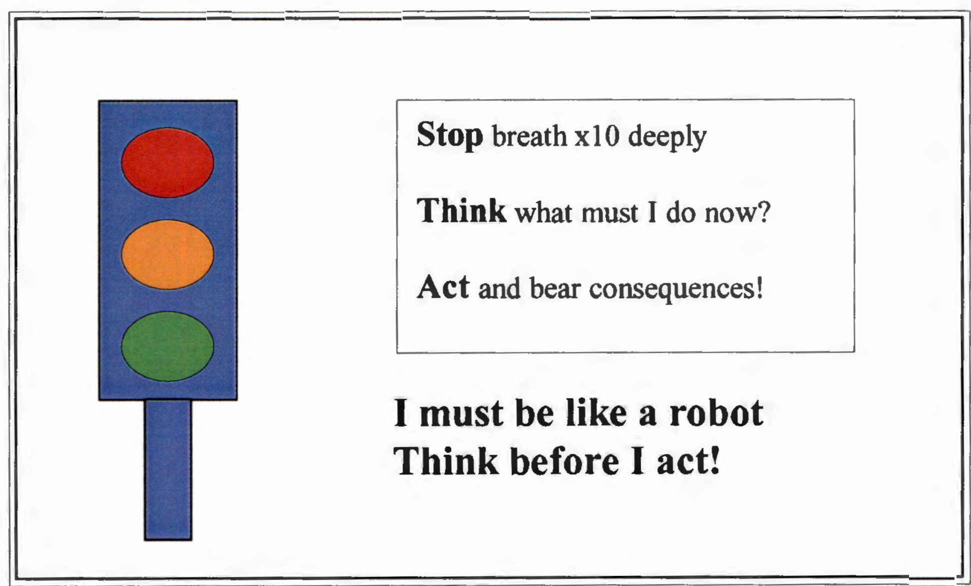
The different subscales are scored to have values ranging from 0 to 100, with a lower score indicating little or no problems in the specific area being measured. A higher score indicates a greater degree of problems in the area being measured.

6.3.4.2 Robot technique

The respondent was taught not to react impulsively in situations that may cause problems. The literature study showed that a child with a learning disability is normally very impulsive and acts without thinking (see chapter 3, table 3.2). This was demonstrated by means of an art activity, namely the making of a robot, similar to figure 6.3, together with role-play, to think before he acts. With the robot as tool, he could be guided in an informal play situation to make and use "robot answers".

Figure 6.3 Robot actions



The robot answer technique works as follows:

- Inform the respondent that each colour of a robot reminds us of something very important.
- The red light tells you to stop and take ten deep breaths. This is necessary to calm down a person so that he won't react with out thinking.
- The orange light says that you must now think before you decide what to do.
- The green light says that you must now do and accept the consequences.

The following example was used to illustrate how to apply the technique:

Scenario:

- A schoolmate keeps picking on a little boy in class.
- The boy gets so angry; he looses his temper and hits the schoolmate.
- The boy now gets blamed by the teacher and is seen as the troublemaker, which he is not.

How to apply the robot technique:

- The boy starts to breath slowly ten times, to allow himself to calm down.
- He now tells himself that he has two choices.
- Firstly, he may hit the other child, who will go to the teacher and this will get him into trouble.
- Secondly, he may tell him that he is not for picking on. If the other child chooses to keep on picking on him he is going to ignore him, every time he picks on him, in future. If he chooses to be nice with him, he will respond to him in a similar way.

The aim of the robot was to help the respondent to act in more socially acceptable ways. This example, together with others, was role-played by the respondent and researcher.

6.3.4.3 Broken window and cloud

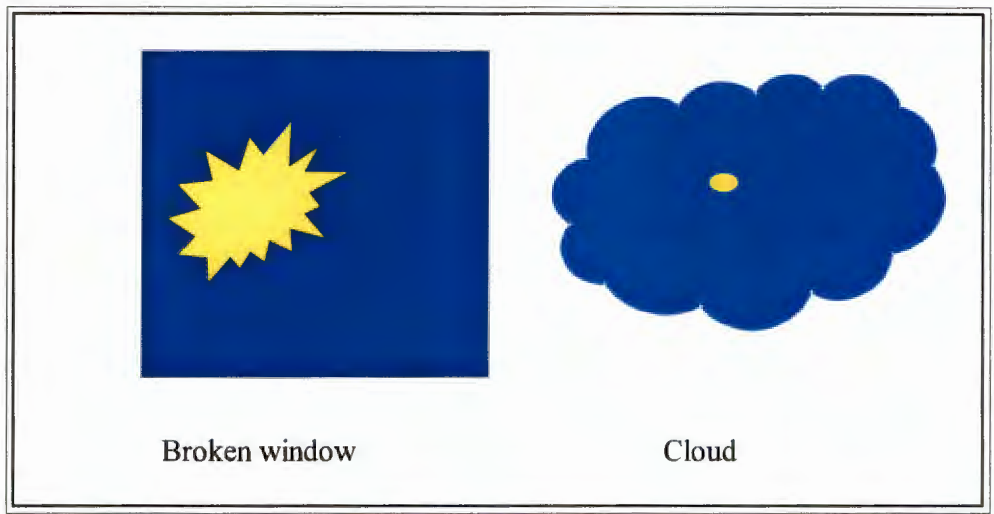
As with the robot technique, the respondent was guided, via the broken window and cloud technique, not to react impulsively in situations that may cause problems. The literature research showed that a child with a learning disability is normally very impulsive and acts without thinking (see chapter 3, table 3.2). The learning disabled child needs help in learning social skills, just as he needs help in academic areas.

According to Irwin and Frank (1977:435-436) several studies have suggested that children with learning disabilities have difficulty in social relationships, being less popular with peers, parents, and teachers than their non-disabled classmates.

Studies indicate that learning disabled children need help in acquiring social skills and social deficits must be remediated during the early years.

The respondent was guided, by means of figure 6.4, the cloud and broken window technique, to act in a sociably acceptable manner.

Figure 6.4 Broken window and cloud



The researcher demonstrated to the respondent how he could respond to the teasing of the other children; he could decide to be like a broken glass window or a cloud (see figure 6.4). He could choose to answer the children in such a way that he did not break like a glass window, but rather be like a cloud. For example:

Scenario:

- A schoolmate says to the respondent: "You are really stupid, no wonder your teacher shouts at you".
- The respondent has two ways of replying, the "broken window" or the "cloud "way.

Applying the technique:

- If he chooses to reply, "Yes I am a real wimp", and cry; he chooses to give a "broken window" answer. With this answer he will allow himself to get hurt

emotionally and he will break like the glass window that has been struck by a stone.

- If he chooses to be like a cloud that only ripples inside (where the other person cannot see) when the stone falls through, he must give a "cloud"-answer. To succeed in being a cloud, his reply could be: "You, may think I am stupid, but I am not. Teachers do shout at kids all the time, that is their job."

This was practiced through role-play. A picture with a cloud and a glass window was drawn, similar to figure 6.4, and the affect of a stone passing through, was shown visually. By choosing other situations, the respondent had to say what answers would lead to which affect, the broken glass window or the cloud.

6.3.4.4 Broken record

Another alternative reaction to teasing was demonstrated. The respondent could become like a stuck record. For example:

Scenario:

- The same example, as used for the cloud and broken window technique.

Applying the technique:

- His schoolmates are teasing the respondent. He could now choose to be like a broken record.
- The respondent then has to say repeatedly the same phrase over and over, just like a stuck record: "You, may think I am stupid, but I am not. Teachers do shout at kids all the time, that is their job."
- The children will eventually stop if they see it has no affect on him any more. The session ended after a few role-play situations.

The researcher then concluded the session by reminding the respondent that although it is sometimes difficult for him to perform scholastically, he is still special. The child is also reminded that it is the last session for means of this study, and that his participation was appreciated.

6.3.5 Findings of the pilot study

The pilot study was done so that the effectiveness of the sessions could be evaluated and the necessary changes could be made. To ensure better therapeutic results, the following findings and changes were made:

Session One:

- The PFI-Prim-C questionnaire is to be done in a one to one situation. The child responds less distractible when the questionnaire is done on an individual basis. There were fewer distractions, less stress resulting in better concentration and fewer questions asked. The questionnaire was done much quicker and much more effectively.

- The child's low self-image was strongly represented through his total amazement of his newfound knowledge of the exact size of his body picture. The need of the teacher and/or parents to strengthen this realization, through focussing on his uniqueness by referring to the body image, was very important for building the self-image, and to destroy the negative self-esteem wreckers.

Session Two:

- The researcher found that the child enjoyed playing the variety of card games. This contributed to a warm atmosphere where the child felt comfortable and safe. The different card games with exactly the same aim prevented boredom and the child responded spontaneously in the games he preferred.
- The researcher found that because of the age group preference for game playing, the games used served a definite therapeutic role and the responses were functional.
- The Draw a Teacher (DAT) technique was very useful and a significant tool in evaluating the teacher-child relationship.

Session Three:

- The researcher found that with the second questionnaire certain changes had to be made. Each question was accompanied with a picture of a bug, the one smiling and the other one sad looking. The child had to choose a bug to demonstrate his feeling.
- The researcher had to double-check certain questions because the child chose according to the pictures, and not the questions. To prevent this the researcher changed the pictures. This meant that the child now had to listen very carefully to the question. This was the only main change done for the purpose of this study.

After the pilot study was done, the therapeutic play therapy sessions started with the rest of the ten respondents.

6.4 Classification of the study population

Figure 6.4 shows the distribution of the respondents used for purpose of this research. The population for study consisted of ten children with learning disabilities. They were from both genders and their ages varied between six and ten. This specific age group was chosen because:

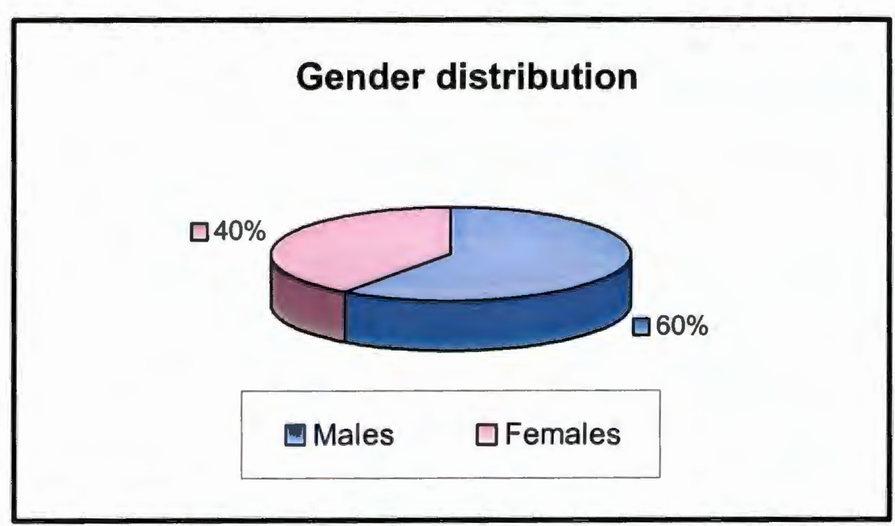
- The respondents are still in the beginning of the first school phase. If the pattern of negativism towards the school environment can be changed, they may gain skills to help them face the long school career, with less frustration and anxiety.
- This age group responds positively to play therapy.
- The specific techniques used fit this specific age group.

Table 6.4 Ages and gender of the study population

Study population	Gender			Total Number
	Age	Number of Males	Number of Females	
	6	3	1	4
	7	1	0	1
	8	2	0	2
	9	0	1	1
	10	0	2	2
		6	**4**	**10**

As illustrated in table 6.4 there are six boys in total and four girls. Their ages varied between six and ten. Figure 6.5 shows the population of boy and girl respondents.

Figure 6.5 Gender of respondents used for research



From the total of ten respondents 50% were day scholars and 50% were in boarding school. From the group of four girls, only 1 girl, 10% was a day scholar. The percentage of boys being day scholars is much more than the girls, namely 40% and 20% are in boarding school.

6.5 Therapeutic contacts with respondents

The following table, table 6.5, shows the number of therapeutic contacts between the researcher and each respondent.

Table 6.5 Number of therapeutic contacts

Respondent	No of direct therapy sessions	Number of client centered therapy	Total no of sessions
1	3	10	13
2	3	4	7
3	3	10	13
4	3	0	3
5	3	0	3
6	3	0	3
7	3	0	3
8	3	0	3
9	3	0	3
10	3	0	3

This table shows that three of the respondents were in therapy for more than three sessions. Respondent one and three both had ten sessions (three structured and seven additional non-directive therapy sessions) and respondent two, seven sessions (three structured and four additional sessions). The others were only seen in therapy three times.

At the time of study two respondents (namely respondent one and three) have just started therapy. Their teachers, because of scholastic – and emotional problems, referred both to the researcher. They came out of the researchers caseload. They, together with respondent two were seen for both structured and non-directive therapy and the positive effect of these extra sessions will be highlighted in this chapter.

6.6 Case studies

This section will focus on the research done by means of a case study presentation. The information gathered through the literature study will form the theoretical dimension for the practical research. According to De Vaus (2001:223-224) the clinical case study design uses theories to understand a case. For example the way in which a social worker deals with a client:

- A child visits a social worker because he performs poorly at school and has become disruptive.
- The task of the social worker is to work out what is going on in this case, and why is it happening.
- An efficient social worker will start with symptoms: what is happening at school and in what areas of school is this child performing poorly? (She will have a range of possible explanations for poor school performance and disruptive behaviour at school.)
- She will gather information to build up a picture of what is going on. She will develop hunches; collect further information to test these hunches.
- The child can be tested for specific learning disabilities, to see if a cognitive explanation of the learning difficulties is applicable.
- She may have his eyesight or hearing tested to see if sight or auditory problems are contributing to his learning disabilities.
- The social worker will evaluate the child's relationship skills to establish if problems in this sphere contribute to the learning difficulties.
- She may probe the child's family relationship to see if something that is going on at home is creating problems at school.
- She may probe the teacher and child relationship
- The child may possibly suffer from anxiety or depression.
- The task of the social worker is to build up a full picture of the case so that she can evaluate which explanation best fits the facts of the case.
- Having directly diagnosed the nature or cause of the child's problems the social worker can then begin treatment.

- In this example the goal is to understand the case and to solve a problem for this case. The purpose is not to test or develop theories but to use existing theories.
- The social worker works with plausible rival hypotheses and progressively collects information to help sort out which fits best.

This example will be used as a basis for the ten case studies (the study population) to be presented. Information obtained will further be used for the purpose of analysis and recommendations.

6.6.1 Case study One

6.6.1.1 Background information

Respondent one is seven years old, an only child, with divorced parents. His father died three years after the divorce. The respondent was selected from the researchers caseload after consulting with his mother. She brought him for therapy because of his negative attitude towards school. He used to be very positive, but after the second school term in grade one his behaviour changed.

He became very anxious about going to school and the teacher started reporting negative behaviour. He was very disruptive in the class and the frequency of fights with peer groups increased. He worked extremely slow, was easily distracted, found it difficult to work in a big group, struggled to stay focused, was disobedient, experienced difficulty with peer-group relations and he was a loner. Problems he experienced are shown in table 6.6 as follows:

Table 6.6 Problems experienced by respondent in the school situation

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• excessive need for assistance and reassurance, • lack of self confidence, • low-self-concepts, • easily distracted by irrelevant and inappropriate stimuli, • extremely shy	• disruptive behaviour in class- room, • aggressive behaviour, • fighting/quarrelling, • low frustration tolerance. • "school-sick" • very anxious	• poor peer group relations, • he is becoming a loner, • shows signs of withdrawal. He initiates lesser contact with his peers.

Resulting from this table it is clear that the respondent does experience emotional, behavioural and relationship problems at school. Table 6.7 shows the emotional, behavioural and relationship problems he experience in his family. The information gathered from the mother, about the respondent, coincides with the information gathered through the literature study (chapter 3, par 3.6).

Table 6.7 Problems experienced by respondent in the family situation

Emotional problems	Behavioural problems	Relationship problems
Family situation • excessive need for assistance and reassurance from mother • lack of self confidence-mother must help him do almost everything.	**Family situation** • becomes irritable if he doesn't succeed in doing house chores.	**Family situation** • good relationship with mother but not with rest of extended family staying in the same house.

The researcher had seen the respondent twice and did client centered therapy. After consulting with his mother he was tested for learning disabilities, which he had. The researcher then started with three structured therapy sessions for research purposes. Eight client centered therapy sessions followed and therapy was successfully terminated. The researcher still had frequent feedback from the teacher and mother.

6.6.1.2 Structured play therapy sessions

Three structured play therapy sessions were held with the respondent. Important information gathered through these sessions was used in the indirect play therapy sessions, which followed. In session one, we started as in the pilot study, by completing the PFI-PRIM-C questionnaire before therapeutic intervention.

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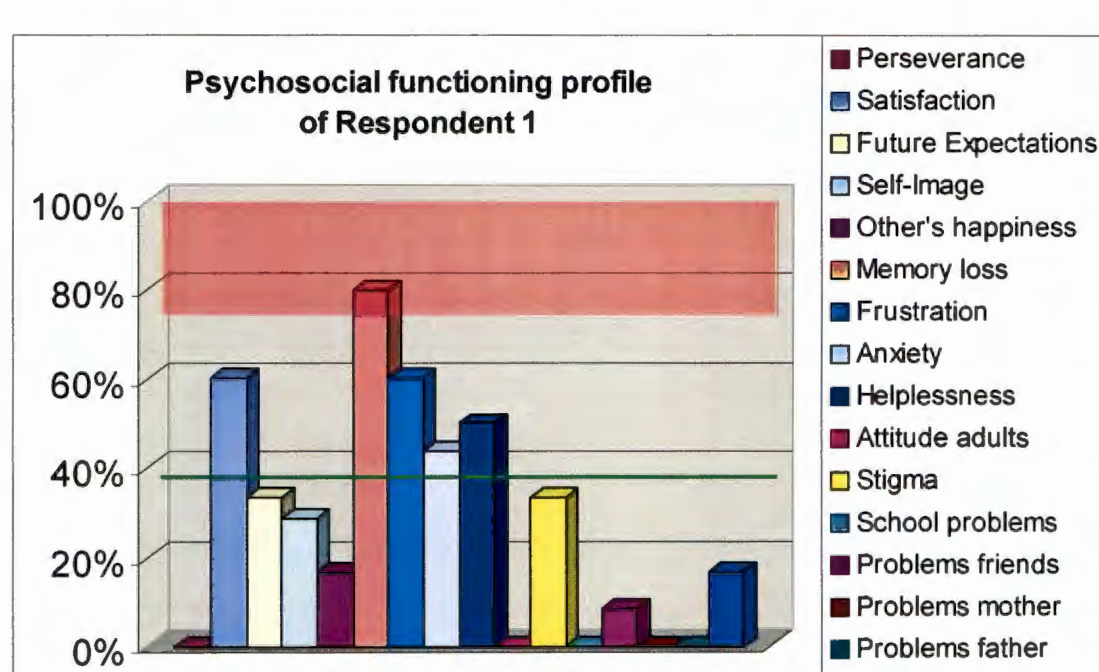
6.6.1.2.1 Findings of the PFI-Prim-C

Figure 6.6 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent one. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.6 Psychosocial functioning profile of Respondent 1



On seven of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicates that the respondent has problems in the following areas:

Memory loss	80%	Anxiety	44%
Satisfaction	60%	Helplessness	50%
Frustration	60%		

On one of these subscales, namely memory loss, the score even exceed the upper-level cutting score of 75%. This indicates that the child has a major problem in re-membering basic things. This respondent has a short attention span, which fits with the characteristics of the learning disabled child, and again leads to memory loss.

Although the sub-scales, self-image, 29%, falls below the cutting score range of 36-40%, he does present problem behaviour that indicates a problem in this area. The

teacher also believes that he has a problem, because of her concern; she referred him, his self-image deteriorating daily.

The following ten subscales indicate no problems in the area being measured.

Stigma	33%	Attitude adults	0%
Future Expectations	33%	School problems	0%
Other's happiness	17%	Problems mother	0%
Family problems	17%	Problems father	0%
Problems friends	8%	Perseverance	0%

The following response to the questionnaire questions, were of concern and importance for the purpose of this study:

- He felt people and friends disliked him, and that nobody loved him.
- He doesn't feel happy, doesn't enjoy anything any more.
- He won't be happy when he is grown-up.
- He is not allowed to make mistakes, feels different from other kids, and they have fewer problems than him.
- People don't listen to him, and everybody scolds him.
- He forgets important things, for instance, he cannot remember where he puts things or small tasks to do.
- He easily becomes angry, and kick friends if they make him cross.
- He gets tummy aches, everybody teases him, and finds it difficult to do things right.

Although the PFI-Prim-C did not show a big problem with self-esteem, the respondent does present a self-image problem. The above questions asked in the questionnaire to which he responded negatively, reflect it. These questions indicated that the respondent experienced problems in his relationship structures, had a low self-esteem, felt helpless, disliked himself and was frustrated. Relevant responses made by the respondent during the therapeutic session, which fit the information gathered from the questionnaire, were the following:

- He stated that he likes school, but dislikes his teacher scolding him and the children always picking on him.
- The children made him mad.

Children with learning disabilities may experience all of the feelings this respondent felt. Intervention by the social worker is therefore relevant. She has a role to fulfil in leading the child to take control of himself and his life-world. By focusing on building his self-image and giving him the tools to cope with relationship structures, she can support him to take control of his life-world and accept his differences. This became the major aim of the three sessions.

6.6.1.2.2 Session 1- Bibliotherapy and making the body image

Bibliotherapy followed the questionnaire. A book about a trip across the human body was read. The respondent could identify with, and imitate the behaviour of the little boy in the story. He participated very eagerly in all the actions. The next step was the drawing of a life-size body picture (trace around child's body as he lies on a large piece of paper) and then, the respondent was requested to draw in facial features. While doing this he and the researcher talked about what his own hands, feet, ears, eyes and various body parts can do. The main objective of this step was to allow the child to experience something positive about his own body, and realise "ownership" of his body.

The respondent experienced his own body with admiration. He started to realize his perceived difference in a positive manner. Responses such as "I didn't realize I am this big, wow!" and "Is this really me? I am really big, this is really me!" was the beginning of a positive outcome of the therapy with this respondent. He then learned the song about being special. He was very impressed with this song and enjoyed singing this immensely. The objectives and outcome of this session can be tabled as follows:

Table 6.8 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of his own body, becoming aware of the differences of own body and other persons body, the child is building his self-image. • The child experiences his own body and becomes aware of his uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being someone worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. His whole non-verbal communication was one of utter disbelieve when the body image was lifted up and he realized how big he really is. He uttered in dismay: "Is it really me... am I really that big... I must go and show my mom she won't believe this!"
Reaffirming of self-image and self awareness The researcher involved the child's mother in the therapeutic process and asked her to make a big fuss about this body image for the next week. She was asked to put it up against his wall and mention something positive every day. They had to remeasure his hands and feet.	**Reaffirming of self-image and self awareness** Feedback from his mother the next week, as well as his teacher, was very positive. He was more aware of things happening around him, more eager to do his homework and was more talkative to the other family members in the house. He also was less aggressive.

This session was followed by session two.

6.6.1.2.3 Session two: Developing insight into feelings

The researcher took into account that most children with a learning disability "are not aware" or "do not realize" the difference between the intensity of feelings. If they experience anger, they do not discriminate between being intensely furious and just being mad, or being happy and being exited. For them being excited or happy, just meant being happy. You can either be happy or sad. This was true of the respondent. He still had to learn how to take control of his feelings so that he can act accordingly, and in a socially acceptable way.

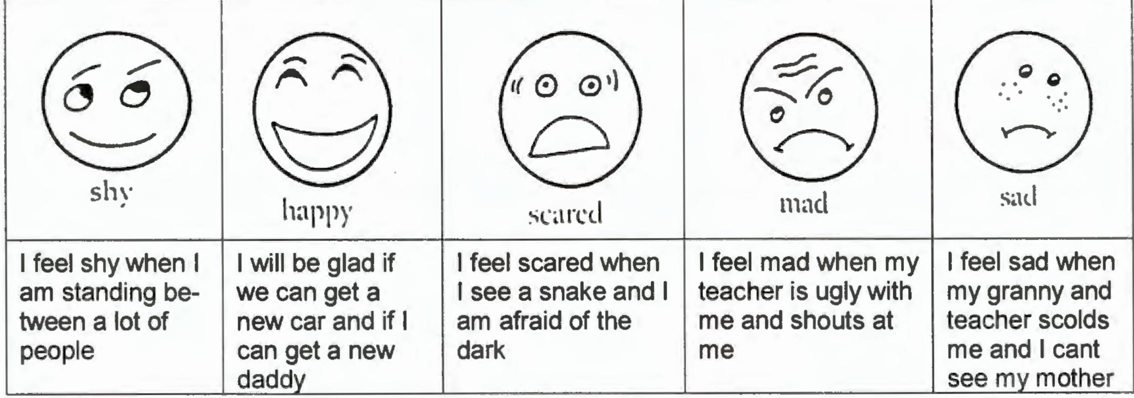
The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap (as described in the pilot study, session two) was played with these cards. The procedure was demonstrated to the respondent and the game began. Feelings experienced (similar to the snap-cards) were discussed. This was followed by the "How would you feel?" game. Examples of questions asked were: "How would you feel if you tidied your room splendidly?", and then the respondent had to show a feeling card that matched his feeling.

The main objectives of these games were:

- to let the respondent experience the role of feelings in a person's life and ,
- how feelings can influence ones behaviour.

The game also illustrated that people have different feelings. The respondent chose five feelings and had to say what caused him feel that way. The respondent recalled feelings he experienced and named the feelings correctly. The researcher responded on the information given. Figure 6.7 shows the five different feeling cards respondent one chose. His responses towards each card are also tabled directly beneath the specific card.

Figure 6.7 Feeling cards and responses



shy	happy	scared	mad	sad
I feel shy when I am standing between a lot of people	I will be glad if we can get a new car and if I can get a new daddy	I feel scared when I see a snake and I am afraid of the dark	I feel mad when my teacher is ugly with me and shouts at me	I feel sad when my granny and teacher scolds me and I cant see my mother

From the information gathered up to this point, the researcher realized that the respondent lacked the skills to respond to his peer group. They tease him, he gets aggressive and hits them and gets into trouble. This was the next focus point in the session.

6.6.1.2.4 Broken window and cloud

The researcher demonstrated to him how he could respond to the teasing; he could decide to become a breaking glass or a cloud (see figure 6.4). He could choose to answer the children in such a way that he did not break like a glass window, but rather be like a cloud.

The example used:

- If a child says to him: "You are really stupid, no wonder your teacher shouts at you", he may choose to reply, "Yes I am a real wimp", and cry. With this answer he will allow himself to get hurt emotionally and he will break like the glass window that has been struck by a stone.
- Or, he may choose to be like a cloud that only ripples inside (where the other person cannot see) when the stone falls through. To succeed in being a cloud, his reply could be: "You, may think I am stupid, but I am not. Teachers do shout at kids all the time, that is their job."

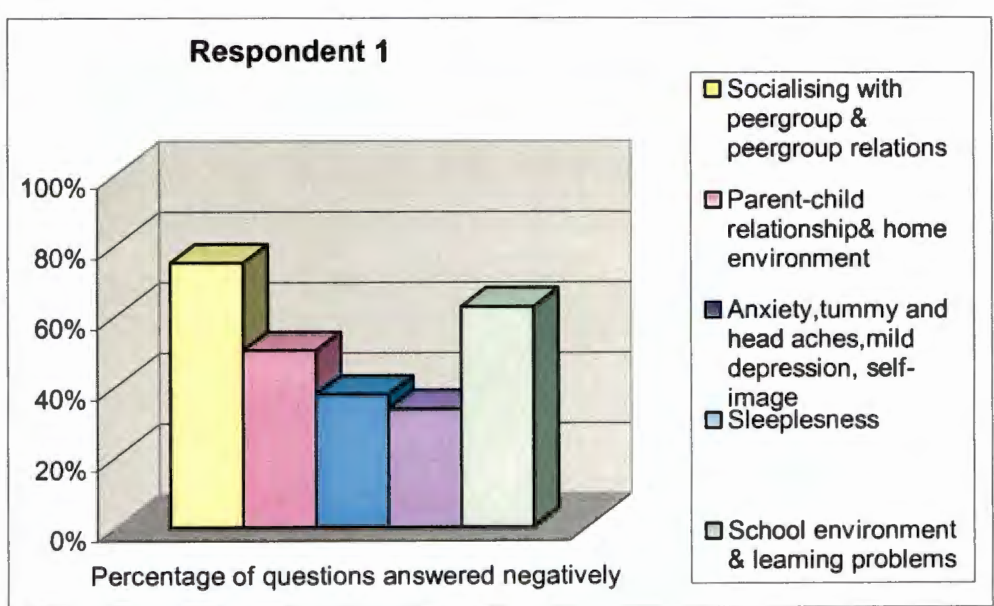
This was enforced through role-play. A picture with a cloud and a glass window was drawn, and the affect of a stone passing through the window, was shown visually. By choosing a situation, he had to say what answers would lead to which affect, the broken glass window or the cloud.

The respondent's reaction was positive. Another alternative reaction to teasing was demonstrated. He could also become like a stuck record. For instance, use the same example, used for the cloud and broken window technique. The children are teasing him and he could repeatedly say the same phrase "You, may think I am stupid, but I am not. Teachers do shout at kids all the time, that is their job." The children will eventually stop if they see it has no affect on him any more. The session ended after a few role-play situations.

6.6.1.2.5 Session three: Taking control of my own behaviour

The next session began with a questionnaire that showed the improvement made during the past two weeks, after the two direct therapy sessions. Although (figure 6.8) the results of the questionnaire, still shows a problem with the peer group, response by the mother was that his relationships with his peers were definitely starting to improve. There were also a slight improvement in the sub-scale school environment and learning problems.

Figure 6.8 Respondent one: Results of questionnaire two



6.6.1.2.6 Robot technique and role play

Session three focused on the impulsive behaviour of the child with a learning disability. This child usually acts before thinking, and this often gets him into trouble. The respondent was guided, by means of an art activity, namely the making of a robot, together with role-play, to think before he reacts. He was guided in formulating and using "robot answers". The same steps as in the pilot study, session three, were applied.

The example chosen for purpose of role-play:

- A schoolmate keeps picking on the respondent; he gets cross, looses his temper and hits the child. He gets blamed by the teacher and is seen as the troublemaker, that he is not.
- The respondent then had to use the robot technique. He firstly breathed slowly ten times, so that he could experience how it felt. The next emotion he had to experience was being calm.
- The researcher then guided him to realize that in similar situations, he could react in only one of two ways. He was responsible for his choice of action.
- Firstly he could choose to hit the other child, who will again go to the teacher, and get him into trouble, and secondly he could tell the other child that he is not for picking on, and if he chooses to continue, he will ignore him, as if he does not exist.

