A Paradigm Shift in Psychological Services for Vulnerable Children:

Clinical Outcomes in the Use of Play and Creative Art Therapies in Ethiopia

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ABSTRACT

The majority of development programmes dealing with vulnerable children claim to have a psychosocial component. Virtually every organization working on education, child protection, and HIV/AIDS implements programmes of psychosocial support for children. Yet, an analytical review of these interventions highlights great differences in the ways the many actors define and implement psychosocial interventions. But a common feature is the lack of analytical data to assess the impact of these interventions on the mental health of supported children.

This paper reviews the outcome of a two years project in Ethiopia for specialised capacity building in the use of professional psychological techniques such as Play and Creative Art Therapies. It presents the lessons learned in the promotion of child-centred therapies to support the mental health development. In doing so, the work also reports on the clinical outcomes of the therapies on the emotional well-being of beneficiaries.

The paper claims originality for a number of reasons. Firstly, it is a systematic attempt to measure psychological outcomes on vulnerable children's mental health in development context. Secondly, it presents an adaptation of specialised techniques previously mainly used in less challenging contexts (where practitioners' skills are of high standard). Finally, it briefly reviews the positive outcomes of the programme using both neuroscience and attachment theory to analyse the reasons for this success. It concludes arguing that, in a context of limited availability of professional capacities and scarce financial resources –such as in most developing countries-, Play and Creative Art Therapies claim a significant cost-benefit advantage, and have a high probability of succeeding in supporting the child in his/her emotional wellbeing development.

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"At the heart of psychotherapy is an understanding of the interwoven forces of nature and nurture, what goes right and wrong in their developmental unfolding, and how to reinstate healthy neural functioning." (Cozolino, 2002:16)[2].

Background

Psychological support for vulnerable children[3], or for children affected by traumas, is a prominent intervention in the landscape of child development programmes. Virtually all funding proposals presented to donors to address the needs of vulnerable children contain specific budget lines for 'counselling', 'mental health', 'PSS services', 'rehabilitation and reintegration', and the like. In Ethiopia, these interventions seem to happen in a vacuum of legislation, professional regulation, and national planning. Ethiopia's National Plan of Action for Children 2003-2010, for instance, does not present any measure, programme, resources or vision for the promotion of psychological services for vulnerable children (MOLSA 2004)[4]. The same omission applies to the 2006-2010 Ethiopian National Plan of Action on Sexual Abuse and Exploitation of Children (MOWA 2007)[5].

A review of the outcomes of psychological services for vulnerable children will highlight the many shortfalls of these programmes in accounting for the results of such interventions. Reports traditionally present the number of children enrolled in PSS services at any given time, the number of people trained in counselling and psychological techniques, the number of social workers recruited for the provision of such services, and a variety of additional process indicators that tell very little about the clinical outcome and impact on the mental health of children reached.

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[2] Cozolino, L. (2002). The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain. W.W. Norton, New York.

[3] The concept of 'vulnerability' is a multidimensional one. For the purpose of this paper, 'vulnerable children' are those more likely to be exposed to, affected by, and less likely to recover from external shocks, whether of social, economic, natural or political nature.

[4] MOLSA (2004). Ethiopia's National Plan of Action for Children (2003-2010 and beyond). Ministry of Labour and Social Affairs, Addis Ababa.

[5] MOWA (2007). Ethiopian National Plan of Action against Sexual Abuse and Exploitation of Children (2006-2010). Ministry of Women Affairs, Addis Ababa.

Over the years of work conducted in Ethiopia by the authors, it became clear that PSS means many things to many people. 'Counselling' is often interpreted as a sort of 'friendly one-to-one chat with a child'; 'rehabilitation and reintegration' are often a synonymous of telling children which ideas and values they must obey in order not to feel excluded by mainstream society; and 'psychological support' is a catchy term including everything that seems to do some good to children's moral. Over the past 5 years of work in Ethiopia, the authors have however not found a single report of PSS services provided to children that clinically presents some form of systematic qualitative or quantitative outcome in the emotional wellbeing and learning capacities of beneficiaries. Similarly, Thomas (2008)[6] laments a lack of data able to prove any successful use of specific therapies in healing different child mental health conditions in the country.

This loose approach to PSS services has three possible explanations that are in turn causes and consequences of low quality services in this development area. Firstly, a number of development practitioners consider mental health issues as a less important intervention when compared to basic needs such as food, shelters, employment or physical health. Instead of considering mental health as a complementary measure able to enhance children's emotional and intellectual capacities and strengths, it is often perceived as a desirable, yet optional addendum to be carried out when time and resources allow. This approach is intrinsically entwined with the second source of problem which is donors' priority setting. Psychological and mental health services for vulnerable people tend to be considered as a 'soft component' of development programmes. As such, they are easily substituted by much preferred 'visible' interventions. A child's mental stability, inner resilience, enhanced learning capacities, bonding and social skills, do not make the headings of newspapers as easily as food provision, sheltering, clothing, education material, vaccination campaigns, and the like. Donors' preference for 'tangible' interventions is also, partially, justified by the objective difficulties in accounting for outcomes and impact results when investing in mental health interventions. This leads to the third source of problem which is a general scarce

[6] Thomas J. (2008). National Strategy for the Psychological Support of Ethiopian Children. Play Therapy International and Ministry of Labour and Social Affairs, Addis Ababa.

availability of professional expertise on the ground able to run effective psychological support services with a solid accountability for interventions' outcomes. Social workers are requested to take up for a too wide range of expertises and this limits their degree of specialisation in any given domain, including psychological services (Conticini 2007)[7].

This paper reviews the positive experience in supporting the establishment of professional psychological services -with a special focus on Play and Creative Art Therapies- for vulnerable children in Ethiopia. It starts by presenting the main features of the programme's context, objectives and methodological challenges. It then proceeds by reviewing the quantitative and qualitative data generated and presents an analysis of the intervention on children's mental health. It then focuses on explaining the reasons for the positive outcomes by linking the intervention with some theories of neuroscience and attachment theories. It concludes by presenting the strengths of the programme *vis-à-vis* previous interventions.

The Programme

The existing survey data reviewed, indicates that the main emotional conditions affecting vulnerable children in Ethiopia are likely to be:

1. Attachment and trauma problems as a result of being orphaned (Young 2005)[8] or separated from main caregiver (FDRE 2008)[9].
2. Emotional and psychological consequences from abuse – all types resulting from traditional practices (Kui 2006)[10], child trafficking (Endeshaw *et al.* 2006, PMC 2008)[11][12], child labour (Kifle 2002)[13], commercial sexual exploitation (Adefrsew 2003, Haile and Kifle 2000)[14][15] and street life (Conticini 2008)[16].

[7] Conticini Alessandro (2007). A Review of Child Protection in Ethiopia. Chapter prepared for the Children and Women Situation Analysis in Ethiopia. UNICEF. Unpublished Research.
[8] Young Helen (2005). More than Words? Actions for Orphans and Vulnerable Children in Africa. World Vision. London.
[9] FDRE (2008) Country Programme Action Plan 2007-2011. FDRE and UNICEF, Addis Ababa.
[10] Kui Way-Lee (2006). Children and Young People's Situation Analysis. Ministry of Youth and Sport and HAPCO, Addis Ababa.
[11] Endeshaw Yoseph *et al.* (2006). Assessment of Trafficking in Women and Children in and from Ethiopia. IOM. Addis Ababa.
[12] Population Media Centre (2008). National Study on the Extent and Magnitude of Internal Child Trafficking in Ethiopia. Unpublished study.

