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BYLAE

BYLAAG 1: KUNDIGES IN DIE VSA WAT GERAADPLEEG IS

Kundiges wat in verband met hierdie navorsing geraadpleeg is:

- Dr. N. de Meilon van die Departement Toegepaste Sielkunde aan die Universiteit van Suid-Afrika – in verband met opleiding in die MIM. Werkswinkels is op 1 en 2 Augustus 2002 en 8 November 2003 bygewoon.

- Me. P.B. Booth, Kliniese Direkteur van die Theraplay® Instituut in Chicago, VSA, is op 21-25 Januarie en 26-30 Junie 2003 gekontak in verband met die MIM. Opleiding in die MIM en die hantering van bindingsprobleme is ontvang.

- Me. S. Lindaman, Opleidingsdirekteur van die Theraplay® Instituut in Chicago is ook op bogenoemde datums geraadpleeg tydens opleiding in die MIM.

- Me. M. Alice, Opleidingsbeampte van die Theraplay® Instituut in Chicago is op 26 Junie 2003 gekontak in verband met groepwerk. 'n Werkswinkel is bygewoon.

- Dr. J. Pickens, dosent van die Departement Sosiale Wetenskappe en Berading aan die Universiteit van Miami is op 12 Mei 2003 per e-pos gekontak in verband met toestemming om die MIMBRS vir die doeleindes van die studie te gebruik.

- Dr. K. O'Conner – professor aan die Alliant Internasionale Universiteit, Californië, en Direkteur van die Spelterapievereniging in die VSA – is op 26 Junie 2003 tydens 'n internasionale kongres van die Theraplay® Instituut gekontak in verband met die gebruik van die MIM in hierdie navorsing. Hy het waardevolle insette oor die gebruik van die MIM by ongeletterde persone gelewer.

- Dr. M. Steward, dosent aan die James Madison Universiteit in Harrisonburg, VSA, is op 26 Junie 2003, tydens 'n kongres in Chicago gekontak omdat sy saam met dr. Pickens die MIMBRS ontwikkel het. Sy het aangedui dat haar studente die MIM in die mees afgeleë gebiede met ongeletterde persone gebruik.

- Dr. E. Munns, Direkteur van die Theraplay® Instituut in Kanada is op 28 Junie 2003 tydens ’n kongres in Chicago gekontak. Sy het waardevolle insette oor die gebruik van die MIM in ’n voor- en natoets gelewer.

- Me. N. Myburgh, Programbestuurder van CMR Benoni. Sy is deurlopend vanaf Januarie tot Junie 2003 gekontak in verband met die betrokkenheid van die CMR by hierdie navorsing.

- Me. De Vos, Voorsitter van die Pleegsorg- en Aannemingskommissie, Nederduits Gereformeerde Barmhartigheidsdiens, Suid-Transvaal, is gedurende Augustus 2003 gekontak in verband met pleegsorg en familiesorg in die swart bevolking.

- Me. R. du Toit, Supervisor: Pleegsorgdienste van die CMR, Mpumalanga, is gedurende Augustus 2003 gekontak in verband met die insidensie van familieplasings by die swart bevolking en ander waarnemings.

BYLAAG 2: OPLEIDING IN DIE VSA

THE THERAPLAY® INSTITUTE

3330 Old Glenview Road, Suite B, Wilmette, IL 60091 * 180 N. Michigan Avenue, #2419, Chicago, IL 60601

Tel: 847.256.7334
Fax: 847.256.7370

info@theraplay.org
www.theraplay.org

January 25, 2003

The purpose of this letter is to confirm that Christelle Blunden completed 26 CE credit hours of the Introductory Theraplay and Marshak Interaction Method training and 6.5 CE credit hours of the Introductory Group Theraplay training. The workshop was held at the Hampton Inn & Suites of Skokie, Illinois, USA, on January 21st through 25th, 2003 from 8:30 until 4:30 daily.