Similar situations were role-played. The researcher observed that the respondent really put in an effort in practicing the role-play situations. It was as if he wanted to assure himself that he would know how to react in similar situations outside the therapy room.

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6.6.1.3 Non-directive play therapy sessions

Up to now the biggest problem, according to figure 6.8 is socialising with his peer group. This was addressed in the following eight sessions of non-directive play therapy. The important themes of play were, nurturing, searching for control, taking control and the outlet of aggression. In the first session of non-directive play the respondent decided to be a shopkeeper. The researcher was directed to buy all kinds of stuff. The researcher called the respondent "Mr" which he liked. As his self-image grew, he himself wanted to be in control and after session five asked the therapist to call him on his name, and not "Mr". This also reflected his behaviour outside the therapy room. According to his mother he started taking control in his life-world, and had courage to do things he never wanted to do before.

In the second session the shopkeeper (respondent) became mean and played bad tricks on the customers (researcher). The researcher had to act as if she did not

know he was responsible for the tricks. The respondent reacted overjoyed when the researcher, as the customer, consulted him, the shopkeeper and asked him for advice on how to handle the "culprit". He took control and enjoyed the situation. This theme was played repeatedly for the next two sessions. He would break the fences and then he would become Mr Good-guy who would repair the fences for free. The researcher then had to tell him what a nice person he was. During the session the researcher would also demonstrate what would happen if the shop-keeper stopped playing bad tricks on the customers, and just carried on being nice anyway. The respondent then asked the researcher if they could change roles.

The respondent wanted the researcher to be the shopkeeper. The shopkeeper was not allowed to play bad things. This was a huge shift in the child's play pattern. He had decided that he was the shopkeeper, and said: " I do not need to be nasty any more, I just want to be your friend, by being me. You may come and buy what ever you want, I won't play hurt you any more."

After this session the respondent lost interest in being the shopkeeper. He took control of his life and did not need to play this game any more. His mother responded that he was a different child: "I don't know my child, he is so matured. A few weeks ago he cried when my older brothers only looked at him. He now even back chats them in a positive way. The whole family is now reflecting on the positive change in my son."

The respondent moved to a new school. The researcher consulted the new teacher on how to handle him. The researcher has had frequent feedback from the teacher. The respondent has developed positively, his self-image kept on growing, social skills improved and the "loner" now has a group of friends where he feels wanted.

This case study illustrates that some children need more than three direct therapy sessions and that frequent teacher involvement is necessary. The teacher needs to be advised on how to handle the child successfully and guide him to optimal

functioning. It is necessary that there should be an open relationship between the teacher and the therapist during this development phase.

6.6.2 Case study two

6.6.2.1 Background information

The child, respondent two, is eight years old, and the youngest of three children. His teacher selected him, as she was concerned about his school performance and low self-image. The researcher asked the teacher to start working on the self-image in the class situation, by praising him more. He did have problems on the gross-motor developmental-, visual- and audio perceptual level. This negatively influenced his schoolwork. The teacher was requested not to reprimand him for not writing neatly.

He was positively tested as a child with learning disabilities. His father was really concerned about the respondent's school situation. He insisted that his mother spend more time helping with his homework. The mother did not feel adequate enough, and preferred taking him for remedial classes. The problems he experienced are tabled in table 6.9.

Table 6.9 Problems experienced by respondent two

Emotional problems	Behavioural problems	Relationship problems
School situation • Excessive need for assistance and reassurance. • Lack of self-confidence • Easily distracted by irrelevant and inappropriate stimuli.	**School situation** • Anxious, • Loner.	**School situation** • Feels responsible for well being of others.

6.6.2.2 Structured play therapy sessions

Three structured play therapy sessions were done with the respondent. Important information was gathered through the sessions. Session one started by completing the PFI-PRIM-C questionnaire, after which therapeutic intervention followed.

6.6.2.2.1 Findings of the PFI-Prim-C

Figure 6.10 is a graphical presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent two. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.10 Psychosocial functioning profile of Respondent 2

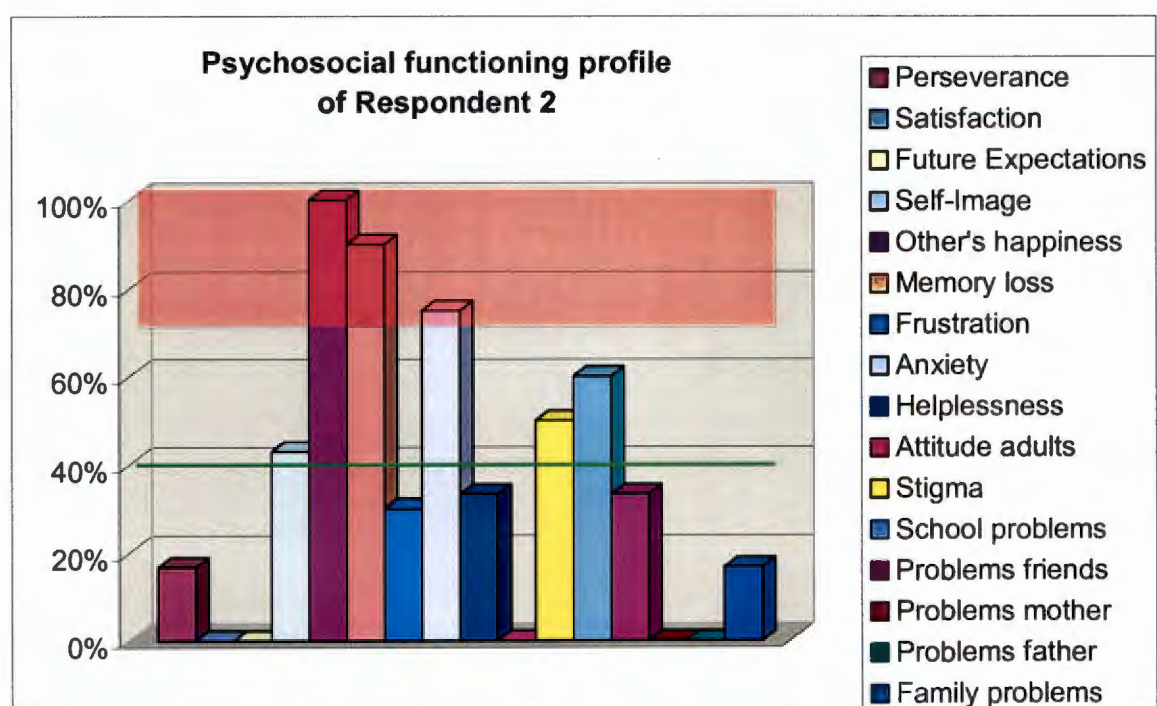


Figure 6.10 indicates that the respondent has major problems in several areas of personal and social functioning. According to the bar chart respondent two has problems in the following areas:

Other's happiness	100%	School problems	60%
Memory loss	90%	Stigma	50%
Anxiety	75%	Self-Image	43%

On six of the subscales the respondent's scores exceed the upper limit of the cutting score range, 36-40%, indicating a clinically significant problem in the area be-

ing measured. On three of the sub scales the scores of the respondent exceed the upper cutting level, 75%. This indicates that this child experiences a lot of anxiety and is totally focused on others happiness. The respondent also shows problems with memory loss, which again correlates with the characteristics of a child with a learning disability, namely poor memory, distractible and cannot stay with an activity (chapter 3, par. 3.6).

Although the following subscale falls just out of the score cutting range, the respondent presented problems in these areas:

Helplessness	33%	Problems friends	33%

Out of information gathered from the teacher, the respondent experienced problems with his peer group relations. He struggled to maintain friendships and was teased frequently. He also experienced problems with feeling helpless and experienced frustration. He verbalized that if he struggles to do things correctly, he becomes cross and just feels bad. Both his teacher and mother confirmed this.

Frustration	30%

The following seven sub-scales indicated no problems in that specific area of functioning:

Perseverance	17%	Attitude adults	0%
Family problems	17%	Problems mother	0%
Satisfaction	0%	Problems father	0%
Future Expectations	0%		

The following questionnaire questions were of concern and importance for the purpose of this study:

- He feels different from other children; they have fewer problems than him.
- He forgets important things, for instance where he puts things, and small tasks to do.
- He struggles to do things correctly.

- He feels responsible for others happiness.

The child experienced feelings of helplessness and was frustrated. A revealing response made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- He hated school, he felt like a dummy.

Children with learning disabilities may experience feelings of failure negatively, which can influence the self-image. This was typical of the respondent who experienced feelings of failure negative. This led to negative feelings of self-worth and caused him to experience a low self-image. Intervention by a social worker is needed to:

- support this respondent and help him conquer feelings of failure,
- teach him to be in control of himself and his life-world, without feeling responsible for the happiness of other people.

As in the pilot study, the questionnaire was followed by bibliotherapy.

6.6.2.2.2 Session one: Bibliotherapy

Bibliotherapy followed. The respondent enjoyed the book and joyfully imitated all the actions. The drawing of a body picture followed and the respondent had to fill in his facial features. The objectives and outcome of this session can be seen as follows:

Table 6.10 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, and the actual size of his own body, he became aware of himself. • The child experienced his own body and became aware of his uniqueness. • Learning a song about being special, accentuated the idea of him being someone worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent communicated utter disbelief when the body image was lifted up. He was amazed how tall he was.
Reaffirming of self-image and self awareness The researcher involved the parents in the therapeutic process and asked them to make a big fuss about this body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from both his parents and teacher was positive.

The next step was to learn to take control of his feelings so that he could act accordingly in a socially acceptable way.

6.6.2.2.3 Session two: Developing insight into feelings

The set of feeling cards containing a feeling word and matching facial expression were used. Snap was played and discussions on feelings experienced, similar to the snap-cards were discussed. This was followed by the "How would you feel like?" game. The main objective of these games was to let the respondent experience the role of feelings in his life and how these feelings could influence his behaviour.

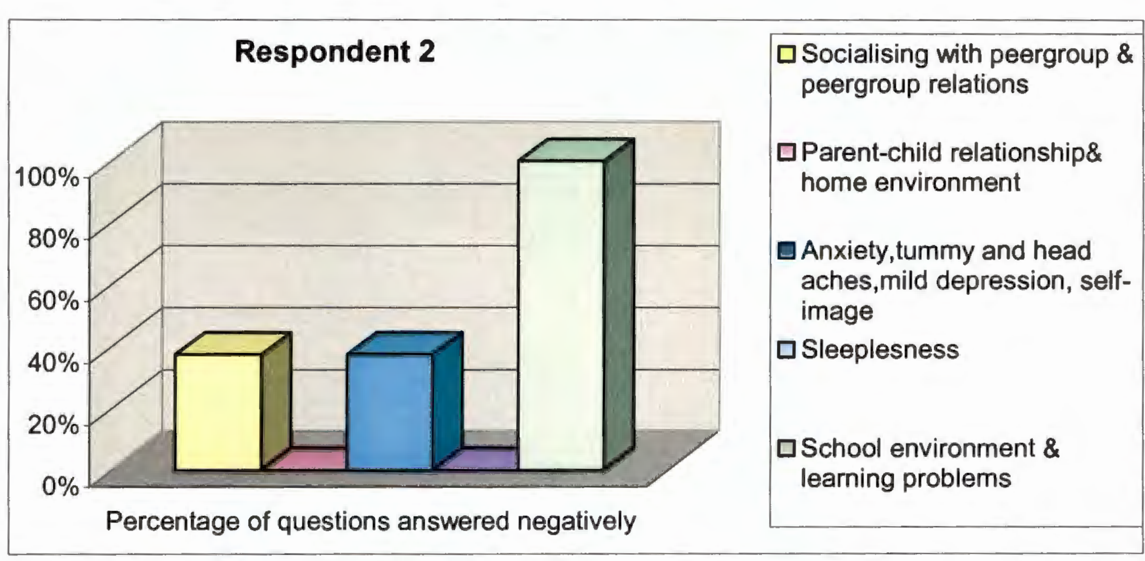
The respondent enjoyed the aspect of winning in the games. He favoured playing snap. By letting him win, the researcher used the situation to boost his self-image.

6.6.2.2.4 Session three: Take control of own behaviour

The third session started with completing of a questionnaire. It showed the improvement made in the past two weeks after the two direct therapy sessions. The questionnaire contained more specific questions about school problems relating to a child with a learning disability.

The respondent was clear in his answers. He did not like school, it makes him anxious and he did not like getting into trouble. This is clearly shown in figure 6.11 where the spectrum of problems is shown and the school environment and learning problems are by far the biggest.

Figure 6.11 Spectrum of problems: Respondent 2



The smile board game on social skills followed. There was a positive ending to the session.

6.6.2.2.5 Non-directive play therapy sessions

Three non-directed play sessions followed. The respondent chose the hand puppets. He chose a few puppets to work with, which started chasing each other. At first he did not mind who won. Later, he became more excited and made it a point to be the winner. This situation of some one being a winner was used and the re-

searcher asked him to say out loud how he felt being the winner and what must happen in life so that he can be a winner. He responded positively. He was excited and shouted repeatedly: "I am winning! I am winning! I love winning! I am the winner, I can beat any body!"

When the researcher asked him what he should do in the classroom to be the winner, he replied: "I must think I can! It is nice to win!" The respondent also became more assertive after these sessions. For this respondent the combination of the structured therapy and non-directive therapy worked very well.

6.6.3 Case study three

6.6.3.1 Background information

The respondent is seven years old, the younger of two children. He was selected out of the researchers caseload after consulting with his mother. She brought him for therapy after his teacher referred him for therapy. His behaviour was very disruptive in the class situation, frequencies of fights with peer group increased; he was very impulsive and would take the other children's sweets, cold drinks, pencils without asking; he is easily distracted and struggles to stay focused, his teacher experienced him as being disobedient. The child was tested for learning problems.

There was a delay in his gross motor development, he experienced visual problems and all of these negatively influenced his school performance. He tested positive for learning disabilities. The respondent is a gifted child and the researcher was concerned that his self-image would deteriorate because of the negative responses he got in the classroom situation. Problems he experienced can be tabled as follow:

Table 6.11 Some problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Very impulsive. • Easily distracted by irrelevant and inappropriate stimuli. • Fear negative responses.	• Disruptive behaviour in class- room. • Aggressive behaviour. • Fighting/quarrelling. • Low frustration tolerance. • Very anxious. •	• Poor peer group relations.

6.6.3.2 Structured therapy

The respondent has been in therapy for a month. The researcher decided to combine non-directive therapy with three structured therapy sessions, for purpose of research. The session sequence of the pilot study was not followed.

6.6.3.2.1 Session one

The first session started with the Smile social-skill board game. The reason was that the respondent experienced problems with relationship structures in the school environment. The previous session was held at the school with his teacher, the researcher and respondent. The researcher and teacher first met in consultation where the teacher was properly informed in understanding the child's behaviour and was given information on how to handle him and build his self-image. He was very hyperactive and this together with his impulsive behaviour frequently disrupts the class.

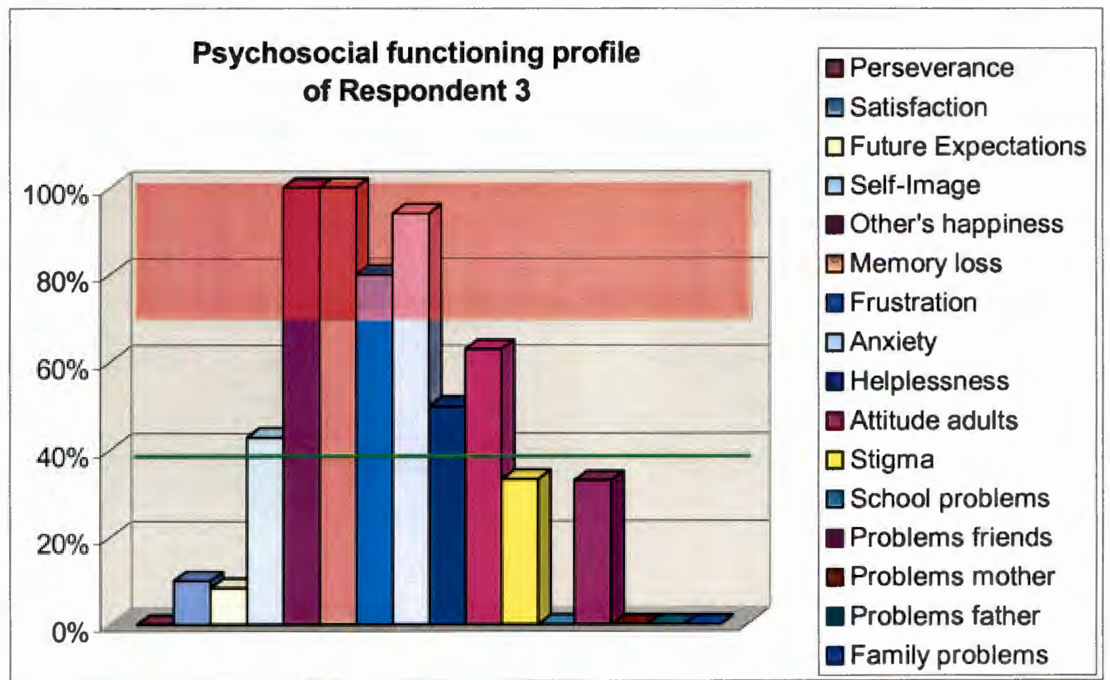
The researcher became aware of the need the respondent experienced to having realistic limit settings in the classroom situation. He felt insecure and the respondent did not see the need of certain class rules. Insight had to be given to him as well as setting limits with him so that he would be able to function optimal in the class setting. Taking this into account, the researcher started with the board game, which focused on healthy relationships and acceptable social skills. This was normally played in either session two or three. During the game the respondent picked up a card showing that it is unacceptable to throw sand at the children. Similar behaviour previously brought him into trouble. He responded positively that he has learned in therapy and that such behaviour is unacceptable and only brings trouble.

After this he spontaneously started hitting the pop bag, Bobo. The researcher reminded him that it is better to hit a pop bag at the house instead of a friend at school and come in trouble, which he confirmed.

6.6.3.2.2 Findings of the PFI-Prim-C

Figure 6.12 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent three. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.12 Psychosocial functioning profile of Respondent 3



On seven of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the areas being measured. It indicates that the respondent has problems in the following areas:

Other's happiness	100%	Attitude adults	63%
Memory loss	100%	Helplessness	50%
Anxiety	94%	Self-Image	43%
Frustration	80%		

On four of these subscales, the score exceed the upper-level cutting score of 75%, namely others happiness, memory loss, anxiety and frustration. This indicated a

very troubled little boy! The child had major problems and the score indicated a potential for violence against the self or others and he fell depressed about his situation. His poor relationship with his teacher is also reflected in the sub-scale attitudes towards adults.

The subscale problem with friends and stigma fell just below the cutting score.

Problems friends	33%	Stigma	33%

The respondent experienced problems with relations with his peer group. Both his mother and teacher confirmed this. He was in trouble frequently because of picking a fight with a classmate.

The following seven subscales indicate no problems in the area being measured.

Satisfaction	10%	Problems mother	0%
Future Expectations	8%	Problems father	0%
Perseverance	0%	Family problems	0%
School problems	0%		

The sub-scale school problems indicated that the respondent had no problems. This was apparently not true, because the teacher as a result of his school problems specifically referred this child. A lot of the frustration he experience was because of problems experienced in the school environment. To address this problem, social work intervention was needed, to guide the child in becoming in control of himself and his life-world. By focusing on building his self-image, giving him tools to cope with his relationship structures, she is helping him to take control of his life-world and accept his differences.

6.6.3.2.3 Session two: Bibliotherapy and body image

The next session focused on self-image and started with bibliotherapy. (The sequence of the pilot study was not followed, session one and two were switched.) The book described in the pilot study was used. The respondent could identify with the boy in the storybook and eagerly took part in doing all the actions. Drawing the

body image followed, and the respondent drew in the facial features. The main objective of this step was to let the child experience something about his own body, and realising his "ownership" of his body. The respondent experienced his own body with amazement. He could not wait to show the image to his mother. He peeped out of the therapy room twice, just checking if his mother did not arrive before time to pick him up. He wanted to show her how big he is! The researcher observed a definite change in behaviour. It was as if he had just conquered the world.

He then learned the song about being special, which he enjoyed. The objectives and outcome of this session can be tabled in table 6.12, as follows:

Table 6.12 Objectives and outcome

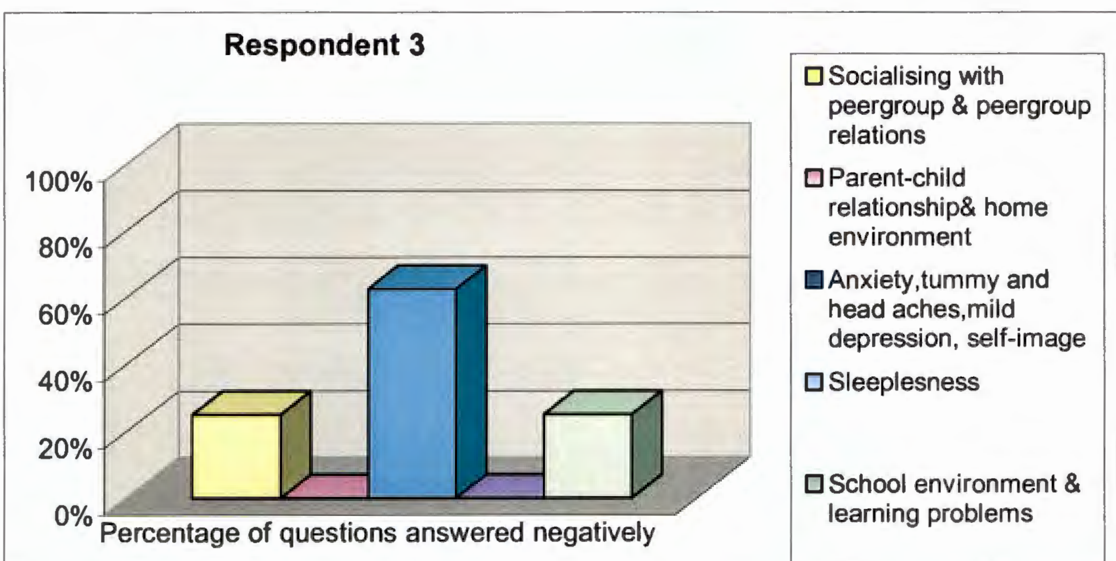
Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of his own body, becoming aware of the differences of own body and other persons body, the child is building his self-image. • The child experiences his own body and becomes aware of his uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. His whole non-verbal communication was one of utter disbelief when the body image was lifted up and he realized how big he really is. He uttered in dismay: "Is it really me... am I really that big... I must go and show my mom she won't believe this!"
Reaffirming of self-image and self awareness The researcher involved his mother in the therapeutic process and asked her to make a big fuss about this body image for the next week. She was asked to put it up against his wall and mentioned something positive every day. They had to re-measure his hands and feet.	**Reaffirming of self-image and self awareness** Feedback from his mother the next week as well as his teacher was very positive. He was more aware of things happening around him, more eager to do his homework and was more talkative to the other family members at the house. And was less aggressive.

Playing the Smile social skill board game completed the session.

6.6.3.2.4 Session three : Feelings and taking control of own behaviour

The session started by doing the second questionnaire. The results are shown in figure 6.13:

Figure 6.13 Respondent three: Results of questionnaire two



As can seen in this figure, the self-image, anxiety tummy and headaches was the area of concerned. This had to be addressed through this session. The researcher therefore focused on guiding the respondent to realize that he had to take control of his own behaviour. The researcher took in account that most children with a learning disability don't realize the difference between the intensity of feelings. If they feel angry, they normally don't know the difference between being furious and just cross, happy and exited.

As with the other respondents, this was true of this respondent. He also still had to learn to take control of his feelings so that he could act accordingly in a socially acceptable way. The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap (as described in the pilot study, session two) was played with these cards. The procedure was demonstrated to the re-

spondent and the game began. Discussions on feelings experienced similar to the snap-cards were discussed. The "How would you feel like game" followed. Questions were asked for instance "How would you feel if you did something good?" The respondent then had to show a feeling card that matches the feeling.

The main objectives of these games were to let the respondent experience the role of feelings in a person's life and how they could influence behaviour. The game also illustrated that different people have different feelings. The respondent recalled feelings he experienced and named the feelings correctly. The researcher responded on the information given.

Out of the information gathered up to this point, the researcher realized that the respondent reacted impulsively in the class situation, he lacked skills in responding to his peer group. They tease him and he gets aggressive, hits them and gets into trouble. The next step was introducing and practicing the robot technique. After this session his mother and teacher was counselled in how this technique works. They were requested to remind him about acting like a robot every time he reacted impulsively in a situation and help him chose the right option.

The respondent did improve after the three sessions. He was seen for a further seven sessions. He enjoyed the Smile social skill game as well as the Snakes and ladder game and wanted to play them each session. He enjoyed winning as much as he enjoyed remembering how to respond in a sociably acceptable way. The researcher observed that he had gained some ego control, a kind of internal structuring which he previously lacked. He could wait for his turn, answered the questions correctly and began interacting in a more organized way.

Therapy with the respondent was terminated successfully. The mother responded that he had grown emotionally, the frequency of peer group fights dropped, his relationship with his peer group improved, and the feedback of the teacher was positive as well. This case study stresses the success with a child in therapy, focussing on relationship structures; self-image and awareness of emotions through structured

therapy and combining non-directive therapy where the child is able to resolve from his own issues. Figure 6.15 shows a picture, the respondent drew of himself, after the fifth session. He named the picture "This is a happy me".

Figure 6.15 This is a happy me

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6.6.4 Case study four

6.6.4.1 Background information

Respondent four, is six years old, and the younger of two children. Her father died when she was four. She was very immature, emotionally overprotected by her mother and felt insecure. Her teacher selected her, as she was concerned about her school performance. The researcher asked the teacher to start working on the self-image in the classroom situation. She experienced problems with concentration, balance, laterality and gross-motor development, which negatively influenced her schoolwork. She was positively tested as a child with learning disabilities.

The mother was not really concerned about the respondent's school performance and never became part of the program. The researcher decided to let the teacher play a more important role in the child's daily life at school.

The teacher focused on improving her self-image, by concentrating only on the positive things she did in class. The teacher ignored the babyish behaviour and focused on socially accepted behaviour. She showed improvement even before she started therapy. The problems she experienced are tabled in table 6.13.

Table 6.13 Problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation • Excessive need for assistance and reassurance. • Lack of self-confidence, cries easy. • Easily distracted by irrelevant and inappropriate stimuli, • Extremely shy.	**School situation** • Very talkative in stressful situations, • Anxious, • Cries easily.	**School situation** • Cries easily (insecure), • Feels responsible for well being of others.
Family situation • Overprotected by mother.	**Family situation** • Insecure.	**Family situation** • Good relationship with mother and brother.

6.6.4.2 Structured play therapy sessions

Before the three structured play therapy sessions were done with the respondent, a session was held so that the researcher and respondent could get acquainted. In this session the respondent had to draw a picture of her self, before doing the questionnaire. (figure 6.16)

Figure 6:16 This is me

Important information was gathered through the questions asked in relation to this picture. One of her most important responses was that the girl she drew, was sad because her father died and did not want to come back to her. She never received therapy after her father died. The researcher observed that she still had a lot of unresolved problems relating to the death of her father. This definitely influenced her emotional state and relationship structures. Completing the PFI-PRIM-C questionnaire followed, after which therapeutic intervention followed.

6.6.4.2.1 Findings of the PFI-Prim-C

Figure 6.17 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent four. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning. On five of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured.

Figure 6.17 Psychosocial functioning profile of Respondent 4

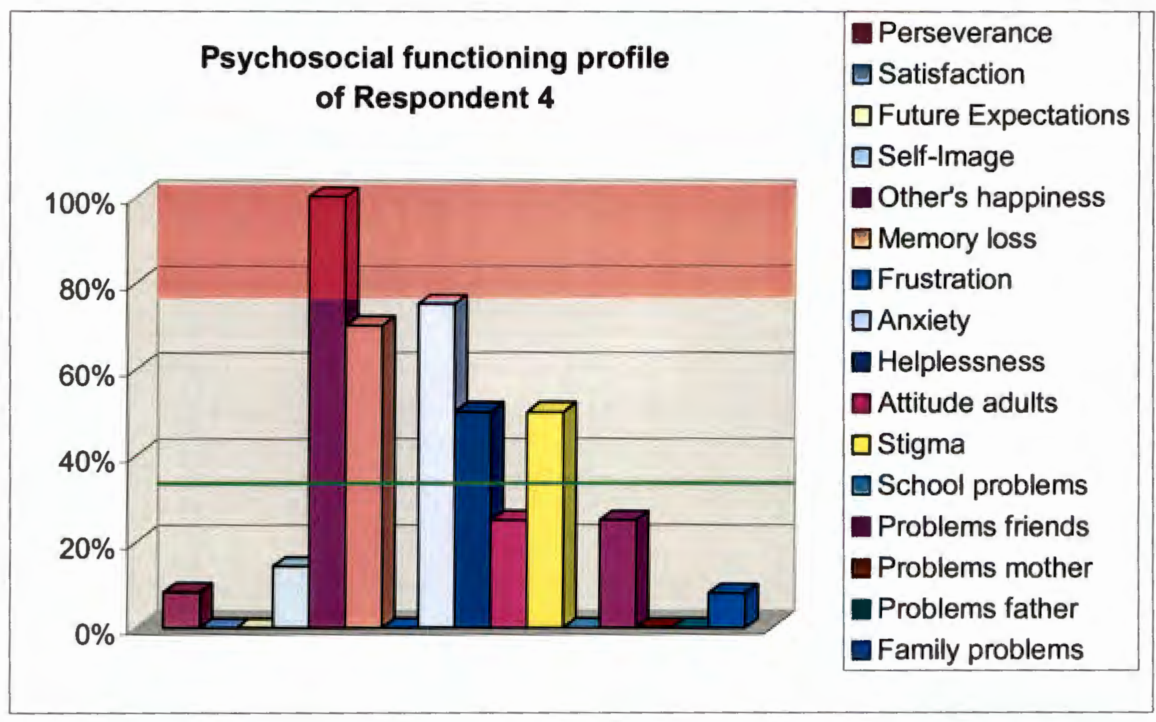


Figure 6.17 indicates that the respondent has problems in the following areas:

Other's happiness	100%	Helplessness	50%
Anxiety	75%	Stigma	50%
Memory loss	70%		

Two of these subscales scores namely others happiness and anxiety exceed the upper-level cutting score of 75%. Memory loss is also very high. This indicates that the child has a major problem in trying to keep other people happy and is experiencing a lot of anxiety in the whole process. She is already experiencing high levels of feeling helpless. The following eleven subscales indicate no problems in the area being measured.