3. Depression and trauma of children affected by HIV/AIDS (MoH 2006)[17], children with disabilities or terminally ill (Mohasen 2006)[18], those exposed to recurrent violence (Alem 2005)[19], or those living in chronic poverty conditions (Erulkar 2004)[20]
4. Secondary traumatisation from entering in contact with criminal justice system both as victims or offenders (Quéré 2005)[21].
5. Bereavement and loss issues as a result of being orphaned (FDRE 2006)[22] or neglected (Taffese 2006)[23].

Against this background, Play Therapy Africa (PTA) was established to provide professional capacity building and service delivery in the area of child protection and child psychological support. The association is the African branch of Play Therapy International (PTI), the leading world association in the use of Play and Creative Arts for children. The ultimate goal of PTA has been the systematic adaptation of qualitative and quantitative techniques used in developed countries to the more challenging context of developing countries, in view of supporting the psychological wellbeing of vulnerable children. PTA's aim in Ethiopia has been facilitating the development of a professional infrastructure which would *(i)* facilitate the referral of cases within an integrated and multi-sectoral approach to prevent and respond to violence against children, *(ii)* ensure

[13] Kifle Abiy (2002). Child Domestic Workers in Addis Ababa: A Rapid Assessment. ILO, Addis Ababa.
[14] Adefrsew Azeb (2003). Study on Child Sexual Abuse and Exploitation in Shashemenae and Dilla Towns. Forum on Street Children Ethiopia, Addis Ababa.
[15] Gileneshe Haile and Woldekidan Kifle (2000). Sexual Exploitation and Abuse of Children in Dessie Town: The Case of Child Prostitution, Enticement and Coercion of Schoolgirls. FSCE, Addis Ababa.
[16] Conticini A. (2008). Surfing in the Air: A Grounded Theory of the Dynamics of Street Life and its Policy Implications. Journal of International Development, April, Vol. 20, 413-436.
[17] Ministry of Health (2008). AIDS in Ethiopia: Sixth Progress Reports. National HIV/AIDS Prevention and Control Office.
[18] Meron Mohasen (2006). Sexual Abuse of Girls with Disability. Addis Ababa School of Graduate Studies, unpublished thesis.
[19] Alem Ellen (2005). Violence Against Children in Ethiopia: Manifestations, the Legal Policy Framework, and Challenges of Implementation. Ministry of Labor and Social Affairs and UNICEF, Addis Ababa.
[20] Erulkar Annabel S. *et al.* (2004). Adolescent Life in Low Income & Slum Areas of Addis Ababa Ethiopia. Population Council, Addis Ababa.
[21] Quéré Valérie (2005). Justice for Children: Good Practices and Remaining Challenges in the area of Justice for Children in Ethiopia. UNICEF, Addis Ababa.
[22] Federal Republic of Ethiopia (2006). National Plan of Action for Orphans and Vulnerable Children, Addis Ababa.
[23] Taffese Makda (2006). What Children and Youth Think – Ethiopia: A Statistical Presentation of Opinions and Perceptions of Children and Youth in Ethiopia. The African Child Policy Forum, Addis Ababa.

that the therapies provided are safe and effective, gain credibility and that practitioners as well as children are well protected, *(iii)* ensure the setting up of standards in terms of service delivery and training, *(iv)* ensure the development of capacities enabling psychological support to reach grass roots level, and *(v)* provide a quantitative and qualitative assessment of the outcomes of psychological support for children reached.

The programme was initiated in December 2007 with a broad consultation organised with government partners: Ministry of Women Affairs, Ministry of Justice and Federal Supreme Court. The consultation held in Addis Ababa gathered together a multitude of child practitioners, child development experts, and policy makers coming from different disciplines and professions. Professionals attending the consultation were also from different departments of Universities (sociology, psychology, social work, and education), representatives from the health sector, NGOs, government officers, police officials from Child Protection Units, judges, prosecutors and policy makers. The overall aim of the consultation was to review the current experiences and practices of psychological services available to vulnerable children, with a special emphasis on child victims of violence/abuse and juvenile offenders.

In this occasion, practitioners expressed the need for a broad capacity building programme to strengthen their knowledge on modern techniques of child psychological support, such as Play and Creative Art Therapies, to learn effective methods of impact assessment in the area of child mental health, and to support the development of the practice through an ethical system able to guarantee minimum standards and safe practice of child psychological support.

This request was addressed through the participatory development of a National Strategy for the Psychological Support of Ethiopian Children (2008)[24] which paved the way for a cross-sectoral capacity building programme to address the specific needs of education, health, social and justice sectors in relation to psychological needs of vulnerable children in the country.

[24] *Op.Cit.*

The implementation of the National Strategy started in June 2008. An initial batch of 80 practitioners was selected from local NGOs, government and university institutes. All training provided matched international standards, with specialised courses developed by the Academy of Play and Child Psychotherapy (APAC) and delivered by PTI, modules accredited by the UK Canterbury Christ Church University and recognised by the International Board of Examiners of Certified Play Therapists (IBCEPT). In-country management, monitoring and clinical supervision was guaranteed by PTA.

Practitioners went through a number of intensive training which included: Certificate in Therapeutic Play Skills, Diploma in Play Therapy, Certificate in Filial Play, Training in Filial Play Coaching, and Supervisors Training. The courses were 70% practical, and 30% theoretical. At the end of each course, practitioners were requested to complete a well defined portfolio of activities that were assessed and supervised before accessing advanced level of training[25].

This extensive capacity building programme was complemented by the support provided in the establishment and development of an Inter-Ministerial Management Team (IMMT) initiated by the Ministry of Justice, the Federal Supreme Court which involved the Ministry of Health, the Ministry of Education, Police and the Ministry of Women Affairs. The IMMT's mandate is the one of guaranteeing an integrated case management of victims of violence and juvenile offenders, and ensuring a multisectoral support to identified children. Within this approach, integrated services for psychological support play a prominent role.

Methodology and Ethics: How to Assess Children to Determine if Therapy is Needed, Appropriate, and how Well it Works

Traditionally, many of the standardised self report questionnaires developed to screen and measure emotional and behavioural problems have been difficult to use in practice, as

[25] This portfolio included practicing at least 100 hours of therapeutic play with the support of a clinical supervisor, record the outcomes of the practice using the Goodman's Strengths and Difficulties Questionnaire (see section on methodology), undertake at least 6 book reviews, prepare one case study, and record each practice hour using appropriate supervisory modules.

they are long to run, exclusively focused on problems and pathology, and requiring a fairly high degree of skills and training.

Data presented in this article have been generated through the use of the Goodman's Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997)[26]. The SDQ is a brief behavioural screening questionnaire that provides balanced coverage of children and young people's behaviours, emotions and relationships, focusing on the most important domains of child psychopathology. It measures total difficulties (emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship issues) and pro-social behaviours of children from 3 to 16 years old. It is independently completed by the referrer (e.g. teacher, NGO worker, etc.), parents/carers and children[27].

