Making the Child's World
Fostering Permanence

by
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I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Making the Child's World: Fostering Permanence, is a redefining, reordering and recalibration of the planning of a centre for children in transition within the child welfare system that would operate alongside foster homes. It is not a prescription for the ideal building design. Instead it is a proposition for a set of standards and qualities necessary of a child-centered environment; one where the child can be comfortable and secure, in the face of his or her family circumstances.

This thesis discusses the period between infancy and school age as crucial in the physical and emotional development of children; a time when they first establish concepts of space, relationships, and feelings. Each environment and social interaction experienced plays a large role in a child's development, both socially and physically. The dynamics, scale and intimacy of Play Therapy need to infiltrate the architectural strategy of this type of centre so that the centre itself adopts the values of Play Therapy, enabling the physical environment to act as a rehabilitative tool in the Play Therapy Programme.

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For my husband Mark
My love, my friend, my home

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Preface

Making the Child's World: Fostering Permanence is a redefining, reordering and re-calibration of the planning of a Play Therapy Centre for children in transition, awaiting reunification with family, or adoption placement. It is not a prescription for the ideal building design. Instead it is a proposition for a set of standards and qualities necessary of a child-centered environment; one where the child can be comfortable and secure, in the face of his or her family circumstances. This thesis is not written in the interest of doctors, administrators, child-youth workers, housekeepers, planners, designers, builders or property managers; instead it is an attempt to capture the interests of children by imagining their circumstances.

In a solely foster home based system, children are shuffled, indefinitely, from location to location; each environment and social interaction playing a large role in each child's development, both socially and physically. Between infant and school-age is a crucial period when children physically and emotionally develop; a time when they first establish concepts of space, relationships, and feelings. In the current foster care system children are not always able to grasp a sense of permanence, ownership or security. The physical environments begin to blur and children lose context with what is appropriate, what is their human right and what they deserve.

Designing a therapeutic environment for children within the child welfare system involves designing for their conscious beings, as developing children, and also for their unconscious selves, harbouring repressed desires, traumatic memories and painful emotions. We, as designers, and as a society, need to celebrate the role of Play Therapy in the rehabilitation of these children. When designing this type of centre for children the architectural strategy itself should adopt the values—the dynamics, scale and intimacy—of Play Therapy, enabling the physical environment to act as a mode of therapy alongside play, speech, family and other such therapeutic programmes. It will be a place to learn, play, eat, sleep and interact with all persons involved in each child's case.

Although others must also feel they are interested in the child's viewpoint, the concern here also encompasses the inevitable problem that a clear idea of the child's interest and a clear vision of their environment can be lost in a whirlwind of building design and management limitations, programme practices, budget formulas, and housekeeping criteria. In order to survive the bureaucratic process the aim is to draw importance on keeping the concept of that environment at the forefront of all our thoughts.

Introduction

This investigation begins with the belief that there has to be a better way to house the thousands of children who are shuffled through our child welfare systems each year. There is a concern with the lack of attention on the physical environments children in care are exposed to from the time they enter the system to when they are freed from it—both physically and psychologically—often many years later, when ongoing care and evaluation is considered.

Historically we have institutionalized children in care and discovered the downfalls of the orphanage leading to the current foster home based system. Although the intention to provide a home-like setting is well meaning, it only addresses the needs of a portion of the children in care and does not provide a rehabilitative atmosphere for children who may enter and exit the system several times before a permanent situation is established. There is a need to redefine and re-calibrate the planning of child-centered architecture for children in care. A child in a state of transience needs a grounding point to take in the anxieties of the child, hold them, and give them back in a more manageable form at an appropriate time, an environment that allows him to express himself unconditionally without fear of rejection, in order for him to establish permanence[1]. A space communicating the values of Play Therapy

integrated with the therapeutic programme is necessary to assist the child in discovering his true self, a state where he becomes self-aware and self-accepting, secure in the sense of who he is. Allowing the dynamics, the scale and the intimacy of Play Therapy to infiltrate the architectural strategy of such an environment encourages this discovery through engagement of the senses, and will help to speak to the needs of the many other children in care.

