EXPLORING THE USE OF SANDPLAY PSYCHOTHERAPY IN OVERCOMING A LANGUAGE BARRIER WHILST SUPPORTING A YOUNG VULNERABLE CHILD

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DECLARATION OF AUTHENTICITY

I, Claudé Kukard, declare that:

EXPLORING THE USE OF SANDPLAY PSYCHOTHERAPY IN OVERCOMING A LANGUAGE BARRIER WHILST SUPPORTING A YOUNG VULNERABLE CHILD

is my own work and that all references appear in the bibliography.

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TABLE OF CONTENTS

Reference Page

CHAPTER ONE

INTRODUCTION AND RATIONALE OF THE STUDY

CHAPTER TWO

LITERATURE REVIEW

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

CHAPTER FOUR

RESULTS AND FINDINGS OF THE STUDY

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

LIST OF FIGURES

Page

LIST OF APPENDICES

SUMMARY

EXPLORING THE USE OF SANDPLAY PSYCHOTHERAPY IN OVERCOMING A LANGUAGE BARRIER WHILST SUPPORTING A YOUNG VULNERABLE CHILD

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The purpose of this study was to explore the use of sandplay psychotherapy, as intervention technique, in overcoming a language barrier, whilst supporting a young vulnerable child emotionally. An empirical study of limited extent was undertaken, which was *qualitative* by nature and conducted from the *interpretivist* paradigm. An *in-depth case study* was used as research design, whilst *educational psychological assessment, intervention* and *re-assessment, observation, interviews, analysis of documentation, field notes* and *visual data (photographs)* were employed as data collection methods. A young Sotho-speaking girl, who resides in an institution for children who are infected with and affected by HIV&AIDS, who had been made vulnerable by various circumstances (death of primary caregivers, emotional difficulties, and being infected with HIV&AIDS), was selected as the primary participant in the study.

The findings of the empirical study are supported by relevant literature with regard to the main concepts guiding the study, namely, *sandplay psychotherapy, vulnerable children,* and *language barriers.* The findings were, firstly, that sandplay psychotherapy supported the primary participant

emotionally, and, secondly, sandplay psychotherapy was an effective technique for overcoming a language barrier. A further finding was that the emotional healing that appeared to take place had a positive effect on the relationships and communication skills of the primary participant.

KEY CONCEPTS

Case study
Educational psychological assessment
Educational psychological intervention
HIV&AIDS
Interpretivism
Language barriers
Psychosocial support
Qualitative research
Sandplay psychotherapy
Vulnerable children

CHAPTER ONE

INTRODUCTION AND RATIONALE OF THE STUDY

1.1 INTRODUCTION AND RATIONALE OF THE STUDY

In today"s society many children are left vulnerable due to circumstances beyond their control, such as poverty, poor housing, overcrowded living conditions, insufficient facilities for playing, limited educational opportunities and the HIV&AIDS pandemic. Many of these factors are interrelated, and vulnerable children are more often than not simultaneously faced with a combination of these circumstances. For example, many children experience the loss of loved ones due to HIV&AIDS, resulting in a vast number of children being orphaned.

Vulnerable children are often referred to as children *at risk*. The question is – *at risk of what?* Literature includes examples such as the risk of dropping out of school; health risk; the risk of being abused, of developing mental health difficulties, of becoming a victim of violence, exploitation, trafficking, discrimination, or death; or the risk of developing problematic outcomes (UNICEF, 2005a; UNICEF, 2005b; Pianta & Walsh, 1996). At present, many support systems are in place to attend to people *at risk*, for example literacy programmes, HIV&AIDS awareness campaigns, life skills programmes, home-based care services and feeding schemes.

In recent years ample support seems to have been provided for vulnerable children and adults, concerning *basic* needs (Pianta & Walsh, 1996; Varma, 1992). In undertaking this study I, however, wanted to focus on children at risk due to mental health challenges, as literature on psychological and emotional support for vulnerable children of diverse cultures and languages still seems to be emerging (UNICEF, 2005a; UNICEF, 2005b).

Several descriptions of children living in challenging circumstances, including the often-associated culture of violence, demonstrate that such children more often than not experience extreme psychological distress. Vulnerable children face physical and psychosocial trauma with often resulting impaired cognitive and emotional development. Vulnerable children could even experience symptoms similar to those of Post Traumatic Stress Disorder, including flashbacks, difficulty maintaining attention due to emotional distractions, lack of motivation, apathy and depression, as well as unpredictable behaviour (Boik & Goodwin, 2000).

Vulnerable children might find it difficult to express their emotions verbally. Despite the possibility of such difficulty being attributed to their developmental level, the difficulty in expressing themselves might also be ascribed to them experiencing challenges with regard to expression, due to limited linguistic skills or insufficient insight into and awareness of their inner feelings. In addition, they might tend to repress feelings and thoughts, as well as dissociate themselves from traumatic and painful experiences. Emotional expression is, however, universally regarded as important, firstly to promote well-being, and secondly to prevent the development of emotions such as anxiety and depression (UNICEF, 2005a; Boik & Goodwin, 2000; Pianta & Walsh, 1996).

One of the factors, that might inhibit the availability and success of psychological and emotional support for vulnerable children, is the language barrier. In South Africa, for example, there are eleven official languages. More often than not the people in helping roles and the children in need do not speak the same language, evidently posing a problem. The use of interpreters to overcome language barriers has been researched in the past and could be one effective solution. However, a shortage of adequately trained, bilingual interpreters appears to exist in South Africa. Due to varying levels of linguistic skills in children as well as diversity of language, people in helping roles might in future more often have to utilise intervention strategies

that rely on nonverbal communication (Dale & Wagner, 2003; Edrich, 2001; Isaac & Hand, cited in Edrich, 2001).

Assisting children who face mental health challenges is rightly an area of great importance (Place, Reynolds, Cousins & O'Neill, 2002). As a result, I decided to explore one possibility of such assistance, more specifically a method of nonverbal intervention, namely sandplay psychotherapy, as a way of supporting a vulnerable child emotionally across a language barrier. If sandplay psychotherapy proved to be effective across the language barrier, whilst supporting a vulnerable child, it could offer an inexpensive, low-skill possibility of psychological and emotional support to other children. Children facing any form of emotional challenge might benefit cathartically and restoratively from such a therapeutic technique. In the words of Sweeney, Minnix and Homeyer (2001:381): *"Sandtray therapy is an inexpensive, versatile modality with the potential to enhance the therapy process of many diverse clients".*

Besides the pragmatic motivation, various personal feelings, beliefs and experiences motivated me to undertake this study. I have always experienced a particular interest in vulnerable children. I often find myself reaching out to them, but at the same time admiring them for their strength and resilience. At a young age I decided to become either a psychologist or a social worker, due to my passion for helping vulnerable people, as well as my natural empathy with them. My decision to become an educational psychologist, specifically, was motivated by my feelings of well-being, satisfaction and relaxation when being around young children. Furthermore, I chose to work with young children, as they often seem to be in greater need of help than adults, and therefore seem to be more vulnerable than adults.

With regard to my decision to work with mental health challenges, two reasons should be mentioned. Firstly, I was trained in the field of the mental health of children and therefore felt adequately competent and comfortable to take on such a task. Secondly, the idea and belief, that I could possibly make a

difference in the emotional life of a young vulnerable child, captivated, motivated and compelled me. I further believe that there are people in the helping professions who are passionate about helping young vulnerable children, but who are prevented from doing so effectively by language barriers.

An opportunity to explore a possible manner of intervention across a language barrier arose when I was requested to provide intervention to a four year old, Sotho-speaking girl, living in an HIV&AIDS support institution in Pretoria, who had lost her parents due to HIV&AIDS. The request provided me with the opportunity to explore whether sandplay psychotherapy, a nonverbal intervention method, could overcome a language barrier whilst helping this vulnerable young child emotionally.

I wanted to explore the possibility of nonverbal intervention, as it might open doors to many children. On a personal level, I have empathy for children who are disadvantaged by language instead of being enriched by it. I make this bold statement based on the fact that most people in helping professions in South Africa are Caucasian and English or Afrikaans speaking (Edrich, 2001). As a result, I often experience feelings of sadness and guilt due to the inequality in helping vulnerable children.

1.2 STATEMENT OF PURPOSE

Based on the above line of argumentation and on the limited research in my field of interest, the purpose of my study was to explore and describe the use of sandplay psychotherapy as a possible method of overcoming a language barrier, whilst supporting a young vulnerable child emotionally.

1.3 RESEARCH QUESTIONS

I was guided by the following primary research question whilst undertaking the study: *How can sandplay psychotherapy be used to overcome a language barrier, whilst supporting a young vulnerable child emotionally?*

In order to address the primary research question, I attended to the following secondary research questions:

What does the process of sandplay psychotherapy entail?

How can sandplay psychotherapy support young vulnerable children emotionally?

How can sandplay psychotherapy be used in overcoming a language barrier during therapeutic support of a young vulnerable child?

1.4 ASSUMPTIONS OF THE STUDY

I approached the study with the following assumptions:

Sandplay psychotherapy is an effective therapeutic technique.

Vulnerable children are in need of psychological and emotional support.

Language barriers can be overcome in the context of psychological and emotional support.

Sandplay psychotherapy can be used when intervening with a child of a different language than that of the professional helper.

An in-depth case study is the most appropriate method to generate elaborate (highly detailed) data in order to answer the primary research question.

1.5 CONCEPT CLARIFICATION

In order to provide a clear understanding of relevant concepts, I now define and clarify the key concepts of my study.

1.5.1 Vulnerable children

Pianta and Walsh (1996) describe *vulnerable children* as children who are at risk of developing emotional and social difficulties due to the effect of HIV&AIDS, poverty, death or chronic illness of primary caregivers, poor housing, homelessness, lack of adequate health care, neighbourhood violence

and maltreatment. A variety of these factors may contribute to the vulnerability of children and these factors can be referred to as hazards. Hazards function as systems and are commonly interrelated.

Other sources (UNICEF, 2005a; UNICEF, 2005b) add to the above-provided description of *vulnerable children*, by describing such children as children who have been deprived of their first line of protection (their legal guardians) by means of detainment, institutionalisation, prolonged hospitalisation, death, or runaway behaviour by them. Policy descriptions of various countries in Africa include the following characteristics in their definitions of vulnerable children: children living on the street, child labourers, children who are sexually exploited, neglected or living in child-headed households, children whose parents are terminally ill, those born to single mothers, those in foster care, in conflict with the law, exposed to crime, and children with disabilities (Smart, 2003). The vulnerability of the child who participated in this study can mainly be ascribed to her being affected by and infected with HIV&AIDS, the death of primary caregivers, her being in foster care, her facing emotional and psychological challenges, as well as suspected abuse.

1.5.2 Sandplay psychotherapy

Carmichael (1994) defines sandplay psychotherapy as: "*a singular, emotional form of individualized expression of the inter- and intrapsychic world of the child. This expression allows the child to take his or her internal „world" and express it externally in the sandtray*". Melanie Klein, Anna Freud, Erik Erikson and others serve as examples of psychologists supporting the use of toys and miniatures for diagnostic and therapeutic purposes. Within the context of my study, I regard sandplay psychotherapy as a method of expressive therapy, which involves playing with miniature toys in a sandtray. I further regard it as a nonverbal intervention technique.

According to Boik and Goodwin (2000), the use of water and sand automatically transports a child to those areas of experience that need

healing. At least two layers of meaning seem evident in a child"s sandplay, namely surface meaning and symbolic meaning. The child communicates both conscious and unconscious material, which is difficult to clarify. Interactive work with both the conscious and the unconscious contributes to the powerful possibilities of the sandplay psychotherapy technique (Boik & Goodwin, 2000; Mitchell & Friedman, 1994). During sandplay psychotherapy an experience or trauma is expressed, defined and eventually integrated. It provides children with the opportunity to express their innermost emotions and thoughts, and to resolve them if needed.

Sandplay psychotherapy is a non-directive technique, allowing the child to play freely and without interruption or interference. It is a non-intrusive method and the child is not confronted in any way. The therapeutic process occurs in the presence of someone who can honour and respect children and their creations without judgment. The helper should therefore avoid interpretation and merely fulfil the role of an empathic observer to children"s processes of healing and growth (Boik & Goodwin, 2000; Thompson & Rudolph, 2000; Vaz, 2000).

1.5.3 Language barriers

We live in a diverse world, populated by diverse people from a variety of cultural groups, speaking different languages – a situation which leads to both enrichment and misunderstanding. For people in helping professions, the challenge seems to be unique, as they should be able to respect and also transcend language barriers. Good language skills are, however, not required for understanding the expressions of the psyche of a child, as a child expresses emotions and thoughts through play. Due to the fact that sandplay psychotherapy is a therapeutic technique in which language skills are not essential for therapeutic intervention, it seems to be appropriate for use within populations with diverse languages, cultures, races, ages and developmental levels (Campbell, 2004; Carey, 1990).

Hanks (1992:59) defines a *barrier* as: *"Anything that prevents progress"* or *"Anything that separates or hinders union".* This study aimed to overcome language differences, which *prevent progress* through a lack of understanding, whilst helping a vulnerable child emotionally. The study further aimed to overcome the effect of limited linguistic understanding in establishing rapport with a vulnerable child (*hindering union).* For the purpose of my study, *language barriers* refers to barriers that prevent a helper and a child from comprehending one another"s verbal messages (Boik & Goodwin, 2000).

1.5.4 Supporting (supporting a young vulnerable child)

The concept *supporting* is defined by Hanks (1992:869) as: "*To give practical or emotional help (to someone)".* Within the context of my study, I explored whether or not sandplay psychotherapy could *help* a vulnerable young child *emotionally*, for instance, by means of a vehicle of emotional expression or the learning of coping mechanisms. Due to the educational psychological nature of my study, I offered further support to the primary participant by establishing a trusting relationship with her.

1.6 PARADIGMATIC PERSPECTIVE

A paradigm refers to the broad theoretical orientation to which a research study belongs. Various paradigms that underlie research exist and each of these paradigms has a unique epistemology, ontology and methodology. Epistemology is regarded as the belief about the nature of knowledge (being either subjective or objective by nature). Ontology refers to the view about the nature of reality, in other words the view about reality being either objective or subjective by nature. Lastly, methodology refers to the method of obtaining knowledge within a certain paradigm (Adams, Collair, Oswald & Perold, 2004). I conducted this study within the *interpretivist paradigm*, following a *qualitative approach.*

Interpretive researchers place great emphasis on interaction and listening, in order to understand the experiences of people. Interpretivism is not about the search for broadly applicable laws and rules, but rather seeks to produce descriptive analyses that emphasise deep, interpretive understandings of social phenomena. Researchers working in the interpretivist paradigm acknowledge people"s subjective experiences as their realities, and view these realities or experiences as valid (Adams *et al*., 2004; De Vos, 2002; McMillan & Schumacher, 2001). I regard Interpretivism as a suitable paradigm for my study, as the study was concerned with individualised, personal intervention with a specific child. Further, it is also compatible with my own life and world view.

I interpreted the information that I obtained during intervention sessions with the participant from a partially subjective, interactive perspective, and I reflected on the information in a descriptive manner. The aim of the study was to search for meanings rooted in interactions during the process of sandplay psychotherapy with one particular child. The value of applying the qualitative approach to my study includes that I gained information that is in-depth and comprehensive by nature, and that subjective information and participant observation led to an elaborate description of the context and the variables (namely the emotional and social functioning of the participant, sandplay psychotherapy and communication with the participant), as well as that the interactions of the different variables offered a wide understanding of the entire situation.

1.7 RESEARCH METHODOLOGY AND STRATEGIES

Although I discuss my selected research methodology and strategies in detail in chapter three, I now provide a brief overview of the main aspects thereof. This brief description should provide the necessary background against which this dissertation can be read.

I conducted the study using an instrumental *case study* design, involving a single case, which was selected purposefully. I regard a case study design as the in-depth analysis of a single case or multiple cases, focusing on one phenomenon. Case studies are therefore detailed investigations of individuals, groups or other social units. The outcome of such research is an in-depth description of the case that is rich in context (De Vos, 2002; McMillan & Schumacher, 2001; Stake, 2000).

I applied *purposeful sampling* in selecting the research participants (De Vos, 2002; McMillan & Schumacher, 2001). I selected the primary participant according to specific criteria pertaining to the study, namely the presence of an apparent language barrier, the participant"s vulnerability and a need for therapeutic intervention. I employed purposeful sampling in order to select a case that would provide the best possible information to in turn address the purpose of the research. My study and research idea were shaped by a particular case being referred to the Department of Educational Psychology, University of Pretoria. The manager at an institution for HIV&AIDS infected children in the Pretoria region referred a four year old, Sotho-speaking girl, whose parents had died of AIDS, to the Department. In addition, secondary participants (namely the social worker, the cook and the caregivers at the institution) were involved in the study in order to enrich the data I collected.

I employed *educational psychological intervention*, in the form of sandplay psychotherapy, to collect data. In addition, I relied on *educational psychological assessment* (at the beginning of intervention) and *re-assessment* (at the end of intervention) to determine whether or not the participant had been supported emotionally during the process of intervention. I employed *simple or passive,* as well as *participatory observation* throughout the study. I utilised simple/passive observation to observe the participant while she was busy with sandplay activities. I used participatory observation whilst I was interacting and playing *with* the participant (during sandplay psychotherapy sessions) in response to her request or gesture (Babbie & Mouton, 2001; Boeree, 1998; Key, 1997).

Apart from observation, I used *guided interviews* and *informal conversational interviews* with significant others in the participant"s life (for example the social worker and daily caregivers) as data collection strategies (De Vos, 2002; Key, 1997). I implemented *visual data* as data collection strategy, in the form of photographs. I took photographs of all the intervention sessions, particularly of the participant"s sandtrays, as these scenes offered valuable information regarding the experiences, emotions, thoughts, traumas and the process of therapy, as well as the progress of the participant. I made *field notes* throughout the research process (in the form of a research journal), which kept record of my personal feelings, thoughts and interpretations, as well as the progress and challenges during the therapeutic process (De Vos, 2002). During data collection I implemented *crystallisation*, which converged multiple data sources with the aim of deriving at conclusions from common themes, and interpreting them from different angles (De Vos, 2002; Janesick, 2000; Key, 1997).

Data analysis consisted of my identification of emerging themes across the variety of data sources, thereby implementing thematic analysis. Visual data of the scenes created in the sandtrays were a primary source of information for analysis. I interpreted all scenes projectively, based on the process of analysis proposed by Dora Kalff, and summarised by Carmichael (1994). In addition, I thematically analised the informal interviews. Besides an analysis of the visual data and informal interviews, I identified themes in the information that was continuously communicated by significant others in the participant"s life, as well as in my personal reflections regarding the progress and pitfalls during intervention (McMillan & Schumacher, 2001). Throughout, data analysis and interpretation were guided by the research questions of my study, firstly, whether or not sandplay psychotherapy offered a form of psychological support and healing to the participant, and, secondly, whether or not it was successful in overcoming the language barrier.

1.8 LAYOUT OF THE STUDY

Chapter one: Introduction and rationale of the study

Chapter one serves as an introductory chapter to the dissertation. It provides a general orientation, states the research questions, defines the key concepts and explains the purpose of the study. It also briefly introduces the research methodology I employed during the study.

Chapter two: Literature review

Chapter two focuses on the literature review of the study, exploring the concepts of *vulnerable children*, *sandplay psychotherapy* as well as *language barriers*. Further, it includes a description of the conceptual framework that guided my study. Chapter two serves as background to the empirical study that is described in the chapters that follow.

Chapter three: Research design and methodology

Chapter three discusses the empirical study in terms of the research design, selection of participants, data collection, data analysis and interpretation. All methodological choices are justified in terms of this particular study and its purpose. The manner, in which ethical issues and the credibility of the study were addressed, is explained.

Chapter four: Results and findings of the study

Chapter four reports on the results and findings of the study. Results are presented in terms of the themes that emerged. This is followed by a discussion of the findings with regard to the questions whether or not the language barrier was indeed overcome during intervention, and whether or not sandplay psychotherapy proved to be effective in supporting this young vulnerable child emotionally. All findings are discussed in light of relevant literature.

Chapter five: Conclusions and recommendations

Chapter five provides a summary of the study. It presents conclusions and recommendations for future research based on the study, as well as discussions of the potential value and challenges posed by the study.

1.9 CONCLUSION

The purpose of this chapter was to orientate the reader regarding the study and what to expect in this dissertation. The chapter provided an introduction to the nature of the study, and an overview of my rationale for undertaking the study. I formulated the research questions and stated the purpose of the study. I briefly clarified, summarised and explained the concepts underlying the study, namely *vulnerable children, sandplay psychotherapy* and *language barriers*. I introduced the paradigmatic perspective, from which the study takes its stance, and indicated the research methodology, data collection methods and data analysis strategies. Furthermore, I presented the layout of the study.

Chapter two takes the form of a literature study, and explains and describes the main concepts and theoretical discourses which guided the study. *Vulnerable children, sandplay psychotherapy* and *language barriers* are explored in terms of relevant and contemporary literature.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one served as background and introduction to my study. Besides explaining my rationale for undertaking this study, I formulated my research questions and purpose of my study. In this chapter, I explore existing literature, according to which I planned and conducted an empirical study, described in chapter three.

As this study is informed by literature on vulnerable children, sandplay psychotherapy and language barriers, these concepts are explored in this chapter. I commence the chapter by discussing vulnerable children in terms of a definition of vulnerable children, the characteristics of vulnerable children and support that exists for vulnerable children. Secondly, I explore sandplay psychotherapy in terms of its history, the way in which sandplay psychotherapy is implemented, the stages it involves, the underlying principles as well as the helper"s role during sandplay psychotherapy. Finally, I discuss language barriers by referring to a definition, to methods that might assist in overcoming language barriers, and, lastly, to alternatives to verbal expression.

2.2 VULNERABLE CHILDREN

After defining *vulnerable children*, I discuss typical characteristics of these children and possible ways of supporting them.

2.2.1 Defining *vulnerable children*

Various definitions and explanations exist of the concept *vulnerable children*. Authors often define and describe *vulnerable children* as children who have lost their parents or caregivers, as a result of death, detainment,

institutionalisation, prolonged hospitalisation or runaway behaviour by the children (UNICEF, 2005a). Other authors (UNICEF, 2005a; UNICEF, 2005b; Pianta & Walsh, 1996) support the assumption of orphanhood being synonymous with vulnerability, and argue that vulnerability further needs to be linked to factors such as poverty; distress; emotional difficulties; lack of nurturing; exposure to crime; whether or not a child is affected by or infected with HIV&AIDS; death or chronic illness of primary caregivers; poor housing; homelessness; lack of adequate health care; maltreatment (including abuse and neglect); paternal unemployment; poor nutrition; parental and child mental health difficulties; and neighbourhood violence. Community descriptions of vulnerable children often include destitute or disabled children (Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou & Chitiyo, 2004).

Various countries in Africa include the following characteristics in their policy descriptions of vulnerable children (Smart, 2003): children living on the street, child labourers; children who are sexually exploited, neglected, and living in child-headed households; children whose parents are terminally ill; those born to single mothers; those in foster care, in conflict with the law, and children with disabilities. Vulnerable children are often regarded as children „at risk", who therefore face challenges related to social, emotional, school and physical adjustment. Such factors that contribute to the vulnerability of children can be referred to as *hazards*. These factors or hazards often function as systems and are usually interrelated (UNICEF, 2005a; Pianta & Walsh, 1996).

Several factors contribute to the vulnerability of the child who participated in my study. Apart from her being orphaned due to her mother having died of AIDS, she herself is infected with HIV. In addition, being in foster care, experiencing emotional and psychological difficulties, suspected abuse and an apparent lack of nurturing added to her vulnerability at the onset of my study.

2.2.2 Characteristics of vulnerable children

Skinner *et al.* (2004) as well as Campion (1992) emphasise the lack of provision for basic needs, as one of the main characteristics describing a *vulnerable child*. Focus is placed on the *basic rights* of a child being denied, thus placing a child in a position of vulnerability.

According to the Constitution of the Republic of South Africa Act 108 of 1996, children have the following rights (Robinson, 1997:50):

"(1) Every child has the right

(a) to a name and a nationality from birth

(b) to family care or parental care, or to appropriate alternative care when removed from the family environment

(c) to basic nutrition, shelter, basic health care services and social services

(d) to be protected from maltreatment, neglect, abuse or degradation

(e) to be protected from exploitative labour practices

(f) not to be required or permitted to perform work or provide services that

are inappropriate for a person of that child's age; or

place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development

(g) not to be detained except as a measure of last resort, in which case, the child may be detained only for the shortest appropriate period of time, and has the right to be –

kept separately from detained persons over the age of 18 years

treated in a manner, and kept in conditions, that take account of the child's age

(h) to have a legal practitioner assigned to the child by the state, and at the state's expense, in civil proceedings affecting the child, if substantial injustice would otherwise result

(i) not to be used directly in armed conflict, and to be protected in times of armed conflict

(2) A child's best interests are of paramount importance in every matter concerning the child

(3) In this section „child" means a person under the age of 18 years"

The vulnerability of children, in terms of their basic rights not being met, means that a vulnerable child might not have parental care or appropriate alternative care, might not have shelter and available health care, is possibly abused or neglected, and is exposed to exploitative labour practices. Being denied these basic rights, a child is placed at risk of facing emotional and social challenges, health dangers, or being exposed to crime and abuse. In my study, the basic rights of the child who participated were not met, in terms of her being possibly abused or neglected. She was, however, in appropriate alternative care, was given shelter and did receive health care.

It seems clear that vulnerable children might experience a wide range of „symptoms". These symptoms can be explained in terms of how they manifest in the social functioning, emotional functioning, physical functioning, cognitive functioning and normative functioning of a child.

On a **social** level, vulnerable children are often characterised by relationship difficulties, behavioural difficulties, the challenge of trusting people, reactive attachments (becoming inappropriately attached to strangers), and they may find managing change difficult. On an **emotional** level, vulnerable children often experience feelings such as anxiety, sadness and sometimes even depressive emotions. They may have nightmares, experience stress or suffer from insomnia. Vulnerable children often experience an unsettling sense of helplessness, which is usually disturbing and can create uncertainty and self-doubt. Vulnerable children also commonly experience grief, bereavement and a sense of rejection (International HIV/AIDS Alliance, 2006; National Child Traumatic Stress Network, 2005; Ohnishi, Anoemuah, Jagah & Feyisetan, 2004).

On a **physical** level, vulnerable children might be exposed to malnutrition, hunger, poor health or HIV infection. They sometimes present with enuresis or somatic complaints. Vulnerability further effects the **cognitive** functioning of a child. Vulnerable children often experience academic difficulties. They may find concentration challenging and present with poor school attendance and truancy. Many vulnerable children also appear to display an underdeveloped sense of identity, because they do not have a parent who can help them develop their own identity, within their own culture. Vulnerable children often use „negative defense mechanisms" as a reaction against stress. These negative defense mechanisms include denial, projection, rationalisation, intellectualisation and reaction formation. Vulnerability may effect the **normative** functioning of the child because of limited parental discipline and guidance regarding social norms and values (International HIV/AIDS Alliance, 2006; National Child Traumatic Stress Network, 2005; Ohnishi *et al*., 2004).

2.2.3 Support for vulnerable children

The potential impact of vulnerability on the various levels of functioning emphasises the importance of support for vulnerable children. At present, various support systems aim to support vulnerable people, for example literacy programmes, HIV&AIDS awareness campaigns, life skills programmes, home-based care services and feeding schemes. Due to the fact that HIV&AIDS is currently a reality contributing to the vulnerability of children, as well as the fact that HIV&AIDS contributed to the vulnerability of the primary participant in my study, I include HIV&AIDS in my discussion of support for vulnerable children.

The effects of HIV&AIDS on infants and young children are unprecedented and might negatively impact on the achievements in child health and education. Young children infected with or affected by HIV&AIDS have special nutritional, educational, psychosocial, and protection needs. Numerous support programmes and initiatives seem to target the *basic* needs of

vulnerable children and adults (within the context of HIV&AIDS) (Young, 2005; UNICEF, 2005a; UNICEF, 2005b).

One such programme, which focuses on the basic needs of children affected by or infected with HIV&AIDS in Africa, is the *Early Childhood Development and HIV&AIDS Programme* (Young, 2005). This programme provides services, including the following interventions: local tracking and monitoring of the conditions of vulnerable children aged naught to eight years, family-based care for young orphans and for children who are neglected or abused; food assistance to households; community-based groups; community care centres for children, which in turn enable parents to take part in income-generating activities; and education, health care and the training of volunteers (in fields) related to the care of young children affected by or infected with HIV&AIDS, including feeding, health and development (Young, 2005; UNICEF, 2005a; UNICEF, 2005b). Another example of a programme that focuses on the basic needs of children affected by or infected with HIV&AIDS in South Africa is the *HIV/AIDS/STD Strategic Plan for South Africa, 2000 to 2005* (United Nations Country Team: South Africa, 2005). This is a broad-based national strategic plan designed to guide the country"s response to the epidemic. The programme has four thematic priority areas: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance.

Practices for caring and supporting vulnerable children have evolved through lessons learned from experiences in various countries. These developments have taken place in the following areas: policy and law, medical care, socioeconomic support, education, human rights, community-based programmes, emphasis on community rather than institutional care, strengthening the care and coping capacities of families and communities, involving children and youth as part of the solution and not part of the problem, building collaboration among key stakeholders, application of long-term perspectives, and finally linking care and prevention (UNAIDS/UNICEF, 1999). Developments in policy and law include the prohibition of discrimination with regard to access to medical services, education, housing and the inheritance

rights of orphans. Medical care entails clinical and preventative health care services, nutritional support and home-based care. With regard to socioeconomic support, attention is presently being diverted to factors contributing to long-term health and well-being, instead of solely focusing on short-term support. In the area of education it is acknowledged that many teachers are losing their lives to AIDS, thereby impacting on the quality of education provided to vulnerable children (UNAIDS/UNICEF, 1999).

The granting of human rights is increasingly being considered essential for the success of HIV prevention and care programmes. Community-based programmes have recently become indicative of a more holistic view of care, with regard to the various areas of child development. Concerning the development of a stronger emphasis on community care, as opposed to institutional care, it is acknowledged that separation from the family often hampers normal child development. A recent development concerning support involves children and youth as part of the solution and not part of the problem, as research increasingly focuses on the exploration of vulnerable children"s resilience and self-efficacy. In addition, emphasis is placed on facilitating collaboration among key stakeholders, such as the different support institutions. Contemporary programmes emphasise sustainability and not only temporary care. Finally, care and prevention are being linked concerning support (UNAIDS/UNICEF, 1999).

Despite numerous attempts to improve support for vulnerable children, psychological or psychosocial support for vulnerable children seems to be an emerging area of research and practice (Ferreira, 2006; Swanepoel, 2005; Viljoen, 2005; UNAIDS/UNICEF, 1999; Donahue & Williamson, 1996). The AIDS pandemic intensifies the urgency of addressing the psychological difficulties of children by supporting them. Within the context of my study, the primary participant displayed a need for psychosocial support, as observed by the staff of the institution in which she resides.

Psychosocial support can be defined as an ongoing process of meeting emotional, social, mental and spiritual needs, all of which are considered essential elements of meaningful and positive human development. It goes beyond simply meeting children"s physical needs, and emphasises children"s psychological and emotional needs, as well as their need for social interaction. Many support programmes for orphans and vulnerable children have, however, in the past primarily focused on children"s physical needs, such as the *Early Childhood Development and HIV&AIDS Programme* and the *HIV/AIDS/STD Strategic Plan for South Africa, 2000 to 2005*.

Psychosocial support is paramount, as orphans and other vulnerable children often experience trauma and stress. Implying an emotional shock, trauma often produces long-lasting effects on the individual. Psychosocial support aims to assist children in coping with emotional trauma and stress (International HIV/AIDS Alliance, 2006). Programmes that indeed focus on psychosocial support for vulnerable children in Africa include *First Eastern and Southern Africa Regional "Thinktank" on Psychosocial Support for Children Affected by AIDS: Voices for Advocacy on Psychosocial Support for Children Affected by AIDS – 2001, Nkundabana Initiative for Psychosocial Support (NIPS): A Participatory Approach to Identification of Nkundabana (Rwanda),* and *Training Programme: Psycho-social support for orphans and vulnerable children* (Young, 2005; Ohnishi *et al*., 2004; UNAIDS/UNICEF, 1999; Donahue & Williamson, 1996).

For the purpose of my study I focused on psychological or psychosocial support for a selected vulnerable child. Limited psychological and emotional support for vulnerable children of diverse cultures and languages seems to exist, therefore I decided on implementing sandplay psychotherapy, in an attempt to explore the possible use of this particular technique in supporting a vulnerable child across a language barrier. I now turn my discussion to this potential mode of supporting vulnerable children.

2.3 SANDPLAY PSYCHOTHERAPY

I explore sandplay psychotherapy in terms of the history thereof, the method it involves, the process and the phenomenon underlying the technique. Finally, the helper"s role is briefly explained.

2.3.1 The history of sandplay psychotherapy

Play and creativity are often used as therapeutic processes. Children, who have experienced considerable stress during their early years, and who have been separated from their families and raised in residential group care, often have difficulty expressing themselves verbally. Play therapy offers these children an opportunity for release and renewal, in other words an opportunity to release and express negative and disturbing emotions, thereby creating the possibility of healing, by helping the child to process his/her painful memories and feelings. For traumatised children, who are embarrassed, resistant, or do not have the linguistic skills to talk about their traumatic memories, creative art therapies, especially play therapy, are regarded as helpful ways to allow children to disclose and process their traumatic experiences and negative emotions in ways that are less threatening than talking (Weiner, 2005; Betman, 2004; Campbell, 2004; Rousseau, Lacroix, Bagilishya, & Heusch, 2003).

The value of sandplay psychotherapy in emotional intervention is well researched and documented. I refer to a few examples: One study examined the use of sandplay psychotherapy as an assessment and intervention tool with 52 abused and non-abused children (Zinni, 1997). The study concluded that significant differences existed in the sandtray constructions of the children in the two groups. Reported differences in content, theme and approach were related to the emotional distress experienced by the children in the abused group. Sandplay therefore served as a medium for emotional expression, with emotional expression being universally regarded as important for preventing the development of anxiety and depression. In a recent Australian review of

expressive therapies used by a sample of school guidance counsellors, it was reported that sandplay psychotherapy was found to be the most helpful modality of the expressive therapies explored, in achieving positive outcomes for learners (Pearson, 2003). Sandplay psychotherapy was also reported to be the technique most favoured by child clients.

In the early 1900"s, Wells wrote a book entitled *Floor Games,* sharing the story of the elaborate games he and his two young sons played on the floor while using lifelike miniatures. He realised that these games concerned his children"s acting out and solving problems of their daily experiences as well as the problems they had in their sibling relationship (Sand Tray Play History, 2005).

The use of the sand tray during intervention dates back to the 1920"s. Several well-known psychologists and theorists, working in the field of children, support the use of toys and miniatures for assessment and intervention purposes. These psychologists include Melanie Klein, Anna Freud, Erik Erikson and Carl Jung. In 1929, Margaret Lowenfeld, a British pediatrician, originated the *world technique,* by asking a child to create a *world* in a sand tray. Lowenfeld"s goal was to find a medium that would be attractive to children but also provide a means through which the observer and child could communicate. She recognised the potential of using small toys as a medium for children to make known their deepest, preverbal thoughts and feelings, and she believed that this method was a pure form of communication in which words were not necessary. In the 1950"s Dora Kalff, a Jungian analyst, renamed this type of play as *sandplay.* Sandplay psychotherapy is a blend of art and drama, and is particularly helpful to people who are grieving a loss, recovering from trauma, or experiencing relationship difficulties (Fitzpatrick, 2005; Van Dyk, 2001; Boik & Goodwin, 2000; Bradway, 1999; Kalff, 1991; Bowyer, 1970).

Apart from the child"s conscious feelings and thoughts that may be communicated through play, Kalff added the dimension of the unconscious

being played out in the sand by means of symbols. These symbols are based on Jungian symbolism. Jungian analysis focuses on the process of exploration of one"s psyche. It is a spiritual approach, which is more concerned with the expression of the soul or psyche, finding underlying meaning in difficulties experienced, rather than with diagnosing psychopathology. Jungian analysis uses dreams and other symbolic material, such as objects and toys as primary tools. In this way, deep memories and even traumatic material may be brought into consciousness. Accepting and reintegrating such memories into the thinking process of the individual during therapy could result in a lasting and healing change (Becker, 2004; Kalff, 1991). Kalff did, however, caution against interpreting these symbols, based on her belief in *therapist bias*. According to Kalff, interpretation is not necessary, as sandplay psychotherapy can be regarded as a self-healing process (Van Dyk, 2001; Carmichael, 1994).

2.3.2 The method of sandplay psychotherapy

Sandplay psychotherapy involves a tray of approximately 70 x 80 x 10 cm in size. The tray is painted blue on the interior, representing water and sky. The tray is half-filled with sand, whilst water is made available to the child. Sandplay is based on and relies on *play* as the basic and most important means of learning by children, unique to their developmental level (Thompson & Rudolph, 2000; Vaz, 2000; Kalff, 1991).

A variety of miniature toys is presented to the child. Miniatures can be grouped into categories such as nature miniatures, animal miniatures, human miniatures, fantasy miniatures, archetypal miniatures, building miniatures, transportation miniatures, and miscellaneous miniatures. *Nature* miniatures include rocks, stones, mountains, semi-precious stones, shells, kelp, driftwood, trees, sticks, shrubs and flowers whilst *animal* miniatures include wild animals, domestic animals, fish, insects, farm animals, prehistoric animals and fantasy animals, such as unicorns and dragons. *Human* miniatures include families, people from different occupations, people from different

ethnic groups and soldiers, whereas *fantasy* miniatures include wizards, witches, smurfs and dwarfs. *Archetypal* miniatures include figures and objects representing shadows such as scary or ugly objects, whilst *building* miniatures include churches, schools, stores, institutions and different kinds of houses. *Transportation* miniatures include trains, cars, airplanes and buses. Lastly, *miscellaneous* miniatures include objects such as household and farm equipment, bridges, fences, mirrors, flags, feathers, string, matches, umbrellas and candles.

Children are invited, in verbal and nonverbal ways, to use any miniatures of their choice to play with. They get the opportunity to select from the variety of miniatures and to construct a portrayal of the world. To the child, the world that is constructed is meaningful on a personal and individual level. The child"s freedom lies in the possibility of constructing anything, according to personal choice and need. The helper is merely an accepting, permissive observer of the child"s creations. The helper creates an empathetic, trusting and safe environment, in which the child can feel free to express and play (Hegeman, 2001; Sweeney *et al.*, 2001; Transpersonal Sandplay Therapy Center, 2001; Thompson & Rudolph, 2000; Kalff, 1991).

2.3.3 The stages of sandplay psychotherapy

Kay Bradway (in Fitzpatrick, 2005:2) explains the process of sandplay psychotherapy as follows:

> *"The focus of sandplay psychotherapy is on play without rules or purpose, with the emphasis on the tangible experience of moving the objects in the sand. It is the experiencing of molding the sand, of adding water, of placing the objects, of burying them, of letting events happen, be it felt as creative or destructive, and of honoring whatever process takes over. That is healing."*

Rather than reductively analysing what is going on in the tray, the helper attends to and appreciates the world that the child is creating within it. Thompson and Rudolph (2000) explain that, in their experience, children feel

nurtured, calmed or soothed by the process of expression during sandplay psychotherapy, and that children enjoy the experience of touching, moulding, and shaping sand, as well as letting it run through their fingers.

The sandplay psychotherapy process entails three stages, namely chaos, struggle and resolution. Emotional turmoil or being emotionally overwhelmed marks the first stage, namely the *chaos stage*. Common responses during this stage include chaotically using too many, or all of the miniatures in the sand, or, on the other hand, not using any objects at all and merely touching the sand. The child imposes no order on the toys or sand. This stage is often apparent for a number of sessions (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991).

The second stage, namely the *struggle stage*, is indicated by destruction. Destructive scenes are often characterised by no survivors. Common responses during this stage include everything being blown up, shot or destroyed. Battles are waged. At the beginning of this stage, no winner triumphs. As the sessions progress, the fighting may become more intense and organised, and struggles may become more balanced. The destruction builds up in intensity, yet, as the child improves, the scenes usually become less violent (Thompson & Rudolph, 2000; Carmichael, 1994). Carmichael (1994:304) provides the following example: *"The antagonists are no longer destroyed, but rendered powerless. A hero emerges."*

The *resolution stage* is characterised by a *normal*, balanced world. Kalff (1991) explains that children have, at this stage, integrated the polarity of the conscious and unconscious. Scenes closely represent reality. The toy figures are in place, and completion and wholeness are apparent. Most children reach the resolution stage within eight to ten sessions, after which they often express the desire to discontinue sessions (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991).

2.3.4 Underlying principles of sandplay psychotherapy

Boik and Goodwin (2000) assert that the use of water and sand tends to guide children to prior experiences that require healing. Two layers of meaning seem evident during sandplay psychotherapy, namely surface meaning, such as conscious experiences, and symbolic meaning, such as subconscious or unconscious feelings and thoughts. This type of communication is nonverbal and the child communicates both conscious and unconscious material, which is difficult to verbalise and clarify. Sandplay psychotherapy is considered a powerful technique with powerful possibilities, because intervention focuses on both the conscious and the unconscious levels of meaning of the child (Boik & Goodwin, 2000; Mitchell & Friedman, 1994).

An experience or trauma is expressed, defined and eventually integrated into the conscious world of the child during sandplay psychotherapy. Children are offered the opportunity to express their inner feelings and thoughts and to resolve and integrate them if needed. Some children need to externalise and objectify certain experiences or traumas in their lives before the traumas can be resolved (Campbell, 2004; Sweeney *et al.,* 2001). The symbols of the objects or miniatures used in sandplay psychotherapy can serve as a common language, as children (especially young children) often do not have the capacity to articulate what is happening to them and find verbal expression threatening. Sometimes trying to “figure things out” intellectually can pull us away from the soul"s natural, intuitive process of healing. One of the limitations of talk therapy is, by definition, that it happens in words. Many of the struggles, disappointments, and wounds of childhood are difficult to describe or to express in words. Sometimes talking causes getting mired up in analytical thinking, or feeling at a loss for words (Fitzpatrick, 2005; Boik & Goodwin, 2000). It has been suggested that in a therapeutic environment, play is to the child what verbal activity is to the adult (Campbell, 2004). Sandplay psychotherapy helps tune the mind to the voice of the soul. Therefore, sandplay psychotherapy can be a powerful tool when dealing with life

experiences, including traumas, relationship difficulties, personal growth and the integration of unpleasant emotions.

Massey (2005) explains the value of sandplay psychotherapy when used with children who are experiencing grief or loss. Expressive sandplay psychotherapy, in her opinion, often evokes the deeper places in the body where trauma and grief are stored. When emotions are strongly felt and/or accompanied by some sort of traumatic shock to the system, people may shut off or close down. In situations that are traumatic, shocking, and/or extremely sad to children, they may attempt to cope or even be expected to cope by denying their feelings. Expressive sandplay psychotherapy provides a safe arena for children to process their losses in whichever way they feel comfortable with. In addition to the potential value of sandplay psychotherapy in supporting bereaved children, Campbell (2004) explains that sandplay psychotherapy can also be used effectively and successfully when helping children with language and communication difficulties, children from various cultural groups, children who have experienced trauma, and children with behavioural difficulties. Based on suggestions like these, I considered sandplay psychotherapy to be potentially valuable in supporting the primary participant in my study, as she was also from a different language and cultural group, and had experienced trauma before the time that I commenced with my field work.

The *symbols* through which a child communicates during play are based on Jungian symbolism. A symbol is a name, term, picture or image, which is familiar in daily life, yet has other connotations besides its conventional and obvious meanings. For example, a child may play with a crocodile with sharp teeth as a medium to express an aggressive message. A symbol usually implies something that is partially unknown or hidden to the interpreter but known to the child. As the mind explores the symbol, it is led to ideas that lie beyond understanding and consciousness. Therefore, a symbol can rarely be precisely defined, as every person expresses different messages through different symbols. Symbols are the language by which the mind carries

messages from the unconscious to the rational level. Although certain symbols appear to be common and even universal, each child has a unique and individual symbol language. It is the helper"s task to try to learn that language before interpreting messages (Daniels, 2005; Meltzer & Porat, 1997; Cirlot, 1981; Jung, 1964).

2.3.5 The helper's role during sandplay psychotherapy

Sandplay psychotherapy is non-directive and permissive by nature. It allows the child to play freely and without interference, instructions or guidance. The child is not confronted in any way and the helper does not intrude into the child"s sand world without invitation (Boik & Goodwin, 2000). The process of intervention by means of sandplay psychotherapy occurs in the presence of someone who is emotionally permissive and respects children as well as their creations, without judgment and excessive interpretation and probing. The helper should limit interpretation and empathetically fulfil the role of an accepting observer during children"s processes of expression and healing. In this manner the helper should provide a safe and accepting environment. The helper plays the role of a "respectful witness". Vinturella and James (in Thompson & Rudolph, 2000) believe that sandplay psychotherapy is more beneficial than other approaches, because no skill is required from the helper or the child (Thompson & Rudolph, 2000; Vaz, 2000). Fitzpatrick (2005) elaborates on this idea by stating: *"This attending and appreciating, so rare in our analytic, critical nature, is at the basis of all therapy that nurtures the soul."*

One of the important aspects of the helper"s role is to record the activity of *world building.* Factual observation is usually recorded by means of photographs or sketches. In addition, notes are made on the miniatures that are taken, rejected or combined by the child. Caution should be taken against hasty interpretation, as symbols might easily be interpreted incorrectly. Hasty interpretations seem to violate the original intention of using the technique as an intervention strategy. Instead of projecting limited concepts and theories

onto the child"s images, helpers should wait for the child"s psyche to unfold in the series of sand scenes. However, the helper can explore symbols in an attempt to understand the meanings that the child gives to his/her world (Cirlot, 1981; Bowyer, 1970). Silent, respectful acceptance of the images that are created during the sandplay psychotherapy process will probably allow children to feel increasingly safe and free. Emotional themes might, however, emerge over several sessions, providing useful insight into the child"s world and therapeutic progress (Dean, 2004; Carmichael, 1994).

2.3.6 Personal thoughts on sandplay psychotherapy

I find the assumption of the self-healing power of sandplay therapy intriguing. The idea, that we all posses our own symbol language, a language only understood by our subconscious, leaves me in awe about the strength of the human mind. If this technique, which is based on symbolism and belief in self-healing, is effective, it holds amazing possibilities and resilience for all people.

However, this technique provides limited space for interpretation by the helper. It may leave the helper feeling slightly helpless, as it is difficult to determine whether or not healing or growth has taken place. In my case study the technique appeared to be successful in supporting a vulnerable child emotionally, despite the presence of a language barrier. Despite the assumption that sandplay psychotherapy is an effective technique, it is important to consider other factors and influences that may have contributed to the emotional healing of the primary participant in my study, namely trust between her and myself, a warm, caring therapeutic relationship, and the participant"s experience of an emotional catharsis.

2.4 LANGUAGE BARRIERS

After defining *language barriers*, I discuss methods of overcoming language barriers during psychosocial support, and thereafter alternatives to linguistic or verbal expression.

2.4.1 Defining *language barriers*

Treffry (1999:449) defines *language* as *"a system of spoken sounds or conventional symbols for communicating thought"* and *"the ability to use words to communicate"*. Treffry (1999:56) defines a *barrier* as *"anything that prevents progress"* and *"anything that hinders union (language barrier)"*. Language differences, limited verbal skills, inadequate language development as well as difficulty in expressing emotions, experiences or thoughts in words, often pose as a barrier in a therapeutic relationship. This barrier often hinders understanding. Therefore, language differences, limited verbal skills as well as difficulty in expressing emotions, experiences or thoughts in words, could pose a challenge to any intervention process (Pifalo, 2005; Betman, 2004; Campbell, 2004; Eveariti, 2004; Boik & Goodwin, 2000; Osborne, 1997). In this study *language barriers* refers to barriers, which prevent a helper and a child from understanding and comprehending each other"s verbal attempts to communicate during intervention sessions, therefore preventing progress and hindering union.

Language barriers impede the intervention process when child and adult clients cannot express the complexity of their thoughts and feelings, or resist discussing emotionally charged issues. Helpers may become frustrated by their lack of bilingual ability and consequent limited understanding of their clients. Language barriers may even lead to misdiagnosis of the difficulties the child is experiencing, limited understanding of the child"s situation, emotions, thoughts and experiences, limited establishment of rapport and trust during the therapeutic relationship, as well as inappropriate intervention and placement (Bolton-Brownlee, 1987; Romero, 1985). A research study entitled *Hablamos Juntos: We Speak Together* (Wirthlin Wordwide Research Report, 2006) found that the strongest driving force behind negative patient health care outcomes is the language barrier. From patients" perspectives, there is a clear sense that language barriers that exist compromise the effectiveness of their care, and positive outcomes are made more difficult. According to this study, the language barrier influences the ability to explain

symptoms and ask questions, the trust between the health care professional and the patient, and the ability to understand recommendations. A study, focusing on embracing diversity in the delivery of rehabilitation and related services (Perez & Gordon, 1997), found that communication between health care professionals and patients often became strained and stressed when miscommunication took place, and that both parties often became frustrated. This impacted on the establishment of rapport. Furthermore, of all the types of barriers to counselling (cultural orientation, accessibility, use of inappropriate counselling approaches, and language), language differences were found to be the most serious and prominent barrier to service delivery.

2.4.2 Overcoming language barriers

Our world is characterised by diversity, as diverse people from a wide variety of cultural groups and linguistic backgrounds populate our world. This creates a situation that leads to enrichment, but also misunderstanding at times. In South Africa specifically, great linguistic diversity exists, as there are 11 official languages.

People in helping professions face the unique challenge of respecting as well as transcending language barriers. Literature mentions various methods of overcoming language barriers (Edrich, 2001; Musser-Granski & Carrillo, 1997; Gong-Guy, Cravens & Patterson, 1991). These methods include the use of ethnically and linguistically matched professionals, the use of ethnically and linguistically matched paraprofessionals or interpreters, as well as the use of nonverbal intervention techniques. However, a lack of trained bilingual, bicultural professionals has been noted with respect to multiple ethnic groups (Edrich, 2001). In South Africa specifically, it is especially difficult to use ethnically and linguistically matched professionals as a result of the fact that most people in helping professions in South Africa are still Caucasian and English or Afrikaans speaking (Edrich, 2001).

The use of *ethnically and linguistically matched paraprofessionals or interpreters* is regarded as another method of overcoming language barriers (Edrich, 2001; Musser-Granski & Carrillo, 1997; Gong-Guy *et al.*, 1991). In cross-linguistic situations, paraprofessionals speaking the same language as the client may be more effective than other methods when conducting community outreach programmes, ensuring access to mental health services, facilitating engagement and retention in mental health services, as well as providing interpretation when needed. However, by definition, paraprofessionals do not have formal training with respect to mental health services. Therefore, in situations where they are called upon to serve as interpreters, this lack of training may lead to misinterpretation of the difficulties experienced by the client, and other distortions that can seriously undermine provision for the mental health needs of the client. As such, the helper"s attempts to provide mental health support may be inhibited. The mere presence of an untrained interpreter or paraprofessional (a third-party in the room) may raise ethical concerns regarding confidentiality, and may further hamper the establishment of good rapport and trust in the therapeutic relationship (Musser-Granski & Carrillo, 1997; Gong-Guy *et al.,* 1991).