Attitude adults	25%	Future Expectations	0%
Problems friends	25%	Frustration	0%
Self-Image	14%	School problems	0%
Perseverance	8%	Problems mother	0%

Family problems	8%	Problems father	0%
Satisfaction	0%		

Interesting to note that her self-image is positive. She only started school that specific term, and her feelings of helplessness and anxiety is high. This may lead to a decline in the self-image. As shown in the literature study (chapter 5, par. 5.5) the incidence of sensitivity to criticism and easy discouragement supports the frequently stated assumption that, with continued school failure experiences, these children tend to become anxious. Feelings of failure can influence the self-image negatively. It may destroy her feelings of self-worth and cause her to experience a low self-image.

The researcher did not want this to happen and asked the teacher to respond positively to the respondent, in the class situation. It was important that her self-image should stay healthy. The following questionnaire questions were of concern and importance for the purpose of this study:

- She feels different from other children; they have fewer problems than she has.
- People don't listen to her and adults are lying to her.
- She forgets important things, for instance where she puts things, and small tasks to do.
- She cries easily and often feels sad.
- She struggles to do things correctly.
- She feels responsible for others happiness.

The respondent experienced feelings of helplessness and was frustrated. Relevant responses made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- She enjoyed school, but didn't like to struggle.
- She then felt like a dummy.

Intervention by a social worker is needed, to support this child and help her to conquer feelings of failure and to teach her to be in control of herself and her life-world, without feeling responsible for the happiness of other people.

6.6.4.2.2 Session 1- Bibliotherapy and making the body image

As in the pilot study, the questionnaire was followed by bibliotherapy. She participated very eagerly in all the actions. The drawing of a life size body picture followed and the respondent had to fill in her facial features. The respondent experienced her own body with admiration. Her response was positive, "I didn't realize I am this big!" and "I am really big already!" She loved the self-image booster song. The objectives and outcome of this session can be seen as follows:

Table 6.14 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-images and awareness of self • Through exploring the different parts of the body, the actual size of her own body, becoming aware of the differences of own body and other persons body, the child is building her self-image. • The child experiences her own body and becomes aware of her uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. She communicated utter disbelieve when the body image was lifted up and she realized how big she really is. She uttered in dismay: "I am I really ...I"
Reaffirming of self-image and self awareness The researcher involved her teacher in the therapeutic process and asked her to make a big fuss about this body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from her teacher was very positive. She eagerly participated in the classroom.

6.6.4.2.3 Session two: Developing insight into feelings

She still had to learn to take control of her feelings and act in a socially acceptable manner. The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap (as described in the pilot study, session two) was played with the cards. Discussions on feelings experienced similar to the snap-cards were discussed. She enjoyed playing snap. At first she rushed through the game with winning being her main aim. After gaining confidence through being the winner for the second time, she spontaneously discussed her feelings related to the feeling cards. She got so involved in the game and responded without request to not only her own, but also the cards of the researcher.

This was followed by the "How would you feel like?" game. Questions were asked for example: "How would you feel if you could read a book all by yourself?" The respondent had to present a feeling card that matches this specific feeling. The respondent acted accordingly and spontaneously acted out some life situations. The researcher also focused on the questions of concern gained through her doing the PFI – questionnaire (chapter 6. par. 6.6.4.2.1).

The main objectives of these games were:

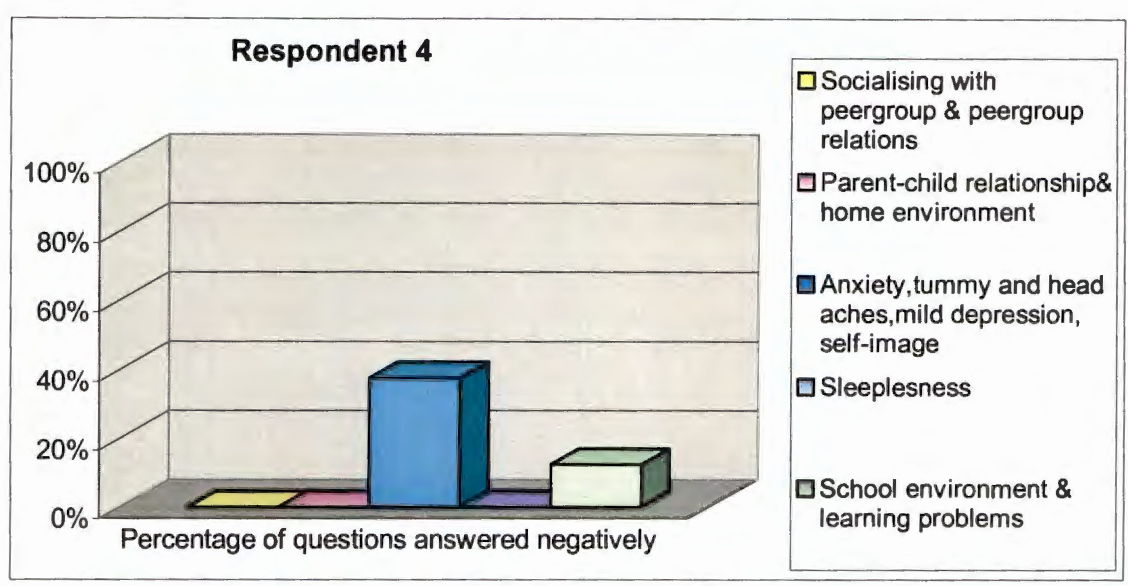
- to let the respondent experience the role of feelings in her own life and
- to know how these feelings can influence one's behaviour.

The next session was the third and last session with this respondent.

6.6.4.2.4 Session three: taking control of own behaviour

The session started with the completion of the second questionnaire, which showed the improvement made in the past two weeks after the two direct therapy sessions, figure 6.18. There was a definite decrease in the respondent's anxiety levels.

Figure 6.18 Respondent four: Results of questionnaire two



The respondent then participated in the making of a robot. Situations concerning peer group issues were addressed. The Smile board game on social skills followed. The last session ended on a very positive note. The respondent was very spontaneous, self-assured and her opinion of school, changed to a positive experience. This respondent coped very well.

The teacher played a very important role in helping the respondent grow emotionally. Frequent feedback from the teacher was essential in assisting this child. The important role of the social worker helping the child through a supportive and well-advised teacher was well demonstrated, and positively accepted.

6.6.5 Case study five

6.6.5.1 Background information

The child, respondent five, is nine years old, and the eldest of two children. She was selected out of the 20 children in the big group, after consulting the teacher. The teacher was concerned about her school performance. She was a very slow learner. She was emotionally immature, had problems with gross-motor development and visual- and auditory perceptual abilities. She was positively tested as a child with learning disabilities. As she was in boarding school, teacher support was essential.

The teacher focused on improving her self-image, by concentrating only on the positive things she did in class. The teacher ignored the babyish behaviour and focused on socially accepted behaviour. She showed improvement even before she started therapy. The problems she experienced are tabled in table 6.15.

Table 6.15 Problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Excessive need for assistance and reassurance. • Lack of self-confidence, cries easy. • Easily distracted by irrelevant and inappropriate stimuli, • Extremely shy.	• Withdraw in stressful situations, • Anxious	• Is a loner (insecure), • Feels responsible for well being of others.

6.6.5.2 Structured play therapy sessions

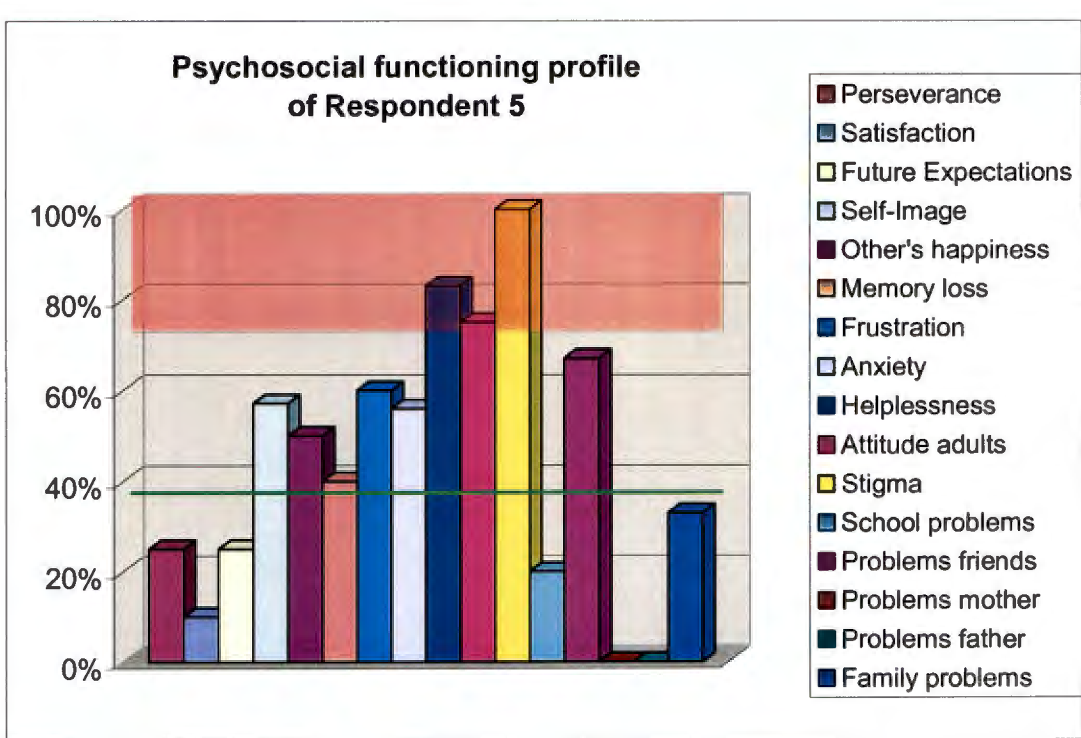
Before the three structured play therapy sessions, a session was held so that the researcher and respondent could get acquainted. In this session the respondent

had to draw a picture of her self and completed the PFI-PRIM-C questionnaire, after which therapeutic intervention followed.

6.6.5.2.1 Findings of the PFI-Prim-C

Figure 6.20 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent five. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.20 Psychosocial functioning profile of Respondent 5



On nine of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicates that the respondent has problems in the following areas:

Stigma	100%	Self-Image	57%
Helplessness	83%	Anxiety	56%
Attitude adults	75%	Other's happiness	50%
Problems friends	67%	Memory loss	40%
Frustration	60%		

Three of the subscales, namely stigma, helplessness, and attitude adults scores exceed the upper-level cutting score of 75%. This indicates that the child has a major problem in functioning optimally.

The following seven subscales indicate no problems in the area being measured.

Family problems	33%	Satisfaction	10%
Future Expectations	25%	Problems mother	0%
Perseverance	25%	Problems father	0%
School problems	20%		

The following response to the questions were of concern and importance for the purpose of this study:

- She feels that she deserves being scolded.
- She felt unimportant and was to blame for everything.
- She felt that she always did things wrongly, should not make mistakes and that people do not listen to her.
- She easily becomes angry, and kicks friends if they make her cross.
- She feels different from other children and wished to be more like them for they can do things better than her, and they are happier.
- She feels her friends do not understand her and she hates them.

The PFI-Prim-C showed a problem with self-esteem, she felt her being totally different from other children (stigma) and experienced feelings of helplessness and was frustrated. Relevant responses made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- She felt that she did not like school, and her friends do not understand her.
- She experience feelings of failure negatively, which destroyed her feelings of self-worth and caused her to experience a low self-image (See chapter 5.5).

Intervention by a social worker was needed;

- to support this child and help her to feel better about herself,
- conquer feelings of failure and
- guide her to take control of herself, her life-world and
- how to cope with relationship structures.

6.6.5.2.2 Session 1- Bibliotherapy and making the body image

The questionnaire was followed by bibliotherapy. She participated very eagerly in all the actions. The drawing of a body picture followed and the respondent had to fill in her facial features. She responded positively about what her own body parts are able of doing and experienced her own body with admiration. She then learned the song about being special. She loved this song, although she at first struggled to learn it, "I can not, I will make a mistake" she later sung it with delight. The objectives and outcome of this session can be tabled, table 6.16, seen as follows:

Table 6.16 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of her own body, becoming aware of the differences of own body and other persons' body, the child is building her self-image. • The child experiences her own body and becomes aware of her uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. • The respondent really had fun in doing the body image.

Reaffirming of self-image and self awareness	Reaffirming of self-image and self awareness
The researcher involved her teacher in the therapeutic process and asked her to make a big fuss about this body image for the next week.	Feedback from her teacher was very positive. She eagerly participated in the classroom.

6.6.5.2.3 Session two: Developing insight into feelings

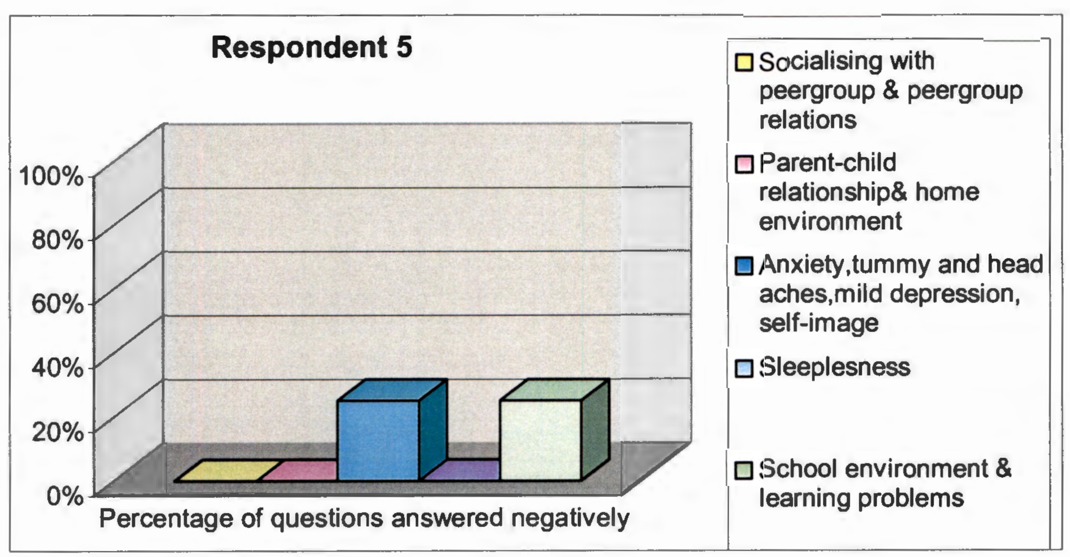
The next step was to develop her skills to take control of her feelings that would enable her to act in a socially acceptable way. The main objective of these games was to let the respondent experience the role of feelings in a person's life and how these feelings can influence one's behaviour.

The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap was played with these cards and discussions on feelings experienced similar to the snap-cards were discussed. The respondent then had to present a feeling card, on request of the researcher that matches the feeling she experienced in specific life situations. The respondent acted spontaneously on some life situations.

6.6.5.2.4 Session three: Taking control of my own behaviour

The next session was the third and last session with this respondent. The session started with the completing the second questionnaire, which already showed a positive improvement after the two direct therapy sessions, figure 6.21.

Figure 6.21 Respondent five: Results of questionnaire two



The respondent felt secure in her family structure, although she felt that she was to blame for everything, and unimportant. According to figure 6.21 the two areas answered negatively indicating problems, are the school environment and learning problems as well as anxiety and low self-image. She really struggled academically, and this caused a lot of anxiety. It was important to address these issues in this session.

The respondent then participated in the making of a robot. Through the robot technique she had the chance of finding means of behaving more acceptable towards her friends. She did not need to bite or kick them, when they made her cross, but she now had the choice in telling them to stop making her angry. The smile board game on social skills followed, she enjoyed the game and reacted positively.

She then had to draw a picture of her favourite teacher. This was an important step in the therapeutic process because of her anxiety towards the school environment. Her fears and dislikes towards certain teacher were also addressed.

Figure 6.22 is the DAT (Draw a Teacher) of the respondent.

Figure 6.22 My favourite teacher

Questions for evaluating the child-teacher relationship		
QUESTIONS	**Yes**	**No**
Is this a nice teacher?	**Y**	**N**
Is the teacher helpful?	**Y**	**N**
Do you like this teacher?	**Y**	**N**
Are you afraid of this teacher?	**Y**	**N**
If you ask this teacher a question, does she help you?	**Y**	**N**
Would you go to the movies with this teacher?	**Y**	**N**
Do you think this teacher likes children?	**Y**	**N**
Do children sometimes get very anxious in this teachers class?	**Y**	**N**
Would you like to be in this teacher's class next year?	**Y**	**N**
Is this teacher concerned about children?	**Y**	**N**

The respondent was very positive of this specific teacher. She felt this teacher understood her, and she felt free to ask her questions. She experienced anxiety when talking about her mathematic teacher. The researcher helped her to address her fear and anxiety. The respondent had to present a feeling card, on request of the researcher, that matches the feeling she experiences when she think of her math teacher. She was reminded that although she struggles with this subject it does not mean that the teacher dislikes her. She is still special. The respondent was reminded of singing the self-image booster song every time she thought of this teacher.

The important role of the social worker helping the child through a supportive and well-advised teacher was well demonstrated. The respondent's teacher played a very important role in helping the respondent grow emotionally, because she was in boarding school during the week. Frequent feedback from the teacher was essential in assisting this child. The last session ended positive. The respondent was now very spontaneous, started to behave more self-assured and her opinion of school, changed to a more positive experience

6.6.6 Case study six

6.6.6.1 Background information

Respondent six is nine years old, and the youngest of three children. She was selected out of the group of 20. The teacher felt that she needed therapy because of her poor self-image. The teacher was concerned about her school performance. She was afraid that, because both of her sisters excel academically, it could have a negative affect on the respondents' self-image. The researcher guided the teacher on how to handle the child in the class situation, to ensure the development of a positive self-image.

She was positively tested as a child with learning disabilities. She experienced visual and auditory perceptual problems. The respondent was in boarding school and the teacher was guided in handling the child correctly at school. The parents had to continue playing a definite role over weekends. The teacher was requested to focus on improving the respondents' self-image, by concentrating only on the positive things she did in class. She had to focus on socially accepted behaviour. The respondent showed improvement. The problems she experienced can be tabled as follows:

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Table 6.17 Problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Excessive need for assistance and reassurance. • Lack of self-confidence, in the classroom situation. • Easily distracted by irrelevant and inappropriate stimuli.	• Very talkative in stressful situations. • Anxious. • Withdrawal. • Daydream to escape pressure.	• Feels responsible for well being of others. • Feels others dislike her and she has not got a lot of friends.

6.6.6.2 Structured play therapy sessions

Before the structured play therapy sessions started the respondent firstly drew a picture of her self and then completed the PFI-PRIM-C questionnaire. Three structured play therapy sessions were done with the respondent. Important information was gathered through these sessions.

6.6.6.2.1 Findings of the PFI-Prim-C

Figure 6.23 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of the respondent. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.23 Psychosocial functioning profile of Respondent 6

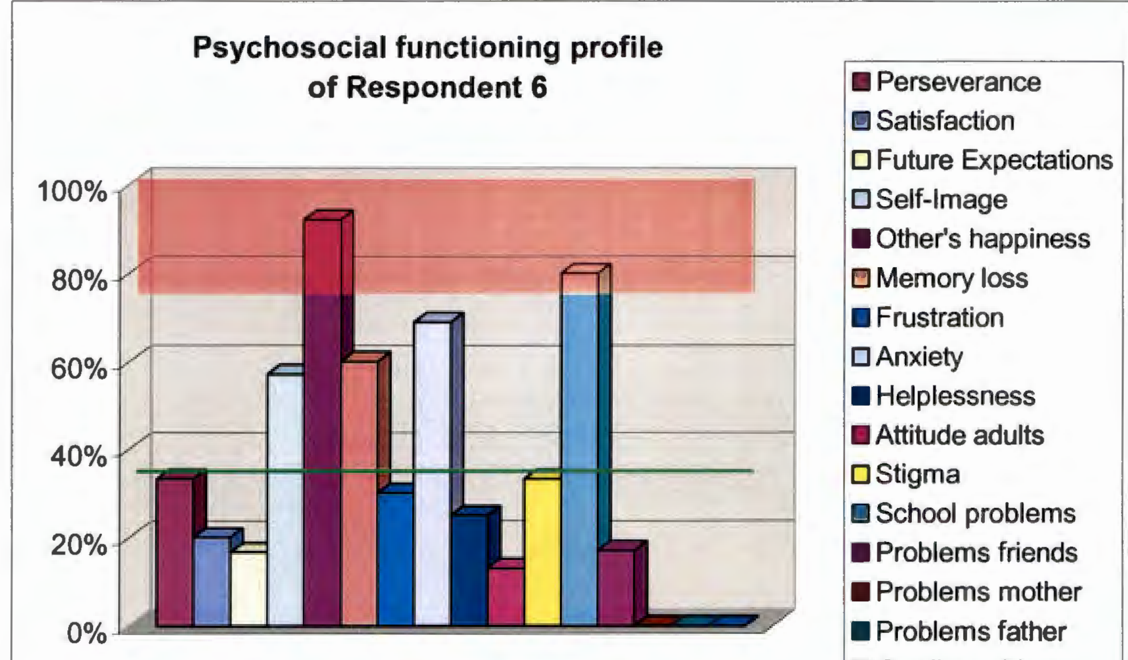


Figure 6.23 indicates that respondent six has problems in the following areas:

On five of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicates that the respondent has problems in the following areas:

Other's happiness	92%	Memory loss	60%
School problems	80%	Self-Image	57%
Anxiety	69%		

Two of these subscale scores namely; others' happiness and school problems exceed the upper-level cutting score. The respondent also experienced high levels of anxiety. This confirmed the teachers concerns about the respondent experiencing problems with school performance and anxiety. She cries easily, and struggles to do things correctly. According to her teacher she also puts in great effort trying to please every one, despite of her self.

The following eight subscales indicate no problems in the area being measured.

Helplessness	25%	Attitude adults	13%
Satisfaction	20%	Problems mother	0%
Problems friends	17%	Problems father	0%
Future Expectations	17%	Family problems	0%

The respondent repeatedly said she hated school. This is seen very clearly in figure 6.18, where school environment as a problem area is 80%, which is high. She also feels responsible for others happiness and said that you have to see to it that others is happy, otherwise they dislike you. Others' happiness, according to figure 6.18, is 92%, and this shows that she really experiences problems in relationship structures, although it did not show up in the other PFI-Prim-C questions asked about relationships with parents, and friends. Out of responses it was true that she did experience problems in maintaining friendship.

The following questions were of concern and importance for the purpose of this study:

- She feels different from other children; they have fewer problems than she has.
- People don't listen to her and adults are lying to her.
- She forgets important things, for instance where she puts things, and small tasks to do.
- She cries easily and often feels sad.
- She struggles to do things correctly.
- She feels responsible for the happiness of others.

The child experienced feelings of helplessness and was anxious. Relevant responses made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- She hates school, because she struggles too much.
- She never feels "OK" in school, and wishes that she could rather stay at home.
- Teachers only like you when you do well in school and she struggles. There are only a few teachers who like her.

Children with learning disabilities may experience feelings of failure negatively, which can influence their self-image. This was true of the respondent who experienced feelings of failure negatively, which destroyed her feelings of self-worth and caused her to experience a low self-image. This is characteristic of children with learning disabilities.

Intervention by a social worker was needed to:

- support the respondent and help her feel better about herself,
- conquer feelings of failure and teach her to be in control of herself and her life-world, without feeling responsible for the happiness of other people.

By raising her self-image, she will learn to look at herself positively, by giving her tools to cope with relationship structures. The social worker is helping her to take control of her life-world and accept her differences, and the pattern of how she thinks about herself.

6.6.6.2.2 Session 1- Bibliotherapy and making the body image

As in the pilot study, the questionnaire was followed by bibliotherapy. She participated very eagerly in all the actions. The drawing of a body picture followed and the respondent had to fill in her facial features. She responded positively. The respondent experienced her own body with admiration. She accepted her differences in a positive manner. Responses such as "Wow, am I really this big already!" were the beginning of a positive outcome in therapy with this respondent. She then learned the song about being special. She loved this and sung this with delight. The objectives and outcome of this session can be seen as follows:

Table 6.18 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of her own body, becoming aware of the differences of own body and other persons bodies, the child is building her self-image. • The child experiences her own body and becomes aware of her uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. She communicated utter disbelief when the body image was lifted up and she realized how big she really is. She uttered in dismay: "Wow I am big.. ...I"
Reaffirming of self-image and self awareness The researcher involved her teacher in the therapeutic process and asked her to make a big fuss about this body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from her teacher was very positive. She eagerly participated in the classroom.

6.6.6.2.3 Session two: Developing insight into feelings

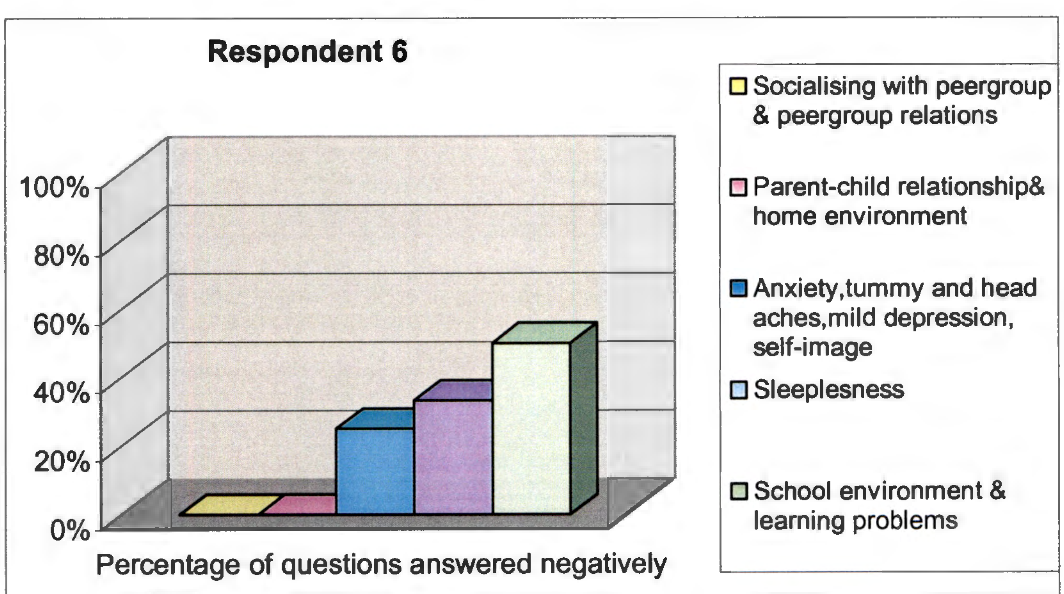
As the other respondents, she too had to learn to take control of her feelings so that she can act accordingly in a socially acceptable way. The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap was played. Discussions on feelings experienced similar to the snap-cards were discussed. This was followed by the "How would you feel like?" game. Questions were asked for instance: "How would you feel if you had a lot of fiends?" The respondent had to present a feeling card that matches this feeling. The respondent acted accordingly and spontaneously acted out some life situations.

The main objective of these games was to let the respondent experience the role of feelings in a person's life and how these feelings can influence one's behaviour.

6.6.6.2.4 Session three: Taking control of my own behaviour

The next session was the third and last session with this respondent. The session started with completing a questionnaire, which showed the improvement made in the past two weeks after the two direct therapy sessions, figure 6.24.

Figure 6.24 Respondent six: Results of questionnaire two

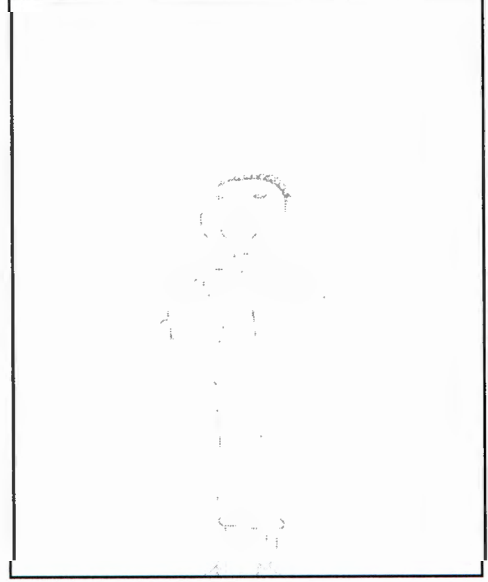


The respondent did show a big improvement in her attitude towards school. She became aware of the fact that she must only perform academically as well as she can and must accept her best, without comparing it with the other children in her class. She did not "hate" school that much and started enjoying it. She felt the teachers were more acceptable towards her.

The next step was her participation in the making of a robot, (same as pilot study). Robot answers were formulated and practiced through role-play. She enjoyed this very much. The Smile board game on social skills followed. The last session ended positive. The respondent became very spontaneous, self-assured and her opinion of school, changed to a positive experience.

This respondent coped very well. Her mother also played a positive part in the three sessions; she focused on building the self-image and supported by giving her very positive feedback, during the weekends when the respondent was at home. Frequent feedback from the teacher was essential in assisting this child and leading her to grow emotionally. The important role of the social worker, together with the parents and a supportive teacher, assisting the child, was well demonstrated. Here is the picture she draw off her teacher (DAT). The teacher looks friendly.

Figure 6.25 I like my teacher



6.6.7 Case study seven

6.6.7.1 Background information

The child (respondent seven) is seven years old, the youngest of four children and in Grade one. The teacher of the respondent requested the researcher if this child could be part of the study. He was a very timid little fellow and struggled to keep up with the other children in class. He had a poor self-image. He also expected that he had learning disabilities that negatively influenced his school performance. He was positively tested as having learning disabilities. He was selected for three therapy sessions.

Before the beginning of the three structured therapy sessions, the researcher asked him to draw a picture of himself as best he could. He then drew a picture of a house and a tree and commented that he was inside the house, figure 6.26. This fitted with the teacher's observation that he had a very poor self-image. The researcher responded that she would like him to draw a picture of himself outside the house as well, which he did, figure 6.27. He did this after the researcher explained to him that she knew he could not draw him exactly as he is, because she as a grown up cannot even draw herself. He need not be scared to do so.