The Theraplay® Institute is approved by the American Psychological Association to offer continuing education for psychologists. The Theraplay Institute maintains responsibility for the program. The Theraplay Institute also is approved by the Association for Play Therapy to offer continuing education specific to play therapy. Our provider number is (95-008). The Theraplay Institute maintains responsibility for the program. Additionally, The Theraplay Institute is approved by the State of Illinois Department of Regulation for Licensed Social Workers (CE Sponsor #159-000177), Licensed Professional Counselors, Licensed Clinical Professional Counselors (CE Sponsor #197-000003), and Licensed Marriage and Family Therapists (CE Sponsor #168-000134).

The workshop was taught by Phyllis Booth, MA, LCPC, LMFT, RPT/S, and Sandra Lindaman, MA, MSW, LSW both are Certified Theraplay® Therapists and Trainers.

Laura Spicer, Psy.D.
Executive Director

THE THERAPLAY® INSTITUTE

3330 Old Glenview Road, Suite 8, Wilmette, IL 60091 * 180 N. Michigan Avenue, #2419, Chicago, IL 60601

Tel: 847.256.7334
Fax: 847.256.7370

info@theraplay.org
www.theraplay.org

December 2, 2003

The purpose of this letter is to confirm that Christelle Blunden attended the Advanced Theraplay® and Marschak Interaction Method Workshop for 10.0 CE credits and 10 credits toward your Theraplay Therapist Certification. The workshop was held at the Days Inn of Chicago, Illinois, USA, on June 28th and June 29th, 2003 from 8:30 until 4:30 daily.

The Theraplay® Institute is approved by the American Psychological Association to offer Continuing Education for psychologists. The Theraplay Institute maintains responsibility for the program. Each workshop hour equals one hour of CE credit. The Theraplay Institute is also approved as a continuing education sponsor by the Association for Play Therapy (95-008) and by the State of Illinois Department of Regulation for Licensed Social Workers (CE Sponsor #159-000177), Licensed Professional Counselors, Licensed Clinical Professional Counselors (CE Sponsor #197-000003), and Licensed Marriage and Family Therapists (CE Sponsor #168-000134).

The workshop was taught by Sandra Lindaman, MA, MSW, LSW, Phyllis Booth, MA, LPC, LMFT, RPT/S, Bill Fuller, MSW, LCSW, and Jukka Mäkelä, M.D. All are Certified Theraplay Therapists and Trainers.

Gayle Christensen
Executive Director

The Theraplay Institute
3330 Old Glenview Rd. #8
Wilmette, IL 60091
www.theraplay.org

March 27, 2003

Ethics Committee
University of Pretoria
South Africa RE: Doctoral research of Christelle Blunden

Dear Committee Members:

We understand that you have had a question about the type of professional qualifications and training that are required for use of the Marschak Interaction Method (MIM). For over thirty years The Theraplay Institute has developed and published the MIM manuals and trained various mental health professionals in its clinical use. These professionals have included psychiatrists, psychologists, social workers, marriage and family therapists, counselors and play therapists. All of these professional fields provide the necessary knowledge of child development and parent-child relationships as well as clinical insight that form the basis for our specific training in MIM administration and interpretation. The MIM is widely used by social workers in the United States, Canada, Finland and Korea.

The technique was first developed by Marianne Marschak in 1958 to study parent-child relationships. Later, Ann Marschak Jernberg, the originator of the Theraplay approach and founder of The Theraplay Institute, adapted the method for use over a wide age range, from pre-natal to adult couples. Three manuals are available that explain its use and interpretation.

In addition to allowing a close look at problem areas in a relationship, the MIM provides a unique opportunity for observing the strengths of both adult and child and of their relationship. It is, therefore, a valuable tool in planning for treatment and in determining how to help families strengthen their relationship. The description of the relationship that results from this observation is a valuable aid in determining the appropriateness of custody arrangements, reunification, foster placement and/or adoption.

Ms. Blunden successfully completed twenty six hours of training in the MIM and Theraplay in January 2003. We support her use of the MIM in her research with neglected and abused children

We would be happy to respond to any questions.