A number of studies have reviewed the analytical features of the SDQ and compared it to the traditional Child Behaviour Checklist (Waldron *et al.* 2002)[28], the Rutter Questionnaire (Goodman 1997)[29], or the diagnoses made by clinicians (Mathai *et al.* 2004)[30]. The SDQ has been tested for validity in developed as well as developing countries (Mullick and Goodman 2001)[31]. The results suggest moderate to high correlations between the measures on a range of subscales and support the claim that the simpler SDQ is a valid short measure for assessing and screening childhood behavioural and emotional problems. The SDQ has been reported to have high internal consistency

[26] Goodman R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry. Vol. 38, 581-586.

[27] The SDQ asks about 25 attributes, 10 of which would generally be thought of as strengths, 14 of which would generally be thought of as difficulties, and one of which is neutral. Summing the items of the scale generates scores for the five sub- scales. The scores for hyperactivity, emotional symptoms, conduct problems and peer problems can be summed to generate a total difficulties score ranging from 0 to 40; the pro-social score is not incorporated in the reverse direction into the total difficulties score since the absence of pro-social behaviors is conceptually different from the presence of psychological difficulties (Goodman 1997). Finally, the SDQ also contains open ended final questions that allow for a qualitative review of parent/caretaker concerns regarding their children.

[28] Waldron B., Sharry J., Fitzpatrick, C., Behan, J., & Carr, A. (2002). Measuring Children's Emotional and Behavioral Problems: Comparing the Child Behavior Checklist and the Strengths and Difficulties Questionnaire. The Irish Journal of Psychology. Vol. 23, 18-26.

[29] *Op.Cit.*

[30] Mathai J, Anderson P, Bourne A (2004). Comparing Psychiatric Diagnoses Generated by the Strengths and Difficulties Questionnaire with Diagnoses Made by Clinicians. Australian and New Zealand Journal of Psychiatry. Vol. 38, 639-643.

[31] Mullick MSI, Goodman R (2001). Questionnaire screening for mental health problems in Bangladeshi children: a preliminary study. Social Psychiatry and Psychiatric Epidemiology. Vol. 36, 94-99.

and good test-retest reliability (Hawes and Dadds 2004)[32]. The SDQ has been assessed for its stability and external validity (Hawes *et al,* 2007)[33]. Multi-informant SDQs identify individuals with a psychological diagnosis with a specificity of 94.6% and a sensitivity of 63.3% (Goodman *et al.* 2001)[34].

As it has been applied in Ethiopia in the case of parent/carer referral, a SDQ's cut-off score of 13 marks the upper boundary of a child having 'normal' emotional development and difficulties (*no risk*). A score between 14 and 16, indicates a child having 'borderline' difficulties and strengths (*moderate risk*). A score above 16 indicates the child having clinically significant -or 'abnormal'- difficulties (*high risk*). PTA used this internationally accepted tool for screening and clinically assessing children as well as evaluating the outcomes of the therapeutic process with them.

Depending on the SDQ results, the number of sessions to be conducted with children is determined - on the basis of one session of 40 minutes per week. A short term intervention (ST) accounts for 6 one-to-one sessions with the child, plus an initial preliminary meeting with the child, and introductory as well as debriefing meeting with the referrer (caretaker, teacher, parents, etc.). A long term intervention (LT) accounts for more than 6 therapeutic sessions, usually 12 or more according to a child's assessed difficulties.

The SDQ was translated into Amharic and went through a trail period for validity and reliability check. Minor cultural adjustments in the translation of some words completed the pre-testing period.

[32] David J. Hawes, Mark R. Dadds (2004). Australian Data and Psychometric Properties of the Strengths and Difficulties Questionnaire Australian and New Zealand Journal of Psychiatry. Vol. 38, Issue 8, 644 – 651. Published Online: 5 Aug.

[33] David J. Hawes, Mark R. Dadds, Smith, Gregory C., Palmieri, Patrick A (2007). Examining the Structural Validity of the Strengths and Difficulties Questionnaire (SDQ) in a U.S. Sample of Custodial Grandmothers American Psychological Association. ISSN:1040-3590.

[34] Goodman R, Ford T, Simmons H, Gatward R, Meltzer H (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. British Journal of Psychiatry. Vol. 177, 534-539.

As a part of their practice portfolio, trained practitioners had to undertake at least 100 hours of supervised clinical practice with children, recording SDQ measures of each treated child before and after intervention (either ST or LT). Practitioners were also required to record each session's contents in specific reporting forms. This important process allowed for a better and continuous clinical supervision of practitioners, but also allowed for a wide set of quantitative and qualitative data to be generated by each practitioner. For confidentiality purposes, all data concerning each child were coded. Ethical principles of fidelity, autonomy, beneficence, non-maleficence, justice and self-respect, as well as child protection training were made compulsory parts of the course modules of certificate and diploma training.

Clinical supervision was a must and practitioners had to report to their supervisor at least once every six hours practice. The role of the supervisor has been the one of coaching and supporting the therapist, reviewing the safety and ethical components of practice to the benefit of both children and therapists, assessing the quality of data gathering and management, and providing additional training material to support the therapeutic intervention in *ad hoc* cases. All practitioners were also requested to provide a police certificate of clean criminal record before starting therapy with children.

A rough total of 8,000 hours supervised and recorded therapy were cumulatively requested to practitioners within 18 months from course completion. Roughly, this is equivalent to 1,000 children treated. Data from a random sample of 160 children (19% of total children population involved in the therapy), equivalent to 1,530 hours of practice, were entered into a specifically designed database. This allowed for an initial review of project's outcomes on children emotional status pre and post therapeutic intervention. Therapists provided the services within their respective NGOs, institutions and private practice all free of charge as a part of their training. PTA also made available spaces and therapeutic toolkits for practitioners without placement to practice within their respective institutions.

Basic Principles of Play and Creative Art Therapy

Play and Creative Arts Therapy is a therapeutic method of helping children with behaviour and emotional problems to help themselves. Each child is different and has different needs. Depending on their experience and their affects, their psychological condition can be *Slight, Moderate* or *Severe* and have various degrees of complexity, ranging from *Single, Several, Multiple* to *Complex.*

Play is essential for children to develop physically, emotionally and socially. It is the primary and natural medium of expression for children. It fosters imagination and creativity and encourages confidence and concentration. It helps children to learn about their ever-expanding world. Play can be used to establish a relationship with a child. It allows them to put feelings into 'words' - the words of play. It can be used when 'talking therapy' does not work – the younger the child, the less likely that words will be of any use. Children may have unresolved issues that, if put into verbal form, could be overwhelming. However, when children 'play out' different issues through toys, it can help them relieve an inner tension.

Play therapy involves helping children gain inner power, explore their resources that come from within, access needed resources from the outside and then learn to make decisions and feel in charge of their own life while accepting what cannot be immediately changed about their own environment and/or family.

PTA uses an integrative and holistic approach that includes non-directive and directive approaches. Non directive play therapy techniques allow a child complete freedom of choice within a set of few (but necessary) limits and safe boundaries. There is no judgment, no right or wrong. The child is neither praised nor blamed. By providing a free atmosphere within safe boundaries, the therapist enables the child freedom to express him/herself verbally, physically or with playthings. It enables children to learn how to cope with feelings and emotions in a safe and constructive way. Therapists trained at Diploma level can also be more directive, in line with the Play Therapy Dimension Model (Yasenik and Gardner 2004)[35].

[35] Yasenik L. And Gardner K. Gardner (2004). Play Therapy Dimension Model: A decision Making Guide for Therapists. Rocky Mountain Play Therapy Institute, Alberta.

Play Therapy works both with the unconscious and conscious. The 'Play Therapy Toolkit' comprises creative visualization, storytelling, drama, sandplay/sandworlds, puppets and masks, art, music, dance and movement based on a set of competencies defined by the Professional Structure Model (PTUK 2004)[36].

Data Analysis

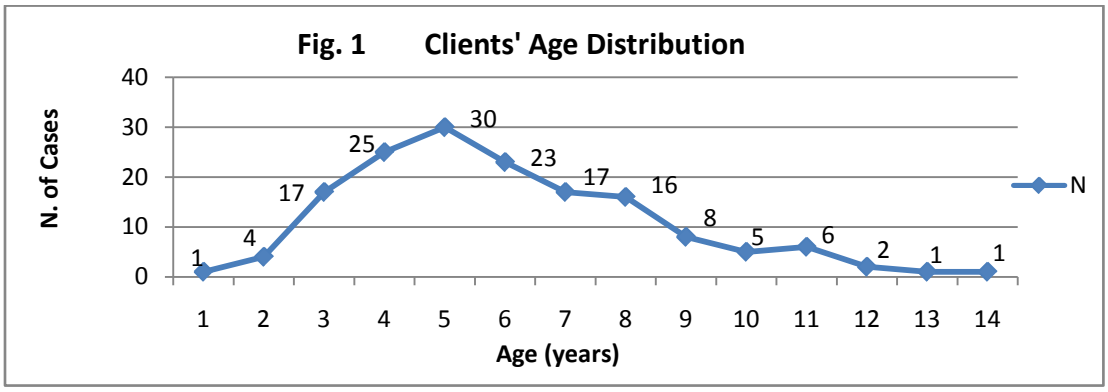
In the identified cohort of 160 children, 4 cases were discarded due to incomplete data record. Among the remaining 156 cases, 72 were girls and 84 were boys. In 93 cases (59.6%) children underwent a long term therapy of approximately 12 hours therapy over a 3 months period[37]. The remaining 63 children (40.4%) enrolled in a 6 hours therapy over approximately one month and half. The overall average hours of therapy with each child for the total sampled population is 9.58.

The age of reached children ranged from 3 to 19 years old, with a mean age of 8.55. The 87.2% of children had an age comprised between 5 and 11 years (see Fig.1). 122 children (78.2% of the cases) were referred to the therapist by one or two parents, while in the remaining 21.8% of the cases children were referred to therapy by main caretaker (other than parent) and teachers. In the cases where the SDQ had been filled in by more than one referrer, the therapies and the data were based on the higher SDQ score among those available. A self evaluation pre and post therapy by the child him/herself (using SDQ child/pupil forms) was conducted in a number of cases, yet it was not made compulsory and many therapists preferred not to administer it with children younger than 10 years old[38].

An overview of the background of reached children, and reasons for referral will provide and idea of the heterogeneity of the cases to which the therapies have been adapted and applied. The background of these children varied greatly, ranging from children placed in

[36] PTUK (2004). The Professional Structure Model. Play Therapy UK. See www.playtherapy.org.uk.
[37] Children that were treated through group therapy were not included in this sample.
[38] For the purpose of this work, data from self-reported emotional status pre and post therapy using SDQ tools have not been inserted into the quantitative analysis but only reviewed for qualitative purposes.

foster care, children living in poor dwellings and slums, school going children with learning difficulties, and natural or social orphans. All children were settled in urban areas at the moment of referral; the vast majority was from Addis Ababa. The multiple causes for referral were: abuse (emotional, physical, sexual), Attention Deficiency Hyperactivity Disorders (ADHD), anger, attachment issues, autistic spectrum, behaviour problems, bereavement/loss, bullied/bullies, communication problems, delayed development, nightmares, separated/divorced parents, social exclusion, trauma, under performing (academically, socially, culturally), withdrawn personality.



Pro-Social Outcomes Pre and Post Therapy

Pro-Social behaviour can be defined as any act initiated and performed with the aim of benefiting another person (Aronson *et al.* 2004)[39]. It is a predisposition to help, share and care (Buckmaster 2004)[40] . An analysis of pro-social scores before interventions will classify children as having 'abnormal' pro-social behaviours in the 35% of the cases, 'borderline' in the 23% of the cases, and 'normal' in the remaining 42% of the cases. The same assessment repeated for each child at the end of therapy showed a substantial improvement, registering only 10% of children

Tab.1

Pro-Social Scores Pre and Post Therapy

Categories	**Pre-Therapy**		**Post Therapy**	
	N. of Cases	%	N. of Cases	%
Abnormal	56	36	16	10
Borderline	36	23	15	10
Normal	67	41	125	80
Total	**156**	**100**	**156**	**100**

[39] Aronson, E., Wilson, T., & Akert, R. (2004). Social Psychology, Media and Research Update (Fourth ed.). Pearson Education. Upper Saddle River, N.J.

[40] Sharon Buckmaster (2004). Prosocial Behaviour: Helping, Caring and Sharing Behaviours. Depth Paper KA6. Graduate Institute, Fielding.

in the cohort as still having 'abnormal' and 'borderline' pro-social behaviours. 80% of *childr*en were recorded having improved to 'normal' pro-social behaviour (Table 1, Figure 1 and 2).

Fig.2 Pro-Social Scores Pre-Therapy

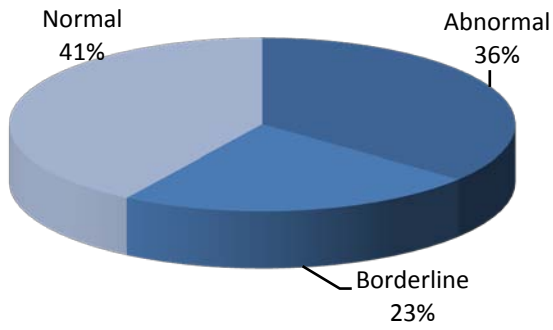
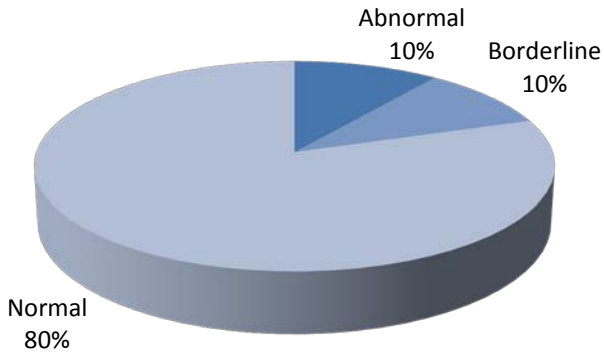
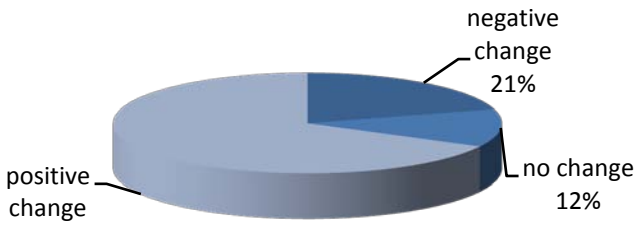


Fig.3 Pro-Social Scores Post-Therapy



Looking at the aggregate changes in pro-social behaviour, 67% of children registered an improvement in pro-social indicators, 12% did not register any change, and the remaining 21% registered a negative change (Figure 4).

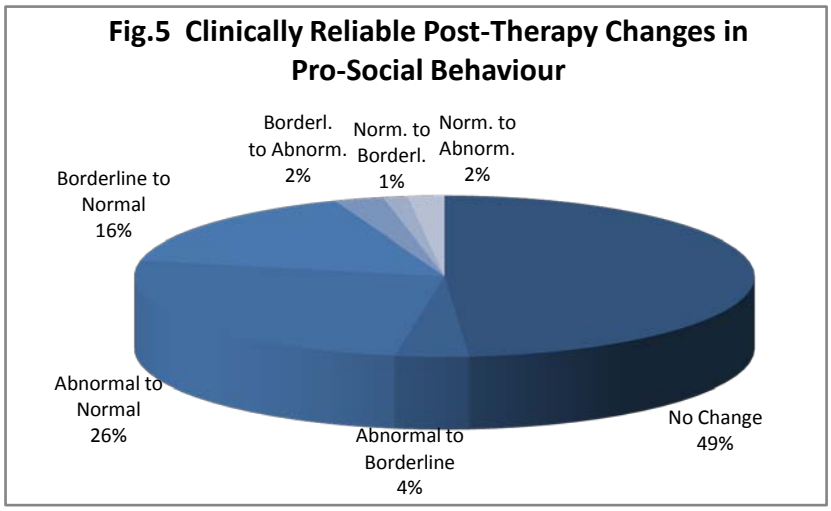
Fig.4 Post-Therapy Changes in Pro-Social Behaviour



Disaggregating these trends by clinical reliability[41], in 76 cases (49% of the total) the change was not sufficiently wide to allow the child to move across categories. In 6 cases (4%) and in 40 cases (26%), the therapy allowed the child to move from 'Abnormal' to 'Borderline, and from 'Abnormal' to 'Normal' respectively. The child moved from 'Borderline' to 'Normal' in 25 cases (16%), and from 'Borderline' to 'Abnormal' in 4

[41] A '*clinically reliable change*' is the change (positive or negative) of child's score from one category to another one. It is a measure able to assess the degree/depth of change for any given category (pro-social, emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship).

cases (2%). The movement from 'Normal' to 'Borderline' and from 'Normal' to 'Abnormal' involved 2 (1%) and 3 (2%) children respectively (Figure 5).



Total Difficulties Outcomes Pre and Post Therapy

Focusing attention on total difficulties, in the pre-therapy stage children classified as having 'Abnormal' difficulties in 105 cases (67%), 'Borderline' in 33 cases (21%), and 'Normal' in 18 cases (12%)[42]. After therapy, 98 cases (63%) were classified as 'Normal', 37 cases (24%) as 'Borderline', and only 21 cases (13%) as 'Abnormal' (see Table 2, Figure 6 and 7).

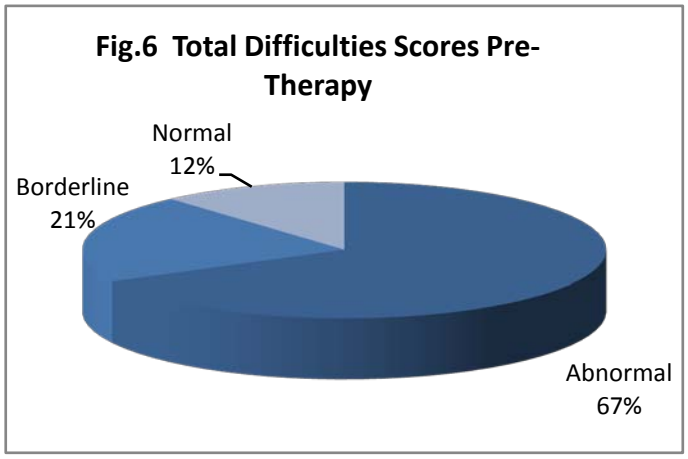
Tab.2

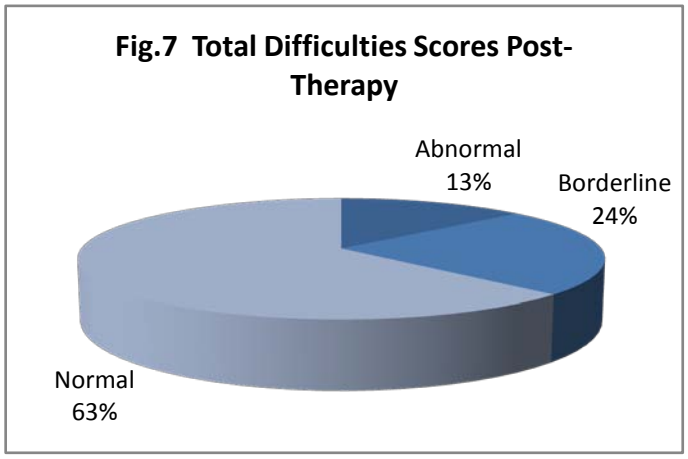
Total Difficulties Scores Pre and Post Therapy

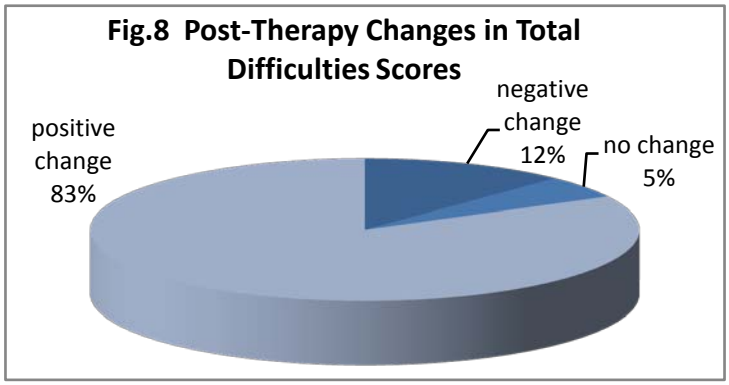
Categories	**Pre-Therapy**		**Post Therapy**	
	N. of Cases	%	N. of Cases	%
Abnormal	105	67	21	13
Borderline	33	21	37	24
Normal	18	12	98	63
Total	**156**	**100**	**156**	**100**

Looking at the aggregate changes in total difficulties scores, 83% of children registered an improvement in total difficulties indicators, 5% did not register any change, and the remaining 19% registered a negative change (Figure 8).

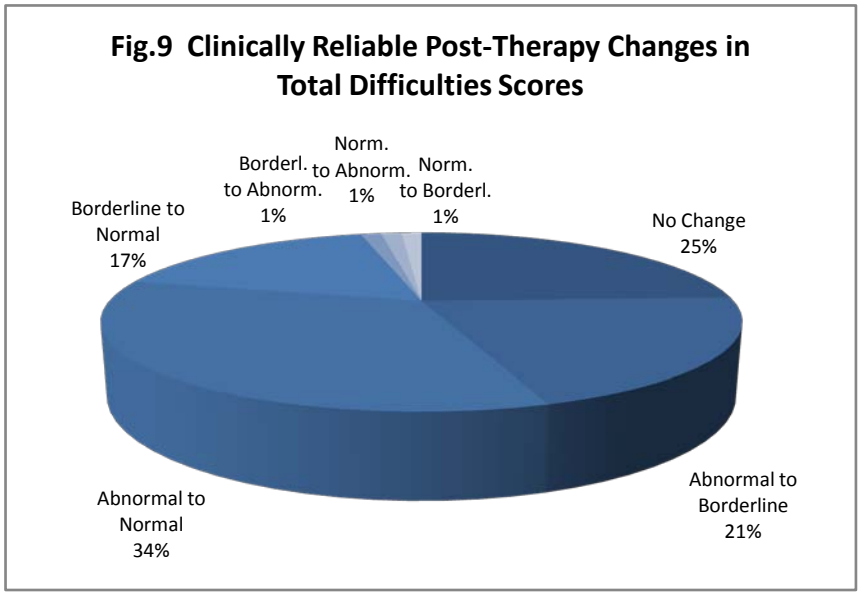
[42] These 'Normal' cases were treated in view of 'Abnormal' values scored in pro-social behaviours.







Analysing these trends in light of clinical reliability, in 38 cases (25% of the cases) the change was not sufficiently wide to allow the child to move across categories. In 32 cases (21%) and in 53 cases (34%), the therapy allowed the child to move from 'Abnormal' to



'Borderline', and from 'Abnormal' to 'Normal' respectively. The child moved from 'Borderline' to 'Normal' in 27 cases (17%), and from 'Borderline' to 'Abnormal' in 2 cases (1%). The movement from 'Normal' to 'Borderline' and from 'Normal' to 'Abnormal' involved 2 children (1%) respectively. A broken down analysis of total difficulties according to each of the main domains of child difficulties is provided in the following paragraphs (Figure 9).

Hyperactivity/Inattention

Hyperactivity was recorded at an 'Abnormal' and 'Borderline' level for 25% and 16% of the children respectively upon registration into the programme. At the end of the programme, only 2% and 8% of the children were still recorded having 'Abnormal' and 'Borderline' levels of hyperactivity respectively (Table 3). An overall 79% of children registered improvements in their hyperactivity scores (Table 4). 39% of children recorded clinical improvements in hyperactivity/inattention.

Table 3 Hyperactivity Scores Pre and Post Therapy

	Pre-Intervention (%)	Post-Intervention (%)
Abnormal	25	2
Borderline	16	8
Normal	59	90
Total	100	100

Table 4 Post Therapy Changes in Hyperactivity Scores

	N. of Cases (%)
Negative Change	10
No Change	11
Positive Change	79
Total	100

Emotional Symptoms

59% of sampled children were recorded as having 'Abnormal' emotional symptoms, while a further 11% were classified as having 'Borderline' emotional symptoms upon registration into the programme. At the end of the programme, only 12% and 17% respectively were still classified as having 'Abnormal' and 'Borderline' emotional symptoms (Table 5). An overall 83% of children registered improvements in their emotional scores (Table 6), and 58% of children experienced clinical improvements.

Table 5 Emotional Scores Pre and Post Therapy

	Pre-Intervention (%)	Post-Intervention (%)
Abnormal	59	12
Borderline	11	17
Normal	30	71
Total	100	100

Table 6 Post Therapy Changes in Emotional Scores

	N. of Cases (%)
Negative Change	6
No Change	11
Positive Change	83
Total	100

Conduct Problems

A large majority of 70% of sampled children were found having different sorts of conduct problems to 'Abnormal' degrees, and an additional 9% to a 'Borderline' degree upon initial screening. Post intervention data for conduct scores highlights 'Abnormal' degrees of conduct in 26% of treated children, and 'Borderline' scores for 20% (Table 7). An overall 84% of children responded positively to the therapies vis-à-vis conduct scores through an improvement (Table 8). In the 53% of the treated cases the positive change has been deep enough to allow for a clinical improvement.

Table 7 Conduct Scores Pre and Post Therapy

	Pre-Intervention (%)	Post-Intervention (%)
Abnormal	70	26
Borderline	9	20
Normal	21	54
Total	100	100

Table 8 Post Therapy Changes in Conduct Scores

	N. of Cases (%)
Negative Change	6
No Change	10
Positive Change	84
Total	100

Peer Relationships

Peer relationships were screened as 'Abnormal' and 'Borderline' in the 67% and 15% of the cases respectively. These percentages changed into 32% and 23% respectively after therapy (Table 9). An Overall positive change in peer relationship was recorded for 73% of treated children (Table 10), with a 47% of clinical improvement.

Table 9 Peer Relationships Scores Pre and Post Therapy		
	Pre-Intervention (%)	Post-Intervention (%)
Abnormal	67	32
Borderline	15	23
Normal	18	45
Total	100	100

Table 10 Post Therapy Changes in Peer Relationships Scores	
	N. of Cases (%)
Negative Change	10
No Change	17
Positive Change	73
Total	100

What the Data Suggests

The application of Play and Creative Art Therapies to vulnerable children proved to be extremely successful. Improvement in pro-social strengths of selected children was registered in 67% of total cases, while an even more important improvement in children's total difficulties was registered in 83% of cases. Only a minimal proportion of 10 to 13% of the sampled children was still classified as 'Abnormal' in pro-social and total difficulties after the intervention. Data showed a very high impact of selected therapies in graduating children from an 'Abnormal' to a 'Normal' condition (a proportion of 26% moved from 'Abnormal' to 'Normal' in pro-social scores, and a greater proportion of 34% reached normality values in total difficulties). The greater the emotional and behavioural condition, the higher the impact of therapies. Graduation from non severe emotional conditions (passage from 'Borderline' to 'Normal') resulted clinically possible, but less important in magnitude, involving 16% and17% of sampled children for pro-social and total difficulties respectively.

Some children registered a negative change of emotional and behavioural scores after therapy. 5% of children had their pro-social scores reduced after intervention, and 3% had their total difficulties increased. This can be explained accounting for the life events a child went through during the months of therapies. For some of these children, a particularly negative life event happened at the time of intervention, resulting in an even more fragile and instable emotional condition than the levels recorded upon registration into the programme (i.e. the loss of a parent, abuse, etc.). Optionally, the therapeutic intervention has brought to surface traumas and abuses that were locked inside the

unconscious of the child and had been ‘forgotten’, and for which the child was not initially referred. In these cases, emotional improvements have not a linear progression and things are likely to get worse before they get better. Under these circumstances, the length and focus of therapy should be adapted to account for the newly emerged elements initially unpredicted.

Looking at the effects of intervention for each of the screened problems, play therapy provided a positive change for the vast majority of children in each domain, ranging form 73% children experiencing a positive change in peer relationships, up to 84% of children registering conduct improvements. Clinical improvements for each category ranged from 39% improvement on hyperactivity, to 58% clinical improvement for emotional symptoms. Overall, Play and Creative Art Therapies had a combined positive impact for both overall and clinical improvements in each assessed domain. A particularly important positive impact in emotional symptoms and conduct problems was recorded. The impact of the therapies on hyperactivity and peer relationships is still extremely positive, yet less important than the positive changes registered for emotional symptoms and conduct.

No correlation was found between the clinical outcomes of the therapies for children and the educational background of the therapist administering them. This suggests a wide application and use of the therapies by adults that are empathic towards children and have a solid experience in working with them, without necessarily having extensive theoretical background in child psychology or psychiatry. Systematic clinical supervision in these cases becomes even more important.

Why Play and Creative Art Therapies Works with Children in General, and with Vulnerable Children in Particular

In order to understand how and why play therapy works, it is important to review and integrate some of the literature of neuroscience and early brain development, emotions regulation and the affects that early experiences have on later development. It is not possible to do so extensively within the scope of the current paper. We therefore provide below a very simplified insight of the critical significance of early childhood experiences

on brain development, what happens when things go wrong and how play and creative art therapies can help rebuild affected developmental processes.