As an adjunct to foster care, a Play Therapy Centre with a residential neighbourhood provides temporary care for children in a highly sensitive transitional state, where children are able to receive Play Therapy on a consistent basis, regardless of their residential circumstances, providing well-needed stability in the care continuum. In the current child welfare system when a child is brought into care and placed in a foster home, changing schools may be necessary, and frequent. For many children, a suitable foster placement is difficult to establish, creating a transient process of shuffling the child from one location to another. Even for those who are reunited with their family of origin or are matched with an adoptive family, the complexity of the care continuum involves myriad family and child protection services of ongoing therapy, child care and supervision. A Play Therapy Centre as suggested in this thesis offers a central location, an oasis of familiarity and stability for the developing child, which may act as a place to sleep, eat, play and interact with service providers and family or may be a place to return to regardless of family status.

Children old enough for full day grade school would continue in the public education system, as they do within the current foster home model, and would now have the home base, to which they may return, helping to comprehend a sense of permanence during a tumultuous period of their development. A centre of this nature hopes to initiate communication through play, allowing the maltreated child to work through emotional uncertainties and experience childhood.

Child-centered architecture was identified only relatively recently as a distinct architectural type. Its gestation can be traced from the educational theories of the 18th and 19th centuries with the teachings

of Froebel and Piaget, to the present architectural and educational synthesis seen in many of the best current examples, as illustrated in the final chapter of this thesis. One is tempted therefore to follow a line of investigation in the hope that there is an intimate relationship between the theory and philosophy of child development and play, and its manifestation in built form.

However, studies relating the quality of early childhood development to the physical environment are inconclusive, tending to focus on utilitarian aspects such as space standards or functional layouts. There are very few studies which relate spatial quality to the more specific needs of young children in relation to their environs. Frequently, there has been a failed communication between the architect and the child advocate to address the imaginative spatial needs of the young child, both theoretically and economically, as in many of our public school system's sterile early childhood classrooms, as well as fantastical "child-like" interiors that succeed more in mimicking cartoon sets than communicating intelligently with the developing child. These concerns, together with the growing social importance of our child welfare system, have been a catalyst for this exploration.

This thesis addresses the distinct needs and requirements of babies and children up to the age of ten; their right (as individuals) to high-quality therapeutic care environments that nurture them and rigorously support their social development is "as crucial in the modern world as is the provision of specific buildings for any section of the population, whether banks, churches, theatres or houses."[2] Legislative child care regulations and existing technical guides, usually compiled by experienced psychologists and educationalists rather than architects, provide strict (often minimal) space and programmatic standards for designers, sharing common roots and ideologies across political boundaries. They do not however, embark on recommendations for harmonized spatial qualities that could act as a primary rehabilitative tool alongside the doctors and social workers. It would be inappropriate to attempt a distinct prescription for the design of a Play Therapy Transitional Centre, given different national, regional and local conditions and the child welfare organizations operating within them. Therefore this thesis does

not attempt to create a 'design guide,' but rather illustrates and surveys the practical and aesthetic concerns of what makes a 'high-quality' emotionally rehabilitative environment for young children.

Cognizant of need for efficiency and economy within this specific genre of building and social concern, criteria for the selection of key examples includes both architectural quality as well as those examples that have highly developed interior programmes, or are overtly economical within their calibre. The issues this text explores relate mainly to post-industrial societies of the west and feature predominantly contemporary examples.

Making the Child's World concentrates particularly on the integration of pedagogic systems into child-centered therapeutic spaces that when successful, create an authentic architecture for children who are in a time of transition. It examines some of the broader cultural aspects of childhood and architecture, discussing the important historical movement of the kindergarten, orphanage and foster home. Japan and most European countries have produced high quality examples of child-centered environments, with architectural quality as a priority, however this quality has not flourished in North America to the same degree.

Although as North Americans, we define child as a young human being below the age of puberty and childhood as the state or period of being a child,[3] generally as adults we communicate with children as though they are a different species. Children are often thought to be adults in training, not quite finished products or solely working models, and children, often much more perceptive than we give them credit for, frequently recognize this and respond by playing children to appease the adults. If childhood is merely the first of many stages within one's life, than the culture of it should develop out of the values of the present day, grounded upon historical experience. Adults should not play at being children through over-systemized structures and child-centered architecture should not pretend to be something it is not, it needs to be a natural environment that supports and protects while it encourages freedom. The architect's *spatial play* needs to harmonize with children's play. American psychoanalyst Bruno Bettelheim stated that:

The children's environment has to be organized in such a way that it not only transmits to him, on both a conscious and unconscious level, the assurance of being secure there and now, but it also has to transmit to him the sensation that venturing into the outside world does not constitute a risk, whilst the future, though difficult, holds success in store for him and not failure."[4]

This is especially true when we are creating spaces for children overcoming tremendous emotional and physical trauma who seek a place that is safe, reassuring and stimulating.

When planning, designing and creating buildings for young children there is a remarkable imaginative potential, which can and must include the functional issues that are of profound importance, but also allow for what we believe are the highest contemporary architectural values.

I   Needs of the Child

Ages and Stages of Development[1]

BIRTH TO 12-18 MONTHS

3-6 months

Physical/Motor

Will bear weight on legs
Can roll over stomach to back
Engages hands in midline
When pulled to sit, head is steady, does not fall back
When on abdomen, can lift shoulders off mat
When on abdomen, can lift head and look about
Will begin to reach for and grasp objects and brings them to mouth
Sits with support

Emotional/Mental

Looks at objects in hand
Looks after a toy which is dropped
Uses a two-hand approach to grasp toys
Looks at objects as small as a raisin
Turns head to voice, follows with eyes
Can distinguish colour in a manner similar to an adult's.
Perceives distances as being close or far.

Language

Coos
Gurgles
Chuckles
Laughs aloud
Squeals
Has expressive noises

Social

Has a social smile
Will pat a bottle with both hands
Anticipates food on sight
Shows displeasure if social contact is broken
Has difficulty tolerating separation from mother or primary caregiver.

6-9 months

Physical/Motor

Rolls from back to stomach
Gets feet to mouth
Sits alone, unsupported, for extended period (over 1 minute)
Stands with hands held
On back, can lift head up
Beginning attempts to crawl or creep
When sitting, reaches forward to grasp without falling

Emotional/Mental

Bangs toys in play
Transfers objects from hand to hand
Reaches for a toy with one hand
Picks up a toy he/she drops, is persistent in obtaining toys
Would pull a toy to self by attached string

Language

Responds to name
Vocalizes to social stimulus
Has single consonants, i.e., ba, ka, ma
Combines syllables, i.e., da-da ba-ba
Likes to make sounds with toys
Imitates sounds

Social

Expects repetition of stimulus
Likes frolicky play
Discriminates strangers
Smiles to mirror image
Takes some solid food to mouth
Bites and chews toys
Beginning to enjoy peek-a-boo

Trust vs. Mistrust

Oral Stage: The mouth is the main source of gratification, everything is mouth oriented.

The child feels: The child feels and knows that they are the centre of the universe, everything revolves around them.
- not much sense of others—only in relation to their needs
- can make things happen around them, i.e. Closes eyes and the world disappears, crying brings food, etc.
- the child is the total magician, able to do wondrous feats

The actual situation: In reality the child is totally and completely dependent on others to meet the basic needs necessary to survive (food, clothing, shelter, love).
- first weeks is concerned mainly with bodily needs, i.e. pain, hunger, cold, sleep

MUTUALITY – The give and take on the part of the child and its mother. This is the basis for the relationship that must develop between the child and the primary caretaker (the person who meets the child's needs).
- if a child feels that their needs will be met, and they will be taken care of, a sense of trust is developed
- if a child's needs are not met on a consistent basis the child learns to mistrust the world
- food is the first factor in establishing trust
- food is the main source of comfort
- main contact with mother is through food—the child will learn to associate food, comfort with mother

WEANING – How weaning is handled is important.
- child needs to feel some control
- weaning is often coupled with teething making it more difficult—all of a sudden the main source of gratification for the child is now causing pain (some children bite at this stage—the concept of holding on and letting go is at work here—by biting the child is holding on or controlling something, while letting go of the pain they are feeling in their mouth)

12-18 MONTHS TO 3 YEARS

18-24 months

Physical/Motor

Can run, albeit stiffly at 18-24 months
Runs well by 24 months
Walks up and down stairs with one hand held at 18-24 months, unaided, one step at a time by 24 months
Hurls a ball
Can kick a ball or object
Jumps with both feet
Stands on one foot with one hand held
Opens doors by 24 months
Climbs on furniture at 24 months

Emotional/Mental

Can tower 2 or more 1 inch blocks
Turns pages of a book, even if 2-3 at a time
Listens to stories with pictures
Will try to imitate what an adult draws with pencil
Can point to 2-3 body parts
Vision is comparable to an adult's by 24 months
Develops spatial awareness (e.g., inside/outside, top/bottom, front/back, and so forth) by 24 months