Sincerely,

Phyllis B. Booth, M.A., LMFT, LCPC, RPT/S
Clinical Director

Sandra L.Lindaman, M.A., M.S.W., LSW
Training Director

BYLAAG 3: DIE MEETINSTRUMENT EN TOESTEMMING OM DIT TE GEBRUIK

Dear Christelle

Thank you for your interest in our research with the Marschak Interaction Method.
I am attaching for you a file that contains the MIMBRS coding system and definitions.
This information is also included in the text of this email message, below.

You have our permission to use the scale. We wish you luck with your research, and we would love to hear from you as you progress, so please write to us again and let us know how things are going. We look forward to seeing the results of your research!

If you wish a copy of the McKay Article that appeared in Current Psychology, send me your mailing address and I will send it to you. Best of luck
Sincerely,
Dr. Jeff Pickens
Dept. of Social Sciences & Counseling
St. Thomas University
16400 N.W. 32nd Ave.
Miami, FL 33054
Phone: (305) 628-6557 Fax: (305) 628-6749
Email: jpickens@stu.edu

Marschak Interaction Method Behavior Rating System (MIMBRS: revised 10/20/98)

Subject #_____ Date_____

Child Gender (M, F) Age _____ Parent: (M,F,Caregiver) Age _____

List Tasks/Domains used during administration of the MIM

PARENT

1. Facial Expression / Appropriateness of Affect	1	2	3	4	5
2. Quality of Vocalization	1	2	3	4	5
3. Proximity / Body Orientation	1	2	3	4	5
4. Contingent/reciprocal/mutual/social	1	2	3	4	5
5. Gaze Fixation / Aversion	1	2	3	4	5
6. Tendency to Remain Task-Focused	1	2	3	4	5
7. Tendency to Offer/Give Assistance	1	2	3	4	5
8. Playfulness	1	2	3	4	5

CHILD

1. Facial Expression/Affect	1	2	3	4	5
2. Quality of Vocalization	1	2	3	4	5
3. Proximity / Body Orientation	1	2	3	4	5
4. Contingent/Responsive Behavior	1	2	3	4	5
5. Gaze Fixation / Aversion	1	2	3	4	5
6. Task Focus/On-Task Attentiveness	1	2	3	4	5
7. Tendency to Ask For/Accept Guidance	1	2	3	4	5

DYAD

1. Social Involvement	1	2	3	4	5
2. Balance of Controlling (Initiating)/ Passive Behavior	1	2	3	4	5
OVERALL QUALITY OF INTERACTION	1 Less Optimal	2	3	4	5 More Optimal

Contacts: Dr. Anne L. Stewart, School of Psychology, James Madison University, Harrisonburg, VA 22807; or,
Dr. Jeffrey Pickens, Social Sciences & Counseling, St. Thomas University, 16400 N.W. 32nd Ave., Miami, FL 33154

Behavioral Ratings for the Overall MIM: Operational Definitions for Rating Scale

Note: For all behaviors, a rating of **1** is least optimal/positive, while a rating of **5** is most optimal/positive.
Use the following definitions to assign a 1, 2, 3, 4, or 5 for each behavior, for each member of the interaction and for the dyad as a whole. Reliability is achieved by comparing the ratings of pairs of observers. Practice the rating system by having two person's rate interactions, and then discuss until you arrive at agreement on the correct ratings. Thereafter, attempt to score additional sets of dyads independently (without discussion) to see if you are in agreement. If you are not agreeing, you must go back to discussion training. It is often helpful to first think of each behavior in terms of "Is a subject on the lower side (1, 2) or on the high/optimal side (4,5) of the scale" and first see if you can agree on that. You may at first count scores that are within 1 point of the other rater as "agreements". Note also that some behaviors are easier to agree about with another rater (such as gaze), while other behaviors such as playfulness or balance of control require more time and discussion to reach agreement. With continued practice you can achieve excellent reliability on the scale such that you and another rater will agree more than 75% of the time on scoring.

Parent Behaviors

I. Facial Expression/Affect

1. Negative facial expression/negative (flat, frowning, tense) or inappropriate affect most of the time, with minimal positive expression (smiling, laughing). inappropriate affect may be shown by tense smile or mocking laughter.
2. Negative facial expression/affect over half of the time, with minimal positive expression.
3. Approximately equal amounts of both negative and positive expression.
4. Positive facial expression/affect over half of the time, with minimal negative expression.
5. Positive facial expression/affect the majority of the time, with minimal negative expression.