Figure 6.26 Drawing of self

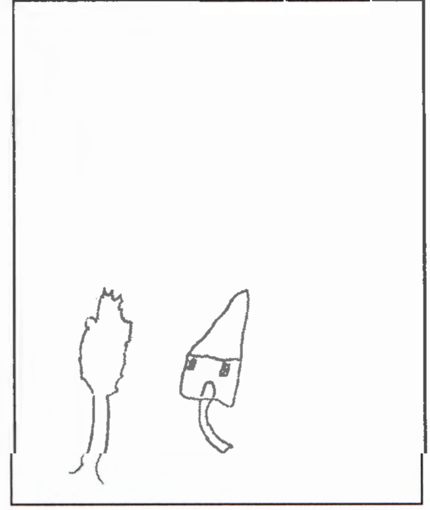
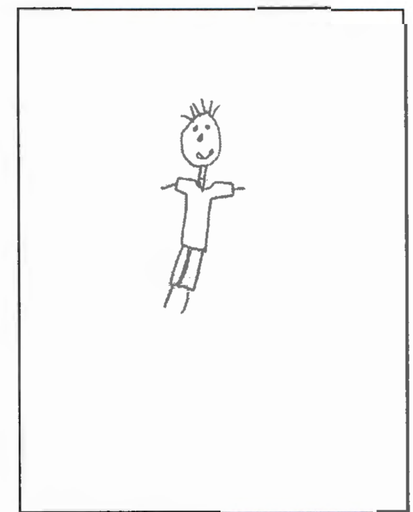


Figure 6.27 Me outside the house



The researcher consulted the respondents' mother. There is a family history of the rest of the family children struggling with academic performances. It was clear that he developed a negative attitude towards school the moment they started with more difficult schoolwork.

The respondent became very anxious about going to school. The teacher reported negative behaviour. He is very disruptive in the class situation, frequent quarrels with peer group occurred; he works extremely slow, is easily distracted and struggles to work in a big group, struggles to stay focused.

The researcher tabled, table 6.19, some of the problems this respondent experienced on emotional, behavioural and relationship levels.

Table 6.19 Problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation • excessive need for assistance and reassurance, • lack of self confidence, • low-self-esteem, • easily distracted by irrelevant and inappropriate stimuli, • extremely shy	**School situation** • disruptive behaviour in class- room, • aggressive behaviour, • fighting/quarrelling, • low frustration tolerance. • very anxious	**School situation** • poor peer group relations

It is clear that the respondent was in need of social work intervention. The researcher had to focus on building the self-image, relationship structures and awareness of different emotional feelings.

6.6.7.2 Structured play therapy sessions

The respondent attended three structured play therapy sessions. Important information gathered through these sessions, was used in the indirect play therapy ses-

sions, that followed. Firstly the researcher and respondent got better acquainted. The respondent drew a picture of himself, answered questions relating to his drawing and then completed the PFI-PRIM-C questionnaire. The structured therapy sessions followed.

6.6.7.2.1 Findings of the PFI-Prim-C

Figure 6.28 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent seven. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

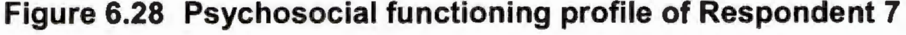
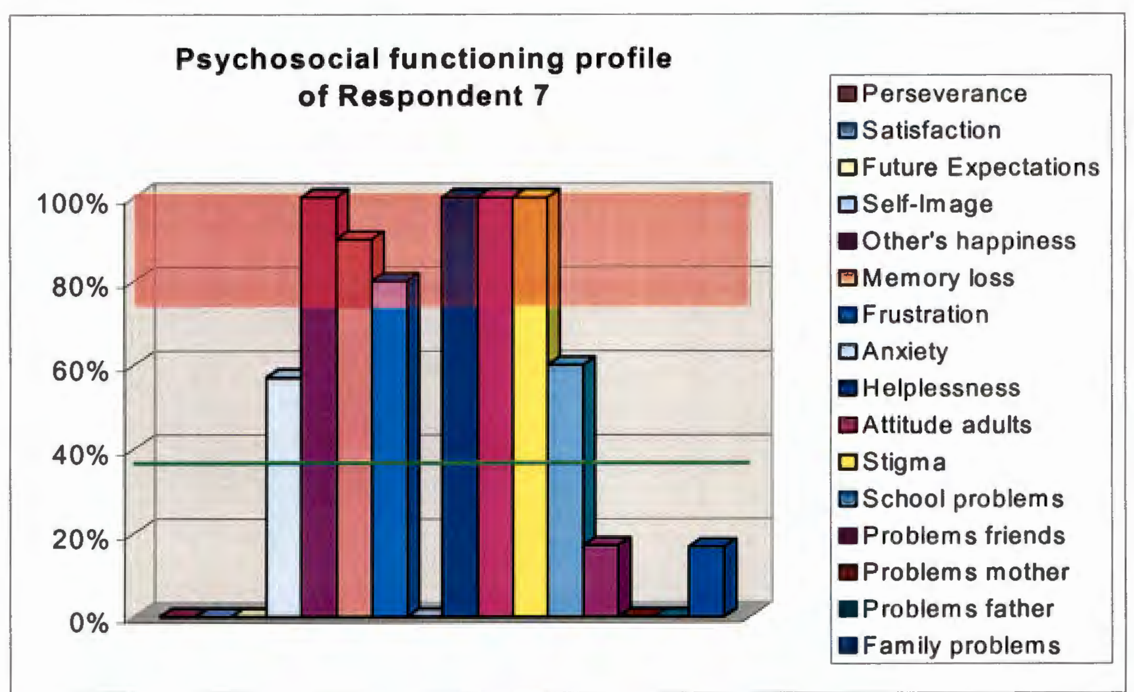


Figure 6.28 Psychosocial functioning profile of Respondent 7



On eight of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicated that the respondent has problems in the following areas:

Other's happiness	100%	Memory loss	90%
Helplessness	100%	Frustration	80%

Attitude adults	100%	School problems	60%
Stigma	100%	Self-Image	57%

On six of these subscales, the score exceed the upper-level cutting score of 75%. This was marked in red in figure 6.28. This indicates that the child has a major problem in remembering basic things. It correlates with the characteristics of a child with a learning disability (chapter 3, par 3.6), who has poor memory, is easily frustrated, cannot stay with an activity, and is very distractible and impulsive. The respondent also showed possible signs of violence against self or others. According to his teacher, the respondent did get cross easily and hit other children out of frustration. This correlates with the findings of the PFI.

The following eight subscales indicated no problems in the area being measured.

Problems friends	17%	Future Expectations	0%
Family problems	17%	Anxiety	0%
Perseverance	0%	Problems mother	0%
Satisfaction	0%	Problems father	0%

The following responses to the questionnaire were of concern and importance for the purpose of this study:

- He felt people and friends disliked him.
- He doesn't feel happy, doesn't enjoy anything any more, cries easily.
- He hits, bites and kicks friends if they make him cross.
- He is not allowed to make mistakes, feels different from other kids, they have fewer problems than he has.
- People don't listen to him, and everybody scolds him.
- He is afraid to make mistakes and feels stupid at school.
- He forgets important things, for instance where he puts things.
- He gets tummy aches, everybody teases him, he finds it difficult to do things right.

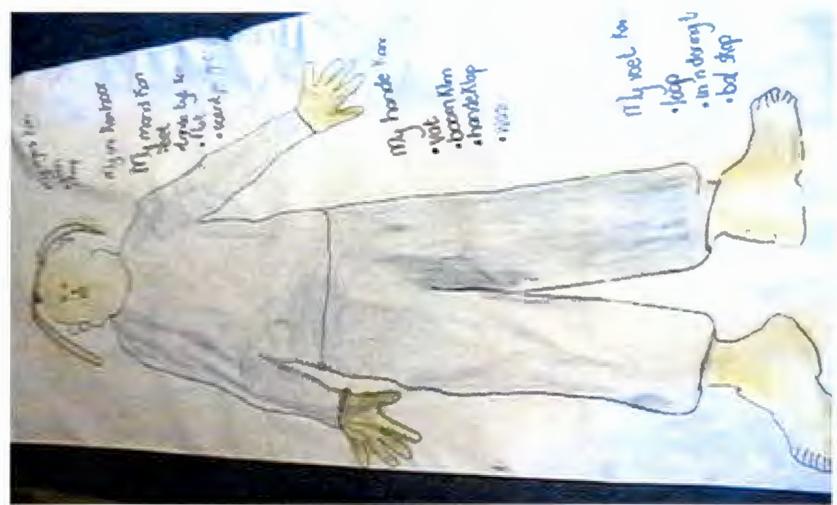
The respondent experienced problems in his relationship structures, had a low self-esteem, felt helpless, disliked himself and was frustrated (PFI did show high levels of frustration, helplessness and low self-esteem, figure 6.3). Responses made by the respondent during the therapeutic session, confirmed feelings of ambivalence towards his school environment. He stated that he likes and dislikes school, he is afraid of his teacher, she scolds him and he thinks she dislikes him and he gets cross easily.

This respondent experienced characteristic feelings of children with learning disabilities. He needed support and guidance to discover the hidden treasures of his own special self to enable him to boost his self-image. Intervention by the social worker, to teach him stress reduction skills, is needed to help him control his emotional world. She has a role to fulfil in leading him to become in control of his life-world. By focusing on a positive self-image, and coping tools for building healthy relationship structures, she should guide him to take control of his life-world and accept his differences and reassure him of his normality.

6.6.7.2.2 Session 1- Bibliotherapy and making the body image

Bibliotherapy followed the questionnaire. The book about a trip across the human body was read, in order that he could identify with the main character, and imitate the behaviour of that little boy in the story. In the beginning the respondent participated half-heartedly, eventually he participated spontaneously, and enjoyed the experience. The drawing of his body image, figure 6.29, followed and the respondent filled in his facial features. While doing this he and the researcher talked about the functions of the various body parts, and what his body parts can do.

Figure 6.29 Body image



The respondent experienced his own body with amazement. He took ownership of his body parts when he said emphatically "I didn't know that I was this big already". This was a positive turning point. He then learned the song about being special, but he did not like singing and he was afraid to sing. He responded that he would sing softly "in my head!"

The objectives and outcome of this session can be seen as follows:

Table 6.20 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of his own body, becoming aware of the differences of his own body and other persons bodies, the child is building his self-image. • The child experiences his own body and becomes aware of his uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was positive. The respondent had fun in doing the body image. His whole non-verbal communication was one of utter disbelief when the body image was lifted up and he realized how big he is.

Reaffirming of self-image and self awareness The researcher involved his mother in the therapeutic process and asked her to make a big fuss about this body image for the next week.	Reaffirming of self-image and self awareness Feedback from his teacher was very positive. He was more aware of things happening around him.

6.6.7.2.3 Session two: Developing insight into feelings

This session was followed by session two. As in the previous cases, this respondent did not realize the difference of the intensity of his feelings, and how feelings influence the behaviour. He still had to learn to take control of his feelings so that he could act positively in a socially acceptable way.

The materials used were a set of feeling cards containing a feeling word and matching facial expression. As in the pilot study, the main objectives of these games were to let the respondent experience the role of feelings in a person's life and how they can influence behaviour. After the card games the respondent was asked to draw a picture of his teacher. At first he did not want to draw her. He felt comfortable enough to do so when he was told that he is allowed to draw her as a stickman figure.

He experienced that his teacher disliked him; he likes her but is afraid of her and did not want to be in her class the following year. After this he did a story in the sand tray. The themes of his story were aggression, angry people and animals chasing each other, people being scared. He identified himself with a lion that fought a lot, and win. The name of his story was "Town", and he called it after his hometown "Stella". This was a reflection of how he experienced his life-world.

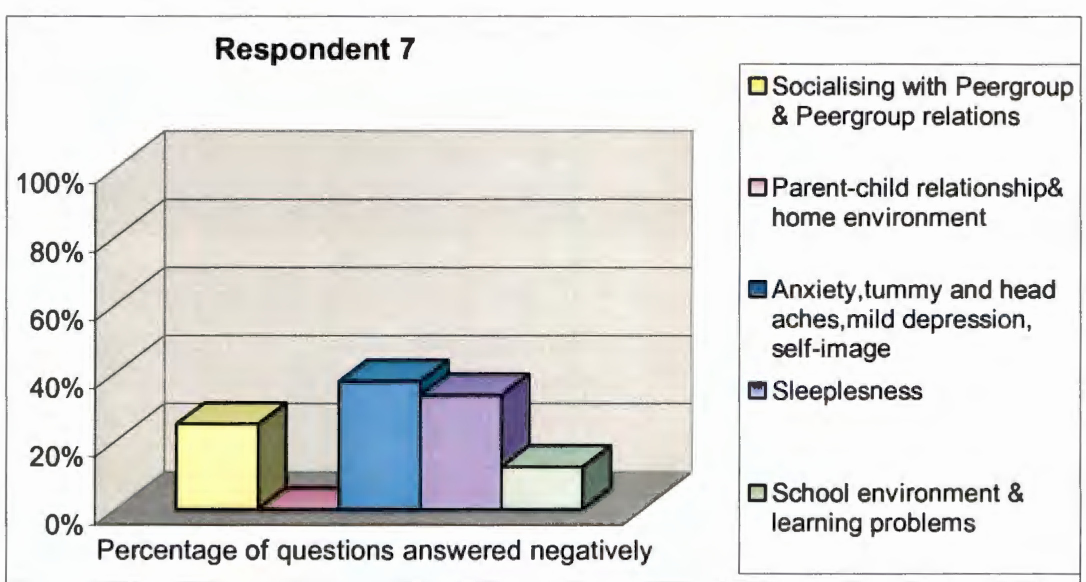
6.6.7.2.4 Session three: Taking control of my own behaviour

The second questionnaire was completed and showed the improvement made, after the two sessions. Figure 6.30 shows the results of the questionnaire.

6.6.7.2.4 Session three: Taking control of my own behaviour

The second questionnaire was completed and showed the improvement made, after the two sessions. Figure 6.30 shows the results of the questionnaire.

Figure 6.30 Respondent seven: Results of questionnaire two.



Compared to the PFI results, this was a remarkable improvement. The four areas out of the five tested, showed low percentages, and are evenly sized except for anxiety that needed further attention.

In the third session the researcher again focused on feelings and relationship structures. The Smile educational game on social skills was played. The researcher used the examples of the game to make the respondent aware of life situations and how he may react in a positive way.

Although a slight positive change was observed according to his teacher, after session one, the researcher felt that this respondent would benefit from at least eight more non-directive therapy sessions so that he can work through his aggression, be more spontaneous, and focus on relationships with his teacher and peer group.

This case illustrates that some children do need more than three therapy sessions, while respondent four in the previous case study coped fine after three sessions together with teacher support.

6.6.8 Case study eight

6.6.8.1 Background information

The child, respondent eight, is nine years old, and the eldest of three children. She is a slow learner, has gross-motor and visual problems, and is becoming a day-dreamer. All of these are negatively influencing her school performance. She was part of the big group of 20 children and was selected by her teacher, as she was concerned about her school performance.

The researcher asked the teacher, as with the other respondents, to start working on the self-image in the class situation. She was emotionally overwhelmed, felt helpless in the class situation and where she used to be a child who could not stop talking, now withdraws as a means of protecting her self from failure.

She was positively tested as a child with learning disabilities. The mother was concerned about the respondent's school situation, especially because she was in boarding school. The mother tried to come and visit her twice during the school week and assisted with her homework where possible. The researcher decided to let the teacher play an important role in the child's daily life at school and that the parents continue over weekends.

The problems she experienced are tabled in table 6.21.

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Table 6.21 Problems experienced in the school environment by the respondent.

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Excessive need for assistance and reassurance. • Lack of self-confidence. • Easily distracted by irrelevant and inappropriate stimuli. • Constantly losing things. • Poor memory.	• Very talkative in stressful situations, and talks out of turn. • Anxious. • Daydreaming and avoiding tasks.	• Withdraws and becomes a loner. • Feels responsible for well being of others.

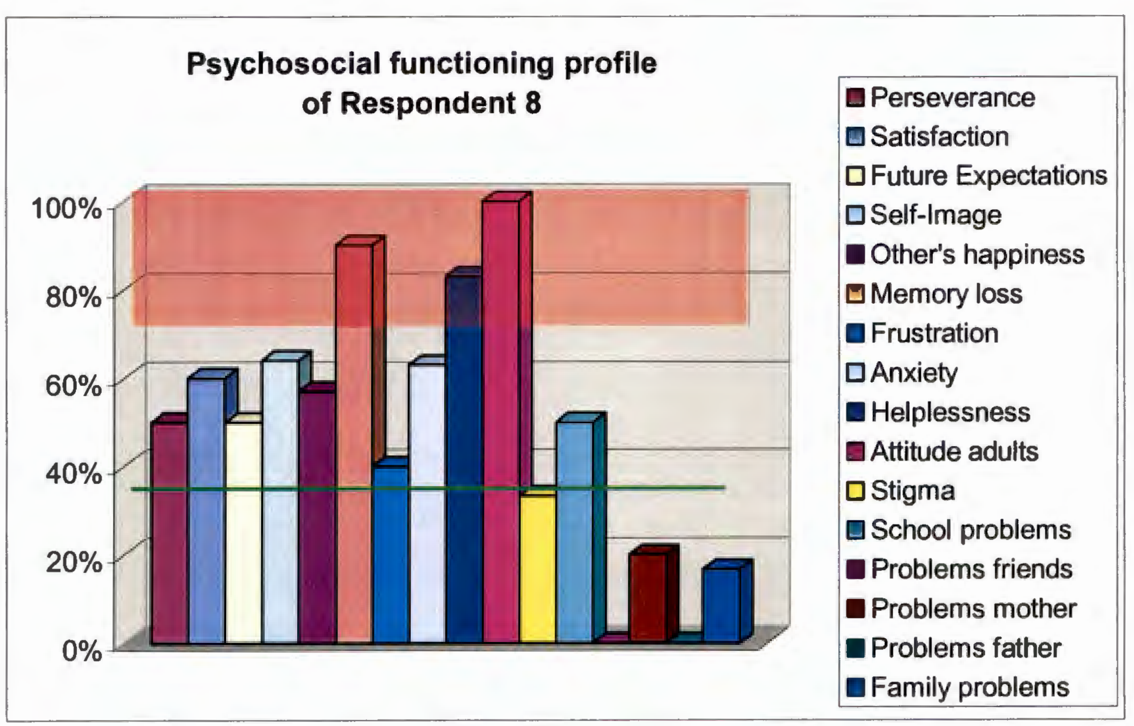
6.6.8.2 Structured play therapy sessions

Three structured play therapy sessions were done with the respondent. Important information was gathered through the sessions. Firstly a PFI-PRIM-C questionnaire was completed and the respondent had to draw a picture of herself. This was done so that the researcher and respondent could get better acquainted after which the therapeutic intervention followed.

6.6.8.2.1 Findings of the PFI-Prim-C

Figure 6.31 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent eight. It indicates that the respondent has problems in the following areas:

Figure 6.31 Psychosocial functioning profile of Respondent 8



On eleven of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicates that the respondent has problems in the following areas:

Attitude adults	100%	Other's happiness	57%
Memory loss	90%	Perseverance	50%
Helplessness	83%	Future Expectations	50%
Self-Image	64%	School problems	50%
Anxiety	63%	Frustration	40%
Satisfaction	60%		

Three of these subscale scores, attitude towards adults, memory loss, and help-lessness exceed the upper-level cutting score of 75%. This indicates that the child has a major problem in these areas.

The following five subscales indicate no problems in the area being measured.

Stigma	33%	Problems father	0%
Problems mother	20%	Problems friends	0%
Family problems	17%		

The following questions were of concern and importance for the purpose of this study:

- She feels different from other children; they have fewer problems than she has.
- People don't listen to her and adults are lying to her.
- She forgets important things, for instance where she puts things, and small tasks to do.
- She cries easily and often feels sad.
- She struggles to do things correctly.
- She feels responsible for others happiness.

The child experienced feelings of helplessness and was frustrated. Relevant responses made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- She enjoyed school, but didn't like to struggle.
- She wants to become a pop star one-day, because you do not have to be able to do well in your schoolwork, and she can sing nicely.
- She feels that the friends at school do not like her therefore she plays alone with herself.

Children with learning disabilities may experience feelings of failure negatively, which can influence the self-image. This was true of the respondent who experienced feelings of failure negatively, which destroyed her feelings of self-worth and caused her to experience a low self-image. This is characteristic of children with learning disabilities. Intervention by a social worker is needed, to support this child and help her to feel better about herself, and conquer feelings of failure and to teach her to be in control of herself and her life-world.

By focusing on building her self-image, giving her tools to cope with relationship structures, the researcher is helping her to take control of her life-world and accept her differences.

6.6.8.2.2 Session 1- Bibliotherapy and making the body image

As in the pilot study, the questionnaire was followed by bibliotherapy. She participated very eagerly in all the actions. The drawing of a body picture followed and the respondent had to fill in her facial features. The respondent experienced her own body with admiration. She accepted her difference in a positive manner. Responses such as "I didn't realize I am this big!" and "I am not that small anymore!" showed the positive outcome of this therapy session with this respondent.

She then learned the song about being special. She loved singing and enjoyed this part tremendously. She responded that she could sing this anytime she felt incapable of doing some thing or get scolded in class "I must just remember to sing it softly, otherwise my teacher is going to be cross!" The researcher observed up to now a definite positive growth in her self-image and coping skills. She was definitely becoming more in tact with self; she is also now taking more risks.

The objectives and outcome of this session can be seen as follows:

Table 6.22 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of her own body, becoming aware of the differences of own body and other persons bodies, the child is building her self-image. • The child experiences her own body and becomes aware of her uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. She communicated with utter disbelief when the body image was lifted up and she realized how big she really is. • She responded very positively.
Reaffirming of self-image and self awareness The researcher involved her teacher in the therapeutic process and asked her to make a big fuss about the body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from her teacher was very positive. She eagerly participated in the classroom. Her withdrawing behaviour was also lesser.

6.6.8.2.3 Session two: Developing insight into feelings

The respondent was more in touch with her feelings. She demonstrated her feeling of helplessness very realistically. This was also reflected in the PFI-Prim-C scale where she had an 83% for helplessness. She still had to learn to control her feelings and that she must react in a socially acceptable way. Crying for instance, if her teacher scolds her will not solve the problem. She must address the problem, for instance: ask herself, what did she do so that she got scolded. She talked to her friend while the teacher was busy demonstrating something on the blackboard. Then she must take action: next time when she feels the urge to talk in class, she must remember the bad feeling she experienced when her teacher scolded her, and rather stay quiet until brake.

The materials used, were a set of feeling cards containing a feeling word and matching facial expression. Snap was played with these cards. Discussions on feelings experienced similar to the snap-cards were discussed. Playing "Fish" combined with the "How would you feel like?" game followed. She enjoyed this extremely. The respondent initiated situations, for instance the teacher misunderstanding her. The researcher used the situation to help her gain skills in handling these situations. The main objective of these games was to let the respondent experience the role of feelings in a person's life and how these feelings can influence one's behaviour.

6.6.8.2.4 Session three: Taking control of my own behaviour

The next session was the third and last session with this respondent. The session started with completing a questionnaire, which showed the improvement made in the past two weeks after the two direct therapy sessions, figure 6.32.

Figure 6.32 Respondent eight: Results of questionnaire two

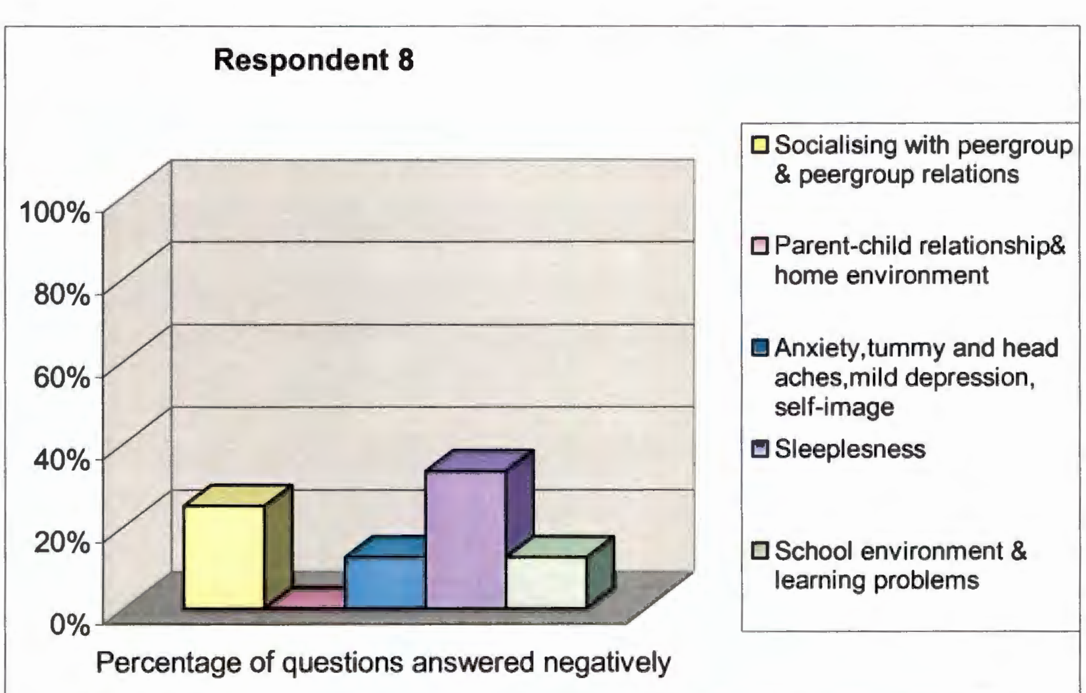


Figure 6.32 indicates a definite drop in the anxiety level of the respondent, if compared to the first questionnaire. This indicates that the therapy definitely had a

positive effect. Her teacher also reported a positive growth in her class behaviour. She withdraws less and reacted much more positive in the classroom. It is as if she again has energy to take on new situations. The researcher asked the teacher to continue building the self-image and focus on the positive behaviour.

The respondent then participated in the making of a robot, (same as pilot study). The aim was to help the respondent gain more assertiveness. This was important to lead the child to feel capable in handling the classroom situation. In the first questionnaire PFI-Prim-C she had a 100% for attitude towards adults, which happened to be her fear for teachers. The researcher showed her how to take control of feelings that may influence her negatively. These feelings originate from other peoples statements and reactions aimed at her. The choice of giving cloud or window answers was well demonstrated. She responded positive.

She initiated situations with the peer group, which bothered her for instance: "If the children say I cannot play with them, what must I do?" We first made broken window reactions, for example, start to cry and say," I don't want to play with you, you are really bad." This reaction will only let her feel bad and they will laugh at her. A cloud reaction would be the better and the researcher prompted her to say: " It's OK if you do not want me to play with you, will you let me know if you change your mind. Your game looks like lots of fun, would you mind if I just sit and watch you playing!" Depending on their answers we tried out a few alternative options. If they responded negative she could politely answer, "That's fine with me, enjoy your game." and just turn around and go find something else to do. This reaction will not give the other children any satisfaction as her crying (broken window) reaction would. Maybe in time they will change their attitude and let her play along.

The last session ended positive. The respondent was very spontaneous, self-assured and her opinion of school, and coping with her peer group changed to a positive experience. This respondent coped very well. The teacher and parents carried on playing a very important role in helping the respondent grow emotionally. They continued giving frequent feedback and asking help in assisting this child.

The important role of the social worker helping the child through a supportive and well-advised teacher and parent team was well demonstrated.

6.6.9 Case study nine

6.6.9.1 Background information

The child, respondent nine, is seven years old, and the eldest of two children. His teacher referred him to the researcher because of very disruptive behaviour in class. He was the clown in the class and was easily distracted. His teacher was concerned about his school performance. The researcher asked the teacher to start working on the self-image in the class situation, by focussing only on his positive behaviour. He did have some problems on the gross-motor development level and visual perceptual problems that influenced his schoolwork negative.

He was positively tested as a child with a learning disability, but was also hyperactive (ADHD). The mother was really concerned about the respondent's school situation, and saw the teacher frequently to assure her child's school development. The researcher decided to let the teacher play an important role in the child's daily life at school, because he was in boarding school. She had to focus on the child's talents and strengths. He must be assured that the fact that he has learning disabilities does not mean that he is dumb or lazy. The problems he experienced are tabled in table 6.23.

Table 6.23 Problems experienced by respondent

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Excessive need for assistance and reassurance • Lack of self-confidence • Easily distracted by irrelevant and inappropriate stimuli • Can not stay with one activity	• Very talkative in stressful situations • Avoid tasks • Very disorganized • Excessive silliness • Can not sit still	• Socially off-base, unaccepted by group • Feels responsible for well being of others • Harassing other children

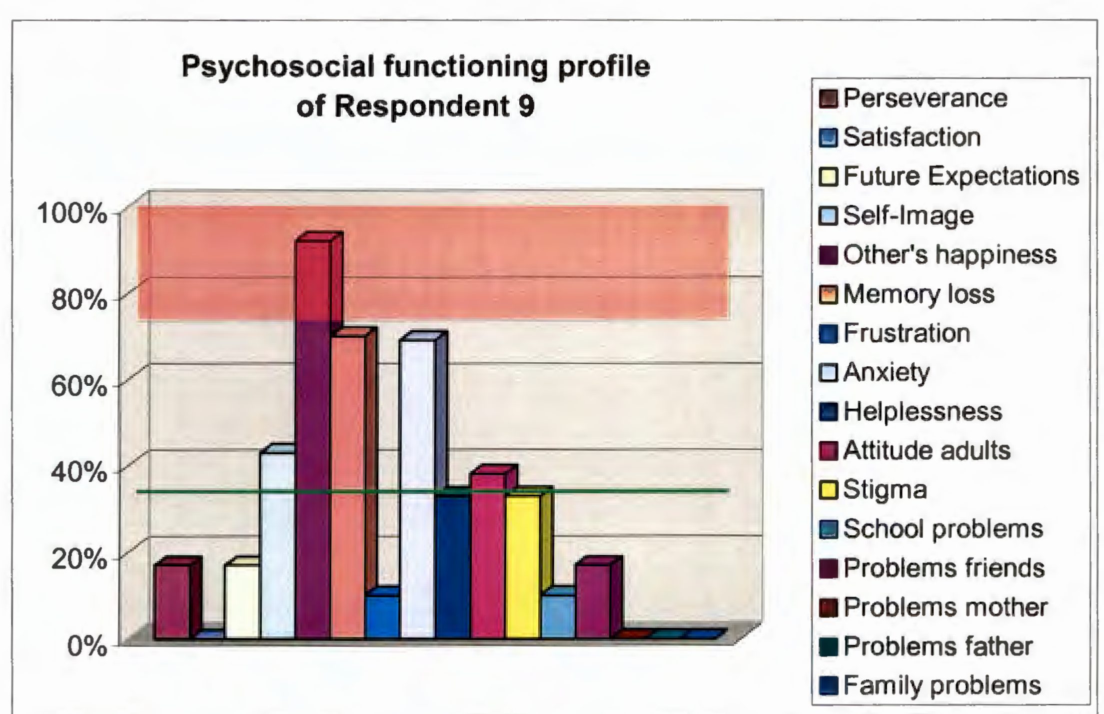
6.6.9.2 Structured play therapy sessions

Three structured play therapy sessions were done with the respondent. Important information was gathered through the sessions. Session one started by completing the PFI-PRIM-C questionnaire, after which therapeutic intervention followed.