The architecture of a person's brain is created by the interaction of their genetically inherited characteristics (nature) and the shaping of this neural architecture within the context of significant interpersonal relationships (nurture). Brain research has shown that parents and significant others/child professionals dramatically affect the long term chemical balance and actual anatomical structures in the child and adolescent brain for better or worse (Cozolino 2006)[43]. The brain, as an organ of adaptation, develops as we record new experiences and learn through positive and negative interactions. Its plasticity thus enables change. This capacity is at its height during the first 3 years of life and during adolescence and it continues throughout life span thus allowing for continual modification of earlier 'patterning' that has been established based on earlier experience - for the good through positive experience, stimulation and therapy; for the bad when deprived of stimulation and programmed to patterns of violence and abuse for instance.

From what we know of the attachment system, much of the really important things we store in our memories at the automatic level go on in the first year and a half. The parent-child relationship is stored in our memory systems from far earlier than we remember. If there are negative impacts on the early developing fragile system of children, the growth of the brain itself will be altered and there will be long term negative consequences. The wound of childhood remain with us throughout life, unless something is done to heal them: this is why people seek psychotherapy.

Research has found that neglect and abuse are amongst the most painful of childhood traumas. The instinctive responses to stress, abuse or neglect are to 'flee' from a danger situation, to 'fight' it or to 'freeze'. A child might be unable to fight' or 'flee', so under repeated situations of neglect or abuse, they will sometime 'freeze' rather than risk more

[43] Cozolino, L. (2006). The Neuroscience of Human Relationships: Attachment and the Developing Social Brain. W.W. Norton & Company, New York, London.

abuse by seeking comfort. Children may then resort to pathological strategies, which could include violence that is often seen in boys, or depression for girls (Bowlby 1997)[44].

Violence and antisocial behaviours are thus among the easiest things to predict from the knowledge of the conditions of the child's history. For children who are aggressive, who chronically show disruptive, deviant or truant behaviours, who are mean to other children, who are defiant to parents or teachers, there is an explanation. Their behaviour can be explained from both a sense of alienation with regard to other people as well as a feeling of anger and resentment for not having had their own needs met (Sroufe 2005)[45]. Girls (under similar circumstances of violence and abuse) are very prone to depression and may resort to drug and alcohol abuse or may self harm; they are also likely to dissociate of freeze under extreme stress and unavoidable violence (Bowlby 1997)[46] having a sense of helplessness and hopelessness[47].

Because of the influences of attachment experiences, parents will normally repeat the behavioural patterns stored at unconscious level and bring their children the way they were brought up despite of any conscious attempt they may make to change their parenting behaviour. This explains how some parent-child problems, could run in some families, generation after generation. Luckily, with help, the pattern can be broken and not everyone that has been abused becomes abusive. Vulnerable families therefore need intensive and skilful help if the children are not to carry these problems into adulthood and pass them on to new generations (Bowlby 1997)[48]

When coupled to practice based research which quantifies how well play therapy works, the above mentioned challenges provide strong evidence that justify making play therapy

[44] Bowlby J. (1997). Attachment and Loss. Vol.1. Pimlico, London. Reprint of the original 1969 version published by Hogarth Press, London.
[45] Sroufe, L. A. (2005). Attachment and development: A Prospective, Longitudinal Study from Birth to Adulthood. Attachment and Human Development. Vol. 7, 349-367.
[46] *Op.Cit.*
[47] Dissociation is in fact a common reaction to traumatic experience. It is characterised by disorientation and disconnection among thoughts, behaviours, sensations and emotions (Cozolino 2006, *Op.Cit.*). These dissociative symptoms predict the later development of post traumatic stress disorders (Koopman C., Classen C., and Spiegle D. (1994). Predictors of Posttraumatic Stress Symptoms among Survivors of the Oakland/Berkeley, Calif., Firestorm. American Journal of Psychiatry. Vol. 151:888-894).
[48] *Op.Cit.*

available for all vulnerable children experiencing emotional, behavioural and mental health problems. The brain neuroplasticity justifies why it is important to address the affects of insecure attachment, traumatic experiences, violence and abuse through a safe and trusting therapeutic approach that can tap on the unconscious where these experiences are stored right from a very early age and from which behaviours are organized and pattern of violence/abuse are at high risk of being – unconsciously – reproduced across generations.

Play and Creative Art Therapies can be sought as an enriched environment that promotes the development of cognitive, emotional and behavioural abilities of children. The principle is to help them helping themselves to develop, regulate, integrate and coordinate the one or more neural networks optimal for functioning that have been affected. Through the establishment of a safe and trusting relationship, much of the exchange between the therapist and the child relies on the aspect of mind-brain relationship, thereby enabling children to learn from previous experience across the domain of emotion, sensation, behaviour and cognition and helps them developing, modifying or reframing future expectations or experiences in light of these. Play Therapy techniques, by focussing on, tuning in, accepting the child as is and reflecting back are allowing children to experience both negative and positive states and, as a result of that, they learn that these states exist within the self and that these feelings are sharable with other human beings.

Play Therapy helps the activation of neural networks that are inadequately integrated or dissociated. When children are helped with their feelings, huge numbers of brain cells in their rational brain start to form pathways which connect to the reptilian brain. When a child feels threatened or angry for instance, the reptilian brain takes over control from the rational brain by triggering defence and/or attack impulses. In dealing with an ‘out of control child’, the reptilian brain has taken over from the rational brain, his/her ‘IQ’ is reduced. Appeals to reason through talking (therapy) are no use. The child has to be calmed down first. A calm body will calm the mind, hence the value of creative visualisation, guided imagery and meditation techniques as a part of the Play Therapy

Toolkit for instance that are more appropriate than a cognitive approach in these situations (PTI 2007)[49].

At other times, due to experiences and adversities, children's mammalian brain can 'cut off' from feelings of love and be ruled by the rational brain, thereby making them unable to form close relationships. Through Play and Creative Art Therapies, children are helped to co-ordinate their rational brain with the emotional systems of the mammalian brain as they are helped in integrating conceptual knowledge with emotional and bodily experience through the freedom offered by non-directive play as well as the narrative that are co-constructed with the therapist through more directive approaches (through storytelling, etc.).

It has also been shown that more brain centres light up in response to metaphor than any other form of human communication, therefore forming new neural pathways (Modell 1997)[50]. So symbolic/fantasy play with its use of metaphors – that are the basics of Play and Creative Art Therapy – provides new experiences that develop the brain/mind.

Play Therapy also helps building new neural pathways by releasing chemicals in the brain and acts as a 'brain sculptor'. Brain oxytocin, opioids and prolactic systemes appear to be the key participants in the feelings that we call 'acceptance', 'nurturance' and 'love' (Panksepp 1998)[51]. Opioids are the key chemicals of the care system. The presence of these opioids removes the urge to fight. When there is a withdrawal of opioids in the brain (e.g. when a relationship ends suddenly), opponent forces are released in the brain, which can make children very angry, hostile, irritated, unless they get help with their grief, from a person who is good at comforting and from whom they accept comfort (Eisenberger *et al.* 2003)[52].