II. Quality of Vocalization

1. Speaks in negative (flat, demanding, harsh, criticizing) manner the majority of the time, with minimal positive (encouraging, comforting, praising) vocalization.
2. Speaks in negative manner over half of the time, with minimal positive vocalization.
3. Speaks in approximately equal amounts of positive and negative vocalizations.
4. Speaks in positive manner over half of the time, with minimal negative vocalizations.
5. Speaks in positive manner the majority of the time, minimal negative vocalization.

III. Proximity/Body Orientation

1. Positioned far from/turned (oriented) away from child the majority of the time, rarely moves towards child.
2. Positioned from/turned away from child over half of the time, some movement toward child.
3. Positioned towards and away from child for equal amount of time.
4. Close to/oriented towards child over half of the time, not away from/far from child over half of the time.
5. Positioned close to/oriented towards child the majority of the time, rarely moves away from child.

IV. Contingent/Responsive Behavior

1. Almost never responds to child's affective cues (speech/actions) or requests for help.
2. Responds to child's cues or requests for help less than half of the time.

3. Responds to child's cues or requests for help for half of the time.
4. Responds to child's cues or requests for help over half of the time.
5. Almost always responds to child's cues or requests for help.

V. Gaze Fixation/Aversion

1. Almost never looks at child or makes eye contact with child; usually averts gaze.
2. Looks at child less than half of the time, tends to look elsewhere.
3. Looks at child half of the time. Looks elsewhere half of the time.
4. Looks at child more than half of the time, occasionally looks elsewhere.
5. Almost always looks at child or makes eye contact with child; rarely averts gaze.

VI. Tendency to Remain Task-Focused

1. Remains rigidly focused on the task most of the time, not allowing child flexibility (seems more focused on the A task than on the child), *or* fails to use Afirm control to keep child on task.
2. Remains task focused the majority of the time, but allows child some flexibility; may allow child too much flexibility in straying from the task.
3. Maintains appropriate balance of task focus with child focus about half the time.
4. Provides some encouragement for child to remain appropriately task-focused; may still be overly harsh/rigid *or* lenient in demanding task focus from the child.
5. Appropriately encourages child to remain task-focused through gentle firm control, and is not overly rigid in demanding task completion; maintains appropriate balance most of the time.

VII. Tendency to Offer/Give Help to Child

1. Almost never offers child help/guidance (i.e. demonstrates behaviors, offers verbal support) in task or offers too much help by completing task for child for majority of the time..
2. Offers help/guidance to child less than half of the time when needed/requested; but not enough, less than half of the time. Or may help inappropriately/too much for more than half of the time.
3. Offers help/guidance to child half of the time when needed/requested. Or may help inappropriately/too much half of the time.
4. Offers help/guidance to child over half of the time when needed/requested. Or may occasionally help inappropriately/too much.

5.Offers appropriate help/guidance to child majority of the time without giving inappropriate/too much help.

VIII. Playfulness

1. Almost never creates or engages in appropriate (temporally or developmentally) playful behavior with the child. For example, is not cheerful, interested, or willing to participate in playful behavior, verbal interactions, or games.
2. Engages in or initiates appropriate playful behavior with the child less than half the time. For example, seems inhibited, embarrassed, or unwilling to fully become engaged in playful behavior.
3. Approximately equal amounts of appropriately playful and not playful behavior. Difficult to assign either positive or negative side of the scale.
4. Creates or engages in appropriately playful behavior frequently, more than half the time. For example, is playful, cheerful, and willing to participate.

5. Creates or engages in appropriately playful behavior for majority of the time. For example, is willing to act "childish" and is not embarassed about play. Demonstrates sincere and real efforts to play with child on their level.

Child Behaviors

I. Facial Expression/Affect

1. Negative facial expression/affect (flat, frowning, tense, crying) the majority of the time, with minimal positive expression (smiling, laughing).
2. Negative facial expression/affect over half of the time, with minimal positive expression.
3. Approximately equal amounts of both negative and positive expression.
4. Positive facial expression/affect over half of the time, with minimal negative expression.
5. Positive facial expression/affect the majority of the time, with minimal negative expression.