6.6.9.2.1 Findings of the PFI-Prim-C

Figure 6.33 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent one. The graphic profile reveals that the respondent has major problems in several areas of personal and sociable functioning.

Figure 6.33 Psychosocial functioning profile of Respondent 9



It indicates the following problem areas:

Other's happiness	92%	Self-Image	43%
Memory loss	70%	Attitude adults	38%
Anxiety	69%		

On five of the subscales the respondent's scores exceed the upper limit of the cutting score range, indicating a clinically significant problem in the area being measured. It indicates that the respondent has problems in these areas. One of these subscales, others happiness, score even exceeds the upper-level cutting score of 75%. Memory loss, 70%, and anxiety, 69%, also indicate a major problem.

According to figure, 6.33, respondent nine has a major problem in the area of other's happiness, 92%. This is true of the respondent when you look at the fact that he struggles to keep friends. He is trying hard to keep others happy just to be accepted. His anxiety level is also high (69%) and this fits in with him saying 'I am afraid that I will do things that will make others not like me any more...it works on my nerves."

He also shows 70% in memory loss. This coincides with the fact that he is hyperactive. He is always on the go and cannot stick to one thing for a long time. He forgets where he has put things down for it is not important to him.

The following eleven subscales show no problems:

Stigma	33%	Frustration	10%
Helplessness	33%	Satisfaction	0%
Future Expectations	17%	Problems mother	0%
Problems friends	17%	Problems father	0%
Perseverance	17%	Family problems	0%
School problems	10%		

The following questions were of concern and importance for the purpose of this study:

- He is afraid things will go wrong, and is not allowed to make mistakes.
- He never does things right and is unimportant.
- He feels that people do not listen to him.

- He cracks jokes to make others happy and feels responsible for the happiness of others.
- He wishes that he were like other kids.
- He sometimes hates his friends and whish that they could understand him.

The literature study showed that children with learning disabilities might experience feelings of failure negatively, which can influence the self-image. This was true of the respondent who experienced feelings of failure negatively, which destroyed his feelings of self-worth and caused him to experience a low self-image.

The researcher also showed with the literature study that intervention by a social worker is needed, to support this child and help him to feel better about himself, and conquer feelings of failure and to teach him to be in control of himself and his life-world, without feeling responsible for the happiness of other people.

The researcher now had to raise the self-image of the respondent so that he may learn to look at himself positively, by giving him tools to cope with relationship structures. The respondent, with the help of the researcher (social worker), is starting to take control of his life-world and accept his differences.

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6.6.9.2.2 Session 1- Bibliotherapy and making the body image

This questionnaire was followed by bibliotherapy. The respondent participated very eagerly in doing all the actions. The drawing of a body picture followed and the respondent had to fill in his facial features. The respondent experienced his own body with amazement. He responded positive with: "I knew I was big already, but I didn't realize I am this big!"

He loved singing and enjoyed learning the song about being special. The researcher had to return him to school after this session and he wanted to sing this song in the car all the way back to school. He was delighted. The objectives and outcome of this session can be seen as follows:

Table 6.24 Objectives and outcome

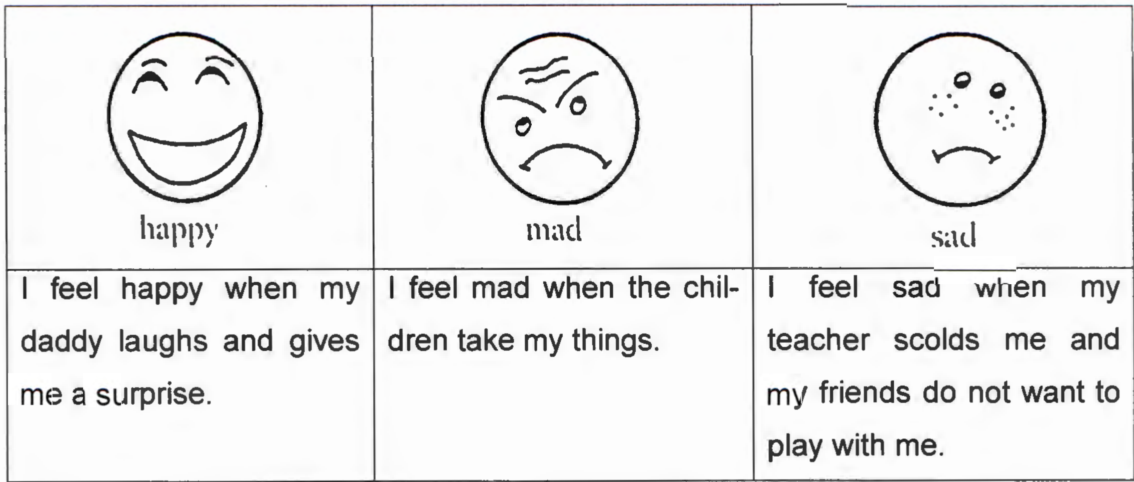
Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of his own body, becoming aware of the differences of own body and other persons bodies, the child is building his self-image. • The child experiences his own body and becomes aware of his uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. He communicated utter disbelief when the body image was lifted up.
Reaffirming of self-image and self awareness The researcher involved his teacher in the therapeutic process and asked him to make a big fuss about this body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from his teacher was very positive..

6.6.9.2.3 Session two: Developing insight into feelings

He now had to learn to take control of his feelings so that he can act accordingly in a socially acceptable way. The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap (as described in the pilot study, session two) was played with these cards. Discussions on feelings experienced similar to the snap-cards were discussed. Playing “Fish” followed this.

The researcher asked the respondent to chose three different feeling cards and say when he feels that way. The three feeling cards he chose, is shown in figure 6.34, as well as his responses.

Figure 6.34 Feeling cards and responses



happy	mad	sad
I feel happy when my daddy laughs and gives me a surprise.	I feel mad when the children take my things.	I feel sad when my teacher scolds me and my friends do not want to play with me.

The main objective of these games was to let the respondent experience the role of feelings in a person's life and how these feelings can influence one's behaviour.

6.6.9.2.4 Session three: Taking control of my own behaviour

The next session was the third and last session with this respondent. The session started with the completion of a questionnaire, which showed the improvement made in the past two weeks after the two direct therapy sessions, figure 6.35.

Figure 6.35 Respondent nine: Results of questionnaire two

Respondent 9

100%
80%
60%
40%
20%
0%

Percentage of questions answered negatively

Socialising with peergroup & peergroup relations
Parent-child relationship& home environment
Anxiety,tummy and head aches,mild depression, self-image
Sleeplesness
School environment & learning problems

Socialising is now his biggest problem.

The respondent then participated in the making of a robot, (same as pilot study). The Smile board game on social skills followed. The last session ended positively. The respondent was very spontaneous, self-assured and his opinion of school, changed to a positive experience.

This respondent coped very well. The teacher played a very important role in helping the respondent grow emotionally. Frequent feedback from the teacher was essential in assisting this child. The important role of the social worker helping the child through a supportive and well-advised teacher was well demonstrated.

6.6.10 Case study ten

6.6.10.1 Background information

The child, respondent ten, is six years old, the only child. His father is a pensioner and his mother 20 years his fathers junior. His father has a speech problem, similar to that of the respondent. The respondent was not part of the group of 20 children. He was selected for purpose of this study after consulting with his teacher. She requested therapy; because he was not attending school at that time the group did the questionnaire, and felt that he had to be one of the ten respondents.

The child was tested for learning problems. He had a developmental speech and language disorder. He experienced problems with his gross motor, visual- and auditory perceptual skills. These problems influenced his school performance negatively. His teacher was concerned about him as he became very aggressive and frustrated with his teacher and/or peer group, when he was misunderstood. He started with speech therapy along side the play therapy. The emotional, behavioural and relationship problems he experienced are tabled as follows:

Table 6.25 Problems experienced by respondent ten

Emotional problems	Behavioural problems	Relationship problems
School situation	**School situation**	**School situation**
• Very impulsive. • Easily distracted by irrelevant and inappropriate stimuli. • Excessive need for assistance and reassurance,	• Aggressive behaviour towards teacher and peer group if understood incorrectly. • Fighting/quarrelling. • Low frustration tolerance. • Very anxious.	• Poor peer group relations.

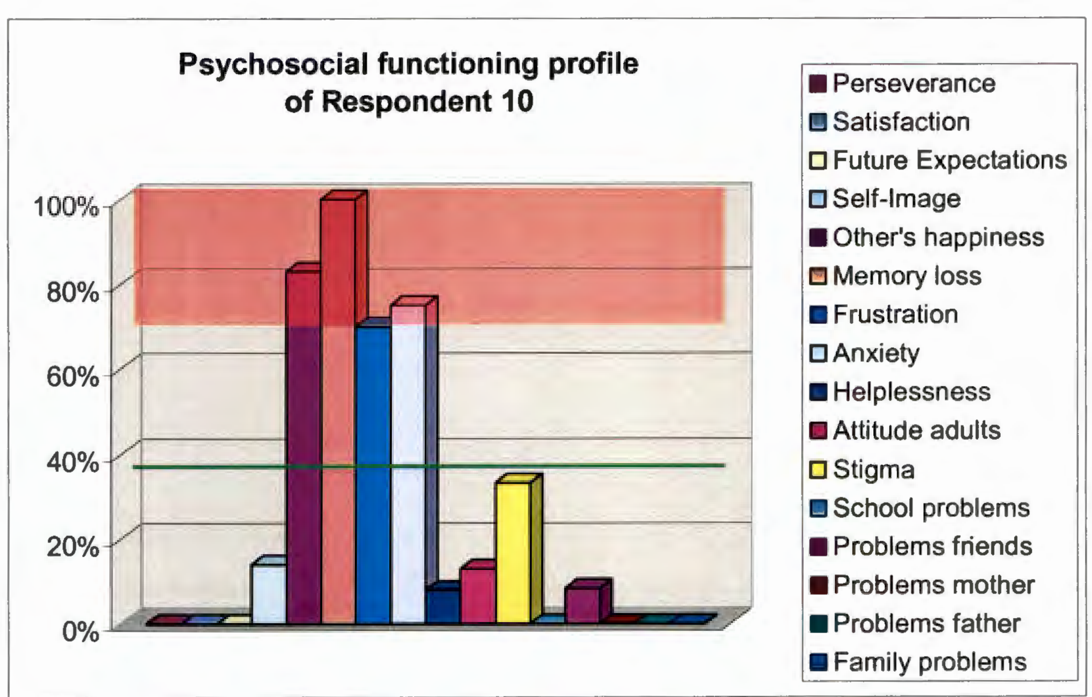
6.6.10.2 Structured therapy

Three structured therapy sessions were done, for purpose of research. Session one started by completing the PFI-PRIM-C, after which therapeutic intervention followed.

6.6.10.2.1 Findings of the PFI-Prim-C

Figure 6.36 is a graphic presentation of the PFI-Prim-C questionnaire. The bar chart presents the psychosocial functioning profile of respondent ten. The graphic profile reveals that the respondent has major problems in several areas of personal and social functioning.

Figure 6.36 Psychosocial functioning profile of Respondent 10



The bar chart presents the psychosocial functioning profile of respondent ten. It indicates that respondent ten has problems in the following areas:

Memory loss	100%	Anxiety	75%
Other's happiness	83%	Frustration	70%

On three of the subscales the respondent's scores exceed the upper limit of the cutting score range, 75%, indicating a clinically significant problem in the areas being measured.

The following eleven subscales indicate no problems in the areas being measured.

Subscale	Score	Subscale	Score
Self-Image	14%	Future Expectations	0%
Attitude adults	13%	School problems	0%
Problems friends	8%	Problems mother	0%
Helplessness	8%	Problems father	0%
Perseverance	0%	Family problems	0%
Satisfaction	0%		

Questions that were of concern and importance for the purpose of this study were:

- He feels sad when others are angry with him, and feels responsible for others happiness.
- He forgets important things, for instance where he puts things, and small tasks to do.
- He easily becomes angry and says ugly things to, or hits, bites or kicks his friends when they make him angry.
- He is afraid to make mistakes and feels like running away from things that scares him.

Relevant responses made by the respondent during the therapeutic session, which correlated with the information gathered from the questionnaire, were the following:

- He responded: "I hit the children if they do not hear me, they keep on saying what do you say and it makes me so cross",
- He responded that he becomes very scared sometimes, his house has a ghost when the wind blows that scares him, but his dad is there to help. (His parents form his security system and they really support him emotionally).

Children with learning disabilities may experience feelings of failure negatively, which can influence the self-image. This was not true of the respondent at this

stage. He started experiencing failure in school, but because of the positive support from his parents, he was able to cope with the situation. He said that he loved school, but "my teacher is a bit stupid because she cannot understand me always".

Therapy was necessary to assure that his self-image can be maintained positively in spite of the school failure he was beginning to experience daily, because of the work becoming difficult. He was a slow learner and struggled to stay with the group.

Intervention by a social worker is needed, to support this child and help him feel in control of himself and his life-world. He must be taught the necessary skills so that he can handle the "teasing" of others without hitting or kicking them. By reassuring a positive self-image he will remember to look at himself positively. The researcher (social worker) is helping him to take control of his life-world and accept his differences.

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6.6.10.2.2 Session 1- Bibliotherapy and making the body image

As in the pilot study, the questionnaire was followed by bibliotherapy. He participated very eagerly in all the actions. The drawing of a body picture followed and the respondent had to fill in his facial features. The respondent experienced his own body with admiration. Responses such as "Big...me big...me really big!" was said in utter amazement. The researcher had to drop him at school after this session. It was amazing to see the impact of this session on him. He commanded five of his classmates to help him carry his body image and they were running through the playground shouting, "look how big I am!!" This was the beginning of a positive outcome in therapy with this respondent. The objectives and outcome of this session can be seen as follows:

Table 6.26 Objectives and outcome

Objectives	Outcome of this session and responses of respondent
Building self-image and awareness of self • Through exploring the different parts of the body, the actual size of his own body, becoming aware of the differences of his own body and other persons bodies, the child is building his self-image. • He experienced his own body and becomes aware of his uniqueness. • Learning a song about being special, easy to remember, can be sung or thought of any time. This helps to accentuate the idea of being some one worthwhile and special.	**Building self-image and awareness of self** • Outcome of session was very positive. The respondent really had fun in doing the body image. He communicated utter disbelieve when the body image was lifted up and he realized how big he really is. His reaction at the playground commanding his schoolmates to help him show of his body image shows the impact of this session.
Reaffirming of self-image and self awareness The researcher involved his teacher in the therapeutic process and asked him to make a big fuss about this body image for the next week.	**Reaffirming of self-image and self awareness** Feedback from her teacher was very positive. He eagerly participated in the classroom.

6.6.10.2.3 Session two: Developing insight into feelings

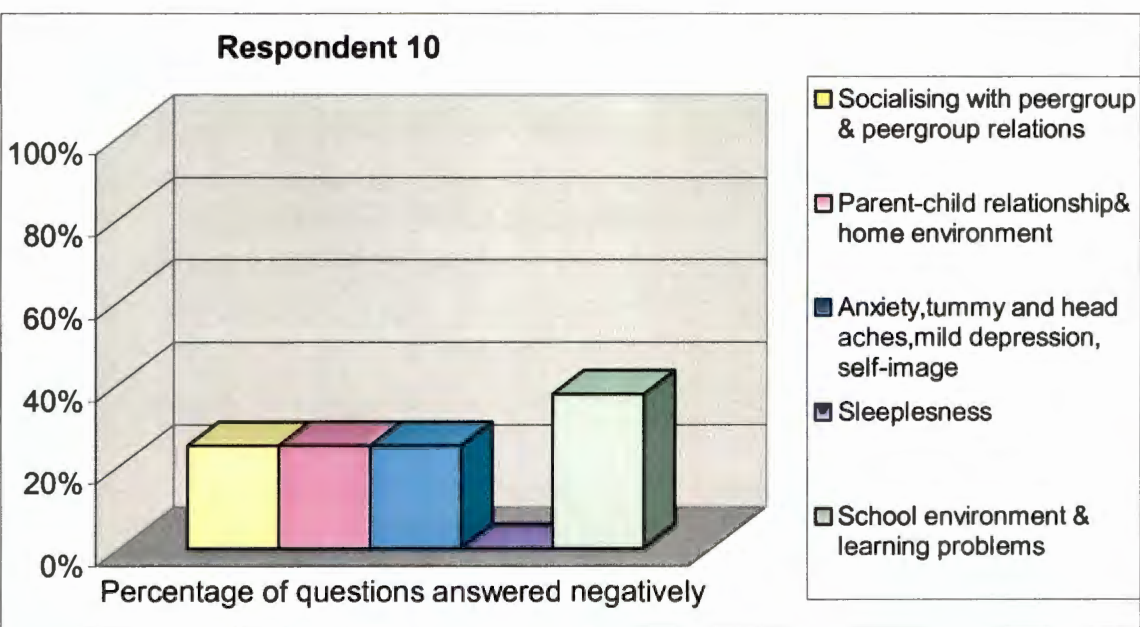
He still had to learn to take control of his feelings so that he could act accordingly in a socially acceptable way. The materials used were a set of feeling cards containing a feeling word and matching facial expression. Snap (as described in the pilot study, session two) was played with these cards. Discussions on feelings experienced similar to the snap-cards were discussed. This was followed by the "How would you feel like?" game. Questions were asked for instance how would you feel if you can read a whole book all by yourself and then the respondent had to present a feeling card that matches the feeling. The respondent acted accordingly and spontaneously acted out some life situations.

The main objective of these games was to let the respondent experience the role of feelings in a person's life and how these feelings can influence one's behaviour.

6.6.10.2.4 Session three: Taking control of my own behaviour

The next session was the third and last session with this respondent. The session started with the completion of a questionnaire, which showed the improvement made in the past two weeks after the two direct therapy sessions, figure 6.37.

Figure 6.37 Respondent ten: Results of questionnaire two



The most questions answered negatively were those related to the school environment. Interesting is that socializing, parent-child relationship and anxiety are similar.

The respondent then participated in the making of a robot, (same as pilot study). The Smile board game on social skills followed. The last session ended positive. The respondent was very spontaneous, self-assured.

This respondent coped very well. The teacher played a very important role in helping the respondent grow emotionally. Frequent feedback from the teacher was essential in assisting this child. The important role of the social worker helping the

child, with a positive parent support, through a supportive and well-advised teacher was well demonstrated.

To conclude:

Taking the above case studies in account, Thompson (1997:2) is correct in stating that the frustrations and anxieties children with learning disabilities experience are beyond the comprehension of people who learn and get along with others satisfactorily.

The most devastating result for these children is the gradual deterioration of their self-esteem. Everything should be done to help these children maintain a healthy self-esteem. The common side effects of having a learning disability may include:

- distractibility,
- impulsiveness,
- mood changes,
- inconsistencies,
- work-avoidance behaviour,
- attention-seeking behaviours, and
- poor social skills.

These behaviours often develop to mask the academic problems that children with learning disabilities face on a daily basis. The social worker provides the therapeutic space where the feelings of the child can be borne and thought about. She can guide the child through play therapy to discover who he really is and maintain a sense of his own unique identity in relation to peers and significant other. The social worker can guide teachers and parents to focus on stabilizing the child's life. The social worker together with the supportive assistance from the teachers and parents can help these children to be truly successful in an inclusive educational environment.

CHAPTER SEVEN

7 CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

The purpose of this chapter is to compile conclusions and recommendations based on the knowledge, experiences and information gained from the data reflected in the previous chapters. The objectives set at the beginning of the study were to:

1. Determine the role of the social worker in dealing with the child with a learning disability, who is experiencing social, emotional and behavioural problems in an inclusive school situation, seen from the focus of Curriculum 2005.
2. Determine how play therapy as a therapeutic aid can help the child cope at all levels of his existence when interacting with other individuals, situations and the environment.

The researcher decided on a specific research design to accomplish these objectives. The choice of design was the Case study design in combination with the descriptive design where the research done was based on a theoretical dimension. The literature study for this reason had to focus on all the crucial elements of the objectives namely:

- Curriculum 2005 and inclusion/inclusive school environment.
- The child with a learning disability.
- Play therapy.
- Social work.

This was a very important step in the whole study, because the literature survey formed the basis from which the researcher did the practical research. This chapter

will now indicate if this study has met the objectives. Conclusions have been made through out the study and will be referred to.

7.2 Conclusions made from the literature survey

The researcher began this study by reviewing the available literature central to this study. She determined by means of a literature survey how the educational environment where inclusion is practised, will affect the child with learning disabilities. The researcher came to the following conclusions based on the information gathered in connection with the child with a learning disability in an inclusive school environment:

7.2.1 Conclusions made concerning the child with a learning disability in an inclusive school environment

- A new and exiting educational philosophy has emerged as a result of Curriculum 2005. From the literature survey (chapter 3, par. 3.2) the researcher came to the conclusion that the integration of the child with a learning disability into the regular classroom setting ensures and promotes the acceptance of differences in people and removes an attitude of stigmatisation. This study focused on the child with a learning disability, seen from the focus of Curriculum 2005. This focus demanded that the school environment had a bigger role to play because of inclusion. The child with a learning disability is included in the normal school grades, and must be helped with-in this system. Teachers have a more important role to play than in previous educational structures, in helping these children develop optimal.

- A benefit of co-operative learning is to provide students with learning disabilities, burdened with social interaction difficulties, an instructional arrangement that fosters the application and practice of learning skills within a natural setting. Based on the literature study, Curriculum 2005 opens the door for teachers to make use of professionals outside the educational environment to participate in helping children to develop to their utmost potentials. The researcher came to the conclusion that the social worker as a professional too, can play a definite

role in this regard. The social worker possesses the specific foundations skills to help the child with a learning disability to develop self-esteem, peer group relations, and social skills. The literature survey, chapter 5, par. 5.3 underlines this conclusion.

- Out of the information gathered the researcher revealed that the social worker who renders services in the educational environment, can fulfil the role of an enabling agent when dealing with the teacher, the principle, the learner (child with a learning disability), and to the parents. She can contribute to the solution of problems, which interfere directly, or indirectly with the child's school performance.

- The social worker can work with the team, consisting of the teacher and parent, to bring about the maximum social and educational benefits in the child with a learning disability. The researcher believes that the integration of the child with a learning disability into the regular classroom setting ensures and promotes the acceptance of differences in people and removes an attitude of stigmatisation. This in turn could only lead to an emotionally healthier community.

- Integration and inclusion of children with a learning disability are more in accordance with modern international trends.

- The social worker has a definite role to play in guiding the child with a learning disability to be a self-fulfilled human being.

7.2.2 Conclusions made concerning the child with a learning disability

The researcher used the information gathered in the literature study to come to the following conclusions:

- Efforts to find a suitable name for the conditions of learning disabilities have been as many and as various as the opinions on the symptoms that should be

included in it. The term "learning disabilities" is a generic term that refers to a heterogeneous group of disorders

- Learning disabilities are neurological in origin. The term learning disability does not include a learning problem, which is primarily the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or of environmental, cultural, or economic disadvantage.

- Learning disabilities can be lifelong conditions that may affect many parts of a person's life, his school or work, his daily routines, his family life, his relationships with friends or strangers and various other facets of his life.

- Learning disabilities are disorders that affect people's ability to either interpret what they see and hear, or to interpret information from various parts of the brain. Learning disabilities can affect a person's ability to speak, listen, read, write, spell, reason, recall, organise information, and do mathematics.

- A learning disability can't be cured or fixed; it is a lifelong issue. However, with the right support and intervention, children with learning disabilities can succeed in school and go on to have successful, often distinguished careers later in life. The researcher believes that these children need specialised instructions in a safe life-world where they can feel loved and especially unique in order to permit their full potential.

- Related problems of learning disabilities are emotional-, behavioural- and low-self esteem problems. Children, who continuously meet with failure, are more apt to anticipate unpleasant outcomes. In dealing with these uncomfortable feelings, they tend to behave in less socially acceptable ways. These children usually have difficulty in their relationship structures.

7.2.3 Conclusions made concerning play therapy

The researcher used the literature study to come to the following conclusions:

- Play is the child's natural medium of communication.
- The development of play in child therapy was an unavoidable process through which a platform was created for the child to be approached by a therapist. The techniques of play therapy evolved because the child cannot express himself adequately on a verbal level and play seems to help the child to verbalise his feelings.

- Therapeutic play behaviour enables the child to reveal his emotions, wishes, attitudes and fantasies. It also releases socially unacceptable impulses and aggressive behaviour without fear of being censured or punished.

- Children develop mentally, physically and socially through play. Children master important skills and learn facts about relationships through play. They learn to create their own life space and learn about themselves and their relationships with others

- Game play therapy can be seen as a therapeutic method that helps relieve the emotional distress of children.

- The therapist can integrate her given theoretical orientation together with the therapeutic game materials in order to help the child move systematically towards mental health.

7.2.4 Conclusions made concerning social work, play therapy and learning disabilities

Through means of a literature study the researcher has up to this point shown that the social worker has a definite role to play in the life world of the child with a learning disability.

- The child with a learning problem adapting to the classroom, the teacher, peers and family, needs the assistance of a trained and skilled social worker. She

has the skills to help him, and assist his parents and teachers, so that he may develop optimally.

- The social worker is skilled to support and guide these children as well as their families in modifying their home situations, so that the learning disabled child can function as smoothly as possible within the family.

- The social worker, through the use of play therapy, can assist the teacher and parents of the child with a learning disability, in an inclusive situation, in leading him to self-fulfilment, and to seek optimal functioning.

The research done through the literature study was accompanied by the practical research done. It is therefore also necessary to show how the information gathered from the study population addresses the objectives of this study.

7.3 Conclusions made from the practical survey

7.3.1 Information on the first questionnaire

The individual case studies have been presented in chapter 6. From the information gathered, the researcher is now in a position to make conclusions from research findings that concern the whole study population. If all the PFI-Prim-C scales are combined, it accumulates in the following data:

Table 7.1 Cumulated data from PFI questionnaires

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10
Perseverance	0%	17%	0%	8%	25%	33%	0%	50%	17%	0%
Satisfaction	60%	0%	10%	0%	10%	20%	0%	60%	0%	0%
Future Expectations	33%	0%	8%	0%	25%	17%	0%	50%	17%	0%
Self-Image	29%	43%	43%	14%	57%	57%	57%	64%	43%	14%
Other's happiness	17%	100%	100%	100%	50%	92%	100%	75%	92%	83%
Memory loss	80%	90%	100%	70%	40%	60%	90%	90%	70%	100%
Frustration	60%	30%	80%	0%	60%	30%	80%	40%	10%	70%
Anxiety	44%	75%	94%	75%	56%	69%	0%	63%	69%	75%
Helplessness	50%	33%	50%	50%	83%	25%	100%	83%	33%	8%
Attitude adults	0%	0%	63%	25%	75%	13%	100%	100%	38%	13%
Stigma	33%	50%	33%	50%	100%	33%	100%	33%	33%	33%
School problems	0%	60%	0%	0%	20%	80%	60%	50%	10%	0%
Problems friends	8%	33%	33%	25%	67%	17%	17%	0%	17%	8%
Problems mother	0%	0%	0%	0%	0%	0%	0%	20%	0%	0%
Problems father	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Family problems	17%	17%	0%	8%	33%	0%	17%	17%	0%	0%

The researcher combined the more significant subscales to highlight the problem areas, namely:

self-image, memory loss, frustration, anxiety, helplessness, attitude adults, stigma, school problems and problems with friends.

Out of the research done with the respondents these areas seem to be the main problem areas. This data is illustrated by figure 7.1.

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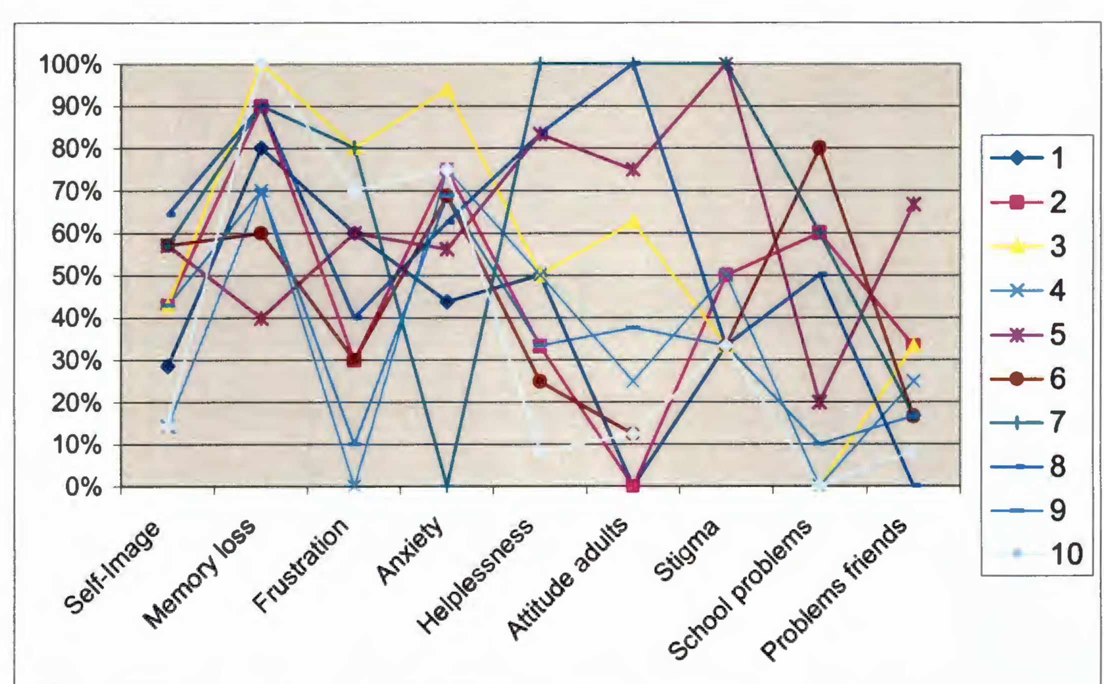
Figure 7.1 Combined data of selected sub-scales.

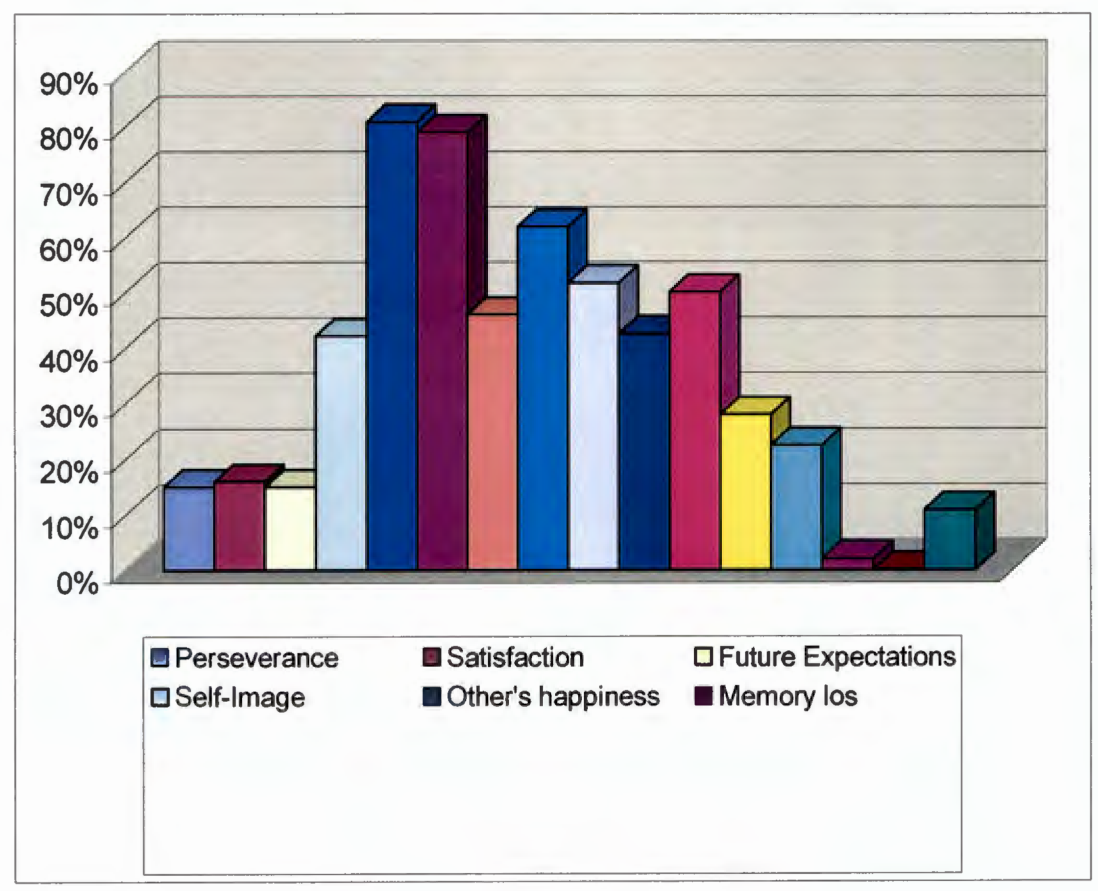


Visually it appears as if there are no causal relations between the respondents. The data appears to be scattered with a high variability and a low degree of correlation. In general, it can be attributed to the fact that every respondent reacts differently due to the influence of his or her personal environment and specific situation or problem.

There is a certain trend in anxiety and especially memory loss that needed attention. The other data were mostly scattered between the ten respondents. With the PFI it is important to remember that a problem up to 36% is "normal". The cutting score range, indicating a clinically significant problem is above 36%. Above 75% it becomes a major problem area.

If the above is taken into account, it is significant to look at the **average graph** of the study population illustrated in figure 7.2. The area below 36% is indicated in a green transparent block, and the area above 75% in a red block indicating a major problem area.

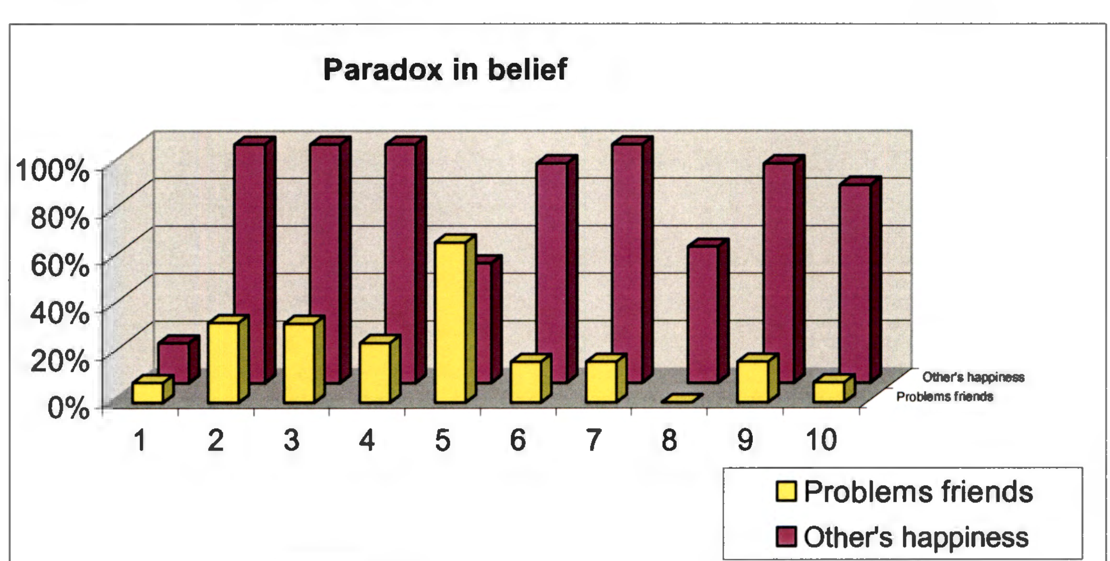
Figure 7.2 PFI-PRIM-C average of the study population



7.3.1.1 Other's happiness

If the above data is taken into consideration, the following should be mentioned. The average of the area "Other's happiness" which is the highest namely 81% is in contrast with "Problems with friends" (23%), which is indicated as no problem area. This calls for looking at the scores of the study population in these areas. Figure 7.3 shows the different respondents experience of problems with other's happiness in purple, and problem with friends in yellow.

Figure 7.3 Paradox in belief

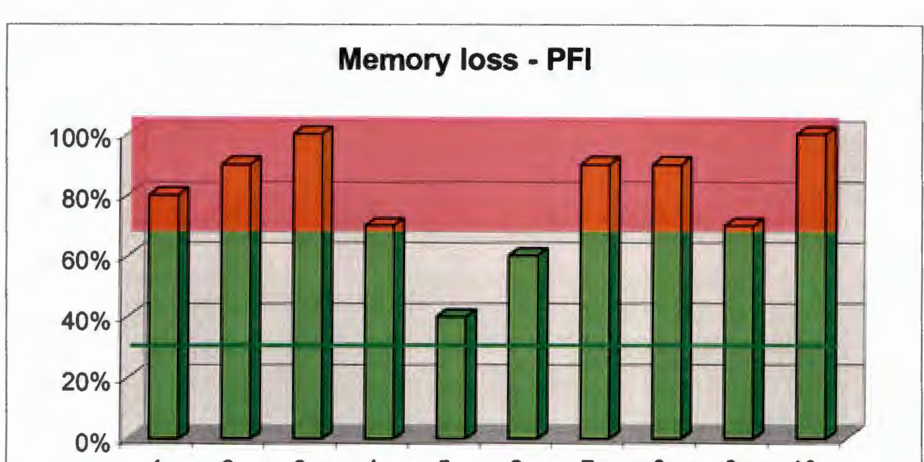


From the research it was clear that the respondents did struggle with peer group relationships. They believed that if they can keep their friends happy they will keep them as friends, bearing in mind that they believed that they do not have problems with friends This correlates with the reason for the sub-scale "Other's happiness" being so high and "Problems with friends" unrealistic low. Children with learning disabilities are unrealistic in believing that everything is fine with their peer group relations, this may be self-defensive. Another reason may be that these children have difficulty in social relationships, being less popular with their peers, parents, and teachers than their non-disabled classmates. This was also seen in the literature study chapter 6 paragraph 6.3.3.3.

7.3.1.2 Memory loss and Anxiety

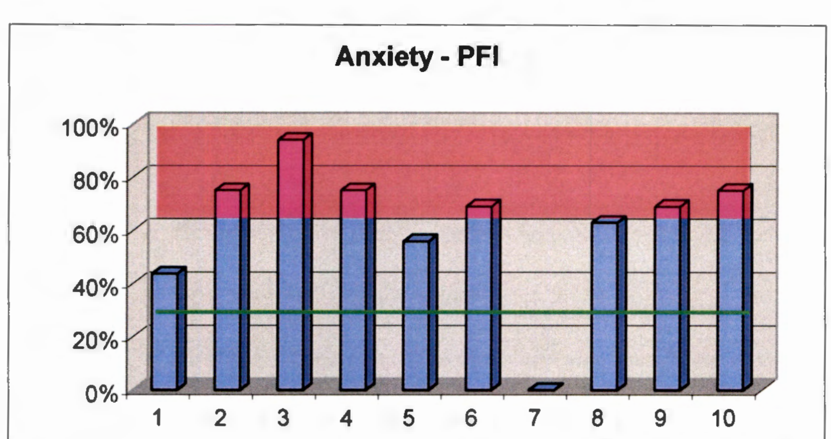
On average, the study population's second highest area of concern is memory loss as illustrated in figure 7.4.

Figure 7.4 PFI-Prim-C Memory loss subscale: study population score



All of the respondents' scores were above 30% and five were above 80%. The area above 75% indicated a major problem area. Memory loss as the second highest area correlates with the respondents' short attention span, which may be caused by anxiety, fear or stress. This phenomena correlate with the high score on the anxiety sub-scale. Being ridiculed, teased and generally made miserable by over strict demands, may make the child to retreat and may also cause fear, anxiety and stress and cause a short attention span. This correlates with Anxiety as being the third largest sub-scale as illustrated in figure 7.5.

Figure 7.5 PFI-Prim-C Anxiety subscale: study population score



Respondent seven tested with a zero anxiety level. This data was found non significant by the researcher as he was a very anxious child during the therapy sessions, and may this be due to ego defensive behaviour. All the respondents experienced high anxiety levels. This confirms that play therapy is essential for these children. They need to learn how to control their anxiety in a relaxed atmosphere so that it does not interfere with their normal functioning.

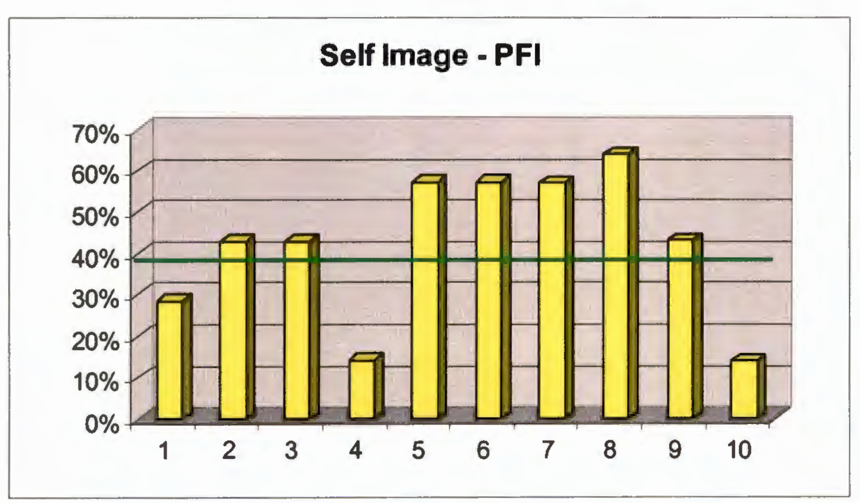
7.3.1.3 Self motivation and self- image

The literature study showed that children with learning disabilities (chapter 3, par. 3.7) usually lack self-motivation and their self-image deteriorates if they keep on getting negative input. From the literature study the researcher obtained data that confirms that self-image is a major problem area, namely:

- Thompson 1997 (see chapter 3 of this study)
- Transley and Gulliford 1962 (see chapter 3 par. 3.7 of this study)
- Lerner 1978 (see chapter 3, par. 3.7.2 of this study)
- Mowbry and Salisbury 1975 (chapter 3, par. 3.7.3. of this study)
- Shelton 1971 (chapter 3, par. 3.7.3. of this study)
- Kissel 1990 (chapter 3, par. 3.7.3. of this study)

The above conclusions again correlated with findings in the study population. Figure 7.6 graphically shows the self-image sub-scale of the whole study population. It is indicated as a problem area.

Figure 7.6 PFI-Prim-C Self-image subscale: study population score



The following findings can be concluded:

- 70 % of the respondents showed that they do have problems in the sub-scale, self-image. Their scores exceed the upper limit score of 75%.
- 20% have scores that indicated no problems in the area being measured.
- 10% fall within the cutting score range, indicating more info needed to be certain if the respondent has a problem. From the research done it was clear that this respondent had a problem. This means that 80% of the study population do have problems in the self-image area.

Out of the literature survey the researcher came to the conclusion that children with learning disabilities who constantly meet with failure, is more apt to anticipate unpleasant outcomes. In dealing with these uncomfortable feelings, they tend to behave in less socially acceptable ways. Related problems of learning disabilities are emotional-, behavioural- and low-self esteem problems. This again correlates with the information gathered in the practical survey from the average graph of the study population (figure 7.2.).

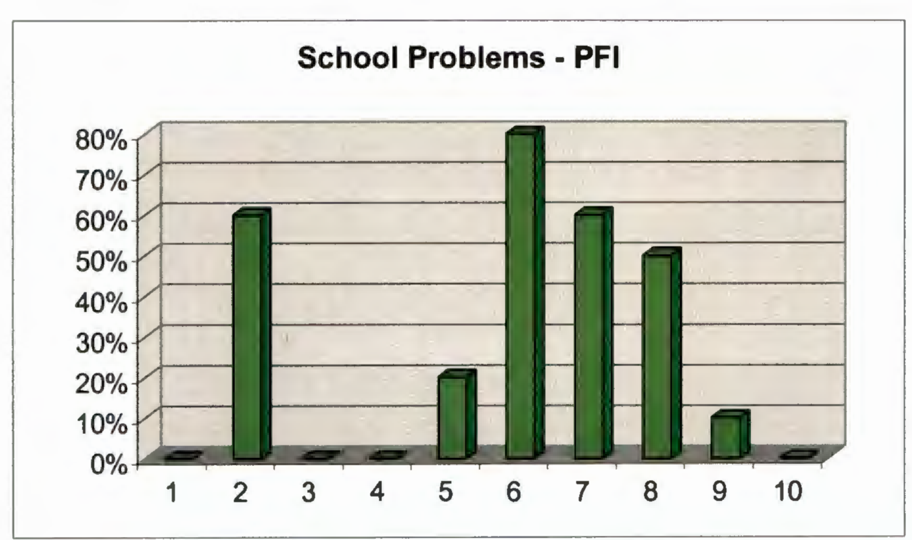
7.3.1.4 School problems

According to Decker and Decker (1977:353) the learning disabled child may present difficulties in the intellectual, conceptual, perceptual-motor, speech and language areas, and because of frustration and failures he has experienced, he frequently develops an emotional overlay to his learning deficit.

> " He begins to take on a concept of himself as "a person who cannot", an inadequate and sometimes worthless individual. Many of these children find it difficult to compete with their normally endowed peers, which further reinforces the crippling negative self-image they developed."

The researcher was concerned about the school situation, which may reinforce this negative concept, which he has developed because of continuous failure. That is why one of the main objectives set at the beginning of the study were to determine the role of the social worker in dealing with the child with a learning disability, who is experiencing social, emotional and behavioural problems in an inclusive school situation. From the research done it is clear that most children feel very exited when they start school. If they continue to perceive feelings of failure and rejection, because of educational barriers, they begin to hate school. Figure 7.7 may reflect this issue.

Figure 7.7 PFI-Prim-C subscale: school problems total score of the study population



Respondents 1, 3, 4, 9 and 10 were all grade one's, and the first year in school. They only now started experiencing negative feelings, because of the academic pressure increasing. This was part of the teachers concerns. The respondents' behaviour indicated that multidisciplinary team intervention was needed for remediation. The researcher came to the conclusion that the social worker has a definite role in the multidisciplinary team, when dealing with the child with a learning disability, who is experiencing social, emotional and behavioural problems in an inclusive school situation. As shown through the literature as well as practical survey the social worker may use play therapy as a therapeutic aid which may help the child cope at all levels of his existence when interacting with other individuals and situations in the school environment.

7.3.2 Information on questionnaire two

Although two different questionnaires were used, issues evolved from the first questionnaire were addressed in the second questionnaire (See chapter 6, par. 6.3.3.1). The main idea of this questionnaire was to indicate to the researcher whether the respondent in fact showed improvement in specific situations of concern. The questions were also more specific. For purpose of this study the researcher was more

concerned about the answers each respondent gave, because it gave a projected image of how the child experienced himself and his life world at that stage in therapy (see addendum 3 for the questions asked).

It is now important to make recommendations, bearing in mind al the information gathered up to this stage

7.4 Recommendations

7.4.1 Recommendations concerning inclusion

The underlying rationale for inclusion is laudable. There is a need for de-emphasises on isolation and labelling; increased protection of human rights; individualization in all phases of education, increased attention to the development of the total child including his social and emotional well-being. From an administrative standpoint, a benefit is the greater cost-efficiency in the delivery of services. Few will openly challenge these points, which frame the inclusive rationale.

Education for all children should be provided on an individual basis. In theory if the teacher is doing her job, all intra-individual and inter-individual differences can be met through regular school programs. The degree of heterogeneity, which exists, defies even the most capable teacher to program and monitor for individual needs in both their cognitive and affective, and psychomotor domains.

One problem that our society presently faces is that of education being asked to do preventive work so that welfare and correction roles will not have to clean up the aftermath of a nine to twelve- year failure experience! Much can be done if there is time to work with the child with advanced techniques and methods.

Schools confronted with inclusive issues should understand that unplanned implementation of the concept is sure to fail where personnel have not been prepared. Given sufficient commitment to ensure its successful implementation, inclusion should allow the quality of education to improve for all children - not just those with handicaps. The abuses of the concept, without the necessary commitment, will

surely lead to disenchanted administrators, teachers, and parents, legal recourse, and floods of children who are forced to become educational casualties.

7.4.2 Recommendations for a parent support group:

The social worker working in the educational environment becomes an adjunct to the family in helping them to accept the purposes of the school and the needs of the child with a learning disability. Parents may function inadequately, simply because of needs and unsolved problems in their own lives. These problems may stem from uncertainty in handling their child with a learning disability.

The social worker is alert to the fact that the family's influence upon children may be the mainstream of their behaviour. There are various physical, social, psychological, and cultural forces, which impinge upon the child with a learning disability. This may result in behaviour that may or may not be conducive to the ultimate development of the child.

Most parents strongly desire academic success for their children, and are disappointed in failures within a culture, which places a high premium on the value of schooling and accomplishments. The child with a learning disability may present specific difficulties for himself and his family.

Through means of a parent support group:

- Parents have the right to be involved in the education of their children.
- Parents can make valuable contributions to the identification of their children's problems. They can provide valuable assistance with regard to these problems as they are now allowed to share their information and skills with the teacher and social worker. Children's problems are more easily solved, when the parents are involved in assisting their children.
- Parents can realise that there are other parents having the same concerns for the well being of their children with a learning disability, they are not alone.
- Parents can view and express their feelings and concerns.

- Gain insight in handling and understanding their own child, so that they will be able to facilitate positive relationships among their family members.
- Parents can come to understand and accept the reality of the situation and to see the potential for change. They can use and apply the new knowledge gained, under supportive circumstances.

Cooperation between the school and parents should be well organised from the beginning. In-service training should be provided to equip parents for these tasks, which they commit themselves to perform. Their roles should be clearly defined. They could enter into a written contract with the team, stating their specific intentions in respect of their child. The parent should assist on behalf of the support programme in the afternoon, over the weekend and during school holiday.

The researcher strongly recommends support groups for parents with children with learning disabilities, especially in the inclusive environment, because it is not only the parents and child who will benefit, but also the community as a whole.

The parents of these children also have a desperate need for therapy to help them understand their children and to assure healthy family structures. It is recommended that further studies be done in this field. The problem was only partly addressed during the one workshop held for the parents and a few individual interviews with some parents.

7.4.3 Recommendations for teacher child relationships:

- Teachers should be lead to awareness in handling children with learning problems.

- In every way possible the teacher should demonstrate interest in the child and concern for his well-being. The teacher must be very careful never to overwhelm the child by her comments, or by drawing close attention of others to the child, or by making him an object of fun or ridicule.

- The child needs a relaxed atmosphere and reassurance. He needs to constantly see that people care about him, without feeling that pressure is being put on him to do what does not come easily to him.

- The teacher should remain tolerant, and continue to demonstrate care and interest. She should hold out to the child frequent opportunities for responding to talk and activity. In this manner the teacher will contribute to the development of a strong self-image.

- The teacher should support the learner by letting him experience that he is competent to cope with the demands of the academic world. She should set achievable and immediate objectives and link his effort to his results. She should praise effectively to ensure that the learner stays motivated and enthusiastic about his performance.

- Teachers and learners in the classroom should cultivate a positive attitude towards the learners with a learning disability in the classroom, to ensure that these learners are positively accepted and helped in the classroom.

Assisting learners with learning disabilities in the inclusive environment should be viewed as a normal part of the school's responsibility. It is recommended that school management should determine how various groups and individuals could be trained and organised to improve and maintain effective support programs and services for learners with special needs. This should ensure that all teachers are involved and properly informed in assisting learners with specific needs, such as children with learning disabilities.

7.4.4 Recommendations on practical survey

- The learning disabled child experiences so much frustration and disappointment in his school accomplishments that his interest and motivation drops. His learning becomes impossible, and his patience shortens with resulting displays of temper and poor emotional control. He becomes a loner, a troublemaker and an

underachiever. It is recommended that because the social worker is qualified to address these forms of crying out-behaviour, she can act as a supportive system.

- The researcher came to the conclusion that the three structured play therapy sessions is not enough for all the children (chapter 6, presentation of case studies). Non-directive therapy combined with the three-structured therapy sessions will be recommended for certain children with learning disabilities.

- Because of the boarding school system, where five of the respondents were actually in boarding school during the week, the teachers were expected to monitor the children's behaviour. This meant that the teacher during the week was responsible for fulfilling the role of the parent. The importance of the teachers being guided in helping these children develop optimally cannot be stressed enough.

- Questionnaire two, designed by the researcher for purpose of this study was used more as a projection tool, to measure what the respondent felt at that specific time. The questionnaire is not yet standardized. The researcher recommends the standardisation of this questionnaire through follow up research so that it can be used by social workers.

- The respondent recommends that the structure of the pilot study as mentioned previously be used as guidance in doing therapy with the child with a learning disability.

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Addendum 1
The Psychosocial Functioning Inventory for Primary School Children, (PFI-PRIM-C) questionnaire – Data, computation and graphs

Psigososiale Funksionering Inventaris vir Laerskool Kinders (PFI-LK)
Psychosocial Functioning Inventory for Primary School Children (PFI-PRIM-C)

Met hierdie vrae wil ons jou graag beter leer ken. Beantwoord die vrae so vinnig as wat jy kan. Moenie te lank dink oor 'n vraag nie. Die eerste antwoord wat by jou opkom, is gewoonlik die beste een. Onthou daar is nie regte of verkeerde antwoorde nie.

With this questionnaire we would like to get acquainted with you. Grade yourself as quickly and as honestly as possible. Do not speculate too long before you answer. The first answer that comes to mind is usually the correct one. There are no wrong or correct answers.

What is your name?
Wat is jou naam? ______________________

How old are you?
Hoe oud is jy? ______________________

Are you a boy or a girl?
Is jy 'n seun of 'n meisie? ______________________

In what grade are you?
In watter graad is jy? ______________________

Encircle each item by making use of the following scale:
Antwoord elke item deur net die regte sirkel te omkring:

NO

NEE

SOMETIMES

PARTYKEER

YES

JA

1.*	I keep on trying until I succeed. Ek hou aan probeer tot ek iets regkry.	1 2 3
2.*	I keep on doing my homework until it is done. Ek doen my huiswerk tot ek klaar is.	1 2 3
3.*	It is important to me to understand my schoolwork. Dit is vir my belangrik om my werk te verstaan.	1 2 3
4.*	I complete my schoolwork, even if it is difficult. Ek maak my werk klaar al is dit moeilik.	1 2 3
5.*	I like my schoolwork. Die werk by die skool is lekker.	1 2 3
6.*	I work hard at school. Ek werk hard by die skool.	1 2 3

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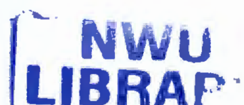
Perspective Training College, PO Box 1658, Silverton, 0127, Tel (012) 804-0289, Fax (012) 804-7412

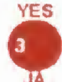
NO	SOMETIMES	YES
NEE	PARTYKEER	JA

7.*	People like me. Mense hou van my.	1 2 3
8.*	I like myself. Ek hou van myself	1 2 3
9*.	I am happy. Ek voel gelukkig.	1 2 3
10.*	I enjoy being with my friends. Dit is vir my lekker by my maats.	1 2 3
11.*	I do the things that I enjoy. Ek doen dinge wat vir my lekker is.	1 2 3

12.*	I shall be happy when I am grown-up. Ek sal gelukkig wees as ek groot is.	1 2 3
13.*	I think about the day that I will be grown-up. Ek dink baie oor wanneer ek gaan groot wees.	1 2 3
14.*	I shall do very well when I am grown-up. Dit sal goed gaan met my as ek groot is.	1 2 3
15.*	I shall like it when I am grown-up. Dit gaan lekker wees as ek groot is.	1 2 3
16.*	I wish I were already grown-up. Ek wens ek is al groot.	1 2 3
17.*	My plans will work out when I am grown-up. My planne sal uitwerk as ek groot is.	1 2 3

18.	I am afraid something will go wrong. Ek is bang iets gaan verkeerd.	1 2 3
19.	I feel I deserve getting scolded. Ek voel altyd ek moet raas kry.	1 2 3
20.*	I am important. Ek is belangrik.	1 2 3
21.	I am to blame for everything. Alles is my skuld.	1 2 3
22.	I always feel I do things wrongly. Ek voel altyd ek doen dinge verkeerd.	1 2 3
23.*	I am allowed to make mistakes. Ek mag foute maak.	1 2 3
24.*	People listen to me. Mense luister na my.	1 2 3



NO	SOMETIMES	YES
		
NEE	PARTYKEER	JA

25.	I crack jokes to make others happy. Ek maak grappies sodat ander gelukkig kan wees.	1 2 3
26.	I am sad when others are angry with me. Ek is hartseer wanneer ander vir my kwaad is.	1 2 3
27.	I have to make my parents happy. Ek moet my ouers gelukkig maak.	1 2 3
28.	When my parents are happy, I am happy too. As my ouers gelukkig is, is ek ook gelukkig.	1 2 3
29.	I have to make my friends happy. Ek moet my maatjies gelukkig maak.	1 2 3
30.	When my friends are happy, I am happy too. As my maatjies gelukkig is, is ek ook gelukkig.	1 2 3

31.	I forget where I put things. Ek vergeet waar ek goed bêre.	1 2 3
32	I forget which day it is. Ek vergeet watter dag dit is.	1 2 3
33.	I find it difficult to remember important things. Ek sukkel om belangrike goed te onthou.	1 2 3
34.	I forget the small tasks I have to do every day. Ek vergeet die werkies wat ek elke dag moet doen.	1 2 3
35.	I forget important things. Ek vergeet belangrike dinge.	1 2 3

36.	Everybody is scolding me all the time. Almal raas net met my.	1 2 3
37.	I easily become angry. Ek voel gou kwaad.	1 2 3
38.	I hit/bite/kick my friends when they make me angry. Ek slaan/byt/skop my maats as hulle my kwaad maak.	1 2 3
39.	I get what I want by making my friends feel threatened. Ek kry wat ek wil hê deur my maats bang te maak.	1 2 3
40.	I use bad language when my friends make me angry. Ek sê lelike goed vir my maats as hulle my kwaad maak.	1 2 3

NO	SOMETIMES	YES
NEE	PARTYKEER	JA

41.	I am afraid to make mistakes. Ek is bang ek maak foute.	1 2 3
42.	I feel like running away from the things that scare me. Ek voel lus om weg te hardloop van die dinge wat my bang maak.	1 2 3
43.	Strange things make me afraid. Vreemde goed maak my bang.	1 2 3
44.	I get tummy-aches. Ek kry maagpyn.	1 2 3
45.	There are places where I feel scared. Daar is plekke waar ek bang voel.	1 2 3
46.	I feel ashamed. Ek is skaam.	1 2 3
47.	I find it difficult to do things correctly. Ek sukkel om dinge reg te doen.	1 2 3
48.	Everybody is teasing me. Almal terg my.	1 2 3

49.	Nobody likes me. Min mense hou van my.	1 2 3
50.	Everybody hates me. Almal haat my.	1 2 3
51.	I easily cry. Ek huil maklik.	1 2 3
52.	Nobody loves me. Min mense is lief vir my.	1 2 3
53.	I am very sad. Ek is baie hartseer.	1 2 3
54.	I enjoy nothing anymore. Min goed is nog vir my lekker.	1 2 3

55.	Adults are stupid. Grootmense is simpel.	1 2 3
56.	Adults make me angry. Grootmense maak my kwaad.	1 2 3
57.	I am afraid of adults. Ek is bang vir grootmense.	1 2 3
58.	Adults are lying to me. Grootmense jok vir my.	1 2 3

NO NEE

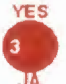
SOMETIMES PARTYKEER

YES JA

59.	I am different from other children. Ek is anders as ander kinders.	1 2 3
60.	I wish I were like other children. Ek wens ek was soos ander kinders.	1 2 3
61.	Other children have fewer problems than I do. Ander kinders het minder probleme as ek.	1 2 3
62.	Bad things happen to me only. Slegte goed gebeur net met my.	1 2 3
63.	Other children are getting on better than I do. Dit gaan beter met ander kinders as met my.	1 2 3
64.	Other children are happier than me. Ander kinders is gelukkiger as ek.	1 2 3

65.*	I like school. Ek hou van skool.	1 2 3
66.*	I like being at school. Dit is vir my lekker by die skool.	1 2 3
67.	I hate school. Ek haat skool.	1 2 3
68.	School bores me to death. Ek is verveeld by die skool.	1 2 3
69.	I feel stupid at school. Ek voel dom by die skool.	1 2 3

70.*	I like my friends. Ek hou van my maats.	1 2 3
71.*	My friends like me. My maats hou baie van my.	1 2 3
72.*	I am friendly with my friends. Ek is vriendelik met my maats.	1 2 3
73.	I hate my friends. Ek haat my maats.	1 2 3
74.*	My friends understand me. My maats verstaan my.	1 2 3
75.*	I enjoy playing with my friends. Ek speel lekker saam met my maats.	1 2 3