When a child or adult is helped to think about their feelings, anti-anxiety chemicals are also released in the brain so that trauma is modified. These are called GABA. Research

[49] PTI (2007). Play for Life. Play Therapy International. Summer Volume.
[50] Modell, A.H (1997). Reflections on Metaphors and Affects. Annual of Psychoanalysis. Vol. 25:219-233.
[51] Panksepp J. (1998). Affective Neuroscience. Oxford University Press, New York.

with other mammals shows that gene expression of these systems is positively affected by warm, physically affectionate parenting and negatively affected by relational stress and deficit in physical affection (Meaney 2001)[53]. In this respect, Play Therapy also acts as brain sculptor and enables the releases of GABA.

Sharing of joy and laughter are key to early brain development. Out of laughter develop the most social behaviour of all: play. By joining and sharing the excitement and exploration of a child, it actively stimulates brain growth by secreting dopamine. Play and Creative Arts techniques build on these basic principles. Research has also shown that social play can increase the activation of a vital brain 'fertilizer', called Brain Derived Neurotrophic Factor (BDNF) that encourages cells to grow and make connection, which helps to program the higher brain regions involved in regulating emotional behaviours (i.e. it helps a child manage his/her feeling better). As a result of play, there is a significantly elevated BDNF expression in the brain (Gordon *et al.* 2003)[54].

Conclusions and Way Forward

The programme implemented and the data gathered allow drawing some interesting conclusions. Firstly, the application and adaptation of Play and Creative Art Therapies in development programmes has a very high degree of success. The greater the degree of child difficulties, the higher the improvement. Children that have been abused, abandoned, or that underwent severe and recurrent traumas resulting in very high levels of total difficulties benefitted the most from therapies. Emotional wellbeing, which is usually mostly negatively affected by any form of abuse and neglect, is also the category more responsive to improvements brought about by play therapy.

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[52] Eisenberger, N.I, M.D. Lieberman, K.D. Williams (2003). Does Rejection Hurt? An fMRI Study of Social Exclusion. Science 10 October. Vol. 302. no. 5643, 290 – 292.

[53] Meaney, M.J. (2001). Maternal Care, Gene Expression, and the Transmission of Individual Differences in Stress Reactivity across Generations. Annual Review Neuroscience. Vol. 24:1161–192.

[54] Gordon, NS., Burke, S., Akil, H., Watson, SJ., Panksepp, J. (2003). Socially-Induced Brain 'Fertilization': Play Promotes Brain Derived Neurotrophic Factor Transcription in the Amygdala and Dorsolateral Frontal Cortex in Juvenile Rats. Neuroscience Letters. Vol. 341, Issue 1, 17-20. 24 April.

While the final impact result is encouraging, equally important is to observe the high degree of fidelity to the programme by supported children. Only 4 cases (2.5%) out of 160 children dropped out from therapy. An explanation for this is the fact that the therapy is presented in a playful and original manner speaking their 'language', allowing children to explore ways of interaction not experienced before. Another reason is linked to the very principle of presenting an intervention that is non-directive. In a highly patriarchal society where children's opinions, ideas and curiosity are subjected to the constant approval and supervision of adults, a child-led intervention allowed for the building of self-esteem, trust, and gave a sense of permission and freedom of expression of both positive and negative emotion hardly experienced outside the playroom. Even traditionally perceived 'rebel' children, such as street children, found in the playroom a space for an emphatic and safe interaction with an adult that had no expectations or demands. The equally important principles of non-judgement and non-interpretation opened the door for a trust building process between the therapist and the child which allowed for a deeper share of emotions and concerns. Whatever was shared inside the playroom could not become the object of preaching or scolding.

Furthermore, Play and Creative Art Therapies proved to be more culturally appropriate and easier to accept than traditional psychological interventions carried out by clinicians. Referrers, parents or children themselves did not perceive play therapy as a form of therapy *per se*. They rather viewed the intervention as giving 'special time' and attention to children. The therapies were easy to explain to adults and encountered no resistance from them.

While SDQ's recorded improvements are an objective important indication of a clinically sound intervention, an equally important outcome of the therapies is the self-reported feeling of increased well-being by children. They reported a change in the areas that affected their emotions and behaviours, and in most cases they managed to reconnect with their emotions, reached a deeper understanding of what was troubling them, and took resolutions for improving their predicaments.

An analysis of Play and Creative Art Therapies in connection to the attachment theory and the recent neuroscience's discoveries helped in shedding light on how and why play therapy works better than comparable and equally important forms of psychotherapy for children. Play Therapy helps building new neural pathways by releasing chemicals in the brain and acts as a 'brain sculptor'. It helps to reframe early traumatic experiences for insecurely attached children, and breaking the intergenerational transmission of emotional instability.

The therapies resulted to be a healing path for children (Barnes 1996)[55] based mainly (but not exclusively) on the process rather than on the capacities and skills of professionals administering them (Oaklander 2007)[56]. The practitioners that took part in this project had all a background of non therapeutic work with children, yet only a minimal part among them had a degree in psychology or previous formal training in psychotherapy. We found no correlation between therapeutic outcomes and degree/field of education of the practitioners that took part into the programme. Practical knowledge and experience, more than theoretical formation seemed having made the difference in the delivery of the services. This highlights an important advantage in using Play and Creative Art Therapies in developing countries, where PSS sectors are traditionally dominated by a scarce availability of professional expertise on the ground able to run effective psychological support services. Systematic formal clinical supervision practitioner-supervisor also acted as an important continuous support for the therapist and enables monitoring safe practice to the benefit of both children and therapists.

The use of the SDQ proved to be an easy, reliable, and quick tool to monitor the quality and clinical outcomes of practice. It allowed moving away from traditional psychological programmes for children unable to report on interventions' outcomes for children mental health. SDQ data record, weekly process diary, supervision sheet, and client post session forms generated a '*modus operandi*' among practitioners that was perceived as highly professional. It allowed the therapists to keep full record of each child's changes

[55] Barnes M. (1996). Healing Path with Children: An Exploration for Parents and Professionals. The Play Therapy Press, London.
[56] Oaklander V. (2007). Windows to Our Children: A Gestalt Therapy Approach to Children and Adolescents. Gestalt Journal Press. Gouldsboro, Maine.

overtime, and gave them a quantitative perspective of their work outcomes in addition to qualitative discussions with the child and referral(s)/parent(s). The data generated through SDQ allowed the donors of the programme to gain a scientific indication of programme's achievements against initial investment, a measure of value for money and results based management.

The role of Play and Creative Art Therapy as a preventive intervention for child emotional and behavioural problems falls outside the scope of the present study, yet it appears to be an important direction for future research. The same applies for the application of Play and Creative Art Therapies in other domains of development assistance, such as child malnutrition for instance, which has been the focus of another programme successfully supported by PTA.

The data presented shed new light on a possible original and potentially very powerful tool available to practitioners working with vulnerable children in developing countries and in Ethiopia in particular. The combination of Play and Creative Art Therapies with the use of the SDQ has proven to be above the shortfalls and criticisms traditionally addressed towards psychological interventions for vulnerable children in developing countries. Much remains to be done to expand the programme to new practitioners, to reach out more children, and to fully integrate it with government initiatives in order to establish strong and lasting referral mechanisms. Psychological interventions for vulnerable children are still often perceived as 'a luxury'. Yet, overlooking them creates degenerative effects that become a social problem into children's adulthood. So one could ask where do we prefer to invest: in supporting the emotional recovery of vulnerable children (*preventive approach*), or in solving violence, crime, domestic abuse and the like further emerging during adulthood parenting (*curative approach*)?