II. Quality of Vocalization

1. Speaks in negative (flat, upset, whining) manner the majority of the time, with minimal positive (excited, happy, laughing) vocalization.
2. Speaks in negative manner over half of the time, with minimal positive vocalization.
3. Speaks in approximately equal amounts of positive and negative vocalizations.
4. Speaks in positive manner over half of the time, with minimal negative vocalizations.
5. Speaks in positive manner the majority of the time, with minimal negative vocalization.

III. Proximity/Body Orientation

1. Positioned far from/turned (oriented) away from parent the majority of the time, rarely moves towards parent.
2. Positioned from/turned away from parent over half of the time, some movements towards parent.
3. Positioned towards and away from parent for equal amount of time.
4. Close to/oriented towards parent over half of the time, not away from/far from parent over half of the time.
5. Positioned close to/oriented towards parent the majority of the time, rarely moves away from parent.

IV. Contingent/Responsive Behavior

1. Almost never responds to parent=s affective cues (speech/behavior) or requests.
2. Responds to parent=s cues or requests less than half of the time.
3. Responds to parent=s cues or requests for half of the time.
4. Responds to parent=s cues or requests over half of the time.
5. Almost always responds to parent=s cues or requests.

V. Gaze Fixation/Aversion

1. Almost never looks at parent or makes eye contact with parent; usually looks elsewhere, averts gaze.
2. Looks at parent less than half of the time, tends to look elsewhere.
3. Looks at parent half of the time. Looks elsewhere half of the time.
4. Looks at parent more than half of the time, occasionally looks elsewhere.
5. Almost always looks at parent or makes eye contact with parent, hardly ever averts gaze.

VI. Task Focus/On-Task Attentiveness

1. Off task/not attentive to task majority of time.
2. Off task/not attentive over half the time. On task/attentive minimal amount of the time.
3. Off task/non attentive half of the and on task/attentive half of the time.
4. On task/attentive over half of the time. Off task/nonattentive minimal amount of the time.
5. On task/attentive majority of the time.

VII. Tendency to Ask For/Accept Help from Parent

1. Does not accept parental help/guidance majority of the time (uncooperative, fussy).
2. Does not accept parental help/guidance over half of the time. Accepts minimal amount of help/guidance.
3. Does not accept parental help/guidance half of the time. Accepts help/guidance half of the time.
4. Accepts parental help/guidance over half of the time. Does not accept minimal amount of help/guidance.
5. Accepts parental help/guidance majority of the time (cooperative, willing).

Dyad Behaviors

I. Degree of Social Involvement/Social Interaction during Task

1. Parent and child are not socially involved/engaged with one another for the majority of the time.
2. Parent and child are not socially involved/engaged with one another for over half of the time.
3. Parent and child are socially involved/engaged half of the time and uninvolved/unengaged half of the time.
4. Parent and child are socially involved/engaged over half of the time.
5. Parent and child are socially involved/engaged majority of the time.

II. Balance of Controlling (Initiating)/Passive Behavior

1. Either parent or child dominates interaction (always initiates, controls tasks) the majority of the time. Other member is mostly passive.
2. Either parent or child dominates interaction the more than half of the time. Other member may initiate some activities, but is passive.
3. Either parent or child dominates interaction half of the time. Other member attempts to initiate some more activities, but is passive.
4. Either parent or child dominates interaction less than half of the time. Other member initiates activities and is less passive.
5. Both parent and child initiate and control some tasks. There is an optimal balance of controlling and passive behaviors. Neither member is dominant or passive.

III. Total Interaction Quality Score

1. Least optimal interaction.
2. Worse than average interaction.
3. Average interaction.
4. Better than average interaction.
5. Most optimal interaction.

Please send the results of your research or reprints of papers to the authors so that we can hear about how you used the scale, and this helps contribute to the standardization of the instrument. THANK YOU FOR USING THE Marschak Interaction Method Behavior Rating Scale.