NO NEE	SOMETIMES PARTYKEER	YES JA
		

76.*	I like my mother. Ek hou van my ma.	1 2 3
77.*	I love being with my mother. Ek hou daarvan om by my ma te wees.	1 2 3
78.*	I love my mother. Ek is lief vir my ma.	1 2 3
79.*	My mother likes me. My ma hou van my.	1 2 3
80.*	My mother does a lot for me. My ma doen bale vir my.	1 2 3

81.*	I like my father. Ek hou van my pa.	1 2 3
82.*	I love being with my father. Ek hou daarvan om by my pa te wees.	1 2 3
83.*	I love my father. Ek is lief vir my pa.	1 2 3
84.*	My father likes me. My pa hou van my.	1 2 3
85.*	My father does a lot for me. My pa doen bale vir my.	1 2 3

86.*	I love being with my family. Dit is vir my lekker om by my gesin te wees.	1 2 3
87.*	I feel part of my family. Ek voel deel van my gesin.	1 2 3
88.*	Our family love each other. Ons gesin is lief vir mekaar.	1 2 3
89.	I feel lonely at home. Ek voel alleen by die huis.	1 2 3
90.*	I love being at home. Dit is vir my lekker by die huis.	1 2 3
91.*	I am fond of being with my family. Ek hou daarvan om by my gesin te wees.	1 2 3

Respondent 1

1	3	25	1	49	3	70	3
2	3	26	1	50	1	71	3
3	3	27	3	51	1	72	3
4	3	28	1	52	3	73	1
5	3	29	1	53	1	74	3
6	3	30	1	54	3	75	2
7	1	31	3	55	1	76	3
8	3	32	1	56	1	77	3
9	1	33	3	57	1	78	3
10	1	34	3	58	1	79	3
11	3	35	3			80	3
12	1	36	3	59	3	81	3
13	3	37	3	60	1	82	3
14	1	38	3	61	3	83	3
15	3	39	1	62	1	84	3
16	3	40	1	63	1	85	3
17	3			64	1		
18	1	41	1	65	3	86	3
19	1	42	1	66	3	87	3
20	3	43	1	67	1	88	3
21	1	44	3	68	1	89	3
22	1	45	1	69	1	90	3
23	1	46	2			91	3
24	1	47	3				
		48	3				

1	0	25	0	49	2	70	0
2	0	26	0	50	0	71	0
3	0	27	2	51	0	72	0
4	0	28	0	52	2	73	0
5	0	29	0	53	0	74	0
6	0	30	0	54	2	75	1
	0%		17%		50%		8%
7	2	31	2	55	0	76	0
8	0	32	0	56	0	77	0
9	2	33	2	57	0	78	0
10	2	34	2	58	0	79	0
11	0	35	2			80	0
	60%		80%		0%		0%
12	2	36	2	59	2	81	0
13	0	37	2	60	0	82	0
14	2	38	2	61	2	83	0
15	0	39	0	62	0	84	0
16	0	40	0	63	0	85	0
17	0			64	0		
	33%		60%		33%		0%
18	0	41	0	65	0	86	0
19	0	42	0	66	0	87	0
20	0	43	0	67	0	88	0
21	0	44	2	68	0	89	2
22	0	45	0	69	0	90	0
23	2	46	1			91	0
24	2	47	2				
		48	2				
	29%		44%		0%		17%

1-6	Perseverance	0%
7-11	Satisfaction	60%
12-17	Future Expectations	33%
18-24	Self-Image	29%
25-30	Other's happiness	17%
31-35	Memory loss	80%
36-40	Frustration	60%
41-48	Anxiety	44%
49-54	Helplessness	50%
55-58	Attitude adults	0%
59-64	Stigma	33%
65-69	School problems	0%
70-75	Problems friends	8%
76-80	Problems mother	0%
81-85	Problems father	0%
86-91	Family problems	17%

NWU LIBRARY

Respondent 2

1	3	25	3	49	3	70	2
2	3	26	3	50	1	71	2
3	3	27	3	51	1	72	2
4	1	28	3	52	1	73	2
5	3	29	3	53	1	74	3
6	3	30	3	54	3	75	3
7	3	31	3	55	1	76	3
8	3	32	3	56	1	77	3
9	3	33	2	57	1	78	3
10	3	34	3	58	1	79	3
11	3	35	3			80	3
12	3	36	1	59	1	81	3
13	3	37	1	60	3	82	3
14	3	38	2	61	2	83	3
15	3	39	3	62	2	84	3
16	3	40	1	63	2	85	3
17	3			64	2		
18	3	41	3	65	2	86	3
19	1	42	1	66	2	87	3
20	3	43	1	67	2	88	3
21	1	44	3	68	3	89	3
22	3	45	3	69	2	90	3
23	1	46	3			91	3
24	3	47	3				
		48	3				

1	0	25	2	49	2	70	1	1-6	Perseverance	17%
2	0	26	2	50	0	71	1	7-11	Satisfaction	0%
3	0	27	2	51	0	72	1	12-17	Future Expectations	0%
4	2	28	2	52	0	73	1	18-24	Self-Image	43%
5	0	29	2	53	0	74	0	25-30	Other's happiness	100%
6	0	30	2	54	2	75	0	31-35	Memory loss	90%
	17%		100%		33%		33%	36-40	Frustration	30%
7	0	31	2	55	0	76	0	41-48	Anxiety	75%
8	0	32	2	56	0	77	0	49-54	Helplessness	33%
9	0	33	1	57	0	78	0	55-58	Attitude adults	0%
10	0	34	2	58	0	79	0	59-64	Stigma	50%
11	0	35	2			80	0	65-69	School problems	60%
	0%		90%		0%		0%	70-75	Problems friends	33%
12	0	36	0	59	0	81	0	76-80	Problems mother	0%
13	0	37	0	60	2	82	0	81-85	Problems father	0%
14	0	38	1	61	1	83	0	86-91	Family problems	17%
15	0	39	2	62	1	84	0			
16	0	40	0	63	1	85	0			
17	0			64	1					
	0%		30%		50%		0%			
18	2	41	2	65	1	86	0			
19	0	42	0	66	1	87	0			
20	0	43	0	67	1	88	0			
21	0	44	2	68	2	89	2			
22	2	45	2	69	1	90	0			
23	2	46	2			91	0			
24	0	47	2							
		48	2							
	43%		75%		60%		17%			

Respondent 3

Item	Answer	Item	Answer	Item	Answer	Item	Answer
1	3	25	3	49	3	70	3
2	3	26	3	50	1	71	3
3	3	27	3	51	1	72	1
4	3	28	3	52	1	73	3
5	3	29	3	53	3	74	3
6	3	30	3	54	3	75	3
7	2	31	3	55	1	76	3
8	3	32	3	56	3	77	3
9	3	33	3	57	3	78	3
10	3	34	3	58	2	79	3
11	3	35	3			80	3
12	3	36	1	59	3	81	3
13	3	37	3	60	1	82	3
14	3	38	3	61	1	83	3
15	3	39	3	62	2	84	3
16	2	40	3	63	2	85	3
17	3			64	1		
18	3	41	3	65	3	86	3
19	1	42	3	66	3	87	3
20	1	43	3	67	1	88	3
21	1	44	3	68	1	89	1
22	3	45	3	69	1	90	3
23	3	46	3			91	3
24	3	47	3				
		48	2				

Item	Score	Item	Score	Item	Score	Item	Score	Range	Scale	%
1	0	25	2	49	2	70	0	1-6	Perseverance	0%
2	0	26	2	50	0	71	0	7-11	Satisfaction	10%
3	0	27	2	51	0	72	2	12-17	Future Expectations	8%
4	0	28	2	52	0	73	2	18-24	Self-Image	43%
5	0	29	2	53	2	74	0	25-30	Other's happiness	100%
6	0	30	2	54	2	75	0	31-35	Memory loss	100%
	0%		100%		50%		33%	36-40	Frustration	80%
7	1	31	2	55	0	76	0	41-48	Anxiety	94%
8	0	32	2	56	2	77	0	49-54	Helplessness	50%
9	0	33	2	57	2	78	0	55-58	Attitude adults	63%
10	0	34	2	58	1	79	0	59-64	Stigma	33%
11	0	35	2			80	0	65-69	School problems	0%
	10%		100%		63%		0%	70-75	Problems friends	33%
12	0	36	0	59	2	81	0	76-80	Problems mother	0%
13	0	37	2	60	0	82	0	81-85	Problems father	0%
14	0	38	2	61	0	83	0	86-91	Family problems	0%
15	0	39	2	62	1	84	0			
16	1	40	2	63	1	85	0			
17	0			64	0					
	8%		80%		33%		0%			
18	2	41	2	65	0	86	0			
19	0	42	2	66	0	87	0			
20	2	43	2	67	0	88	0			
21	0	44	2	68	0	89	0			
22	2	45	2	69	0	90	0			
23	0	46	2			91	0			
24	0	47	2							
		48	1							
	43%		94%		0%		0%			

Respondent 4

Item	Score	Item	Score	Item	Score	Item	Score
1	2	25	3	49	1	70	3
2	3	26	3	50	1	71	3
3	3	27	3	51	3	72	3
4	3	28	3	52	1	73	3
5	3	29	3	53	3	74	3
6	3	30	3	54	3	75	2
7	3	31	3	55	1	76	3
8	3	32	2	56	1	77	3
9	3	33	3	57	1	78	3
10	3	34	1	58	3	79	3
11	3	35	3			80	3
12	3	36	1	59	3	81	3
13	3	37	1	60	3	82	3
14	3	38	1	61	3	83	3
15	3	39	1	62	1	84	3
16	3	40	1	63	1	85	3
17	3			64	1		
18	1	41	3	65	3	86	3
19	1	42	1	66	3	87	3
20	3	43	1	67	1	88	3
21	1	44	3	68	1	89	2
22	1	45	3	69	1	90	3
23	3	46	3			91	3
24	1	47	3				
		48	3				

1	1	25	2	49	0	70	0	1-6	Perseverance	8%
2	0	26	2	50	0	71	0	7-11	Satisfaction	0%
3	0	27	2	51	2	72	0	12-17	Future Expectations	0%
4	0	28	2	52	0	73	2	18-24	Self-Image	14%
5	0	29	2	53	2	74	0	25-30	Other's happiness	100%
6	0	30	2	54	2	75	1	31-35	Memory loss	70%
	8%		100%		50%		25%	36-40	Frustration	0%
7	0	31	2	55	0	76	0	41-48	Anxiety	75%
8	0	32	1	56	0	77	0	49-54	Helplessness	50%
9	0	33	2	57	0	78	0	55-58	Attitude adults	25%
10	0	34	0	58	2	79	0	59-64	Stigma	50%
11	0	35	2			80	0	65-69	School problems	0%
	0%		70%		25%		0%	70-75	Problems friends	25%
12	0	36	0	59	2	81	0	76-80	Problems mother	0%
13	0	37	0	60	2	82	0	81-85	Problems father	0%
14	0	38	0	61	2	83	0	86-91	Family problems	8%
15	0	39	0	62	0	84	0			
16	0	40	0	63	0	85	0			
17	0			64	0					
	0%		0%		50%		0%			
18	0	41	2	65	0	86	0			
19	0	42	0	66	0	87	0			
20	0	43	0	67	0	88	0			
21	0	44	2	68	0	89	1			
22	0	45	2	69	0	90	0			
23	0	46	2			91	0			
24	2	47	2							
		48	2							
	14%		75%		0%		8%			

Respondent 5

1	1	25	3	49	3	70	3
2	3	26	1	50	3	71	3
3	3	27	1	51	3	72	1
4	3	28	3	52	3	73	3
5	2	29	1	53	1	74	1
6	3	30	3	54	3	75	1
7	3	31	1	55	3	76	3
8	3	32	3	56	3	77	3
9	2	33	1	57	3	78	3
10	3	34	3	58	1	79	3
11	3	35	1			80	3
12	3	36	1	59	3	81	3
13	1	37	3	60	3	82	3
14	3	38	3	61	3	83	3
15	2	39	2	62	3	84	3
16	3	40	2	63	3	85	3
17	3			64	3		
18	2	41	3	65	3	86	3
19	3	42	2	66	3	87	3
20	1	43	2	67	1	88	1
21	2	44	1	68	3	89	3
22	3	45	2	69	1	90	3
23	3	46	2			91	3
24	3	47	2				
		48	3				

1	2	25	2	49	2	70	0	1-6	Perseverance	25%
2	0	26	0	50	2	71	0	7-11	Satisfaction	10%
3	0	27	0	51	2	72	2	12-17	Future Expectations	25%
4	0	28	2	52	2	73	2	18-24	Self-Image	57%
5	1	29	0	53	0	74	2	25-30	Other's happiness	50%
6	0	30	2	54	2	75	2	31-35	Memory loss	40%
	25%		50%		83%		67%	36-40	Frustration	60%
7	0	31	0	55	2	76	0	41-48	Anxiety	56%
8	0	32	2	56	2	77	0	49-54	Helplessness	83%
9	1	33	0	57	2	78	0	55-58	Attitude adults	75%
10	0	34	2	58	0	79	0	59-64	Stigma	100%
11	0	35	0			80	0	65-69	School problems	20%
	10%		40%		75%		0%	70-75	Problems friends	67%
12	0	36	0	59	2	81	0	76-80	Problems mother	0%
13	2	37	2	60	2	82	0	81-85	Problems father	0%
14	0	38	2	61	2	83	0	86-91	Family problems	33%
15	1	39	1	62	2	84	0			
16	0	40	1	63	2	85	0			
17	0			64	2					
	25%		60%		100%		0%			
18	1	41	2	65	0	86	0			
19	2	42	1	66	0	87	0			
20	2	43	1	67	0	88	2			
21	1	44	0	68	2	89	2			
22	2	45	1	69	0	90	0			
23	0	46	1			91	0			
24	0	47	1							
		48	2							
	57%		56%		20%		33%			

Respondent 6

1	3	25	3	49	1	70	3
2	2	26	2	50	1	71	3
3	3	27	3	51	2	72	2
4	2	28	3	52	1	73	1
5	1	29	3	53	2	74	2
6	3	30	3	54	2	75	3
7	2	31	3	55	1	76	3
8	3	32	2	56	1	77	3
9	3	33	2	57	2	78	3
10	2	34	2	58	1	79	3
11	3	35	2			80	3
12	3	36	1	59	3	81	3
13	3	37	1	60	2	82	3
14	2	38	2	61	2	83	3
15	3	39	3	62	1	84	3
16	3	40	1	63	1	85	3
17	2			64	1		
18	3	41	2	65	1	86	3
19	3	42	3	66	1	87	3
20	3	43	3	67	3	88	3
21	2	44	2	68	2	89	1
22	2	45	3	69	2	90	3
23	2	46	2			91	3
24	2	47	2				
		48	2				

1	0	25	2	49	0	70	0	1-6	Perseverance	33%
2	1	26	1	50	0	71	0	7-11	Satisfaction	20%
3	0	27	2	51	1	72	1	12-17	Future Expectations	17%
4	1	28	2	52	0	73	0	18-24	Self-Image	57%
5	2	29	2	53	1	74	1	25-30	Other's happiness	92%
6	0	30	2	54	1	75	0	31-35	Memory loss	60%
	33%		92%		25%		17%	36-40	Frustration	30%
7	1	31	2	55	0	76	0	41-48	Anxiety	69%
8	0	32	1	56	0	77	0	49-54	Helplessness	25%
9	0	33	1	57	1	78	0	55-58	Attitude adults	13%
10	1	34	1	58	0	79	0	59-64	Stigma	33%
11	0	35	1			80	0	65-69	School problems	80%
	20%		60%		13%		0%	70-75	Problems friends	17%
12	0	36	0	59	2	81	0	76-80	Problems mother	0%
13	0	37	0	60	1	82	0	81-85	Problems father	0%
14	1	38	1	61	1	83	0	86-91	Family problems	0%
15	0	39	2	62	0	84	0			
16	0	40	0	63	0	85	0			
17	1			64	0					
	17%		30%		33%		0%			
18	2	41	1	65	2	86	0			
19	2	42	2	66	2	87	0			
20	0	43	2	67	2	88	0			
21	1	44	1	68	1	89	0			
22	1	45	2	69	1	90	0			
23	1	46	1			91	0			
24	1	47	1							
		48	1							
	57%		69%		80%		0%			

Respondent 7

1	3	25	3	49	3	70	3
2	3	26	3	50	3	71	3
3	3	27	3	51	3	72	3
4	3	28	3	52	3	73	3
5	3	29	3	53	3	74	3
6	3	30	3	54	3	75	3
7	3	31	3	55	3	76	3
8	3	32	2	56	3	77	3
9	3	33	3	57	3	78	3
10	3	34	3	58	3	79	3
11	3	35	3			80	3
12	3	36	3	59	3	81	3
13	3	37	3	60	3	82	3
14	3	38	3	61	3	83	3
15	3	39	1	62	3	84	3
16	3	40	3	63	3	85	3
17	3			64	3		
18	3	41		65	3	86	3
19	3	42		66	3	87	3
20	3	43		67	3	88	3
21	3	44		68	3	89	3
22	3	45		69	3	90	3
23	3	46				91	3
24	3	47					
		48					

1	0	25	2	49	2	70	0	1-6	Perseverance	0%
2	0	26	2	50	2	71	0	7-11	Satisfaction	0%
3	0	27	2	51	2	72	0	12-17	Future Expectations	0%
4	0	28	2	52	2	73	2	18-24	Self-Image	57%
5	0	29	2	53	2	74	0	25-30	Other's happiness	100%
6	0	30	2	54	2	75	0	31-35	Memory loss	90%
	0%		100%		100%		17%	36-40	Frustration	80%
7	0	31	2	55	2	76	0	41-48	Anxiety	0%
8	0	32	1	56	2	77	0	49-54	Helplessness	100%
9	0	33	2	57	2	78	0	55-58	Attitude adults	100%
10	0	34	2	58	2	79	0	59-64	Stigma	100%
11	0	35	2			80	0	65-69	School problems	60%
	0%		90%		100%		0%	70-75	Problems friends	17%
12	0	36	2	59	2	81	0	76-80	Problems mother	0%
13	0	37	2	60	2	82	0	81-85	Problems father	0%
14	0	38	2	61	2	83	0	86-91	Family problems	17%
15	0	39	0	62	2	84	0			
16	0	40	2	63	2	85	0			
17	0			64	2					
	0%		80%		100%		0%			
18	2	41	0	65	0	86	0			
19	2	42	0	66	0	87	0			
20	0	43	0	67	2	88	0			
21	2	44	0	68	2	89	2			
22	2	45	0	69	2	90	0			
23	0	46	0			91	0			
24	0	47	0							
		48	0							
	57%		0%		60%		17%			

Respondent 8

1	1	25	3	49	2	70	3
2	2	26	3	50	3	71	3
3	3	27	1	51	2	72	3
4	2	28	3	52	3	73	1
5	3	29	2	53	3	74	3
6	1	30	3	54	3	75	3
7	1	31	3	55	3	76	3
8	1	32	3	56	3	77	1
9	2	33	3	57	3	78	3
10	2	34	3	58	3	79	3
11	3	35	2			80	3
12	1	36	1	59	1	81	3
13	2	37	2	60	1	82	3
14	1	38	1	61	3	83	3
15	3	39	3	62	3	84	3
16	2	40	2	63	1	85	3
17	3			64	1		
18	1	41	3	65	2	86	3
19	3	42	2	66	3	87	3
20	2	43	2	67	3	88	3
21	2	44	3	68	1	89	3
22	3	45	3	69	3	90	3
23	1	46	1			91	3
24	2	47	1				
		48	3				

1	2	25	2	49	1	70	0	1-6	Perseverance	50%
2	1	26	2	50	2	71	0	7-11	Satisfaction	60%
3	0	27	0	51	1	72	0	12-17	Future Expectations	50%
4	1	28	2	52	2	73	0	18-24	Self-Image	64%
5	0	29	1	53	2	74	0	25-30	Other's happiness	75%
6	2	30	2	54	2	75	0	31-35	Memory loss	90%
	50%		75%		83%		0%	36-40	Frustration	40%
7	2	31	2	55	2	76	0	41-48	Anxiety	63%
8	2	32	2	56	2	77	2	49-54	Helplessness	83%
9	1	33	2	57	2	78	0	55-58	Attitude adults	100%
10	1	34	2	58	2	79	0	59-64	Stigma	33%
11	0	35	1			80	0	65-69	School problems	50%
	60%		90%		100%		20%	70-75	Problems friends	0%
12	2	36	0	59	0	81	0	76-80	Problems mother	20%
13	1	37	1	60	0	82	0	81-85	Problems father	0%
14	2	38	0	61	2	83	0	86-91	Family problems	17%
15	0	39	2	62	2	84	0			
16	1	40	1	63	0	85	0			
17	0			64	0					
	50%		40%		33%		0%			
18	0	41	2	65	1	86	0			
19	2	42	1	66	0	87	0			
20	1	43	1	67	2	88	0			
21	1	44	2	68	0	89	2			
22	2	45	2	69	2	90	0			
23	2	46	0			91	0			
24	1	47	0							
		48	2							
	64%		63%		50%		17%			

Respondent 9

1	3	25	3	49	1	70	3
2	3	26	3	50	1	71	3
3	3	27	3	51	1	72	3
4	3	28	3	52	2	73	2
5	3	29	3	53	3	74	2
6	1	30	2	54	2	75	3
7	3	31	3	55	1	76	3
8	3	32	3	56	1	77	3
9	3	33	1	57	3	78	3
10	3	34	2	58	2	79	3
11	3	35	3			80	3
12	3	36	1	59	1	81	3
13	3	37	1	60	3	82	3
14	3	38	1	61	2	83	3
15	3	39	1	62	1	84	3
16	3	40	2	63	2	85	3
17	1			64	1		
18	3	41	3	65	3	86	3
19	1	42	3	66	3	87	3
20	3	43	3	67	1	88	3
21	1	44	2	68	1	89	1
22	3	45	3	69	2	90	3
23	3	46	1			91	3
24	1	47	2				
		48	2				

1	0	25	2	49	0	70	0	1-6	Perseverance	17%
2	0	26	2	50	0	71	0	7-11	Satisfaction	0%
3	0	27	2	51	0	72	0	12-17	Future Expectations	17%
4	0	28	2	52	1	73	1	18-24	Self-Image	43%
5	0	29	2	53	2	74	1	25-30	Other's happiness	92%
6	2	30	1	54	1	75	0	31-35	Memory loss	70%
	17%		92%		33%		17%	36-40	Frustration	10%
7	0	31	2	55	0	76	0	41-48	Anxiety	69%
8	0	32	2	56	0	77	0	49-54	Helplessness	33%
9	0	33	0	57	2	78	0	55-58	Attitude adults	38%
10	0	34	1	58	1	79	0	59-64	Stigma	33%
11	0	35	2			80	0	65-69	School problems	10%
	0%		70%		38%		0%	70-75	Problems friends	17%
12	0	36	0	59	0	81	0	76-80	Problems mother	0%
13	0	37	0	60	2	82	0	81-85	Problems father	0%
14	0	38	0	61	1	83	0	86-91	Family problems	0%
15	0	39	0	62	0	84	0			
16	0	40	1	63	1	85	0			
17	2			64	0					
	17%		10%		33%		0%			
18	2	41	2	65	0	86	0			
19	0	42	2	66	0	87	0			
20	0	43	2	67	0	88	0			
21	0	44	1	68	0	89	0			
22	2	45	2	69	1	90	0			
23	0	46	0			91	0			
24	2	47	1							
		48	1							
	43%		69%		10%		0%			

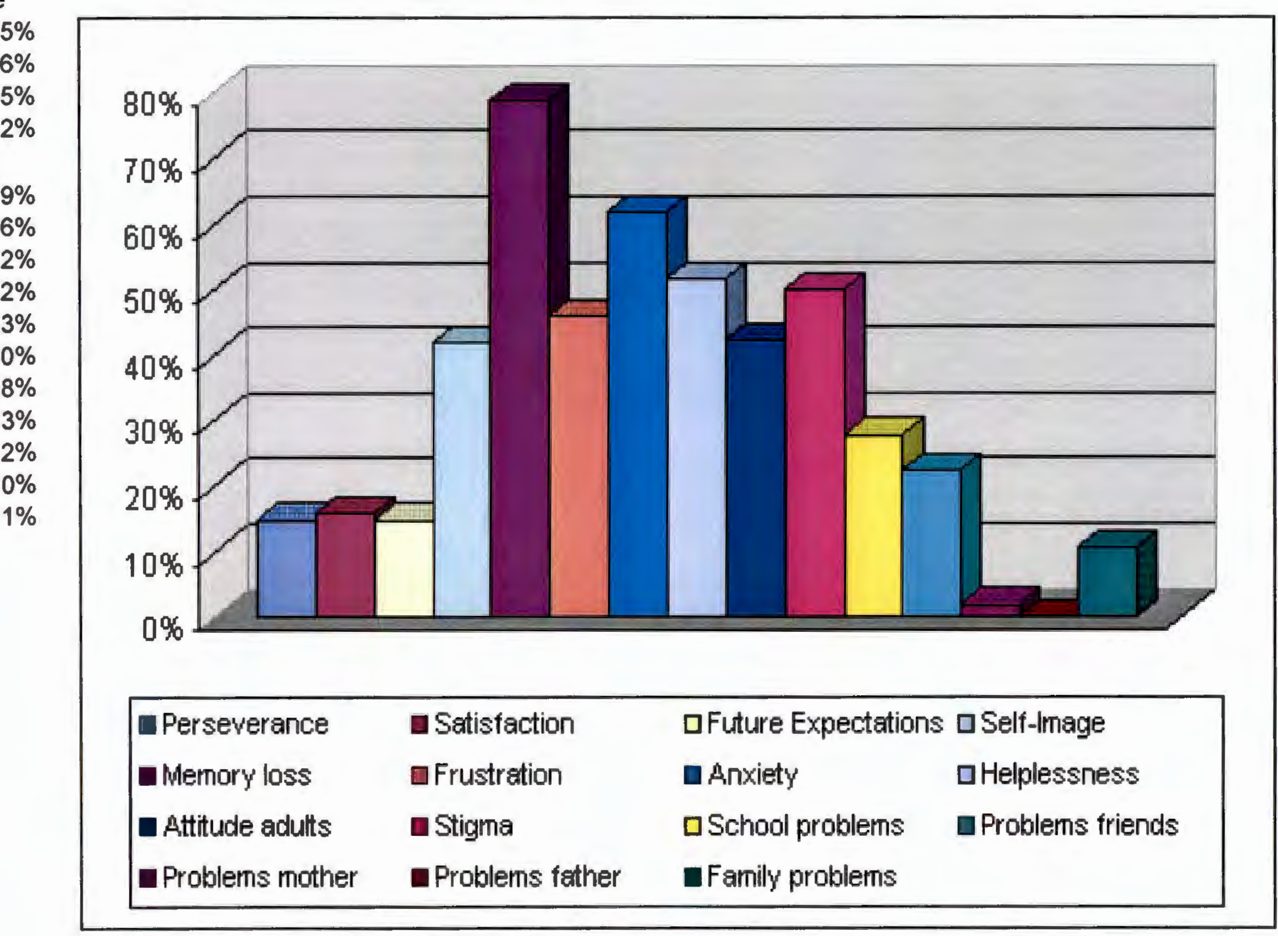
Respondent 10

1	3	25	1	49	1	70	3
2	3	26	3	50	1	71	3
3	3	27	3	51	2	72	3
4	3	28	3	52	1	73	1
5	3	29	3	53	1	74	2
6	3	30	3	54	1	75	3
7	3	31	3	55	1	76	3
8	3	32	3	56	2	77	3
9	3	33	3	57	1	78	3
10	3	34	3	58	1	79	3
11	3	35	3			80	3
12	3	36	1	59	3	81	3
13	3	37	3	60	1	82	3
14	3	38	3	61	1	83	3
15	3	39	2	62	1	84	3
16	3	40	3	63	3	85	3
17	3			64	1		
18	1	41	3	65	3	86	3
19	1	42	3	66	3	87	3
20	3	43	3	67	1	88	3
21	1	44	2	68	1	89	1
22	1	45	3	69	1	90	3
23	3	46	3			91	3
24	1	47	1				
		48	2				

1	0	25	0	49	0	70	0	1-6	Perseverance	0%
2	0	26	2	50	0	71	0	7-11	Satisfaction	0%
3	0	27	2	51	1	72	0	12-17	Future Expectations	0%
4	0	28	2	52	0	73	0	18-24	Self-Image	14%
5	0	29	2	53	0	74	1	25-30	Other's happiness	83%
6	0	30	2	54	0	75	0	31-35	Memory loss	100%
	0%		83%		8%		8%	36-40	Frustration	70%
7	0	31	2	55	0	76	0	41-48	Anxiety	75%
8	0	32	2	56	1	77	0	49-54	Helplessness	8%
9	0	33	2	57	0	78	0	55-58	Attitude adults	13%
10	0	34	2	58	0	79	0	59-64	Stigma	33%
11	0	35	2			80	0	65-69	School problems	0%
	0%		100%		13%		0%	70-75	Problems friends	8%
12	0	36	0	59	2	81	0	76-80	Problems mother	0%
13	0	37	2	60	0	82	0	81-85	Problems father	0%
14	0	38	2	61	0	83	0	86-91	Family problems	0%
15	0	39	1	62	0	84	0			
16	0	40	2	63	2	85	0			
17	0			64	0					
	0%		70%		33%		0%			
18	0	41	2	65	0	86	0			
19	0	42	2	66	0	87	0			
20	0	43	2	67	0	88	0			
21	0	44	1	68	0	89	0			
22	0	45	2	69	0	90	0			
23	0	46	2			91	0			
24	2	47	0							
		48	1							
	14%		75%		0%		0%			

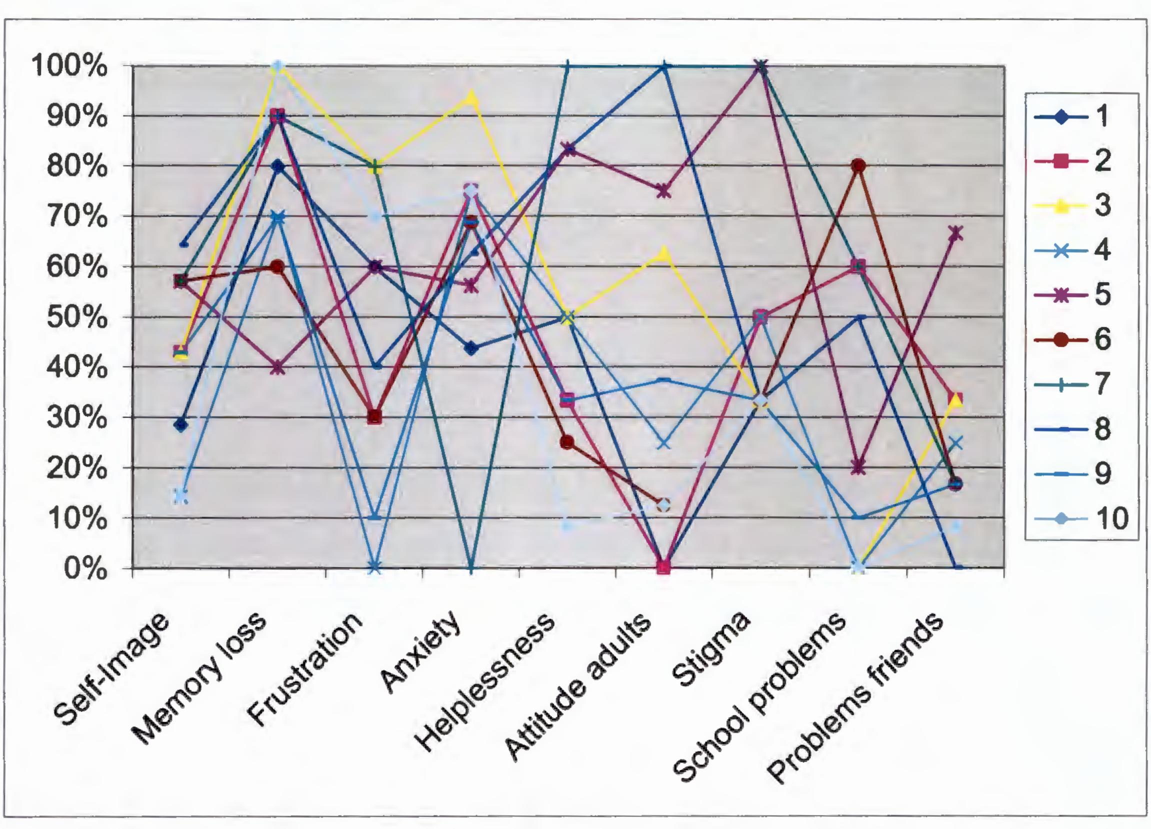
Average of the whole study population

		Average
1-6	Perseverance	15%
7-11	Satisfaction	16%
12-17	Future Expectations	15%
18-24	Self-Image	42%
31-35	Memory loss	79%
36-40	Frustration	46%
41-48	Anxiety	62%
49-54	Helplessness	52%
55-58	Attitude adults	43%
59-64	Stigma	50%
65-69	School problems	28%
70-75	Problems friends	23%
76-80	Problems mother	2%
81-85	Problems father	0%
86-91	Family problems	11%

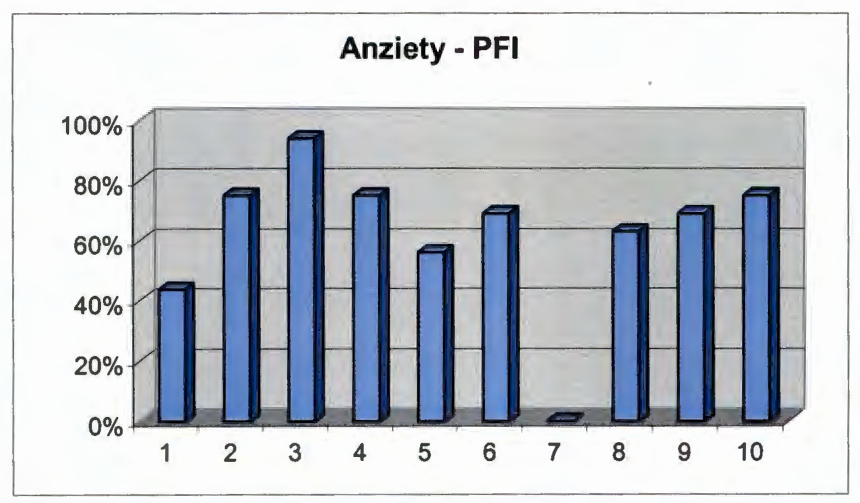


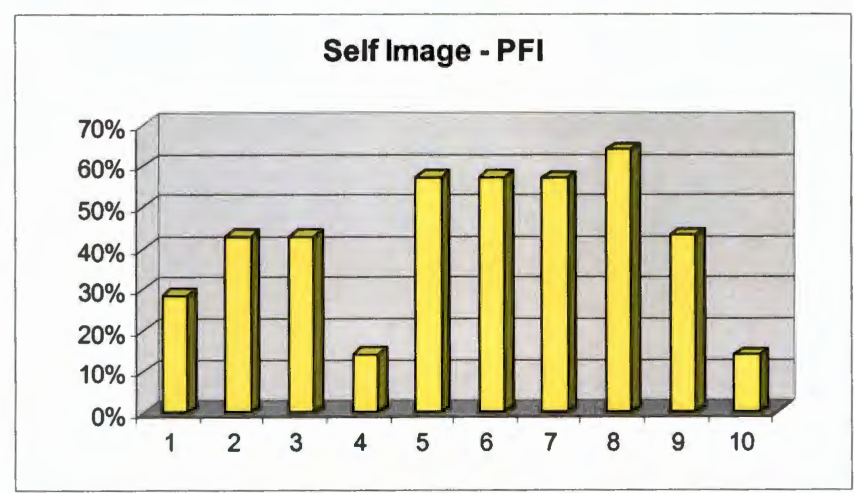
Combined it resulted in the following:

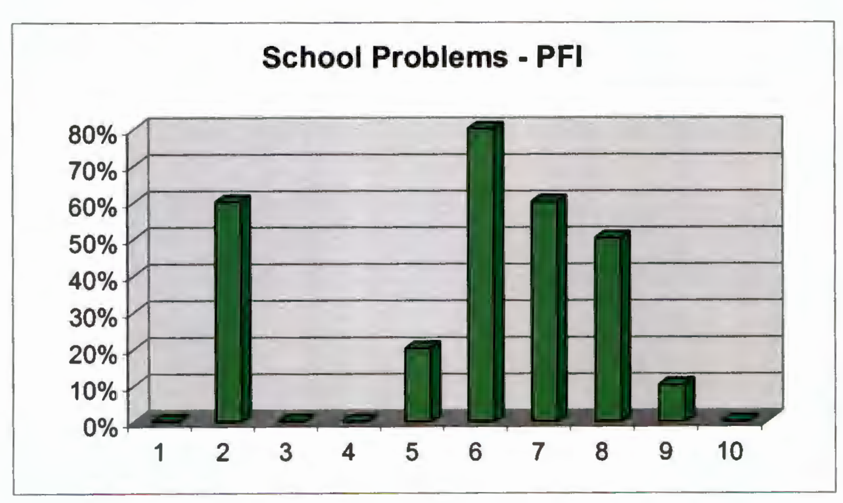
	1	2	3	4	5	6	7	8	9	10	Ave-rage
Perseverance	0%	17%	0%	8%	25%	33%	0%	50%	17%	0%	15%
Satisfaction	60%	0%	10%	0%	10%	20%	0%	60%	0%	0%	16%
Future Expectations	33%	0%	8%	0%	25%	17%	0%	50%	17%	0%	15%
Self-Image	29%	43%	43%	14%	57%	57%	57%	64%	43%	14%	42%
Memory loss	80%	90%	100%	70%	40%	60%	90%	90%	70%	100%	79%
Frustration	60%	30%	80%	0%	60%	30%	80%	40%	10%	70%	46%
Anxiety	44%	75%	94%	75%	56%	69%	0%	63%	69%	75%	62%
Helplessness	50%	33%	50%	50%	83%	25%	100%	83%	33%	8%	52%
Attitude adults	0%	0%	63%	25%	75%	13%	100%	100%	38%	13%	43%
Stigma	33%	50%	33%	50%	100%	33%	100%	33%	33%	33%	50%
School problems	0%	60%	0%	0%	20%	80%	60%	50%	10%	0%	28%
Problems friends	8%	33%	33%	25%	67%	17%	17%	0%	17%	8%	23%
Problems mother	0%	0%	0%	0%	0%	0%	0%	20%	0%	0%	2%
Problems father	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Family problems	17%	17%	0%	8%	33%	0%	17%	17%	0%	0%	11%

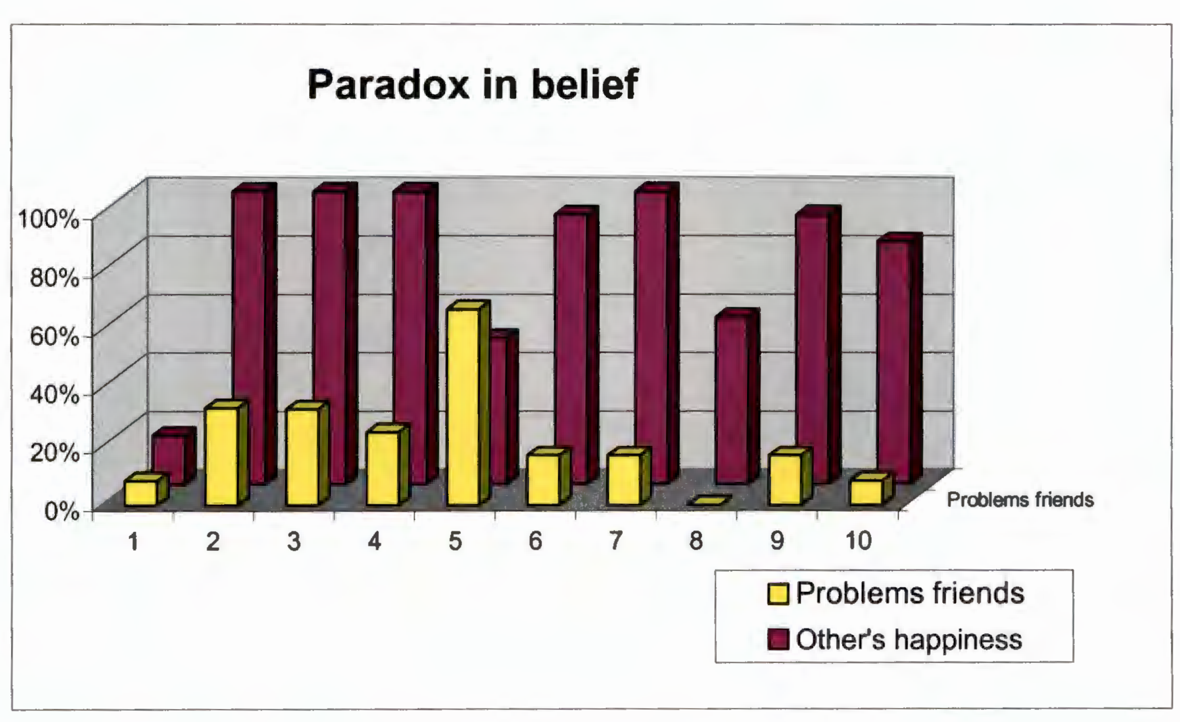


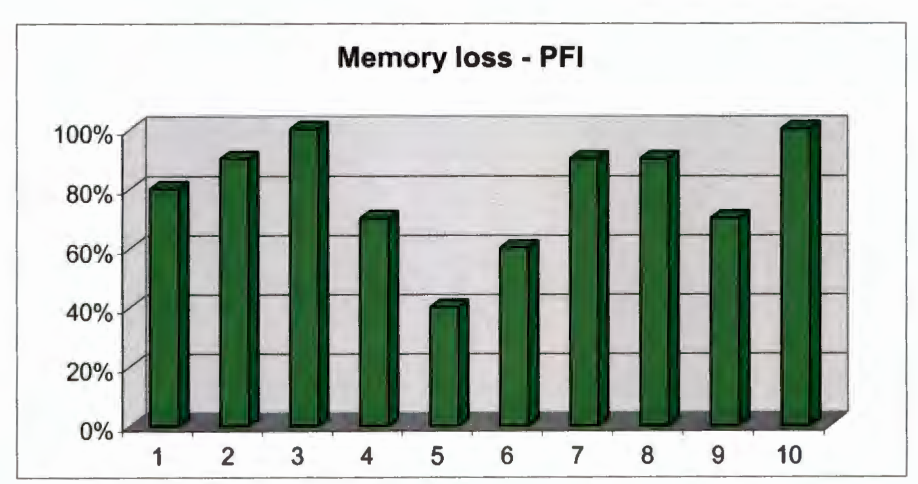
The following problem areas were discussed from the data above:



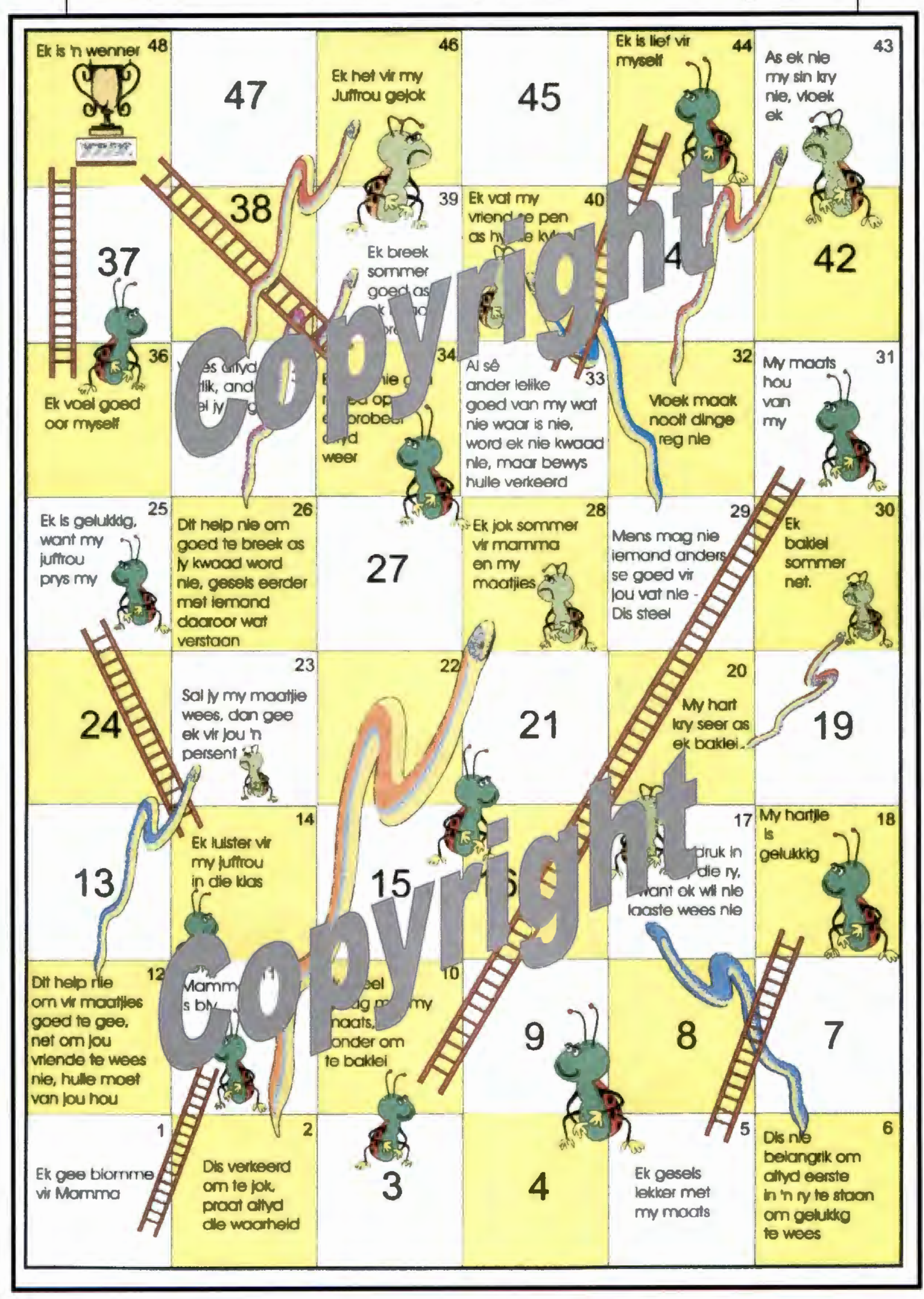




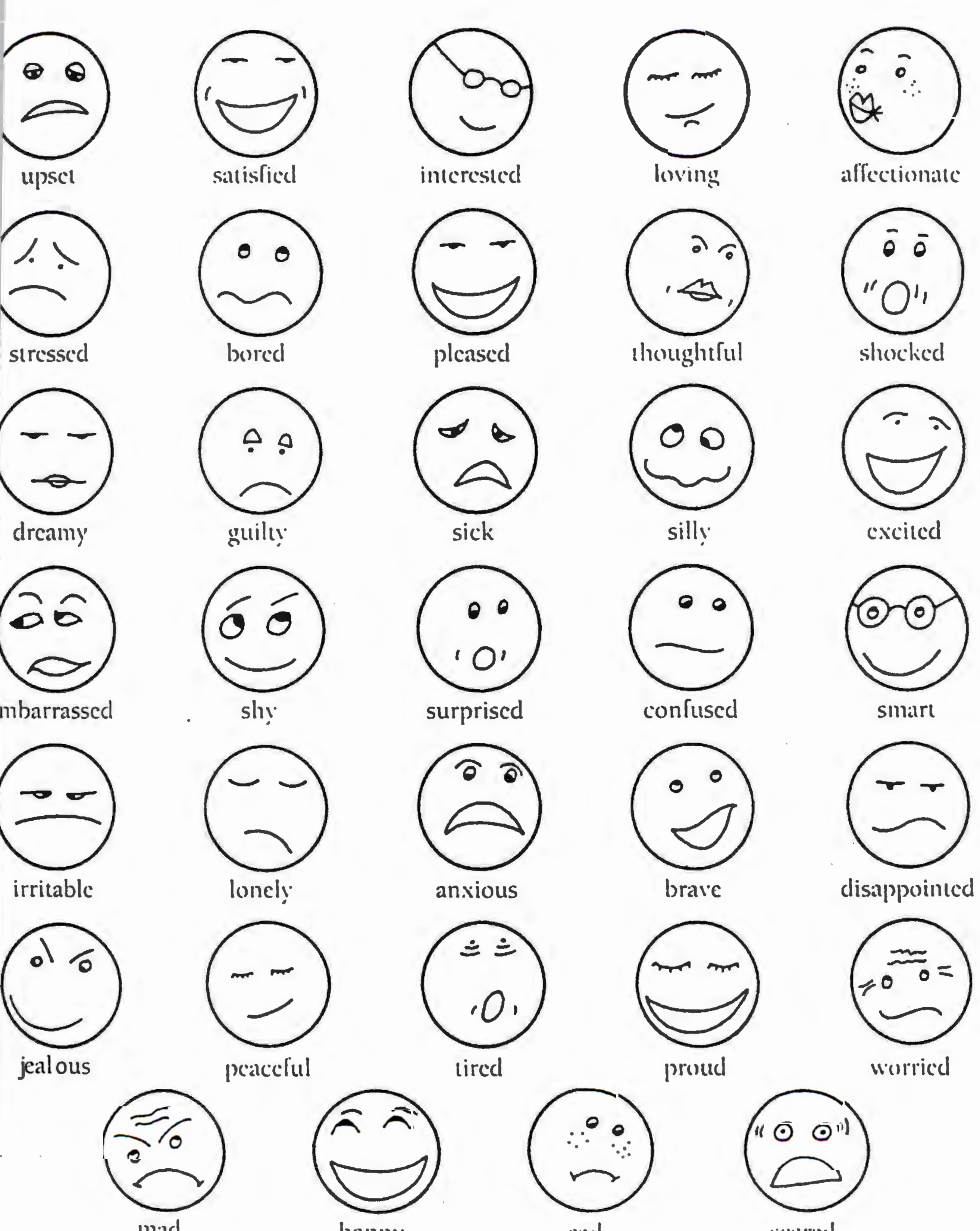

Paradox in belief
100%
80%
60%
40%
20%
0%
1
2
3
4
5
6
7
8
9
10
Problems friends
Problems friends
Other's happiness


Memory loss - PFI
100%
80%
60%
40%
20%
0%
1
2
3
4
5
6
7
8
9
10

Addendum 2: Social skill - Snakes and ladders game

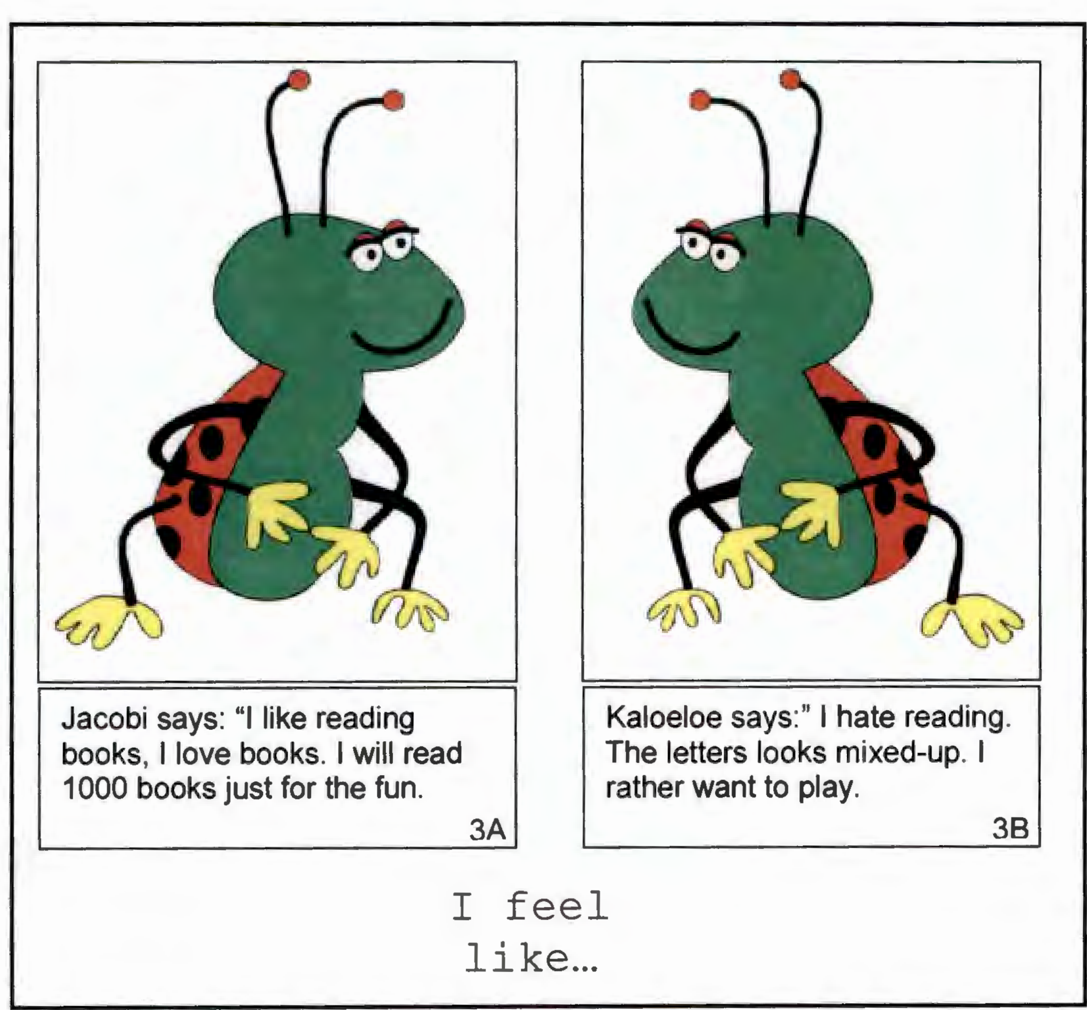


Feelings Faces



Addendum 3:
The Psychosocial Functioning questionnaire two – Data, computation and graphs.

The questionnaire consisted of 30 questions. An example of one of the question cards used:



The 30 questions are:

1a Jacobi says: "We play nicely together with the building blocks."
1b Kaloeloe says: "The children do not want to play with me. "

2a Jacobi says: "I am very cross, I feel like kicking the children in my row. I do kick them sometimes."
2b Kaloeloe says: "I am not cross, I walk nicely in my row."

3a Jacobi says: "I like reading books, I love books. I will read 1000 books just for the fun."
3b Kaloeloe says: "I hate reading. The letters looks mixed-up. I rather want to play."

4a Jacobi says: "I feel good."
4b Kaloeloe says: "I do not feel well."

5a Jacobi says: "I do not feel tired."
5b Kaloeloe says: "I feel very tired."

6a Jacobi says: "My schoolmates always choose me to play with them."
6b Kaloeloe says: "My schoolmates never wants too choose me to play with them."

7a Jacobi says: "I like working in groups with other children in the class."
7b Kaloeloe says: "I hate working in groups with other children."

8a Jacobi says: "I like my friends and I like doing things with them."
8b Kaloeloe says: "My friends do not really like me."

9a Jacobi says: "Most of the time I do not struggle to get things done."
9b Kaloeloe says: "I struggle to do things right, I hardly ever get things right."

10a Jacobi says: "I can remember what task to do without mommy or my teacher reminding me what to do."
10b Kaloeloe says: "I forget what task to do, and mommy and my teacher must remind me what to do."

11a Jacobi says: "I am not afraid of the dark."
11b Kaloeloe says: "I am afraid of the dark."

12a Jacobi says: "I do not feel sick."
12b Kaloeloe says: " I feel miserable, my tummy aches"

13a Jacobi says: "School is difficult. I feel like a dummy and my teacher must help me most of the time."
13b Kaloeloe says: "I like school. I am clever and can mostly do every thing without help.

14a Jacobi says: "I like reading, it is easy."
14b Kaloeloe says: "I hate reading, the letters confuses me and I can not remember the words."

15a Jacobi says: "I like my friends. I do not hurt them."
15b Kaloeloe says: " If I get angry I feel like hurting everybody."

16a Jacobi says: "I do not pull my friend's hair. "
16b Kaloeloe says: "I feel like pulling my friends hair."

17a Jacobi says: " My tummy aches again. I think I am ugly."
17b Kaloeloe says: "I seldom get tummy ache. I think I am cute."

18a Jacobi says: " I struggle to finish my work. My teacher scolds me a lot."

18b Kaloeloe says: "I finish my work quickly. I do not make mistakes. My teacher does not scold me."

19a Jacobi says: " I struggle with maths. It makes me feel bad. I rather want to play.
19b Kaloeloe says: "I love maths. I enjoy counting things all day long."

20a Jacobi says "I wish I were as big as my daddy and mommy."
20b Kaloeloe says: "I wish I were a baby again. "

21a Jacobi says: "I am big. I do not cry easy."
21b Kaloeloe says: "I am small. I cry very easy."

22a Jacobi says: "I sleep well at night."
22b Kaloeloe says: "I can not sleep at night."

23a Jacobi says: "I know my mommy loves me."
23b Kaloeloe says: "I think my mommy does not love me."

24a Jacobi says: "I am not afraid of the dark, when it becomes dark I sleep well."
24b Kaloeloe says: " I am afraid to sleep when it becomes dark."

25a Jacobi says: "I know my teacher likes me."
25b Kaloeloe says: "I think my teacher dislikes me."

26a Jacobi says: " I do not like food."
26b Kaloeloe says: "I love food, I enjoy eating."

27a Jacobi says: "I do not struggle to say words correctly. "
27b Kaloeloe says: "I struggle to say things correctly."

28a Jacobi says: "I do not want a pill. I feel well."
28b Kaloeloe says: "Give me a pill please, I do not feel well."

29a Jacobi says: "I do not think my daddy loves me."
29b Kaloeloe says: "I think my daddy loves me."

30a Jacobi says: "I enjoy living in my house."
30b Kaloeloe says: "I do not enjoy living in my house."

Answers to questions of respondents:

Question	1	2	3	4	5	6	7	8	9	10
1	**b**	**b**	a	a	a	a	a	**b**	**b**	**b**
2	**a**	b	b	b	b	b	**a**	b	**a**	b
3	**b**	**b**	a	a	**b**	**b**	a	a	**b**	**b**
4	a	a	**b**	a	a	a	a	a	a	a
5	**b**	**b**	a	a	a	a	**b**	a	a	a
6	**b**	**b**	**b**	a	a	a	a	**b**	**b**	a
7	a	a	a	a	a	a	**b**	a	a	a
8	**b**	a	a	a	a	a	a	a	a	a
9	**b**	**b**	a	a	a	**b**	a	a	a	**b**
10	a	**b**	**b**	a	a	**b**	a	**b**	**b**	**b**
11	a	a	a	a	a	**b**	a	**b**	a	a
12	a	a	a	a	a	a	a	a	a	**b**
13	**a**	**a**	b	b	b	b	b	b	b	b
14	**b**	**b**	a	a	a	**b**	a	a	a	a
15	a	a	**b**	a	a	a	a	a	a	a
16	**b**	a	a	a	a	a	a	a	a	a
17	**a**	**a**	**a**	**a**	b	b	b	b	b	**a**
18	b	**a**	b	**a**	b	b	b	b	**a**	b
19	b	**a**	**a**	b	**a**	b	**a**	b	b	b
20	a	a	a	**b**	a	**b**	**b**	a	a	a
21	a	**b**	**b**	a	a	**b**	**b**	**b**	a	a
22	**b**	a	a	a	a	a	**b**	a	a	a
23	a	a	a	a	a	a	a	a	a	a
24	a	a	a	a	a	a	a	a	a	a
25	**b**	**b**	a	a	a	a	a	a	a	a
26	b	b	**a**	**a**	**a**	b	b	b	b	b
27	**b**	**b**	a	a	a	a	a	a	**b**	**b**
28	**b**	a	**b**	a	**b**	a	a	a	a	a
29	**b**	a	a	a	a	a	a	a	a	a
30	**b**	a	a	a	a	a	a	a	a	**b**

(yellow)	Socialising with Peer group & Peer group relations
(pink)	Parent-child relationship& home environment
(blue)	Anxiety, tummy and head aches, mild depression, self-image
(purple)	Sleeplessness
(green)	School environment & learning problems
When letter a or b is **bold** it means negative	

Number of answers answered negative by the different respondents:

Respondent	1	2	3	4	5	6	7	8	9	10
Socialising with Peer group & Peer group relations										
	6	3	2	0	0	0	2	2	4	2
	75%	38%	25%	0%	0%	0%	25%	25%	50%	25%
Parent-child relationship& home environment										
	2	0	0	0	0	0	0	0	0	1
	50%	0%	0%	0%	0%	0%	0%	0%	0%	25%
Anxiety, tummy & head aches, mild depression, self-image										
	3	3	5	3	2	2	3	1	0	2
	38%	38%	63%	38%	25%	25%	38%	13%	0%	25%
Sleeplessness										
	1	0	0	0	0	1	1	1	0	0
	33%	0%	0%	0%	0%	33%	33%	33%	0%	0%
School environment & learning problems										
	5	8	2	1	2	4	1	1	3	3
	63%	100%	25%	13%	25%	50%	13%	13%	38%	38%