Another method of overcoming language barriers whilst supporting vulnerable children emotionally entails the use of *nonverbal intervention techniques*. Nonverbal intervention techniques are regarded as effective because they bypass the limitations of structured speech and go directly to issues of the heart and soul. According to Evearitt (2004), nonverbal methods imply the possibility of assisting electively mute, foreign language speakers and children. Two examples of nonverbal intervention techniques are the use of art and the use of play during psychological intervention (Massey, 2005; Pifalo, 2005; Becker, 2004; Campbell, 2004; Grieve, 1992; Kalff, 1991; Bowyer, 1970). Using therapeutic techniques that are based on play or art seems to provide a natural and non-threatening means for children to communicate and act out sensitive experiences related to emotionally laden and difficult situations (Campbell, 2004; Tharinger & Stafford, 1995).

Art can be used as a method of intervention across language barriers as it provides children with the opportunity to express graphically what they are unable to express verbally. Engagement with the art form appears to simultaneously facilitate the unearthing of unconscious, subconscious and conscious material, including memories, images and experiences as a way of "speaking". The use of art therapy provides a medium for the child to communicate information without relying on words. Traumatic memories are often characterised by highly visual and sensorimotor qualities. Art therapy might provide the opportunity to communicate these memories in a clearer form (visual and sensorimotor) than verbal descriptions (Pifalo, 2005; Evearrit; 2004).

In a counselling context, play is to the child what verbal activity is to the adult. Literature pertaining to the use of therapeutic techniques with children frequently describes play as the *language of the child,* and toys as *their words* (Daniels, 2005; Campbell, 2004; Thompson & Rudolph, 2000; Meltzer & Porat, 1997; Tharinger & Stafford, 1995). In traditional counselling approaches, when children experience complex feelings and thoughts pertaining to the events in their lives, they often experience difficulty in trying to communicate their feelings and thoughts verbally. As a result, play might be utilised, in order to enable children to express themselves.

As discussed earlier, one example of play as a therapeutic technique is **sandplay psychotherapy**. The nonverbal nature of the sandplay psychotherapy process adds to its potential usefulness with children from a different language background to that of the helper, as well as children with language and communication difficulties (more specifically children who experience difficulty in verbal expression). Sandplay psychotherapy has also been shown to improve concentration and peer relations in children with speech and language difficulties. In addition, it seems to be useful with children who use excessive verbalisation as an ego defense strategy (Campbell, 2004; Carey, 1990; Vinturella & James, 1987). The foregoing discussion on how children naturally express their thoughts, emotions and

experiences, emphasises the importance of language, and of overcoming language barriers in providing mental health intervention.

2.4.3 Alternatives to verbal expression

In the previous section, I highlighted the fact that language skills are not necessarily required for comprehending the expressions of a child, as children might express emotions, thoughts and experiences through play. Grieve (1992) states that, according to Vygotsky, emotions and intellect are unified in a dynamic and meaningful system, and that emotions serve as the language of the young child, who might lack advanced verbal skills. Language or verbal expression is therefore not a necessity when communicating with and supporting a young vulnerable child emotionally.

Nonverbal intervention and emotional support, such as with sandplay psychotherapy, seems to be an appropriate intervention technique with children, as it seems appropriate for use within multi-cultural populations with diverse languages, cultures, ethnicity, ages and developmental levels. Sandplay psychotherapy could generate a feeling of intense connection and unity amongst helpers and children from different languages, as it seems to represent a common culture and language. It might also provide a needed and effective communication medium for a child with limited verbal skills (Edrich, 2001; Sweeney *et al.*, 2001; Boik & Goodwin, 2000; Mitchell & Friedman, 1994).

Contributing to the argument for using nonverbal intervention as an alternative to verbal intervention, it can be argued that verbalisation in itself could pose a barrier to the process of intervention. An excess of words might hinder progress during intervention, as the words themselves may stand in the way of direct communication. This may manifest in various ways. Firstly, some children may speak incessantly and use language to intellectualise and avoid issues. Secondly, a verbal description of an image might not represent the image itself, and thirdly, nonverbal intervention (for

example sandplay psychotherapy) might be a less threatening approach than verbal intervention techniques for children who are resistant to the helper"s inquiries into difficult issues. Sandplay psychotherapy therefore seems to discourage the rational mind, which uses language to express, and appears to allow the unconscious mind to tell its story through nonverbal expression (Boik & Goodwin, 2000; Weinrib, 1983).

2.5 CONCEPTUAL FRAMEWORK

Derived from the literature that I reviewed, I conceptualised a framework to inform my study. My primary role as researcher was to explore the use of sandplay psychotherapy in supporting a young vulnerable child emotionally across a language barrier. Pertaining to the specific case in my study, I defined the main concepts as follows:

Myself: I fulfilled the role of a researcher who explored the use of sandplay psychotherapy in an effort to support a young vulnerable child emotionally, despite the presence of a language barrier. Further, I fulfilled the role of interventionist (or helper) by providing psychological intervention and forming a trusting relationship with her.

The vulnerable child (primary participant): I regarded the vulnerable child in my study as „at risk" due to various factors, and therefore she faced challenges related to social and emotional adjustment at the onset of my study. Factors that contributed to her vulnerability included her experience of mental health difficulties, the fact that she is in foster care, is orphaned, and is infected with and affected by HIV&AIDS.

Sandplay psychotherapy: Sandplay psychotherapy is a nonverbal form of play therapy. The young child plays with toy miniatures by constructing scenes in the sand. Thereby, an experience or trauma is expressed, defined and eventually integrated into the conscious world of the child. The child is offered the opportunity to express her inner feelings and thoughts, and to resolve and

integrate them if needed. The symbols of the miniatures used in sandplay psychotherapy could serve as a common language, between the young child and myself (as researcher and interventionist), as the young child in my study did not have the capacity to articulate what was happening to her, and found verbal expression threatening.

Language barrier: The primary participant and I experienced language differences (in terms of different mother tongue languages), she had limited verbal skills, her language development was inadequate, and she experienced difficulty in expressing her emotions, experiences and thoughts in words. This posed a barrier regarding intervention and the development of a therapeutic relationship. In this study *language barrier* referred to a barrier, which prevented myself and the primary participant from understanding and comprehending each other"s verbal attempts to communicate during intervention sessions.

Therefore, as a result of the nature of this specific case study, sandplay psychotherapy was implemented in an attempt to overcome the language barrier, to eventually support the young vulnerable child emotionally.

2.6 CONCLUSION

This chapter provided a literature review concerning *vulnerable children*, *sandplay psychotherapy* and *language barriers*. I defined these three concepts, and elaborated on relevant aspects of each.

Based on the theoretical background as provided in this chapter, I planned and conducted an empirical study. I discuss my research design and methodology in the following chapter.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter two took the form of a literature review, according to which I planned and conducted an empirical study. The literature review explored and discussed the topics of vulnerable children, sandplay psychotherapy and language barriers.

In this chapter I explain the manner in which I planned and conducted my empirical study. I commence the chapter by discussing the paradigmatic perspective underlying the study. Secondly, I describe the research methodology that I implemented in terms of my selected research design, and the manner in which data were collected and eventually analysed and interpreted. I then discuss the rigour of my study, and finally the ethical considerations that guided me in conducting the study.

3.2 PARADIGMATIC PERSPECTIVE

The concept *paradigm* refers to the broad theoretical orientation to which a research study belongs. A paradigm encompasses a basic school of thought that includes certain assumptions that are accepted and followed. Assumptions that characterise a paradigm include its rationale for human constructions of thought, for specific methodologies and research techniques, and for certain metaphysical assumptions (Terre Blanche & Durrheim, 2002; Denzin & Lincoln, 1998).

Various paradigms underlie research studies, each of which has a unique epistemology, ontology and methodology. Epistemology refers to the belief about the nature of knowledge. Epistemology questions the way in which we know the world, as well as the relationship between the researcher and the

participant. Ontology is regarded as the view about the nature of reality and the content thereof. For instance, a view about reality may include notions about objectivity and subjectivity. Ontology generates fundamental questions regarding the nature and content of the reality that is being observed. Methodology refers to the method that is used whilst obtaining knowledge about the world, within a certain paradigm (Adams *et al.,* 2004; Terre Blanche & Durrheim, 2002; Babbie & Mouton, 2001; Denzin & Lincoln, 2000). I conducted my study according to the ***interpretivist paradigm***, following a qualitative approach.

Interpretivist researchers emphasise interaction and listening, in order to understand the experiences and contexts of people. Interpretivism is not about generalisation or a search for broadly applicable laws and rules, but rather seeks to produce descriptive, in-depth analyses that emphasise interpretive understandings of social phenomena. As interpretivist I regard human behaviour as meaningful and argue that it cannot be understood in the same way as natural phenomena. I further believe that human behavior cannot be explained simply in terms of external stimuli (as in the natural sciences), due to the fact that humans are not simply physical bodies, but are conscious and have unique internal ideas, feelings and motives. As interpretivist researcher I acknowledge people"s subjective experiences as their realities, and view these realities or experiences as credible and authentic. Reality is therefore mind-dependent and influenced by the process of observation (ontology) (Adams *et al*., 2004; De Vos, 2002). I view qualitative research, anchored in Interpretivism, as a suitable approach and paradigm for my study, as the study was concerned with individualised, personal intervention with a specific child (primary participant), with the aim of understanding the child and her experiences and perceptions of her context.

I therefore interpreted the information, that I gained during intervention sessions and interviews with the participant"s meaningful others, from a partially subjective, interactive perspective and reflected on it in a descriptive manner. The aim of my study was to search for meanings rooted in

interactions, and to understand these, during the process of sandplay psychotherapy with one particular child (the primary participant). As such, my study was not concerned with detecting widely applicable facts and truths about intervention with other children from different linguistic backgrounds.

Qualitative research methods enabled me to gain a descriptive understanding of the emotions, actions and experiences of the participant, rather than an explanation or prediction of these. In conducting qualitative research, I sought to gain an extensive picture of the phenomenon that was researched. A holistic description of events occurring in natural settings was needed to make accurate, situational interpretations and conclusions (unique to the case), as qualitative research assumes that people attribute meanings to situations and events, and that these meanings include feelings, beliefs, ideas, thoughts and actions (Adams *et al*., 2004; De Vos, 2002; McMillan & Schumacher, 2001; Key, 1997).

The value of having applied the qualitative approach to my study includes that the information that I gained was in-depth and fairly comprehensive. Subjective information and participant observation enabled me to obtain an elaborate description of the context of the variables, and of the interactions between the different variables (namely, the primary participant"s emotional functioning and daily functioning, as observed by myself and the meaningful others in her life). Therefore, I could gain a wide understanding of the research situation.

In using the qualitative approach, I had to keep certain challenges in mind whilst conducting my study (Key, 1997). With regard to qualitative researchers often being susceptible to subjectivity and selective perceptions based on a close link between the researcher and the participant, a close relationship (link) did indeed exist between the primary participant and myself. I remained aware of this potential challenge throughout my study. However, as I conducted my study according to the interpretivist paradigm, I did not strive for objectivity, but instead to gain insight into the participant"s life-world and

perceptions. Besides being aware of this challenge throughout my study, I continuously reflected on my subjective experiences and feelings during the intervention process, in the form of a research journal. I reflected on the manner in which my experiences and feelings might have influenced my understanding of the primary participant"s situation, and on my interpretations of her progress and pitfalls. The aim of my reflections was to raise my awareness of personal subjective influences, in order to reduce the influence of these.

3.3 RESEARCH DESIGN

A research design is regarded as a flexible set of guidelines, which brings a paradigm into perspective with certain research methodologies and strategies, with the aim of collecting empirical data (Denzin & Lincoln, 1998). For the purpose of my study, I utilised a case study research design.

3.3.1 Case study as research design

Mouton (2001) defines a *case study* as a study that is fundamentally qualitative by nature. A small amount of cases are usually studied, with the primary purpose of providing in-depth descriptions. A case study can be regarded as an exploration of a case, where multiple resources, providing in-depth data, are collected over a period of time. In this manner, a case study research design entails the in-depth analysis of a single case or multiple cases, focusing on one phenomenon. Case studies are therefore detailed investigations of individuals, groups or other social units. The outcome of such research is an in-depth description of the case that is rich in context (De Vos, 2002; McMillan & Schumacher, 2001; Denzin & Lincoln, 2000; Stake, 2000; Creswell, 1998). I conducted my study by utilising an instrumental case study design, involving a single case, which was selected purposefully.

The sole criterion for selecting cases for a case study design should be the possibility to learn from them. Although the researcher situates the case within

its larger context, the focus remains on either the case or an issue that is illustrated by the case. In my study I focused on a single case, with regard to which I explored the application value of sandplay psychotherapy whilst supporting a young vulnerable child emotionally, across a language barrier. In conducting a case study design, I adhered to an inductive and a-theoretical mode of reasoning. Although I did not formulate hypotheses, I realised that expectations or general ideas could act as guides during my study. I did not focus on generalisation, but rather on understanding the particulars of the case in its complexity (namely how the primary participant could be supported emotionally, despite her vulnerability and an apparent language barrier). I therefore focused on a phenomenon (emotional support for a vulnerable child across a language barrier), under natural conditions (at her place of safety, amongst familiar people), with the purpose of gaining a better understanding of a social issue (improvement of emotional functioning), and of elaborating on a theory (psychotherapy for vulnerable children across a language barrier) (De Vos, 2002; Babbie & Mouton, 2001; McMillan & Schumacher, 2001; Stake, 2000; Key, 1997).

3.3.2 Strengths and challenges of a case study research design

In selecting a case study research design, I could rely on the strengths of such a design. In my study, these strengths included that high credibility could be accomplished due to in-depth insights and understanding of the primary participant and her immediate context. In addition, observations of the primary participant in her natural environment (an institution for children infected with and affected by HIV&AIDS) possibly increased the scientific value of the study, as my perceptions and those of significant others could be better researched and understood. Thirdly, I was able to establish good rapport with the primary participant, due to regular personal contact. Finally, as case studies are familiar to me as researcher, due to my experience with individual cases during my years of study and training as an educational psychologist, I was comfortable and knowledgeable with regard to collecting and interpreting data in this manner, which might have increased the scientific

value of the study. I established rapport with the primary participant nonverbally, as the participant was not able to communicate in English (Babbie & Mouton, 2001; Cohen, Manion & Morrison, 2000; Stake, 2000).

In conducting my study, I had to address certain challenges. Challenges with regard to using a case study design (in my study) included the potential lack of generalisability of the results and a potentially limited scope, as my study focused on a single case, where sandplay psychotherapy was explored as a medium to overcome a language barrier whilst supporting the child emotionally. In this manner, the results will only be credit-worthy for cases similar to the selected case. The non-standardisation of the evaluations posed another challenge regarding credibility. Furthermore, I faced the challenge of data collection and analysis being time-consuming (Babbie & Mouton, 2001; Mouton, 2001).

Although I did not seek generalisability (based on the basic principles of Interpretivism), the potential challenge, that data collection might be time-consuming, applies to my study, due to the fact that I speak a different language than that of the participant in my study. I addressed the apparent language barrier by utilising a nonverbal technique of psychotherapeutic intervention, namely sandplay psychotherapy, and relied on the information supplied to me by significant others in the primary participant"s life. The fact that my study was time-consuming, contributed positively to the strength of the therapeutic relationship between the primary participant and myself, and also enriched my understanding of the primary participant and her situation.

3.3.3 Selection of participants

I used *purposeful sampling* in selecting the research participants. I selected the primary participant in terms of specific criteria pertaining to my study, namely her vulnerability, an apparent language barrier, and her need for therapeutic intervention. Besides the primary participant, I purposefully selected significant others in the primary participant"s life, namely her social

worker, her caregivers, the nurse at the institution, her teacher and the chef at the institution, who participated as secondary participants. These participants were selected based on their knowledge and understanding of the functioning of the primary participant.

I therefore employed purposeful sampling to select a suitable case, as well as participants that would provide the best possible information to address the purpose of my research. I simultaneously utilised two types of purposeful sampling during the sampling process, namely reputational-case sampling and critical-case sampling (De Vos, 2002). Through reputational-case sampling a best-suited participant is selected, based on the recommendations of knowledgeable experts, whilst a critical-case is identified on the basis of its ability to illustrate the phenomenon that is researched. The selected primary participant in my study was a young vulnerable child, in need of emotional support (with secondary participants being selected on the basis of their relationship to the child). There existed a language barrier between the primary participant and myself (De Vos, 2002; McMillan & Schumacher, 2001).

My study and idea were shaped by a particular case that was referred to the Department of Educational Psychology, University of Pretoria. The manager at an institution for children infected with HIV&AIDS in the Pretoria region referred a four year old, Sotho-speaking girl, whose parents had died of AIDS, to the Department. The institution serves as a place of safety for children infected with HIV&AIDS. The young girl had been living there since the age of four weeks. The manager at the institution briefly explained that the girl was at that time experiencing anxiety. Besides the girl being infected with HIV, the manager raised the possibility of her having been sexually abused. The need for therapeutic intervention with this girl was communicated. As a result, my study was shaped according to the circumstances of the young girl, amidst my realisation of the challenges of intervention with someone of another language.

3.4 DATA COLLECTION

In order to address the primary research question, I utilised various data collection strategies. The various techniques were employed interactively, and included educational psychological assessment and intervention, observation, interviews, visual data and field notes (in the form of a research journal).

3.4.1 Educational psychological assessment and intervention

I conducted an educational psychological assessment at the beginning of my field work and a re-assessment at the end of the research process. This data collection technique was used to determine whether or not the primary participant had been supported emotionally during the process of intervention. In addition, I employed educational psychological intervention, in the form of sandplay psychotherapy, throughout the research process, with the goal of supporting the primary participant emotionally. The initial educational psychological assessment aimed to determine the primary participant"s emotional functioning (at the time) and to gain insight into the difficulties she was experiencing. This assessment entailed four assessment sessions with the primary participant. During these sessions I requested the participant to draw, paint and play with the sandplay miniatures. I also administered the Von Staabs (Der Scenotest). I further conducted informal interviews with the social worker and the chef at the institution (Appendix B), in order to obtain information for assessment purposes. I requested the primary participant"s caregiver, as well as her teacher, to complete an observation checklist (based on her development and functioning) (Appendix D). I consequently integrated all information obtained from the various assessment techniques in order to gain insight into, and identify the difficulties the primary participant was experiencing at the onset of my study.

Thereafter, I continued with educational psychological intervention aiming to address the difficulties that had been identified during the assessment. The

educational psychological intervention took the form of sandplay psychotherapy, and at times general play therapy without the use of sand (when the primary participant wished to do so). I conducted thirteen educational psychological intervention sessions with the goal of supporting the primary participant emotionally. Intervention sessions took place at the institution, and each lasted between 20 and 30 minutes. I include more detail on the activities and processes involved during the sessions in chapter four.

Finally, toward the end of the research process, I conducted an educational psychological re-assessment in order to determine whether or not the intervention had supported the primary participant emotionally. In an attempt to re-assess, I interpreted the participant"s final few sand scenes, and conducted guided interviews (which were recorded on audiotape) with the social worker and the chef at the institution (refer to section 3.4.3, Appendix C and Appendix E).

3.4.2 Observation

I utilised observation as data collection strategy throughout my study. I employed two forms of observation, namely ***simple or passive*** observation and ***participatory*** observation. I relied on simple/passive observation to observe the primary participant while she was playing during intervention and assessment sessions. In fulfilling this observational role, I remained an outside observer, being present at the scene of action but not interacting with the primary participant. I therefore assumed the role of a spectator. During my study, I regarded simple observation as a way of avoiding interference with the primary participant"s process of projection. Although I acquired knowledge by means of such observation, it was challenging to achieve the needed depth from a detached perspective at times (Babbie & Mouton, 2001; Boeree, 1998; Key, 1997).

At times, however, my involvement became important to gain insight into the meaning that the primary participant was giving to her social environment.

This type of observation is referred to as participatory observation. I therefore secondly used participatory observation whilst interacting and playing *with* the primary participant during intervention sessions. I did so only when she requested me to, or made a gesture for me to do so. I employed participatory observation in order to gain knowledge and understanding of the participant"s experiences. This involved a level of interaction between myself (as researcher), the primary participant, and her milieu (Babbie & Mouton, 2001; Boeree, 1998; Key, 1997).

The value of having used simple observation in combination with participatory observation lies in the in-depth information that I gathered, and consequently in the depth of my understanding. I regard observation as an appropriate data collection technique, as the nature of my study necessitated the collection of elaborate, in-depth information in order to draw conclusions and obtain sufficient understanding.

Having used observation as a data collection method in my study implied certain challenges. Firstly, I did at times experience personal emotional involvement – which consequently could have altered my perceptions and understanding. Furthermore, my presence and emotional involvement as researcher might have influenced the participant"s behaviour. This challenge is known and described as the *Hawthorne-effect* (Anderson, 2002; Boeree, 1998). I attempted to address these challenges by continuously reflecting on my own emotions in my research journal, and by guarding against becoming too emotionally involved, especially against the background of my empathy with vulnerable children. My training in Educational Psychology served to my advantage, as I often encounter vulnerable children, with whom I have to work. I am thus fairly competent in regulating my levels of emotional involvement and reflecting on the ways in which it influences my professional practice. In this study then I transferred my skills as intern-educational psychologist to those of being a researcher, for this purpose.

3.4.3 Interviews and observation checklists

I utilised two forms of interviewing as data collection strategies, namely ***guided*** interviews and ***informal conversational*** interviews, with significant others in the primary participant"s life (the social worker, chef, caregivers and nurse at the institution). In conducting guided interviews I employed a basic checklist (Appendix B) to make sure that I had covered the relevant topics during interviews. Questions that were included in the interviews, were based on the initial difficulties the primary participant had experienced. The purpose of these interviews was to discover the views that the significant others in the primary participant"s life held (Key, 1997). I used this type of interview in obtaining background information from the social worker, caregiver, nurse, and chef at the institution, with specific emphasis on the participant"s relationships with significant others, background information on her family and life so far, as well as her emotional, behavioural, social, scholastic and developmental functioning. I conducted individual, guided interviews with the social worker and chef towards the end of my study (audio-taped and transcribed – Appendix C). Each interview lasted approximately thirty minutes.

Informal conversational interviews, or unstructured interviews, are interviews in which the questions flow from the immediate context, resembling an informal “chat”. This is an informal, non-threatening data collection strategy. One technique that can be used during informal conversational interviews is reflection – the technique of obtaining more detail or insight by rephrasing what the person has said, and putting it in the form of a question (De Vos, 2002). I used informal conversational interviews with meaningful others in the life of the primary participant throughout my study (namely the social worker, her caregivers, the chef and the nurse). The purpose of these interviews was to gather information on the functioning of the primary participant (progress and pitfalls), as well as any other information about her. Six informal interviews

were conducted in passing at the institution, and these resembled an informal “chat”. Refer to Appendix B for the field notes that I made during these interviews.

In addition, I compiled an observation checklist when my study commenced. I requested the primary participant"s teacher and caregivers to complete the checklist (included in Appendix D). The observation checklist required the teacher and caregivers to indicate the primary participant"s level of functioning regarding her social development, emotional development, intellectual development, development of play, as well as her behaviour (De Witt & Booysen, 1994).

I regard interviewing as having been essential and beneficial to my study, as I could not communicate verbally with the participant, due to a language barrier. I had to depend on interviews in order to obtain background information, as well as information on the participant"s behaviour, emotional functioning and progress before, during and after intervention (De Vos, 2002; Rogers cited in Boeree, 1998; Key, 1997).

The use of the interview as data collection technique did, however, imply certain challenges. I found that the data generated by means of interviews were at times difficult to analyse, due to the fact that the opinions and descriptions of the interviewees had to be interpreted within their specific contexts. Therefore the information gained during these interviews might have been subjective and one-sided (De Vos, 1998). Although an interpretivist approach often implies subjective interpretations, I aimed to address this challenge by correlating the information I gained from the various interviews, and other data collection techniques, in order to obtain a fairly holistic understanding of the primary participant and her situation. Secondly, I found that the use of the observation checklist posed a challenge, as responses to the checklist were rather negative. Due to the fact that I was not present during the completion of the checklist, I could not probe for further elaboration

of the information provided. I aimed to address this challenge by exploring further during individual interviews.

3.4.4 Visual data

I implemented visual data collection techniques in the form of photographs. Bogdan and Biklen (2003) differentiate between two categories of photographs in qualitative research. The first category consists of photographs taken by other people (such as participants), and the second category entails photographs taken by the researcher. For the purpose of my study, I relied on the second category, taking photographs during intervention sessions, particularly of the sand scenes.

The potential value of using photographs as data collection strategy in my study lies in the fact that the sand scenes could be documented, offering valuable information regarding the experiences, emotions, thoughts, traumas, and the progress of the primary participant, as well as the process of intervention (Berg, 1998). Further, photographs were of value because they assisted me in revisiting the sessions when analysing the detail of intervention sessions (Bogdan & Biklen, 2003).

Using photographs as data collection technique did, however, also pose certain challenges. Firstly, I had to consider the ethical implications of publishing the photographs in this dissertation. Although the reader might benefit by viewing the visual data with the purpose of gaining a holistic understanding of my study and the manner in which I conducted data analysis, the use of photographs raised ethical questions concerning the anonymity of the primary participant (Bogdan & Biklen, 2003). I addressed this challenge by obtaining written permission from the primary participant"s legal guardian, for photographs to be taken during sessions and to be published as part of this dissertation. I further protected the anonymity of the primary participant by editing photographs so that she is not recognisable in the published visual data. A second challenge relates to the risk of the camera or memory card,

containing valuable visual data, being damaged. Unfortunately, in my study, this did occur. Although I photographed all intervention sessions, only photographs of sessions one, two, four, ten, eleven, twelve, fourteen, fifteen, sixteen and eighteen are available (Appendix E), due to damage to the camera"s memory card. I attempted to address this challenge by writing detailed field notes and process notes in my research journal after each intervention session (Appendix E). Thirdly, the camera did initially distract the primary participant during intervention sessions. However, she soon became familiar with the camera and photographs being taken.

3.4.5 Field notes and research journal

I documented field notes in the form of a research journal, throughout the research process. Field notes are used to document observations, by describing observations as literally and accurately as possible (Anderson, 2002; Mayan, 2001). Bogdan and Biklen (2003) explain that field notes ought to include the thoughts, feelings and reflections of the researcher during the research process. For the purpose of my study, I used field notes to firstly keep record of my personal feelings and thoughts, to secondly document my observations during intervention sessions, and, finally, to record interpretations of the primary participant"s progress and pitfalls (Appendix E). I also noted the progress and challenges during the therapeutic process. The purpose of making field notes was to provide me with unedited, hands-on information on the process, as well as to construct a historical record of the process (De Vos, 2002). I documented field notes after every contact session with the primary participant, as well as after every interview with the secondary participants (meaningful others).

The value of using field notes, in the form of a research journal, was twofold. Firstly, my field notes contain valuable in-depth information about the progress of the research participant, the pitfalls that are experienced and the themes that emerged during sessions. This made my data analysis and interpretation easier. Secondly, field notes provided me, as researcher, with an opportunity

to debrief on personal feelings, thoughts and subjectivity during the research process. This continuous awareness of my subjectivity helped me in my attempt to address this particular challenge.

Using field notes as a data collection strategy posed distinct challenges. Although my field notes were subjective by nature, I regard this potential challenge as a value to my study as it raised my awareness of subjectivity and therefore helped me to curb it. Secondly, it was not always possible to document field notes directly after contact sessions, resulting in the possibility of finer detail and information being lost. I could address this challenge by referring to the photographs (those available), that I had taken during intervention sessions, in assisting me to revisit, and therefore document, the finer detail and information gained during intervention sessions.

3.5 DATA ANALYSIS AND INTERPRETATION

Data analysis can be described as a systematic search for meaning. It refers to the processing and organisation of data, in order to communicate to others that which was learned during the study (results of the study – see chapter four) (Bogdan & Biklen, 2003; Hatch, 2002). Data interpretation, on the other hand, involves the process in which the findings of the study are developed, considered and discussed in the light of associated literature (findings of the study – chapter four) (Bogdan & Biklen, 2003).

Various methods of processing and organising information exist. One of the methods that I employed during my study was *crystallisation*. Crystallisation involves converging information from multiple data sources with the aim of deriving conclusions. In this manner, data analysis and interpretation entail the identification of emerging themes across a variety of data sources (McMillan & Schumacher, 2001; Janesick, 2000). I conducted thematic data analysis and interpretation, being guided by my research questions.

Thematic data analysis and interpretation entails the identification of the essence, flavour or nature of the phenomenon being studied. It involves in-depth, personal reading and thinking about the data collected in order to develop authentic conceptualisations and understanding. It also involves using more structured analytical techniques such as categorising, identifying and naming themes, and counting them. In qualitative research the method of data analysis depends on the nature of the study, the context of the study and the subjective experiences of the researcher. The initial step involves sorting the content (information/data) into themes. Then a coding system is devised to sort the detail of the data into the various themes. At the next level the researcher engages in latent coding. This requires knowledge, usually gained from the field work, about deeper meanings in the study. This is interpreted in context by a knowledgeable researcher (Mayring, 2000).

During data analysis and interpretation I converged information from the following data sources:

Visual data of the scenes created in the sandtray (Appendix E). I interpreted all the scenes projectively, based on the process of analysis proposed by Dora Kalff, and summarised by Carmichael (1994), as well as Thompson and Rudolph (2000). In this way, I interpreted both the unconscious and conscious messages that were conveyed by means of toys. I recorded my interpretations in detail in my research journal, and identified and documented emerging themes and messages (Appendix E).

Raw data obtained during informal interviews with meaningful others in the participant"s life (Appendix B).

Information gained from the observation checklists (Appendix D).

Transcribed guided interviews (Appendix C).

Personal reflections and observations (my field notes) regarding the progress and pitfalls during intervention (Appendix E).

3.6 ROLE OF THE RESEARCHER

Due to the nature of my study, I fulfilled the secondary role of interventionist, besides my primary role as researcher. Therefore, my role encompassed being a *research instrument,* doing research whilst intervening with a child in an educational psychological manner.

Wheeler (1995) regards qualitative researchers as *research instruments,* due to them being part of the situation of data collection and analysis. As a qualitative researcher, I was personally responsible for all data collection activities, namely educational psychological assessment and intervention, observation, interviewing, photographing and making field notes. Due to my responsibility for analysing and interpreting the data gained during the research process, my role also included that of a *critical analyst.*

During my study I had to constantly reflect on my dual role and keep in mind that I primarily fulfilled the role of researcher. However, my research implied intervention, with me fulfilling the role of therapist. My role as interventionist naturally implied my role as *helper* and *observer.*

3.7 RIGOUR OF THE STUDY

In contrast to quantitative research, which requires that a study meet the criteria of *validity* and *reliability*, qualitative research requires a study to meet the criteria of *credibility, transferability, confirmability, dependability* and *authenticity* in order to ensure rigour (Terre Blanche & Durrheim, 2002; Hoepfl, 1997; Mitchell & Friedman, 1994; Krefting, 1991).

Credibility relates to the quantitative term *internal validity,* that refers to the extent to which a test measures what it is intended to measure (Terre Blanche & Durrheim, 2002; Babbie & Mouton, 2001). Therefore, in my study, credibility refers to whether or not the intervention technique that I explored, was suitable for supporting a young vulnerable child emotionally. Secondly, it

refers to whether or not my data analysis indeed analysed what I had intended to analyse, in other words, whether or not the primary participant was supported emotionally, despite a language barrier.

I aimed to increase the credibility of my study in various ways. Firstly, the therapeutic technique that I chose for my study, namely sandplay psychotherapy, has proved to be credible in other settings (Pearson, 2003; Zinni, 1997). Secondly, the method of implementation, recording and analysis took place according to the recommendations by sandplay psychotherapy experts such as Dora Kalff (Kalff, 1991) and Kay Bradway (in Fitzpatrick, 2005). Thirdly, the credibility of my study might be enhanced by the fact that I relied on continuous interviews with significant others, to confirm or challenge the information I had obtained during intervention sessions, by means of interpretation and observation. Finally, I employed multiple methods of data collection with the aim of gaining elaborate, in-depth information, and therefore more credible interpretations. As such, crystallisation promoted credibility, which strengthens the probability that my findings accurately reflect the primary participant"s perceptions, feelings and thoughts. This also enhances the probability that my findings are worthy of consideration by others (De Vos, 2002; Key, 1997). Refer to Appendices B, C, D and E to view the data that were analysed.

Transferability relates to the quantitative term *external validity,* which refers to the extent to which a study can be generalised to the greater population and applied to similar contexts (Terre Blanche & Durrheim, 2002; Babbie & Mouton, 2001). In qualitative research, the concept *transferabililty* refers to how applicable a theory might be in making sense of similar situations and people, rather than arriving at conclusions that can be generalised. Due to the fact that I approached my study according to Interpretivism, which implies that meanings differ with regard to various contexts and situations of human interaction, I did not attempt to generalise the findings that I obtained. As the purpose of my study was to merely understand and describe the specific case in-depth, this might in turn increase the value of the findings that I obtained. I

adhered to Merriam"s (2002) recommendation to rather focus on providing an elaborate, descriptive study, in an attempt to increase the transferability of my findings. I present my results in the form of condensed descriptions, thereby increasing transferability. In an attempt to further contribute to an in-depth understanding of the data that I had collected, I conducted my field work over a period of 12 months and included 18 individual contact sessions with the primary participant.

Dependability relates to the term *reliability,* used in quantitative research, which refers to the extent to which a study, conducted in a similar time frame with a similar sample, will produce the same results. In qualitative studies the term *dependability* is similar, yet emphasises *consistency* (Cohen *et al.,* 2000; Denzin & Lincoln, 2000). My research design consisted of a single case study, which was unique. As the behaviour and emotions of the primary participant, and the therapeutic relationship with her, were unique, it is unlikely that a replica of this study might be produced. What is more important in a qualitative study, however, is whether or not the results of the study are consistent with the data that were collected during the study. I attempted to obtain results that are consistent with the data that I collected in various manners. Firstly, I utilised multiple methods of data collection, thereby crystallising the themes (included as results) from multiple sources. Secondly, I relied on various forms of information, for example repeated interviews with significant others, personal notes and repeated informal assessments, in order to confirm or challenge the information that I derived from projections and expressions during intervention sessions. Thirdly, I repeatedly consulted experts in the field, such as my supervisor and co-supervisor, social workers and psychologists, as well as significant others in the participant"s life, regarding my interpretations and the research process. Another aspect, that might have contributed to the dependability of my study, is the fact that I was trained in a mental health profession, specialising in intervention with children. My training included assessment and intervention with regard to emotional difficulties of young children.

Confirmability relates to the term *objectivity,* used in quantitative research, which refers to the extent to which a study is relatively value-free. However, qualitative research relies on interpretations, which therefore imply a certain degree of subjectivity. Patton (1990) encourages researchers to neither use the term *objective* or *subjective.* Rather, a researcher should aim to be neutral and non-judgmental, and should strive to report findings in a balanced way. *Confirmability* therefore refers to the degree to which a researcher can demonstrate the neutrality of research interpretations. I attempted to demonstrate the neutrality of my interpretations by comparing my raw data, field notes, information obtained from others, and relevant literature. All raw data, field notes and interviews are included in the final report, and are available to the reader. I further strived to increase confirmability by making my study available for critique by professionals in the field of research and educational psychology.

I included several measures in an attempt to increase the *authenticity* of my study. Firstly, I made field notes, in the form of a research journal, throughout the entire research process. These notes and reflections were unedited raw data, and are included in Appendix E, even in cases where I found it difficult to interpret the raw data. As such, I aim to provide a holistic picture by acknowledging the difficulties experienced. Secondly, I captured concrete raw data in the form of photographs, by photographing the primary participant"s sand scenes as well as other forms of play and interaction. I filed and interpreted these photographs separately, but in a chronological order.

3.8 ETHICAL CONSIDERATIONS

I indicate the ethical considerations that I adhered to by referring to three categories, namely ethical values, ethical principles and personal moral qualities.

3.8.1 Ethical values

I adhered to various fundamental values during my fieldwork and throughout my study (British Association for Counselling and Psychotherapy, 2006; Patton, 1990). I respected human rights and dignity by assuring the anonymity of the participants as well as working ethically throughout the study. Furthermore, I aimed to ensure the integrity of helper-client relationships by always considering and practising in the best interest of the participants. Throughout my study I attempted to enhance the quality of my own professional knowledge and application. As such, others might benefit from the knowledge gained through my study. I was devoted to alleviating the personal distress of the primary participant by exploring an intervention technique that supported her emotionally. I aimed to increase my personal effectiveness by consulting literature and seeking advice from professionals, such as my supervisor, who is a senior educational psychologist. Finally, I strived to provide adequate psychotherapeutic service whilst conducting research.

Values inform ethical principles. Values represent an important way of expressing a general ethical commitment that becomes more precisely defined and action-orientated when expressed as a principle, as presented below.

3.8.2 Ethical principles

For the purpose of my study I applied the following ethical principles (British Association for Counselling and Psychotherapy, 2006; Faculty of Education, University of Pretoria, 2003; Terre Blanche & Durrheim, 2002; Allan, 2001):

Voluntary participation: The participant was permitted to withdraw from the process at any time. As she is still very young, her legal guardian assisted in making such a decision, and was free to withdraw the participant from the process. The principle of autonomy prevented the manipulation of the child client. This principle was upheld, despite the girl"s young age.

Informed consent: The participant"s legal guardian was fully informed about the research process and purposes, in order to obtain informed consent. The participant and her legal guardian were asked for permission for photographs of the sand scenes to be taken. In addition, permission was obtained from the institution to conduct the study. Refer to Appendix A for relevant documentation in this regard.

Safety in participation: Although psychotherapy inevitably implies risk, I aimed to counter such risks through prolonged engagement and by conducting the study under supervision.

Beneficence: The principle of beneficence was adhered to throughout the research process. I acted in the best interest of the child client (the primary participant). I worked strictly within my limits of competence, and provided a service on the basis of adequate training and experience. An obligation to work in the best interest of the primary participant was paramount in my study, as her autonomy had been diminished, due to her vulnerability.

Privacy: The confidentiality and anonymity of the participants were protected.

Trust: The participant was not exposed to any acts of deception or betrayal in the research process or its published outcomes. I honored the trust that was placed in me as researcher and psychotherapist. Confidentiality was regarded as an obligation arising from the participant"s trust.

Self-respect: I (as researcher and psychotherapist) appropriately applied all the above principles as entitlements for self. This included seeking counselling and other opportunities for personal development as required. I received supervision for appropriate personal and professional support.

In addition to the above-mentioned ethical guidelines, I obtained ethical approval from the Ethics Committee of the Faculty of Education (University of Pretoria) for my study to be conducted (Appendix A) and adhered to the Ethical Code for Psychologists, as provided by the Health Professions Council of South Africa (refer to www.hpcsa.co.za for viewing). As I am registered at the Council as a psychologist in training, I am bound to their Ethical Code of Conduct when conducting intervention with a child (Allan, 2001).

3.8.3 Personal moral qualities

Many of the personal qualities considered important in the provision of psychological services have an ethical or moral component. These are considered as virtues or good personal qualities. The British Association for Counselling and Psychotherapy (2006) encourages certain personal qualities when a psychologist deals with clients in a psychotherapeutic manner. I identified several of these qualities in myself as researcher and psychotherapist. These include:

Empathy: I believe that I was able to communicate understanding of the participants" experiences, in a verbal and nonverbal manner.

Sincerity: I had a personal commitment to striving for consistency between what I professed and what I did.

Integrity: I was committed to upholding morality in all my dealings with participants, being straightforward, honest and coherent.

Resilience: I believe that I had the capacity to work with the participants" concerns without being personally diminished.

Respect: I strived to respect participants and accept their views as being of great value at all times.

Humility: I am of the view that I assessed accurately and acknowledged my personal strengths and weaknesses.

Competence: I believe that I possessed the knowledge and skills that were essential to doing what was needed.

Courage: In my opinion, I had the capacity to act in spite of known fears, risks and uncertainty.

3.9 CONCLUSION

In this chapter I described my research design and methodology, by explaining the various aspects of planning and conducting my study. I discussed the paradigmatic perspective underlying my study, as well as the data collection strategies that I implemented. Thereafter I discussed my

process of data analysis and interpretation. Finally, I described my role as researcher, the rigour of my study, as well as the ethical aspects that I considered during my study. In the following chapter I report on and discuss the results and findings of my study.

CHAPTER FOUR

RESULTS AND FINDINGS OF THE STUDY

4.1 INTRODUCTION

In chapter three I explained how I had planned and conducted my empirical study. Besides explaining my selected research design and the methodological choices I made, I related the procedures that I employed to my research questions and purpose of this study.

In this chapter I report on the results and findings of my study. I include an account of some of my personal reflections, describe the research process as it progressed and summarise my observations of the research participant. Then I present and discuss the results of my study, in terms of the themes and sub-themes that emerged. Thereafter, I discuss the findings of my study, in terms of the questions whether or not the language barrier was overcome during intervention, and whether or not sandplay psychotherapy proved to be effective in supporting the selected young vulnerable child emotionally. Throughout, I relate my findings to relevant literature.

4.2 REPORTING ON THE RESEARCH PROCESS

After discussing the progress and stages of my field work, I provide a summary of my observations of the primary participant. I conclude the section by reflecting on the research process.

4.2.1 The process

The therapeutic process consisted of 18 intervention sessions, which took place on a weekly basis and lasted approximately 30 minutes. During the first two sessions I introduced the primary participant to the sandplay miniatures and established rapport with her.

In order to assess the difficulties that the participant was experiencing at the onset of my field work, I conducted informal interviews with the social worker at the institution, as well as with the chef, with whom the primary participant has a good relationship. In addition, I requested her teacher and her caregivers to complete a developmental checklist concerning her daily functioning. I conducted three initial assessment sessions with the primary participant herself, during which I requested her (via an interpreter) to paint and draw. I further administered the Von Staabs (Der Scenotest) as an assessment tool that is based on non-directive play. I analysed the information that I obtained and established three primary areas of difficulty that the research participant was experiencing at that stage. These broad areas were: her experiences of negative emotions such as sadness, anger and anxiety; her difficulty in establishing and maintaining relationships, in conjunction with apparent limited social skills; and her difficulty with regard to communication (refer to Appendix B: Interview 1 and 2; Appendix D: Observation Checklist 1 and 2; and Appendix E: Session 1, 3, 4 and 5 for the initial analysis that I conducted).

Following the initial assessment, I conducted intervention sessions with the aim of the improvement and growth of the primary participant in the areas of difficulty. Although I mainly applied sandplay psychotherapy as an intervention technique, I occasionally incorporated general play therapy and the marchach technique (physical contact component for the purpose of emotional nurturing), at times when the primary participant indicated that she wanted to do so. Improvement in the three mentioned areas of difficulty became apparent as my field work progressed, as reported by significant others in the participant"s life, and as observed during intervention sessions by myself. During the final two sessions I focused on the task of terminating intervention.

4.2.2 Observations

During the first two contact sessions the primary participant avoided eye contact. She seldom interacted with the sandplay miniatures or with me for

more than a few seconds at a time. She did not show emotion at my arrival, nor at my departure; she also failed to use fantasy play. After rapport and a therapeutic relationship had been established between the primary participant and myself, she started playing for longer periods of time and began expressing emotion by means of the sandplay miniatures. Initially, her play appeared to be chaotic and her scenes were difficult to make sense of. As the process progressed (approximately from session six onwards), she did, however, start communicating nonverbally by means of facial expression, eye movements and hand-gestures. She also started relying on regular verbal utterances in an effort to communicate with me from session seven onwards. The primary participant commenced playing with play material other than the sandplay miniatures during session two (and often during other intervention sessions) in an attempt to communicate her thoughts and feelings. Her sand scenes progressed through the stages of chaos, struggle and resolution, as identified by the theory underlying sandplay psychotherapy (refer to section 2.3.3). By her progress through these stages, I could observe the manner in which the participant projected and expressed her feelings and experiences.

During the tenth session the primary participant openly displayed joy at my arrival and the play process. At this time, her play started to resemble reality, which might be interpreted as indicative of the probability that she had resolved her negative feelings and experiences to a certain extent. I observed less aggression and avoidance of human figures in her sand scenes. At the end of session 17 she displayed distress at my departure. She was expressing her feelings with more ease at this stage, although most expressions were nonverbal by nature.

As the research process and therapeutic intervention continued, I observed that the participant was interacting socially with other children more often than at the onset of my field work, and that she was more willing to answer questions that the social worker and caregivers asked her. During the second last session (first closure session) the social worker explained to her that I would only be coming one more time, after which her play indicated

regression. She expressed high levels of anger and avoidance in her sand scenes during this particular session, and cried when I departed. During the last session, however, I observed that her sand trays reflected realistic play and that regression was no longer apparent. She parted from me easily and showed no signs of distress at my final departure after session 18.

4.2.3 Reflecting on the research process

Initially, I was apprehensive with regard to the probability of a positive outcome of the therapeutic intervention that I had planned to conduct with the primary participant. Various factors made me question a favourable prognosis. Factors, which contributed to my apprehensiveness, included the apparent language barrier, the fact that the primary participant had previously avoided participation and communication with helping professionals, the fact that she was ill, my limited experience with sandplay psychotherapy as intervention technique, and, finally, my own fears that she would become ill or pass away during the intervention process.

However, I established rapport with the primary participant fairly easily. I established rapport in a nonverbal manner by encouraging eye contact, smiling and exchanging other forms of emotion, through facial expressions, and by often touching the primary participant on her shoulder. I experienced a sense of contentment in the participant during the first session already. I wondered about this phenomenon and consequently hypothesised that a possible reason for the participant"s non-resistance might be because I did not pressurise her to communicate verbally. I sensed the possibility that other professionals might have been pressurising her to speak, thereby possibly contributing to her resistance to establishing rapport and communicating with them.

The assessment process was difficult, due to the participant"s young age and the existing language barrier. Her drawings and paintings indicated an immaturity and were very difficult to interpret. I therefore had to rely on the

opinions and descriptions of significant others in her life, in order to assess which difficulties she was experiencing at the onset of my study. I gained in-depth information through interviews with the social worker and the chef at the institution. I also requested the caregivers and teacher of the participant to complete an observation checklist regarding the development and behaviour of the participant. However, this information was limited with regard to its scope, and, as the checklists were completed in my absence, I could not probe into the caregivers" and teacher"s descriptions.

Initially the participant"s attention span was extremely short. As a result, she experienced difficulty in playing out scenes in the sand tray. However, she did appear to express herself by means of the miniatures. As the intervention process continued, certain themes prevailed and the time-length of her play extended. Themes with regard to emotional healing, improvement of relationships, and improvement of communication became evident. The participant started making eye contact after session two, making verbal and nonverbal gestures, and starting to express enjoyment more often as the process continued. She projected and expressed a variety of feelings and experiences by means of play, which she appeared to resolve as the process progressed. Being a respectful witness to these signs of healing was an incredible experience for me. I enjoyed our sessions and I learned a tremendous amount about play and this young child.

Besides the above-mentioned themes that emerged, I observed that the participant"s play resembled her developmental growth. For instance, she found the mechanical working of toys amusing at one stage. I soon started receiving positive feedback from significant others regarding her functioning. These moments were rewarding to me, and I felt that my efforts were worthwhile. I struggled with the termination of therapy as I had, to an extent, become emotionally involved with the primary participant and the significant others in her life.

When the primary participant was informed that therapy would soon be terminated, regression became apparent in her play. She played out negative emotions. I felt guilty about terminating intervention and I feared that I might cause her further trauma by stepping out of her life. Thankfully, by the next session her play indicated that she had recovered, with no further signs of regression.

I was comfortable with my role as interventionist as I have prior experience in this field. However, my role as researcher was new to me. My role as researcher included being an observer and interviewer. Although I was accustomed to both these roles through experience in the field of educational psychology, I found the role of photographer and „reflector" challenging. Making detailed field notes and making notes of my reflections after each session was time-consuming and tiring, but definitely contributed not only to the depth of my study, but also to my own growth. Another role that I had to fulfil was that of critical analyst – analysing and interpreting data. This was particularly challenging, as I had to consider the process of scientific knowledge creation. Due to my natural empathetic nature and personal subjectivity I found this role exhausting, as it constantly required of me to think meta-cognitively about my own roles in the process, and the purposes of my thoughts, feelings and actions. This did, however, raise my awareness and contribute to the credibility of my findings.

4.3 RESULTS OF THE STUDY

Based on the data analysis that I conducted, three main themes emerged. Figure 4.1 presents an overview of the main themes and sub-themes, which I discuss in the following sections.

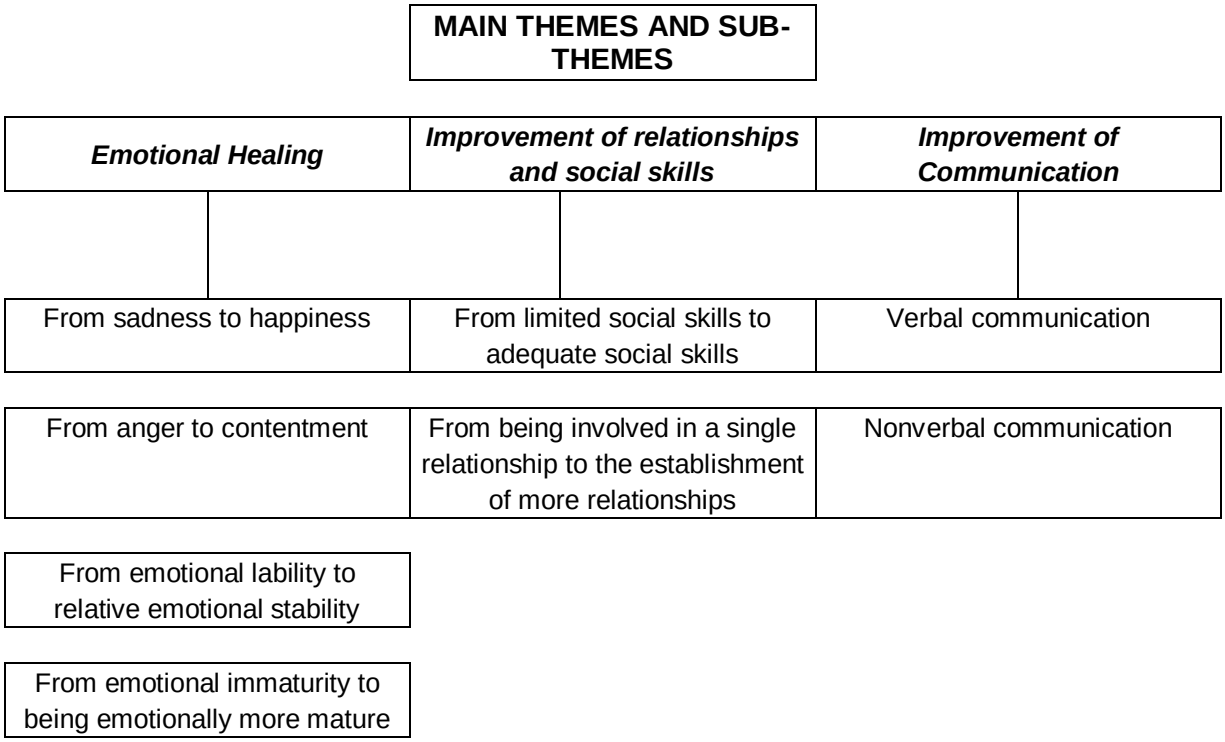

FIGURE 4.1: OVERVIEW OF EMERGED THEMES AND SUB-THEMES

4.3.1 Emotional healing

From the raw data obtained during intervention sessions, during my observation of the primary participant, and during interviews with significant others in her life, I derived that the primary participant was seemingly emotionally more stable at the end of my field work than at the onset thereof. She appeared to be happier and more content. She also experienced less feelings of anger. She expressed her emotions more easily and appropriately, and did so in a seemingly more mature manner.

4.3.1.1 From sadness to happiness…

Initially, I observed the primary participant to be sad. Her facial expressions indicated sadness and she seldom smiled or laughed (Appendix E: Visual data, Session 1 [4 February 2005]). Besides my own analysis of the initial assessment that I conducted, several comments made by significant others in

the primary participant's life, also indicated that she was experiencing feelings of sadness. The social worker, for example, explained that the primary participant cried a lot, and mentioned that she would cry for very long periods of time (up to 3 hours), during which she could not indicate her reason for crying to her caregivers. According to the social worker, she did not respond to comforting during these periods either (Appendix B: Informal interview 1 [21 January 2005], p. 2). In addition, the chef at the institution mentioned that the primary participant would often cry *"uncontrollably"* (Appendix B: Informal interview 2 [4 March 2005], p. 3). One of the caregivers at the institution further indicated that *"… her behaviour is very poor, because if she cries she can't stop. She will stop on her own when she is satisfied to stop"* (Appendix D: Observation Checklist 2 [15 April 2005]). During the first few sessions, I observed that the primary participant's sand scenes were representing the *chaos* stage of the sandplay psychotherapy process, which is usually indicative of emotional turmoil (Appendix E: Visual data, Session 1 [4 February 2005]).

The primary participant appeared to experience happiness more often as the intervention process progressed. She smiled more often and even laughed at times (Appendix E: Field notes, Session 3 [19 February 2005]; Session 11 [14 July 2005]; Session 12 [29 July 2005]), Visual data, Session 18 [15 November 2005]). After approximately five months of intervention, the chef at the institution mentioned that the participant seemed happier (Appendix B: Informal interview 4 [24 June 2005], p. 5). After eight months of intervention, the social worker was of the opinion that the primary participant appeared to be cheerful and more mature (Appendix B: Informal interview 5 [23 September 2005], p. 6). During my final interview with the social worker, she added: *"She displays emotion now and it is very appropriate to the situation. For instance, when she smiles she is having fun…"*, and: *"she doesn't cry like that anymore"*, and further: *"she is a normal, happy child now"* (Appendix C: Guided interview 1 [15 November 2005], p. 3).

Besides verbal reports by significant others, I observed this change toward her being more happy during intervention sessions. The participant"s sand scenes appeared to progress through the *struggle* stage of sandplay psychotherapy. Thereafter, her sand scenes resembled those of the *resolution* stage of sandplay psychotherapy (Appendix E: Visual data, Session 18 [15 November 2005]).

4.3.1.2 From anger to contentment…

During my first interview with the social worker she commented that the primary participant had presented with aggressive behaviour. She expressed her concern that the primary participant often fought with and hit other children at the institution (Appendix B: Informal interview 1 [21 January 2005], p. 2). I also observed aggression in the participant"s play during the initial assessment sessions (Appendix E: Visual data, Session 2 [11 February 2005]; Session 4 [25 February 2005]) as well as during numerous other intervention sessions (Appendix E: Visual data, Session 11 [14 July 2005]; Session 14 [2 September 2005]). These scenes that I observed involved the participant"s play with the crocodile (a universally accepted symbol of aggression), as well as scenes of the violent destruction of certain sandplay miniatures. During session 14, for example, the participant took three toy soldiers out of the box and played with them in the sand. She buried one and let the other two soldiers fight. Thereafter, she „blew" the soldiers up by means of an explosion. This type of play indicates the destruction theme (Appendix E: Field notes, Session 14 [2 September 2005]).

During final sessions and later interviews it became apparent that the primary participant"s levels of aggression and anger seemed to have decreased as the study progressed. She appeared to experience a sense of contentment. During the final interview that I conducted with the social worker, she said: “I haven"t seen her fighting for a long time” (Appendix C: Guided interview 1 [15 November 2005], p. 4). According to the chef, the primary participant no longer presented aggressive behaviour. She elaborated by saying “…she likes

to look after the small babies and hold them. She is playing nicely", and "No (she doesn't hit them). She tells them rather" (Appendix C: Guided interview 2 [15 November 2005], p. 6). The anger that she initially appeared to have been experiencing seemed to diminish over time, as I observed her lesser use of aggressive symbols as the sessions progressed. She also appeared to move from the struggle stage of sandplay psychotherapy into the resolution stage (session 6 to 18). These changes were apparent in the participant's creation of sand scenes, which reflected reality, from session 15 to 18 (a sign of the resolution stage) (Appendix E: Visual data, Session 16 [28 October 2005]; Session 18 [15 November 2005]).

4.3.1.3 From emotional lability to relative emotional stability…

I observed that the primary participant was emotionally labile the first time I met her. She did not make eye contact and showed no emotion. When I was introduced to the participant, she did not respond in any way (Appendix E: Field notes [21 January 2005]). During the first contact session she also did not play with the toys, but merely picked them up and put them down. I observed that she did not express any emotion through play during the initial session (Appendix E: Field notes, Session 1 [4 February 2005]).

However, as my field work progressed, I observed that the primary participant progressively started expressing and projecting emotions. She, for example, smiled at my arrival at times and expressed emotions by means of her sand scenes (Appendix E: Field notes, Session 3 [19 February 2005]; Session 5 [1 April 2005]; Session 12 [29 July 2005]; Visual data, Session 4 [25 February 2005]; Session 11 [14 July 2005]). In addition, the participant started using facial expressions from session 11 onwards, which appeared to be appropriate to the situation (Appendix E: Field notes, Session 11 [14 July 2005]; Session 17 [11 November 2005]). The social worker agreed with my observation, stating the following during our final interview: *"… she had a very flat affect. She displays emotion now and it is very appropriate to the situation. For instance, when she smiles she is having fun and you can see it from the*

situation that it is appropriate for her to smile at that moment" (Appendix C: Guided interview 1 [15 November 2005], p. 3).

4.3.1.4 From emotional immaturity to being emotionally more mature…

Initially, I observed various indications that the primary participant was emotionally immature, in comparison with her developmental stage. One of the initial primary concerns of the institution was that she did not give her caregivers an indication of her reasons for crying (Appendix B: Informal interview 1 [21 January 2005], p. 2; Appendix D: Observation Checklist 2 [15 April 2005]). This apparent inability to explain relates to emotional immaturity or an inability to verbalise emotions. According to the social worker, the participant also did not respond to the comforting of her caregivers during the instances when she cried (Appendix B: Informal Interview 1 [21 January 2005], p. 2).

In addition to the data obtained from significant others, I observed that the primary participant"s play was indicative of emotional immaturity. Her initial sand scenes and play activities did not include fantasy, which I regard as an age-appropriate form of emotional play. I further observed that the participant"s initial play did not resemble household mimicry, for instance nurturing and caring – which is age appropriate emotional play (Appendix E: Field notes and visual data, Session 1 [4 February 2005]; Session 2 [11 February 2005]). At the onset of my field work, her caregivers further indicated that she did not display self-control, did not express feelings of pride, did not comprehend the feelings of her caregivers, did not show appropriate communication skills, and did not express her feelings appropriately (Appendix D: Observation Checklist 2 [15 April 2005]).

However, later on in the research process I observed that the primary participant was expressing emotions by means of facial expressions. The emotions that she expressed appeared to be appropriate to the situation (Appendix E: Field notes, Session 11 [14 July 2005]; Session 17 [11 November 2005]). From session nine onwards, her play began to resemble that of fantasy play (Appendix E: Field notes, Session 9 [24 June 2005]; Visual data, Session 11 [14 July 2005]). She eventually (during session 14 onwards) also appeared to start resolving negative experiences through fantasy play, which indicated that she might have developed the coping mechanism of dealing with difficult experiences by means of play (Appendix E: Visual data, Session 14 [2 September 2005]). These observations correlate with age-appropriate emotional maturity.

From session three onwards, the primary participant started playing out scenes of looking after a baby, having "tea parties", and doing household chores, which are possible indications of emotionally age-appropriate play (Appendix E: Visual data, Session 12 [29 July 2005]; Session 16 [28 October 2005]). During the final interview that I conducted with the social worker, she emphasised the primary participant"s growth in terms of emotional maturity, by saying: *"She asks for things now"*. She further commented that: *"she now easily communicates to the mamma as what she wants and needs. She doesn"t cry like that anymore. She asks and says what she wants and what she doesn"t want"* (Appendix C: Guided interview 1 [15 November 2005], p. 3). She explained the participant"s improvement by elaborating with the following comments: *"That stability. She is getting there"*, and: *"She is a happy normal child now. She is confident and can communicate. Her behaviour is appropriate"* (Appendix C: Guided interview 1 [15 November 2005], p. 4, 5). The chef commented that *"…* (she tells us) *what she did at school, what she needs, everything"* (Appendix C: Guided interview 2 [15 November 2005], p. 6).

4.3.2 Improvement of relationships and social skills

Based on the raw data that I obtained by means of observation during contact sessions, as well as during interviews conducted with significant others in the primary participant"s life, it appeared that the social skills of the primary participant were initially limited. However, toward the end of the research process she seemed to have developed certain social skills.

Another concern that was raised at the onset of my study was that the primary participant had only one meaningful relationship. However, as the research process progressed, she appeared to be able to form and maintain relationships with others within her milieu, and seemed to have acquired appropriate social skills.

4.3.2.1 From limited social skills to adequate social skills… .

Based on the raw data that I obtained during initial interviews, as well as from my observations of the primary participant during initial contact sessions, she appeared to possess limited social skills at the onset of my field work. When I met the primary participant she, for example, avoided eye contact and did not even look at me when the social worker made a gesture in my direction (Appendix E: Field notes [21 January 2005]). During the session, the social worker confirmed my observation by mentioning that the primary participant rarely made eye contact with others (Appendix B: Informal interview 1 [21 January 2005], p. 1). The social worker further mentioned that the occupational therapist, music therapist and chef at the institution were of the opinion that the primary participant had failed to cooperate with helping professionals prior to my intervention (Appendix B: Informal interview 1 [21 January 2005], p. 1; Informal interview 2 [4 March 2005], p. 3). In addition, according to the social worker, the participant"s teacher had apparently mentioned that she did not work or play with the other children in class (Appendix B: Informal interview 1 [21 January 2005], p. 2). My observation of the participant"s initial sand scenes supports this result, as it seemed that she

initially avoided human miniatures (Appendix E: Visual data, Session 1 [4 February 2005]; Session 2 [11 February 2005]).

I was, however, pleasantly surprised at the manner in which the participant cooperated during the first session. She played with the toys when I indicated to her to do so, and helped me tidy up when I started to do so (Appendix E: Field notes, Session 1 [4 February 2005]; Session 2 [11 February 2005]). This is contradictory to the initial information that I obtained and the assumption that the participant was lacking social skills, as she displayed and applied certain age-appropriate social skills in the therapeutic environment, and reacted to my nonverbal gestures.

However, as my research progressed, changes became apparent regarding the level of social skills that the primary participant displayed. She often started smiling at me when I smiled at her, indicating possible socially appropriate behaviour, taking into consideration the specific situation and its stimuli (Appendix E: Field notes, Session 1 [4 February 2005]; Session 2 [11 February 2005]). During later sessions, when playing, she often seemed to "invite" me to "have tea with her", by setting the table for two people, smiling at me and passing me a "cup of tea". These gestures emerged as a sub-theme with regard to social skills and the participant initiating a relationship (Appendix E: Visual data, Session 2 [11 February 2005]).

As the research process continued, significant others in the primary participant"s life also commented that her social skills were improving. The chef, for example, mentioned that the primary participant was socialising with other children more often, and that the institution was considering sending her to a full-time pre-school based on this improvement (Appendix B: Informal interview 3 [1 April 2005], p. 4). The nurse of the institution mentioned, in passing, that the primary participant was communicating, playing with her peers, and expressing her thoughts and emotions towards others more regularly (Informal interview 3 [15 April 2005], p. 4). During my final interview with the social worker, toward the end of the research process, she made the following comments, indicating that the primary participant had seemingly

developed age-appropriate social skills (Appendix C: Guided interview 1 [15 November 2005]):

> *"The occupational therapist said she is cooperating and doing the exercises"* (p. 1)
>
> *"At first her new teacher said that she was very quiet and that she didn't play with the other children. But there has been an improvement now. She is doing her work and socialising with the other children"* (p. 2)
>
> *"Yes, she has two friends. They are always together. They play with the dolls and do everything together. She shares now"* (p. 2)
>
> *"She now easily communicates to the mammas what she wants and needs"* (p. 3)
>
> *"… yes, she stops (crying) when she gets some attention or a hug", "she makes eye contact"* (p. 4)
>
> *"… she is able to share now and communicate and play with the other children"* (p. 2)
>
> *"Her behaviour is appropriate"* (p. 5)

During interviews with the chef at the institution, at the final stages of my field work, she mentioned that the primary participant had made a friend and that she had started enjoying school (Appendix B: Informal interview 6 [22 November 2005], p. 7). She further stated that the primary participant had learned to share and *"likes to look after the small babies and hold them"* (Appendix C: Guided interview 2 [15 November 2005], p. 6). During my final interview with one of the caregivers, she expressed the opinion that the primary participant had learned to cooperate and respond to the caregivers as the study progressed. She also mentioned that the primary participant started picking up and playing with the other children (Appendix B: Informal interview 6 [22 November 2005], p. 7).

4.3.2.2 From being involved in a single relationship to the establishment of more relationships… .

Early on in the research process the social worker explained that the primary participant was at that stage only involved in one meaningful relationship, and that she experienced difficulty with establishing relationships. The social worker stated that the primary participant only had a bond with the chef at the institution, and that this was the only bond that the primary participant had ever formed during her stay (of 4 years) at the institution. The social worker further mentioned that, when the other children were playing, the primary participant would sit in the kitchen with the chef. She added that the primary participant did not have a bond with any of the caregivers or social workers (Appendix B: Informal interview 1 [21 January 2005], p. 1, 2). In addition to the social worker"s perception, the chef emphasised the fact that the primary participant did not form relationships easily (Appendix B: Informal interview 2 [4 March 2005], p. 3).

In contrast with the perceptions of the social worker and the chef, I found that the primary participant was able to form a relationship with me fairly easily (Appendix E: Field notes, Session 1 [4 February 2005]; Session 2 [11 February 2005]). The relationship improved as the study progressed, and towards the end of the process, the participant and I had formed a seemingly close trusting relationship (Appendix E: Visual data, Session 14 [2 September 2005]).

I regarded the improvement of our relationship as indicative of improvement of her social skills and of her ability to form and maintain relationships. As the research process progressed, meaningful others in the primary participant"s life noticed that she had started forming relationships with others. The following comments serve as examples: The chef mentioned that the primary participant was socialising more often (Appendix B: Informal interview 3 [1 April 2005], p. 4), the nurse at the institution explained that the primary participant was communicating, playing and expressing her thoughts and

feelings towards others more regularly (Appendix B: Informal interview 3 [15 April 2005], p. 4), and the manager of the institution mentioned that the primary participant was playing with other children (Appendix B: Informal interview 4 [14 July 2005], p. 5) towards the end of my field work. During my final interview with the chef, she stated: *"But now she has got lots of them* (friends)*"* (Appendix C: Guided interview 2 [15 November 2005], p. 6). During my final interview with the social worker, she stated the following, implying that the primary participant had formed other meaningful relationships during the research process (Appendix C: Guided interview 1 [15 November 2005]):

> *"… two friends. They are always together. They play with dolls and do everything together"* (p. 2)
>
> *"She used to only make contact with *(the chef), but now she talks to the other mammas and children and spends time with them "* (p. 2)
>
> *"… she isn't only comfortable with *(the chef) anymore, she is comfortable with the other caregivers, the children, and with me too. She even tells us what she did at school, when she gets home, and she tells us what she has to take to school the next day"* (p. 2)

4.3.3 Improvement of communication

Based on the raw data that I obtained, and the analysis that I conducted, the primary participant appeared to have experienced difficulty with communication at the onset of my study. She rarely expressed herself verbally or nonverbally. However, toward the end of the research process, her communication skills seemed to have improved. She made use of verbal and nonverbal communication more regularly, and with more ease. I discuss the improvement of communication in terms of the two sub-themes that emerged, namely verbal communication and nonverbal communication.

4.3.3.1 Verbal communication

One of the primary concerns that were emphasised during the initial interviews with significant others in the primary participant"s life, was that she seldom communicated verbally with others. My observation of her, during initial contact sessions, confirms this perception (Appendix E: Field notes [21 January 2005]). The social worker indicated this inability to communicate by stating that the primary participant never spoke a word to other helping professionals, such as the nursing staff or doctors. She mentioned that the participant was able to speak Sotho, but seldom spoke to her peers, and never spoke to her caregivers and other adults at the institution (Appendix B: Informal interview 1 [21 January 2005], p. 1). On the other hand, the chef indicated that the primary participant did speak to her on a regular basis. The chef was also of the opinion that the primary participant did not form relationships easily, and therefore did not speak to other people often. She agreed that the primary participant never spoke to helping professionals prior to my intervention (Appendix B: Informal interview 2 [4 March 2005], p. 3).

Indications, that the primary participant"s verbal communication might have improved, became apparent as the research process progressed. During the second contact session the primary participant said one word to me, in her language, whilst indicating that she wanted me to comb the doll"s hair, pointing to the doll whilst holding the hairbrush out to me (Appendix E: Field notes, Session 2 [11 February 2005]). I only realised that she had said a word whilst nobody was pressurising her to speak, once the session was over (Appendix E: Field notes [11 February 2005]). During session three, she often spoke single words in Sotho (Appendix E: Field notes: Session 3 [19 February 2005]). At my arrival on the 2nd of September 2005 (Session 14) I overheard her speaking to her peers in Sotho whilst playing (Appendix E: Field notes, Session 14 [2 September 2005]). She spoke to me in English on the 15th of November 2005 when I arrived at the institution to conduct an interview with the social worker. I recorded this very brief conversation and included it as an

informal interview in Appendix B (Appendix B: Informal Interview 6 [15 November 2005], p. 7).

In addition to my own observations and experiences, the nurse at the institution mentioned that the primary participant communicated, played and expressed her emotions more regularly as the study progressed, but that she refused to speak when she did not feel like doing so (Appendix B: Informal interview 3 [15 April 2005], p. 4). During my final interview with the chef she explained that the primary participant's verbal communication had improved by saying that *"she tells us everything… about her teacher, the children that were naughty, what she did at school, what she needs and everything"* (Appendix C: Guided interview 2 [15 November 2005], p. 6). The social worker supported this perception, by making the following comments (Appendix C: Guided interview 1 [15 November 2005]):

> *"She makes contact with adults. She makes eye contact. She asks for things now. She used to only make contact with *(chef), but now she is speaking to other adults too."* (p. 1)
>
> *"She even tells us what she did at school when she gets home and she tells us what she has to take to school the next day. A big improvement."* (p. 2)
>
> *"She now easily communicates to the mammas what she wants and needs. She asks and says what she wants and what she doesn't want."* (p. 3)

4.3.3.2 Nonverbal communication

Another initial concern of the social worker, at the commencement of my study, was that the primary participant did not make eye contact with others. The social worker explained (during an informal interview) that the primary participant would appear nervous amidst others, and fiddles with objects in an attempt to avoid eye contact. When the primary participant cried, she would, for example, fail to indicate nonverbally what the matter was (Appendix B:

Informal interview 1 [21 January 2005], p. 2). My observations support this emerged theme with regard to the participant's avoidance of eye contact, as she avoided eye contact with me during the first two contact sessions (Appendix E: Field notes [21 January 2005]; Session 1 [4 February 2005]).

An improvement in the primary participant's nonverbal communication became apparent as the study progressed. The social worker commented the following, during our final interview (Appendix C: Guided interview 1 [15 November 2005], p. 1): *"She makes contact with adults. She makes eye contact. She asks for things now"*. I also observed (during later contact sessions) that the primary participant communicated nonverbally with me on a regular basis. She made eye contact and indicated her needs and wants to me in a nonverbal manner. During the second contact session she indicated to me that I should comb the doll's hair, by handing me the comb and pointing to the doll (Appendix E: Field notes, Session 2 [11 February 2005]). On the 29th of July 2005 (Session 12) she indicated to me which objects she wanted me to pass to her, by pointing at the objects. She further pointed at the chair when she wanted me to sit down for the "tea party" (Appendix E: Field notes, Session 12 [29 July 2005]).

The foregoing results of the study will now be interpreted and discussed in the light of relevant literature. I structure my discussion of the findings in accordance with the research questions, as formulated in chapter one.

4.4 FINDINGS

My study was guided by the following primary research question: **"*How can sandplay psychotherapy be used to overcome a language barrier, whilst supporting a young vulnerable child emotionally?*"** Based on the results that I obtained, I found that sandplay psychotherapy supported the primary participant emotionally in a variety of manners, despite the existence of a language barrier. Firstly, sandplay psychotherapy seemed to provide the primary participant with a medium for expressing her emotions and therefore

going through a process of healing. Secondly, the method and process of sandplay psychotherapy (as explained by authors such as Kalff and Bradway) appeared to be effective and applicable in this particular case study. Thirdly, the participant"s relationships and communication skills appeared to improve as a result of the intervention technique, namely sandplay psychotherapy. Finally, the language barrier was partially overcome by means of the intervention that I undertook. I now discuss my main findings in terms of the secondary research questions that guided my study.

4.4.1 Secondary research question 1: "What does the process of sandplay psychotherapy entail?"

I found that the process of sandplay psychotherapy, as described by a number of authors (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991), closely resembled the process of sandplay psychotherapy by means of which the primary participant progressed. This included certain stages of emotional healing, as symbolised by means of her sand scenes. I regard the progress, which the primary participant demonstrated in her sand scenes, as evidence of the emotional healing that she experienced in the series of therapeutic stages. The stages, as described in relevant literature, and the description of typical sand scenes that characterise these stages (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991), correspond with the sand scenes that the primary participant created during the research process. The chaos stage, the struggle stage and the resolution stage, as explained in the above-mentioned literature, closely resemble the primary participant"s stages of sandplay psychotherapy.

Thompson and Rudolph (2000), Carmichael (1994) and Kalff (1991) explain the stages of emotional healing, and the manner in which they might be evident in the sand scenes of children. They mention that emotional turmoil usually marks the first stage, namely the *chaos* stage. Common responses during this stage include the chaotic use of too many, or all the miniatures in the sand, or on the other hand failure to use any objects at all, and the child

merely touching the sand. The above-mentioned authors state that the child usually fails to bring about any order with regard to the toys and the sand. I found this to be apparent in the sand scenes created by the primary participant in my study, during the first few contact sessions. She, for instance, picked up toys and merely put them down, not playing with them and not arranging them in any way. As such, she probably experienced emotional turmoil during these sessions.

According to Thompson and Rudolph (2000), Carmichael (1994) and Kalff (1991), the second stage, namely the *struggle* stage, is characterised by destructive activities. During this stage, children supposedly express their troublesome feelings and experiences, with destructive scenes that are characterised by the destruction of sandplay miniatures. I found that the primary participant underwent a stage where destruction was evident, during sessions six to 14. For instance, she „blew up" miniatures in the form of an explosion and „drove" over human figures with a „car" miniature. This finding corresponds with findings in relevant literature (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991) that describe the *struggle* stage of the sandplay psychotherapy process. I further found that this stage was distinctly made up of two phases. During the first phase, the participant destroyed the non-threatening human figures and animals. During the second phase, she destroyed the threatening human figures such as witches and other scary miniatures, as well as certain aggressive animals. I interpreted this behaviour as evidence of the fact that she emotionally progressed from experiencing and displaying feelings of helplessness (being “attacked”) to experiencing and expressing assertiveness (“attacking”).

The final stage, namely the *resolution* stage of sandplay psychotherapy, is usually characterised by a “normal”, balanced world (Thompson & Rudolph, 2000; Carmichael, 1994; Kalff, 1991). Kalff (1991) explains that scenes during this stage closely represent reality. Emotional healing is regarded as having occurred when the sand scenes have progressed up to this stage. In my study, I found that the primary participant reached this stage toward the end of

the research process and that her scenes and play closely resembled reality. For example, she played with a doll in a „motherly" manner, by changing diapers, feeding it, and carrying it on her back. She also created a „house" with a „family" „sleeping" during the final contact session.

4.4.2 Secondary research question 2: "How can sandplay psychotherapy support young vulnerable children emotionally?"

I found that the primary participant presented with improved emotional functioning after the research process (in the form of intervention) had been completed. She appeared happier and more content than she had appeared at the onset of my study. She seemed to be able to express her emotions more easily and did so in a verbal and nonverbal manner. The primary participant also appeared to have grown in terms of emotional maturity.

During the initial phase of the research process, I conducted an educational psychological assessment. I found that the participant was experiencing emotional difficulties, for example by experiencing and displaying intense feelings of aggression, sadness and anxiety. These findings correspond with findings in relevant literature that describe the emotional characteristics of vulnerable children. Literature published by, for example, the International HIV/AIDS Alliance (2006), the National Child Traumatic Stress Network (2005) as well as Ohnishi *et al.,* (2004) indicates that vulnerable children usually experience emotions such as anxiety, sadness and even depression.

Towards the end of the research process I re-assessed the primary participant, finding that emotional healing had taken place to an extent. She no longer appeared to experience such intense feelings of aggression, anxiety and sadness. I therefore regard sandplay psychotherapy as an effective intervention technique for the primary participant, as it resulted in a degree of emotional healing. This finding correlates with findings in relevant literature on the benefits of sandplay psychotherapy with regard to emotional healing. Fitzpatrick (2005) and Campbell (2004) explain that sandplay psychotherapy

might offer children the opportunity to express their inner feelings and thoughts, and to resolve and integrate these. The resolution and integration of feelings and thoughts supposedly brings emotional healing to effect. Massey (2005) further explains the value of sandplay psychotherapy when used with children experiencing grief or loss. She explains how expressive sandplay psychotherapy often evokes the trauma and grief that were experienced in earlier years. This author is of the opinion that sandplay psychotherapy provides a safe arena for children to process their losses in whichever way they feel comfortable to do so. The primary participant in my study indeed seemed to process her losses and experiences during sandplay psychotherapy.

Besides my finding, that sandplay psychotherapy seemingly provided emotional support for the primary participant, it appeared that her emotional wellness and growth consequently had a positive effect on her interpersonal relationships and communication skills. Based on my initial educational psychological assessment, I found that the primary participant was experiencing social and relationship difficulties when my study commenced. She did not play with her peers and experienced difficulty in establishing and maintaining relationships with significant others in her mileu. This finding, with regard to typical characteristics of vulnerable children, corresponds with findings reported in relevant literature. Literature published by the International HIV/AIDS Alliance (2006), the National Child Traumatic Stress Network (2005) as well as Ohnishi *et al.,* (2004) highlights the tendency of socially vulnerable children to often experience difficulty in relationships and in trusting people.

As the research process progressed, I found that the primary participant appeared to have established several relationships with her peers and adults at the institution. It became apparent that her social skills had improved. An article entitled Play Therapy (2006) supports this finding, by explaining the therapeutic benefits of non-directive play therapy (of which sandplay psychotherapy is an example) on relationships. The therapeutic benefits include enhanced levels of communication and socialisation, quality-improved

attachments, as well as improved relationships (Schaefer, 2006; Seeman, 2006). Carey (1990) also found that sandplay psychotherapy has been shown to improve peer relations in children with speech and language difficulties. In my study, I found that the language difficulties of the participant initially appeared to effect her social functioning negatively.

Concerning communication skills, I found that the primary participant"s verbal and nonverbal communication skills markedly improved as the research process continued. She made use of verbal and nonverbal communication more often as my study progressed. She did so during intervention sessions, but also amongst her peers and adults at the institution. Although literature pertaining to the effect of sandplay psychotherapy on communication skills appears emergent and somewhat limited, an article entitled Play Therapy (2006), Cogher (1999), and Axline (1947) corroborate this finding. These authors discuss the therapeutic benefits of non-directive play therapy (including sandplay psychotherapy), and emphasise its benefit regarding the improvement in communication and language skills, and an increase in the use of communication. In my study, I found that the primary participant communicated (with me as well as with others in her mileu) more often and with greater ease and confidence as the study progressed.

4.4.3 Secondary research question 3: "How can sandplay psychotherapy be used in overcoming a language barrier during therapeutic support of a young vulnerable child?"

I found that verbal language was not necessary during the intervention process, as support was provided by means of sandplay psychotherapy, despite the presence of a language barrier. Therefore, I found that the language barrier was partially overcome by means of the intervention that I selected, namely sandplay psychotherapy. This finding correlates with the findings of Boik and Goodwin (2000), who highlight one of the benefits of sandplay psychotherapy as the fact that it provides a way of support, without the need for verbal communication.

Concerning the language barrier, the primary participant in my study displayed limited verbal skills at the onset of my study. Her mother tongue is also different to mine. Despite these facts, I found sandplay psychotherapy to be an effective means of communication between the primary participant and myself. I further found that the primary participant was able to communicate her innermost emotions and thoughts through play, without the use of language. These findings correlate with the findings of several authors. Campbell (2004), Carey (1990), as well as Vinturella and James (1987) explain that the nonverbal nature of sandplay psychotherapy holds potential value for children from a different language background to that of the helper, as well as for children with language and communication difficulties.

Fitzpatrick (2005), Campbell (2004), Sweeney *et al.* (2001), as well as Boik and Goodwin (2000) further explain that the miniatures used in sandplay psychotherapy serve as symbols – a common language between the helper and the child, as young children are often unable to verbally express what is happening to them, and may sometimes experience verbal expression as threatening. These authors are of opinion that many negative childhood experiences, including negative emotions and thoughts, are difficult to describe in words. It has been suggested that, in a therapeutic environment, play is to the child what verbal activity is to the adult (Campbell, 2004). Tharinger and Stafford (1995), for example, describe play as the *language of the child* and toys as *their words*. In my study, I found that the participant indeed used miniatures (symbols) to communicate her thoughts and feelings to me. She played out her negative past experiences, vented anger and expressed other emotions, and made her needs known through the toys and miniatures with which she played. I was able to understand her feelings and thoughts, as well as her prior experience better, by interpreting and observing how and with which miniatures she was playing.

4.5 CONCLUSION

In this chapter I presented the results of my study in terms of the themes and sub-themes that emerged. I included various direct quotations, photographs and extensive references to Appendices, in order to support the results that I presented. I then interpreted my results and presented them as findings, relating what I had found to findings in relevant literature. By discussing my findings in terms of the secondary research questions, as formulated in chapter one, I attempted to address my primary research question.

Chapter five presents an overview of this study. Based on the previous chapters and the findings of my empirical study, I come to a number of conclusions.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter four reported on the results and findings of my study. After reflecting on the research process, I presented the results that I obtained in terms of the themes and sub-themes that emerged. I then discussed my main findings in terms of the questions, whether or not the language barrier had indeed been overcome during intervention, and whether or not sandplay psychotherapy had proved to be effective in supporting the selected young vulnerable child emotionally. I discussed my findings in terms of relevant literature.

In this chapter I firstly provide a brief overview of the previous chapters. I then summarise the main findings and conclusions of my study. Thereafter, I indicate the limitations and possible contributions of my study. I conclude by formulating recommendations for training, practice and further research.

5.2 OVERVIEW OF THE PREVIOUS CHAPTERS

Chapter one served the purpose of orientating the reader regarding the study and what to expect in this dissertation. I informed the reader with regard to the nature of my study and presented an overview of the rationale for undertaking the study. I formulated the research questions and stated the purpose of the study. I also briefly defined the concepts underlying the study, namely *vulnerable children, sandplay psychotherapy* and *language barriers*. I introduced the paradigmatic perspective from which my study took its stance (Interpretivism), and clarified my research design (instrumental case study design), data collection methods (educational psychological assessment and intervention, interviews, observation, visual data and field notes) and data analysis and interpretation strategies. I also provided the reader with a layout of the dissertation, as an overview of what was to follow in chapters two to five.

As this study was informed by literature on *vulnerable children, sandplay psychotherapy* and *language barriers*, I explored these topics in **chapter two**. I commenced the chapter by defining vulnerable children as children who are

at risk of developing emotional and social difficulties due to the effect of HIV&AIDS, poverty, death or illness of primary caregivers, poor housing, homelessness, lack of adequate health care, neighbourhood violence and maltreatment. I identified the unfulfilled basic needs of children and the rights that are being denied – factors that place them in a position of vulnerability. I discussed the support that exists for vulnerable children, referring to support programmes in Africa concerning basic needs and psychosocial support. Thereafter, I explored sandplay psychotherapy in terms of its history, the way in which it is implemented, the stages it involves (namely the chaos stage, the struggle stage and the resolution stage), the underlying principles thereof, as well as the helper"s role during sandplay psychotherapy. I then discussed language barriers, by defining them as barriers that prevent a helper and a child from understanding and comprehending each other"s verbal attempts to communicate. I also discussed methods that might assist in overcoming language barriers, such as the use of ethnically and linguistically matched professionals, ethnically and linguistically matched interpreters, and nonverbal intervention techniques. I identified an alternative to verbal expression, namely sandplay psychotherapy (nonverbal intervention technique). I concluded chapter two by presenting my conceptual framework. I briefly explained my conceptual framework of the study in terms of my role as researcher and interventionist, the selected vulnerable child, sandplay psychotherapy (as intervention method for emotional support), and the language barrier that exists.

In **chapter three** I explained how I had planned and conducted my empirical study. I commenced the chapter by discussing Interpretivism as the paradigmatic perspective underlying my study. I described the research methodology that I implemented in terms of my selected research design, namely an instrumental case study design. For the purpose of the study, I purposefully selected a single case, namely a Sotho-speaking girl as primary participant, whom I selected based on the following selection criteria: her vulnerability, an apparent language barrier, and a need for therapeutic intervention. I identified the secondary participants in my study (significant

others in the primary participant"s life, namely her social worker, the chef at the institution, her caregivers, the nurse at the institution, and her teacher), based on their knowledge and understanding of the functioning of the primary participant. Thereafter, I explained the various data collection strategies that I employed, namely educational psychological intervention and assessment, observation, interviews, visual data and field notes (in the form of a research journal). I discussed the manner in which I employed *crystallisation* to analyse and interpret data, which I conducted in accordance with the guidelines for thematic analysis and for analysis in sandplay psychotherapy, as proposed by Dora Kalff (1991) and Kay Bradway (1999). I then discussed my attempts to enhance the rigour of my study, by referring to *credibility, transferability, dependability, conformability* and *authenticity*. I concluded the chapter by explaining the ethical principles that I adhered to in planning and undertaking my study.

In **chapter four** I reported on the results and findings of my study. I commenced the chapter by reporting on the research process in terms of my observations of the research participant, the process itself, and my personal reflections. Thereafter, I presented the results of my study and discussed them in terms of the main themes and sub-themes that emerged. The three primary themes that emerged were *emotional healing*, *improvement of relationships and social skills*, and *improvement in communication*. I concluded the chapter with a discussion of the findings of my study, by referring to the following questions: whether or not the language barrier had indeed been overcome during intervention, and whether or not sandplay psychotherapy had proved to be effective in supporting this young vulnerable child emotionally. I discussed my findings in terms of relevant literature, highlighting correlations, but also pointing out possible contradictions.

5.3 SUMMARY OF THE MAIN FINDINGS

The purpose of this study was to explore and describe the use of sandplay psychotherapy as a possible way of overcoming a language barrier, whilst

supporting a young vulnerable child emotionally. In order to achieve the purpose of the study, I aimed to establish whether or not sandplay psychotherapy was, firstly, effective in overcoming a language barrier, and, secondly, whether or not it supported a young vulnerable child emotionally. I conducted the study by commencing with an educational psychological assessment process (including art and play activities, interviews and observations) in order to uncover the difficulties that the primary participant was experiencing at the onset of my field work. Secondly, I implemented sandplay psychotherapy as intervention technique (in sessions), according to the guidelines offered in literature regarding sandplay psychotherapy. Finally, I conducted an educational psychological re-assessment (including interviews and the analyses of sandtray scenes that had been constructed by the primary participant), with the aim of determining whether or not the primary participant had been supported emotionally, and consequently whether or not the language barrier was overcome. In addition to my own assessments and intervention, I relied upon the information that I had gained from the significant others in the primary participant"s life, in order to obtain my research results and findings.

Based on the results that I obtained, I found that sandplay psychotherapy did indeed support the primary participant emotionally, despite the existence of a language barrier. Sandplay psychotherapy appeared to provide the primary participant with a medium to express her emotions and thereby go through a process of healing. Initially, I found that the participant was experiencing emotional, relationship and communication difficulties. She experienced feelings of sadness and anger, and appeared to be emotionally labile and immature. She appeared to find establishing and maintaining relationships difficult, and possessed limited social skills. The primary participant also appeared to experience difficulty with verbal as well as nonverbal communication. These are common characteristics experienced by vulnerable children.

Therefore, I found sandplay psychotherapy to be an effective intervention technique for this participant, as it resulted in emotional healing for her. Sandplay psychotherapy appeared to support the primary participant in my study, by offering her the opportunity to express her inner feelings, thoughts and prior experiences, and to resolve and integrate them. She appeared to move through the same stages of emotional healing that are described in literature (as evident in her sand scenes). Towards the end of my field work the primary participant appeared happier and more contented. She expressed her emotions and appeared to be more emotionally mature. I further found that her relationships and her communication skills (therefore her social skills) had improved. These improvements are often described in literature as secondary effects of emotional wellness.

The technique of sandplay psychotherapy that was employed with the primary participant in my study resembled distinct stages. After completing the *chaos stage* (by exhibiting less confusion in her trays), she appeared to progress into the *struggle stage* (by exhibiting conflict and destruction). Finally, she appeared to reach the *resolution stage* (by exhibiting scenes and play that closely resemble reality). The participant"s emotional healing (to an extent) might be attributed to these stages, as her healing was symbolised and observed in the sand scenes that she created.

I further found that language was not necessary during the intervention process, and that emotional support could be provided by means of sandplay psychotherapy, despite the existence of a language barrier. I regard sandplay psychotherapy as an effective means of nonverbal communication between the primary participant and myself. I further found that the participant seemed to be able to communicate her innermost emotions and thoughts through play, without the use of language.

An unexpected finding of my study relates to my discovery that therapeutic intervention was beneficial in areas other than emotional support, namely in the participant"s relationships, social skills and communication skills. The

intervention appeared to facilitate an enhancement of relationships and social skills, as well as verbal and nonverbal communication skills. She made use of verbal and nonverbal communication more often (with myself and others at the institution) and established various meaningful relationships as my study progressed.

5.4 CONCLUSIONS

In Africa (during recent years) much support has been provided to vulnerable children, concerning their basic needs. In undertaking this study I, however, focused on a child that was vulnerable due to mental health challenges. Literature regarding psychological and emotional support for vulnerable children of diverse cultures appears to be emerging (Magome, 2006; Skinner & Davids, 2006). Several factors contributed to the vulnerability of the child who participated in my study. Apart from her being orphaned due to her mother having died of AIDS, she herself is infected with HIV. In addition, she is in foster care and was experiencing emotional difficulties at the onset of my study. Apart from the language differences that existed between the primary participant and myself, she presented with limited verbal skills and inadequate language development. I decided on using sandplay psychotherapy as a method of intervention for various reasons, namely that it is an expressive therapy, that it is a nonverbal intervention technique, that language skills are not essential, and that it seemed to be appropriate for use within populations with diverse languages, cultures, races, ages and developmental levels.

Based on the findings of the empirical study that I conducted, I conclude that sandplay psychotherapy proved to be an effective intervention technique for supporting the selected child emotionally, across a language barrier. She gave indications of emotional healing in various areas. Firstly, her feelings of sadness appeared less intense, as well as her feelings of anger and anxiety. She also seemed to be more emotionally mature towards the end of my study.

The research process (in the form of intervention by means of sandplay psychotherapy) seemed to have assisted the participant in various areas of functioning (other than the initial aim of emotional support), namely in her establishment of relationships, in her social skills, and in her communication skills. I can further conclude that her improvement of emotional functioning positively impacted on her confidence, resulting in an improvement of her skills for establishing relationships and communicating with others. I found that the participant had established meaningful relationships and was communicating more easily (verbally and nonverbally) with others towards the end of my study. As such, her emotional state seemed to have improved as my study progressed. Therefore, sandplay psychotherapy offered a low-skill modality of psychological and emotional support for the selected participant in my study. In the same manner, it might offer a form of emotional support for other vulnerable children from diverse cultures and languages. It is important to consider, however, that sandplay psychotherapy, as a means of intervention, is time-consuming and can only be implemented in one on one situations, within a relationship of trust. Therefore the application value of sandplay psychotherapy for vulnerable children can be questioned, considering that time constraints, limited skilled volunteers, as well as limited resources, are a reality with regard to vulnerable communities in South Africa.

5.5 LIMITATIONS OF THE STUDY

I identified a variety of potential limitations in my study. Firstly, as I fulfilled the role of observer, and as my study is qualitative by nature, I often relied upon my own perceptions. As such, I experienced some difficulty in preventing and detecting researcher-induced bias in my study. As a qualitative researcher, I was often susceptible to subjectivity, as a close link was formed between the primary participant and myself (as researcher). Despite the fact that this might appear to be a limitation, I did not strive for objectivity (based on my selected paradigm). Instead, I rather strived to gain insight into the primary participant"s life-world and perceptions. I remained, however, aware of this potential

limitation throughout my study, and constantly reflected on my role as researcher and the possibility of researcher-bias.

Secondly, my study involved a single case. As a result, I faced the challenge of generalisability of the findings. However, generalisability was not the aim of my study, as I selected to employ an interpretivist stance. Instead, I aimed to provide elaborate descriptions of one case, in order to gain elaborate, in-depth data on the perceptions and experiences of the primary participant.

Thirdly, my selected methods of data collection and analysis were time-consuming. Although this might be regarded as a challenge, the fact that the study is based on a *single* case study, allowed time for thorough data collection and in-depth analysis. The fact that these activities were time-consuming also adds a certain value to my study, as the time spent contributed to the quality of the therapeutic relationship. The fact, that the participant was not able to communicate in English, further impacted on the time-consuming challenge that I faced.

A fourth potential limitation relates to observation as data collection technique, as the primary participant appeared to try and please me at times. However, she did not try to create a more favourable impression of herself and her situation. Furthermore, I relied on crystallisation to obtain data with regard to the behaviours, emotions and thoughts that she expressed, and that I could observe, before I could identify themes and draw conclusions.

Fifthly, a degree of emotional involvement developed between the primary participant and myself as researcher. This may have altered my perceptions and understanding of the primary participant. Furthermore, my presence and emotional involvement may have influenced the primary participant"s behaviour. Although this factor presents itself as a limitation, it did contribute towards achieving an aim of my study, namely to form a close emotional relationship with the primary participant, in order for her to feel safe enough to project and express emotions and thoughts. I did, however, repeatedly reflect

on my own emotions, and I guarded against becoming too emotionally involved. My training in Educational Psychology assisted me in addressing this challenge. In this regard I further faced the challenge of balancing the dual role of researcher and interventionist, which I experienced as being strenuous and disruptive (for example, having to take photographs during intervention sessions).

Finally, the possibility (and probability) exists that various other factors might have impacted on the results and findings that I obtained. The therapeutic activity of sandplay psychotherapy may therefore not be the sole contributor to the participant"s emotional healing. The study was not designed to establish a singular causal relationship between the use of sandplay psychotherapy and support for a young, vulnerable child. As such, the positive therapeutic relationship, the establishment of other meaningful relationships, regular contact with the participant, as well as her natural emotional, social and language development might also have been of therapeutic value and could have impacted on the results and findings of the study. I remained aware of this potential limitation and constantly reflected on, and reminded myself of, my primary role of researcher, and the fact that I needed to interpret the progress and outcomes of the sandplay psychotherapy process in its various phases, while also allowing for alternative explanations.

5.6 POTENTIAL CONTRIBUTIONS OF THE STUDY

This study holds potential value for various reasons. Firstly, the results of my study contribute to the literature base on preventative and intervention measures for children at risk of developing mental health difficulties, as vulnerable children often face psychosocial trauma with resulting impaired cognitive and emotional development. My study could further add value to the emerging literature on psychological and emotional support for vulnerable children of diverse languages. Vulnerable children often find it difficult to express their emotions verbally. They may experience difficulty with regard to expression due to their developmental levels, a lack of linguistic skills, or

because of insufficient insight and awareness of their inner feelings. For this reason, a nonverbal expressive therapeutic technique (such as sandplay psychotherapy) might be valuable for people in the helping professions.

A nonverbal method of intervention could be helpful in South Africa in particular, as our country has eleven official languages, resulting in the common phenomenon of people in helping roles and children in need not speaking the same language. In my study, sandplay psychotherapy proved to be effective in overcoming a language barrier whilst supporting a young vulnerable child emotionally. As such, it could offer an alternative manner of intervening with vulnerable children in need of emotional support.

Secondly, elaborate, in-depth information on the outcomes of sandplay psychotherapy was obtained from my study. Such information provides insight into the emotional state of the child, and the process of emotional healing, as experienced by this particular vulnerable child. Furthermore, the information that I obtained provides insight into the participant"s experiences of sandplay psychotherapy as an intervention technique. My findings could be added to the existing literature on the experiences (particularly emotional experiences) of vulnerable children. Furthermore, they might contribute to literature on the experiences of children in places of safety, such as institutions for children orphaned as a result of AIDS. They can also contribute to the literature base on psychological intervention for *young* vulnerable children.

Thirdly, a personal, caring, emotional relationship was formed with the primary participant, which promoted the therapeutic process and well-being of the child in general. This outcome implies certain practical possibilities, particularly in the South African context, where many caring volunteers, who often are not formally trained, are willing to support vulnerable children in the field of specialised psychological intervention. As a close, trusting relationship with a vulnerable child might add to emotional healing, caring volunteers could have a positive impact on the lives of the vulnerable children that they become involved with.

5.7 RECOMMENDATIONS

In this section I make recommendations with regard to the fields of training, practice and further research.

5.7.1 Recommendations for training

As sandplay psychotherapy is an accessible, low-skill technique of nonverbal intervention with vulnerable children, it seems applicable in the South African context. Therefore, I recommend that this technique be included in the practical training of social workers, educational psychologists, teachers in the field of special needs, and helping volunteers. If people in helping professions are made aware of this technique, it might create the possibility of sandplay psychotherapy being implemented more often. As such, other young vulnerable children might benefit from this intervention technique.

5.7.2 Recommendations for practice

I recommend that schools and places of safety increase the availability of toys and play miniatures for vulnerable children, as play in itself appears to be a non-threatening, self-healing activity for children. Furthermore, I recommend that helping professionals (including educational psychologists, social workers, nurses and doctors) have a collection of toy miniatures and sand trays available for children to play with. I recommend that toys be considered as important on donation lists of large companies and donating institutions, as they may promote social and emotional well-being.

5.7.3 Recommendations for further research

As mentioned previously, limited research appears to have been undertaken in the field of provision of psychological intervention for vulnerable children

across *language barriers*. Therefore, I recommend that further studies be conducted in this field of research, with the purpose of broadening and improving on the current knowledge base. The following areas of interest may be explored in future research:

Research that explores the application potential of sandplay psychotherapy with a larger sample of vulnerable children, across a language barrier.

Research on the application potential of other forms of nonverbal psychological intervention for children across language barriers.

Research on the effect of emotional well-being on the physical health of people infected with HIV.

Research that explores the possibility of lay volunteers being trained in and applying sandplay psychotherapy for children in places of safety and vulnerable communities.

Research on the possible impact of factors other than the therapeutic process itself, during support of a vulnerable child across a language barrier, by means of sandplay psychotherapy.

5.8 CONCLUDING REMARKS

My study was guided by the following primary research question: ***"How can sandplay psychotherapy be used to overcome a language barrier, whilst supporting a young vulnerable child emotionally?"*** As such, I attempted to explore whether or not a language barrier could be overcome by using sandplay psychotherapy as intervention technique, and, secondly, whether or not sandplay psychotherapy can support a young vulnerable child emotionally.

Reflecting on the findings that I obtained, it appears that sandplay psychotherapy can indeed be used successfully and effectively in supporting a young vulnerable child emotionally, across a language barrier. Sandplay psychotherapy appeared to offer the child (primary participant) a nonverbal possibility to express her negative feelings and experiences, and thereby to integrate them. The sandplay miniatures provided her with concrete objects to

express her feelings and experiences. Furthermore, the therapeutic relationship provided her with the experience of a safe atmosphere and secure environment, in which she felt free to express herself. It therefore appears that sandplay psychotherapy can be an effective support modality for vulnerable children from diverse cultures, races and linguistic backgrounds.

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APPENDIX B

INFORMAL INTERVIEWS

(PLEASE NOTE: APPENDICES A, D, F, AND THE VISUAL DATA ARE NOT AVAILABLE ELECTRONICALLY)

INTERVIEW WITH SOCIAL WORKER

21 January 2005

(the social worker) gives me the background information.

(participant) has been at the institution since the age of 3 months.

Her mother died at birth, she was too weak to recover (AIDS).

Her grandmother brought her to the institution when she was 3 months old.

The grandmother phones the institution almost everyday to hear how (participant) is doing, but has never been to visit or taken (participant) for a weekend.

(participant) is 3 years 8 months old.

She has been receiving occupational therapy since December. Until now there has been no progress. According to the occupational therapist she does not cooperate during sessions.

(social worker) says that (participant) never cooperates with professionals. She doesn't speak a word to them and doesn't make eye contact.

When she is hospitalised she does not speak to the nursing staff or doctors for the whole duration of her stay.

(social worker) says that she can speak Sotho, but seldomly speaks to her peers and never speaks to adults.

(participant) has no friends.

She does however have a bond with the cook. This is the only bond she has ever formed. When the other children play, (participant) sits in the kitchen by the cook.

The cook used to take (participant) to her home some weekends. This stopped when (social worker) spoke to the cook and her husband about making a fixed arrangement regarding visits and the importance of consistency.

Apparently (participant) cried a lot when she heard that she would no longer visit. She seemed angry and spent less time in the kitchen with the cook.

She is in group music therapy for over a year now. According to the therapist she does not cooperate during sessions. Apparently she moved to the music for the first time during their last session.

(participant) suffers from HIV/AIDS. She gets hospitalised 3 – 4 times a year for pneumonia. She throws up a lot from chest problems.

(participant) cries a lot. Apparently she cries for very long periods of time (3 hours). She does not respond to any comfort. She usually cries until she3 throws up or falls asleep.

(social worker) says that (participant) presents with anxious behaviour. She appears nervous around others and then fiddles with objects to avoid eye contact.

She also presents with sexual behaviour. She regularly touches her genitals, lifts the dresses of the caregivers, stands between their legs and touches their upper legs.

She also presents with aggressive behaviour. She often fights with the other children for toys and hits them.

According to (participant) teacher she does not work in class, play with the other children or cooperate.

She does not have a bond with any of the caregivers nor social workers.

INTERVIEW WITH THE (CHEF) 4 March 2005

She loves (participant) dearly, like her own child.

She doesn't understand why (participant) has been referred for therapy. She doesn't believe that there are any problems.

She says (participant) always speaks to her and has no trouble expressing herself.

She says she has heard (participant) speak to her caregivers too.

(participant) sits by her in the kitchen everyday while she cooks and chats a lot.

She says that when (participant) cries uncomfortably she only responds to the comfort of ((chef)).

She doesn't believe that (participant) has had trauma.

She doesn't believe that (participant) has social problems.

She says (participant) has a friend that she often plays with.

She does express her concern that (participant) doesn't form relationships easily, and that this may be the reason that she doesn't talk much.

Says that (participant) doesn't speak to or cooperate with professionals and is of opinion that this may be because she associates them with her being sick and not feeling well. She may be scared of them.

I asked her what her opinion is, what I should work with. She said: social skills, school readiness, emotional preparation for hospitalisation, possible rejection because they no longer take her home for weekends.

She explains that she no longer takes (participant) for weekends because the social workers asked her to commit to 3 weekends a month. She cannot because of church and her family.

She says (participant) might be angry at her because of this.

INFORMAL INTERVIEW WITH THE (CHEF) 1 April 2005

((chef)) and I greet eachother in a friendly manner. I am glad that we too have started developing a relationship. Her views are important to me as she appears to be the only person emotionally involved with (participant).

((chef)) says that (participant) is socializing more and she"s excited because they are thinking of sending (participant) to an „outside" nursery school if she is ready (socially).

INFORMAL INTERVIEW WITH THE SISTER 15 April 2005

Sister said that she has noticed a difference in (participant). She says she talks, plays and expresses her thoughts and emotions more regularly these days, and more openly. She did express her concern however, that

(participant) is extremely moody and refuses to talk or respond when she doesn't feel like doing so.

INFORMAL INTERVIEW WITH THE (CHEF) 3 June 2005

((chef)) says (participant) is sick with bronchitis. She is excited because (participant) will be joining the private nursery school next term. They are of opinion that (participant) is socially ready.

INFORMAL INTERVIEW WITH THE (CHEF) 24 June 2005

((chef)) is very pleased. (participant) has been at her new school for nearly a month. She seems happier and there have been no complaints from her new teacher. (participant) is healthy.

INFORMAL INTERVIEW WITH THE MANAGER AND (CHEF) 14 July 2005

The manager of the institution said that there is a big difference in (participant). She said that no one is complaining about (participant) anymore. (chef) (the cook) said that she is playing with the other kids.

INFORMAL INTERVIEW WITH THE NURSE AND (CHEF) 29 July 2005

The manager of the institution said that there is a big difference in (participant). She said that no one is complaining about (participant) anymore. (chef) (the cook) said that she is playing with the other kids.

INFORMAL INTERVIEW WITH THE SOCIAL WORKER 23 September 2005

(social worker) says (participant) is a different child. She says she is very cheerful and mature.

INTERVIEW WITH THE (CHEF) AND THE CAREGIVER ON DUTY 15 November 2005

(CHEF):

(participant) is speaking to her peers and adults at the centre

She has a friend, Lebo

She is independent

She is stable

She loves school

She is open

She can share

She is healthy and doesn't complain

No one has phoned and complained about her from school

(participant) and the (chef) still have a very good relationship –mother figure

She hasn't been admitted to hospital once this year

She has problems with her chest but otherwise healthy

She doesn't cry often anymore

She smiles a lot

CAREGIVER:

She cooperates and responds to the caregivers

She still doesn't make eye contact often

No aggressive behaviour anymore – she picks up the small children and plays with them

Not showing any sexual behaviour anymore

Loves school

APPENDIX C

GUIDED INTERVIEW

INTERVIEW WITH SOCIAL WORKER 15 November 2005

Claude:	Okay, when I started seeing her, you guys said that she doesn't speak to adults.
Social worker:	Yeah
Claude:	And now? Does she speak to adults?
Social worker:	Yes, she is more comfortable now. She makes contact with adults. She makes eye contact. She asks for things now. She used to only make contact with ***** (the cook), but now she is speaking to the other adults too.
Claude:	Oh, so she speaks to other adults too now?
Social worker:	Yes, much better.
Claude:	You said that she never used to cooperate with other adults such as the doctors, her teacher and the occupational therapist?
Social worker:	Hmm, uh yes, she is much better now. She even looks for attention by saying she also needs to see the doctor when he comes to see the other children. I mean she used to avoid going to the doctor altogether, and when she did, she wouldn't open her mouth or do anything the doctor asked her to do.
Claude:	Great. Okay. And does she still the occupational therapist?
Social worker:	Yes she does.
Claude:	And did you receive any feedback?

Social worker: Yes, she is doing much better now. The occupational therapist said she is cooperating and doing the exercises.

Claude: When I started seeing ******* a teacher was coming to the centre once a week to teach her. You were receiving complaints that she wasn't cooperating and not doing her work or playing with the other children. Then later, she went to a new full-time school….how is it going there? Have you received any complaints?

Social worker: At first her new teacher said that she was very quiet and that she didn't play with the other children. But there is an improvement now. She is doing her work and socializing with the other children.

Claude: And over here? She never had friends here. Has she started socializing here?

Social worker: Oh yes, she is talking to the other children now. She never used to talk to them.

Claude: And has she developed a bond with any of the children here? Does she have a friend or a best friend?

Social worker: Yes, two friends. They are always together. They play with the dolls and do everything together. She shares now.

Claude: That's wonderful. And her relationship with ***** (the cook)?

Social worker: Uh. Its still very good. But she isn't so extremely attached anymore. She used to only make contact with *****, but now she talks to the other mamma's and children and spends time with them. She isn't only by ***** anymore. Ja, she and ***** are still very close. But she isn't only comfortable with ***** anymore, she is comfortable with the other caregivers, the children, and with me too. She even tells us what she did at school when she gets home and she tells us what she has to take to school the next day. A big improvement.

Claude:	But ****** is still her mother figure?
Social worker:	Ja.
Claude:	Okay, but she can separate from *****?
Social worker:	Yes, she can separate from her.
Claude:	How is it going with her health, the HIV? When I started seeing her she had been admitted into hospital 4 times that year. Now?
Social worker:	She still struggles with her chest. She gets sick sometimes and sees the doctor, but she hasn't been admitted once in over a year.
Claude:	Ok that's good. She seldom used to smile when I started seeing her. That was one of your concerns. She hardly ever smiled and had difficulty showing expression with her face. She hardly showed emotion.
Social worker:	Yes, she had a very flat affect. She displays emotion now and it is very appropriate to the situation. For instance, when she smiles she is having fun and you can see it from the situation that it is appropriate for her to smile at that moment.
Claude:	Okay, so she is showing her feelings now?
Social worker:	Yes.
Claude:	One thing I didn't pick up in the time I was working with her was the possibility of sexual abuse. One of your concerns in the beginning was the possibility of this, because she was showing sexual behaviour. However, it did not come out in her play. How is it going now? Do you think it could've been a developmental display of sexual awareness?
Social worker:	Yes, hmmm. I think she was just exploring her body. It anyway didn't continue for long. Shortly, after you started seeing her, the sexual behaviour stopped.

Claude: I agree. And she used to cry a lot. She would cry until she fell asleep. Not responding to the comfort of anyone, and not saying what was the matter. Does she still do that?

Social worker: No (laughs). She now easily communicates to the mamma"s what she wants and needs. She doesn"t cry like that anymore. She asks and says what she wants and what she doesn"t want. Ja, she stopped that completely.

Claude: Oh okay, and now, when she cries? Does she respond to comfort? Because she never used to do that.

Social worker: Yes, she stops when she gets some attention and a hug. No, she"s a good girl. Much more appropriate.

Claude: Much more appropriate. And I remember you telling me that she appeared to be very anxious. That was one of your concerns. I remember you saying that she used to fidget with things when around other people, even familiar ones and not make eye contact. A lot of anxious behaviour. How is that going?

Social worker: Hmmm, hmmm, hmmm. Yes that has changed. She is able to make eye contact now and she doesn"t fiddle with this and that. The fact that she is able to talk now, relieves her anxiety. She makes eye contact and she is not nervous anymore.

Claude: Perhaps she is more confident now.

Social worker: Yes definitely, since she is talking and making eye contact she is much more confident.

Claude: Okay. You said that she was showing aggressive behaviour at times. Like fighting with the other children?

Social worker: No not that much. I haven"t seen her fighting for a long time. No she is able to share now and communicate and play with the other children.

Claude: Yes, she can communicate with them now, so she doesn"t have to hit someone when she is angry. Her

	language has improved a lot! I couldn"t believe it when she spoke to me now.
Social worker:	(laughs) Yes, her vocabulary. Its amazing.
Claude:	She used to be moody. One minute, or one day she would seem happy and stable, and the next in a terrible mood, not smiling and avoiding contact. Is she still unstable? Is it better now?
Social worker:	Much better. That stability. She is getting there.
Claude:	That"s great! And can you think of anything else that you can tell me?
Social worker:	Just that she has improved so much. She is a happy normal child now. She is confident and can communicate. Her behaviour is appropriate. I was so worried when I referred her, but Im happy now. She is a good girl. She is doing well. She tells us about her day at school.
Claude:	I am so happy. That girl climbed into my heart. The day I left here I cried so much. Thank you so much *******. I really appreciate everything.

INTERVIEW WITH (CHEF) 15 November 2005

Claude: Remember, when I started seeing her in the beginning of the year she was only speaking to you?

(chef): Mmm mmm. Yes. Does she speak to you now?

Claude: Sometimes she says “yes”, but I can see she understands. I just think she"s not fluent in English yet; it"s not her home language. I asked her to go and show me her bed just now. She went straight there and showed me.

(chef): She went to show you where she sleeps?

Claude: Ja!

(chef): Oh (laughs). Now, she comes home from school, she tells us everything. She is so clever. She tells us everything. Even about her teacher, the children that were naughty, what she did at school, what she needs, everything!

Claude: Oh, she is speaking now. Remember in the beginning she was speaking only to you? Is she speaking to the other children and people too now?

(chef): Ja! And she got her report now, they say she can go to grade naught next year!

Claude: What!? That"s wonderful. So she is talking. And is she playing with the other children?

(chef): Yes, very well. And she likes to look after the small babies and hold them. She is playing nicely.

Claude: Has she got friends? And does she laugh with them?

(chef): Yes, she never had. But now she"s got lots of them.

Claude: And laughing?

(chef): Everything. I can"t believe it. You remember how she was? And just last week, ***** (social worker) asked me: "*****((chef)) what happened? When did ****(primary participant) become so clever?" (laughs). We said we think it is you.

Claude: (laugh) And your relationship with her? ****(primary participant) loves you very much? Are you still her mamma?

(chef): (laughs) Yes, I will always be her mamma. And she knows I"m her mamma. When she sees me, I can see she knows I"m her mamma. And when she gets hurt, then she cries and shouts "MAMMA" for me to come help her. But I saw now, if I leave her when she shouts for me, she allows the other mamma"s to comfort her.

Claude: I remember in the beginning she would cry without stopping and only want you. She would only be comforted by you.

(chef): Yes, even weekends they would have to phone me to come in because she wouldn"t stop crying.

Claude: And now? Does she stop crying more easily? Can the other ladies that work here get her to stop crying?

(chef): Yes, the other ladies. She doesn"t cry so much anymore.

Claude: That"s wonderful.

(chef): And she doesn"t tell me alone. Remember she only used to want to tell me what"s wrong. Now she tells everybody. She tells everyone, even about school.

Claude: And does she like school? Does she look forward to going to school?

(chef): Very. Every day she is ready to go.

Claude: I was thinking about that. I think her new teacher and the school environment may have played a big role in helping her. Remember she was only at this school. Once a week, the teacher would come in to teach. Then she went to a proper full time school in the middle of the year.

(chef): Yes, maybe. She has never got a letter for us complaining. The school has never phoned us to complain.

Claude: That"s good. In the beginning of the year you guys said that when she got angry she used to hit the other children. Does she still do that?

(chef): No. She tells them rather. But sometimes the children do fight. You never know who started it. But sometimes the children hit each other. But they are still small.

Claude: So, there"s no problem?

(chef): No problem. She"s good, good. Very good. No one complains.

Claude: And she has many relationships now? Not only one with you?

(chef): Yes, she listens and talks to everyone now. But I"m still her mamma. When she is naughty, the other mamma"s tell her that they are going to tell me. Then she stops. She doesn"t want them to tell me (laughs). You know how it is with your mother. You don"t want your mother to know when you"ve done something wrong. The other day she told one of the mamma"s that she won"t listen to her, because she is not her mother. She said she will only listen to me because I"m her mother (laughs). So I called her and I said "*****(primary participant) you must listen to the other mamma"s. If they ask you to go and do something you must do it" (laughs). Now she does.

Claude: The social worker said that she never used to speak to her either. She would fidget and not make I contact. As if she was nervous. Is she still so nervous?

(chef): But now….uh uh. She is not nervous at all.

Claude: Oh good. I"m very happy about everything.

(chef): Me too. Thank you Claude.

Claude: No thank you. You make such a difference in her life. Thanks for chatting to me.

APPENDIX E

FIELD NOTES

(VISUAL DATA NOT AVAILABLE ON ELECTRONIC COPY)

18 November 2004

Ronel bel en vra of ek belangstel om my skripsie te doen oor terapie vir kleuters wat vulnerable is. Sy se ek gaan die terapie self doen en my skripsie gaan in die vorm van „n gevalle studie wees.

Die eerste emosie wat ek voel is opgewondenheid. Dit pas by my…by hoe ek is! Ek is „n praktiese mens, nie „n akademikus wat hou van groot woorde nie. Dit pas by my want ek is life vir kleintjies veral vir die wat ondersteuning nodig het.

Tweedens, voel ek gevlei….Wow! Hoekom het Ronel my gevra? My gekies? Wow! My ouers is trots.

Emosie nommer drie….bang, baie bang…..en bietjie angstig. Hoe op aarde gaan ek dit regkry om in Middelburg skool te hou, my 2de jaar meesters te doen en my skripsie doen? In een jaar!!!?? Dit voel bietjie onmoontlik. Maar duidelik dink Ronel dis moontlik en dit laat my beter voel.

Ai tog….kleintjie…..vigs……skeidingsangs…..seksuele misbruik….. Se nou maar ek slaag nie? Se nou ek kry dit nie reg nie? Toemaar wat… maak nie saak wat nie, ek sal lief wees vir haar en DIT sal sekerlik help.

20 November 2004

Al wat deur my kop gaan is skripsie, skripsie, skripsie. Ek moet volgende week vir Prof. Eloff gaan sien en vir haar se wat my idees is.

Ek dink sandterapie…..psigoanalitiese spelterapie…..met sand. Wanneer „n kind so klein is (3), kan hulle nog nie lekker praat nie, hulleself uitdruk nie. Ja, ek dink spelterapie sal moontlik werk. En biblioterapie. Ek sal my eie boekies skryf, spesiaal ontwerp vir die kindjie se behoeftes, met baie maklike woordjies.

Ek gaan lees bietjie oor sandterapie. Dit klink interessant, maar „n bietjie “too good to be true”. Die terapeut neem nie aktief deel nie. Sy is net daar, net by. Luister, wees empatiek, wees aanvaardend, laat die kind haar eie ding doen, laat haar veilig voel. Die kind gaan blykbaar self deur 3 fases van spel. Chaos – konflik – resolusie. (oor „n groot hoeveelheid sessies). Dis geskik vir kinders wat getraumatiseer is en aan oorweldigende emosie blootgestel is, of ervaar het. Die kind ontlont en los self probleme op. Die spel werk met fenomenologiese simbole.

Wel okay, dit klink maklik genoeg. Kan dit regtig so maklik wees?

22 November 2004

Ek bel vir Tiekie de Vos (die bestuurder) by die Mohau kliniek. Sy se die kindjie is Sotho sprekend en kan skaars Engels of Sotho praat. Oh gats! Sy klink regtig teleurgesteld dat ek Afrikaans ……. en wit is…. Sy se sy het verwag dat die universiteit vir hulle „n swart Sotho-sprekende sielkundige sou stuur.

Sy se sy wil nie my of die kind se tyd mors nie. Ek se ek sal met my supervisor praat en terug kom na haar toe. Nee man, dit voel nie lekker nie, ek is seker ek sal dit nogsteeds kan doen. Ja man, mens hoef mos nie te praat met sandterapie nie.

Iemand anders sal net die assessering moet doen. Ek moet net weet presies wat die kind se behoeftes is.

Die kind? Aggenee……, ek het vergeet om te vra wat die kleintjie se naam is! Ek bel weer vir Tiekie “wat is die dogtertjie se naam?”

(PARTICIPANT)……..PRAGTIG

1 December 2005

Afspraak met Prof Eloff en Ronel. Eks is senuwee-agtig…. ek ken nie vir Prof Eloff nie.

Dit gaan baie goed. Hulle stem saam dat ek nogsteeds kan terapie doen en se ek moet self die assessering behartig. Hoe??? “Dink” se Ronel. Assesseer ook dmv sand en spel, dink ek. Hulle hou van my idees…..Yes! Sover gaan dit goed. Ons verander my tema na “CROSSING THE LANGUAGE BARRIER……THERAPY…..VULNERABLE CHILD”. Klink goed. Maar is dit moontlik?

Stap 1: kry my navorsingsvoorstel klaar.

Kan ek maar die kind gaan ontmoet?? “Ja” se hulle. Yes!

ONDERHOUD MET (SOCIAL WORKER) (MAATSKAPLIKE WERKSTER)

21

January 2005

Vandag het ek „n afspraak gehad met (social worker), (participant)seng se maatskaplike werkster. Ek was senuwee-agtig en nuuskierig om te sien hoe dit daar lyk. (social worker) was baie vriendelik oor die telefoon, daarom was ek nie senuwee-agtig om haar te ontmoet nie, maar om vir (participant)seng te ontmoet.

(social worker) het my vriendelik verwelkom. Van buite af lyk die gebou maar verwaarloos, maar binne! Binne was daar „n warm atmosfeer en dit was so mooi. Die kinders het alles wat hulle nodig het en hulle lag en glimlag almal. (social worker) se hulle kry baie borge, en al die kinders is in „n privaat skool. Behalwe die 3 – 4 jariges. Daar is „n gekwalifiseerde onderwyseres wat een maal per week inkom om vir hulle skool te hou. Hulle het „n pragtige klaskamer.

Die eerste keer toe my gemoed sak tot onder in my skoene is toe ek vir (social worker) var tot op watter ouderdom die kinders in die tehuis mag woon. Sy se toe dat die kinders daar bly en nie oorgeplaas word na kinderhuise toe nie. Ek vra toe vir haar hoe oud hulle oudste kind is. Sy se toe 14 jaar, die meeste van hulle sterf lank voordat hulle so oud word. Ek kry toe dadelik „n knop in my keel en dit voel asof ek wil weghardloop, vinnig, voordat ek die kind ontmoet. Want ek het nooit so daaraan gedink nie. Dat hierdie kindjie dalk sal sterf terwyl ek en sy nog in terapie is. Toe besef ek hoe selfsugtig ek is, ek het dadelik gedink hoe dit my hart gaan breek en hoe ek daarmee gaan cope. Wie gee my die reg om so selfsugtig te dink? Sy sal al my aandag en

liefde kry wanneer ek tyd saam met haar spandeer, maak nie saak wat nie, want sy verdien dit.

(social worker) gee my al die agtergrond inligting. Sy se (participant) is al daar vandat sy 3 maande oud is. Haar ma het gesterf net na die geboorte, sy was te swak om te herstel. Haar ouma het haar by die kliniek aangebring op 3 maande. Die ouma bel amper elke dag die maatskaplike werkster om te hoor hoe dit gaan, maar het nog nooit kom kuier of haar uitgeneem nie. Dis vreemd?
(participant) is nou 3 jaar 8 maande. Sy is sedert Desember in arbeidsterapie. Daar is geen vordering nie en sy gee nie haar samewerking nie. (social worker) se sy gee nooit haar samewerking met professionele mense nie en praat nie „n woord met hulle nie.

Sy se dat selfs wanneer (participant) gehospitaliseer word, praat sy vir die hele tydperk nie „n woord met die susters of docters nie. (social worker) se sy kan praat. Sy verstaan en kan Sotho praat. Sy praat soms met die ander kinders by die kliniek, maar skaars met die volwassenes.

(participant) het nie vriende nie. Die enigste binding wat sy nog ooit gehad het is met (chef) (die kok). (chef) het haar soms uitgeneem vir naweke, maar nadat (social worker) 8 maande gelede met (chef) en haar man gepraat het oor „n meer vaste reeling en die belangrikheid van konsekwentheid, het (chef) die naweek besoeke stop gesit.

(social worker) se (participant) was kwaad, en sedertdien sit sy nie meer so baie by (chef) in die kombuis nie. (participant) het baie gehuil.

(participant) is al oor „n jaar in musiekterapie (groep). Sy gee nie haar samewerking nie. Blykbaar nou die dag vir die eerste keer beweeg op die musiek. Ek begin bekommerd raak oor hoe lank/indien ooit, dit sal neem voordat (participant) my vertrou, en minder resistant sal wees. Ek bekommer ook of sy sal inkoop op sandspel.

(participant) is baie sieklik. Sy word 3 – 4 keer „n jaar gehospitaliseer. My hart pyn. Wat sal ek maak as dit gebeur? Dit gaan gebeur. Hoe gaan ek dit hanteer? Sy kry baie pneumonia en gooi baie op. (participant) huil blykbaar baie. Sy kan maklik vir 3 ure huil sonder om op te hou. Sy huil gewoonlik totdat sy opgooi en slaap, ten spyte van enige troos. Aggenee….

(social worker) se (participant) toon angstige gedrag. Sy maak nie oogkontak nie en vroetel dikwels en vat aan voorwerpe wanneer sy in (social worker) se kantoor is. Sy toon ook seksuele gedrag. Sy vat gereeld aan haar geslagsdele. Ek sal moet gaan oplees oor die ouderdom wat sulke eksplorasie van die liggaam normaal is. Sy tel die personeellede se rokke op en hou daarvan om tussen hulle bene te loop en hulle bobene vas te hou.

Sy toon ook aggressiewe gedrag. Dit is vir my vreemd… Sy was so jonk en klein toe sy hier aangekom het, waar en wanneer het die beweerde seksuele misbruik plaasgevind? Is dit moontlik? Ander trauma sluit in siekte en hospitalisering. Wat my ook deurmekaar maak is dat as dit waar is dat (participant) nie bind of verhoudings het met die personeel nie, hoekom hou sy dan hulle bobene vas?

(social worker) laat roep vir (participant). My hart klop van banggeid. Sy is pragtig. So klein, met die grootste oe. Sy het „n koorsblaar op haar lippie. Sy kyk nie vir my nie, sy kyk vir (social worker) vlugtig maar praat nie met haar nie. (social worker) vertel vir haar in haar moedertaal wie ek is en dat ek weekliks gaan kom kuier. Ek vat haar handjie en hou hom vas. Sy staan doodstil en kyk nie vir my nie. Ek sit weer en hou nogsteeds haar klein handjie vas. Ek begin die knop in my keel sluk. Ek praat verder met (social worker) en sy staan doodstil en hou my hand vas. Dit reen buite so daar is nerens waar ons bietjie alleen kan gaan stap nie.

Ek se vir (social worker) ek sal 4 Feb begin met terapie. Ons stap uit na my kar toe en sy hou heeltyd my hand vas. Ek groet vir (social worker) en wil haar

hand los sodat ek vir haar „n drukkie baai kan gee. Sy druk my hand vas!! Sy wil nie he ek moet gaan nie. Ons bind alreeds! Ek klim in my kar en huil en huil en huil.

SESSION ONE 4 February 2005

Ons eerste sessie was glad nie wat ek verwag het nie. (participant) het mooi saamgewerk, dadelik begin speel, met my probeer kommunikeer nie-verbaal en het tot met tye geglimlag! Veral toe ek fotos geneem het.

Die fotos is vir my bietjie van „n probleem op die oomblik want dit lei haar aandag af van wat sy besig is om te doen.

Sy het eers my speelgoed geignoreer en met haar rug na my met (social worker) se speelgoed gespeel (ek werk in haar kantoor). Nie regtig speel nie, maar hier vat en daar los. Later toe sy meer gemaklik was met my (ek dink), het sy die mensfigure almal in die sand gepak en toe meeste van hulle in die huisie gedruk. Sy het gehuiwer om die “evil” figuur in te druk, maar het toe naderhand. Sy het bietjie aan die krokodil gevat, bietjie gekyk, en toe op die mat gelos.

Daarna het sy „n Barbie gevat en haar hare gekam, syt my aangemoedig om dieselfde te doen en dit was die eerste keer wat sy met my probeer kommunikeer het. Deur om vir my te wys ek moet ook dit doen. Daarna het ons tee-tee gespeel. (participant) het weer met (social worker) se speelgoed gaan speel. Daar was tekens van realiteitsgebaseerde spel, soos stryk en kos inskep. Baie domesticated maar die stimulus van die toegeruste kamers in pophuis was dalk leidend.

Ek is tevrede. Dit voel asof sy van my hou. Ons „click" en ek dink sy vertrou dat ek weer sal terugkom, ek kan dit in haar oe sien. Elke keer wat sy hoes, mis my hart „n klop….en die seertjies op haar bene herinner my deurlopend aan die fieslike virus wat homself tuis kom maak het binne hierdie pragkind se lewe.

Interpretasie: kort aandagspan

Speel nie regtig (vat en los)

Chaotiese spel met mensfigure

Aggressie

Goeie verhoudingstigting met my

Behoefte aan emosionele versorging

SESSION TWO 11 February 2005

(participant) was half aan die slaap toe ek daar aankom. Te oulik. Toe dit lyk of sy meer bykom het sy groot geglimlag en ek het vir haar „n drukkie gegee. Sy het oogkontak gemaak. Ek wonder hoekom sien ek nie die vermydende gedrag wat die ander terapeute genoem het nie. Miskien is dit omdat ek nie van haar verwag om verbaal te kommunikeer nie.

Vandag het sy bietjie langer „gespeel" as die vorige keer. Sy kon „n bietjie langer konsentreer. Sy het heel eerste die krokodil uit die boks gevat. Sy het vir „n paar sekondes (redelik lank) daarna gekyk en dit in die neergesit. Later het sy weer die krokodil gevat en het met haar tong en mond die tande van die krokodil gevoel. Ek dink hierdie was „n uiting van aggressie.

Sy het al die mensfigure uit die boks gevat (behalwe hulk), na hulle gekyk en op die mat neergesit. Sy het die wit poppie met die lang hare in die sand gesit saam met die krokodil. Bedreiging? Aggressie teenoor haar vanaf die wereld?

Daarna het sy die slang in haar hand geneem, bietjie gekyk en saam met die krokodil en die pop in die sand gesit. Sy het dit tot en met 5 minute voor die einde van die sessie so gelos. Seksuele misbruik? Seksuele bedreiging? Seksuele bewustheid?

Sy kon nie vir lank op een ding konsentreer nie (ouderdom? Resistance?). Sy het egter baie meer gefokus gespeel. (meer gemaklik om my om uit te druk?).

Sy het „n dinasaurus gaan haal in die kas. „n Groot een met groot tande! Aggressie? Sy het ander speelgoed ook uit die kas gehaal. Sy het nie met dit gespeel nie. Net op die mat neergesit. Niks kon haar aandag behou nie,

behalwe die stetoskoop. Sy het dit 2 keer op haar kop gesit en toe weer neergesit. Ekspressie van haar ervarings met dokters en hospitaal?

Sy het twee borsels gevat en vir my een gegee (sy het „n woord in haar taal gese). Sy het 2 poppies gevat (die wit en die swart een) en het vir my beduie ek moet die een se hare kam. Sy het geglimlag. Dit was „n goeie teken van groei in ons verhouding. Sy het ook met my gekommunikeer (verbaal en nie-verbaal). Dit voel vir my goed, ons verstaan mekaar sonder taal. Ek dink sy kommunikeer met my omdat ek geen druk op haar sit om te praat nie. Ek praat self nie baie nie. Ek sit in stilte. Elke keer wat ons saam gespeel het het sy „n woordjie gese.

Sy het met tye ook met die karretjie gespeel (ontvlugting?).

Sy het teen die einde die wit en die swart poppie gevat en hulle begrawe in die sand. (Dit was die eerste tekens van die konflik fase wat begin het. Hierdie fase word gekenmerk deur „total destruction"). Alhoewel haar spel nog baie chaoties was en nie sin gemaak nie (chaos phase: eerste fase). Die slang het nog daar gele en is nie begrawe nie? (Dalk dat sy die aggressie ervaar, en deur om die mensfigure te begrawe en nie die slang nie, toon sy nog aggressie teenoor haarself (depressie). Sy destruct nog nie die aggressor nie).

Sy het opgestaan en na die maatskaplike werkster se pophuis gegaan waar sy weer gestryk het (vermyding van negatiewe gevoelens – ontsnapping?). Ekt langs haar gaan sit en sy het geglimlag (aanvaarding van my kant af). Sy het die koppies tee en pierings uitgehaal. Sy het vir my „tee geskink" en ons het saam „gedrink". Dit was weereens goeie bonding en aanmoediging vir verhoudingstigting van haar kant af. Die tee en pierings dui dalk „n behoefte aan emosionele versorging aan.

„n Kind het by die kantoor ingeloer, sy het daarna die speelgoed neergegooi. Jaloesie en openbare uiting van aggressie?

Ekt vir haar aangedui dat ek gaan loop. Sy het gehelp om op te ruim en geglimlag. Sy het dus haar samewerking gegee en het vertrou dat ek sou terugkeer.

Baie vordering vandag. Ek weet nou verseker dat sy van my hou en dat ons verhouding gestig het. Dit is teenstrydig met wat die ander terapeute ervaar het. Miskien is dit die individuele aandag? Of die feit dat ek nie van haar verwag om te praat nie? Sy het „n reeks goed aan my geopenbaar:

Verhoudingstigting
Samewerking
Beter gemoed (lyk gelukkiger)
Aggressie teenoor haar
Moontlike seksuele misbruik of bewustheid
Minder angs
Meer kommunikasie (verbaal en nie-verbaal)
Oog kontak
Minder spanning
„n behoefte aan emosionele versorging
Aggressie (toe iemand in loer by kantoor) (social skills?)

Dit maak my hart warm. Syt baie gehoes vandag…….bang.

SESSION THREE 19 February 2005

(participant) het so happy gelyk vandag. Dis moeilik om te beskryf in woorde. Dit klink so vlak in woorde. Dit sou great gewees het as iemand my gedagtes kon lees en deur my oe kyk wat aan die gebeur is. Dis beautiful! Sy het gegiggel en gelag en dikwels gesmile. Sy het baie gepraat. Ek verstaan nie wat sy se nie, maar sy praat! Met my…."n volwassene! Ek sal moet reel vir „n vertaler.

Ekt vir Ronel gesien. Syt gese ek sal moet assesseer. Ekt gedink ek sal net steun op my observasies en haar spel en wat die betekenisvolle ander in haar lewe se. Want die sandspel is blykbaar „selfgeneesend" en mens moet blykbaar nie te veel probeer interpreteer nie. Maar ek verstaan Ronel se punt. Ek sal moet assesseer sodat ek na die proses kan herassesseer om te bepaal of daar verbetering is.

Ekt probeer om tekeninge met haar te doen, maar sy is te klein en haar menstekening lyk nie naastenby soos „n mens nie. Dit gaan moeilik of eerder onmoontlik wees om dit te interpreter. „n Dame wat daar werk het die opdrag vir haar in Sotho verduidelik. Ekt „n boek in die bib gekry wat die assessering van klein kinders verduidelik. Ek sien uit daarna om dit te lees, want ek weet regtig nie waarnatoe van hier af nie.

Dit gaan beter met haar. Ek kan dit voel. Sy hou daarvan as ek saam met haar speel en sy nooi my dikwels uit. Ek moet nog onderhoude voer met die kok, versorger, onderwyseres.

Temas vandag:

Die toilet (potty training? Ontwikkelingsfase)

Samewerking en goeie vertrouensverhouding met my (hare kam saam)

Behoefte aan emosionele versorging (hare kam van pop/kos en tee)

Twyfel of daar seksuele misbruik was

SESSION FOUR 25 February 2005

Ekt vir (social worker) gevra om vir (participant) universiteit toe te bring. Ek wil die Von Staabs afneem vir assesserings doeleindes. (participant) het „n bietjie verskrik gelyk in die nuwe omgewing. Haar oe was groot oop en sy het nie vir my geglimlag nie. Eers toe ek en sy alleen in die lokaal was en sy gespeel het het sy geglimlag.

(social worker) is van mening dat die teenwoordigheid van „n vertaler haar vrymoedigheid om gevoelens uit te druk, en die terapeutiese verhouding negatief beinvloed sal word. Sy se dat die teenwoordigheid van volwassenes juis vir haar „n bekommernis is. Ek stem saam.

Temas:

Aggressie (teenoor ander en haarself) - krokodil
Seksuele misbruik of bewustheid (slang)
Ontvlugting (karretjie)
Ervarings met dokters, medisyne en hospitale (botteltjie met pille)
Behoefte aan „n moederfiguur (koei)
Behoefte aan emosionele versorging (kombersie)

Haar spel is nogsteeds chaoties. Sy speel nie met die speelgoed nie. Sy vat en los net. Kort aandagspan of vermyding van die taak? Sy druk tog gevoelens uit.

ONDERHOUD MET (CHEF) (DIE KOK) 4 March 2005

She loves (chef) dearly, like her own child.

She doesn"t understand why (participant) has been referred for therapy. She doesn"t believe that there are any problems.

I asked her what her opinion is, what I should work with. She said: social skills, school readiness, emotional preparation for hospitalisation, possible rejection because they no longer take her home for weekends.

She does not believe that there has been any trauma.

She is a bit resistant with me because she doesn"t believe that she needs therapy. She gives me the idea that she doesn"t like that I (an expert) come into the picture. She makes it clear that she knows the child better. I like her.

SESSION FIVE 1 April 2005

(chef) and I greet eachother in a friendly manner. I am glad that we too have started developing a relationship. Her views are important to me as she appears to be the only person emotionally involved with (participant).

(chef) says that (participant) is socializing more and she"s excited because they are thinking of sending (participant) to an „outside" nursery school if she is ready (socially).

(participant) seems a little cross with me, or unsure maybe, because I havnt been there in 2 weeks. She looks so cute when she is angry or sulky, and it makes me smile. She doesn"t smile or try to communicate with me for 20 mins and then she starts appearing to be comfortable again.

She finger paints on an A4 paper. I am letting her paint as part of my assessment. She seems to enjoy it. Towards the end of the session she starts playing with (social worker)"s toys.

Themes:

Food and drink: emotional nurturing

Food and drink: relationship with me

Facial/nonverbal expression of emotion

8 April 2005

I go to Kalafong but (participant) is sleeping. I don"t want to wake her, because sleep is important for her health. I have other appointments too, so I cant wait. I ask (chef) to tell her I was there.

SESSION SIX 15 April 2005

(participant) is happy to see me. It lifts my mood. I am feeling quite frustrated and tired today. This week has just been too full.

(social worker) has had the 2 questionaires that I set up filled in by (participant)"s teacher and caregiver respectively. I am so grateful to her. She is so busy, but always finds the time to help me. I hope that the info I gain from the questionnaires is helpful for my assessment. It is extremely difficult to assess (participant)seng and I hope that my findings will be trustworthy. The language and age barrier is really impeding on the assessment process.

In the mean time, therapy is going forth, as it is supposedly self-healing and my interpretations are not so important.

Today (participant) buried miniatures again. The horse, the cow, „hulk", and the witch. She also threw the witch repeatedly and showed some aggression. This is a good sign as it appears that she has gone into the „conflict or destruction phase". She is showing aggression towards aggressive symbols and therefore expressing her innermost emotions. There are less signs of aggression towards her from others. I cant find my crocodile, therefore she didn"t have the opportunity to play with it.

I am quite disappointed with the negative responses on the questionnaires. There experiences of (participant) seem to be very negative.

As I left today Sister (resident nurse) called me to ask me how (participant) is doing. I told her that (participant) seems to be opening up a lot more and that she smiles often and also verbalizes. Sister (resident nurse) said that she has noticed a difference in (participant). She says she talks, plays and expresses her thoughts and emotions more regularly these days, and more openly. She

did express her concern however, that (participant) is extremely moody and refuses to talk or respond when she doesn't feel like doing so.

Themes:

- Conflict or destruction phase of healing
- Aggression toward the aggressor
- Expression of aggression
- Playing / concentrating for longer periods
- Improvement in mood
- Improvement of relationships

SESSION SEVEN 27 April 2005

Ooh! (participant) is moody today. She frowns as I arrive and is upset with one of the other children because they are sitting on her chair. I take her by the hand to walk with me to the office. She doesn"t smile once, or make a sound. We get to the therapy room and I get the urge to put her on my lap because she looks so sad or angry. I pick her up and hold her. She puts her head on my shoulder and we sit there in silence for about 10 minutes. It is great that she responded to my comfort.

After a while, I asked her in English if she wants to play. She answers „yes". This is great! She spoke to me. That felt good.

She takes out the crocodile and puts it on her lap. Aggression? She buries a variety of objects: pig, horse, aeroplane, fence. She avoids the human figures. Still has relationship difficulties? In the destruction phase?

When she finishes burying, she moves to (social worker)"s toys. Avoidance? She plays the same as always. Food and drink with me. Ironing.

When I tell her its time to leave, she doesn"t resist and helps me tidy up. She appears to understand me. I put her on my hip and take her back to the other children. She smiles all the way. She appears to be „proud" of me and appears to brag with me to the other children with her smile. It was nice leaving her with a smile on her face.

Themes:

- Projection of aggression
- Destruction phase
- Avoidance of other people (human figures)

Need for emotional healing (food and drink)

Good relationship with me (sharing food and drink)

Nonverbal facial expression of a variety of emotions

Cooperation

Response to comfort

Avoidance of intense emotion

20 May

(participant) is sick. I cannot do therapy today. She looks very sad and tired. I am worried.

SESSION EIGHT 27 May 2005

(participant) plays with more realistic scenes. Packs out the house, animals and humans. She buries the house and all the figures.

She seem sick and sad. She doesn't smile once. She cries when I leave.

Themes:

Destruction phase

Scenes seem more realistic – signs that she is starting to move into the resolution phase

Sadness

Sick

Distraught when I leave (more attached when she is sick?)

3 June 2005

(participant) is sick with bronchitis. I go to see her, but she is sleeping. I speak to (chef) and she says that (participant) will be fine. Im worried about her. (chef)"s calmness is soothing.

(chef) is excited because (participant) is going to start going to the private nursery school next term. Im excited too. I must remember to call her new teacher.

I have exams for the rest of June and will only be able to see (participant) again on the 24th of June.

SESSION NINE 24 June 2005

Im worried about (participant) because she doesn"t smile or say a word. She never seems excited to see me, for example, she doesn"t run to me when I arrive like the other children do. I cant figure out why? Maybe it is because I haven"t been here for a while. Maybe she has regressed? Or doesn"t trust me anymore? Does she keep all her emotions bottled up inside? And could this be the reason that when she cries, she cant stop?

She played with the crocodile and the snake again today (aggression, sexual awareness/ abuse). She played differently today in the following ways:
She explores the mechanical workings of toys eg. How they move (cognitive development). She played a bit of fantacy today when she „walked" the horse and „drove the car" (escape?) (development in play)

Her scenes were much more realistic today with no signs of destruction. It appears that she is moving into the resolution phase.

(chef) is very pleased. (participant) has been at her new school for nearly a month. She seems happier and there have been no complaints from her new teacher. (participant) is healthy. My camera was stolen so I have no photos of today"s session.

Themes:

- Regression in our relationship
- Regression in emotion
- Appears sad
- Aggression
- Escape
- Resolution phase
- Cooperation at school – adequate functioning at school

SESSION TEN 28 June 2005

(social worker)"s office is locked so we have to go and play outside with the sandplay toys. The other children stare at (participant) from inside and it distracts her. Later though, she starts interacting with them by making as if she wants to pass them a toy. This is the first time I see her attempt interaction with the other children. (participant) doesn"t smile once. Im concerned about her social skills? Anger? Repression?

She plays more maturely these days. She moves the toys and does not merely pick them up and leave them again. Unfortunately we didn"t have sand today, and this could of prevented her presenting with her common theme of burying objects.

(chef) and I chat often and have established a good relationship.

Themes:

House and kennel – need for security? Or maybe she is feeling more secure

Snake – sexual abuse/exposure

Car – escapism

Plays with the same doll as always – identity formation or improvement in relationship?

Plays with hair – emotional nurturing

Horse – fantasy play

Crocodile – aggression

Boat – escapism

SESSION ELEVEN 14 July 2005

I could not believe the difference in (participant)seng today. She smiled all the time, laughed, mimicked my facial expressions, teased me, held out her hand to hold mine and lifted her arms for me to pick her up. I couldn't believe it! She was so responsive and expressive. She initiated communication and contact. Big improvement in social skills, relationship and mood. I think she is enjoying school and I think it takes her a long time to trust someone.

She made sound effects with the car today, which she has never done. Her play contains fantasy, and she is more confident. (still the theme of escapism). She buried all the human figures today. Then she put them with their heads in the sand and rammed the cars into them. Definitely complete destruction of the figures. Destruction phase. She progressed to playing with the human figures and not burying the other objects as usual. I think she has built up the ego strength to deal with her aggression toward people and her relationship to them. She then put the car and farmer in the house, and gave me the doll with the blue shirt. She picked up the crocodile but didn't play with it.

The manager of the institution said that there is a big difference in (participant). She said that no one is complaining about (participant) anymore. (chef) (the cook) said that she is playing with the other kids.
Themes:

Destruction phase: including human figures
Expression of aggression toward people
Big improvement in mood: happiness
Confidence
Fantasy play
Improvement of social skills
Good expression of emotion through facial expression and gestures
Improvement of therapeutic relationship
Initiation of contact and communication

SESSION TWELVE 29 July 2005

(participant)seng smiled when I arrived today….i cant remember her ever doing that. She never seems excited when I arrive, so today warmed my heart. She smiled a lot during the session and laughed. She is acting and interacting with me more and more these days. What stuck with me today is that she pointed at things she wanted me to pass to her. A good sign. An effort to say what she wants, more assertive. Good communication. She actively invited me to join her for „tea" by pulling a chair to the table and pointing for me to sit down on it. She is communicating constantly and showing much more confidence and interaction.

It was good, normal, fantacy play that resembles reality. Moving into resolution phase? We also played in the sand with the sand toys.

Sister (resident nurse) said that she is playing with the other children now and is communicating verbally with them. (chef) said that (participant) is “happy”. I can see it!

Themes:

Snake – sexual awareness or abuse

Burying „hulk" – not the other human figures (possibly improvement from last week, where she no longer shows aggression to all the human figures, but only the „bad" one.

She also constantly unburied them – as if she was experiencing conflicting emotions of anger and forgiveness

Resolution phase

Cars – escapism

Social skills

Verbal communication with the other children

Happiness

SESSION THIRTEEN 19 August 2005

(participant) smiled a lot. Throughout the play she could figure out the mechanical working of toys and could play fantasy play for longer periods of time.

Her scenes reflected reality. Example she built a living room with chairs and tables, tea cups and then her and I each had a human figure and had lunch and tea. There was no burying or destruction. Definitely in resolution phase. She still shows a need for emotional nurturing (eating and drinking). She shows much better relationship abilities and social skills.

She then played with the social worker"s docters toy set. This is the first time that she wanted to play with this. She showed me to lie on the floor and then she examined me. I did the same to her thereafter. It seems that she is now dealing with her traumatic experiences of hospitalisation and seeing doctors in a very constructive, confident way. She is familiarising herself with the medical tools and situation and making it a fun game. Wow! Major progress. We touched eachother a lot during this game, which could have nurtured her emotionally (Marschach therapy). She has a bad cough.

Themes:

- Cognitive development (play)
- Resolution phase – realistic fantacy play
- No signs of aggression
- Good social skills
- Happiness
- Need for emotional nurturing
- Confidence
- Dealing with bad experiences (hospitalisation)

SESSION FOURTEEN 2 September 2005

She ran to me when she saw me today! This is the first time she expresses excitement! Today is also the first time I hear her speak to the other children. They usually ask her questions when I arrive, and she always ignores them. Today she answered them. Great social skill and communication improvement.

She immediately wanted to play doctor-doctor again today. We role-played and took turns. She thoroughly enjoyed it. I think she is resolving the trauma of hospitalisation and is developing her own coping skills for dealing with hospitalisation in the future. Great resiliency!

She then played with the horse and the crocodile. Venting aggression after previous game perhaps? She filled the crocs mouth with sand. Taking control over whatever is causing aggression? Doesn"t feel hulpeloos anymore? She buried the truck and made a joke by saying „ahh" and covering her mouth with her hand. She unburied it and „drove" it in the sand.(realistic play). She played in a mechanical manner again and fixed the doctors glasses that were broken.

She took 3 soldiers, buried one, and let the other 2 fight. This is the first time she shows this intensity of fantasy play. Aggression and destruction theme reemerges. She blew the soldiers up.

She brushed my hair. Im worried about a bad vibe im getting from the daily caregivers – toward (participant) and myself.?

Themes:

- Resolving trauma of hospitalisation
- Developing own coping skills
- Cognitive development

Good social skills

Confidence

Destruction and aggression thereafter

Escapism

Emotional nurturance (brushing my hair)

23 September 2005

(participant) is not at the institution. She has gone on a school picnic. (social worker) says (participant) is a different child. She says she is very cheerful and mature.

SESSION FIFTEEN 14 October 2005

(participant) was sleeping when I arrived, but was happy to see me. Today"s session was wonderful and I can see improvement every time I see her. She shows emotion, has established a solid relationship with me, has a good relationship with (chef), and according to (social worker) and Sister (resident nurse) she is playing with the other children. According to Allison there have been no complaints from her new teacher.

(participant) played with the doctors set again and we examined each other. There was a lot of physical contact (Marchach therapy) which is supposedly good for emotional nurturing. She didn"t play with the set as long as usual and lost interest quickly. It seems as if she has resolved that trauma. She is in the resolution phase of healing. She was very interested in the doll that was lying on the table. She held it and covered it with a blanket (this type of play is age appropriate and emotionally appropriate for her age).

My highlight of the day was when she passed me a brushed and indicated that she wanted me to brush her hair. This was very confident and mature of her to request nurturance. Good communication too. And proves that she has developed trust in me. I think that our relationship has had a major impact on her healing.

(participant) spoke to me today! She took the puppet and I asked her in English what the puppet was saying. She answered that it was speaking. This is the first time she speaks a sentence to me. Great improvement in communication.

She cried when I left today. It broke my heart. But it is good that she openly shows emotion and isn"t emotionally flat anymore. Her emotions also seem to be appropriate to the situation she is in. (chef) comforted her and she responded well.

Themes:

- Openly expressing emotion
- Emotion appropriate to situation
- Socializing with other children
- Adapting well in school
- Resolved trauma of hospitalisation
- Resolution phase of healing
- Emotional healing through touching and trust
- Age appropriate emotional play
- Confidence
- Assertiveness
- Expressing her needs
- Improvement in communication (spoke a sentence)
- Responding to comfort of someone other than myself

SESSION SIXTEEN 29 October 2005

(participant) didn"t smile when I arrived today. She is still a bit moody. This was a bit disappointing. When I gave her a doll however, she was all smiles. She absolutely loved it! The reason I bought her a doll with a blanket is because she showed me last week her need for emotional nurturing and to nurture. It also indicated age appropriate emotional play, and I wanted to encourage this.

She put it in the blanket, brushed its hair, held it in her arms….and then said „help" to me….indicating that she wanted me to help her tie the doll to her back. She showed the theme of emotional nurturance and age appropriate emotional play again today. I really appreciated her attempts to communicate verbally with me. It showed me that she WANTS to communicate, something she didn"t want to do in the beginning.

She has completely lost interest in the sandplay toys as well as the doctors set. It seems that she is emotionally healed. I should start thinking of terminating therapy.

Themes:

Age appropriate emotional play
Emotional nurturance
Good communication skills

SESSION SEVENTEEN 11 November 2005

Today was an extremely emotional day for me. I asked (social worker) to explain to (participant) in her mother tongue that I would only come one more time after today. My supervisor explained to me that I should expect some regressive or aggressive play from her after she receives the news. This is exactly what happened….and more.

(participant) smiled when she saw me and the other children shouted "(participant)"s mother is here". This worries me because I don"t want her to think that this is a long term relationship and today is the day I had to prepare her for my permanent departure. She just nodded when (social worker) explained to her and didn"t appear to comprehend.

At first she showed normal play, good play actually. She packed the animals (the non-threatening ones) in a row in the sand. She made a fence around them. Say played that the cat was sitting on the fence and the horse was running. Feeling more secure? Maybe a sense of belonging where she is? Safety, yet freedom? She then took the crocodile out and considered putting it in the tray, seemed to think about it, change her mind, put it back, and didn"t touch it again. Doesn"t have feelings of aggression anymore? No more aggression toward her? Her environment non-threatening? Unfortunately my camera"s batteries were flat today.

Then her regressive play came into action, as my supervisor predicted and she started burying everything that she had played with. She hadn"t presented with this theme for some time. I think this was a reaction to the news that im leaving. It appeared as if she regressed into the destruction and conflict phase of play.

I feel guilty and sad that I am causing her trauma. Im wondering how effective therapy is when a child gets too attached to you. At the same time im hopeful

that these feelings of hers are only temporary and that the therapy has helped more than harmed her.

After she buried everything she went through her frequent nurturing ritual again. Dishing up „food" and pouring „tea". This seems to nurture her, and she often escapes to it when she has built a scene which presents negative feelings. We connect in these moments because we play together and make a lot of eye contact.

The session made record time…..45 minutes. The longest session up until now was 25 minutes. She concentrated well and played with the toys for longer periods of time.

The worst was still to come however, (participant) was absolutely devastated when I left. She clung to my neck and arms whilst screaming and crying. She had never been this devastated since I met her. I felt terrible and there was no „parent" I could pass her on to. I was very sad and filled with guilt on the way home and im dreading the last session next week.

Themes:

- Anger
- Avoidance
- Regression
- Extreme sadness
- Security and safety
- Experiences her environment as non-threatening

SESSION EIGHTEEN 15 November 2005

I had an interview with (chef) (the (chef)), the caregiver on duty and (social worker) (her social worker) today. I was relieved and happy that they all agreed and explained that the initial concerns, negative emotions, and difficult behaviour has changed for the better. They give (participant) beautiful compliments and I feel good. They were so negative about her initially.

(chef) explains to (participant) that this will be the last time I see her. (participant) greets me with a shy smile. She takes out the „ordinary", non-threatening human figures immediately. She makes a bed with cloth and packs the figures on the bed. Five girls and a boy. She covers them with a blanket and tucks them in. She gives me a big smile.

She passes one of the human figures to me and takes one for herself. She puts out a cloth and „sets the table" for a tea party for our dolls. We play that our dolls are having tea and eating.

Afterward I give her a soft teddybear as a symbol of nurturing and myself, that she can keep to remind her of me when im gone and to nurture her. She loves it and wants to go and show (chef). (chef) explains to her that the bear is a present that she can remember me by.

She insists on taking the little human figure we had tea with for herself (this is the first time she does this). She says in English “I want this”. She smiles in a naughty type of way and puts it behind her back. I smile and agree.

She gives me a hug and a kiss and waves good-bye. She smiles and does not cry. Wonderful closure. Nor do I cry, I smile. It definitely helps that (chef) is present. A great person and comfort in (participant)"s life. Good-bye gorgeous!

Themes:

Safety

Security

Normal imaginative play that represents reality

Resolution phase

Nurturing

Comfort and warmth

Experiences environment as non-threatening

Happiness

Peacefulness