BYLAAG 4: TOESTEMMING OM CMR-KLIËNTE TE GEBRUIK

NG BARMHARTIGHEIDSDIENS
SUID-TRANSVAAL
VERBIND TOT VERSORGING

NG MINISTRY OF CARING
SOUTHERN TRANSVAAL
COMMITTED TO CARE

8 September 2003

Christelle Blunden
Pieringstraat 748
ELARDUS PARK
0181

Geagte Christelle

NAVORSING OOR PLEEGSORG

U skrywe gedateer 20 Augustus 2003 en 4 September 2003 verwys.

Die Senior Personeelkomitee het u navorsingsvoorstel noukeurig nagegaan en besef dat u navorsing waardevolle inligting kan bied ten opsigte van inter-kulturele intervensie veral by dienslewering aan pleeggesinne.

Die NGBD verleen gevolglik aan u goedkeuring om u navorsing by CM Rade in Suid-Transvaal te doen waartydens geregistreerde pleegouers inter-aksionele analise sessies deurloop met die oog op die data-invordering en prosessering.

Maatskaplike werkers van die onderskeie CM Rade in Suid-Transvaal sal versoek word om die teikengroep soos deur u benodig, te identifiseer Goedkeuring sal dan van respondente verkry word vir deelname aan u navorsing.

Dit sal waardeer word indien u so spoedig moontlik die volledige verspreiding van respondente wat u benodig kan deurgee sodat ons met die identifisering en voorbereiding van moontlike respondente kan begin.

Sterkte met u navorsingsproses.

Vriendelike groete

AM KILJOEN
DIREKTEUR:MAATSKAPLIKEWERKDIENSTE

POSBUS 31145, BRAAMFONTEIN, 2017 TEL (011) 403 2800
FAKS (011) 339 3659 E-pos: ngbarmt@mweb.co.za
Verenigd staan as 'n Organisasie Sonder Winsoogmerk
Registrasie-nommer 001-17-NPO

PO BOX 31145, BRAAMFONTEIN, 2017 TEL (011) 403 2800
FAX (011) 339 3659 E-mail: ngbarm@mweb.co.za
Held Jointly as a Non-profit Organisation
Registration number 001-17-NPO

BYLAAG 5: SKRIFTELIKE OOREENKOMS AANGAANDE ETIESE ASPEKTE

Dear Foster Mothers and Foster Children

I am currently doing a D Phil (Social Work) degree at the University of Pretoria. The attachment programme that I wish to develop is the product of research on the strengthening of the emotional tie between related single-parent foster mothers and foster children. However, I need your inputs to help me with the research. The research can be to your advantage, as it can help you with handling emotional problems between you (foster mother and foster child).

The programme will be run in ten weekly sessions. It will be presented at CMR Daveyton's office in Daveyton.

All information will be treated confidentially. No identifying particulars of you or your foster child will be published in the final research report. Pseudonyms will be used. You are entitled to a copy of the final report.

You will participate voluntarily and may withdraw from the research at any time you wish, after which you will receive individual therapy according to your needs.

I also need your co-operation to video-tape the research process (attachment programme), but for data collection purposes only. The video tapes will not be shown to any member of the public, or will not be discussed with them. They will only be viewed by me and possibly also the examiners. The video tapes will be destroyed after the examination.

In the light of the foregoing exposition, the following agreement will be binding upon the researcher (Ms C. Blunden) and each research participant upon their signing of the agreement:

- I hereby give permission that a video-tape recording, as discussed with me beforehand, be used during the research. I understand that the video tapes will be destroyed after the research.
- I understand that no identifying particulars of me or my foster child will appear in the final research report and that pseudonyms will be used.
- I understand that the therapeutic process that is part of the research will be terminated at the end of ten sessions, but that the therapy can be expanded and that an open-door policy will be followed with regard to my and my foster child's therapeutic needs.
- I understand that my foster child and I may withdraw from the research at any time and will be entitled to individual therapy.
- I give permission that my minor foster child participate in the research.

_____

Signature: Foster mother

Date:

_____

Signature: Foster child

Date:

_____

Signature: Researcher (Ms C. Blunden)

Date: