

**Towards Developing a Teddy Bear Therapy Training Programme for
Psychotherapists**

by

L. van der Ryst

under the supervision of

Prof. C. Vorster

Submitted in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE (CLINICAL PSYCHOLOGY)

in the

Department Clinical Psychology

in the

School of Social Science

and the

Faculty of Medicine

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Declaration

I, Leandri van der Ryst, declare that the research, entitled ‘Towards Developing a Teddy Bear Therapy Training Programme for Psychotherapists’, to the best of my knowledge and belief, is my own work and contains no plagiarism.

All sources have been acknowledged and all references contained within it have been correctly cited and the original authors acknowledged, making use of the American Psychological Association 6th edition referencing guidelines.

I have not previously submitted or intend to submit in future this work or any version of it for assessment in any other unit or award offered by the University of Limpopo, its partner institutions, or any other institution.

Signed: _____

Ms. L. van der Ryst

Date: _____

Abstract

Teddy Bear Therapy is a specialised type of intervention which calls for effective training of therapists interested in conducting Teddy Bear Therapy. However, no structured training programme for psychotherapists in this child therapy exists to this date. The current study therefore developed a training programme for psychotherapists in Teddy Bear Therapy.

The investigation was done by using a qualitative, descriptive research design. This allowed for a systematic description of the nature of child psychotherapy training programmes by means of a narrative literature review. From the literature review, questions were derived to be used in semi-structured interviews with three clinical psychologists. The data obtained from the interviews were analysed and common themes identified. These findings were combined with the data obtained from the literature review.

This integration resulted in a training programme in Teddy Bear Therapy. The training programme incorporates theoretical as well as experiential learning. The programme outline provides the facilitator with clear instructions as to what each session's objectives and tasks are. The trainee is provided with a manual that firstly provides background information necessary to understand the application of Teddy Bear Therapy. Secondly, the manual provides specific information on the development and process of Teddy Bear Therapy. The trainee must work through the manual, do exercises, take part in discussions or prepare readings whenever indicated to do so by the facilitator.

In spite of the contribution which the training programme and its manual can make to the South African context, it is limited to the theoretical framework of a dissertation and has not yet been implemented or empirically tested.

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This journey of becoming a psychotherapist has been excruciating, adventurous and meaningful. The thrill of knowing that it will be an ever-improving, never-ending path only adds to the joy and glory of the process.

I would however like to acknowledge the following people without whom this journey would not have been possible:

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Table of Contents:

Declaration	i
Abstract	ii
Acknowledgements	iii
I. Chapter 1	
1. Introduction	1
II. Chapter 2	
2. Literature Review	6
2.1 Introduction	6
2.2 The Development of Child Psychotherapy	6
2.2.1 Hugh-Hellmuth: Play Therapy	7
2.2.2 Anna Freud: Play Therapy	7
2.2.3 Melanie Klein: Unstructured Play	8
2.2.4 Virginia Axline: Play Therapy	8
2.2.5 Richard Gardner's Mutual Storytelling Technique	9
2.2.6 Vorster's adaptation of and dissatisfaction with Gardner's Mutual Storytelling Technique towards developing Teddy Bear Therapy	11
2.3 Teddy Bear Therapy	12

2.3.1	The process of Teddy Bear Therapy	12
2.3.2	Indications of Teddy Bear Therapy	13
2.3.3	The significance of Teddy Bear Therapy	14
2.3.4	Research on the effectiveness of Teddy Bear Therapy	15
2.3.5	The effectiveness of Teddy Bear Therapy	19
2.4	Training Psychotherapists	20
2.4.1	Training contexts in psychotherapy	21
2.4.2	Fundamental elements of psychotherapy training programmes	21
2.4.3	The different approaches in psychotherapy training	23
2.4.3.1	The storytelling approach in psychotherapy training	24
2.4.3.2	The behaviouristic approach in psychotherapy training	24
2.4.3.3	Rogerian approach to training psychotherapists	25
2.4.3.4	The systemic approach in psychotherapy training	26
	i. Systemic training at Medunsa	27
	ii. The Interactional Pattern Analysis	29
2.5	Fundamental elements of a Teddy Bear Therapy training programme	30
2.6	The proposed training programme	32
2.7	Conclusion	34

III. Chapter 3

3.	The Investigation	37
3.1	Introduction	37
3.1.1	Aim of the study	37
3.2	Research design	37
3.2.1	Research paradigm	38
3.2.1.1	Quantitative versus qualitative research	38
3.2.1.2	Qualitative research	39
3.2.2	Descriptive research design	40
3.2.3	Research question	41
3.2.4	Research procedure	41
3.2.4.1	Step 1	41
3.2.4.2	Step 2	42
3.2.4.3	Step 3	42
3.2.4.4	Step 4	42
3.2.4.5	Step 5	42
3.2.5	Sampling approach	42

3.2.5.1	Sampling	42
3.2.5.1.1	Target population	44
3.2.5.1.2	Study population	44
3.2.5.1.3	Research sample	45
i.	Sample size	45
ii.	Type of sampling	45
iii.	Conducting the sample	47
3.3	Data collection	47
3.3.1	Narrative literature review	48
3.3.2	Semi-structured interviews	50
3.4	Data analysis	53
3.5	Validity and reliability	56
3.6	Bias	57
3.7	Ethical considerations	57
3.8	Method	58
3.8.1	Research procedure	58
3.8.2	Data collection	58

3.8.2.1	Narrative literature review	59
3.8.2.1.1	Introduction	59
3.8.2.1.2	General themes in a training programme for child Psychotherapists	60
3.8.2.1.3	Requirements of a child psychotherapist prior to training	62
3.8.2.1.4	Specific elements of training child psychotherapists	64
	i. Life span developmental psychology	66
	ii. Life span developmental psychopathology	67
	iii. Child, adolescent and family assessment	67
	iv. Intervention strategies	68
	v. Research methods and system evaluation	69
	vi. Professional, ethical and legal issues	70
	vii. The role of the clinical child psychotherapist	71
3.8.2.1.5	Important skills in working with children	72
3.8.2.1.6	Methods of training	74
	i. Methods for theoretical training	74

ii. Methods for practical training	76
3.8.2.2 Semi-structured interviews	78
3.8.3 Data analysis	80
IV. Chapter 4	
4. Results and Discussion	81
4.1 Introduction	81
4.2 Aim of the study	81
4.3 Research results	81
4.3.1 Conclusions drawn from literature review	81
4.4 The thematic analysis of the interviews	87
4.4.1 Question one	88
4.4.1.1 Integration: Question one	92
i. Themes identified in all three interviews	92
ii. Themes identified in two interviews	93
4.4.2 Question two	94
4.4.2.1 Integration: Question two	95
i. Themes identified in all three interviews	95

ii. Themes identified in two interviews	95
4.4.3 Question three	96
4.4.3.1 Integration: Question three	97
i. Themes identified in all three interviews	97
ii. Themes identified in two interviews	97
4.4.4 Question four	99
4.4.4.1 Integration: Question four	101
i. Themes identified in all three interviews	101
ii. Themes identified in two interviews	101
4.4.5 Question five	103
4.4.5.1 Integration: Question five	105
i. Themes identified in all three interviews	105
ii. Themes identified in two interviews	105
4.4.6 Integrations of the conclusions drawn from the literature review with themes identified in the interviews	106
4.5 Programme and manual	111

V. Chapter 5

5. Conclusion 122

References 128

Appendices

Appendix A

Appendix B

Appendix C

For my parents, Henri and Etresia van der Ryst – *sonder julle sou hierdie alles maar*

net n droom gebly het.

Towards Developing a Teddy Bear Therapy Training Programme for Psychotherapists

Chapter 1: Introduction

The impact of early experiences on children's frames of reference have a significant influence on their development (Ciottone & Madonna, 1996). When these experiences are characterised by instability and distress, children show evidence of emotional or behavioural problems (Geldard & Geldard, 1997). For South African children, instability and distress are a common phenomenon. People under the age of 20 years make up 43,1% of the South African population (Macleod, 2004) and during 2008/2009 about 8.3% of these children were directly affected by crime (Statistics, 2009). In 2009, around 14.1 million children lost one or both parents to HIV/Aids, and in 2008 an estimated 1.8 million children were living with HIV (Statistics, 2009). This immense distress which children in the South African context are facing just highlights the need for effective child psychotherapy.

Although traditional psychotherapy for adults has proven efficacy, its effectiveness for children and adolescents has yet to be demonstrated (Weiss, Catron & Harris, 2004). According to Eysenck (1952, p. 323), "roughly two-thirds of children will recover or improve . . . whether they are treated by means of psychotherapy or not."

More than fifty years have passed since this provocative statement was made. However, more recent studies confirmed the statement and found equal outcomes amongst children who were undergoing traditional child psychotherapy and those who were not exposed to any kind of psychotherapy (Weiss, Catron & Harris, 2004). These authors concluded that neither their data nor the literature supported the effectiveness of traditional child psychotherapy. On the one hand it is evident that there is a crucial need for effective

psychotherapy with children and on the other hand there is a significant void in as far as innovative psychotherapy is concerned.

Against the above background of child therapy, Teddy Bear Therapy seems to hold some possibilities. Charl Vorster developed this form of therapy based on the mutual story telling technique as developed by Richard Gardner and Play Therapy from the works of Virginia Axline (Baloyi, 2001). Teddy Bear Therapy thus incorporates storytelling as well as play.

Throughout the years, various studies have investigated and confirmed the effectiveness of Teddy Bear Therapy on a range of different presenting complaints that will be shown below.

It has been proven to be effective with children who suffer from separation anxiety (Duncan, 2004), through reducing the symptoms as indicated by specific behaviours. These behavioural indications were measured by means of a Behavioural Checklist for both a control and experimental group (Duncan, 2004). The findings showed reduced levels of anxiety, thus indicating that a structured Teddy Bear Therapy programme can be utilised as intervention method to effectively treat separation anxiety in children (Duncan, 2004).

Hanney (2003) investigated the effect of a structured form of Teddy Bear Therapy on a group of young hospitalised children in the medical context. She utilised this form of therapy experimentally by playing a short series of pre-recorded stories for the young clients to listen to. By statistically comparing a control group with the children exposed to Teddy Bear Therapy, she found that the latter had lower levels of anxiety, depression and a healthier appetite than members of the control group. She could thereby conclude that Teddy Bear Therapy enabled the young patients to cope with the hospital situation away from home.

Ncute (2004) studied the effects of a structured Teddy Bear Therapy programme on children with dental fear/phobia. The levels of fear in the experimental group of children were measured with an adapted Children Fear Survey Schedule – Dental subscale, as well as the control group, pre and post intervention. Lower scores were found post intervention for the experimental group who was exposed to the structured Teddy Bear Therapy programme in comparison to the control group who has been exposed to randomly selected Setswana stories. It could hence be concluded that this programme is significantly effective in the reduction of dental fear/phobia in young children (Ncute, 2004).

Romanis (2003) initiated a study aimed at investigating the effects of standardised Teddy Bear Therapy on children about to testify in court. A quantitative approach was used by doing an Adaptive Behavioural Checklist as a baseline measure to assess the children's behavioural changes after the intervention was conducted (Romanis, 2003). Subsequently, Teddy Bear Therapy has been found to be an effective and brief intervention that can be offered to all children who are testifying in court against an alleged abuser (Romanis, 2003).

Teddy Bear Therapy as intervention programme was also investigated to see how it could assist children who suffer from enuresis (Selamolela, 2001). The therapy was aimed at addressing the enuresis as a psychological symptom after all medical conditions have been eliminated (Selamolela, 2001). This quantitative study indicated that Teddy Bear Therapy is significantly effective in alleviating enuresis in children (Selamolela, 2001).

In a combined study of qualitative as well as quantitative nature, Sepato (2002) investigated the impact of Teddy Bear Therapy on children with newly divorced parents (Sepato, 2002). Children of divorced parents often have difficulty coping with the crisis of their parent's divorce, which results in different symptomatic behaviour, such as irritability,

anger outbursts, depression and rebellion (Sepato, 2002). Teddy Bear Therapy enabled the children to develop more effective coping strategies (Sepato, 2002). The children were also able to talk to their parents about the issue of divorce, ensuring change in the whole system (Sepato, 2002).

Da Cruz (2008) investigated the effectiveness of an adapted form of Teddy Bear Therapy for trauma debriefing on a large group of children, using an ex post facto research design. From the results of the study it could be derived that Teddy Bear Therapy can serve as mitigating factor against the development of post-traumatic stress symptoms with children who have witnessed violence in the school environment (Da Cruz, 2008). It was concluded that Teddy Bear Therapy can be effectively applied to groups of children exposed to the same traumatic event (Da Cruz, 2008).

As supported by the above-mentioned research, the significance of Teddy Bear Therapy lies in its potential to ensure change in the child's interaction, as well as the child's whole family system (Vorster, 1995). Teddy Bear Therapy addresses the child's difficulty on his/her developmental and emotional level (Baloyi, 2001). It focuses on empowering the child to solve his/her own problems and strengthen his/her resources (Vorster, 1995).

In view of the overwhelming need for effective psychotherapeutic interventions in respect of children as has been indicated at the beginning of the chapter, Teddy Bear Therapy thus seems to offer at least a partial solution. As such, this form of therapy should be made readily available, which would necessitate training significant large numbers of therapists to effectively utilise this form of therapy.

Teddy Bear Therapy is a highly specialised form of therapy, which implies the need for highly specialised therapists who are efficiently trained. Up to this date there is no

structured training programme for psychotherapists on Teddy Bear Therapy. The development of such a programme is thus called for. This study hence focuses on developing a training programme on Teddy Bear Therapy to address this limitation. The study will further enable psychotherapists to expand their repertoire and deliver an invaluable service to children and the systems they function in.

Chapter two of this study will provide a review of literature relevant to the study.

In chapter three, a practical description of the research and methodology will be outlined.

In chapter four, the results of the study will be presented and discussed.

Lastly, chapter five will provide a conclusion.

Chapter 2: Literature Review

2.1. Introduction

The literature review aspires to provide a scientific context for the research that will follow (Whitley, 2002). As background to the research this chapter will commence with an overview of the development of child psychotherapy.

When looking at the development of child psychotherapy Hug-Hellmuth, Anna Freud, Melanie Klein and Virginia Axline will be referred to with regard to their contributions to the play therapy technique. Richard Gardner's Mutual Storytelling Technique is discussed thereafter, with the aim of shedding light on the evolution of Teddy Bear Therapy. Thereafter the development, previous research, the nature and effectiveness of Teddy Bear Therapy will be discussed in-depth.

Lastly, the training of psychotherapists will be reviewed and discussed to provide a foundation for the study that will follow.

2.2 The Development of Child Psychotherapy

The birth of Psychology can be traced back to 1879, to the establishment of the first recognised laboratory for the study of human behaviour at the University of Leipzig in Germany (Mandler, 2007). One of the founders, Wilhelm Wundt, owned the reputation as the father of experiential psychology after publishing the first psychological text titled "Principals of Physiological Psychology" (Mandler, 2007). This established psychology as a separate science from other topics (Mandler, 2007). Since these developments, the field of psychotherapy has expanded and has seen many meaningful and diverse contributions. In

this evolution of psychotherapy with adults, the focus later shifted to psychotherapy with children.

According to Kazdin (2000), theories in adult psychotherapy have been modified and adapted to use in therapy with children. However, psychotherapy with children has expanded into a rich and sophisticated field as time passed (Prout & Brown, 2007). Therapists from different perspectives developed different ways to use play as therapeutic tool and will be referred to below (Prout & Brown, 2007).

2.2.1 Hugh-Hellmuth: Play Therapy.

According to Yawkey and Pellegrini (1984) Hugh-Hellmuth was the first to introduce Play Therapy with children in 1919. She was the first psychologist practising psychoanalysis with children (Yawkey & Pellegrini, 1984). From this vantage point, she was also the first person to make use of systematic child observation from a psychoanalytic point of view (Maclean, 1986). She used play as a method to analyse a child by interpreting the child's behaviour into symbols mainly directed at repressed, hostile and sexual desires towards his/her parents (Yawkey & Pellegrini, 1984). Her work contributed to the beginning of play therapy, followed by Anna Freud and Melanie Klein.

2.2.2 Anna Freud: Play Therapy.

In order to adapt adult psychoanalysis for children, Anna Freud started interpreting children's imaginative play, drawings and paintings by searching for the unconscious motivation behind it (Yawkey & Pellegrini, 1984). However, the value of her contribution to the field of child psychotherapy was rather in terms of her working method that entailed understanding a child's play in context (Geldard & Geldard, 1997). She requested

background information from the parents on the child's functioning (Geldard & Geldard, 1997) and supplemented this with observations of the child's play (Yawkey & Pellegrini, 1984). Geldard and Geldard (1997) adds that for Anna Freud, play also had the function of facilitating a close relationship between the therapist and child, which had the possibility of enhancing the process of therapy. The significance of rapport with a child is still recognised as means of successful psychotherapy (Combs, 1989).

2.2.3 Melanie Klein: Unstructured play.

Klein took a non-directive stance in her therapy with children (Haworth, 1990). She saw children's play as their primary mode of emotional communication (Seagal, 2004). After observing troubled children play with toys, such as dolls, animals, pencil and paper, Klein attempted to analyse the unconscious motivations behind the play (Seagal, 2004). Klein argued that children's unconscious lives could be understood by analysing their non-verbal behaviour (Seagal, 2004). She saw most play activities as a symbolic expression of sexual conflict and aggression towards parents (Seagal, 2004).

2.2.4 Virginia Axline: Play Therapy.

Similar to her predecessors, Anna Freud and Klein, Axline interpreted play from an intra-psychic point of view (Geldard & Geldard, 1997).

In 1947 she developed a non-directive method of using play (Prout & Brown, 2007). This method was based on Carl Rogers's humanist approach to therapy, referred to as person-centred therapy (Axline, 1947). The basic premise of this approach is that each individual has the potential to strive towards self-actualisation (Haworth, 1990). Axline (1947) believed that children have the ability to develop optimal levels of self-realisation if they are not

prevented to do so by their environment. Axline contended that, when a child's needs are not met, he/she will develop conniving strategies in order to satisfy the needs.

The non-directive therapeutic space suffices as the most favourable milieu for the child to self-actualise (Haworth, 1990). By taking a non-directive stance, the therapist empowers the child to solve his/her own problems, make choices and take responsibility (Axline, 1947). He/she can 'play out' his/her feelings and problems – his/her fears, hatred, loneliness, and feelings of failure and inadequacy (Axline, 1947). Throughout this process the child is accepted as he/she is without judgment or pressure to change (Axline, 1947). The therapist facilitates insight through empathetic reflections (Axline, 1947). Since the therapist's reflections convey a feeling of being understood and accepted unconditionally, the child is more likely to seek deeper into his/her inner world and reveal his/her own self (Axline, 1947).

Based on the above-mentioned contributions, play within the therapeutic context has significant value. Play as therapeutic medium can assist children in expressing themselves, work through emotional difficulties and solve their own problems (Haworth, 1990).

Similar to play, storytelling can also be used as therapeutic modality (Sepato, 2002). As with play, stories are easy for children to relate to (Gardner, 1971). Richard Gardner's Mutual Storytelling Technique will hence be discussed below.

2.2.5 Richard Gardner's Mutual Storytelling Technique.

Gardner (1971) raised his dissatisfaction with play as therapeutic modality, stemming from two aspects. Firstly, he contended that the presence of play material in the therapy room contaminates the acclaimed non-directiveness of the therapy (Gardner, 1971).

Secondly, he disagreed with the principle of communicating the psychodynamic interpretations of the play to the child (Gardner, 1971). He stated that a child is not cognitively developed to fully comprehend and engage in a meaningful psychoanalytic inquiry before the age of ten years (Gardner, 1971).

In opposition to Play Therapy, he developed the Mutual Storytelling Technique in 1971. To compensate for the flaws listed above, he chose to focus on auditory stimuli and used a tape recorder as only distracting variable when engaging in storytelling with children (Gardner, 1971). Secondly, he moved away from relaying psychotherapeutic interpretations directly to the child and chose to rather make use of humor and drama to enhance a child's receptivity for change (Gardner, 1971).

Gardner (1971) observed the pleasure storytelling brings to children and saw it as one of children's favourite modes of communication. He hypothesised that communicating with the child in that way might be useful in therapy (Gardner, 1971). Hence the development of mutual storytelling as a therapeutic modality (Gardner, 1971).

The session would start off with Gardner involving the child in 'a storytelling game' (Gardner, 1971). He would enhance participation by telling the child that all of the children who come to see him tell him a story which is then recorded and played back to them (Gardner, 1971). The child chooses his/her own characters and is not restricted in any way by the therapist (Gardner, 1971). The child is requested to tell a story with a beginning, middle and end (Gardner, 1971). The therapist then responds by telling a more 'therapeutic' story, that is similar to the child's story in terms of the characters used, as well as the setting of the story (Gardner, 1971). The therapist will interpret the story psychodynamically and use the child's language to introduce mature responses and healthier resolutions to the child's

difficulties (Gardner, 1971). The moral of the story is made explicit and discussed with the child (Gardner, 1971).

Evolving from Play Therapy and Gardner's Mutual Storytelling Technique, Vorster (1995) developed what he labeled 'Teddy Bear Therapy', which essentially combines an element of play with storytelling, as will be set out below.

2.2.6 Vorster's adaptation of and dissatisfaction with Gardner's Mutual Storytelling Technique towards developing Teddy Bear Therapy.

Vorster (1995) developed Teddy Bear Therapy out of his practical experience and subsequent to his dissatisfaction with using Gardner's Mutual Storytelling Technique. This dissatisfaction roused due to the disempowering effect the definition of the relationship between the therapist and child has on the child (Poodhun, 2002). Vorster was of opinion that the therapist is being placed in a superior position when he/she improves on the story the child told (Poodhun, 2002). This then has an immobilising effect on the child (Poodhun, 2002).

Furthermore, Vorster displayed dissatisfaction with Gardner's insistence on exposing the underlying moral of the story (Poodhun 2002). He mentioned that this practice comes across as prescribing to the child and taking a parental stance (Poodhun, 2002). He contended that in prescribing behaviours that are spontaneous, you are paradoxing the child, which results in the child feeling immobilised (Poodhun, 2002).

In an attempt to address this dissatisfaction with the Mutual Storytelling Technique, Vorster implemented changes which are notable in the process of Teddy Bear Therapy, as discussed below.

2.3 Teddy Bear Therapy

2.3.1 The process of Teddy Bear Therapy.

Teddy Bear Therapy goes beyond exploring fears and anxiety, as is the case with Play Therapy or finding a solution through storytelling as in the Mutual Storytelling Technique (Poodhun, 2002). It encourages optimal interaction with others while assisting children to overcome their emotional difficulties (Duncan, 2004).

The session usually starts with the child choosing a teddy bear and the therapist involving the child in a story (Vorster, 1995). The story usually consists of animal characters – such as a teddy bear family, who lives in a forest (Baloyi, 2001). Vorster (1995) promotes the use of the animal in the story as a means to add another relationship. The child's position thereby changes from a disempowered position to an empowered position (Hanney, 2002).

The therapist sets the context by describing the daily routine of the family (Baloyi, 2001). A similar problem that the child is facing is then introduced process-wise to the story by the therapist, but it becomes evident that the teddy bear in the story is the one facing the crisis and not the child (Baloyi, 2001).

The story evolves as the child starts to talk about the teddy's problem and how the teddy handles the problem (Baloyi, 2001). The therapist would interject and steer the story line towards a more optimal direction when deemed necessary (Baloyi, 2001). This will be required when the teddy displays ineffective problem solving, for example to go and sit in the corner or run away or hide from the world (Baloyi, 2001). The therapist would suggest alternative solutions, such as to go and tell somebody or ask advice from someone like a wise owl (Baloyi, 2001). At some point in the therapy the child realises that there are more

effective ways of handling the problem at his/her disposal (Vorster, 1995). Solutions to the teddy's problem are eventually worked out in a mutual effort (Baloyi, 2001), but the moral of the story is not made explicit (Vorster, 1995).

The story is recorded on tape and replayed to the child (Baloyi, 2001). After listening to the tape with the child, the therapist then suggests that the child takes the teddy with him/her to help the teddy with his problem until the next session (Baloyi, 2001). The child is empowered by the teddy bear who now 'needs his/her help' to solve problems that are similar to that of the child (Vorster, 1995). The child is therefore no longer the identified patient (Vorster, 1995). Each session hereafter would continue with helping the teddy (Vorster, 1995).

The parents would be briefed on the therapy so that the new 'member' of the family that the child has to take care of is not surprising to them (Duncan, 2004). The parents would further be advised to listen to the child if he/she relates the story but to refrain from commenting about it.

The next session would be used to ask the child to give feedback on the teddy bear and what had happened since the previous session (Duncan, 2004). This feedback would be indicative of the child's progress. Each session could be recorded and played back if necessary (Duncan, 2004).

2.3.2 Indications for Teddy Bear Therapy.

Teddy Bear Therapy may be used with children between the ages of three and twelve (Vorster, 1995; Baloyi, 2001). Baloyi, Botha, De Wet and Vorster (cited in Poodhun, 2000) identified indications for Teddy Bear Therapy to be interpersonal difficulties, such as:

- lack of assertiveness;
- inappropriate distance in a relationship;
- inability to take risks;
- difficulties with friends at school;
- being rejected;
- having difficulty separating from mother;
- divorce issues;
- phobias;
- encopresis and enuresis; and
- victims of trauma.

2.3.3 The significance of Teddy Bear Therapy.

The teddy bear is an essential figure and is the key to the success of this form of therapy (Duncan, 2004). The system in which the child functions is extended with the inclusion of the teddy bear to the family (Baloyi, 2002). Thus punctuating from a systems perspective the value of Teddy Bear Therapy is that, by changing the system, it therefore changes the nodal point in the family (Baloyi, 2002). The teddy bear becomes part of the system the child functions in, hence bringing about change in the whole system and not just the child, which is also in line with systems theory (Vorster, 1995).

In creating a conjoint story, the emphasis is firstly placed on the therapeutic relationship (Duncan, 2004). The therapist communicates with the child on his/her level, facilitating a sense of empathy, congruence and unconditional positive regard between the child and therapist (Vorster, 1995). Vorster (1995) states that Teddy Bear Therapy puts the therapist and child on equal footing whilst engaging in the process.

The second point of interest is in the relationship between the child and the teddy bear (Duncan, 2004). Vorster (1995) states that the introduction of the teddy redefines the child's role as 'identified patient' to that of 'helper'. The teddy is now the one who has to fulfil the one-down position (Vorster, 1995). Teddy Bear Therapy thus empowers children to solve their own problems as the teddy is the one in distress – not them (Vorster, 1995). Baloyi (2001) concurs, stating that the child is mobilised through engaging him/her in an active process of working through the presenting problem. Children thus also develop mechanisms of coping through their 'interaction' with a teddy bear (Vorster, 1995). A child's role repertoire is hence broadened and self-esteem enhanced (Baloyi, 2001). Furthermore, the child is being distanced from his/her problem, as the focus is on the teddy bear and not on him/herself (Vorster, 1995).

2.3.4 Research on the effectiveness of Teddy Bear Therapy.

The effectiveness of Teddy Bear Therapy has been researched extensively. In light of this research, the theme that emerges is a favourable one. The different types of research that has been conducted range from a qualitative to a quantitative nature. It has been proven effective as an individual intervention for children who are faced with a variety of problems, but also effective as a group intervention.

The first substantial research in respect of Teddy Bear Therapy was undertaken by Poodhun (2002). She explored the nature and therapeutic effect of Teddy Bear Therapy by examining it as intervention on a single case study. A subject was selected for the dual purpose of being used for research purposes, as well as to receive psychological assistance. The researcher substantiated her findings and experience of using Teddy Bear Therapy as intervention with a literature study and interviews on Teddy Bear Therapy. This study

provided a description of Teddy Bear Therapy and brought about an awareness of this new form of therapy. It furthermore provided a foundation for all further research regarding Teddy Bear Therapy.

Selamolela (2001) followed Poodhun (2000) by narrowing the research down to evaluating Teddy Bear Therapy within the context of treating enuresis. Due to children being exposed to various environmental challenges, behavioural symptoms can develop as a result of their limited problem solving skills. A common symptom found with children who experience emotional difficulties is enuresis. Teddy Bear Therapy was hence used as intervention to address the enuresis as a psychological symptom after all medical conditions have been eliminated (Selamolela, 2001).

The research data was collected by using questionnaires, which was given to the parents and using Tepper's Adapted Checklist for Bedwetting. After exposing a group of children to Teddy Bear Therapy, the results indicated a statistically significant decrease in the amount of children suffering from enuresis. Teddy Bear Therapy was thus concluded to be effective in alleviating enuresis in children (Selamolela, 2001).

Hanney (2002) followed Selamolela (2001) by investigating the effect of a structured Teddy Bear Therapy programme on young hospitalised children. It is widely accepted that being hospitalised poses a potential threat to the psychological as well as physiological development of children. The study found that young children showed signs of protest, despair and even denial when hospitalised. This is evident in their crying, fear, aggression, impatience and social withdrawal. The study aimed to prevent these symptoms from arising by exposing hospitalised children to a standardised Teddy Bear Therapy programme. The children listened to pre-recorded stories over a few days.

An Adapted Behavioural Checklist was used and subsequently indicated that the results of the study were statistically significant in emotional, cognitive, as well as psycho-physiological dimensions. The study tentatively postulated that this programme can be utilised as an effective and brief intervention that can be offered to all hospitalised children (Hanney, 2002).

In the same year Sepato (2002) focused her research on children with newly divorced parents. Various research results indicate that children of divorced parents are often troubled by the crisis of their parent's divorce and have difficulty adjusting and coping effectively with the situation. As a result of this they display a wide range of symptomatic behaviour. Irritability, anger outbursts, changed sleeping and eating patterns and lack of concentration, to name a few, are indicative of their difficulties in handling the problems they are confronted with. In her study she investigated Teddy Bear Therapy as a therapeutic intervention to see how it could assist these children.

An Adapted Behavioural Checklist was used to evaluate typical behaviour in the context of divorce before and after the intervention was implemented. Overall, the Teddy Bear Therapy programme rendered the parental separation and emotional process involved less threatening for the children. It was concluded that it contributed to the psychological welfare of the children of parents going through divorce (Sepato, 2002).

Romanis (2003) diverted the focus away from the hospital context to the legal context. She explored the option of using a standardised Teddy Bear Therapy to prepare children before they have to testify in court. Testifying has been described as secondary traumatisation, as children are forced to retell the alleged horrific experience they have been through (Romanis, 2003). Children may find it difficult to cope effectively within the

testifying situation, resulting in symptoms such as depression, changes in eating habits and appetite problems, lack in confidence, isolating behaviour and poor school performance (Romanis, 2003).

An Adaptive Behavioral Checklist was used as baseline measure to assess the children's behavioural changes after the intervention was implemented. The results were statistically significant for the "emotional", "psychological", "social" and "cognitive" dimensions, indicating that a structured Teddy Bear Therapy programme was deemed effective as intervention to children who are testifying in court against an alleged abuser (Romanis, 2003).

Duncan (2004) investigated the treatment of separation anxiety with a structured Teddy Bear Therapy programme. She found that there is a large increase in the number of children that is being placed in care outside of home, such as preschools, for various reasons. This shift presents an important challenge for the child, as well as the family system. Duncan identified the biggest challenge to be the influence it has on the parent-child bond, which can lead to separation anxiety. This manifested in the child objecting to go to preschool; refusing to stay behind at the preschool; parental use of force in order to get the child to preschool; the need of repeated reassurance; clinging to the parents on arrival at the preschool; shadowing of parents and indications of anxiety.

The structured Teddy Bear Therapy programme thus aimed to address these symptoms. The results of this study as indicated by a behaviour checklist indicated that this programme was effective in reducing the levels of anxiety (Duncan, 2004).

Ncute (2004) studied the effectiveness of a structured Teddy Bear Therapy programme on children with dental phobia. On discovering that there was an escalating

demand for dental consultation amongst children, a need for decreasing the levels of fear that accompanies dental consultation was indicated. An adapted Children Fear Survey Schedule – Dental Subscale was used to measure the levels of fear in the experimental and the control group, pre- and post intervention. The experimental group was exposed to randomly selected Setswana stories.

The results were statistically significant with the experimental group showing a decline in their levels of dental fear/phobia. The findings hence indicated that a structured form of Teddy Bear Therapy constituted an effective and brief intervention, which can be offered to young children presenting with dental fear/phobia (Ncute, 2004).

Da Cruz (2008) was the first to investigate the therapeutic significance of Teddy Bear Therapy in group context. She explored the effect it might have as trauma debriefing method of a large group of children who have been exposed to the same traumatic event. An ex post facto research design was used and interviews with a clinical psychologist who administered the intervention and three teachers who were present during the session were analysed qualitatively. The study found that Teddy Bear Therapy as a group trauma debriefing method mitigates against the development of post-traumatic stress symptoms with children who have witnessed violence in the school environment. The study confirmed that Teddy Bear Therapy can effectively be applied to groups of children exposed to the same traumatic event.

2.3.5 The effectiveness of Teddy Bear Therapy.

Baloyi (in Poodhun, 2000; Sepato, 2002; Hanney, 2002) summarises the above-mentioned elements by attributing the effectiveness of Teddy Bear Therapy to the following criteria:

- The spontaneous manner in which the child's presenting problem is addressed reaches the child on an emotional as well as developmental level.
- It increases the child's self-esteem and broadens his/her role repertoire.
- It mobilises the child and generalises the empowerment to other contexts and situations the child may face.
- The storytelling process enables the child to actively participate in working through difficulties.

From the above it is evident that Teddy Bear Therapy is a highly specialised form of therapy, which has been researched extensively and found to be an effective intervention in various contexts. This implies the need for highly specialised therapists who are efficiently trained to ensure optimal results. Up to date there is no structured training programme for psychotherapists on Teddy Bear Therapy. In order to develop such a programme, the following section will focus on how psychotherapists are trained and specifically what a training programme for Teddy Bear Therapy will entail.

2.4. Training Psychotherapists

Training in any field consists of a systematic series of activities which trainees are exposed to in order to acquire new knowledge, skills or a change in behaviour (Meyer, Moore & Viljoen, 1997). Training is defined by the South African Concise Oxford Dictionary (2002) as "the acquisition of knowledge, skills, and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies" (p.89). However, this research is primarily concerned with training in psychotherapy.

2.4.1 Training contexts in psychotherapy.

The different training contexts within psychology as discipline include education, training and supervision (Bosman, 2004). Training within these contexts implies a learning environment where the trainee therapists learn and develop skills, which could then be applied to their therapeutic work (Bosman, 2004).

Within the education, training and supervision contexts, the training system can be perceived as a relational system that is subject to frequent change (Bosman, 2004). This implies constant evolution and development, flexibility in restructuring content and including new materials in training (Bosman, 2004). The present study will focus on the psychotherapy training context and elements that are deemed essential will be discussed below.

2.4.2 Fundamental elements of psychotherapy training programmes.

Considering the evolving nature of training, research has found certain elements of a psychotherapeutic training programme to be essential and therefore constant (Fernandez, Rodriguez, Ortiz-Sanchez & Baldor, 2010). Fundamental elements are those aspects of a psychotherapeutic intervention that are present, regardless of the therapist's theoretical approach – as with therapeutic alliance – empathy, goal consensus, and collaboration (Fernandez et al., 2010). Nevertheless, it is striking that most of the training programmes do not take this into consideration (Herschell, Kolko, Baumann & Davis, 2010). In fact, most psychotherapeutic training programmes focus more on training discrete skills (Herschell, et al., 2010).

Aside from these elements, Tomm and Wright (1979) stated that there are three interrelated sets of skills a trainer should facilitate in learning and developing when training

psychotherapists, namely perceptual, conceptual and executive skills. Perceptual skills imply the psychotherapist's ability to make observations that are relevant and accurate. Conceptual skills refer to the interpreting of those observations in a meaningful way, while executive skills involve implementing previously acquired knowledge to the current therapeutic situation.

In order to attain the above, Oomkes (in Swart & Wiehann, 1979) suggests a comprehensive training programme, which includes a process in which:

- the therapist becomes aware of how he/she is experienced by others and how he/she influences them;
- individuals invest through personal involvement in the programme;
- demonstrations are given;
- the individual learns through experience;
- theoretical input is given;
- there are group discussions on theory;
- there is individual study;
- observation is important;
- there is a analysis of psychotherapeutic skills;
- tape analysis is done;
- role play is used;
- role change is used; and
- video recordings are made.

Dimeff et al. (2009) concurred the need for theoretical input and found input in the form of reading manuals and material to be necessary, but not sufficient, for skills acquisition

and adoption of a psychosocial treatment. Studies found that reading often resulted in knowledge changes, but the changes were short-lived and did not lead to significant changes in skills or treatment mastery (Herschell et al.)

Fernandez et al. (2010) agrees with Oomkes, but argues the effectiveness of using video recordings not only for training but also for evaluation purposes when training has ended. Follow-up evaluations are crucial to assess the maintenance of acquired skills (Herschell et al.). It has been found that individuals who expected to undergo follow-up evaluations showed more frequent adoption of innovation and improved retention of skill proficiency (Herschell et al.).

The above-named elements are essential for the development of a training programme for psychotherapists. This, however, only provides a framework for the training programme and will need to be supplemented with other relevant approaches in psychotherapy training, which will be discussed below.

2.4.3 The different approaches in psychotherapy training.

Several different approaches have seen the light within the psychotherapy training context. This research is however primarily concerned with the development of a training programme on Teddy Bear Therapy and thus only related and relevant approaches which will contribute specifically to developing the programme will be discussed. The focus of most research on the training of psychotherapists is generally on the subjective experiences of trainees rather than the content of the training programmes itself. Due to this definite lack of research available only brief descriptions on certain approaches will follow.

2.4.3.1 The storytelling approach in psychotherapy training.

Training in storytelling therapy for children relies less on traditional training methods and more on a trainees' imagination and playfulness (Dowling & Vetere, 2005). Trainees practice how to give constructive resolutions to the identified issue, which is presented by the child in the form of a story (Dowling & Vetere, 2005; Kazdin, 2000). The emphasis is on training the therapist to use the child's language to introduce healthier resolutions to the child's difficulties, as they are communicated in the child's spontaneously produced story (Dowling & Vetere, 2005). Listening is therefore very important in training storytelling therapists, as well as responding therapeutically to the painful narrative. Active listening skills and the importance to ask questions and make sure the story is understood correctly are taught (Kazdin, 2000).

Trainees are trained to create an environment for children to develop their imaginations, experiment with different behavioural rules, problem solving methods, and learn to understand and express their emotions (Dowling & Vetere, 2005). It is the therapist's training and experience with children that takes this activity from a game to a therapeutic tool (Kazdin, 2000).

2.4.3.2 The behaviouristic approach in psychotherapy training.

The behaviouristic approach focuses on training therapists to identify and focus on observable maladaptive behaviour (Dimeff, 2009). The overall focus of training behaviourists is on observable outcomes.

In order to obtain observable outcomes, trainers strive for behaviour modification. Trainees are exposed to trial-and-error learning. Training methods usually include instructor-led training workshops, written treatment manuals with evidence-based guidelines, research-based journal articles and electronic journals (Dimeff, 2009). Feedback, behavioural rehearsal/role-play and supervision have been found to be effective in training behaviourists (Herschell et al.). Lastly, modelling is also considered to be a useful tool in the behaviouristic trainer's kit.

2.4.3.3 Rogerian approach to training psychotherapists.

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude (Rogers, 1951). Three interrelated attitudes on the part of the therapist are central to the success of client-centred therapy: congruence, unconditional positive regard, and empathy (Rogers, 1951). A non-judgmental, empathic and congruent stance is taken by the trainers in order to facilitate the necessary changes in the trainees (Rogers, 1951). Personal therapy is a training and accreditation requirement of client-centred therapy (Lucock, 2006). The implicit emphasis in Rogerian training is on description rather than explanation (Lucock, 2006).

Rogerian trainers advocate a non-directive mode of psychotherapy in which the trainee must learn how to facilitate an atmosphere in which the client is free to express him/herself and is subject to a minimum of organisation or expert 'treatment' by the therapist (Lucock, 2006).

A client-centred therapist is trained to demonstrate empathy to the client through a special method called reflection, which consists of paraphrasing and/or summarising what a client has just said (Rogers, 1951). Experiential learning is central to client-centred training and this technique is thus taught through role play (Knight, 2005). It lets the trainees check the accuracy of their perceptions while showing “clients” that they are paying careful attention to and are interested in what is being said (Lucock, 2006).

2.4.3.4 The systemic approach in psychotherapy training.

General Systems Theory is the foundation for the systemic approach and suggests that no model of intervention or of training exists in a theoretical vacuum. De Shazer (1982) goes further and states that for a clinical model to be teachable and coherent, it requires an epistemological foundation. Epistemology reflects the rules one use to make sense of the world (Silverman, 2005). The application of General Systems Theory to psychotherapy has implied a drastic shift in approaches to training psychotherapists (Bosman, 2004). The systemic approach goes beyond theory and challenges a trainee’s epistemology.

The systemic approach implies a change in focus from a traditional linear perspective, which goes hand in hand with psychiatric terminology and the classical medical model of psychopathology. Traditional linear epistemology is atomistic, reductionistic and does not consider context (Bosman, 2004). Non-linear epistemology focuses on ecology, relationship, whole systems and context (Keeney, 1983). Essential elements in General Systems Theory include wholes, patterns, structure, organisation and relationships (Keeney, 1983).

In the context of training, the focus of the systemic paradigm is on changing the conceptual framework in which the trainees operate (Bor, 1984). The emphasis is on the process of learning and not the content of what is learned. In order to do ‘effective’ training

and change a trainee's view of reality, attention needs to be given to the principle of connections and patterns and eventually to patterns of patterns (Bateson, 1980). 'Resistance' towards systems thinking on the part of trainees has been raised as a concern by several authors (Bosman, 2004). This 'resistance' is derived from trainees' embeddedness in the traditional, linear paradigm (Bor, 1984). Furthermore, the dominance of a medical paradigm in the university and hospital context is a factor which needs to be accounted for (Bor, 1984).

Systems training is an intricate process by which a trainee acquires a systemic perspective of the world, understands characteristic elements and principles that governs systems behaviour and learns to apply system methods and models and integrate everything within the general framework of a systems view (Bor, 1984).

i. Systemic training at Medunsa.

The training course offered at the Medical University of South Africa (Medunsa) is an example of a clinical psychology training programme operating from a systemic framework. The training course also includes exposure to Teddy Bear Therapy, which explains the elaborative description which is to follow.

The training programme is essentially experiential and based on participant-learning, including the basic methods as already outlined by Oomkes (Bosman, 2004). Experience and personal interaction in a group setting facilitate learning and the development of a trainee's skills (Bosman, 2004).

General Systems Theory is used as a meta-theory, allowing for the integration of various other theoretical approaches (Bosman, 2004). The most prominent systemic principles listed in Vorster (2003, pp. 110-111) that allows for this integration, are:

1. Recursively connected hierarchies – all systems are hierarchically structured. This allows for the conceptualisation of systems within systems. In turn systems and their comprising subsystems are linked through recursive patterns of interaction, which render them interdependent.
2. Punctuation – to allow for the observation of various systems or sequences of interaction within these recursive patterns, arbitrary punctuations can be made.
3. Rejection of either/or dualities – because systemic thought rejects either/or dualities, it is possible to punctuate on linear sequences within the larger circular patterns.

Utilising General Systems Theory as a meta-theory allows a shift from traditional linearity, as well as the opportunity to use different interventions from different theoretical approaches (Bosman, 2004). The focus shifts from the individual, as the system becomes the “client” and not the individual. Change in one part of a system is considered to result in change in the total system.

In order to ensure change in the system, the role of the therapist is one of ‘participant-observer’ (Vorster, 2003). This implies that the therapist is part of the system that he/she is attempting to assist. This is possible by operating on a higher logical level than the family members, as the therapist observes the circular interaction between members and registers the impact it has on the various members (Vorster, 2003).

Even though the therapist may register the impact of behaviour and be subjective in his/her observations, he or she is educated to operate from a meta-perspective (second order

perspective). This enables the therapist to act as a ‘trained’ observer and be in control of the therapeutic context, hence providing effective intervention (Bosman, 2004).

ii. The Interactional Pattern Analysis (IPA).

According to Vorster (2003), systems theory advocates a more tangible and observable process of psychotherapy. This places the emphasis on inter-psychic solutions to behavioural problems (Vorster, 2003). The Interactional Pattern Analysis was developed as a diagnostic tool to logically link a presenting complaint and/or symptomatic behaviour with a detailed pattern analysis, based on observable behaviour (Vorster). In keeping within the principals of systems theory, this diagnosis relies on circular interaction, relationships and context (Vorster). It focuses on describing what is happening in a system and how it is happening, rather than the underlying reasons of why it is happening.

In order to formulate an IPA, skilled observation is required and the key elements will only be outlined briefly (Vorster, 2003):

1. Context: This provides a picture of the circumstances in which the interview took place. This will define the meaning of behaviour and the interpersonal communication.
2. Presenting complaint: This entails an account of the problem experienced, as well as who formulated it. This subjective experience of an individual is linked to the individual’s observable pattern of interaction.
3. Definition of the relationship: This describes the nature of the definition of the relationship between the therapist and the client. It can be complementary, symmetrical or parallel. The definition of the therapeutic relationship provides the

context in which other relationships and interactions are to be interpreted and understood.

4. Emotional distance: This is a description of the emotional distance in the therapeutic relationship and manoeuvres used to maintain this.
5. Manoeuvres: Manoeuvres refer to the strategies that clients use in order to elicit certain responses. The type of manoeuvre, the manner of using it and the impact it had on the therapist needs to be noted here.
6. Hypothetic link: This is an integration of the presenting complaint and the observed interactional pattern of behaviour as formulated by the therapist. It also provides an indication as to the most effective form of therapeutic intervention.

A training programme on Teddy Bear Therapy for psychotherapists would include some of the above-mentioned elements of training programmes for psychotherapists. However, there are specific skills that are essential for a Teddy Bear Therapy psychotherapist to have that needs to be accounted for in the training programme and which will be discussed below.

2.5 Fundamental Elements of a Teddy Bear Therapy Training Programme

Teddy Bear Therapy is a very specific area of expertise and therefore requires particular skills from a psychotherapist. The target population for this programme is psychotherapists who have been trained in both General Systems Theory and basic child development.

Training in General Systems Theory and the application of it are prerequisites for this training course, as this will aid the therapist in analysing a system, identifying whether the behaviour of the child is functional for his/her system and in linking the behaviour with emotions.

Training in General Systems Theory will imply that psychotherapists are thoroughly trained in the Interactional Pattern Analysis (IPA). The therapist will, however, need to know how to look at the different variables within the context of a child and Teddy Bear Therapy. The IPA will assist the therapist in identifying the context of the presenting problem, as well as the nodal point that needs intervention. Prior training in normal and exceptional child development, developmental abilities including causes and classifications of child psychiatric conditions, as well as behavioural and learning disabilities (Rustin, 1999) will assist the therapist further in accurately identifying the nodal point.

In order to draw up an IPA, it is assumed that the therapist is trained in conducting a client-centred interview with the parents of the children. Children cannot communicate accurately about their context and as all behaviour only make sense in a context, the parents need to be seen first. In treating the child, the therapist is expected to know how to sustain a setting conducive to therapeutic work, including the management of the relationship to the child's family (Rustin, 1999). The therapist will need to accurately observe the impact of behaviour, which will assist in drawing up a preliminary IPA for the child.

Following the non-directive approach, the therapist will need to be trained on how to take a relevant and comprehensive history through direct questioning. In order not to contaminate the two contexts, the trainee needs to know how to separate the non-directive context from the directive.

Aside from being able to conduct a client-centred interview, the therapist would have already been trained to engage in a client-centred manner, which will aid the therapist in building rapport with the child and consolidating the therapeutic relationship.

Training would therefore include knowledge on how to relate to the child on his/her level, for example using language which is non-threatening and easy to understand when engaging in the storytelling process.

In order to let the story flow, the trainee will need creativity and efficient problem solving skills to steer the child's story into a more optimal direction. In order to do this, the trainee will need training in strategic intervention, which will already have been accounted for in systemic training. The trainee further needs good observation skills to give feedback to the child on his/her behaviour or problem solving skills. The trainee also needs to model appropriate behaviour to the children in order for them to learn more effective coping skills.

Lastly, the therapist needs to have knowledge of ethical implications when dealing with children and their parents.

2.6 The Proposed Training Programme

From the literature it is possible to formulate a preliminary draft of the proposed training programme.

First and foremost, Teddy Bear Therapy is a systemic intervention and training in Teddy Bear Therapy would therefore require an in-depth understanding or prior training in the systems approach. A basis of being trained in the systemic approach would already have changed the trainee's epistemology, the trainee would have acquired an ability to understand

context, wholes, patterns and structure, and the ability to formulate an IPA, all necessary to conduct Teddy Bear Therapy. The training programme needs to only touch on these elements, especially in implementing it within the context of Teddy Bear Therapy.

With the systems theory as basis, the trainees will need prior knowledge on child development, developmental abilities including causes and classifications of child psychiatric conditions, as well as behavioural and learning disabilities. This is assumed to already be part of the therapists' frame of reference and will not form a part of this training programme.

Skills that is proposed by the literature to be part of the training programme not exclusive to systems training, include how to give constructive resolutions to the identified issue as presented by the child. The emphasis should be on training individuals to use the child's language to introduce healthier resolutions to the child's difficulty. Active listening skills are also suggested to be taught, as well as to ask questions and make sure the story is understood correctly. Trainees are suggested to be trained to create an environment for children to develop their imaginations, experiment with different behavioural rules, problem solving methods, and learn to understand and express their emotions.

In addition to skills and knowledge, a certain attitude is also promoted by the literature and more specifically the client-centred approach to training. A congruent, non-judgmental, and empathetic attitude, as well as a non-linear perspective, is essential for the trainee. This is also suggested to be modelled by the trainers.

Aside from the skills and attitudes proposed, suggestions are also made by the literature regarding the content and format of the training programme. Theoretical input on Teddy Bear Therapy is firstly suggested. Written treatment manuals are suggested that will include the development of Teddy Bear Therapy, indications for it, the effectiveness of it and

the process of the therapy. Group discussions on theory can be made as additional learning experience and development of critical thinking. Individual study can also be incorporated as way of reflecting on what has been done.

Most literature, including the systemic and the client-centered approaches to training, are of the belief that an individual learns most through experience. In training psychotherapists on Teddy Bear Therapy, role play as used by the behaviourists is proposed to be useful, and in the same breath – role change. This can afterwards be analysed by making tape or video recordings and analysing this as a learning experience. This exercise will also sharpen observation skills and serve as an analysis of psychotherapeutic skills. Follow-up evaluations at a later stage are suggested by researchers as last step to the training process.

However, this is an incomplete picture and therefore the next chapter will provide empiric research on how a Teddy Bear Therapy training programme will look.

2.7 Conclusion

This chapter began with a discussion of the development of child psychotherapy and touched on the work of different theorists that made a significant contribution to the establishment of the field.

It was indicated that, in critique of these earlier child psychotherapeutic interventions, Charl Vorster developed Teddy Bear Therapy as a systemic intervention to address various difficulties children are faced with (1995). The significance of this form of child psychotherapy and its empirically proven effectiveness have been discussed extensively.

Attention was given to the skills necessary for a psychotherapist to conduct Teddy Bear Therapy. The focus then shifted to how psychotherapists are trained according to different theoretical approaches, which led to suggestions to consider when developing a training programme for psychotherapists on Teddy Bear Therapy.

Against the background of chapter 2, the next chapter will develop a method of training psychotherapists in the application of Teddy Bear Therapy. As indicated in the literature, the emphasis will fall on the following elements:

- A review of systemic concepts and IPA variables relevant to Teddy Bear Therapy;
- theoretical input on Teddy Bear Therapy;
- written treatment manuals on the development of Teddy Bear Therapy, indications for it, the effectiveness of it as well as the process of the therapy;
- group discussions on theory;
- individual study on the theory;
- training observation skills;
- training individuals to identify the ineffective behaviour, the function of it and thus the nodal point that needs intervention;
- training on how to use the child's language to introduce healthier resolutions to the child's difficulty with the use of a story;
- training individuals' active listening skills;
- congruence, unconditional positive regard , and empathy;
- circularity;
- experiential learning;

- role play;
- role change;
- tape or video recordings and analysing this; and
- follow-up evaluations when training is finished.

Chapter 3: The Investigation

3.1 Introduction

The research design and methodology direct the researcher in planning and implementing the study in accordance to the goal that has been formulated (Whitley, 2002). It serves as a blueprint for the study (Silverman, 2005). The purpose of this chapter is hence to expand on the planned research design and report on the actual methodology employed.

The section discussing the proposed research design will now begin by discussing the research aim of the study.

3.1.1 Aim of the study.

The aim of this investigation is to develop a Teddy Bear Therapy training program for psychotherapists.

Now that the research objective has been defined, the proposed research plan to investigate this will be discussed.

3.2 Research design

Salkind, Dougherty and Frey (2010) describe the research design as the plan that provides logical structure that guides the investigator to address research problems and answers research questions. It further informs and guides all methodological decisions (Salkind et al., 2010).

This research design is embedded within a theoretical research paradigm, which has certain implications for the research plan (Whitley, 2002). The research design will therefore

start with a discussion of the research paradigm. The research plan will then be described in further detail.

3.2.1 Research paradigm.

Creswell (1994) defines a research paradigm as the underlying assumptions and intellectual structure upon which research and development in a field of inquiry are based. Durrheim (1999) goes further by referring to the research paradigm as a structure that provides the objective for the research. This commits the research to certain data collection methods as well as interpretation (Durrheim, 1999). Paradigms are thus essential to research design because they impact both on the nature of the research question – i.e. what is to be studied – and on the manner in which the question is to be studied (Durrheim, 1999).

3.2.1.1 Quantitative versus Qualitative research.

According to Whitley (2002) behavioral science data can broadly be classified into a quantitative and qualitative paradigm. A quantitative study, consistent with the quantitative paradigm, is an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalisations of the theory hold true (Creswell, 1994).

Where a quantitative study will thus consists of numerical information such as frequency of specific behaviour or scores on a test, qualitative research is used to describe behaviour or the content of people's responses to questions (Whiltey, 2002).

Qualitative research develops an understanding of other people's opinions and provides the researcher with an in-depth account of a research participant's frame of reference (Somehk & Lewin, 2005). According to Cresswell (p.64, 1994)

"A qualitative study is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting."

3.2.1.1 Qualitative research.

Qualitative research can hence be described as dialectic and interpretive (Terreblanche, Durrheim & Painter, 2006). During the interaction between the researcher and the research participant, the latter's world is discovered and interpreted by means of qualitative methods (Silverman, 2005). As mentioned earlier, this provides the researcher with a detailed and rich account of a subject's experience (Silverman, 2005). This implies that qualitative research is also an inductive approach to knowledge development (Salkind, 2010). The researcher attempts to make sense of the phenomena through summarising the meanings the participants attach to them (Salkind, 2010).

Terreblanche et.al (2006) argue that the central achievement of qualitative methodology is to understand human phenomena in context. Qualitative research adopts a person-centred and holistic approach. The role of the researcher in qualitative research entails being a good listener, non-judgmental, warm and flexible (Somehk & Lewin, 2005).

The current study strives towards developing a Teddy Bear Therapy training programme for psychotherapists. The qualitative approach, appropriate to the use of words and reporting detailed views of informants will be used in this study. The qualitative paradigm were chosen based on the need to present a detailed view on the topic presented. In order to develop this programme the data required needs to be specific to the context of Teddy Bear Therapy. A qualitative research approach will hence be best suitable for the aim of this study.

3.2.2 Descriptive research design.

As already mentioned, this study functions from within the qualitative paradigm. Within this paradigm a descriptive research design is selected to describe the subject of a training programme for psychotherapists on Teddy Bear Therapy. In this study 'descriptive' refers to the data collection strategies as well as the analysis. The descriptive approach will be adopted in the literature review and in the interviewing process where the psychotherapists will be asked to describe how a training programme for psychotherapists on Teddy Bear Therapy will look like. The data analysis will also have a descriptive nature.

According to Whitley (2002) a description process acquires an extensive amount of information. Pollit and Hunger (1996) state that descriptive research studies have the accurate portrayal of the characteristics of persons, situations or groups as their main objective. A descriptive approach in data collection in qualitative research is also able to provide a clear account of the phenomenon under study (Mouton & Marias, 1992). In the present study the descriptive approach is particularly appropriate because a clear and authentic account of how a Teddy Bear training programme would look like, will be required from the psychotherapists.

Whitley (2002) states that a descriptive method in data collection in qualitative research is central to open, unstructured qualitative research interview investigations. This implies the opportunity for the researcher to obtain a clear and uncontaminated description from the psychotherapists with the use of the structured interviews.

The descriptive design is therefore the most suitable to develop a Teddy Bear Therapy training programme for psychotherapists.

Before engaging in any methodology the research question needs to be formulated as it guides the rest of the process.

3.2.3 Research question.

The research question serves as the methodological point of departure of a research design (Salkind, 2010). The proposed research should answer the posed question (Salkind, 2010).

The research question for the present study is:

How does a programme look which has been developed and designed for the effective training of psychotherapists in conducting Teddy Bear Therapy?

In order to answer the research question by means of a descriptive research design, the research process needs to commence and a sample needs to be selected. The sampling approach used to select the participants for the descriptive design will be discussed just after the research procedure is set out as can be seen below.

3.2.4 Research procedure.

The present study's research process can be divided into distinctive steps.

3.2.4.1 Step 1: Permission from the Medunsa Campus Research Ethics Committee (MCREC).

The research was accepted and the necessary research permission granted by the Medunsa Campus Research Ethics Committee (MCREC).

3.2.4.2 Step 2: Narrative literature review.

After the acceptance of the research the data collection process will commence. This will be twofold, firstly data will be collected by means of a narrative literature review on the nature of child psychotherapy training programmes.

3.2.4.3 Step 3: Semi-structured interviews.

Based on the narrative literature review, questions will be derived to use in semi-structured interviews with three established psychotherapists on how a training programme for psychotherapists in Teddy Bear Therapy would look like.

3.2.4.4 Step 4: Data analysis.

The data collected from the interviews will then be analysed by the researcher herself by means of a thematic analysis.

3.2.4.5 Step 5: Compiling a training programme and manual.

Based on the themes identified in the data analysis a training programme and manual will be developed for the training of psychotherapists in Teddy Bear Therapy.

Now that the *how* of the research process has been discussed, we can move on to the discussion regarding *who*.

3.2.5 Sampling approach.

3.2.5.1 Sampling.

“Sampling is the process of selecting a portion, piece or segment that is representative of a whole” (The South African Concise Oxford English Dictionary, 2002). Sampling is

thus concerned with how the target population selected for the study is reduced to a representative sample (Whitley, 2002).

However, not all research designs are concerned with generalising from a sample to a population of people (Thompson, 2011). Qualitative studies use rich and detailed descriptions to inform understandings of certain topics and contribute to broader theoretical understanding (Silverman, 2005; Thompson, 2011). Sampling in qualitative research is neither statistical nor purely personal, it is theoretically grounded (Silverman, 2005). The purpose of sampling in this context is thus to identify specific individuals who possess certain characteristics relevant to the phenomenon being studied (Thompson, 2011). This enables the researcher to select key informants with access to important sources of knowledge (Thompson, 2011).

In accordance to the present study, sampling can be defined as the process of selecting individuals from a target population to conduct the research with (Somehk & Lewin, 2005). These individuals will need to possess certain characteristics to contribute relevant knowledge and a broader theoretical understanding of the topic.

As the target population of a study refers to the entire group of people to which the results of the study apply (Maree & Pietersen, 2007; Whitley, 2002), a sample hence refers to a subset of the target population selected to participate in a research study (Whitley, 2002). In social science research the target population refers to the theoretically specified aggregation of the elements in a study (Babbie, 2010). A target population needs to be operationally defined in terms of a study population that refers to the group of elements a sample is actually selected from (Babbie, 2010). Individuals who match the operational definition of the target population thus constitute the study population (Whitley, 2002).

With the above definitions in hand, the importance of accurately defining the research sample, target population as well as study population is stressed. Errors in the definitions of the above will compromise the validity and reliability of the study (Whitley, 2002). The following section will hence outline the target population, study population and research sample.

3.2.5.1.1 Target population.

The target population of this study will be psychotherapists in the field of psychology.

3.2.5.1.2 Study population.

The target population will be operationally defined as established psychotherapists who have sufficient experience in the Teddy Bear Therapy field. For clarification purposes the following terms will now be discussed: Established psychotherapist; sufficient experience; Teddy Bear Therapy.

‘Psychotherapist’ refers to an individual who has had extensive training in and are now practicing psychotherapy (Combs, 1989). Psychotherapy is the process by which a client and therapist interact to address a presenting complaint (Vorster, 2003). A registered psychotherapist has obtained at least a masters’ degree in Psychology, underwent a supervised clinical internship and is registered by a government or psychological health association to which he/she is accountable .

As described extensively in the Literature review, **Teddy Bear Therapy** is a systemic psychotherapeutic intervention for children with various difficulties. The training programme will be on effectively conducting this new kind of therapy. The sample of psychotherapists is therefore required to have knowledge and experience in the field. This

experience can be specified as having more than three years of practical experience in conducting Teddy Bear Therapy.

3.2.5.1.3 *Research sample.*

The sample for the present study consists of three established psychotherapists in the field of Teddy Bear Therapy.

The sample size, type of sampling and how the sampling will be conducted will now be discussed.

i. Sample size

In general sample sizes in qualitative research should not be so small as to make it difficult to achieve data saturation, theoretical saturation or informational redundancy (Sandelowski, 1995). At the same time the sample should not be so large that it is difficult to undertake a deep, case orientated analysis (Sandelowski, 1995). In the present study the sample size was chosen based on this as well the research objective, research question and subsequently the research design (Collins, 2007).

In summary to the above, the choice of sample size was made in an attempt to prevent data saturation or informational redundancy and also ensure rich detailed information according to the descriptive research design.

ii. Type of sampling

Sampling schemes fall into one of two classes: random sampling schemes (probability) or non-random (non-probability) sampling schemes (Collins, 2007). These

sampling schemes encompass methods for selecting samples according to the research paradigm (Collins, 2007).

Random sampling is utilised when the objective of the study is to generalise the findings to the population from which the sample was drawn (Collins, 2007). Non-random sampling is chosen when the goal is not to generalise to a population but to obtain insights into a phenomenon, individuals or events (Collins, 2007).

For the present study the researcher will use non-random sampling to purposefully select individuals for this phase who will maximise the understanding of the underlying phenomenon. The individuals will thus be considered for selection if they are ‘information rich’.

Within the two classes of sampling there are various different sampling methods. From within the non-random sampling class, purposive sampling will be used as sampling method in the present study. Purposive sampling starts with a purpose in mind and the sample is thus selected to include people of interest and exclude those who do not suit the purpose (Whitley, 2002). Pollit and Hungler (1996) defines purposive sampling as a process by which people are selected to participate based on their first-hand experience of a phenomenon or interest.

Most sampling are done with a purpose in mind (Collins, 2007). For this reason it is necessary to specify the sub-category of sampling methods relevant to the proposed study (Collins, 2007; Mouton & Marias, 1992). The current study will make use of expert sampling as sub-case to purposive sampling. Expert sampling involves the assembling of a sample of persons with known or demonstrable experience and expertise in some area (Mouton & Marias, 1992).

As mentioned earlier, Teddy Bear Therapy is a highly specialised field which requires the three participants who will give recommendations on the development of the proposed training programme to give contributions that are of substance. The three established psychotherapists as well as the experienced psychotherapist who will do the programme evaluation will thus be selected according to their expertise in the field of Teddy Bear Therapy. In the case of selecting an independent experienced psychotherapist to evaluate the training programme, the main objective is to provide evidence for the validity of the research as the expert minimises the amount of bias involved.

iii. Conducting the sampling

The sampling will be conducted by consulting with the developer of Teddy Bear Therapy, Prof. Charl Vorster for recommendations concerning three experienced psychotherapists in the field of Teddy Bear Therapy. The three psychotherapists will be contacted, informed about the study and asked whether they will be willing to participate in the present study.

The sampling approach has now been discussed and it is hence necessary to describe the measurement strategies which will be applied to collect data from these samples.

3.3 Data collection

Data refers to the basic material with which researchers work (Durrheim, 1999) that has been produced, analysed and interpreted in the research process (Babbie, 2010). This material is a product of observation that can take the form of either numbers (quantitative) or language (qualitative) (Durrheim, 1999). The quality of the data gathered has a direct impact on the validity of the research (Durrheim, 1999).

This process of gathering information relevant to the research problem in a precise and systematic manner is referred to as data collection (Whitley, 2002). The data collection procedure dictates the strategy for conducting a study (Silverman, 2005). In order to present the data collection procedure in a logical and systematic manner the outline of the present study's data collection procedure will now be discussed.

Interviews and a literature review will be used as methods to collect the necessary data. The combination of methods is chosen in order to corroborate each other so that some form of methodological triangulation takes place. Mouton and Marais (1992) refer to methodological triangulation as a method of cross-checking data from multiple sources to search for regularities in the research data. Silverman (2005) states that the purpose of triangulation in qualitative research is to increase the credibility and validity of the results. These two methods will be discussed in the following sections.

3.3.1 Narrative literature review.

Robinson and Reed (1998) define a literature review as a systematic search of published work to find out what is already known about the research topic. Mouton and Marais (1992) assert that the literature review as a research method has multiple functions such as to deepen the theoretical framework of the research; to identify variables that need to be considered in the research and to familiarise the researcher with any developments relevant to the topic.

There is a variation of different literature reviews available in the field of social science research of which meta-analysis and narrative analysis are deemed the most popular (Riessman, 1993). The most significant difference between meta-analysis and narrative analysis is that the latter can be qualitative as well as quantitative in nature whereas meta-

analysis is purely quantitative (Moser & Schmidt, 2008). Meta-analysis is preferred when there are many studies available testing the same hypothesis (Baumeister & Leary, 1997). A narrative literature review is valuable, however, when one is attempting to link together many studies, either for purposes of reinterpretation or interconnection (Baumeister & Leary, 1997; Riessman, 1993). As such, narrative literature reviewing is a valuable theory building technique, and it may also serve hypothesis-generating functions (Baumeister & Leary, 1997). Meta-analysis is, in contrast, a hypothesis-testing technique (Baumeister & Leary 1997).

In the present study a hypothesis needs to be formulated on how to train psychotherapists in a form of child psychotherapy. The literature review which will be most suitable for the design of the current study, based on the fact that it is most interpretive-qualitative in nature, is the narrative review (Riessman, 1993).

The narrative review is an approach used to synthesise and review results. The narrative review relies on a researcher's ability to "digest the array of findings across studies and arrive at a hypothesis" (Moser & Schmidt, 2008, p. 6). Narrative literature reviews present conclusions of a scope and theoretical level that individual empirical reports cannot normally address (Baumeister & Leary, 1997). According to Riessman (1993), the objective of a narrative literature review is to either describe the current states of both practice and research in focused areas of inquiry; to add dimensions of insight or application that are not available in existing literature, or to provide critical analyses of standing works.

The purpose of the literature review for this study is to provide theoretical descriptions of the training of child psychotherapists. This information will then be analysed and referred to when developing a training programme on Teddy Bear Therapy.

In order to fulfill the purpose as set out above, Riessman (1993) provides general guidelines to conduct a narrative literature review which will be followed by the researcher:

1. Identify a research area.
2. Identify inclusion criteria for studies.
3. Select studies that meet the inclusion criteria.
4. Identify themes that emerge from the set of studies.
5. Draw conclusions.

The process as discussed above has its limitations (Robinson & Reed, 1998). First and foremost it is said that the nature of the method is too subjective with reference to determining which studies to include, the way in which the studies are analysed, and the conclusions that are drawn (Riessman, 1993).

Another drawback of using a literature review as research method is that it does not provide the researcher with a holistic view of the topic as it only delves into the theoretical framework and neglects the empirical framework (Terreblance et al.). This is however accounted for as the researcher aims to supplement the literature review with data collected from interviews.

3.3.2 Semi-Structured interviews.

Interviews can be defined as the methods of maintaining and generating conversations with people on a specific topic or range of topics and the interpretations (Whitley, 2002). Interviews yield rich insights into people's biographies, experiences, opinions, values, aspirations, attitudes and feelings (Babbie, 2008). The purpose of conducting an interview is

to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena (Kvale, 1996).

Based on the degree of structuring, interviews can be divided into three categories: structured interviews, semi-structured interviews, and unstructured interviews (Somehk, 2005; Whitley, 2002). A structured interview is an interview that has a set of predefined questions and the questions would be asked in the same order for all respondents (May, 2001). This standardisation is intended to minimise the effects of the instrument and the interviewer on the research results (Kvale, 1996). It is however rigid in its approach as there is no leeway for the researcher to ask for clarification or ask another question for elaboration purposes (Whitley, 2002). In sharp contrast to this unstructured interviews can be defined as conversations in which neither the question nor the answer categories are predetermined (Kvale, 1996). Instead, they rely on social interaction between the researcher and the informant (May, 2001). Interviewees have the freedom to tell their stories in their own way, although the interviewer may prompt in order to keep the narrative going (Babbie, 2008).

Semi-structured interviewing is a compromise of both of these methods described above. An interview guide is usually prepared for the interview which comprises of both closed-ended and open-ended questions (Kvale, 1996). However, in the course of the interview, the interviewer has a certain amount leniency to adjust the allowing new questions to be brought up during the interview as a result of what the interviewee says (Pollit & Hungler, 1996). This thus introduces a more flexible way of interviewing and places the focus on clarification and elaboration (Babbie, 2008).

For this study, the interview guide will be prepared and presented in the following chapter based on the information gathered in the narrative literature review. To get to the

core of the reality of the phenomenon under study probing will further be used as a clarification method. Probing is a method used to obtain more information from someone and to encourage the interviewee to elaborate on a statement eg. “Please tell me more ” (Pollit & Hungler, 1996).

This will allow depth to be achieved as it provides the opportunity for the interviewer to query and expand the interviewee's responses (Whitley, 2002). It creates some kind of balance between the interviewer and the interviewee which can provide room for negotiation, discussion, and expansion of the interviewee's responses (Pollit & Hungler, 1996). This means the interviewer is in control of the process of obtaining information from the interviewee, but is free to follow new leads as they arise (Pollit & Hungler, 1996).

The nature of data collected from interviews is significantly more elaborate than most other methods of data collection as informants are allowed the freedom to express their views in their own terms (Terreblance et al., 2006). In the case of the present study this is especially important.

The downfall of using interviews as data collection method is that the quality of the interview relies on the nature of the interactions with the interviewees (Somehk & Lewin, 2005). The data that is obtained might be corrupted by inappropriate questioning, inadequate listening or the absence of desirable interpersonal skills on the part of the interviewer (Somehk & Lewin, 2005). Effective interviewing is a complex task requiring attendance to a range of skills and information all at once (Whitley, 2002). The quality of data obtained can vary considerably depending upon the skill of the interviewer in establishing rapport, following up leads and demonstrating attention and interest (Whitley, 2002).

Human error is always a factor in research and can only be controlled up to a point (Babbie, 2005). In the current study the interviewer is however trained in person-centred interviewing, providing the necessary skills to listen attentively, build rapport and to eliminate any contamination of the interviewing process.

Another disadvantage of unstructured questions which form part of semi-structured interviews is that free responses solicited tend to produce results that are more difficult to analyse (Pollit & Hungler, 1996). As a point of caution regarding this the interviewer in the present study will be well prepared before beginning the interviewing process.

The interviews will also be recorded so that any extra information could be recalled at the time of data analysis. This will also ensure that researchers and readers will have access if further inspection is desired (Silverman, 2005). An interview guide will be prepared beforehand, but as the interviews will progress and more issues arise, relevant questions might need to be inserted naturally into the flow of the interview. The use of the interview guide will however ensure that all relevant topics will be covered.

3.4. Data Analysis

After the data collection process the data needs to be analysed. Data analysis is a mechanism for reducing and organising data to produce findings that require interpretation by the researcher (Mouton & Marais, 1992).

Qualitative data analysis is “the non-numerical examination and interpretation of observations for the purpose of discovering underlying meanings and patterns of relationships” (Babbie, 2008, p. 415). It aims to provide an answer to the research question

(Durrheim, 1999). The qualitative paradigm provides a variety of analytic techniques to adhere to this aim.

Qualitative data analysis techniques can roughly be divided into two camps (Braun, 2006; Durrheim, 1999). The first one is linked to a theoretical perspective and is epistemologically based (Braun & Clarke, 2006). The implication is that there is relatively limited variability in how the method is applied, within that framework (Braun & Clarke, 2006). The second camp consists of methods that are essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006).

Within this research, use will be made of the latter to select a flexible and independent method in accordance to the descriptive research design. Thematic analysis will be the method used to describe and categorise the data collected from both the literature review as well as the interviews. Thematic analysis can be defined as a method for identifying , analysing and reporting themes within data (Babbie, 2008; Braun & Clarke, 2006). It minimally organises and describes the data set in rich detail (Braun & Clarke, 2006).

Thematic analysis is chosen for this study as it serves as insightful analysis to answer the research question at hand (Braun & Clarke, 2006). The flexibility of the method will enable the researcher to summarise key features of a large body of data, and will offer a thorough description of the data set whilst simultaneously highlighting similarities and differences across the data set (Aronson, 1994).

The disadvantages of using a thematic analysis depend more on poorly conducted analyses or inappropriate research questions than on the method itself (Braun & Clarke,

2006). This is when themes identified are not internally coherent and consistent (Aronson, 1994) .

A pattern in data is rarely, if ever, going to be 100% complete and non-contradicted, so an analysis which suggests that it is, without a thorough explanation, open to suspicion (Silverman, 2005). In the present study attention will be given to ensure that all aspects of the theme cohere around a central idea or concept and if not, provide an explanation as to why.

The flexibility of thematic analysis requires that the researcher needs to be clear and explicit about what he/she is doing, and that it correlates with what he/she says he is doing (Aronson, 1994). Braun and Clarke (2006) asserts that the theory and method therefore need to be applied rigorously, and that 'rigour lies in devising a systematic method whose assumptions are congruent with the way one conceptualizes the subject matter' (p.12). In the current study this will be accounted for by meticulously following the steps as set out by Aronson (1994).

The steps that will be followed are:

1. Collecting the data by recording the interviews.
2. Transcribing the data into patterns of experiences by the researcher. The identified patterns will then be expounded on. All of the information that fits under the specific pattern will be identified with a corresponding pattern.
3. Combining and cataloguing related patterns into sub-themes. Themes derived from the three psychologists' conversations will then be pieced together to form a more comprehensive picture.
4. Justifying the choice of each individual theme by referring back to the text.

5. Once the themes are formulated and the literature consulted, theme statements will be devised to develop a story line. This will ensure that the data collected from the interviews is comprehensive and more concise for the purpose for which it will be used.

Based on the separate findings from the interviews as well as the literature review that will be presented, conclusions will be reached on the development of a training programme on Teddy Bear Therapy.

3.5 Validity and Reliability

The data analysis as set out above will be directly influenced by the validity and reliability of the study and the extent to which it is accounted for.

Validity refers to the extent to which an account accurately represents the social phenomena to which it refers (Silverman, 2005). As mentioned previously the process of triangulation will be used to safeguard validity. Silverman (2005, p.76) refers to triangulation as “the use of multiple perspectives to interpret a single set of data, and this also means that the research findings can be incorporated into a more macro analytical level of inference”. For the purpose of this study, the information gathered from the interviews will be supplemented with a literature study on Teddy Bear Therapy.

Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer (Silverman, 2005). Reliability will be ensured in this study by recording the interviews on a voice recorder as well as

transcribing the verbal information into text to ensure that other researchers can inspect the information at any point in time.

3.6 Bias

Another factor that needs to be considered in whether the study can be deemed reliable and valid is the amount of bias present in the research process. According to Whitley (2002) the researcher should be aware of the fact that bias will infiltrate every step of the research process. This awareness will ensure a conscientiousness to detect bias easier (Whitley).

In the present study bias is hence a factor to acknowledge as the researcher will conduct the data analysis herself. In an attempt to minimise bias, the data analysis will be done precisely according to the structured steps as set out by Aronson (1994).

3.7 Ethical Considerations

Ethics generally refers to confirming to the standards of conduct of a given profession or group (Babbie, 2005). In the context of social research and more specific psychological research that implies adhering to the standards as set out by the psychological community (Babbie, 2005). In order to protect the participants and the quality of the research, the following principals will be implemented:

- First and foremost ethical clearance was granted from the Medunsa Campus Research Ethics Committee (MCREC) to conduct the research as set out.

- Furthermore the participants will be informed about the nature of the study in order for them to give informed consent. Letters of informed consent will be obtained from each participant before engaging in the data collection process with the participant.
- The privacy of the participants will be ensured and all data kept confidential.
- Anonymity of the participants will be guaranteed and hence no identifying information of the participants will be published.
- The research and findings will be released and published in a manner that protect the participants from any discreditation.

3.8 Method

The following section will discuss the actual methodology employed. The focus is on documenting areas where the field research deviated from the proposed research design.

3.8.1 Research procedure.

The research design as set out in Section 3.2 *Research Design* was followed as well as the research procedure. Sampling was done as set out in the research design. Three research subjects were interviewed. This sample was considered to be adequate.

3.8.2 Data collection.

Data was obtained as planned in the research design by means of a narrative literature review and semi-structured interviews. The narrative literature review is set out below.

3.8.2.1 Narrative literature review.

3.8.2.1.1 Introduction.

Child psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with their emotions or behaviour (Kazdin, 2000). The status of clinical child psychology exists as a specialisation within adult-oriented clinical psychology and is generally not recognised as a field on its own (Herschelle, McNeil & McNeil, 2004). This contributes to the negligence of child psychotherapy as a research topic (Macleod, 2004).

Research dedicated to understanding the process of child therapy is rare (Chu & Kendal, 2009). In the past five years about 2% of all studies published in the South African Journal of Psychology focused on psychotherapy with children (Macleod, 2004). Given the fact that 43,1% of the population of South Africa consists of people under the age of 20 years, this can be seen as a significant limitation in our knowledge production (Macleod, 2004).

Macleod (2004) further indicates that it is not only the subject of child therapy that is being neglected as research topic but also by implication the subject of the child therapist and consequently the training of child psychologists. Only 6.1 % of the studies published in the South African Journal of Psychology focused on the development of training programmes for psychotherapist and also psychotherapy as a subject for research and development (Macleod, 2004). It is thus evident that there is a significant lack of studies that systematically examine specific aspects of training programmes (Herschelle, McNeil & McNeil, 2004).

The current literature review strives towards an analysis of the published research available on the topic of training child psychotherapists without limiting the search to the South African context.

A literature search was performed to locate articles relating to training psychotherapist in child psychotherapy within psychological disciplines, using PubMed, PsycINFO, Scopus and EBSCOhost databases (key words 'training child psychotherapists') from 2000 to 2011. This yielded just a few relevant articles and therefore a further search was conducted with broadened parameters (1980–2011; key words 'training' and 'child' 'psychologists') to include information dating back further. From 111 results, 27 were selected by browsing abstracts for evidence of relevant information based on judgment regarding the accessibility of the article.

3.8.2.1.2 General themes in a training programme for child psychotherapists.

At present there is no consensus on standards for training child psychotherapists as distinct from training clinical psychologists in general (Routh, 2005; Sori & Sprenkle, 2004). This presents a dilemma for the development of training programmes and research (Routh, 2005). The literature concerning training programmes for child psychotherapists is as diverse as the field of clinical psychology itself. The studies focus on different schools of thought and training programmes within these schools. However, each of these training programmes is required to formulate a set of goals and measurable objectives related to each goal which in turn implement the training model (Patton, 2000). Generally these objectives and expectations of child psychotherapists in training have been found to overlap across contexts.

It is expected of a trainee in child psychotherapy to attain a sound understanding of the relevant principles and theories and to apply these skills practically and appropriately to assess the client's needs (Prendiville, 2011). In child psychotherapy, these skills also need to be directed towards the caretakers or parents of these clients, hence broadening therapeutic interaction to include them as support system (Prendiville, 2011).

The child psychotherapist is further expected to be skilled in play-based interventions with children and young people with developmental issues and/or mild to moderate emotional difficulties. Interventions are expected to be applied in an ethical and safe manner and also across a variety of settings (Prendiville, 2011; Sori & Sprenkle, 2004).

When looking at training programmes, there are also similarities evident when comparing the general characteristics that constitutes a training programme for child psychotherapists. This literature review will focus on these characteristics.

A 1999 special section of the *Journal of Clinical Child Psychology* 28(4) summarised three overarching themes emerging from recommendations for the training of child therapists, which was later confirmed in a study 2003 by the American Psychology Association (Spirito et al., 2003). Firstly, the importance of training experiences that provides exposure to interdisciplinary, coordinated, and comprehensive models of care; secondly, including a developmental framework to the training programme with emphasis on normal development and developmental theory, and lastly adopting a multicultural perspective throughout all aspects of education and training (Goodyear et al., 2000; Ollendick, 1999; Spirito et al., 2003). Two of these three themes are distinguishing features of work with children: a focus on impacting and integrating systems such as educational, health care, child welfare, family, and community rather than the individual directly; and incorporation of lifespan

developmental theory, and, by implication, a sensitivity to the developmental appropriateness of specific behaviours and the multiple changes children go through (Ollendick, 1999).

Another theme, not mentioned above, but found to be emphasised in several of the studies under investigation, is personal professional development (House, 2008; Sheikh, Milne & MacGregor, 2007). This refers to a training context where trainees receive theoretical input and develop professional skills but bring relevant personal experiences to their training in order to develop personally (Sheikh, Milne & MacGregor, 2007). Implicit in this way of training is the central role of the trainees' active engagement with the processes of their development (Sheikh, Milne & MacGregor, 2007). The dynamic cycle of training of child psychotherapists to some extent, relies on the commitment from the trainee to propel the process forward to their own advantage (Sheikh, Milne & MacGregor, 2007).

This is therefore a person-centred model, with the role of personal agency at the heart of a developmental process (Sheikh, Milne & MacGregor, 2007).

Against the background of these themes, an exploration into the specific elements of training child psychotherapists is possible. Before delving into that, it is necessary to take a look at the theoretical foundation that is required from a child psychotherapist before engaging in training.

3.8.2.1.3 Requirements of a child psychotherapist prior to training.

To be considered for selection into the field of psychotherapy a candidate is required to have at least a graduate qualification in psychology (Patton, 2000; Sheikh, Milne & MacGregor, 2007). Patton (2000) states that it forms the intellectual and ideological core of the potential psychologist. Regardless of the level of entry into the field, the trainee should

have obtained the necessary background experiences to develop the basic foundation to function successfully in the training setting (Spirito et al., 2003). With concerns of streamlining training, trainees are required to be familiar with general interpersonal and psychotherapy skills and knowledge prior to engaging in specific forms of psychotherapy training (Sudak, 2009). At graduate level, the focus of training is typically on the acquisition of general child clinical skills (Routh, 2005). This basic formal training in clinical child psychology on graduate level has however been found to be insufficient (Patton, 2000; Routh, 2005).

Aside from being found insufficient, it was also found to differ in the theory focused on (Routh, 2005). Clinical child psychologists are not solely from graduate training programmes in clinical psychology but also from educational, developmental, counseling or school psychology backgrounds (Routh, 2005). The fact that different graduate programmes focus on different theoretical aspects pose a dilemma in what a trainee knows and what not. Sheikh, Milne and MacGregor (2007) propose a solution in that it is ensured that child psychotherapists receive a systematic training, one that is based on a needs assessment. Goodyear et al. (2000) agrees and states that it is important that trainers maintain open communication channels with students about training emphases.

In doing as Sheikh, Milne and Macgregor (2007) proposes that each training programme should differ according to the trainees' needs. There is however specific elements that have been found essential for a child psychotherapist training programme, which will now be discussed.

3.8.2.1.4 Specific elements of training child psychotherapists.

Within the context of child psychotherapy there is a tendency to only offer child psychotherapy training during or after the completion of an adult programme (Zimmer, 2001). This can be attributed to the fact that there are very specific skills and knowledge that must be mastered prior to training in child psychotherapy.

Psychotherapy with children requires particular skills to be mastered as it is complicated by unique issues, such as difficulty in distinguishing normal versus abnormal behaviour at particular developmental stages (e.g., adolescence) and differences in individual developmental trajectories (Chu & Kendal, 2009). Many child and adolescent problems involve failure to show expected developmental progress (Mash & Wolfe, 2005). Determining the problem requires familiarity with normal as well as abnormal development. Many problem behaviors shown by children and youth are not entirely abnormal (Mash & Wolfe, 2005). Decisions about what to do also require familiarity with known psychological disorders and troublesome problem behaviours. Interventions for children and adolescents are often intended to promote further development rather than merely to restore a previous level of functioning. The goal for many children is to boost their abilities and skills, and not only to eliminate distress. (Mash & Wolfe, 2005).

Aside from this, another issue that is specific to psychotherapy with children is the fact that when adults seek services for children it is not often clear whose problem it is (Mash & Wolfe, 2005). This has important implications for identifying problems in children and addressing them (Mash & Wolfe, 2005).

Training for psychotherapists who work with children is hence quite different from the training of psychotherapists who work with adults. Based on this, recommendations were

made by the National Institute of Mental Health (NIMH) work group established in 1992 to define clinical training guidelines for services to children and adolescents. The seven areas cited in Spirito et al. (2003), which will be elaborated on later are:

1. life span developmental psychology;
2. life span developmental psychopathology;
3. child, adolescent, and family assessment methods;
4. intervention strategies;
5. research methods and systems evaluation;
6. professional, ethical and legal issues pertaining to children, adolescents, and families; and
7. the role of the clinical child psychotherapist.

More recently, La Greca and Hughes (1999) reframed and essentially summarised the 1992 'guidelines' of a training programme for child psychotherapists to 'competencies'. They identified five critical 'competencies' for clinical child psychologists that overlap with the training recommendations made by the NIMH group: (1) multicultural competencies; (2) delivery and evaluation of comprehensive and coordinated systems of care; (3) collaborative and inter-professional skills; (4) empirically supported assessment and treatments for promoting behavioural change in children, families, and other systems; and (5) entrepreneurial and supervisory skills (La Greca & Hughes, 1999).

Several studies followed hereafter, incorporating the guidelines and elaborating on them as will now be discussed below.

i. Life span developmental psychology.

Life span development includes the knowledge of typical development and behaviour expected in infants, preschool-age children, school-age children, adolescents, adults, and elderly persons within the contexts they function in (Mash & Wolfe, 2005). Life span development is an important foundation for the practice of child clinical psychology (Mash & Wolfe, 2005). Developmental issues specific to the practice of child psychology include the emotional, social, motor, and behavioural development, as well as physiologic maturation (Spirito et al., 2003). Although fundamental knowledge is required prior to training, developmental and theoretical information on the family life cycle are included in most child psychotherapy training programmes (Herschelle, McNeil & McNeil, 2004). It is seen as a vital foundation for training child psychotherapists (Mash & Wolfe, 2005).

Many problems arise as children and families move through the different stages and accommodate either changing developmental stages (i.e., beginning preschool, kindergarten, primary school or high school) or crises within the family (i.e., divorce, relocation, death of a grandparent, illness of a child or trauma) (Pickar & Lindsay, 2008). Frequently, the therapist assists by normalising and reframing issues that place the problem in a developmental framework (Pickar & Lindsay, 2008). This is quite different from a pathology or “cure” orientation, as potential problems arising in the life of a child are viewed as an inevitable and normal part of development (Pickar & Lindsay, 2008).

ii. Life span developmental psychopathology.

Clinical child psychologists are trained in models of developmental psychopathology that emphasise trajectories of adaptation and maladaptation under conditions of risk (Spirito et al., 2003). Additionally, awareness of developmental psychopathology is beneficial to the

child psychologist who assists healthy children with behavioural/emotional problems who undergo diagnostic medical procedures (Spirito et al., 2003). Knowledge of psychopathology is also necessary to make a differential diagnosis between psychological conditions and health related symptoms (Spirito et al., 2003). Training in life span developmental psychopathology enables child psychologists to identify children at risk for problems of adaptation in primary and other health care settings, thereby promoting positive adaptation and emotional well-being (Spirito et al., 2003).

iii. Child, adolescent, and family assessment.

Child psychologists must be knowledgeable in the administration and interpretation of psychometric assessments in order to gain a holistic understanding of their clients (Mash & Wolfe, 2005). Assessment in neurological functioning, intellectual functioning, personality, and behaviour of the child and adolescent, family assessment, and assessment of the socio-cultural context (e.g., school environment, peer relationships, community resources) (La Greca & Hughes, 1999) are all required. This will aid in clarifying a diagnosis or assisting in focal treatment planning (Pickar & Lindsay, 2008). It provides the psychotherapist with an understanding of the child and adolescent as well as the systems affecting him or her (La Greca & Hughes, 1999). Training settings provide opportunities for refining skills in psychological assessment (Spirito et al., 2003).

Training also involves stressing the importance of the timing of assessment as it has a significant influence on the validity of the results as well as the therapeutic rapport with the child (Pickar & Lindsay, 2008). If conducted too soon, the therapeutic rapport might be compromised and an invalid reflection of the child's abilities obtained (Pickar & Lindsay, 2008).

iv. Intervention strategies.

Training in theory-driven, empirically supported treatments for a variety of childhood problems is necessary for child psychotherapists (Spirito et al., 2003). Whereas the field of child psychology previously focused on the child as a means of enhancing coping and adjustment to illness, and even promoting health, there is now widespread recognition that the family is an important mediator of how children adjust or adapt to the experience of illness and how healthy behaviours are learned (Mash & Wolfe, 2005). Child therapy, by necessity, typically requires the involvement of other family members, as well as the utilisation of varied interventions stemming from systemic, behavioral, dynamic, or cognitive approaches (Weiss, Catron, & Harris, 2004). Although family assessments and interventions have been a mainstay of clinical psychology for the past three decades, only recently has the importance of the family system in understanding health outcomes been more fully realised (La Greca & Hughes, 1999). Most child psychotherapy training approaches are therefore including family systems assessments and interventions (La Greca & Hughes, 1999).

It is equally important for trainees to have exposure to other treatment approaches, such as parent interventions (e.g., consultation, education and training), family interventions (family therapy, family empowerment and support), and school and community interventions that may have less demonstrated empirical support but has a significant impact on the child's whole system (La Greca & Hughes, 1999; Spirito et al., 2003).

Effective case management when doing these interventions is vital in psychotherapy with adults and hence also in child psychotherapy (Pickar & Lindsay, 2008). Without goal-directed behaviour, psychotherapy can be reduced to no more than a friendly chat or play with no scientific basis (Swart & Wiehahn, 1979). Decisions about the most appropriate and time-

efficient form of treatment for a particular clinical problem, frequency and intensity of treatment, when to reduce the frequency of the sessions with the child, and when to end a course of treatment are important to include in training child psychotherapists (Pickar & Lindsay, 2008).

v. Research methods and systems evaluation.

In all aspects of training and professional activities, child psychologists should strive to maintain an empirical orientation (Spirito et al., 2003). Child psychologists conduct assessment, treatment, epidemiological, and prevention research (Spirito et al., 2003). Training in the processes necessary to conduct clinical research and treatment outcome studies is particularly important (Spirito et al., 2003). Trainees usually have the opportunity to conduct clinical research that includes analogue, observational, cross sectional, prospective longitudinal designs and retrospective designs, as well as controlled treatment outcome research (Spirito et al., 2003). There are also opportunities for students to design qualitative research and single-subject experimental methods that may be applied to low-incidence cases (Spirito et al., 2003). In conducting and writing up the research students should be aware of the most recent ethical and regulatory guidelines as they apply to clinical research (Spirito et al., 2003). Training in the treatment of human subjects and getting experience with writing protocols and assessment documents for hospital and university institutional review boards forms part of the training of a child psychotherapist (Spirito et al., 2003). Also included in the training is providing opportunities to critically evaluate the quality of research in the field, thus developing critical reasoning skills (La Greca & Hughes, 1999).

vi. Professional, ethical, and legal issues.

Pertaining to children, adolescents, and families, child psychologists need to be aware of professional, ethical and legal issues pertinent to children and adolescents with specific physical, emotional and learning challenges (Spirito et al., 2003). It further includes child abuse reporting, custody evaluations, confidentiality of child and parent report, the child's right to agree to or refuse treatment, obtaining informed consent, and limits of privilege communication (House, 2008).

Similarly, when consulting with other health care professionals and providers who refer patients and families for psychotherapy, special ethical issues may arise regarding situations of privileged communication, definition of the primary client (e.g., referring physician, child, caregiver, or family member), and delineation of the respective roles and boundaries of patient care among the providers (Spirito et al., 2003). Appropriate communication in health care settings, including adequate documentation in medical records, is an important professional skill that needs to be emphasised in training (Spirito et al., 2003). Many ethical and legal issues arise in the communication of information to the patient, family members, and health care providers that need to be addressed during training (Spirito et al., 2003). Training programmes for child psychologists usually offer seminars, lectures, and directed readings on the ethical and legal issues specific to child psychology (Spirito et al., 2003).

vii. The role of the clinical child psychotherapist.

The role of the clinical child psychotherapist is one that is multifaceted. First and foremost it is the role of the child psychotherapist to foster a therapeutic relationship with the child and the child's parents (Mash & Wolfe, 2005). Children are often not self-referred, so

effective rapport with a child or adolescent is paramount for initial investment in therapy and a positive treatment outcome (Pickar & Lindsay, 2008).

Training focuses on equipping a therapist with a wide range of child-responsive behaviour while maintaining treatment integrity (Pickar & Lindsay, 2008). Trainees need to learn to use a technique adapted to the developmental level of the individual child in order to build rapport with the child (Zimmer, 2001). Therapist flexibility and creativity are conceptualised as engagement-enhancing strategies (Chu & Kendall, 2008; Herschelle, McNeil & McNeil, 2004). Most common forms of flexibility include providing multiple/detailed examples, adapting lessons to a child's interests, allowing a child freedom in discussion, to make the session more active and demonstrating lessons in multiple formats (e.g., games, art, role plays, involving others) (Chu & Kendall, 2009).

The therapeutic alliance in child and family work is however more complex than in adult therapy, as it involves the therapist's relationship not only with the child but also with the parents (Pickar & Lindsay, 2008). Training programmes hence stress the importance for trainees to build relationships with children and their parents, characterised by warmth, acceptance, and kindness (Chu & Kendal, 2009; Pickar & Lindsay, 2008). Vital to the therapeutic rapport is a non-judgmental attitude towards their clients and the parents (Spirito et al., 2003).

An important part of training child psychotherapists is to teach the trainees to have a goal in mind, then to attend closely to children and their parents' verbal and non-verbal behaviours, to which they then have to adjust the timing, tone, and content of their own behaviour. In essence, the trainee is then being trained in strategic intervention (Isaacs, Embry & Baer, 1982). The importance of observation is essential in this and is also stressed

in several training programmes as non-verbal activity is an important mode of communication in children and varies widely according to their development (Mash & Wolfe, 2005).

The role of the child psychotherapist has transformed from these traditional roles that focus on the client and parents to more unorthodox roles that are relevant to the current health context (La Greca & Hughes, 1999). This involves the role to consult with providers from other disciplines in a variety of settings (Drotar, 1995). Children and adolescents served by health care systems often require evaluation by multiple disciplines (Spirito et al., 2003). It is important for child psychologists to be able to liaise with the different disciplines about a client whilst maintaining confidentiality with the client (Drotar, 1995; Spirito et al., 2003).

Another important role for child psychologists is that of psycho-educator; promoting healthy lifestyles and preventing the development of health-risk behaviours in both healthy and chronically ill children (Spirito et al., 2003).

In investigating the role of the child psychotherapist it became evident that there is certain skills that are important for child psychotherapists to have, which need to be addressed in training.

3.8.2.1.5 Important skills in working with children.

In conducting child psychotherapy there are several skills that are considered crucial for effective results (Mash & Wolfe, 2005; Sori & Sprenkle, 2004). Sori and Sprenkle (2004) however attempted to find empirical evidence as to which skills are essential to effective child psychotherapy.

Sori and Sprenkle (2004) found that therapists who works successful with children have to develop certain key attributes. Respecting children and their ways of being were regarded the most important attributes by child therapists (Sori & Sprenkle, 2004). Other attributes that were considered important are a therapist's flexibility, own playfulness and being comfortable with the child client (Sori & Sprenkle, 2004; Swart & Wiehahn, 1979). An attitude that is warm, congruent and caring was also rated as a significant factor in effective child psychotherapy (Sori & Sprenkle, 2004).

Apart from therapist attributes, relational skills are essential to effective therapy work with children (Sori & Sprenkle, 2004). The ability to show empathy and confirm a child client has been found to have significant influences on the therapeutic relationship (Sori & Sprenkle, 2004). The therapist's ability to build rapport, join and emotionally bond with children and their parents are also a key factor in effective psychotherapy with children (Sori & Sprenkle, 2004). This includes how to talk to children of all ages and how to interact with them in a creative manner (Sori & Sprenkle, 2004).

In order to apply these relational skills discussed above it is a prerequisite for the therapist to be able to conceptualise the child's case in context of his/her system (Sori & Sprenkle, 2004). This implies the ability to do a detailed evaluation of the various relationship variables in the child's system to gain an understanding of the reciprocal impact a child's behaviour has on the family and of the family's functioning on the child's behaviour (Sori & Sprenkle, 2004). In turn the psychotherapist also needs to be sensitive to his/her own influence on the child and the child's influence on him/her (Swart & Wiehahn, 1979).

There are several techniques and approaches which can be used to facilitate the development of these skills discussed and which will be elaborated on in the next section.

3.8.2.1.6 Methods of training.

The imparting of specific skills, abilities and knowledge to a trainee can be done in various ways. Each training programme should use training methods that help trainees acquire both the declarative knowledge base in clinical child psychology as well as procedural knowledge such as intervention skills (Patton, 2000). A number of studies has shown the superiority of multi-component training packages which have combined several training methods (Bailey et al., 1980; Bouchard et al., 1980; Dimeff et al., 2009; Isaac, Embry & Baer, 1982). There is no specific technique that has been found to be the most, or only, effective technique – which advocates the use of multiple-training techniques for maximally effective training (Isaac, Embry & Baer, 1982).

In review of the studies investigated in this study, the different paradigms in child psychotherapy all implement different models of training. It is however evident that, in an attempt at efficiency, a balance between theory and practice is strived for when training child psychotherapists. As Patton (2000, p.67) states; “Training programmes need to minimise the discontinuities between theory and practice and thereby bring about a closer connection between the two.”

The following discussion will be done by dividing the literature into training methods for teaching the theory and training methods that focuses more on practice.

i. Methods for theoretical training.

Didactic instruction

Didactic instruction can be defined as the delivery of factual information (Herschelle, McNeil & McNeil, 2004). Using case examples, discussing implementation strategies,

giving lectures, demonstrations, videos, and readings are all common forms of didactic instruction (Goodyear et al., 2000; Herschelle, McNeil & McNeil, 2004). The goal of didactic instruction is for students to acquire the basic "must know information" about a subject (Weissman et al., 2006). Didactic instruction typically puts students in a passive role, hence it is proposed to limit didactic instruction to 10-15% of a training programme (Weissman et al., 2006).

Didactic training has been found effective in several training paradigms when used in combination with other methods (Goodyear et al., 2000). Recent reports have articulated the didactic and clinical experiences believed necessary for psychology trainees preparing to work with children, adolescents, and families (Spirito et al., 2003). What distinguishes didactic training with psychotherapists from didactic training on a pre-graduate level is the facilitation of ongoing comparison between hypotheses and observations which underlies empirical research and fosters a greater spirit of critical thinking and creativity in candidates (Weissman et al., 2006).

In child psychotherapy training there is a great emphasis on skills development and working in accordance with a clear theoretical framework which is ideal to be taught through didactic training (Spirito et al., 2003). In an attempt to make didactic instruction more tangible, manuals can be used.

Manuals

Manuals designed for child psychotherapy training generally includes information on developmental, theoretical, systems integration, and the application of the treatment to various age groups (Weissman et al., 2006). Furthermore, information on therapy process

variables, such as the importance of flexibility and case management issues are also included in some training manuals (Herschelle, McNeil & McNeil; Weissman et al., 2006).

Treatment manuals have played a vital role in the evaluation and dissemination of child psychotherapy interventions because of their session-by-session account of therapy activities (Herschelle, McNeil & McNeil, 2004). Manuals offer a level of detail that allows for standardisation of treatment (Herschelle, McNeil & McNeil, 2004). Some authors have advocated for treatment manuals, arguing that they can enhance clinical outcomes by specifying procedures so that adherence and competence can be assessed (Dimeff et al., 2009) and by capitalising on an actuarial approach to treatment decisions. Unnecessary variability can also be reduced, and accountability, development of practice guidelines, and formulation of specific treatment recommendations for clinical practice can be improved (Herschelle, McNeil & McNeil, 2004). Manuals also provide invaluable “how to” resources, in addition to theoretical books and articles (Herschelle, McNeil & McNeil, 2004).

ii. Methods for practical training.

Experiential learning

Kolb’s (1984) model of experiential learning has been one of the most influential theories of the development of training programmes and is implicit in the way that trainees are assisted to develop competence in therapy and training (Sheikh, Milne & MacGreggor, 2007). It includes conceptualising, experiencing and experimenting (Sheikh, Milne & MacGreggor, 2007). To date, most psychotherapy training has followed this route using an

internship model together with a graduate education in order for the trainee to execute what they have learned (Herschelle, McNeil & McNeil, 2004; Sudak, 2009).

Methods used frequently in training are role-play, psycho-drama and other forms of behavioural rehearsal (Patton, 2000; Sudak, 2009, Swart & Wiehahn, 1979). Training programmes currently use technology to record the experiential learning, such as feedback through reviewing audio- or videotapes of sessions with patients (Spirito et al., 2003). This provides the listener with the words, tone of voice and movement that can be used in a observation exercise in training but also as commentary in supervision (Swart & Wiehahn, 1979).

Supervision

It is considered that therapeutic skills are developed, at least in part, from specific feedback and guided practice, which are offered by supervision (Chu & Kendal, 2009; Theriault & Gazzola, 2006). Supervised clinical experience remains the gold standard for psychotherapy education and also in the case of child psychotherapy (Sudak, 2009; Chu & Kendal, 2009). Supervision serves as a form of training as it provides the trainee with constant and sensitive feedback (Chu & Kendal, 2009). The role of supervisors in clinical child psychotherapy training cannot be over emphasised (Theriault & Gazzola, 2006; Spirito et al., 2003).

Trainees frequently follow the model often described as “see one, do one, and teach one” (Spirito et al., 2003). Therapeutic techniques can be taught at the moment when the therapist is using them (Swart & Wiehahn, 1979). Supervision is a vital ingredient of effective training and can take on many forms, such as individual supervision with a clinical

supervisor focusing on feedback and training, small group case presentation and small group supervision of tape-recorded case material (Sudak, 2009).

During supervision the emphasis is on meta-cognition as the faculty by which the mind has knowledge of itself and its operations, or by which it deals with ideas—‘thinking about thinking’, this concerns challenging assumptions or procedures so as to inform decisions and actions, leading to a monitoring phase for the trainee (Sheikh, Milne & MacGregor, 2007).

The objectives of supervision include awareness of the limits of own competence; using supervision to reflect on practice; and developing strategies to handle the impact of own practice; knowing yourself and understanding how your experience shapes your subsequent encounters with the world (Cross & Papadopoulos, 2003). More specifically it represents that part of the curriculum that is dedicated to ‘developing in trainees the capability to reflect critically and systematically on the work-self interface . . . fostering a personal awareness and resilience’ (Gillmer & Marckus, 2003, p. 23) necessary for optimal professional functioning and self care (Therriault & Gazzola, 2006). Swart and Wiehahn (1979) empathetically states that it is only by involvement that we learn.

The central themes extracted from the above literature review will be presented in chapter 4.

3.8.2.2 Semi-structured interviews.

Semi-structured interviews were held with three independent psychologists. The following interview agenda was created on the basis provided by the narrative literature review in the previous section:

1. Based on your experience in the field of Teddy Bear Therapy, what would the essential features of a Teddy Bear Therapy training programme for psychotherapists be?
2. From the literature that I have reviewed it is evident that prior to training, most training programmes on child psychotherapy has certain requirements candidates have to meet in order to function successfully in the training setting. In the context of Teddy Bear Therapy training – what is in your opinion the requirements a trainee has to meet before engaging in training?
3. What are the most important skills for therapists to develop in order to be effective as Teddy Bear therapists?
4. What training methods would you recommend to train these skills to psychotherapists in Teddy Bear Therapy?
5. According to my research, the training of child psychotherapists can broadly be grouped into experiential learning and theoretical learning. Whereas experiential learning should form a significant part of the training process. How would you incorporate that into a Teddy Bear Therapy training programme?
6. What theoretical information would you include in the training process?
7. From my research, manuals were recommended as a way to include theoretical information. What would you recommend should be included in such a manual when training Teddy Bear therapists?

The verbatim transcripts of the interviews are presented in Appendix A.

3.8.3 Data analysis.

The data were analysed as proposed in the research design. The transcripts of the interviews were analysed by means of thematic analysis by the researcher herself. The steps as set out by Aronson (1994) and cited in *Section 3.4* were used to reduce the data to common themes that emerged across interviews.

By interpreting the identified themes the researcher was then able to determine how a training programme for psychotherapists on Teddy Bear Therapy would look like according to three established psychotherapists. In addition to this, the researcher was able to combine this information with information obtained from the literature review to get a holistic picture.

The drawing of conclusions and the verifications were directed by the research question and the aim of the study. Bosman (2004) states that the researcher's role involves interpreting and explaining observations or data by formulating hypotheses or theories that account for observed patterns and trends in the data. This implies relating the results, outcomes and findings of a study to current existing theoretical frameworks, models and the related hypothesis, and also assessing whether these are confirmed or falsified by the information gained from the new study (Bosman, 2004).

The results and findings are presented and discussed in the next chapter.

Chapter 4: Results and Discussion

4.1 Introduction

In this chapter the results and discussion will be presented. In presenting this, it is however necessary to restate the aim of the study in order to set the context of what is to follow.

4.2 Aim of the Study

The aim of this investigation is to develop a Teddy Bear Therapy training programme for psychotherapists.

4.3 Research Results

The results of the research will now be discussed. Firstly, the conclusions drawn from the literature review on the training of child psychotherapists will be presented, whereafter the data of the interviews will be analysed and presented.

4.3.1. Conclusions drawn from the literature review on the training of child psychotherapists.

Based on the literature presented in section 3.8.2.1 *Narrative literature review*, certain conclusions were made on the nature of a training programme for child psychotherapists. These will be presented, punctuating from a general point of view four broad themes covered in most child psychotherapy programmes, followed by the presentation of requirements trainees have to meet before engaging in training. Thereafter a more specific stance is taken with the presentation of specific elements identified in most child psychotherapy training programmes, as well as certain skills that are necessary to develop to

be an effective child psychotherapist. Lastly, training methods to facilitate the specific elements identified and facilitate the development of these skills are outlined.

As outlined in section 3.8.2.1.2, four general themes in the training programmes of child psychotherapists were identified:

- Exposure to interdisciplinary, coordinated, and comprehensive models of care.

Interdisciplinary, comprehensive models of care focus on impacting and integrating systems relating to the child, such as educational, health care, child welfare, family, and community systems rather than focusing on the individual child (La Greca & Hughes, 1999). This implies that child psychotherapists require exposure to working in an interdisciplinary context and expertise in appropriate referrals to said systems when necessary (La Greca & Hughes, 1999).

- Knowledge of a developmental framework with emphasis on normal development and developmental theory.

Incorporating lifespan developmental theory, and, by implication, a sensitivity to the developmental appropriateness of specific behaviours and the multiple changes children go through, will equip the therapist in identifying which behaviours are age appropriate and which not, allowing them to decide when to intervene and when not and how to intervene when necessary (Spirito et al., 2003).

- Adopting a multicultural perspective throughout all aspects of training.

Child psychologists need to be aware of the cultural and ethnic context in which medical and psychological services are delivered to children and families (Spirito et al., 2003). Child psychology training should enhance clinicians' sensitivity to ethnic, cultural,

and religious factors that affect health beliefs, as well as family, health care, and professional relationships (La Greca & Hughes, 1999).

- Focusing on personal professional development.

The training context needs to facilitate opportunities where trainees receive theoretical input to develop professional skills, but also opportunity for them to bring relevant personal experiences to their training in order to develop personally (La Greca & Hughes, 1999).

From these themes it is evident that specific skills and knowledge are required before training commences. For this reason, at least a graduate qualification is a requirement prior to training. In an attempt to make training most sufficient according to the needs of the trainees, a needs assessment is proposed prior to the beginning of each training programme (see section 3.8.2.1.3).

This said, there are more specific elements than the themes identified that have been recognised as essential in the training of child psychotherapists and was discussed in section 3.8.2.1.4. These seven elements include:

- Life span developmental psychology.

The knowledge of normal and abnormal development and behaviour expected in children across different developmental phases enables the therapist to identify problematic behaviour that needs intervention (Pickar & Lindsay, 2008).

- Life span developmental psychopathology.

Life span developmental psychopathology refers to whether emotional distress within a child is within normal limits for children or whether psychiatric or psychotherapeutic intervention is needed (Spirito et al., 2003).

- Child, adolescent, and family assessment methods.

Experience with the administration and interpretation of psychometric assessment are essential for psychotherapists working with children and their families (Mash & Wolfe, 2005). Assessment in neurological functioning, intellectual functioning, personality, behaviour and family provide the psychotherapist with a holistic diagnosis of the client's problem (La Greca & Hughes, 1999). Knowledge about assessment enables the therapist to identify the problem and assists the therapist to intervene on the appropriate level (La Greca & Hughes, 1999).

- Intervention strategies.

Exposure to and experience with empirically supported interventions for a variety of childhood difficulties are essential for child psychotherapists (Spirito et al., 2003). Efficient training is therefore crucial.

- Research methods and systems evaluation.

In all aspects of training and professional activities, child psychologists ought to strive to maintain an empirical orientation (Spirito et al., 2003). Child psychotherapists should thus be expected to conduct assessment, treatment, epidemiological, and prevention research (Spirito et al., 2003). Training in the processes necessary to conduct clinical research and

treatment outcome studies is thus particularly important to ensure child psychotherapists functions with an empirical, scientific accuracy (Spiriot et al., 2003).

- Professional, ethical, and legal issues pertaining to children, adolescents and families.

Knowledge and experience with issues such as reporting abuse, custody evaluations, the confidentiality of child and parent reports, the child's right to refuse treatment, obtaining informed consent and limits of privilege information are important to include in a training programme for child psychotherapists (Spirito et al., 2003).

- The role of the clinical child psychotherapist.

The diverse role of a child psychotherapist needs to be stressed in a training programme (Mash & Wolfe, 2005). This includes the responsibility to build rapport with both child and parent (Chu & Kendal, 2009; Pickar & Lindsay, 2008; Spirito et al., 2003); to be a strategist (Isaacs, Embry & Baer, 1982); to observe accurately (Mash & Wolfe, 2005), to consult with other professionals (Drotar, 1995; Spirito et al., 2003) and to be a psycho-educator (Spirito et al., 2003).

Aside from including theoretical training, an emphasis on practical skills is necessary, as identified in the review. The skills found to be necessary for a child psychotherapist to be an effective child psychotherapist was discussed in section 3.8.2.1.5 and can be listed as:

- respecting children and treating them with dignity;
- being flexible and lenient enough to adapt to the child's needs;
- playfulness whilst maintaining your therapeutic role will ensure effective rapport;
- the ability to be comfortable with children;
- conveying warmth in your interaction with children;

- congruence or ‘realness’ in your relationship with a child client;
- caring attitude towards children and parents;
- the ability to have empathy but also to convey this understanding to the client and caretakers;
- the ability to confirm the child and parents for appropriate behaviour;
- the ability to build rapport with a child, which varies from building rapport with an adult. The therapist needs to communicate on the level of the children to earn their trust and facilitate therapeutic relationships;
- the ability to show creativity in ways that engage children, grab their attention, build rapport and facilitate trust;
- efficient conceptual skills – or rather the ability to do a detailed evaluation of the various relationship variables in the child systems and interpret these observations in a meaningful way;
- the ability to evaluate the child’s system to gain an understanding of the reciprocal impact a child’s behaviour has on the family and of the family’s functioning on the child’s behavior; and
- self-awareness, which is essential for a therapist. The ability to know what impact you as therapist have on children or their parents and what impact they have on you and how that may influence the therapeutic process.

The methods used to train these skills to child psychotherapists includes (see *section 3.8.2.1.6*):

- didactic instruction: Lectures, demonstrations, videos and readings, among others;
- written instruction: Manuals, recommended readings and textbooks, among others;

- experiential learning: Role play, psycho-drama, behaviour rehearsal and internships; among others; and
- supervision: Case presentations, individual supervision, group supervision, feedback and video or voice recordings, among others.

The studies reviewed emphasised the range of experiences important in the training of child psychologists, which has several implications for developing a training programme for psychotherapists in Teddy Bear Therapy. A Teddy Bear Therapy training programme should thus aim to facilitate as wide a range of experiences as possible to facilitate the training of effective child psychotherapists. It can thus be concluded that a programme combining personal growth and experience and an awareness and improvement of personal deficiencies, combined with a training in skills and theory, is most effective in training psychotherapists working with children (Swart & Wiehahn, 1979).

In addition to the literature consulted, interviews were conducted with clinicians with experience in training child therapists in Teddy Bear Therapy. These will now be presented and discussed.

4.4 The Thematic Analysis of the Interviews

Interviews were conducted with three clinicians who have had extensive experience with Teddy Bear Therapy, as well as the training of psychotherapists. The thematic analysis was done by identifying themes from transcripts of the interviews that were held with the clinicians and following the steps as set out by Aronson (1994) in section 3.4.

To ensure a sense of transparency the transcripts of these interviews are included in this dissertation (Appendix B), but for confidential considerations no identifying information of the three clinicians were provided.

The analysis of each of the clinicians is presented below (in tabular format). Corresponding themes have been identified and numbered. This is followed by an integration of the respective themes.

After this is presented, an integration of the conclusions derived from the literature review and the themes identified from the interviews will follow. In conclusion to this, a final discussion will follow. The chapter is concluded with a training programme for psychotherapists on Teddy Bear Therapy and a relevant manual based on the analysed data.

4.4.1 Question 1: “Based on your experience in the field of Teddy Bear Therapy, what would the essential features of a Teddy Bear Therapy training programme for psychotherapists be?”

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3
<p>The programme will need to equip the practitioner to really develop an <u>empathetic understanding of children</u>¹ between the ages of about 3 and 12. It should also equip the practitioner to really <u>understand the developmental stages of children</u>³ in order to have an accurate idea of what they are capable of at various ages and phases of development. And then it should equip the practitioner with certain <u>details of the procedure of TBT</u>². It should also equip</p>	<p>One of the first things is a basic rationale of <u>TBT – what it involves</u>². The second aspect to it involves understanding how to work with children. That in principle how you <u>approach a child is different</u> to how you approach an adult. Just being aware of that essential difference.</p> <p>And another important feature would then be really looking more specifically now when <u>TBT is indicated</u>² – so looking at the age for when it is relevant and then</p>	<p>The essential features of a TBT training programme for psychotherapists would essentially be divided into a theoretical element and a practical (experiential) element.</p> <p>The theoretical element would include an understanding and knowledge of <u>Child Development and Child Developmental Theories in Psychology</u>,³ including training (both theoretically and practically) in using <u>the</u></p>

<p>the practitioner with the necessary <u>basis of ethics</u> and also the relevant sections of the <u>Children's Act</u>, so that the practitioner would know within what scope he/she can practice and to what extent the parents/ caregivers need to be involved.</p>	<p>understanding that it has <u>both therapeutic uses and it also serves assessment purposes</u>² so that you can use it to investigate and it can assist with diagnosis.</p> <p>Another important feature here would be to look at how to <u>establish a therapeutic relationship with a child</u> – so in that respect if you would work with an adult you would use person-centered therapy, hence you have to do the same with a child, it's just the way you do it that is different. So there would have to be – I suggest that there is emphasis on how to engage the child in a safe way. That involves things like the use of drawings, playing with the teddy to work through any anxiety the child has towards the clinician, in other words how to establish the therapeutic relationship – that is the key there.</p> <p>Another important feature is how to understand the nature of the problem, which involves <u>diagnosis</u>⁴ – key there is that when working with children it is necessary to <u>first interview adults/other caregivers</u>. It is very important because it helps to clarify the nature of the problem – this is particularly important because when working with children, the approach to a child needs to have appropriate structure, otherwise if completely unfocused, it can become</p>	<p><u>IPA as diagnostic tool</u>⁴, an understanding the presenting problem according to Charl Vorster's Systems Theory. Theoretical and practical training that would enhance the therapists skills of <u>empathy</u>¹, congruence, unconditional positive regard and specifically the therapists <u>skills in effective storytelling</u>, which may be preceded by a theoretical understanding and knowledge of Gardner's Storytelling Technique as a background or foundation on which to build.</p> <p>Finally, both a <u>theoretical and a practical guidance and understanding of TBT</u>.²</p>
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	<p>threatening and unsafe for the child – so it’s important to have sufficient structure. And because children by their nature of communication is often symbolic, they engage in fantasy – it is even more important to use the caregivers to set the context to better understand the difficulty that is occurring in the family.</p> <p>The next feature should be <u>how to introduce storytelling</u>, in other words how to introduce TBT, which involves establishing context – how do you get across to the child, the therapeutic activity you are now going to engage in. For instance explain to the child that you are now going to play a game of pretend and that you are going to pretend that you are in a radio station and you are going to tell a story to boys and girls and you are going to tell a story about the teddy.</p> <p>Then the next feature it should involve is addressing <u>how the story is constructed</u>, in other words what the story is about, and that requires considerable skill, because the story should involve the therapeutic elements of the problem and the client’s system – or the functioning of the system. It has to be presented in a way that is not threatening to the child – so that they feel safe so that’s one of the features that needs to be addressed.</p>	
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	<p>The next feature should be the use of empathy – how to <u>empathise with a child</u>¹ in the form of storytelling.</p> <p>Other features should involve <u>problem solving</u>, because part of TBT involves not only the expression of empathy but also problem solving. This is not addressed in the same way as with an adult – with the child it would be addressed through the story.</p> <p>Another feature should be how to end / terminate the storytelling – and here one should bear in mind that that sets up the therapeutic change or what should happen between now and the next session – <u>where to focus the child – what kind of activities to engage the child in.</u></p> <p>Another feature should be to establish <u>feedback with the child about the therapeutic experiences</u> or in this case about the storytelling – what do they think about the story as it is now playing back to the child – just basically some feedback around that and then also feedback from the child as to how they feel about the teddy and how they feel about taking the teddy home cause you want to establish there what kind of identification is there now with the teddy.</p> <p>Another essential feature is <u>involving the parents</u>. It is very important to involve</p>	
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	<p>them and to invoke their help in the play therapy – specifically outlining that they should not investigate and ask questions about the child’s session or the nature of the relationship with the teddy bear because one of the rationales of TBT is that it is a form of play therapy and children process things often on an unconscious or subconscious way and if you bring it to their attention it can be threatening, uncomfortable and it can take away from the effectiveness. So parents shouldn’t then go and ask questions about what was involved and start probing.</p> <p>And then also another feature there is <u>eliciting a parent’s support to the process with the teddy</u> that the child is now going to take home and that the teddy should be taken to school or wherever it is appropriate.</p>	
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4.4.1.1 Integration: Question 1.

i. Themes identified in all three interviews.

A prominent feature identified by all three clinicians was that the training programme need to equip the trainees with an empathetic understanding of children¹.

Details on the procedure of Teddy Bear Therapy² featured in all three interviews as an essential element of the training programme. Clinician 3 divided this element into theoretical and practical guidance and understanding of Teddy Bear Therapy, while Clinician 2 specified what features of Teddy Bear Therapy to focus on. This included the indications for Teddy Bear Therapy, how to introduce the process of storytelling and how to construct the story therapeutically.

ii. Themes identified in two interviews.

According to two of the three clinicians, the proposed training programme should enable the trainees to make an accurate diagnosis and have a clear understanding of the nature of the problem⁴. Clinician 2 identified the use of the IPA as diagnostic tool.

An understanding of the developmental stages of children³ will ensure that the therapist has an accurate idea of what the child client is capable of at various ages and phases of development.

4.4.1.2 Conclusion.

The essential features of a training programme for psychotherapists on Teddy Bear Therapy identified in the three interviews included the use of empathy towards children and that the training on Teddy Bear Therapy needs to consist of a practical as well as theoretical component.

In order to conduct Teddy Bear Therapy successfully, an understanding of the nature of the problem presented by the child client is key to include in a training programme on Teddy Bear Therapy. An understanding of the IPA as diagnostic tool is recommended to accomplish this.

Lastly, an overview of the developmental phases of children are deemed as an important element to include in the training programme.

4.4.2 Question 2: “From the literature reviewed it is evident that prior to training, most training programmes on child psychotherapy has certain requirements candidates have to meet in order to function effectively in the training setting. In the context of Teddy Bear Therapy training – what is in your opinion the requirements a trainee has to meet before engaging in training?”

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3
<p>Basically <u>the requirements of an effective therapist</u> - psychotherapist, that certainly will be <u>high levels of unconditional PR, congruence, and exceptionally high levels of empathy¹</u> and also a <u>high level of flexibility²</u> and a <u>preference to work with children³</u> therapeutically. Generally a sufficiently high functioning therapist and all the – well it’s actually quite an extensive topic so I would want to go into all the details, but I would say whatever you probably found in the literature described as the minimum requirements for an effective therapist.</p> <p>And in addition to that a special affinity for children and then exceptional empathic abilities regarding</p>	<p>I would say the main requirement is firstly that they have a master’s degree within the therapeutic field – so that includes forms of psychotherapy – and to a limited degree even social work. Before this they should also have had some <u>exposure to person centred therapy¹</u> because TBT is based on a person.-centred approach. They should also have had exposure to the systems approach and ideally some exposure to the IPA. The reason for this is that TBT is a more specialised form of therapy so it’s an advanced form of therapy. And it is based on an integration of systems theory, communications theory and a person.-centred therapy approach – so they need</p>	<p>A trainee would first and foremost need to have a <u>passion and desire to work with children³</u>. They would need to demonstrate <u>high degrees of empathy, congruence, UPR¹</u> and have effective problem solving skills, and finally they should demonstrate a good <u>flexibility²</u> to be able to work well with and relate to children of a wide range of ages.</p>

<p>children. The ability to really enter the frame of reference of a child and to really understand a child's world.</p>	<p>some exposure to that. Also what is important is what I indicated earlier, the approach to a child is different to the approach to an adult and they should have some knowledge of developmental psychology. So it is to set a context for working with a child.</p>	
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4.4.2.1 Integration: Question 2.

i. Themes identified in all three interviews.

High levels of empathy, unconditional positive regard and congruence¹ were regarded by all three clinicians as requirements trainees have to adhere to prior to training. Clinician 1 described it as elements constituting an effective psychotherapist, whilst Clinician 2 labeled it as elements of person-centred therapy.

ii. Themes identified in two interviews.

The ability to demonstrate flexibility² when working with children of different ages and needs, as well as an affinity for working with children therapeutically³ featured in two interviews as requirements prior to training.

4.4.2.2 Conclusion.

Before training in Teddy Bear Therapy commences, trainees are expected to exhibit high levels of empathy, unconditional positive regard and congruence. The ability to show

flexibility and a preference and affinity for working with children in a therapeutic manner were also regarded as prerequisites.

4.4.3 Question 3: “What are the most important skills for therapists to develop in order to be effective as Teddy Bear therapists?”

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3
<p>Really <u>in-depth knowledge of the developmental phases of children</u>. Exceptional <u>high levels of empathy</u>¹ regarding children and their world of the child and also a keen <u>awareness of the therapeutic abilities of stories</u> and the impact of stories. And also in that respect have an <u>effective and in-depth grasp of interactional therapy</u>² in the broader sense – and the impact of individuals on each other. A good grasp of <u>systems theory</u> and the <u>ability to apply it</u>³. High level of <u>problem solving expertise</u>, the therapist should be able to be an exceptional problem solver <u>within the frames of children</u>⁴ because in essence the children needs the therapist to assist with solving their problems and difficulties. The therapist should also have an <u>exceptional ability to translate the therapeutic messages and concepts into</u></p>	<p><u>Skills in a person.-centred approach</u>¹ – that is key. Having skills in <u>systems approach</u>³ and in communication. <u>The IPA</u> – the importance in the IPA and having skills in that is <u>really to understand the presenting complaint in relation to the child’s environment and interaction</u>² and that takes a lot of skill. And then some skill in addition to the psychological diagnosis that has to do with the IPA is how to engage a child in a way that is not threatening and yet not social – so it’s <u>how to engage with the child in an asocial, therapeutic way</u>⁷ with sufficient levels of security and trust so that requires some skill.</p>	<p>The most important skills would be: <u>creativity</u>⁶, <u>flexibility, congruence, UPR and essentially a high degree of empathy</u>¹. Good <u>storytelling techniques</u>⁵ and <u>good problem solving skills</u>⁴.</p>

<p><u>stories and to convey therapeutic messages via stories on the level attuned to the particular child</u>⁵. Then in addition the therapist should be a <u>creative story teller</u>⁶ and should have the skill to <u>really grab the attention of the child, to involve the child effectively</u>⁷ and to tell a creative story in tandem with the child.</p>		
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4.4.3.1 Integration: Question 3.

i. Themes identified in all three interviews.

Skills that constitute an effective Teddy Bear therapists according to all three clinicians are exceptional high levels of empathy and the ability to convey it¹. Clinician 2 refers to it under the concept of person-centred skills.

ii. Themes identified in two interviews

An understanding of interactional therapy² and systems theory³ and the ability to apply it were identified by two clinicians as important skills for Teddy Bear therapists to exhibit. Clinician 2 elaborated by referring to the Interactional Pattern Analysis, which is a combination of both systems, as well as interactional therapy as a tool to use to understand the presenting complaint in relation to the child's environment and interaction.

According to two clinicians, problem solving expertise⁴ is part of the Teddy Bear therapists' repertoire, because in essence the children need the therapist to assist with solving their problems and difficulties through the use of stories.

The ability to tell these stories⁵ in such a way that the therapeutic messages get translated on the level of the child and have a therapeutic effect was regarded as a significant skill.

Creativity⁶ in this storytelling was also regarded as a necessary skill. Clinician 1 regarded creativity as a necessary skill to find ways to grab the attention of the child. The ability to involve a child effectively⁷ in an manner that is asocial but still therapeutic requires some skill.

4.4.3.2 Conclusion.

Skills important for trainees to develop in order to be effective Teddy Bear therapists include high levels of empathy towards children as well as the ability to show it.

An operational understanding of systems theory and interactional therapy, and skills necessary to be an effective therapeutic storyteller, which include creativity, good problem solving skills and the ability to engage with a child in a therapeutic manner are all skills identified in the interviews to be important for Teddy Bear therapists.

4.4.4 Question 4: “What training methods would you recommend to train these skills to psychotherapists in Teddy Bear Therapy?”

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3
<p>Specific <u>exercises to enhance empathy</u>¹, intensive <u>experiential learning</u>² into storytelling and the impact of stories in the broad sense and specifically in the context of children’s stories. Intensive <u>case studies should be worked through</u>³ thoroughly and <u>role playing</u>⁴ and <u>role rehearsal</u>⁵. <u>Continuous feedback</u>⁶ – in other words the essence is experiential learning and then, together with relevant <u>theoretical knowledge</u>⁷, there should be in-depth reading which should be made compulsory, especially again in the area of <u>developmental psychology</u>⁸, and child psychopathology. Then, a general <u>knowledge of child therapies</u>⁹, especially play therapy. Definitely exposure to <u>Richard Gardner’s Mutual Storytelling Technique</u>¹⁰ in terms of printed material as well as exercises. And then <u>periods of supervision</u>¹¹ – working under supervision where the sessions should be recorded and also be utilised as part of the process of supervision.</p>	<p>I would suggest a brief overview – a <u>theoretical</u>⁷ <u>introduction of what TBT involves</u>¹², then a demonstration of TBT, which would involve a complete session as demonstration. What is important there is that it need not necessarily be demonstrated because it is assumed that the participant or trainee has <u>had exposure to the IPA</u>¹³, person-centred and systemic approach the starting point should be the information derived from the interview with the caregivers and then actually demonstrating how to involve the child, how to engage the child, how the child separates from the caregivers, how to engage the child in a non-threatening way with drawings through demonstrations or role play of an actual case – my first choice would be a <u>visual case and then role play</u>⁴ – so it is engaging the child in drawing, involving the child to work through anxiety by playing with the teddy and then moving into story telling – so actually demonstrating that – how the storytelling was done</p>	<p>Training methods would need to incorporate a <u>theoretical</u>⁷ and <u>practical (experiential)</u>² element.</p> <p>Experiential would be demonstrated <u>through case studies</u>³. <u>Role playing</u>⁴ can also aid the experiential learning, however, I feel that exposure to numerous case studies, and <u>discussions around the case studies</u>⁴ would prove highly beneficial to trainees.</p> <p>Theoretical: Knowledge and <u>understanding of childhood psychological developmental theories</u>⁸, <u>brief understanding of how child psychotherapy has evolved</u>⁹, <u>IPA (Charl Vorster)</u>¹³; <u>Gardner’s storytelling technique</u>¹⁰ and finally <u>the theory underlying TBT</u>.¹²</p>

	<p>and the suggestion around that the teddy would go home with the child. Then I would suggest that the trainees would <u>then practice in ideally groups of three</u>.⁵ one person in the observer role ,one in the clinicians role and the other in the role of the client. Benefit there is that it is safe, the clinician gets to practice his skills in a way that is not threatening, the observer can give feedback about what is effective and what not – and the person playing the client is actually expanding their repertoire and becoming more sensitive around the child’s frame of reference. Fourth aspect around it should be feedback from the facilitator – so <u>active feedback</u>⁶ and training and the next I would recommend that a complete <u>theoretical overview is given of it</u>⁷ – why I suggest that this is done in this way is that then they have the experience of it and they can more acutely listen or be receptive of the nuances around it – if that is given in the beginning all of it can be lost. And then further <u>case studies</u>³ and <u>practice</u>⁵.</p> <p>There should ideally be a follow-up workshop – because you need to test this out and practice – so a follow-up workshop where there is further fine tuning around the application of TBT dealing with more</p>	
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	challenging cases – so it really should be in 2 stages this kind of training – an introductory course/a beginners course and then an intermediate to advanced course.	
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4.4.4.1 Integration: Question 4.

i. Themes identified in all three interviews.

Training methods would need to consist of a theoretical⁷ as well as experiential² (practical) component. Experiential learning could be demonstrated by working through case studies³ and doing role plays⁴. Clinician 2 specified in terms of what elements to focus on, such as starting with how to engage the child, for example through drawing, then how to relief the child of any anxiety by letting him/her play with the teddy and then how to introduce storytelling and Teddy Bear Therapy.

ii. Themes identified in two interviews.

To practice skills in Teddy Bear Therapy role rehearsal⁵ was recommended by two clinicians. Clinician 2 suggested that trainees practice in groups of three so that one trainee fulfills the role of observer, another the role of therapist and then the last trainee playing the role of the child client. The observer would give continuous feedback⁶, the therapist would fine-tune Teddy Bear Therapy skills and the child role would gain an empathetic understanding¹ of the real child client. Continuous feedback⁶ from the trainer would further

facilitate experiential learning and Clinician 2 stated that a theoretical overview of the feedback can be a significant training experience.

Theoretical knowledge on developmental psychology and theories⁸, the evolution of child psychotherapy⁹ and exposure to Richard Gardner's Mutual Storytelling Technique¹⁰ were recommended by two clinicians. Clinician 2 recommended that trainees have prior experience of the IPA¹³ whilst Clinician 3 recommended creating an understanding of the IPA. Lastly, theoretical information on Teddy Bear Therapy¹² was recommended.

4.4.4.2 Conclusion.

Training methods recommended to train trainees in Teddy Bear Therapy were grouped into experiential and theoretical learning.

Methods that aided experiential learning included role play, role rehearsal, working through case studies and active feedback from peers as well as the trainer.

Theoretical knowledge on developmental psychology, the historical evolution of child psychotherapies including the works of Richard Gardner's Mutual Storytelling Technique, and Teddy Bear Therapy were recommended. Prior exposure to the IPA or/and an understanding of it is necessary for Teddy Bear therapists.

4.4.5 Question 5: “Based on research on child psychotherapy training programmes, manuals were recommended as a way to include theoretical information. What theoretical information would you recommend should be included in such a manual when training Teddy Bear therapists?”

CLINICIAN 1	CLINICIAN 2	CLINICIAN 3
<p>I would include some <u>basic written material on TBT</u>¹ - because there is a section that sets out the <u>TBT process step-by-step</u>¹. I would include a reading list that should include <u>developmental psychology</u>², <u>Play Therapy</u>³, <u>Gardner’s Mutual Storytelling</u>⁴. Also specifically Ginotte’s book: ‘Between parent and child’ and a number of case histories – <u>case studies</u>⁵ – preferably with some verbatim examples of stories, and then also just a summary of existing research done specifically at this university – masters’ dissertations that has been done – just provide perhaps the extracts so they can briefly see how it was done and what has been found – to broaden their frames of reference.</p>	<p>Firstly <u>brief history – child psychotherapy</u>³, setting the context for child therapy and that should include <u>Gardner’s Mutual Storytelling Technique</u>⁴ and again setting the context for its orientation and assumptions which is a strong psychodynamic orientation then identifying later developments in Play Therapy or specifically storytelling and that’s <u>Charl Vorster’s introduction to TBT</u>¹. There specifically it should identify that it involves a combination of the person-centred approach, communications theory and the systemic approach. There should again be an overview of <u>developmental psychology</u>² – briefly an overview of that and that again set the context for working with the child. A brief summary of the person-centred approach with the key variables there. A summary of the IPA. The next step should be looking at it very much as a procedure now it should be – because it is complicated and steps can be omitted – so <u>describing this procedure</u>¹ and involving the following</p>	<p><u>Case Studies</u>⁵ with a discussion around types of problems encountered when working with children and solutions provided in a practical manner to the trainee through the TBT.</p>

	<p>aspects - interviewing the parents; drawing up the IPA, again I just want to emphasise the importance of that – it sets the context of working with a child when doing TBT in a meaningful way .Without that often you don't have clear context to work with. The next step in the procedure is the first session with a child – again as we discussed how to engage the child in a safe way – introduction of storytelling; facilitation of the child-teddy relationship and involvement with the parents so that they support and facilitate the process. What's really important is part of the theoretical information – the complete rationale for TBT which includes here getting across the idea that TBT involves setting up another therapeutic relationship with the child in which the child can engage with a new range of problem solving behaviour and the potential for experiencing or undergoing a corrective emotional experience – so just clarify that.</p> <p>What would be helpful is an <u>example – a case</u>⁵ with a client where the trainee can refer back to and also just a brief overview of the developmental stages for instance that should also be there.</p>	
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4.4.5.1 Integration: Question 5.

i. Themes identified in all three interviews.

The inclusion of case studies⁵ in a manual on Teddy Bear Therapy was recommended by all three clinicians as something a trainee can refer back to after or during training. Clinician 1 suggested a verbatim example of a story used in Teddy Bear Therapy or extracts from previous studies on the effectiveness of Teddy Bear Therapy. Clinician 3 recommended that the case history is followed with guidelines on how to address practical problems that can be encountered when working with children in Teddy Bear Therapy.

ii. Themes identified in two interviews.

In order to set the context for training in child therapy two clinicians recommended an overview on developmental psychology as well as the development of child psychotherapy. The latter includes a section on play therapy as well as Richard Gardner's Mutual Storytelling Technique.

Also important to include in the manual according to two clinicians is basic written information on Teddy Bear Therapy. This includes a section on the step-by-step procedure of Teddy Bear Therapy. Clinician 2 stated that it is important to specify in the manual that Teddy Bear Therapy consists of a combination of the person-centred approach, communications theory and systems theory.

4.4.5.2 Conclusion.

Theoretical information recommended to be included in a manual on Teddy Bear Therapy includes an overview of developmental psychology followed by a section on the development of child psychotherapy. Specific reference to play therapy and Richard

Gardner's Mutual Storytelling Technique were also regarded as important to include in such a manual.

Furthermore basic written information on Teddy Bear Therapy, such as the step-by-step procedure and specifically identifying the theories it consists of were recommended. Lastly, it was recommended to include case studies on Teddy Bear Therapy for trainees to refer back to with for example verbatim examples of stories, extracts from research on the effectiveness of Teddy Bear Therapy or a discussion on solutions to practical problems encountered when working with children in the context of Teddy Bear Therapy.

4.4.6 Integration of the conclusions drawn from the literature review with the themes identified in the interviews.

In this section the conclusions drawn from the literature review as presented in section 4.3.1 will be integrated with the conclusions drawn from the interviews with three clinicians in order to be able to formulate a training programme for psychotherapists on Teddy Bear Therapy.

The results from the literature review indicated four broad themes that are usually incorporated in child psychotherapy training programmes. Firstly, the importance of exposing trainees to interdisciplinary, coordinated, and comprehensive models of care implies that trainees are exposed to working in an interdisciplinary context or are trained to refer to other disciplines when necessary .

Secondly, adopting a multicultural perspective throughout all aspects of training was further indicated by the literature review as a general aspect to included in a training

programme. This will enable the child psychologist to be sensitive to ethnic, cultural and belief systems that may have an impact on the therapeutic relationship.

The literature review thirdly indicated that the training of a child psychotherapist should be on a personal as well as professional level. The focus should thus be to develop professional skills but also to use relevant personal experiences in the training process to develop personally.

Lastly, the literature review as well as the interviews which were more specific to Teddy Bear Therapy training, indicated the importance of including an overview of the developmental phases of children. The rationale behind this is to equip the practitioner with a sensitivity to the developmental appropriateness of specific behaviours, as well as have an indication of which level to engage with the child.

Specifically with reference to a training programme on Teddy Bear Therapy, the interviews with the three clinicians identified the essential features of a training programme for psychotherapists on Teddy Bear Therapy. Aside from the inclusion of information on developmental psychology as discussed above, the use of empathy towards children and an understanding of the IPA as diagnostic tool to understand the nature of the problem presented by the child client were deemed as essential.

From the literature review specific elements essential to include in a child psychotherapy programme are: life span developmental psychology; life span psychopathology; training in empirically-based interventions; research methods and systems evaluation; professional, ethical, and legal issues and the role of the child psychotherapist.

Knowledge and training on life span psychopathology enable the therapist to differentiate normal from abnormal developmental behaviour in order to identify behaviour that needs intervention.

Knowledge on life span developmental psychopathology will equip the clinician to identify whether emotional distress within a child is within normal limit for children or whether psychiatric or psychotherapeutic intervention is needed.

Experience with child, adolescent, and family psychometric assessment in terms of administration and interpretation enable the therapist to identify the problem and assist the therapist to intervene on the appropriate level (La Greca & Hughes, 1999).

Exposure to and experience with empirically supported interventions for a variety of childhood difficulties are essential for child psychotherapists and efficient training is thus crucial.

Research methods and systems evaluation are also important to incorporate in training child psychotherapists. Training in research methods and systems evaluation enables child psychotherapists to conduct assessment, treatment, epidemiological, and prevention research.

Knowledge of and experience with professional, ethical, and legal issues pertaining to children, adolescents, and families with issues such as abuse reporting, custody evaluations, confidentiality of child and parent report, the child's right to refuse treatment, obtaining informed consent and limits of privilege information are important to include in a training programme for child psychotherapists.

Lastly, the diversity of the role of the clinical child psychotherapist needs to be stressed in a training programme. This includes the responsibility to build rapport with both

child and parent; to be a strategist; to observe accurately, to consult with other professionals and to be a psycho-educator.

Before engaging in training and emerging into these aspects mentioned, the literature study indicated at least a graduate qualification as requirement. This implies a theoretical background which may differ across training contexts. In an attempt to make training most sufficient according to the needs of the trainees, a needs assessment is proposed prior to the beginning of each training programme.

According to the interviews, requirements specific to the context of Teddy Bear Therapy training are exceptional high levels of empathy, unconditional positive regard and congruence. The ability to show flexibility and a preference and affinity for working with children in a therapeutic manner were also regarded as prerequisites.

From the literature review, certain skills have been identified as necessary for a trainee to develop in order to be an effective child psychotherapist. The clinicians who have been interviewed specifically identified skills that constitute an effective Teddy Bear therapist. The latter are more specific to Teddy Bear Therapy and will thus be discussed last.

The following skills are essential for an effective child psychotherapist, based on the literature review: Respecting children and treating them with dignity; flexibility; playfulness whilst maintaining your therapeutic role, which will ensure effective rapport; the ability to be comfortable with children; conveying warmth in your interaction with children; congruence or 'realness' in your relationship with a child client; a caring attitude; empathy and conveying this understanding to the client and caretakers; confirming the client; the ability to build rapport with a child; creativity in ways to engage with a child, grabbing their attention, building rapport and facilitating trust. The ability to do a detailed evaluation of the various

relationship variables in the child's system and interpret these observations in a meaningful way; the ability to evaluate the child's system to gain an understanding of the reciprocal impact a child's behaviour has on the family and of the family's functioning on the child's behavior and self-awareness are essential for a therapist. The ability to know what impact you as therapist have on children or their parents and what impact they have on you and how that may influence the therapeutic process are also essential.

Skills important for trainees to develop in order to be effective Teddy Bear therapists include high levels of empathy towards children and the ability to show it; an operational understanding of systems theory and interactional therapy; and skills in effective therapeutic storytelling. Effective therapeutic storytelling relies on creativity, good problem solving skills and the ability to engage with a child in a therapeutic manner.

These skills can be enhanced in trainees with the use of various methods. The training methods identified in the literature review coincided with the recommendations made by the clinicians in the interviews.

From the interviews, training methods recommended to train trainees in Teddy Bear Therapy were grouped into experiential and theoretical learning. In terms of theoretical learning, the literature review found didactic instruction in the form of lectures, demonstrations, videos and readings, to be effective as training method when used in combination with manuals and other training methods. Theoretical knowledge on developmental psychology, the historical evolution of child psychotherapies, Richard Gardner's Mutual Storytelling Technique, and Teddy Bear Therapy are recommended specifically in the context of Teddy Bear Therapy training and were identified in the

interviews as significant. Prior exposure to the IPA or/and an understanding of it is also necessary for Teddy Bear therapists.

Methods that aided experiential learning identified in the literature review as well as the interviews included role play, role rehearsal, working through case studies and active feedback from peers as well as the trainer. The literature review further suggested the use of internships, as well as periods of supervision as experiential training methods.

Theoretical information recommended to be included in a manual on Teddy Bear Therapy is an overview of developmental psychology followed by a section on the development of child psychotherapy with specific reference to play therapy and Richard Gardner's Mutual Storytelling Technique.

Furthermore, basic written information on Teddy Bear Therapy, such as the step-by-step procedure and specifically identifying the theories it consists of, was recommended to form part of the manual. Lastly, it was recommended to include case studies on Teddy Bear Therapy for trainees to refer back to with for example verbatim examples of stories, extracts from research on the effectiveness of Teddy Bear Therapy or a discussion on solutions to practical problems encountered when working with children and giving Teddy Bear Therapy.

4.5 Programme and Manual

Based on the results presented above, a programme and manual were developed to train psychotherapists in Teddy Bear Therapy. The programme was developed to be utilised by the facilitator in conjunction with the manual (Appendix C), which will be handed out to trainees and referred to when indicated in the programme outline. The

programme outline which is presented below is organised according to themes, learning objectives, tasks and preparation for the next session:

Session 1:

Theme: Introduction

Learning objectives:

- Set the context for the training process.
- Introduce the trainees to the programme.
- Determine the trainees' pre-existing knowledge on child psychotherapy.

Tasks:

- Hand out the manual to the trainees.
- Work through the introduction (section 1) of the manual with the trainees.
- Conduct a needs assessment with the trainees by inquiring about their background knowledge on child psychotherapy, systems theory and interactional therapy to establish where the focus of the training needs to be.
- Give an overview of what the programme is about and what the sessions will consist of to the trainees.

Preparation for next session:

- Instruct the trainees to do an individual study of Section A in the training manual in order to comprehend Teddy Bear Therapy, the context in which it developed

and in which it now functions. Trainees are hence required to have an understanding of developmental psychology (refer to section 2), Person-centred Therapy (refer to section 3), the IPA (refer to section 4), the development of child psychotherapy (section 6) in the next session.

Additional prescribed reading:

In addition to the theory in Section A of the manual, recommend to the trainees to read the following for a comprehensive understanding, either on their own time or in time for the next session:

Abnormal Child Psychology, Mash, E.J. & Wolfe, D.A.

Client Centered Therapy, Rogers, C.R

Impact, Vorster, C.

General systems theory and psychotherapy: Beyond post-modernism, Vorster, C.

Session 2:

Theme: Setting the context for Teddy Bear Therapy

Learning objectives:

- Review theory essential for a thorough understanding of Teddy Bear Therapy: developmental psychology, Person.-centred Therapy, the IPA.
- Set the context for a discussion on Teddy Bear Therapy by discussing the development of child psychotherapy according to section B in the manual.

Tasks:

- Refer to the manual (section 2-5) and facilitate a group discussion on the developmental phases of children, the person-centered approach and the IPA.
- Discuss how all of this fits in with Teddy Bear Therapy.
- Give theoretical input on the development of child psychotherapy with specific reference to Play Therapy and Richard Gardner's Mutual Storytelling Technique as set out in section 6 of the manual.

Prescribed reading:

Recommend that trainees read the following, on their own time, as validation for what have been discussed during the session:

Play therapy, Axline, A.E.

Therapeutic communication with children: The Mutual Storytelling Technique, Gardner, A.E.

Session 3:

Theme: The development of Teddy Bear Therapy

Learning objectives:

- Establish a theoretical foundation for Teddy Bear Therapy.
- Put emphasis on the rationale of Teddy Bear Therapy.
- Provide theoretical input on the indications for Teddy Bear Therapy.

Tasks:

- Give input on the development of Teddy Bear Therapy by referring trainees to section 7.1 in the manual.
- Discuss the rationale behind Teddy Bear Therapy and the various indications by referring to section 7.3 in the manual.

Preparation for next session:

- In preparation for the next session, recommend individual study on the step-by-step process of Teddy Bear Therapy (as outlined in section 7.2 of the manual).

Session 4:

Theme: The process of Teddy Bear Therapy

Learning objectives:

- Familiarise the trainees with the process of Teddy Bear Therapy.
- Assist the trainees in developing an operational understanding of the systems approach and interactional theory by describing the family system from a systemic perspective and drawing up an IPA.
- Train trainees to be able to make a link between the presenting complaint with the system's behaviour.
- Train trainees to identify the nodal point that needs intervention by means of integrating the IPA and findings from history taking.
- Sharpen the trainees' observation skills.
- Facilitate a meta perspective on the process of Teddy Bear Therapy.

Tasks:

- Work through an entire case study with the trainees as set out in the manual's section 8.
- Get two volunteers to do a role play on the step-by-step process of Teddy Bear Therapy, with one trainee being the child, one the therapist. Assign the rest of the group to do the IPA without glancing at the manual.
- Facilitate a discussion of the exercise and the process of Teddy Bear Therapy.

Preparation for next session:

- Refer trainees to section 7.4 of the manual and recommend individual study on the significance of Teddy Bear Therapy.

Session 5:

Theme: The significance of Teddy Bear Therapy

Learning objectives:

- Facilitate high levels of empathy for the child client and a child's frame of reference.
- Develop the trainees' flexibility.
- Enhance effective problem solving skills amongst trainees.
- Facilitate exercises for the trainees on how to engage a child in a comfortable therapeutic, asocial manner and thus how to facilitate effective rapport.
- Facilitate the development of a caring, confirming, respectful attitude towards children.

- Enhance the trainees' storytelling skills.
- Develop the trainees' creativity as storytellers as well as how to convey the therapeutic message to the child in the form of a story.
- Facilitate feedback amongst the trainees' from and to each other.
- Create self-awareness.

Tasks:

- Do role rehearsal with the trainees.
- Split the trainees into groups of three; one trainee who serves as observer and who gives feedback to the other two trainees on their skills and their impact; another trainee as the child client and the last trainee as the Teddy Bear Therapy therapist.
- Do a role change to broaden the trainees' frame of references.
- Facilitate a theoretical overview of the process of Teddy Bear Therapy and facilitate a group discussion on the significance of Teddy Bear Therapy.

Preparation for next session:

- Recommend additional practice on the process of Teddy Bear Therapy outside the training context, in groups of two, and instruct the trainees to bring voice recordings of the exercise for the next session.

Session 6:

Theme: Feedback

Learning objectives:

- Facilitate an awareness amongst the trainees of how he/she is experienced by fellow trainees and the trainer and the impact of that style in the Teddy Bear Therapy situation.

Tasks:

- Listen to the voice recordings of the role plays with the trainees.
- Provide feedback to the trainees on their skills as reflected in the voice recordings and the impact they have on you as facilitator.
- Facilitate feedback amongst the trainees on each other's skills as reflected in the voice recordings and impact they have on each other.

Preparation for next session:

- Recommend individual study on previous master's research on the effectiveness of Teddy Bear Therapy as set out in the manual (see section 7.5).

Session 7:

Theme: The effectiveness of TBT

Learning objectives:

- The trainees should be able to motivate the application of Teddy Bear Therapy based on its effectiveness.

Tasks:

- Facilitate a group discussion on the effectiveness of Teddy Bear Therapy.

Preparation for next session:

- Recommend that trainees read through the relevant sections in the Child Care Act 1998 and ethical guidelines for psychotherapists as set out by the HPCSA (as referred to in section 5 of the manual) .

Prescribed reading:

Aside from the preparation for the next session, recommend that trainees read the article on Ethics in a Multicultural Setting, written by John Brown as prescribed in section 5 of the manual.

Session 8:

Theme: Ethics

Learning objectives:

- Create an awareness of the ethical and legal implications of working with children.
- Facilitate a sensitivity for multicultural perspectives that may influence the therapeutic process.
- Facilitate an understanding of the diversity of the child psychotherapist's role definition.

Tasks:

- Initiate a discussion on the ethical implications of working with children.
- Facilitate suggestions from the trainees on ethical factors that needs to be considered when working as Teddy Bear therapists.
- Add ethical guidelines which has not been accounted for in the discussion by means of the rules of conduct as set out by the HPCSA.
- Discuss the prescribed article on multicultural perspectives and ethics and how it may impact on the therapeutic relationship as well as process.
- Discuss the role of the child psychotherapist with regard to but not only limited to the discussed ethical implications. Using the manual (section 9) as reference it is especially necessary to focus on the child psychotherapist's responsibilities when working in a interdisciplinary setting.

Session 9:

Theme: Consolidation and reflection

Learning objectives:

- Consolidate with the trainees on what they have learnt.

Tasks:

- Facilitate a group discussion on what have been presented and learnt by referring to the theoretical information as set out in the manual but also referring to the practical skills and feedback trainees received.

Preparation for the next session:

Instruct the trainees to bring recordings and IPA's of a Teddy Bear Therapy case they have conducted two months after the training ended. Inform the trainees that these cases also needs to be presented by themselves.

Session 10:

Theme: Follow-up evaluation

Learning objectives:

- Evaluate the effectiveness of the training.
- Evaluate and analyse the therapeutic skills of the trainees.
- Evaluate and assist trainees with case management.

Tasks:

- Instruct the trainees to each present a Teddy Bear Therapy case by playing their voice recording of the sessions and presenting the IPA's of the clients.
- Facilitate a feedback session from trainees to each other on their skills and case management and as facilitator either validated or expand on the feedback.
- Recommend regular supervision for trainees on their Teddy Bear Therapy cases in order to maintain and fine tune their skills.

Chapter 5: Conclusion

Around the world, health care systems have failed to meet the mental health needs of the world's population (Pilay & Lockhat, 1997). South Africa however evidence more serious levels of unmet mental health needs than other countries (Macleod, 2004). In South Africa there are far too few mental health specialists and inadequately developed infrastructure to deliver mental health services in accordance with the needs of its inhabitants (Pilay & Lockhat, 1997; Macleod, 2004).

Mental health care specialists are well acquainted with the fact that many adult psychological problems are related to childhood experiences (Pilay & Lockhat, 1997). Exposure to a psychological high risk environment or individuals during the first five years of a child's life could result in vulnerabilities for the development of psychiatric conditions in later life (Geldard & Geldard, 1997). This clearly indicates the need for preventative measures during the childhood years.

Unfortunately, evidence also indicates a tremendous unmet need for psychological services for specifically the children and the youth of South Africa (Gilbert, 2000; Pilay & Lockhat, 1997; Swartz & Gibson, 2001). It was found that in general, mental health services for children in South Africa are experienced as inaccessible and ineffective (Macleod, 2004; Rock & Hamber, 1994; Swartz & Gibson, 2001). As a result, the majority of children and adolescents who are in need of psychological services will not receive such services or may be treated ineffectively (Macleod, 2004; Rock & Hamber, 1994; Swartz & Gibson, 2001).

The inaccessibility of psychological services in South Africa can be attributed to a number of factors of which poor socio-economic status is regarded the most prominent (Pilay & Lockhat, 1997; Swartz & Gibson, 2001). South Africa has neither the facilities nor

the infrastructure to effectively deal with the large numbers of emotionally disturbed children in need for psychological help (Pilay & Lockhat, 1997). The majority of South African children live in rural or peri-urban areas (Pilay & Lockhat, 1997). In these areas there are a lack of essential services such as sanitation, education and housing, resulting in services such as mental health services not being perceived as priority (Pilay & Lockhat, 1997). Practical issues that contribute to the inaccessibility of psychological services include transport difficulties, cost, the regularity of appointments and the length of time away from work spent in the session with the psychologist (Berger & Lazarus, 1987).

Another factor, aside from socio-economical factors, that is regarded as significant in contributing to the inaccessibility of mental health services is an unawareness of what psychological services entail (Rock & Hamber, 1994). Most psychologists operate in the private sector, providing services to a limited number of people (Macleod, 2004). State provision of psychological services has for the most part been scant (Swartz & Gibson, 2001). In cases where services are provided, the planning and implementation are experienced as poor, with services being excessively duplicated in certain areas and non-existent in others (Rock & Hamber, 1994).

Potential consumers of psychological services often do not know what a psychologist is or what he/she does, nor are they aware of what are expected of them in any psychological encounter (Donald, 1991; Swartz & Gibson, 2001). Swartz and Gibson (2001) argue that this unfamiliarity, together with familiarity with other healing modalities, can foster a number of expectations and stem from a variety of misconceptions.

Moving on to factors that influence ineffective psychological treatment, a lack of research on children and their emotional wellbeing in the South African context, as well as a

lack of effectively trained professionals can be seen as contributing factors (Rock & Hamber, 1994).

There is a significant lack of epistemological research focusing on the psychological problems of childhood in a multicultural setting (Macleod, 2004; Pilay & Lockhart, 1997). This trend may be related to a number of factors, each of which has different implications in terms of addressing the problem. Firstly, the types of topics studied by researchers are limited (Pilay & Lockhat, 1997). For example, accessing a rural population around psychotherapy, when there is a scarcity of psychologists working in these areas and people living in these areas and a tendency for people living in these areas to be negative towards receiving psychotherapy, would be difficult (Pilay & Lockhat, 1997). Secondly, a lack of research funding may force researchers to use convenient samples, which includes samples like university students (Macleod, 2004).

There is thus a pressing need for more research on the psychological wellbeing of children in South Africa and by implication child psychotherapy. This will provide an understanding of the extent to which the problem needs to be addressed, as well as what the planning, development and provision of adequate and effective services need to entail.

The second factor which contributes to the ineffectiveness of psychological services is a lack of effectively trained mental health workers (Gilbert, 2000). The shortfall in the number of psychologists is clearly problematic. There clearly exists a need for intensive curriculum development at every level of training that can begin to meet the overwhelming need for psychological services (Gilbert, 2000). Moreover, creative ways of using psychological skills could enable psychologists to reach a wider band of people (Gilbert, 2000; Pilay & Lockhat, 1997). This would necessitate shifts in training modalities.

It is evident that a concrete and less theoretical plan is called for. Approaches and intervention strategies which deviate from the traditional passive role that mental health workers usually assume will have to be developed. By implication, this poses many challenges to the training and practice of mental health workers.

Within the current South African contexts, active attempts to create an awareness of what psychotherapy for children entails and when it is indicated, more research on the wellbeing of children and the expansion of training to include health workers other than psychologists are strongly suggested. A recommendation made by Pilay and Lockhat (1997) is to expand the training of mental health workers to the training of primary care workers. This will ensure the inclusion of large numbers of effectively trained professionals in the field.

The provision of adequate and accessible mental health services to the youth of our country is a critical contemporary issue and one that unfortunately will not be solved overnight. It is not in the scope of this study to provide an instant solution for this social crisis. It is, however, in this context that the development of a Teddy Bear Therapy training programme for psychotherapists was identified as at least a partial solution.

Teddy Bear Therapy is an innovative form of child psychotherapy that brings about change not only in the child's behaviour but also to the system he/she functions in (Vorster, 1995). It is inexpensive to implement and is usually effective within three to six sessions. All of these elements make it a suitable intervention for the third world context, characterised by its poor socio-economic status.

Teddy Bear Therapy is a novel but specialised form of child therapy and therefore requires the training of highly effective therapists. In relation to this need, it was the aim of

this study to develop a training programme to train psychotherapists in Teddy Bear Therapy. This aim has been met.

A training programme for psychotherapists in Teddy Bear Therapy was developed by means of a literature review on the nature of child psychotherapy training programmes. From this, certain conclusions were drawn and questions were deduced from these conclusions to use in semi-structured interviews. These interviews were conducted with three clinicians who has had extensive experience in Teddy Bear Therapy as well as the training of psychotherapists. The data obtained from these interviews were analysed by means of a thematic analysis. The findings from the interviews were then integrated with the conclusions derived from the literature review. Based on this integration, a programme has been developed for the use of the facilitator and a manual was compiled for the use of the trainees.

The training programme consists of nine sessions that incorporate theoretical as well as experiential learning. The programme outline (see section 4) provides the facilitator with clear instructions as to what each session's objective and tasks are. The trainee is provided with a manual that is divided into two sections. Section A provides the trainee with background information which will enable a thorough understanding of Teddy Bear Therapy and the application thereof. Section B provides more specific information on Teddy Bear Therapy itself and the context in which it was developed. The trainee needs to work through the manual or prescribed readings, do exercises, take part in discussions or prepare readings whenever indicated to do so by the facilitator.

It should however be noted that this programme has been developed within the limited framework of a dissertation and is thus neither a fully fledged project nor has it been

empirically tested. It is thus recommended that this training programme is implemented and its effectiveness evaluated.

References

- Aronson, J. (1994). A pragmatic view of thematic analysis. *The qualitative report*, 1(2), 10-13.
- Axline, V. (1947). *Play therapy*. Edinburgh: Churchill Livingstone.
- Babbie, E. M. (2005). *The practise of social research* . Cape Town: Oxford University Press.
- Babbie, E. (2008). *The Basics of Social Science Research*. California: Wadsworth.
- Babbie, E. (2010). *The practice of social science research*. California: Wadsworth.
- Baloyi, L. (2001). *Teddy Bear Therapy*. Pretoria: UNISA.
- Bailey, K. G., Deardorff, P. & Nay, W. R. (1980). Students play therapist: Relative effects of role playing, videotape feedback, and modeling in a simulated interview. *Journal of Consulting and Clinical*, 45(2), 257-266.
- Bateson, G. (1980). *Mind and Nature: A Necessary Unity*. New York: E.P. Dutton.
- Baumeister, R. & Leary, M. (1997). Writing narrative literature reviews. *Review of General Psychology* , 3(1), 311-320.
- Bor, R. (1984). *Systems Training from the Inside out*. Unpublished Master of Arts dissertation in Clinical Psychology, Pretoria: UNISA.
- Bosman, E. (2004). *The Effect of a One-Year Clinical Psychology Training Programme on the Family Systems of Trainees: A Preliminary Investigation*. Master's Dissertation, MEDUNSA: Pretoria.

- Bouchard, M. C., Wright, J., Mathieu, M., Lalonde, F., Bergeron, G. & Toupin, J. (1980).
Structured learning in teaching therapists social skills training. *Journal of Consulting and Clinical Psychology* , 48 (4), 491-502.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Chu, B. C. & Kendal, P.C. (2009, May 28). Therapists Responsiveness to Child Engagement: Flexibility within Manual Based CBT for Anxious Youth. *Journal of Clinical Psychology*, 65(7), 736-754.
- Ciottone, R. & Madonna, J. M. (1996). *Play therapy with sexually abused children: A synergistic clinical-developmental approach*. New Jersey: Jason Aronson Inc.
- Collins, K. (2007). A Typology of Mixed Methods Sampling Designs in Social Science Research. *The Qualitative Report* , 6 (1), 281-316.
- Combs, A. (1989). *A theory of therapy: Guidelines for counseling practise*. California: Sage Publications.
- Creswell, J. (1994). *Research Design: Qualitative and Quantitative Approaches*. California: Sage Publications.
- Cross, M. & Papadopoulos, L. (2003). *Becoming a therapist: A manual for personal and professional development*. East Sussex: Brunner-Routledge.
- Da Cruz, C. (2008). *Group Trauma Debriefing throug Teddy Bear Therapy: An ex post facto study*. Master's Dissertation, MEDUNSA: Pretoria.

- De Shazer, S. (1982). *Patterns of Brief Family Therapy: An Ecosystemic Approach*. New York: Guilford Press.
- Dimeff, L.A., Koerner, K., Woodcock, B., Beadnell, M., Brown, J., Skuch, A., ... Harnet, M. (2009). Which training method works best? A randomized controlled trial comparing three methods of training clinicians in dialectical behaviour therapy skills. *Behaviour Research and Therapy*, 47 (11), 921-930.
- Donald, D. R. (1991). Training needs in educational psychology for South African social and educational conditions. *South African Journal of Psychology*, 21(1), 38-44.
- Dowling, E. & Vetere, A. (2005). *Narrative Therapy with Children and their Families: A Practitioner's guide*. New York: Routledge.
- Drotar, D. (1995). *Consulting with Clinical Psychologists*. New York: Plenum.
- Duncan, S. (2004). *Treating separation anxiety with Teddy bear therapy: A preliminary investigation*. Master's Dissertation, MEDUNSA: Pretoria.
- English, D. U. (2002). *South African Concise Oxford Dictionary*. Cape Town: Oxford University Press South Africa.
- Eyseneck, H. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16(1), 319-324.
- Fernandez, A., Rodriguez, B., Ortiz-Sanchez, D., & Baldor, T. (2010). Effectiveness of a structured training program in psychotherapeutic skills used in clinical interviews for psychiatry and clinical psychology residents. *Psychotherapy Research*, 20(1), 113-121.

- Gardner, R. (1971). *Therapeutic communication with children. The mutual storytelling technique*. New York: Science House Inc.
- Geldard, K., & Geldard, D. (1997). *Counselling children. A Practical Introduction*. London: Sage Publications.
- Gilbert, A. J. (2000, July). *Localising the global and globalising the local: Some insights out of Africa*. Paper presented at the symposium on 'Indigenous psychology: Assessment of progress in development', XXVII International Congress of Psychology, Stockholm, Sweden.
- Gillmer, B. & Marckus, R. (2003). Personal professional development in clinical psychology training: Surveying reflective practice. *Clinical Psychology*, 27(1), 20-23.
- Ginot, H. (1959). Theory and practise of therapeutic intervention in child treatment. *Journal of consulting psychology*, 23(2), 243-246.
- Goodyear, R.K., Cortese, J.R., Guzzardo, C.R., Allison, R.D and Claiborn, C.D. (2000). Factors, Trends and Topics in the Evolution of Psychology Training. *The Counselling Psychologist*, 28(5), 603-621.
- Hanney, L. (2002). *The effectiveness of a standardised Teddy bear therapy programme with young hospitalized children: a preliminary investigation*. Master's Dissertation, MEDUNSA: Pretoria .
- Haworth, M. R. (1990). *A Child's therapy: Hour to Hour*. Modisan: International Universities Press Inc.

- Herschell, A., Kolko, D., Baumann, B., & Davis, A. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical Psychology Review*, 30(4), 448-466.
- Herschelle, A.D. , McNeil,C.B. & McNeil, D.W. (2004). Clinical Child Psychology's Progress in Disseminating Empirically Supported Treatments. *Clinical Psychology: Science and Practice*, 11(3), 267-289.
- House, R. (2008, March 1). Training and education for therapeutic practitioners: Trans-modern perspectives. *Counselling Psychology Quaterly*, 21(1), 1-10.
- Isaacs, C.D., Embry,L.E. & Baer, D.M. (1982). Training Family Therapists: An Experimental Analysis. *Journal of Applied Behaviour Analysis*, 15(4), 505-520.
- Kazdin, A. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. Oxford: Oxford University Press.
- Keeney, B. P. (1983). *Aesthetics of Change*. New York: Guilford Press.
- Kvale, S. (1996). *Interviews : An introduction to qualitative research interviewing*. London: Sage Publications.
- La Greca, A.M. & Hughes, J.N. (1999). United We Stand, Divided We Fall: The Education and Needs of Clinical Child Psychologists. *Journal of Clinical Child & Adolescent Psychology*, 28(4), 435-447.
- Lambert, W., & Bickman, L. (2004). The clock setting cure: Ineffective Psychotherapy. *Journal of Child and Adolescent Psychiatry*, 55(4), 381-382.

- Lucock, M. H. (2006). A Survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology and Psychotherapy*, 13(2), 123-130.
- Maclean, G. (1986). A Brief Story About Dr. Hermine Hugh-Hellmuth. *Canadian Journal of Psychiatry*, 31(6), 586-590.
- Macleod, C. (2004). South African psychology and relevance: Ongoing challenges. *South African Journal of Psychology*, 34(4), 613-629.
- Mandler, G. (2007). *A history of modern experimental psychology: From James and Wundt to cognitive science*. Cambridge: MIT Press.
- Maree, K. & Pietersen, J. (2007). *The quantitative research process*. (K. Maree, Ed.) Pretoria: Van Schaik.
- Mash, E. & Wolfe, D.A. (2005). *Abnormal Child Psychology*. Belmont: Thomson Wadsworth.
- May, T. (2001). *Social research : Issues, Methods and Process*. Buckingham: Open University Press.
- Meyer, W. F. (1997). *Personology: From Individual to Ecosystem*. Johannesburg: CTP Book Printers.
- Moser, G. & Schmidt, P. (2008). Meta-analysis: An alternative to narrative reviews for synthesising social research. *Current Research in Social Psychology*, 13(1), 3-36.

Mouton, J. M. & Marias, H.C. (1992). *Basic Concepts: Methodology of Human Sciences*.

Pretoria: Humanity Press.

Ncute, M. (2004). *A preliminary investigation into the effectiveness of a structured Teddy bear therapy program on children with dental phobia*. Master's Dissertation,

MEDUNSA: Pretoria.

Ollendick, T. (1999). Empirically supported treatments for children with phobic and anxiety disorders: Current status. *Journal of Clinical Child Psychology*, 28(4), 112-116.

Oomkes, F. (1976). *Handboek voor Gesprekstraining*. Antwerpen: Boom Meppel.

Patton, M. (2000). Counselling Psychology Training: A Matter of Good Teaching. *The Counselling Psychologist*, 28(5), 701-711.

Pickar, D.B. & Lindsay, R. L. (2008). Preparing Child Psychologists for Managed Care: Educational and Training Considerations. *Brief Treatment and Crisis Intervention*, 8(4), 370-381.

Pilay, A. L. & Lockhat, M.R. (1997). Developing Community Mental Health Services for Children in South Africa. *Social Sciences and Medicine*, 45(10), 1493-1501.

Pollit, D. & Hungler, H. (1996). *Research: Methods and appraisal and utilisation*.

Philadelphia: Lippincolt.

Poodhun, S. (2002). *Teddy Bear Therapy: An explorative case study*. Master's Dissertation,

MEDUNSA: Pretoria.

Prendiville, E. (2011, February 24). *About us: Training Child Psychotherapists*. Retrieved May 5, 2011, from Children's Therapy Centre:

http://www.childrenstherapycentre.ie/training_prof.html

Riessman, C. (1993). *Narrative analysis*. California: SAGE Publications Inc.

Robinson, D. & Reed, V. (1998). *The A-Z of Social Research*. Michigan: Ashgate/ARENA.

Rock, B. & Hamber, B. (1994). Psychology in a future South Africa: The need for a national psychology development programme. Available:

<http://www.csvr.org.za/papers/papbrbh.htm>. Retrieved 8 July 2006.

Rogers, C. (1951). *Client centred therapy*. London: Constable.

Romanis, A. (2003). *The effects of a structured Teddy bear therapy program on children about to testify in court*. Master's Dissertation, MEDUNSA: Pretoria .

Routh, D. (2005). Training Child Psychologists. *Proceedings of the Conference on Training Clinical Child Psychologists* (pp. 9-13). Louisiana: Land and Land Inc.

Salkind, N. J., Dougherty, D. M., & Frey, B. (Eds.). (2010). *Encyclopedia of research design*. Thousand Oaks, CA: Sage Publications.

Sandelowski, M. (1995). Focus on qualitative methods: Sample sizes in qualitative research. *Research in Nursing and Health*, 18(2), 230-240.

Seagal, J. (2004). *Melanie Klein: Key Figures in Counselling and Psychotherapy*. London: Sage Publications.

- Selamolela, M. (2001). *The effectiveness of Teddy Bear Therapy in treating enuresis*.
Master's Dissertation, MEDUNSA: Pretoria.
- Sepato, M. (2002). *A preliminary investigation of the effectiveness of Teddy Bear Therapy with children of newly divorced parents*. Master's Dissertation, MEDUNSA: Pretoria .
- Sheikh, A.I., Milne, D.L. & MacGregor, B.V. (2007). A Model of Personal and Professional Development in the Systematic Training of Psychotherapists. *Clinical Psychology and Psychotherapy*, 14(4), 278-287.
- Silverman, D. (2005). *Doing qualitative research* . London: SAGE Publications.
- Somekh, B. & Lewin, C. (2005). *Research methods in the social sciences*. London: Sage Publications.
- Sori, C.F. & Sprenkle, D.H. (2004). Training Family Therapists to Work with Children and Families: A Modified Delphi Study. *The Journal of Marital and Family Therapy*, 30(4), 479-495.
- Spirito, A., Brown, R.T., D'Angelo, R., Delamater, E.A., Rodrigue, J. and Siegel, L. B. (2003). Society of Pediatric Psychology Task Force Report: Recommendations for the Training of Pediatric Psychologists. *Journal of Pediatric Psychology*, 28(2), 85-98.
- Statistics, S.-S. A. (2009, March 27). *HIV and AIDS Topics*. Retrieved January 11, 2011, from Avert.org Statistics Website: <http://www.avert.org/africa-hiv-aids-statistics.htm>

Sudak, D. (2009). Training in Cognitive Behaviour Therapy: An Overview for Educators. *Behaviour Modification*, 33(1), 124-137.

Swart, N. & Wiehahn, G. (1979). *Interpersonal Manoeuvres and Behaviour Change*. Pretoria: Academica.

Swartz, L. & Gibson, K. (2001). The 'old' versus the 'new' in South African community psychology: The quest for appropriate change. In M. Seedat, N. Duncan, and S. Lazarus (Eds), *Community psychology: Theory, method and practice – South African and other perspectives* (pp. 37–50). Oxford: Oxford University Press.

Terre Blanche, M. & Durrheim, K. (2002). *Research Design*. Cape Town: University of Cape Town Press.

Terreblanche, M. D., Durrheim, K. & Painter, D. (2006). *Research in Practice: Applied methods for the social sciences*. Cape Town: University of Cape Town Press.

Therriault, A. & Gazzola, N. (2006). What are the sources of feelings of incompetence in experienced therapists? *Counselling Psychology Quarterly*, 19(4), 313-330.

Thompson, C. (2011). If you could just provide me with a sample: Examining sampling in qualitative and quantitative research papers. *Evidence-based research*, 68(2), 64-70.

Tomm, K. M. & Wright, L.M. (1979). Training in family therapy: Perceptual, Conceptual and Executive skills. *Family Process*, 18(3), 227–250.

Vorster, C. (2003). *General Systems theory and psychotherapy: Beyond Post-Modernism*. Bloemfontein: Satori Publishers.

- Vorster, C. (1995). Teddy bear therapy: The art of empowering a child. *Monograph*.
Department of Psychology, MEDUNSA: Pretoria: Unpublished article.
- Weiss, B., Catron, T., & Harris, V. (2004). The effectiveness of traditional child
psychotherapy. *Journal of Consulting and Clinical Psychology*, 67(1), 82-94.
- Weissman, M. W., Verdelli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K. & Mufson, L.
(2006). National survey of psychotherapy training in psychiatry, psychology and
social work. *Archives of General Psychiatry*, 63(1), 925-934.
- Whitley, B. (2002). *Principles of research in behavioural science* (2nd ed.). New York:
McGraw Hill.
- Yawkey, T., & Pellegrini, A. D. (1984). *Child's Play Developmentally Applied*. New Jersey:
Lawrence Erlbaum Associates.
- Zimmer, R. (2001). Reassessment of Psychoanalytic Education: Controversies and Changes.
Internal Journal of Psychoanalysis, 84(1), 143-155.

Appendix A: Consent forms**UNIVERSITY OF LIMPOPO (Medunsa Campus) CONSENT FORM****Statement concerning participation in a clinical research study.**

Name of study:

‘Towards Developing a Training Programme for Psychotherapists on Teddy Bear Therapy’

I have heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I understand that participation in this clinical study is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this study has been approved by the Research, Ethics and Publications Committee of the Faculty of Medicine, University of Limpopo (Medunsa Campus) / Dr George Mukhari Hospital. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

.....

Name of recipient

.....

Place

Date

Witness

Statement by the researcher

I provided verbal information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

Leandri van der Ryst

Name of researcher

Signature

Date

Place

Appendix B: Interview Transcripts

Clinician 1, Interview; 1/06/2010

Interviewer: Based on your experience in the field of Teddy Bear therapy what would the essential features of a Teddy Bear Therapy training programme for psychotherapists be?

Interviewee: Essential features...hmmm...The programme will need to equip the practitioner to really develop an empathetic understanding of children between the ages of about 3 and 12. Ughm it should also equip the practitioner to really understand the developmental stages of children in order to have an accurate idea of what they are capable of at various ages and phases of development. And then it should equip the practitioner with certain details of the procedure of TBT. It should also equip the practitioner with necessary basis of ethics and also the relevant sections of the Children's Act so that the practitioner would know within what scope he/she can practice and to what extent the parents/ caregivers need to be involved. I think that would broadly be the essential features.

Interviewer: From the literature that I have reviewed it is evident that prior to training most training programmes on child psychotherapy has certain requirements candidates have to meet in order to function successfully in the training setting. In the context of Teddy Bear Therapy training – what is to your opinion the requirements a trainee has to meet before engaging in training?

Interviewee: The trainee?

Interviewer: Ja

Interviewee: Basically the requirements of an effective therapist - psychotherapist, and ughm that certainly will be high levels of Unconditional PR, congruence, and exceptionally

high levels of empathy and also a high level of flexibility and a preference to work with children – therapeutically. Yes I would say – generally a sufficiently high functioning therapist and all the – well it’s actually quite an extensive topic so I would want to go into all the details, but I would say whatever you probably found in the literature described as the minimum requirements for an effective therapist.

Interviewer: Okay.

Interviewee: And in addition to that a special affinity for children and then exceptional empathic abilities regarding children. The ability to really enter the frame of reference of a child and to really understand a child’s world.

Interviewer: Then, What are the most important skills for therapists to develop in order to be effective as Teddy Bear therapists?

Ughm, really in-depth knowledge of the developmental phases of children. Exceptional high levels of empathy regarding children and their ughm world of the child and also a keen awareness of the therapeutic abilities of stories and the impact of stories. And also in that respect grasp an effective and in-depth grasp of interactional therapy in the broader sense – and the impact of individuals on each other. A good grasp of ughh systems theory. And the ability to apply it. High level of problem solving expertise and the therapist should be able to be an exceptional problem solver within the frames of children because in essence the children needs the therapist to assist with solving their problems and difficulties. The therapist should also have an exceptional ability to translate the therapeutic messages and concepts into stories and to convey therapeutic messages via stories on the level ughm attuned to the particular child. Then in addition the therapist should be a creative story teller

and should have the skill to really grab the attention of the child, to involve the child effectively and to tell a creative story in tandem with the child.

Interviewer: Okay, now what training methods would you recommend to train these skills to the therapists?

Specific exercises to enhance empathy, intensive experiential learning into storytelling and the impact of stories in the broad sense and specifically in the context of children stories. Intensive case studies should be worked through thoroughly and role playing and role rehearsal. Feedback ughhm continuous feedback – in other words the essence is experiential learning and then together with relevant theoretical knowledge – there should be in-depth reading which should be made compulsory especially again in the area of developmental psychology, and child psychopathology and then a general knowledge of existing child therapies especially play therapy. Definitely exposure to Richard Gardner's Mutual Storytelling Technique in terms of printed material as well as exercises. And then periods of supervision – working under supervision where the sessions should be recorded and also be utilised as part of the process of supervision.

Interviewer: Okay that basically covers the next two questions – ughhm – I'm going to skip the question on experiential learning and then move on to theoretical information that you touched on. From my research, manuals were recommended as a way to include theoretical information. What exactly would you recommend should be included in such a manual when training Teddy Bear therapists?

Interviewee: I would include some basic written material on TBT – cause there is a section that sets out the TBT process step-by-step. I would include a reading list ughhm that should include developmental psychology, play therapy, Gardner's Mutual Storytelling and

then also specifically Ginotte book: 'Between parent and child' and then also a number of case histories – case studies – preferably with some verbatim examples of stories and then also just a summary of existing research done specifically at this university – masters' dissertations that has been done – just provide perhaps the extracts so they can briefly see how it was done and what has been found – to broaden their frames of reference.

Interviewer: Thank you – that is it!

Interviewee: You are welcome.

Clinician 2: Interview, 12/06/2011

1. Based on your experience in the field of Teddy Bear Therapy what would the essential features of a Teddy Bear Therapy training programme for psychotherapists be?

Uggmmm okay, so the key thing is the essential features of the training programme?

Interviewer: Yes, just generally.

Interviewee: Okay, one of the first things is a basic rationale of TBT – what it involves. And the second aspect to it involves understanding how to work with children. That in principle how you approach a child is different to how you approach an adult. Just being aware of that essential difference. And another important feature would then be really looking more specifically now when TBT is indicated – so looking at the age for when it is relevant and then understanding that it has both therapeutic uses and it also serves assessment purposes so that you can use it to investigate and it can assist with diagnosis.

Interviewer: Okay.

Interviewee: Another important feature here would be to look at how to establish a therapeutic relationship with a child – so in that respect if you would work with an adult you would use person centered therapy hence you have to do the same with a child it's just how you do it that is different. So there would have to be – I suggest that there is emphasis on how to engage the child in a safe way. That involves things like the use of drawings, playing with the teddy to work through any anxiety the child has towards the clinician in other words how to establish the therapeutic relationship – that is the key there. Uggghm another important feature is how to understand the nature of the problem which involves diagnosis – key there that it requires working with children it is necessary to first interview adults/other caregivers.

It is very important because it helps to clarify the nature of the problem – this is particularly important because working with children the approach to a child needs to have appropriate structure otherwise if completely unfocused it can become threatening and unsafe for the child – so it's important to have sufficient structure. And because children by their nature of communication is often symbolic they engage in fantasy – it is even more important then to use the caregivers to set the context to better understand the difficulty that is occurring in the family.

Interviewer: Mmmm, it makes sense.

Interviewee: Next feature should be how to introduce storytelling in other words how to introduce TBT which involves establishing context – how do you get across to the child the therapeutic activity you are now going to engage in. In other words just for instance explain to the child that what you are gonna do know is you are gonna play a game and ughhm it's a game of pretend and that you are going to pretend that you are in a radiostation and you are going to tell a story to boys and girls and you are going to tell a story about the teddy. Okay so just basically how to introduce that.

Then the next feature it should involve is addressing how the story is constructed in other words what the story is about and that requires considerable skill cause the story should involve the therapeutic elements of the problem and the client's system – or the functioning of the system – it has to be presented in a way that is not threatening to the child – so that they feel safe so that's one of the features that needs to be addressed.

Next feature should be the use of empathy – how to empathise with a child in the form of storytelling.

Other features should involve problem solving, because part of TBT involves not only the expression of empathy but also problem solving. This is not addressed in the same way as with an adult – with the child it would be addressed through the story.

Another feature should be how to end/terminate the storytelling – and here key thing there is that one should bear in mind that that sets up the therapeutic change or what should happen between now and the next session – where to focus the child – what kind of activities to engage the child in.

Another feature should be to establish feedback with the child about the therapeutic experiences or in this case about the storytelling – what do they think about the story as it is now playing back to the child – just basically some feedback around that and then also feedback from the child as to how they feel about the teddy and how they feel about taking the teddy home cause you want to establish there what kind of identification is there now with the teddy.

Another essential feature is involving the parents. Very important to involve them and to invoke their help in the play therapy – specifically outlining that they should not investigate and ask questions about the child's session or the nature of the relationship with the teddy bear because one of the rationales of TBT is that it is a form of Play Therapy and children process things often on an unconscious or subconscious way and if you bring it to their attention it can be threatening, uncomfortable and it can take away from the effectiveness. So parents shouldn't then go and ask questions about what was involved and start probing. And then also another feature there is eliciting a parent's support to the process with the teddy that the child is now going to take home and that the teddy should be taken to school or wherever it is appropriate.

I think those are some of the features.

Interviewer: Okay, now from the literature that I have reviewed it is evident that prior to training most training programmes on child psychotherapy has certain requirements candidates have to meet in order to function effectively in the training setting. In the context of Teddy Bear Therapy training – what is to your opinion the requirements a trainee has to meet before engaging in training?

Interviewee: I would say the main requirement is firstly that they have a master's degree within the therapeutic field – so that includes forms of psychotherapy – ughhmm and to a limited degree even social work. Before this they should also have had some exposure to person-centred therapy because TBT is based on a person-centred approach. They should also have had exposure to the systems approach and ideally some exposure to the IPA. The reason for this is that TBT is a more specialised form of therapy so it's an advanced form of therapy. And it is based on an integration of systems theory, communications theory and person-centered therapy approach – so they need some exposure to that. Also what is important is what I indicated earlier the approach to a child is different to the approach to an adult and they should have some knowledge of developmental psychology. So it is to set a context for working with a child.

Interviewer: What are the most important skills for therapists to develop in order to be effective as Teddy Bear therapists?

Interviewee: Okay key is skills in a person-centered approach – that is key. Having skills in systems approach. Skills in communication. The IPA – the importance in the IPA and having skills in that is really to understand the presenting complaint in relation to the child's environment and interaction and that takes a lot of skill. And then some skill in

addition to the psychological diagnosis that has to do with the IPA is how to engage a child in a way that is not threatening and yet not social – so it's how to engage with the child in an asocial, therapeutic way with sufficient levels of security and trust so that requires some skill.

Interviewer: What training methods would you recommend to train these skills to psychotherapists in Teddy Bear Therapy?

Interviewee: Okay the training method – I would suggest a brief overview – a theoretical introduction of what TBT involves then a demonstration of TBT so that would involve a complete session as demonstration what is important there is that it need not necessarily be demonstrated because it is assumed that the participant or trainee has had exposure to the IPA, person centered and systemic approach the starting point should be the information derived from the interview with the caregivers and then actually demonstrating how to involve the child, how to engage the child, how the child separates from the caregivers, how to engage the child in a non-threatening way with drawings through demonstrations or role play of an actual case – my first choice would be a visual case and the n role play – so it is engaging the child in drawing, involving the child to work through anxiety by playing with the teddy and then moving into storytelling – so actually demonstrating that – how the storytelling was done and the suggestion around that the teddy would go home with the child. Then I would suggest that the trainees would then practice in ideally groups of three, one person in the observer role ,one in the clinicians role and the other in the role of the client. Benefit there is that it is safe, the clinician gets to practice his skills in a way that is not threatening, the observer can give feedback about what is effective and what not – and the person playing the client is actually expanding their repertoire and becoming more sensitive around the child's frame of reference. Fourth aspect around it should be feedback – from the facilitator – so active feedback and training and the next I would recommend that a complete

theoretical overview is given of it – why I suggest that this is done in this way is that then they have the experience of it and they can more acutely listen or be receptive of the nuances around it – if that is given in the beginning all of it can be lost. And then further case studies and practice.

Interviewer: Well that basically covers question five that focuses on experiential learning.

Interviewee: Okay – there is just one thing that I would add there is that there should ideally be a follow-up workshop – because you need to test this out and practice – so a follow-up workshop where there is further fine tuning around the application of TBT dealing with more challenging cases – so it really should be in two stages this kind of training – an introductory course/a beginners course and then an intermediate to advanced course.

Interviewer: What theoretical information would you include in the training process?

Interviewee: Okay firstly brief history – child psychotherapy, setting the context for child therapy and that should include Gardner’s Mutual Storytelling Technique and again setting the context for its orientation and assumptions which is a strong psychodynamic orientation then identifying later developments in play therapy or specifically storytelling and that’s Charl Vorster’s introduction to TBT, there specifically it should identify that it involves a combination of the person-centered approach, communications theory and the systemic approach. There should be again an overview of developmental psychology – briefly an overview of that and that again sets the context for working with the child. A brief summary of the person-centered approach with the key variables there. A summary of the IPA. The next step should be looking at it very much as a procedure now it should be – because it is complicated and steps can be omitted – so describing this procedure and involving the

following aspects - interviewing the parents; drawing up the IPA, again I just want to emphasise the importance of that – it sets the context of working with a child when doing TBT in a meaningful way .Without that often you don't have clear context to work with. The next step in the procedure is the first session with a child – again as we discussed how to engage the child in a safe way – introduction of storytelling; facilitation of the child-teddy relationship and involvement with the parents so that they support and facilitate the process. What's really important is part of the theoretical information – the complete rationale for TBT which includes here getting across the idea that TBT involves setting up another therapeutic relationship with the child in which the child can engage with a new range of problem solving behaviour and the potential for experiencing or undergoing a corrective emotional experience – so just clarify that.

Interviewer: My next question links with this one that we covered now. From my research, manuals were recommended as a way to include theoretical information. What would you recommend should be included in such a manual when training Teddy Bear therapists?

Interviewee: Well the way in which I approached the theoretical question was with a manual in mind so everything that I suggested should be included as theoretical information should be included in the manual .

Interviewer: Anything else that you would like to include aside from those that you have mentioned?

Interviewee: In the manual – what would be helpful is an example – a case with a client where the trainee can refer back to.

Interviewer: Okay, an actual case study?

Interviewee: Yes, a case study. Just a simple case study – highlighting the essential elements and again what I said around developmental psychology – around the stages – that holds true, so just a brief overview of the developmental stages for instance that should also be there .

Interviewer: Okay. Anything else?

Interviewee: Again it is like I already mentioned – I am just emphasising that even the developmental part – just briefly give an overview .

Interviewer: Okay. That's it. Thank you for your time.

Interviewee: Okay.

Clinician 3: Interview, 20/06/2011

Interviewer: Based on your experience in the field of Teddy Bear Therapy, what would the essential features of a Teddy Bear Therapy training programme for psychotherapists be?

Interviewee: The essential features of a TBT training programme for psychotherapists would essentially be divided into a theoretical element and a practical (experiential) element. The theoretical element would include an understanding and knowledge of Child Developmental Theories in Psychology, including training (both theoretically and practically) in the IPA according to Charl Vorster's Systems Theory. Theoretical and practical training that would enhance the therapists skills of empathy, congruence, unconditional positive regard and specifically the therapists skills in effective storytelling, which may be preceded by a theoretical understanding and knowledge of Gardner's Storytelling Technique as a background or foundation on which to build.

Finally both a theoretical and a practical guidance and understanding of TBT.

Interviewer: From the literature that I have reviewed it is evident that prior to training most training programmes on child psychotherapy has certain requirements candidates have to meet in order to function successfully in the training setting. In the context of Teddy Bear Therapy training – what is to your opinion the requirements a trainee has to meet before engaging in training?

Interviewee: A trainee would first and foremost need to have a passion and desire to work with children. They would need to demonstrate high degrees of empathy, congruence,

UPR and have effective problem solving skills, and finally they should demonstrate a good flexibility to be able to work well with and relate to children of a wide range of ages.

Interviewer: What are the most important skills for therapists to develop in order to be effective as Teddy Bear therapists?

Interviewee: The most important skills would be: creativity, flexibility, congruence, UPR and essentially a high degree of empathy. Good storytelling techniques and good problem solving skills.

Interviewer: What training methods would you recommend be used to train these skills for trainees?

Interviewee: Training methods would need to incorporate a theoretical and practical (experiential) element. Experiential: would be demonstrated through case studies. Role playing can also aid the experiential learning, however, I feel that exposure to numerous case studies, and discussions around the case studies would prove highly beneficial to trainees. Theoretical: Knowledge and understanding of childhood psychological developmental theories, brief understanding of how child psychotherapy has evolved, IPA (Charl Vorster); Gardner's storytelling technique and finally the theory underlying TBT.

Interviewer: What theoretical information would you include in a training manual for Teddy Bear therapists?

Interviewee: Manuals could include: Case Studies with a discussion around types of problems encountered when working with children and solutions provided in a practical

manner to the trainee through the TBT.

Interviewer: Thank you so much for your time.

Interviewee: It was a pleasure.

Appendix C: Programme and Manual

Session 1:

Theme: Introduction

Learning objectives:

- Set the context for the training process.
- Introduce the trainees to the programme.
- Determine the trainees' pre-existing knowledge on child psychotherapy.

Tasks:

- Hand out the manual to the trainees.
- Work through the introduction (section 1) of the manual with the trainees.
- Conduct a needs assessment with the trainees by inquiring about their background knowledge on child psychotherapy, systems theory and interactional therapy to establish where the focus of the training needs to be.
- Give an overview of what the programme is about and what the sessions will consist of to the trainees.

Preparation for next session:

Instruct the trainees to do an individual study of Section A in the training manual in order to comprehend Teddy Bear Therapy, the context in which it developed and in which it now functions. Trainees are hence required to have an understanding of developmental psychology (refer to section 2), Person-centred Therapy (refer to section 3), the IPA (refer to

section 4), the development of child psychotherapy (section 6) in the next session. Additional prescribed reading:

In addition to the theory in Section A of the manual, recommend to the trainees to read the following for a comprehensive understanding, either on their own time or in time for the next session:

Abnormal Child Psychology, Mash, E.J. & Wolfe, D.A.

Client Centered Therapy, Rogers, C.R

Impact, Vorster, C.

General systems theory and psychotherapy: Beyond post-modernism, Vorster, C.

Session 2:

Theme: Setting the context for Teddy Bear Therapy

Learning objectives:

- Review theory essential for a thorough understanding of Teddy Bear Therapy: developmental psychology, Person-centred Therapy, the IPA.
- Set the context for a discussion on Teddy Bear Therapy by discussing the development of child psychotherapy according to section B in the manual.

Tasks:

- Refer to the manual (section 2-5) and facilitate a group discussion on the developmental phases of children, the person-centered approach and the IPA.
- Discuss how all of this fits in with Teddy Bear Therapy.
- Give theoretical input on the development of child psychotherapy with specific reference to Play Therapy and Richard Gardner's Mutual Storytelling Technique as set out in section 6 of the manual.

Prescribed reading:

Recommend that trainees read the following, on their own time, as validation for what have been discussed during the session:

Play therapy, Axline, A.E.

Therapeutic communication with children: The Mutual Storytelling Technique, Gardner, A.E.

Session 3:

Theme: The development of Teddy Bear Therapy

Learning objectives:

- Establish a theoretical foundation for Teddy Bear Therapy.
- Put emphasis on the rationale of Teddy Bear Therapy.
- Provide theoretical input on the indications for Teddy Bear Therapy.

Tasks:

- Give input on the development of Teddy Bear Therapy by referring trainees to section 7.1 in the manual.
- Discuss the rationale behind Teddy Bear Therapy and the various indications by referring to section 7.3 in the manual.

Preparation for next session:

- In preparation for the next session, recommend individual study on the step-by-step process of Teddy Bear Therapy (as outlined in section 7.2 of the manual).

Session 4:

Theme: The process of Teddy Bear Therapy

Learning objectives:

- Familiarise the trainees with the process of Teddy Bear Therapy.
- Assist the trainees in developing an operational understanding of the systems approach and interactional theory by describing the family system from a systemic perspective and drawing up an IPA.
- Train trainees to be able to make a link between the presenting complaint with the system's behaviour.
- Train trainees to identify the nodal point that needs intervention by means of integrating the IPA and findings from history taking.
- Sharpen the trainees' observation skills.
- Facilitate a meta perspective on the process of Teddy Bear Therapy.

Tasks:

- Work through an entire case study with the trainees as set out in the manual's section 8.
- Get two volunteers to do a role play on the step-by-step process of Teddy Bear Therapy, with one trainee being the child, one the therapist. Assign the rest of the group to do the IPA without glancing at the manual.
- Facilitate a discussion of the exercise and the process of Teddy Bear Therapy.

Preparation for next session:

- Refer trainees to section 7.4 of the manual and recommend individual study on the significance of Teddy Bear Therapy.

Session 5:

Theme: The significance of Teddy Bear Therapy

Learning objectives:

- Facilitate high levels of empathy for the child client and a child's frame of reference.
- Develop the trainees' flexibility.
- Enhance effective problem solving skills amongst trainees.
- Facilitate exercises for the trainees on how to engage a child in a comfortable therapeutic, asocial manner and thus how to facilitate effective rapport.
- Facilitate the development of a caring, confirming, respectful attitude towards children.

- Enhance the trainees' storytelling skills.
- Develop the trainees' creativity as a storytellers as well as how to convey the therapeutic message to the child in the form of a story.
- Facilitate feedback amongst the trainees' from and to each other.
- Create self-awareness.

Tasks:

- Do role rehearsal with the trainees.
- Split the trainees into groups of three; one trainee who serves as observer and who gives feedback to the other two trainees on their skills and their impact; another trainee as the child client and the last trainee as the Teddy Bear Therapy therapist.
- Do a role change to broaden the trainees' frame of references.
- Facilitate a theoretical overview of the process of Teddy Bear Therapy and facilitate a group discussion on the significance of Teddy Bear Therapy.

Preparation for next session:

- Recommend additional practice on the process of Teddy Bear Therapy outside the training context, in groups of two, and instruct the trainees to bring voice recordings of the exercise for the next session.

Session 6:

Theme: Feedback

Learning objectives:

- Facilitate an awareness amongst the trainees of how he/she is experienced by fellow trainees and the trainer and the impact of that style in the Teddy Bear Therapy situation.

Tasks:

- Listen to the voice recordings of the role plays with the trainees.
- Provide feedback to the trainees on their skills as reflected in the voice recordings and the impact they have on you as facilitator.
- Facilitate feedback amongst the trainees on each other's skills as reflected in the voice recordings and impact they have on each other.

Preparation for next session:

- Recommend individual study on previous master's research on the effectiveness of Teddy Bear Therapy as set out in the manual (see section 7.5).

Session 7:

Theme: The effectiveness of TBT

Learning objectives:

- The trainees should be able to motivate the application of Teddy Bear Therapy based on its effectiveness.

Tasks:

- Facilitate a group discussion on the effectiveness of Teddy Bear Therapy.

Preparation for next session:

- Recommend that trainees read through the relevant sections in the Child Care Act 1998 and ethical guidelines for psychotherapists as set out by the HPCSA (as referred to in section 5 of the manual) .

Prescribed reading:

Aside from the preparation for the next session, recommend that trainees read the article on Ethics in a Multicultural Setting, written by John Brown as prescribed in section 5 of the manual.

Session 8:

Theme: Ethics

Learning objectives:

- Create an awareness of the ethical and legal implications of working with children.
- Facilitate a sensitivity for multicultural perspectives that may influence the therapeutic process.
- Facilitate an understanding of the diversity of the child psychotherapist's role definition.

Tasks:

- Initiate a discussion on the ethical implications of working with children.
- Facilitate suggestions from the trainees on ethical factors that needs to be considered when working as Teddy Bear therapists.
- Add ethical guidelines which has not been accounted for in the discussion by means of the rules of conduct as set out by the HPCSA.
- Discuss the prescribed article on multicultural perspectives and ethics and how it may impact on the therapeutic relationship as well as process.
- Discuss the role of the child psychotherapist with regard to but not only limited to the discussed ethical implications. Using the manual (section 9) as reference it is especially necessary to focus on the child psychotherapist's responsibilities when working in a interdisciplinary setting.

Session 9

Theme: Consolidation and reflection

Learning objectives:

- Consolidate with the trainees on what they have learnt.

Tasks:

- Facilitate a group discussion on what have been presented and learnt by referring to the theoretical information as set out in the manual but also referring to the practical skills and feedback trainees received.

Preparation for the next session:

Instruct the trainees to bring recordings and IPA's of a Teddy Bear Therapy case they have conducted two months after the training ended. Inform the trainees that these cases also needs to be presented by themselves.

Session 10:

Theme: Follow-up evaluation

Learning objectives:

- Evaluate the effectiveness of the training.
- Evaluate and analyse the therapeutic skills of the trainees.
- Evaluate and assist trainees with case management.

Tasks:

- Instruct the trainees to each present a Teddy Bear Therapy case by playing their voice recording of the sessions and presenting the IPA's of the clients.
- Facilitate a feedback session from trainees to each other on their skills and case management and as facilitator either validated or expand on the feedback.
- Recommend regular supervision for trainees on their Teddy Bear Therapy cases in order to maintain and fine tune their skills.

MANUAL AND GUIDE



TRAINING TEDDY BEAR THERAPY THERAPISTS

- A MANUAL -

Compiled by: Leandri van der Ryst

Table of Contents

1. Introduction	3
Section A:	
2. Developmental Psychology	5
3. Person-centred Therapy	38
4. Interactional Pattern Analysis	45
5. Prescribed Reading List	47
Section B:	
6. The Development of Child Psychotherapy	48
7. Teddy Bear Therapy	53
7.1 The development of Teddy Bear Therapy	53
7.2 The procedure of Teddy Bear Therapy: Step-by-step	53
7.3 The indications for Teddy Bear Therapy	55
7.4 The significance of Teddy Bear Therapy	56
7.5 Research on the effectiveness of Teddy Bear Therapy	57
7.6 The effectiveness of Teddy Bear Therapy	62
8. Case Study	62
9. The Role of Child Psychotherapist	73
10. References	75

1. Introduction

"In a world where everyone seems to be larger and louder than yourself, it is very comforting to have a small, quiet en furry companion."

- Peter Gray

Teddy Bear Therapy (TBT) for children (aged between three and twelve years) is an exciting, relatively new form of therapy that yields rapid and dramatic results within three to six sessions. Charl Vorster developed this form of therapy based on the Mutual Storytelling Technique as developed by Richard Gardner and Play Therapy from the works of Virginia Axline (Baloyi, 2001). Teddy Bear Therapy thus incorporates storytelling and play.

The significance of Teddy Bear Therapy lies in its potential to ensure change in the child's interaction as well as the child's whole family system (Vorster, 1995). Teddy Bear Therapy addresses the child's difficulty on his/her developmental and emotional level (Baloyi, 2001). It focuses on empowering the child to solve his/her own problems and strengthen his/her resources (Vorster, 1995).

Teddy Bear Therapy is a highly specialised form of therapy, which implies the need for highly specialised therapists who are efficiently trained. To accomplish this, the training of Teddy Bear Therapy therapists incorporates theoretical as well as practical learning. The focus on theory as well as practice will evidence in the nine sessions of this training programme.

This manual is developed as part of the training programme to be used as a theoretical reference by the trainees as well as the facilitator. The facilitator of the training programme in Teddy Bear Therapy will utilise the present manual when presenting

theoretical information. The manual will also be a reference for trainees to prepare certain sections, as indicated by the facilitator.

The manual is divided into two sections. Section A includes an overview of the fundamental theoretical aspects necessary in order to grasp the essence of Teddy Bear Therapy and assist in the application thereof. This will have to be worked through by the trainees when indicated to do so by the facilitator and will also be touched on in specific training sessions. The section includes an overview of developmental psychology, developmental milestones of children aged three to twelve, the person-centred approach and the Interactional Pattern Analysis. A reading list is provided in addition to this information and must be referred to as indicated by the facilitator.

Following this, Section B focuses on Teddy Bear Therapy. It commences with a historical overview of child psychotherapy, which will be worked through to set the context for an overview of the development of Teddy Bear Therapy. Thereafter Teddy Bear Therapy is discussed in depth and a case study is provided for trainees to refer back to whenever necessary. In conclusion, the role of the clinical child psychotherapist will be discussed briefly by the facilitator and trainees must consult the manual for information on this.

Section A

2. Developmental Psychology

In order to conduct Teddy Bear Therapy, a clinician has to have a thorough understanding of a child and their development. Developmental psychology will hence be discussed in accordance to this objective. Developmental psychology is the scientific analysis of the social, emotional and intellectual changes that enable progression over the lifespan (Louw, Van Ede & Louw, 1998).

Knowledge on life span development is an important foundation for the practice of child clinical psychology (Mash & Wolfe, 2005). Developmental issues specific to the practice of child psychology include the emotional, social, motor, and behavioural development, as well as physiologic maturation (Spirito et al., 2003).

Many problems arise as children and families move through the different stages and adapt to either changing developmental stages (i.e., beginning preschool, kindergarten, primary school or high school) or to crises within the family (i.e., divorce, relocation, death of a grandparent, illness of a child or trauma) (Pickar & Lindsay, 2008). Frequently, the psychotherapist assists by normalising and reframing issues that place the problem in a developmental framework (Pickar & Lindsay, 2008).

In the context of Teddy Bear Therapy, it is essential that the psychotherapist has sufficient knowledge of the developmental phases appropriate to a child's age to differentiate between normal and abnormal development. Being able to identify the level of a child's functioning also enables the therapist to plan the intervention accordingly.

In order to do that, the psychotherapist needs to have an understanding of developmental psychology. As developmental psychology is a broad and extensive field of expertise, this manual will only attempt to provide a brief overview of the key theories in developmental psychology, where after the different developmental stages of children aged three to twelve will be outlined.

2.1 Key theories in developmental psychology.

Many theoretical perspectives attempt to explain development. Adapted from Louw, Van Ede and Louw (1998), the most prominent are:

1. cognitive – developmental theories;
2. psychodynamic theories;
3. behavioural learning and social cognitive learning;
4. contextual developmental theories; and
5. nativist theories

2.1.1 Cognitive developmental theories.

These theories focus on how thinking and problem solving develop as well as how cognitive activities contribute to development in general.

2.1.1.1 Piaget's age stage theory.

Piaget was of the opinion that children show qualitatively different levels of comprehension and reasoning at different ages and at different stages of development. He described four stages of cognitive development and relates them to a person's ability to understand and assimilate new information.

1. Sensorimotor: *(birth to about age 2)*

During this stage, the child learns about himself and his environment through motor and reflex actions. Thought derives from sensation and movement. The child learns that he is separate from his environment and that aspects of his environment – his parents or favourite toy – continue to exist even though they may be outside the reach of his senses. Teaching for a child in this stage should be geared to the sensori-motor system. You can modify behaviour by using the senses: a frown, a stern or soothing voice – all serve as appropriate techniques.

2. Preoperational: *(begins at about the age that the child starts talking until about age seven)*

Applying his new knowledge of language, the child begins to use symbols to represent objects. Early in this stage he also personifies objects. He is now better able to think about things and events that are not immediately present. Oriented to the present, the child has difficulty conceptualising time. His thinking is influenced by fantasy and he assumes that others see situations from his viewpoint. He takes in information and then changes it in his mind to fit his ideas. Teaching must take into account the child's vivid fantasies and undeveloped sense of time. Using neutral words, body outlines and equipment a child can touch, gives him an active role in learning.

3. Concrete: *(about first grade to early adolescence)*

During this stage, accommodation increases. The child develops an ability to think abstractly and to make rational judgments about concrete or observable phenomena, which in the past he needed to manipulate physically to understand. In teaching this child, giving him

the opportunity to ask questions and to explain things back to you allows him to mentally manipulate information.

4. Formal operations: (*adolescence*)

This stage brings cognition to its final form. This person no longer requires concrete objects to make rational judgments. At his point, he is capable of hypothetical and deductive reasoning. Teaching the adolescent entails a broad scope of methods because he'll be able to consider many possibilities from several perspectives.

2.1.1.2 Information processing theories.

In contrast to Piaget's, who was of the opinion that thought development occurred in stages, this theory emphasises a continuous pattern of development. These theories are concerned with how information is stored, retrieved, organised and manipulated. It is based on the idea that humans process the information they receive, rather than merely responding to stimuli. According to the standard information-processing model for mental development, the mind's machinery includes attention mechanisms for bringing information in, working memory for actively manipulating information, and long term memory for passively holding information so that it can be used in the future. This theory addresses how, as children grow, their brains likewise mature, leading to advances in their ability to process and respond to the information they received through their senses.

2.1.2 Psychodynamic theories.

The psychodynamic theories perceive development as an active process influenced by inborn biological drives and conscious or unconscious, emotional or social experiences.

2.1.2 .1 Freud's psychoanalytical theory.

Freud and his followers believed that children are born with basic animal unconscious instincts and that development depends on transforming these into socially acceptable, rational behaviour. Children are thus seen as human beings in turmoil, struggling to achieve control over biological needs and to make themselves acceptable to society through the microcosm of the family.

Freud's Stages of Psychosexual Development are, like other stage theories, completed in a predetermined sequence and can result in either successful completion or a healthy personality or can result in failure, leading to an unhealthy personality. This theory is probably the most well known as well as the most controversial, as Freud believed that we develop through stages based upon a particular erogenous zone. During each stage, an unsuccessful completion means that a child becomes fixated on that particular erogenous zone and either over- or under-indulges once he or she becomes an adult.

Oral stage (birth to 18 months). During the oral stage, the child focuses on oral pleasures (sucking). Too much or too little gratification can result in an oral fixation or oral personality, which is evidenced by a preoccupation with oral activities. This type of personality may have a stronger tendency to smoke, drink alcohol, over eat, or bite his or her nails. Personality wise, these individuals may become overly dependent upon others, gullible, and perpetual followers. On the other hand, they may also fight these urges and develop pessimism and aggression toward others.

Anal stage (18 months to three years). The child's focus of pleasure in this stage is on eliminating and retaining feces. Through society's pressure, or pressure from parents, the

child has to learn to control anal stimulation. In terms of personality, after effects of an anal fixation during this stage can result in an obsession with cleanliness, perfection, and control (anal retentive). On the opposite end of the spectrum, they may become messy and disorganised (anal expulsive).

Phallic stage (ages three to six). The pleasure zone switches to the genitals. Freud believed that during this stage, boys develop unconscious sexual desires for their mother. Because of this, he becomes rivals with his father and sees him as competition for the mother's affection. During this time, boys also develop a fear that their father will punish them for these feelings, such as by castrating them. This group of feelings is known as Oedipus Complex (after the Greek Mythology figure who accidentally killed his father and married his mother).

Later it was added that girls go through a similar situation, developing unconscious sexual attraction to their father. Although Freud strongly disagreed with this, it has been termed the Electra Complex by more recent psychoanalysts.

According to Freud, out of fear of castration and due to the strong competition of his father, boys eventually decide to identify with him rather than fight him. By identifying with his father, the boy develops masculine characteristics and identifies himself as a male, and represses his sexual feelings toward his mother. A fixation at this stage could result in sexual deviancies (both overindulgence and avoidance) and weak or confused sexual identity, according to psychoanalysts.

Latency stage (age six to puberty). It's during this stage that sexual urges remain repressed and children interact and play mostly with same sex peers.

Genital stage (from puberty onwards). The final stage of psychosexual development begins at the start of puberty when sexual urges are once again awakened. Through the lessons learned during the previous stages, adolescents direct their sexual urges onto opposite sex peers, with the primary focus of pleasure being the genitals.

2.1.2 .2 Erikson's psychosocial theory.

This theory focuses on the role of internal psychological processes; life circumstances and historical contexts; social, cultural and historical context. Erikson identified eight psychosocial stages of development based on a sequence of crises. Resolution of these crises is essential for healthy social development.

Hope: Trust versus mistrust (infants, from birth up to 12-18 months)

- Psychosocial crisis: Trust vs. mistrust
- Virtue: Hope

The first stage of Erik Erikson's theory is about the infant's basic needs being met by the parents. The infant depends on the parents, especially the mother, for food and comfort. The child's relative understanding of world and society come from the parents and their interaction with the child. If the parents expose the child to warmth, regularity, and dependable affection, the infant's view of the world will be one of trust. Should the parents fail to provide a secure environment and to meet the child's basic needs, a sense of mistrust will result. According to Erik Erikson, the major developmental task in infancy is to learn whether or not other people, especially primary caregivers, regularly satisfy basic needs. If

caregivers are consistent sources of food, comfort, and affection, an infant learns trust – that others are dependable and reliable. If they are neglectful, or perhaps even abusive, the infant instead learns mistrust – that the world is in an undependable, unpredictable, and possibly a dangerous place.

Will: Autonomy vs. shame and doubt (toddlers, 18 months to three years)

- Psychosocial crisis: Autonomy vs. shame and doubt
- Main question: "Can I do things myself or must I always rely on others?"
- Virtue: Will

As children gain control over eliminative functions and motor abilities, they begin to explore their surroundings. The parents still provide a strong base of security from which the child can venture out to assert their will. The parents' patience and encouragement helps foster autonomy in the child. Children at this age like to explore the world around them and they are constantly learning about their environment. Caution must be taken at this age as children may explore things that are dangerous to their health and safety. At this age, children develop their first interests. For example, a child that enjoys music may like to play with the radio. Children that enjoy the outdoors may be interested in animals and plants. Highly restrictive parents, however, are more likely to instill the child with a sense of doubt and reluctance to attempt new challenges. As their muscular coordination and mobility increase, toddlers become capable of satisfying some of their own needs. They begin to feed themselves, wash and dress themselves, and use the bathroom. If caregivers encourage self-sufficient behaviour, toddlers develop a sense of autonomy – a sense of being able to handle many problems on their own. But if caregivers demand too much too soon, refuse to let

children perform tasks of which they are capable, or ridicule early attempts at self-sufficiency, children may instead develop shame and doubt about their ability to handle problems.

Purpose: Initiative vs. guilt (preschool, three to six years)

- Psychosocial crisis: Initiative vs. guilt
- Main question: "Am I good or am I bad?"
- Virtue: Purpose
- Related elements in society: Ideal prototypes/roles

Initiative adds to autonomy, the quality of undertaking, planning and attacking a task for the sake of being active and on the move. The child is learning to master the world around them, learning basic skills and principles of physics. Things fall down, not up. Round things roll. They learn how to zip and tie, count and speak with ease. At this stage, children want to begin and complete their own actions for a purpose. Guilt is a confusing new emotion. They may feel guilty over things that logically should not cause guilt. They may feel guilt when this initiative does not produce the desired results.

The development of courage and independence are what set preschoolers, three to six years of age, apart from other age groups. Young children in this category face the challenge of initiative versus guilt. As described in Bee and Boyd (2004), the child during this stage faces the complexities of planning and developing a sense of judgment. During this stage, the child learns to take initiative and prepare for leadership and goal achievement roles. Activities sought out by a child in this stage may include risk-taking behaviours, such as crossing a street alone or riding a bike without a helmet; both these examples involve self-

limits. In instances requiring initiative, the child may also develop negative behaviour. These behaviours are a result of the child developing a sense of frustration for not being able to achieve a goal as planned, and he/she may then engage in behaviour that seems aggressive, ruthless, and overly assertive to parents. Aggressive behaviour, such as throwing objects, hitting, or yelling, are examples of observable behaviours during this stage.

Preschoolers are increasingly able to accomplish tasks on their own, and can start new things. With this growing independence comes many choices about activities to be pursued. Sometimes children take on projects they can readily accomplish, but at other times they undertake projects that are beyond their capabilities or that interfere with other people's plans and activities. If parents and preschool teachers encourage and support children's efforts, while also helping them make realistic and appropriate choices, children develop initiative – independence in planning and undertaking activities. But if adults discourage the pursuit of independent activities or dismiss them as silly and bothersome instead, children develop guilt about their needs and desires.

Competence: Industry vs. inferiority (childhood, six to twelve years)

- Psychosocial crisis: Industry vs. inferiority
- Main question: "How can I be good?"
- Virtue: Competence
- Related elements in society: Division of labour

The aim of bringing a productive situation to completion gradually supersedes the whims and wishes of play. The fundamentals of technology are developed. To lose the hope

of such "industrious" association may pull the child back to the more isolated, less conscious familial rivalry of the oedipal time.

At this stage, children might express their independence by being disobedient, using back talk and being rebellious.

Erikson viewed the elementary school years as critical for the development of self-confidence. Ideally, elementary school provides many opportunities for children to achieve the recognition of teachers, parents and peers by producing things – drawing pictures, solving addition problems and writing sentences. If children are encouraged to make and do things and are then praised for their accomplishments, they begin to demonstrate industry by being diligent, persevering at tasks until completed, and putting work before pleasure. If children are instead ridiculed or punished for their efforts or if they find they are incapable of meeting their teachers' and parents' expectations, they develop feelings of inferiority about their capabilities.

At this age, children start recognising their special talents and continue to discover interests as their education improves. They may begin to choose to do more activities to pursue that interest, such as joining a sport if they know they have athletic ability, or joining the band if they are good at music. If not allowed to discover own talents in their own time, they will develop a sense of lack of motivation, low self esteem, and lethargy.

2.1.3 Behavioural learning and social cognitive theories.

These theories believe that developmental change is the result of learning and experiences. Development thus gradually occurs as we learn new responses as a result of experience. As individual life experiences differ, learning differs accordingly.

2.1.3.1 Behaviourist theories.

Behavioural theories of child development focus on how environmental interaction influences behaviour and are based upon the theories of theorists such as John B. Watson, Ivan Pavlov and B. F. Skinner. These theories deal only with observable behaviour. Learning is seen as a process of conditioning. Conditioning refers to a process of learning through responses to stimuli. Development is considered a reaction to rewards, punishments, stimuli and reinforcement. This theory differs considerably from other child development theories because it gives no consideration to internal thoughts or feelings. Instead, it focuses purely on how experience shapes who we are.

2.1.3.2 Social cognitive learning theories.

Social cognitive learning refers to how social skills are used and observed in order to learn. This refers to observational learning, imitation and modelling. John Bowlby proposed one of the earliest theories of social development. Bowlby believed that early relationships with caregivers play a major role in child development and continue to influence social relationships throughout life. He refers to this bond as 'attachment', which is a special emotional relationship that involves an exchange of comfort, care and pleasure.

Bowlby shared the psychoanalytic view that early experiences in childhood have an important influence on development and behaviour later in life. Early attachment styles are thus established in childhood through the infant/caregiver relationship.

In addition to this, Bowlby believed that attachment had an evolutionary component; it aids in survival.

Bowlby believed that there are four distinguishing characteristics of attachment:

1. **Proximity maintenance** – the desire to be near the people we are attached to.
2. **Safe haven** – returning to the attachment figure for comfort and safety in the face of a fear or threat.
3. **Secure base** – the attachment figure acts as a base of security from which the child can explore the surrounding environment.
4. **Separation distress** – anxiety that occurs in the absence of the attachment figure.

Many theorists followed after Bowlby and elaborated on this attachment theory.

2.1.4 Contextual developmental theories.

Development is viewed as a process of reciprocal interactions between the child and his physical environment. The focus is on the physical environment and as it is continuously changing, development itself is also seen as continuous.

2.1.4.1 Vygotsky's theory.

Vygotsky was of the belief that development occurs gradually as the child interacts with the environment and that, through these interactions, children internalise new ways of behaving and thinking. Like Piaget, Vygotsky believed that children learn actively and through hands-on experiences. His socio-cultural theory also suggested that parents, caregivers, peers and the culture at large were responsible for the development of higher order functions.

An important concept in socio-cultural theory is known as the zone of proximal development. According to Vygotsky, the zone of proximal development "is the distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers". Essentially, it includes all of the knowledge and skills that an individual or child cannot yet understand or perform on their own, but is capable of learning with guidance.

2.1.4.2 Ethological theory.

This theory emphasises the role of evolution in development. It is believed the inborn tendencies children possess predisposes them to act in certain ways. However, it is interactions with the environment that mould behaviour.

2.1.5 Nativist theories.

Nativists assert that development is the product of an interaction between environment and innate, domain-specific modules. Certain skills or abilities are seen as 'native' or hard wired into the brain at birth. The role of the environment is seen as minimal.

With these theories as foundation, a broad overview of the developmental stages of children aged three to twelve with relevance to Teddy Bear Therapy will now be provided as an adapted summary of the literature presented by Louw, van Ede and Louw (1998). It should however be noted that the developmental milestones listed should not be seen as a checklist for a psychotherapist to judge whether the child's development is normal or delayed – it should just be seen as a rough indication of the child's development and should always be

seen in context with all other clinical information in order to obtain a holistic picture of the presenting problem.

2.2 The three year old child.

By the age of three, many of the troublesome issues of infancy have been overcome. Physically, three year olds should now have control over their bowels and bladder, at least during the day. If however they are anxious, physically ill, overtired or experiencing other stressors, 'accidents' may occur during the day. Their physical movement become increasingly more agile and they can run, jump and climb without effort. Their fine motor ability is increasingly more refined and they should have good pencil control and be able to cut paper with scissors.

Socially, they are now able to talk more freely, exchange greetings and news, asks for information and talk about their own adventures. They are also extremely inquisitive, with most sentences starting with 'what' or 'where' or 'who'. They also constantly learn new words.

A big step in the child's social development is that he/she now begins to enjoy the companionship of other children. However, according to Feldman (1999), their social development at this stage can be either significantly enhanced or restricted by the nature of their relationships with adults. According to Mash and Wolfe (1995), this is a stage in the child's development when the child not only copies the gestures and actions of adults around him, but also tends to adopt an attitude to life. With the opportunity of being with other

children their own age, they start to learn that sharing, being patient and cooperating can actually enhance their own enjoyment.

Three year olds spend a good deal of time in imaginative and dramatic play and they also tend to project their own experience on to their play things (Lee, 1999). Any experience that has puzzled, disturbed or interested them are worked over and dramatised in their play, and their dolls and animals often play the leading roles. Imaginative play can be solitary but it becomes more elaborate, with more children joining in, as the children find enjoyment in sharing and cooperating with each other.

2.2.1 Cognitive/intellectual development:

- They have the ability to talk so that 70-80 % of their speech is understandable.
- They have a vocabulary of about 900 words.
- They talk in complete sentences, using about three to five words.
- They may stumble over words occasionally, although it is not a sign of stuttering.
- They enjoy repeating words and sounds.
- They listen attentively to short stories and books.
- They like familiar stories told without change in the words.
- They enjoy listening to stories and repeating familiar rhymes.
- They are able to tell simple stories from books.
- They enjoy singing and can carry a simple tune.
- They are able to stack five to seven blocks.
- They enjoy playing with clay or play dough.
- They are able to draw a circle and a square.
- They are able to recognise common, everyday sounds.

- They are able to match an object to the picture of that object.
- They can count two to three objects.
- They can solve problems if they are simple, concrete, real and immediate.
- They are interested in similarities and differences.
- They can distinguish, match and name common colors,
- They have good self-knowledge and can understand the difference between themselves and younger children but not yet between themselves and older children.
- They are able to say how old they are.

2.2.3 Emotional development:

- Their emotions are usually extreme and short-lived.
- They may have moments when they are still afraid of noises, the dark, monsters etc.
- They adopt the attitudes and feelings of the adults around them.
- They have the ability to show sympathy.
- They refer to themselves as 'I' or 'me'.
- Closer to the age of four they may show feelings of insecurity expressed as shyness, irritability, self-consciousness or nervousness.

2.2.4 Social development:

- They are very inquisitive.
- They enjoy dramatic play with other children.
- They begin to learn how to share and consider the needs of others.
- They want attention and approval of loved adults.

- They sometimes show preference for one parent (often the other sex).
- They accept suggestions and are able to follow simple instructions.
- They have the ability to make simple decisions.
- They are developing a sense of humor and may enjoy being silly.
- They may initiate play or join in play with others.
- Make believe play is still prominent.
- They are able to comprehend the difference between boys and girls and stereotyped ideas around gender.
- They may express interest in the difference between ethnic identities and the differences between themselves and others.

2.2.5 Needs:

- Companionship with other children.
- Encouragement and confirmation of adults.
- As much independence as possible with tactful assistance from adults.
- Dress-up clothes, stories, picture books, songs, finger plays and opportunities to participate in imaginative play.
- Opportunities for painting, drawing, modeling, building.
- Freedom and opportunities for vigorous physical play in suitable environments.
- Sand and water play.

2.3 The four year old child.

The four year old tends to be energetic and physically agile. They prefer to be given reasons for what adults demand, but respond well to sensible direction. At this stage they

develop some standards by which to judge their own behaviour and that of other people (Oesterreich, 1995).

In their play, four year olds can plan ahead and work with an end in view. They display an increasing amount of control over their emotions, and can show a remarkable amount of patience in working out a practical problem or learning to manipulate some new piece of material (Lee, 1990).

Four year olds show an increasing enjoyment in social interactions and the company of older children, and if given the opportunity, they tend to play in groups (Cole & Cole, 2001). They begin to seek out constant companions with whom they are especially friendly and with whom they do most things together. Patterns in behaviour become increasingly observable and within this group play, 'leaders' and 'followers' become increasingly visible.

Four year olds tend to respond quickly to adult enthusiasms, however, they rely less on constant, active companionship of adults. A significant need that they have of adults at this age is to answer questions (Thompson, 1996). They probably have already gathered a lot of information and now wants reasons, starting a lot of their sentences with the question "why". They are however still struggling with distinguishing between fact and fantasy and tend to be fond of telling long, elaborate stories about their own doings, many of which can be purely imaginary.

2.3.1 Cognitive/Intellectual development:

- They are able to recognise some letters if taught, and even be able to write their own name.
- They can recognise familiar words in simple books or signs (eg. STOP sign).

- They can demonstrate the understanding of concepts like tallest, biggest, same, more, on, in, under and above.
- They can count one to seven objects out loud, and understand the order of daily routines such as breakfast before lunch, lunch before dinner etc.
- They display progress in separating fact from fiction.
- They have the ability to speak in fairly complex sentences.
- Their vocabulary ranges to about 1 500 words.
- They ask many questions.
- They may enjoy simple songs, rhymes and nonsensical words.
- They are able to learn their name, address and phone numbers if taught.
- They are able to pursue an activity for 10 - 15 minutes.
- They can name about six to eight colors and three shapes.
- They can follow about two unrelated instructions.
- They have basic understanding of concepts related to number, size, weight, colors, textures, distance and time.

2.3.2 Emotional development:

- They display some control over their emotions, but intense anger, frustration and jealousy can be observed.
- They show persistence and purpose.
- They have the ability to display and convey concern for others.
- They may still have fear of the dark and monsters etc.
- They begin to understand danger, and at times can be quite fearful.
- Anger is usually expressed verbally rather than physically.

2.3.4 Social development:

- They may swear or use foul language.
- They enjoy playing with large groups of children.
- They may develop one or two particularly close friends.
- Play is elaborate, prolonged and imaginative.
- They seek out adult approval.
- They don't yet understand the concept of lying and may lie to protect themselves and friends.

2.3.5 Needs:

- Careful and truthful answers to questions.
- Approval of adults in a secure context of consistent behaviour and standards.
- To be treated as a reasonable person.
- Opportunities and safe places for vigorous physical and imaginative play with other children.
- Large play materials for building (lego and wooden construction sets), as well as sand, water, paint and drawing material.

2.4 The five year old child.

This stage forms the beginning of a 'weaning' process as the five year old begins to take on much more responsibility for his/her own behaviour and depends less on adult support (Lee, 1990). They tend to become well spoken and show persistence when trying to master a new skill. They can control their emotions fairly well, especially in the pursuit of their own purposes. Although they may play in groups, each child is performing for himself

in the company of others and may even perceive their playmates as rivals as well as collaborators (Feldman, 1999).

The five year old is very eager to learn and please adults and may appear to show off or boast, as they are actively seeking praise and encouragement (Thompson, 1995).

A significant change that a five year old undergoes is that he is probably going to school. This adjustment can be made easier or harder depending on the extent of prior exposure to social interaction with other children. The availability of more authority figures also provides a variety of models for the child to imitate (Feldman, 1999).

2.4.1 Cognitive/Intellectual development:

- Their vocabulary consists of about 3 000 words.
- They tend to use five to eight words in a sentence.
- They like to argue and use words like 'because'.
- They know the basic colors.
- They are able to memorise addresses and phone numbers.
- They understand that stories have a beginning, a middle and an end.
- They are able to remember stories and repeat it to others.
- They enjoy creating and telling stories .
- They can draw pictures that are identifiable as animals, people and objects.
- They understand time concepts like yesterday, today and tomorrow.
- They are able to recognise categories.
- Their block and dramatic play is much more elaborate and complex.
- They have good attention span and the ability to concentrate.

- They are interested in cause and effect.

2.4.2 Emotional development:

- They tend to boast and threaten but also display friendliness and generosity.
- They begin to show a desire to excel.
- Their fears are still present but also directed towards more realistic dangers.
- They express anger and jealousy physically.
- They are becoming more sensitive to the feelings of others and notice when other children are happy or sad.
- They like to feel and be treated as adults.
- They begin to have a very basic understanding of right and wrong.
- They are sometimes critical of others and embarrassed by their own mistakes.

2.4.3 Social development:

- They are often content to play alone for long periods mastering a skill, but also function well when playing with other children, especially in building and imaginative play.
- They tend to prefer games of rivalry to team games, but do not like to fail at these games.
- They enjoy stories of strong and powerful people (eg. superman or batman).
- They depend strongly on adults, parents, teachers, and caregivers for approval, praise and encouragement.
- They may have a best friend and an enemy.
- They tend to prefer playmates of the same sex.
- They start to develop a moral sense, but they tend to associate 'good' and 'bad' with what teachers and caretakers approve and disapprove of.

- They are able to invent games with simple rules and to organise friends and toys for pretend play.
- They may begin to use swear words or 'bad' words to get attention.
- They can sometimes be very bossy, especially in the presence of younger children.
- They like to try new things, to take risks and to make their own decisions.
- They may often exclude other children in play and may become bossy when other children join in.
- They may begin to understand and respect rules and often ask for permission.
- They understand and enjoy both giving and receiving .
- They enjoy collecting things .
- They can understand relationships among people.
- They have developed a good sense of humor and enjoy sharing jokes and laughter with adults.

2.3.4 Needs:

- A calm, reasonable approach from parents who can control their rivalry, encourage a serious attitude towards achievements and counter his showing off with affectionate banter.
- Skillful introduction to school life by teachers.
- Accurate answers to questions.

2.5 The six year old child,

At age six children begin to build on the important developments that occurred in the first six years of life, and seem to settle down to a steadier pace of growing and learning (Cole & Cole, 2001). This age group are interested in real life tasks and activities, and

pretend and fantasy lessen considerably. School agers want to make 'real' jewelry, take 'real' photographs etc.

Six year olds have a significantly longer attention span and are more likely to stick with things that they have started until the project is finished, the problem solved or the argument resolved. Doing things together with friends, teamwork and following rules becomes very important. This age group is fascinated by rules and can develop games with extensive rules and rituals (Feldman, 1999).

2.5.1 Cognitive development:

- Their ability to speak and express themselves has developed rapidly.
- During play they practice using the words and language they have learned in school.
- They are able to tell left from right.
- Their attentions span is longer.
- They are able to start learning how to read.
- They like to 'work'.
- They like explanations.
- They still ask a lot of questions.
- They learn best through discovery and love the novelty value of experiences.
- Representable symbols become important to them.

2.5.2 Emotional development:

- They appear to be more emotionally labile than in their fifth year and swing from love to hate and then back again rapidly.

- They tend to be self-centered, obsessive, irritable, aggressive and rebellious – however they can also be friendly open and cooperative.
- They are intensely enthusiastic, curious and competitive.
- They find frustration and failure difficult to accept.

2.5.3 Social development:

- They talk freely and are interested in new words.
- They start being more independent from adults but still need unobtrusive help and demands praise.
- They may become quarrelsome with other children but show a need of cooperation in their play.
- They become tenacious over their own possessions.
- They tend to come across as having a ‘know-it-all’ attitude and are free with opinion and advice.
- They are proud of their accomplishments.
- They may be anxious to do well.
- They are able to observe family rules.
- Their father’s authority remains unquestioned but their teacher’s standards may often be accepted over those of their mother’s.
- Gender role stereotypes are usually quite rigid.
- Friends are gained easily but are also easily lost.
- They compare themselves with their peers and often have a need to belong.
- Friends are usually of the same sex.

2.5.4 Needs:

- Firm control over daily routine within which he can be allowed enough freedom to inquire, experiment and explore.
- A stimulating environment at home and at school.
- Encouragement for their efforts and praise for their achievements.
- Play material that requires skills.
- Arrangements for adequate rest and sleep.

2.6 The seven to eight year old child.

Children in the age groups seven to eight are in a stage of development often referred to as middle childhood (Oesterreich, 1995). They attend school and they are likely to enjoy the mastering of lots of new physical skills. They learn rapidly at school and the opinions of their classmates matter more than ever before, as they are more sensitive to peer pressure.

2.6.1 Cognitive/intellectual development:

- They have an increased ability to remember and pay attention and are also able to speak and express ideas more fluently as their vocabulary have almost doubled.
- They tend to have quite rigid perspectives on things – it's viewed as black and white, right and wrong, great or terrible etc.
- They are learning to plan ahead and evaluate what the consequences of their behaviour are.

- With increased ability to think and reason, they enjoy different types of activities, such as clubs and games with rules.
- Their problem solving abilities increase and they can use logical systematic thinking.
- Although they are increasingly becoming more considerate of other people, they still tend to be self-centered.
- They are able to grasp more abstract concepts and can focus on the past, the future and the present.
- Their self control increases and they are more able to conform to adult ideas of what is acceptable and appropriate behaviour.

2.6.2 Emotional development:

- The seven year old is less emotionally labile than at age six.
- They are even more independent and may be solitary for short periods of time.
- They are sensitive to other people's reactions.
- They tend to be self-critical .
- They may appear moody and dissatisfied at times as they are adapting to the new phase but gradually become more self-reliant and emotionally stable.
- They want more privacy and become embarrassed by physical attention or expressions of love.
- They need love and support but are less willing to ask for it.
- They understand and experience more complex emotions, such as confusion and excitement.
- They begin to form a broader self-concept and recognise their own strengths and weaknesses.

2.6.3 Social development:

- They tend to read more.
- They are able to distinguish between fact and fiction most of the time.
- They watch television with comprehension and appreciation.
- Being with and having friends becomes increasingly important to them.
- They are interested in rules and rituals.
- Their friends are mainly constituted of members of the same sex.
- They are exposed to peer pressure and may feel the need to belong.
- They tend to relate physical competence to self-concept.

2.6.4 Sexual development:

- At this age children prefer to socialise with their own gender almost exclusively and maintain a fairly rigid separation of males and females.
- They understand gender stereotypes.
- They recognise the social stigmas and taboos around sexuality.
- They start to understand more complex ideas with regard to sexuality and begin to understand that intercourse results in making a baby.
- They tend to look for peers, media and other sources for information about sex.
- They have stronger self-concept in terms of gender and body image.

2.6.5 Needs:

- Firm control over daily routine within which he can be allowed enough freedom to inquire, experiment and explore.
- A stimulating environment at home and at school.
- Encouragement for their efforts and praise for their achievements.
- Play material that requires skills.

- Arrangements for adequate rest and sleep.

2.7 The nine and ten year old child.

This age group is a developmental middle zone. They tend to show a new maturity, self-confidence and refinement of behaviour. They can evaluate themselves and find that they are lacking, but not feel guilty about it (Feldman, 1999).

2.7.1 Cognitive/intellectual development:

- They tend to develop deep satisfaction from intellectual pursuits.
- Attention becomes selective.
- They begin to devise memory strategies and memory encoding, storage and retrieval develop.
- They start to evaluate behaviour.
- Problem solving behaviour shows marked improvement as they begin to apply logical operations to problems.
- Language pragmatics and metalinguistic awareness improve.

2.7.2 Emotional development:

- They tend to be self-motivated and goal driven.
- They have occasions of intense emotions and impatience, but their outbursts are more controlled.
- They can think and reason for themselves, which gives them a feeling of independence.
- They are less likely to feel compelled to boast or show off in order to get attention.

2.7.3 Social development:

- In their relationships with both adults and peers they show consideration and fairness.
- Their tolerance for failure and mistakes increases and they are more willing to take responsibility for their own actions.
- They have increased awareness of sex-differentiated behaviours.
- Girls tend to have an increased awareness about their appearance, clothes and fashion.
- Friendships tend to be more solid.
- They make fewer demands on parents.
- Boys and girls tend to mix fairly well.

2.7.4 Needs:

- They need to opportunity to learn accurately about the real world.
- A rich academic environment.
- Exposure to books, music and creative materials.
- Reliable, confident adults to set reasonable standards.
- Independence.
- Undemonstrative, stable affection at home.
- Straightforward information in reply to questions.
- Opportunities for games and physical activities.

2.8 The eleven and twelve year old child.

This developmental phase is characterised by many changes as the child is on the verge of puberty. Physically this age group has increased body strength and hand dexterity

and their coordination and reaction time improve. Their appetite increases and they require more food and sleep. Energy abounds and over-stimulation can occur when participating in competitive, physical activities. They enjoy socialising in groups of both boys and girls. For both girls and boys of twelve, the start of puberty is usually accompanied by shame and embarrassment. They have an increased need for privacy. For girls, the onset of menstruation usually comes around age 12 and many boys at age 12 are concerned because they are putting on weight and may even seem to be developing "breasts". This is in preparation for the growth spurt that is about to hit.

2.8.1 Cognitive/intellectual development:

- May enjoy reading alone.
- Has a need to know and understand "why".
- Beginning to think about possible occupations.
- May be interested in finding a part-time job or a way to earn money.
- Better understand the value of money and what it will buy.
- Can manage own time to meet homework and project deadlines.
- Introduction to geometry and algebra. Applies math problems and by implication deductive reasoning to everyday situations.
- Becomes capable of formal operational reasoning.
- Becomes better at coordinating theory with evidence.
- Can argue more effectively.
- Metacognition and cognitive self-regulation continue to improve.

2.8.2 Emotional development:

- Likely to become aware of sexual orientation.
- Becomes more self-conscious and self-focused.
- Becomes more idealistic and critical.
- Moodiness and parent–child conflict increase.
- Is likely to show increased gender stereotyping of attitudes and behaviour.
- As they strive for autonomy, they spend less time with parents and siblings.

2.8.3 Social development:

- Selects friends based on mutual interests.
- Interest in opposite sex is changing.
- May be argumentative with parents.
- Peer group becoming more important. May begin to beg for "must have" objects and clothing.
- May not wish to be seen with parents in public.
- Needs more privacy.

2.8.4 Needs:

- More privacy.
- Needs parents' involvement in their school activities.
- Needs to know that parents are interested in their lives, without suffocating them.

- Discuss what is right and wrong as they now develop the perspective that there are a lot of gray areas.
- Discipline and boundaries are important.
- Parents need to teach their children about money at this age. They need to be taught about saving money, contribute to society by giving to charity and even have money to spend on themselves.
- Although they are more self-regulating, adults still need to take charge when it comes to their schoolwork. They need a place to complete her homework each day and assistance with studying for tests, if needed.

3. The Person-centred Approach

Against the background of the developmental stages outlined above, it is necessary to start looking at more specific aspects necessary in grasping the essence of Teddy Bear Therapy and assist in the application thereof. As Teddy Bear Therapy involves a combination of the person-centred approach, communications theory and the systemic approach, Person-centred Therapy will hence now be discussed.

Person-centred Therapy is a non-directive psychotherapeutic approach that is based on the assumption that clients have the potential to sort out their own problems and to develop positively. The requirement, however, is that the psychotherapist has to generate a warm, accepting atmosphere, where clients can work through their problems uninterruptedly and through this find a better understanding of themselves. The psychotherapist plays a non-directive role through not advising, interpreting or intruding in any way, except when

motivating and every now and then when reformulating, with the goal to emphasise and enlighten (Plug, Louw, Gouws & Meyer, 1997).

3.1 Nature of Person-centred Therapy.

To understand the nature of Person-centred Therapy (PCT), it is necessary to understand the context in which it was developed. **Carl Rogers'** (1902 – 1987) theory is one of very few theories which actually originated within a therapeutic context (Meyer, Moore & Viljoen, 2003). Rogers developed a non-directive counseling approach in reaction to the behaviouristic and psychoanalytic trends of the time (Avis, Pauw & Van der Spuy, 2004), (Phares, 1988). This development stemmed from his work with children and schizophrenic patients, which led him to believe in the innate goodness of each individual (Avis, Pauw & Van der Spuy, 2004). According to Parrott (1997), Carl Rogers is seen as the father of the PCT.

Person-centred Therapy is a central approach within **humanistic** psychology (Rowan, 1998), (Barlow & Durand, 2005). According to Barlow & Durand (2005), humanist therapists have great faith in the ability of human relations to foster growth. Humanistic therapists propose that relationships, including the therapeutic relationship, have the greatest influence on the facilitation of human growth (Barlow & Durand, 2005). There is a basic respect for the wholeness of the client (Rowan, 1998). The humanistic approach states a respect for client's subjective experience and trust in the capacity of the client to make positive and constructive conscious choices (Corey, 2005). There is an emphasis on freedom, choices, values, personal responsibility, autonomy, purpose and meaning (Corey, 2005). Person-centred Therapy is, therefore, experiential and relationship orientated (Corey, 2005).

Rogerian Person-centred Therapy therefore places high value on human dignity and autonomy (Bugental, 1987).

According to Boy and Pine (1990), an effective therapeutic relationship consists of **two phases**. Phase one requires that the therapist builds a substantive, collaborate and therapeutic relationship with the client. Once this is accomplished, it will serve as a basis for further interactions with the client (Boy & Pine, 1990).

Boy and Pine (1990) stated that during **phase one**, the reflection of the client's feelings is vital to make clients feel understood, accepted and open to reveal their true emotions. When these reflections are accurate, the therapist assumes the client's internal frame of reference (Boy & Pine, 1990). During this phase the therapist is expected to be an empathetic and sensitive listener, which will enable the client to grow as a person (Boy & Pine, 1990). The rationale behind this mirroring of the client's emotions is that the client becomes aware of it, releases it and understands it better (Boy & Pine, 1990). This phase should enable the client to engage with his/her problem and then move beyond it (Boy & Pine, 1990).

Phase two of therapy will only be effective once there is trust in the therapist and the process of therapy. The client will then be mobilised to collaboratively focus on the needs of him/herself (Boy & Pine, 1990). Phase two is characterised by facilitating the client to make choices according to his/her needs and perceiving the client holistically (Boy & Pine, 1990). The client plays a more active role with regard to his/her problems, which results in him/her becoming more independent (Boy & Pine, 1990).

The therapeutic relationship should be a complementary relationship with the therapist in the one-up position and the client in the one-down position (Vorster, 2003). The

therapist gives the client permission to control the therapy situation and in this manner actually retains control (Vorster, 2003).

This brings us to the topic of objectivity. According to Vorster (2003) there is no such thing as true objectivity in PCT, since everything that a human observes is interpreted according to the individual's **frame of reference**. Frame of reference refers to all of a person's prior knowledge and experiences. It is made up of all that a person has internalised (Vorster, 2003). Frame of reference can be seen as the lens through which individuals observe and experience things (Vorster, 2003). People's frame of references can overlap in certain areas so that they can understand each other (Vorster, 2003).

The therapist should observe from the client's frame of reference and see as the client sees (Meyer, Moore & Viljoen, 2003). Since clinicians cannot be separated from their frame of reference and cannot move away from being human, they cannot gain a full perspective on all human behaviour (Vorster, 2003). Since we cannot be a 'higher' species than the species being studied, we can never fully understand human behaviour. Clinicians only study one aspect of behaviour in a certain context (Vorster, 2003).

The **purpose** of Person-centred Therapy is thus to give clients the opportunity to get to know their own potential in a therapeutic climate where the therapist unconditionally accepts the client (Meyer, Moore & Viljoen, 2003). Rogers promoted a non-directive therapeutic approach (Bugental, 1987). A non-directive approach entails the therapist not directing the client in ways in which he/she feels the client should move (Avis, Pauw & Van der Spuy, 2004). If the therapist provides the client with empathy, congruence and unconditional positive regard, it will allow the client to use his/her innate abilities to attain healing (Avis, Pauw & Van der Spuy, 2004). The **emphasis is not on method or technique**

but rather on the quality of the relationship between the client and therapist (Meyer, Moore & Viljoen, 2003).

The role of the therapist is therefore to create a growth-facilitating climate including the above three values (Meyer, Moore & Viljoen, 2003). During the therapeutic process, the client is the focus and must take responsibility for his/her own change (Meyer, Moore & Viljoen, 2003). This does, however, not allow the therapist to be lazy and passive, leaving the client to feel rejected (Meyer, Moore & Viljoen, 2003).

3.2 Values underlying Person-centred Therapy.

Rogers believed that people are capable of growing and developing into what he called ‘the fully functional person’ and viewed this development as the **goal** of counselling, psychotherapy and group work (Rowan, 1998). This is congruent with the value that the basic human tendency is to enhance the self and to self-actualise (Phares, 1988). This is what creates the forward movement in life (Phares, 1988).

Rogers saw the client as a constructive force reaching towards health and self-fulfilment (Phares, 1988). Every person has the ability to take responsibility for their own growth and to find constructive ways for growth (Avis, Pauw & Van der Spuy, 2004). Each person has a tendency towards positive growth, which Rogers called the ‘**actualising tendency**’ (Avis, Pauw & Van der Spuy, 2004).

One of the elements of PCT that enables actualisation is PCT’s emphasis on the **empowerment** of the client, which entails transferring power to the client (Meyer, Moore &

Viljoen, 2003). The individual is seen as the **expert** of their own experiences and thus the best source of information about the self (Phares, 1988).

Clients are empowered to help themselves by providing them with a safe environment in which they can release their true emotion, explore and accept themselves (Ivey et al., 1997).

As mentioned above, Rogers emphasises three **conditions** essential for good therapy (Rowan, 1998), (Corey, 2005). These are empathy, congruence and unconditional positive regard (Rowan, 1998). These will aid clients to be more straightforward and honest and will allow enhancement of their innate tendencies toward growth (Barlow & Durand, 2005).

Empathy involves the understanding and acceptance of the client and his/her thoughts and feelings (Rowan, 1998). Empathy allows the client to be heard and shows that the therapist is on the client's wavelength (Rowan, 1998). Empathy can be defined as "showing a deep understanding and respect for another person and endeavoring to understand their life world" (Avis, Pauw & Van der Spuy, 2004, p. 99).

Empathy is, however, of no use if it is not evident to the client (Rowan, 1998). According to Vorster (2003), empathy is not only understanding someone, but to accurately understand someone from their frame of reference, as well as to be able to communicate that frame of reference. Empathy is attained by the accurate reflection of the client's feelings (Vorster, 2003). Brunner and Shostrom (1977) in Boy and Pine (1990) identified that when a therapist is accurate in the reflection of the client's emotion, the client feels deeply understood and in some cases it even clarifies their thoughts by enabling them to be more objective. They will then be able to examine their overt motives. Through reflecting

emotions, clients are also able to see that their emotions are causes of behaviour (Brunner & Shostrom, 1977 in Boy & Pine, 1990).

Congruence can be seen as genuineness, realness and authenticity of the therapist (Rowan, 1998). According to Hackney & Cormier (1994), congruence is a condition which reflects honesty, transparency, and openness to the client. The therapist is without front or façade, openly being the feelings and attitudes which at the moment are flowing in him (Hackney & Cormier, 1994). It is a human quality and not a skill which can be used at will (Rowan, 1998). It requires that the therapist is aware of his/her own feeling and process, as well as that of the client (Rowan, 1998). Congruence can be defined as “genuineness, relating to others with honesty, being real towards others and showing who you really are” (Avis, Pauw & Van der Spuy, 2004, p.99). Corey (2005) is of opinion that congruence is when a therapist’s inner experience and outer expression of that experience match. He also states that one pitfall may be when a clinician tries too hard to be genuine (Corey, 2005). On the one hand it may immobilise the client if a therapist expresses disapproval, but if the therapist doesn’t show congruence, on the other hand, the client will experience transference effects and also become incongruent (Corey, 2005). It is, therefore, important for clinicians to broaden their values and judgments so he or she will not be influenced in any way not to accept the client fully (Vorster, 2003).

Unconditional positive regard can also be called non-possessive warmth (Rowan, 1998). It allows the client to express whatever feelings or thoughts are going on inside of them and not adding the clinician’s evaluations to their troubles (Rowan, 1998). Unconditional positive regard can be defined as “caring and valuing somebody unconditionally, without expecting certain behaviours before accepting them (Avis, Pauw &

Van der Spuy, 2004, p. 99). This entails respecting the client regardless of differences in values and worldviews (Hackney & Cormier, 1994). It is an attitude of valuing the client and expressing appreciation of the client as a unique and worthwhile person (Hackney & Cormier, 1994). Vorster (2003) defines unconditional positive regard as when there is no value judgment or judgment on morals and when the client feels accepted and has an experience of congruency and genuine acceptance from the clinician. He states that once a clinician truly understands a client, then there will be no judgment of the client (Vorster, 2003). Unconditional positive regard communicates to the client that the therapist does not judge him/her, is not shocked and does not regard them as different from other clients (Ivey et. al, 1997).

3.3 Application and usefulness of the values of PCT.

The person-centred approach can be used early in the therapeutic relationship or it can be the basis for the whole therapy process (Rowan, 1998). It provides a therapist with a powerful tool which enables growth, learning and change within the client (Boy & Pine, 1990). This approach also aids in facilitating good rapport between the therapist and client of any age. The person-centred approach allows the client to be open and honest and feel true empathy, which is of utmost importance (Corey, 2005).

4. Interactional Pattern Analysis (IPA)

As mentioned in the previous section, Teddy Bear Therapy involves a combination of the person-centred approach, communications theory and the systemic approach. Taking a person-centered approach enables the therapist to have a clear and uncontaminated picture of

the presenting complaint. In order to identify where to intervene, the therapist needs to be able to apply the systemic approach and furnish an IPA.

The IPA was developed within the systemic approach as a psycho-diagnostic tool to logically link a presenting complaint and/or symptomatic behaviour with a detailed pattern analysis based on observable behaviour (Vorster, 2003). According to Vorster (2003), systems theory advocates a more tangible and observable process of psychotherapy. This places the emphasis on inter-psychic solutions to behavioural problems (Vorster, 2003).

In keeping within the principals of systems theory, this diagnosis relies on circular interaction, relationships and context (Vorster, 2003). It focuses on describing what is happening in a system and how it is happening, rather than the underlying reasons.

In order to formulate an IPA, skilled observation is required and the key elements can briefly be outlined as follows (Vorster, 2003):

1. Context: This provides a picture of the circumstances in which the interview took place. This will define the meaning of behaviour and the interpersonal communication.
2. Presenting complaint: This entails an account of the problem experienced, as well as who formulated it. This subjective experience of an individual is linked to the individual's observable pattern of interaction.
3. Definition of the relationship: This describes the nature of the definition of the relationship between the therapist and the client. This can be complementary, symmetrical or parallel. The definition of the therapeutic relationship provides the context in which other relationships and interactions are to be interpreted and understood.

4. Emotional distance: This is a description of the emotional distance in the therapeutic relationship and manoeuvres used to maintain this.
5. Manoeuvres: Manoeuvres refer to the strategies which clients use in order to elicit certain responses. The type of manoeuvre, the manner of using it and the impact it had on the therapist needs to be noted here.
6. Hypothetic link: This is a integration of the presenting complaint and the observed interactional pattern of behaviour as formulated by the therapist. This also provides an indication as to the most effective form of therapeutic intervention.

5. Prescribed Reading List

In addition to the provided information, the following prescribed reading will enhance the understanding of the development and process of Teddy Bear Therapy even more:

Abnormal Child Psychology, Mash, E.J. & Wolfe, D.A.

Client-centred therapy, Rogers, C.R

Impact, Vorster, C.

General systems theory and psychotherapy: Beyond post-modernism, Vorster, C.

Play therapy, Axline, A.E.

Therapeutic communication with children: The mutual story telling technique, Gardner,

Child care Act, HPCSA can be obtained from: <http://www.hpcsa.co.za/Acts>

Ethical guidelines of the HPCSA can be obtained from:

http://www.hpcsa.co.za/downloads/ethical_rules/ethical_rules_of_conduct_2011.pdf

Ricardo, I. B., & Holden, E. W. (1994). Multicultural training in pediatric and clinical child psychology internship programs. *Journal of Clinical Child Psychology*, 23, 32–38.

Section B

6. The Development of Child Psychotherapy

To set the context for a discussion on Teddy Bear Therapy as form of child psychotherapy, the nature and development of child psychotherapy is explored below.

The birth of psychology can be traced back to 1879, to the establishment of the first recognised laboratory for the study of human behaviour at the University of Leipzig in Germany (Mandler, 2007). One of the founders, Wilhelm Wundt, owned the reputation as the father of experiential psychology after publishing the first psychological text entitled “Principals of Physiological Psychology” (Mandler, 2007). This established psychology as a separate science from other topics (Mandler, 2007). Since these developments, the field of psychotherapy has expanded and has seen many meaningful and diverse contributions. In this evolution of psychotherapy with adults, the focus later shifted to psychotherapy with children.

According to Kazdin (2000), theories in adult psychotherapy have been modified and adapted to use in therapy with children. However, psychotherapy with children has expanded into a rich and sophisticated field as time passed (Prout & Brown, 2007). Therapists from different perspectives developed different ways to use play as therapeutic tool and will be referred to below (Prout & Brown, 2007).

6.1 Hug-Hellmuth: Play Therapy.

According to Yawkey and Pellegrini (1984), Hugh-Hellmuth was the first to introduce Play Therapy with children in 1919. She was the first psychologist practicing psychoanalysis with children (Yawkey & Pellegrini, 1984). From this vantage point she was also the first person to make use of systematic child observation from a psychoanalytic point of view (Maclean, 1986). She used play as a method to analyse a child by interpreting the child's behaviour into symbols mainly directed at repressed, hostile and sexual desires towards his/her parents (Yawkey & Pellegrini, 1984). Her work contributed to the beginning of Play Therapy, followed by Anna Freud and Melanie Klein.

6.2 Anna Freud: Play Therapy.

In order to adapt adult psychoanalysis for children, Anna Freud started interpreting children's imaginative play, drawings and paintings by searching for the unconscious motivation behind it (Yawkey & Pellegrini, 1984). However, the value of her contribution to the field of child psychotherapy was rather in terms of her working method that entailed understanding a child's play in context (Geldard & Geldard, 1997). She requested background information from the parents on the child's functioning (Geldard & Geldard, 1997) and supplemented this with observations of the child's play (Yawkey & Pellegrini, 1984). Geldard and Geldard (1997) adds that for Anna Freud, play also had the function of facilitating a close relationship between the therapist and child, which had the possibility of enhancing the process of therapy. The significance of rapport with a child is still recognised as means to successful psychotherapy (Combs, 1989).

6.3 Melanie Klein: Unstructured play.

Klein took a non-directive stance in her therapy with children (Haworth, 1990). She saw children's play as their primary mode of emotional communication (Seagal, 2004). After observing troubled children play with toys such as dolls, animals, pencil and paper, Klein attempted to analyse the unconscious motivations behind the play (Seagal, 2004). Klein argued that children's unconscious lives could be understood by analysing their non-verbal behaviour (Seagal, 2004). She saw most play activities as a symbolic expression of sexual conflict and aggression towards parents (Seagal, 2004).

6.4 Virginia Axline: Play Therapy.

Similar to her predecessors, Anna Freud and Klein, Axline interpreted play from an intra-psychic point of view (Geldard & Geldard, 1997).

In 1947 she developed a non-directive method of using play (Prout & Brown, 2007). This method was based on Carl Rogers's humanist approach to therapy, referred to as Person-centred Therapy (Axline, 1947). The basic premise of this approach is that each individual has the potential to strive towards self-actualisation (Haworth, 1990). Axline (1947) believed that children has the ability to develop optimal levels of self-realisation if they are not prevented to do so by their environment. Axline contended that, when a child's needs are not met, he/she will develop conniving strategies in order to satisfy the needs.

The non-directive therapeutic space suffices as the most favorable milieu for the child to self-actualise (Haworth, 1990). By taking a non-directive stance, the therapist empowers the child to solve his/her own problems, make choices and take responsibility (Axline, 1947).

He/she can 'play out' his/her feelings and problems – his/her fears, hatred, loneliness, and feelings of failure and inadequacy (Axline, 1947). Throughout this process, the child is accepted as he/she is without judgment or pressure to change (Axline, 1947). The therapist facilitates insight through empathetic reflections (Axline, 1947). Since the therapist's reflections convey a feeling of being understood and accepted unconditionally, the child is more likely to seek deeper into his/her inner world and reveal his/her own self (Axline, 1947).

Based on the above-mentioned contributions, play within the therapeutic context has significant value. Play as therapeutic medium can assist children in expressing themselves, work through emotional difficulties and solve their own problems (Haworth, 1990).

Similar to play, storytelling can also be used as therapeutic modality (Sepato, 2002). As with play, stories are easy for children to relate to (Gardner, 1971). Richard Gardner's Mutual Storytelling Technique will hence be discussed below.

6.5 Richard Gardner's Mutual Storytelling Technique.

Gardner (1971) raised his dissatisfaction with play as therapeutic modality. His dissatisfaction stemmed from two aspects. Firstly, he contended that the presence of play material in the therapy room contaminates the acclaimed non-directiveness of the therapy (Gardner, 1971).

Secondly, he disagreed with the principle of communicating the psychodynamic interpretations of the play to the child (Gardner, 1971). He stated that a child is not cognitively developed to fully comprehend and engage in a meaningful psychoanalytic inquiry before the age of ten years (Gardner, 1971).

In opposition to Play Therapy, he developed a Mutual Storytelling Technique in 1971. To compensate for the flaws listed above, he chose to focus on auditory stimuli and use a tape recorder as only distracting variable when engaging in storytelling with children (Gardner, 1971). Secondly, he moved away from relaying psychotherapeutic interpretations directly to the child and chose to rather make use of humor and drama to enhance a child's receptivity for change (Gardner, 1971).

Gardner (1971) observed the pleasure storytelling brings to children and saw it as one of children's favourite modes of communication. He hypothesised that communicating with the child in that way might be useful in therapy (Gardner, 1971). Hence the development of mutual storytelling as a therapeutic modality (Gardner, 1971).

The session would start off with Gardner involving the child in 'a storytelling game' (Gardner, 1971). He would enhance participation by telling the child that all of the children who come to see him tell him a story that is then recorded and played back to them (Gardner, 1971). The child chooses his/her own characters and is not restricted in any way by the therapist (Gardner, 1971). The child is requested to tell a story with a beginning, middle and end (Gardner, 1971). The therapist then responds by telling a more 'therapeutic' story, that is similar to the child's story in terms of the characters used as well as the setting of the story (Gardner, 1971). The therapist would interpret the story psychodynamically and use the child's language to introduce mature responses and healthier resolutions to the child's difficulties (Gardner, 1971). The moral of the story is made explicit and discussed with the child (Gardner, 1971).

Evolving from Play Therapy and Gardner's Mutual Storytelling Technique, Vorster (1995) developed what he labeled 'Teddy Bear Therapy', which essentially combines an element of play with storytelling, as will be set out below.

7. Teddy Bear Therapy

7.1 The development of Teddy Bear Therapy: Vorster's adaptation of and dissatisfaction with Gardner's Mutual Storytelling Technique towards developing Teddy Bear Therapy.

Vorster (1995) developed Teddy Bear Therapy out of his practical experience and subsequent to his dissatisfaction with using Gardner's Mutual Storytelling Technique. This dissatisfaction roused due to the disempowering effect the definition of the relationship between the therapist and child has on the child (Poodhun, 2002). Vorster was of opinion that the therapist is being placed in a superior position when he/she improves on the story the child told (Poodhun, 2002). This then has an immobilising effect on the child (Poodhun, 2002).

Furthermore Vorster displayed dissatisfaction with Gardner's insistence on exposing the underlying moral of the story (Poodhun 2002). He mentioned that this practise comes across as prescribing to the child and taking a parental stance (Poodhun, 2002). He contended that in prescribing behaviour that are spontaneous you are paradoxing the child which results in the child feeling immobilised (Poodhun, 2002).

In an attempt to address this dissatisfaction with the Mutual Storytelling Technique Vorster implemented changes which are notable in the process of Teddy Bear Therapy as discussed below.

7.2 The process of Teddy Bear Therapy

Teddy Bear Therapy goes beyond exploring fears and anxiety as is the case with Play Therapy or finding a solution through storytelling as in the Mutual Storytelling Technique (Poodhun, 2002). It encourages optimal interaction with others while assisting children to overcome their emotional difficulties (Duncan, 2004).

The session usually starts with the child choosing a teddy bear and the therapist involving the child in a story (Vorster, 1995). The story usually consists of animal characters – such as a teddy bear family, who lives in a forest (Baloyi, 2001). Vorster (1995) promotes the use of the animal in the story as a means to add another relationship. The child's position thereby changes from a disempowered position to an empowered position (Hanney, 2002).

The therapist sets the context by describing the daily routine of the family (Baloyi, 2001). A similar problem that the child is facing is then introduced process-wise to the story by the therapist, but it becomes evident that the teddy bear in the story is the one facing the crisis and not the child (Baloyi, 2001).

The story evolves as the child starts to talk about the teddy's problem and how the teddy handles the problem (Baloyi, 2001). The therapist would interject and steer the story line into a more optimal direction when deemed necessary (Baloyi, 2001). This will be required when the teddy displays ineffective problem solving, for example to go and sit in the corner or run away or hide from the world (Baloyi, 2001). The therapist would suggest

alternative solutions, such as to go and tell somebody or ask advice from someone like a wise owl (Baloyi, 2001). At some point in the therapy the child realises that there are more effective ways of handling the problem at his/her disposal (Vorster, 1995). Solutions to the teddy's problem are eventually worked out in a mutual effort (Baloyi, 2001) but the moral of the story is not made explicit (Vorster, 1995).

The storytelling is recorded on tape and replayed to the child (Baloyi, 2001). After listening to the tape with the child the therapist then suggests that the child takes the teddy with him/her to help the teddy with his problem until the next session (Baloyi, 2001). The child is empowered by the teddy bear who now 'needs his/her help' to solve problems that are similar to that of the child (Vorster, 1995). The child is therefore no longer the identified patient (Vorster, 1995). Each session here after would continue with helping the teddy (Vorster, 1995).

The parents would be briefed on the therapy so that the new 'member' of the family that the child has to take care of is not surprising to them (Duncan, 2004). The parents would further be advised to listen to the child if he/she relates the story but to refrain from commenting about it.

The next session would be used to ask the child to give feedback on the teddy bear and what had happened since the previous session (Duncan, 2004). This feedback would be indicative of the child's progress. Each session could be recorded and played back if necessary (Duncan, 2004).

7.3 Indications for Teddy Bear Therapy.

Teddy Bear Therapy may be used with children between the ages of three and twelve (Vorster, 1995; Baloyi, 2001). Baloyi, Botha, De Wet and Vorster (cited in Poodhun, 2000) identified indications for Teddy Bear Therapy to be interpersonal difficulties, such as:

- lack of assertiveness;
- inappropriate distance in a relationship;
- inability to take risks;
- difficulties with friends at school;
- being rejected;
- having difficulty separating from mother;
- divorce issues;
- phobias;
- encopresis and enuresis; and
- victims of trauma.

7.4 The significance of Teddy Bear Therapy.

The teddy bear is an essential figure and is the key to the success of this form of therapy (Duncan, 2004). The system in which the child functions in is extended with the inclusion of the teddy bear to the family (Baloyi, 2002). Thus punctuating from a systems perspective the value of Teddy Bear Therapy is that, by changing the system it therefore changes the nodal point in the family (Baloyi, 2002). The teddy bear becomes part of the system the child functions in hence bringing about change in the whole system and not just the child, which is also in line with systems theory (Vorster, 1995).

In creating a conjoint story the emphasis is firstly placed on the therapeutic relationship (Duncan, 2004). The therapist communicates with the child on his/her level facilitating a sense of empathy, congruence and unconditional positive regard between the child and therapist (Vorster, 1995). Vorster (1995) states that Teddy Bear Therapy puts the therapist and child on equal footing whilst engaging in storytelling.

The second point of interest is in the relationship between the child and the teddy bear (Duncan, 2004). Vorster (1995) states that the introduction of the teddy redefines the child's role as 'identified patient' to that of 'helper'. The teddy is now the one who has to full fill the one-down position (Vorster, 1995). Teddy Bear Therapy thus empowers children to solve their own problems as the teddy is the one in distress – not them (Vorster, 1995). Baloyi (2001) concurs, stating that the child is mobilised through engaging him/her in an active process of working through the presenting problem. Children thus also develop mechanisms of coping through their 'interaction' with a teddy bear (Vorster, 1995). A child's role repertoire is hence broadened and self-esteem enhanced (Baloyi, 2001). Furthermore, the child is being distanced from his/her problem, as the focus is on the teddy bear and not him/herself (Vorster, 1995).

7.5 Research on the effectiveness of Teddy Bear Therapy.

The effectiveness of Teddy Bear Therapy has been researched extensively. In light of this research the theme that emerges is a favourable one. The different types of research that has been conducted at the Medical University of South Africa (Limpopo Campus) range from a qualitative to a quantitative nature. It has been proven effective as an individual intervention for children who are faced with a variety of problems but also effective as a group intervention.

The first substantial research in respect of Teddy Bear Therapy was undertaken by Poodhun (2002). She explored the nature and therapeutic effect of Teddy Bear Therapy by examining it as intervention on a single case study. A subject was selected for the dual purpose of being used for research purposes as well as to receive psychological assistance. The researcher substantiated her findings and experience of using Teddy Bear Therapy as intervention with a literature study and interviews on Teddy Bear Therapy. This study provided a description of Teddy Bear Therapy and brought about an awareness of this new form of therapy. It furthermore provided a foundation for all further research regarding Teddy Bear Therapy.

Selamolela (2001) followed Poodhun (2000) by narrowing the research down to evaluating Teddy Bear Therapy within the context of treating enuresis. Due to children being exposed to various environmental challenges, behavioural symptoms can develop as a result of their limited problem solving skills. A common symptom found with children who experience emotional difficulties is enuresis. Teddy Bear Therapy was hence used as intervention to address the enuresis as a psychological symptom after all medical conditions have been eliminated (Selamolela, 2001).

The research data was collected by using questionnaires, which was given to the parents and using Tepper's Adapted Checklist for Bedwetting. After exposing a group of children to Teddy Bear Therapy the results indicated a statistically significant decrease in the amount of children suffering from enuresis. Teddy Bear Therapy was thus concluded to be effective in alleviating enuresis in children (Selamolela, 2001).

Hanney (2002) followed Selamolela (2001) by investigating the effect of a structured Teddy Bear Therapy programme on young hospitalised children. It is widely accepted that

being hospitalised poses a potential threat to the psychological as well as physiological development of children. The study found that young children showed signs of protest, despair and even denial when hospitalised. This is evident in their crying, fear, aggression, impatience and social withdrawal. The study aimed to prevent these symptoms from arising by exposing hospitalised children to a standardised Teddy Bear Therapy programme. The children listened to pre-recorded stories over a few days.

An Adapted Behavioural Checklist was used and subsequently indicated that the results of the study were statistically significant in emotional, cognitive as well as psycho-physiological dimensions. The study tentatively postulated that this programme can be utilised as an effective and brief intervention that can be offered to all hospitalised children (Hanney, 2002).

In the same year Sepato (2002) focused her research on children with newly divorced parents. Various research results indicate that children of divorced parents are often troubled by the crisis of their parent's divorce and have difficulty adjusting and coping effectively with the situation. As a result of this they display a wide range of symptomatic behaviour. Irritability, anger outbursts, changed sleeping and eating patterns and lack of concentration to name a few, are indicative of their difficulties in handling the problems they are confronted with. In her study she investigated Teddy Bear Therapy as a therapeutic intervention to see how it could assist these children.

An Adapted Behavioural Checklist was used to evaluate typical behaviour in the context of divorce before and after the intervention was implemented. Overall the Teddy Bear Therapy programme rendered the parental separation and emotional process involved

less threatening for the children. It was concluded that it contributed to the psychological welfare of the children of parents going through divorce (Sepato, 2002).

Romanis (2003) diverted the focus away from the hospital context to the legal context. She explored the option of using a standardised Teddy Bear Therapy to prepare children before they have to testify in court. Testifying has been described as secondary traumatisation as children are forced to retell the alleged horrific experience they have been through (Romanis, 2003). Children may find it difficult to cope effectively within the testifying situation resulting in symptoms such as depression, changes in eating habits and appetite problems, lack in confidence, isolating behaviour and poor school performance (Romanis, 2003).

An Adaptive Behavioral Checklist was used as baseline measure to assess the children's behavioural changes after the intervention was implemented. The results were statistically significant for the "emotional" "psychological" "social" and "cognitive" dimensions, indicating that a structured Teddy Bear Therapy programme was deemed effective as intervention to children who are testifying in court against an alleged abuser (Romanis, 2003).

Duncan (2004) investigated the treatment of separation anxiety with a structured Teddy Bear Therapy programme. She found that there is a large increase in the number of children that is being placed in care outside of home, such as preschools, for various reasons. This shift presents an important challenge for the child, as well as the family system. Duncan identified the biggest challenge to be the influence it has on the parent-child bond which can lead to separation anxiety. This manifested in the child objecting to go to preschool; refusing to stay behind at the preschool; parental use of force in order to get the child to preschool; the

need of repeated reassurance; clinging to the parents on arrival at the preschool; shadowing of parents and indications of anxiety.

The structured Teddy Bear Therapy programme thus aimed to address these symptoms. The results of this study as indicated by a behaviour checklist indicated that this programme was effective in reducing the levels of anxiety (Duncan, 2004).

Ncute (2004) studied the effectiveness of a structured Teddy Bear Therapy programme on children with dental phobia. On discovering that there was an escalating demand for dental consultation amongst children, a need for decreasing the levels of fear that accompanies dental consultation was indicated. An adapted Children Fear Survey Schedule – Dental Subscale was used to measure the levels of fear in the experimental and the control group, pre- and post intervention. The experimental group was exposed to randomly selected Setswana stories.

The results were statistically significant with the experimental group showing a decline in their levels of dental fear/phobia. The findings hence indicated that a structured form of Teddy Bear Therapy constituted an effective and brief intervention, which can be offered to young children presenting with dental fear/phobia (Ncute, 2004).

Da Cruz (2008) was the first to investigate the therapeutic significance of Teddy Bear Therapy in group context. She explored the effect it might have as trauma debriefing method of a large group of children who have been exposed to the same traumatic event. An ex post facto research design was used and interviews with a clinical psychologist who administered the intervention and three teachers who were present during the session were analysed qualitatively.

The study found that Teddy Bear Therapy as a group trauma debriefing method mitigates against the development of post-traumatic stress symptoms with children who have witnessed violence in the school environment. The study confirmed that Teddy Bear Therapy can effectively be applied to groups of children exposed to the same traumatic event.

7.6 The effectiveness of Teddy Bear Therapy.

Baloyi (in Poodhun, 2000; Sepato, 2002; Hanney, 2002) summarises the above-mentioned elements by attributing the effectiveness of Teddy Bear Therapy to the following criteria:

- The spontaneous manner in which the child's presenting problem is addressed reaches the child on emotional level as well as developmental level.
- It increases the child's self-esteem and broadens his/her role repertoire.
- It mobilises the child and generalises the empowerment to other contexts and situations the child may face.
- The storytelling process enables the child to actively participate in working through difficulties.

8. Case Study

The following case study was derived from the study done by Sepato (2002) on the effectiveness of Teddy Bear Therapy with children of newly divorced parents. Information on the presenting problem, background information and the framework of the therapeutic process and the story as formulated by Sepato will be presented below. The trainees are

expected to use this information when instructed by the facilitator to do a role play on the Teddy Bear Therapy process.

An IPA will also be presented for future reference for the trainees. For an example of a complete and detailed version of the story analysed below, it is recommended that trainees refer to Sepato, M.P. (2002), 'A Preliminary Investigation of the Effectiveness of Teddy Bear Therapy with Children of Newly Divorced Parents', Masters Dissertation, MEDUNSA: Pretoria.

8.1 Presenting problem.

The client's parents report that the client displays high levels of irritation, anger, aggression and sadness, which they believe are the result of their current divorce. The client is experienced as being impatient, having temper outbursts and presenting as restless. Since the father moved out of the house, the client does not show any interest in things he usually loves doing. The client's schoolwork is also influenced negatively by the divorce, resulting in a significant decline in his marks.

8.2 Background information.

The following was derived from limited information provided by Sepato (2002):

a. *Family history.*

The client is the only child and does not have any siblings. His biological father and mother are officially divorced for the past two months, after they ceased living together for the previous six months. Although the client's mother is the custodian, the father has a

right of access to the client. The client's parents report that the client presents hostile and resentful behaviour towards his father for leaving the family.

b. *Developmental history.*

The client's parents report that the client reached all his developmental milestones at the appropriate ages. Currently the client is however reverting back to thumb-sucking and bed-wetting, which he did when he was younger.

c. *Educational history.*

The client is currently in grade 4. His parents have not experienced any difficulty with his academics until the father moved out of their family home due to relationship difficulties within the marital subsystem. His teacher reports poor concentration and attention for the past five months. As a result of this, there is a drastic decline in his school marks compared with a couple of months before.

d. *Medical history.*

No significant medical problems are reported, except for the current bed-wetting in which case medical factors cannot be eliminated.

8.3 Interactional pattern analysis (IPA).

8.3.1. *Context.*

First contact with the child in an office, after contact was made with the parents who referred the client for therapy. The client is a 10 year old boy and in grade 4.

8.3.2 Presenting complaint.

The client's parents report that he is irritated, angry, aggressive and sad almost every day. The parents believe it is the result of their current divorce. The client is experienced as being impatient, having temper outbursts and appearing restless. Since the father moved out of the house, the client does not show any interest in things he usually loves doing. He also started wetting his bed and sucking on his thumb.

The client's teacher reports inattention and a lack of concentration. The client's schoolwork is also influenced negatively by this, resulting in a significant decline in his marks.

8.3.3 Definition of the therapeutic relationship.

The therapeutic relationship can be described as complimentary with the therapist in the lead and the child following.

8.3.4 Clarity of self-presentation.

The child presents himself in a clear manner.

8.3.5 Distance in the therapeutic relationship.

The therapeutic relationship is characterised by fluctuating distance. At times the child would manoeuvre for closeness from the therapist and then distance himself, maintained by a lack of eye contact and a closed body posture.

8.3.6 Empathy.

The client does not give or receive empathy, maintained by his somewhat self-isolating style.

8.3.7 Unconditional positive regard.

The client neither receives nor gives unconditional positive regard, maintained by blaming manoeuvres, especially in his relationship with his father.

8.3.8 Confirmation.

The client does not receive or give confirmation from his environment, maintained by his somewhat self-isolating style.

8.3.9 Congruence.

The client presents congruent to the context and his verbal and non-verbal communication match.

8.3.10 Potential for rejection/acceptance.

The client has the potential for rejection, maintained by his self-isolating style and blaming manoeuvres.

8.3.11 Effective/ineffective expression of needs.

The client does not present his needs clearly in the therapeutic relationship.

8.3.12 *Linear/circular approach.*

The client presents linear in his relationship with his father, which leads to the hypothesis that he exhibits a linear approach.

8.3.13 *Skill to meta-communicate.*

Not exhibited.

8.3.14 *Control of immediate environment.*

The client does not appear to be in control of his environment, maintained by sucking his thumb and appearing vulnerable and lost at times during the session.

8.3.15 *Rigidity/flexibility.*

The client presents in a flexible manner, allowing the therapist's input.

8.3.16 *Problem solving skills.*

The client presents with ineffective problem solving skills, maintained by his self-isolating style.

8.3.17 *Traumatic incidence.*

The client's parents' divorce is experienced by the child as traumatic and it has a significance influence on his emotional, academic and interactional functioning.

8.3.18 Hypothesized link between presenting complaint and IPA.

The client is not coping well with the traumatic impact of the divorce of his parents. He does not receive nor give empathy or confirmation, and exhibits ineffective problem solving skills and a lack of control over his environment, maintained by his somewhat self-isolating style.

8.3.19 Therapeutic aims.

- To work through the trauma of the divorce.

Check if these aims still need to be addressed after the trauma has been worked through:

- To address the client's somewhat self-isolating style.
- To empower the client to have more control over his immediate environment.
- To address the client's problem solving skills.
- To provide the client with high levels of empathy and confirmation.

8.3.20 Therapeutic interventions.

Teddy Bear Therapy

8.4 Teddy Bear Therapy process.

Session 1: Meet Benny Bear

Objectives:

- Build rapport with the child where he/she can feel safe and comfortable.

- Provide the child with a safe and therapeutic space.
- Introduce the child to Benny Bear by means of starting with the storytelling process.

Tasks:

- Play or draw/color with the child in a person-centered, non-intrusive manner.
- Start with the storytelling process.
- Tell the story in a non-threatening manner by using words you usually start a story with: “Far, far away”.
- Bring all kind of characters into the story, and focus on the family of bears who lived in a safe and loving environment.
- Introduce the daily routine of the bears, referring to the daily tasks of Mommy bear, Daddy bear and Benny himself.
- Conclude the story with how at the end of the day the family all get together and are very happy because they all love each other and feel safe in their cave.

Session 2: Bad news for Benny Bear

Objectives:

- Start working through the trauma of the divorce.
- Empathise with the child in a non-threatening way.
- Start empowering the child.

Tasks:

- Incorporate his school problems, such as inattention and lack of concentration into the story.
- Introduce the bad news of the divorce into the story, and Benny’s reaction of sadness on hearing the news. Elaborate on the questions Benny has about divorce.
- Tell about how Mommy bear explains what divorce is and how Benny is going to be affected by it. Focus on the fact that Benny will still see his Daddy bear, but that things are going to change.

- Normalise and reflect the child's feelings by referring to the specific emotions which he feels, such as sadness, feeling scared, worrying and feeling unhappy into the story.
- Introduce the teddy as the identified patient that needs the child's help and who needs to take him home to help him feel better.

Session 3: Daddy Bear leaves

Objectives:

- Work through the trauma of the divorce.
- Empathise with the child client.
- Introduce the fact that Daddy bear is leaving and moving all of his things.
- Refer to the ineffective ways in which the child or rather 'Benny' handles the situation.

Tasks:

- Express the emotions the child is feeling as Benny's feelings, such as feeling heartbroken, unhappy, confused, angry, not understood and alone by incorporating it into the story line.
- Refer to the problems the child has at school by reframing it as Benny's problems.
- Elaborate on the moving phase, how Daddy assures Benny that he will come and visit him.
- Elaborate on the changes that are occurring in the household now that Daddy bear moved and how Benny misses his Daddy.
- Refer to the way the child handles Daddy's moving, such as blame, anger and ineffective problem solving as Benny's reaction to the changes in his life.

Session 4: Daddy Bear comes to visit

Objectives:

- Work through the trauma of the divorce.
- Refer to Daddy bear's first visit since he moved out.
- Empathise with the child.

Tasks:

- Refer to emotions the child experiences such as unhappiness, conflicting emotions between missing his mom when he is with his dad and vice versa, joy when spending time with his dad.
- Elaborate on Benny and his dad's day together and what they did.
- Tell about how Benny asks if his Dad and Mom can't work something out and live together again, and then how his dad explains how divorce works and that it will not be possible.
- Emphasise the conflicting emotions of wanting to stay with both parents and guilt when he is with one parent and not the other.

Session 5: Good advice from Uncle Owl

Objectives:

- Introduce Uncle Owl into the storytelling process.
- Empathise with the child.
- Address the child's ineffective problem solving skills by proposing more effective ways.

Tasks:

- Refer to emotions the child may experience in the story, such as at the beginning of the following day he felt happy until he remembered about the divorce, which made him feel sad and lonely again. He might also feel hopeless because he can't think of a way to solve the problem of his mom and dad. Refer to the guilt towards one parent if he spends time with the other.
- Introduce Uncle Owl as a wise and clever bird who gives advice for everyone in the forest.
- Use Uncle Owl to empathise with Benny and provide him with advice when Benny tells him about the guilt he feels towards one parent when spending time with the other parent.
- Emphasise by means of Uncle Owl that Benny's mom loves him and so does his dad, and that nothing is ever going to change that. Emphasise that they will always love him and always be his parents, no matter with whom he spends time with more.
- Propose more effective problem solving skills through the advice Uncle Owl gives to Benny, especially that it is not his responsibility to try and solve the problem between his parents – he is only a kid, they are the grownups, not him.
- Refer to the relief Benny felt when he expressed how he felt and asked for advice from Uncle Owl.

Session 6: Benny Bear grows up

Objectives:

- Consolidate the therapeutic message.
- Instill hope.
- Confirm the child for the progress he has made.

Tasks:

- Start the story with how Benny is pondering about Uncle Owl's advice.
- Reinforce how much his parents love him.

- Emphasise how he would always have a daddy and mommy and even though they didn't live together anymore, they could still be happy.
- Normalise the doubt that 'Benny' may have about the advice Uncle Owl gave him by working it into the story, but also refer to how Benny could see as time passed by, how it really was true.
- Refer to the school routine and how Benny has progressed and is working hard; how his dad comes for regular visits and how he became a very happy bear just like Uncle Owl promised he would.
- Confirm the child by means of Uncle Owl; when Benny goes back to thank him for his advice, let Uncle Owl complement Benny on how hard he has been working in school, how clever and strong he now looks and how his Mommy and Daddy are very proud of him.

9. The Role of the Child Psychotherapist

The role of the clinical child psychotherapist is one that is multifaceted. First and foremost, it is the role of the child psychotherapist to foster a therapeutic relationship with the child and the child's parents (Mash & Wolfe, 2005). Children are often not self-referred, so effective rapport with a child or adolescent is paramount for initial investment in therapy and a positive treatment outcome (Pickar & Lindsay, 2008).

Trainees need to learn to use a technique adapted to the developmental level of the individual child in order to build rapport with the child (Zimmer, 2001). Therapist flexibility and creativity is conceptualised as an engagement-enhancing strategy (Chu & Kendall, 2008; Herschelle, McNeil & McNeil, 2004).

The therapeutic alliance in child and family work is more complex than in adult therapy, as it involves the therapist's relationship not only with the child but also with the

parents (Pickar & Lindsay, 2008). Vital to the therapeutic rapport is a non-judgmental attitude towards their clients and the parents (Spirito et al., 2003).

The role of the child psychotherapist has however transformed from this traditional role that only focuses on the client and parents, to more unorthodox roles that are relevant to the current health context (La Greca & Hughes, 1999). This involves consulting with providers from other disciplines in a variety of settings (Drotar, 1995). Children and adolescents served by health care systems often require evaluation by multiple disciplines (Spirito et al., 2003). It is important for child psychologists to be able to liaise with the different disciplines about a client whilst maintaining confidentiality with the client (Drotar, 1995; Spirito et al., 2003).

When consulting with other health care professionals and providers who refer patients and families for psychotherapy, special ethical issues may arise regarding situations of privileged communication, definition of the primary client (e.g., referring physician, child, caregiver, or family member), and delineation of the respective roles and boundaries of patient care among the providers (Spirito et al., 2003). Appropriate communication in health care settings, including adequate documentation in medical records, is an important professional skill that needs to be emphasised (Spirito et al., 2003). Many ethical and legal issues arise in the communication of information to the patient, family members, and health care providers (Spirito et al., 2003).

Lastly, another important role of a child psychologists is that of psycho-educator; promoting healthy lifestyles and preventing the development of health-risk behaviours in both healthy and chronically ill children (Spirito et al., 2003) without harming the therapeutic rapport with the child.

10. References

- Avis, P., Pauw, A., & Van der Spuy, I. (2004). *Psychological perspectives: An introductory workbook*. Cape Town: CTP book printers.
- Axline, V. (1947). *Play therapy*. Edinburgh: Churchill Livingstone.
- Baloyi, L. (2001). *Teddy Bear Therapy*. Pretoria: UNISA.
- Barlow, D.H. & Durand, V.M. (2005). *Abnormal psychology: An integrative approach*. USA: Thomson Wadsworth.
- Boy, A. & Pine, V. (1990). *A Person Centred foundation for counselling and psychotherapy*. USA: Charles Thomas Publishers.
- Bugental, J.F.T. (1987). *The art of the psychotherapist: How to develop the skills that take psychotherapy beyond science*. New York: W.W. Norton & Company, Inc.
- Combs, A. (1989). *A theory of therapy: Guidelines for counseling practise*. California: Sage Publications.
- Corey, G. (2005). *Theory and Practice of Counselling & Psychotherapy* (7th ed.). California: Thomson Brooks/Cole.
- Da Cruz, C. (2008). *Group Trauma Debriefing through Teddy Bear Therapy: An ex post facto study*, Masters Dissertation: MEDUNSA: Pretoria.
- Duncan, S. (2004). *Treating seperation anxiety with Teddy bear therapy: A preliminary investigation*. Masters Dissertation, MEDUNSA: Pretoria.
- Feldman, R. (2003). Infant-mother and infant-father synchrony: The co-regulation of positive arousal. *Infant Mental Health Journal*, 24(1), 1-23.

- Gardner, R. (1971). *Therapeutic communication with children. The mutual storytelling technique*. New York: Science House Inc.
- Geldard, K., & Geldard, D. (1997). *Counselling children. A Practical Introduction*. London: Sage Publications.
- Hanney, L. (2002). *The effectiveness of a standardized Teddy bear therapy program with young hospitalized children: a preliminary investigation*. Master's Dissertation, MEDUNSA: Pretoria .
- Haworth, M. R. (1990). *A Child's therapy: Hour to Hour*. Modisan: International Universities Press Inc.
- Ivey, A.E., Ivey M.B. & Simeck-Morgan, L. (1997). *Counselling and Psychotherapy: A multicultural perspective*. USA: Allen and Bacon.
- Kazdin, A. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. Oxford: Oxford University Press.
- Louw, D.A., Van Ede, D.M. & Louw, A.E. (1998). *Human Development*. Cape Town: Pearson South Africa.
- Maclean, G. (1986). A Brief Story About Dr. Hermine Hugh-Hellmuth. *Canadian Journal of Psychiatry*, 31(6), 586-590.
- Mandler, G. (2007). *A history of modern experimental psychology: From James and Wundt to cognitive science*. Cambridge: MIT Press.
- Mash, E.J. & Wolfe, D.A. (1995). *Abnormal Child Psychology*. Belmont: Thomson Wadsworth.

- Meyer, W., Moore, C. & Viljoen, H. (2003). *Personology: From individual to ecosystem* (3rd ed). Cape Town: Heinemann Publishers.
- Ncute, M. (2004). *A preliminary investigation into the effectiveness of a structured Teddy bear therapy programme on children with dental phobia*. Masters Dissertation, MEDUNSA: Pretoria.
- Oesterreich, L. (1995). *Ages and stages - nine through eleven-year-olds*. Ames: Iowa State University Press.
- Parrott, L. (1997). *Counselling and Psychotherapy*. USA: McGraw-Hill Inc.
- Phares, E.J. (1988). *Clinical psychology: Concepts, methods and profession* (3rd ed). Chicago: The Dorsey press.
- Pickar, D.B. & Lindsay, R.L. (2008). Preparing child psychologists for managed care: Educational and Training Considerations. *Brief Treatment and Crises Interventions*, 8(1), 370-381.
- Plug, C., Louw, D. A. P., Gouws, L. A., & Meyer, W. F. (1997). *Verklarende en Vertalende Sielkundewoordeboek*. Sandton: Heinemann.
- Poodhun, S. (2002). *Teddy Bear Therapy: An explorative case study*. Masters Dissertation, MEDUNSA: Pretoria.
- Prout, D., and Brown, T. (2007). *Psychotherapy and counseling for children and adolescents*. Canada: Wilsley & sons.
- Romanis, A. (2003). *The effects of a structured Teddy bear therapy programme in children about to testify in court*. Master's Dissertation, MEDUNSA: Pretoria.

- Rowan, H. (1998). *The reality game: A guide to humanistic counselling and psychotherapy* (2nd ed.) New York: Routledge.
- Seagal, J. (2004). *Melanie Klein: Key Figures in Counselling and Psychotherapy*. London: SagePublications.
- Selamolela, M. (2001). *The effectiveness of teddy bear therapy on treating enuresis*. Master's Dissertations, MEDUNSA: Pretoria.
- Sepato, M. (2002). *A preliminary investigation of the effectiveness of Teddy Bear Therapy with children of newly divorced parents*. Master's Dissertation. MEDUNSA: Pretoria.
- Spiroto, A., Brown, R.T., D'Angelo, H., Delamater, A.E., Rodrigue, J. & Siegel, L. (2003). Society of Pediatric Psychology Task Force Report: Recommendations for the Training of Pediatric Psychology. *Journal of Pediatric Psychology*, 25(2), 85-98.
- Stevenson, H.W. & Lee, S.Y. (1990). Contexts of achievement: A study of American, Japanese and Chinese children. *Monographs of the Society for Research and Child Development*.
- Thompson, D.N. & Hogan, J.D. (1996). *A History of Developmental Psychology*. London: Westview Press.
- Vorster, C. (2003). *General Systems theory and psychotherapy: Beyond Post-Modernism*. Bloemfontein: Satori Publishers.
- Vorster, C. (1995). Teddy bear therapy: The art of empowering a child. *Monograph*. Department of Psychology, MEDUNSA: Pretoria: Unpublished article.

Yawkey, T., & Pellegrini, A. D. (1984). *Child's Play Developmentally Applied*. New Jersey:
Lawrence Erlbaum Associates.