Language

By two years, has at least 20 words
By two years, is combining two to three words in a phrase
Jargon, which was elaborate by 18 months, is gone by 24 months
Verbalizes desires with words

Social

Uses spoon, spilling very little
Removes one piece of clothing
Imitates housework more and more (Dramatic play)
Handles a cup quite well
Sand, rock, and water play are enjoyed
Actively works to maintain a close proximity [20 ft (6m)] to mother or primary caregiver at 24 months
Enjoys being with other children and will play alongside them, but not with them (parallel play) at 24 months

Autonomy vs. Shame

ANAL STAGE – When child must learn to become an "I"—with the feeling that I'm made of good stuff.
- separation is very prominent in this stage
- stage of "No, I don't want to"—defiance—trying to exert autonomy
- struggle here in that the child wants to be separate and do things for themselves, but on the other hand, they are still trying to hold on—the child is torn
- has to learn the concept of holding on and letting go
- conscience begins to develop

SEPARATION – A time of turmoil.
- child wants to be separate and independent but at the same time wants to resort back to being the baby and being looked after by mother
- time of a lot of anxiety
- time of monsters in the closet and fears of all kinds
- nightmares are very scary and very real
- time when the parent is in the difficult position of being the protector and the enemy at the same time

9-12 months

Physical/Motor

Crawls well
Can sit steadily for more than 10 minutes
Stands holding on to furniture
Can pull to sitting position then to standing position
Stands alone
Walks, holding on to a hand or to furniture

Emotional/Mental

Will uncover a toy he/she sees covered up
Can grasp object small as raisin with thumb and one finger
Beginning to put things in and out of containers
Goes for an object with index finger outstretched
Likes to drop objects deliberately
Shows interest in pictures

Language

Understands "no," or inflection of "no!"
Uses mama, or dada, first inappropriately, then with meaning
By 12 months has at least one other word
Knows meaning of 1-3 words

Social

Cooperates in games
Will try to roll ball to another person
Plays pat-a-cake and peek-a-boo
Waves goodbye
Will offer toy without releasing it
Likes to interact in play with adult

12-18 Months

Physical/Motor

By 18 months, walks well alone
Creeps up stairs
Walks up stairs with one hand held by 15-18 months
Can get to standing position alone
Can stoop and recover an object
Walking, pulls a pull-toy
Seats self on chair
Descends stairs by crawling backward or sliding while in seated position

Emotional/Mental

Looks at pictures in a book
Will scribble spontaneously with pencil or crayon
Uses spoon
Drinks from a cup
Will follow one or two directions, i.e., "take a ball to . . . "
Can identify location of sounds
Explores everything (e.g., drawers, wastebaskets, and so forth)
Seeks help when in trouble

Language

Has 3-5 words at 12-15 months and 50 by 12-18 months
Will point to one or more body parts
Will point to at least one picture at 12-15 months and several by 15-18 months
Uses jargon, i.e., unintelligible "foreign" language with inflection
Imitates some words

Social

Cooperates in dressing
Holds down own bottle or cup
Finger feeds
Indicates desires and needs by pointing and/or uttering noises
Shows or offers a toy
Plays "catch the ball" and "hide and seek"
Gives hugs
May complain when wet or soiled

MAKING STRANGE (6-9 Months) - Happens when the child begins to realize that he and his mother are two separate beings.
• only happens when a relationship is established—that sense is very positive
• when mother is out of sight it is as if a part of the child is missing
• lack of concept of time and of coming and going makes each separation devastating
• memory is beginning to develop, helping the separation process—will learn that things that go away do come back
• repetition is most important at this stage
• peek-a-boo is a very popular

WALKING – The concept of walking "away from".
• now more separate from mother
• first concrete step in dealing with separation
• perspective of world changes—world becomes a bigger place since the child is not longer at the sole mercy of others to get them around, and where they want to go

TALKING – The start of sound recognition.
• important concept of a sound signifying a person or object is beginning to be learned
• learning happens through repetition and reinforcement

SELF CONTROL – There is little control at this age.
• works on impulses
• little sense of time, therefore immediate gratification is sought
• lives totally in the present—gratification of needs is utmost
• takes things personally—everything exists in relation to him and therefore things in his environment are seen as having willingly hurt or frustrated him
• rage emerges and control of that rage is extremely difficult

BODY AWARENESS AND AWARENESS OF ENVIRONMENT – Child begins to learn about their body and have control over it.
• very preoccupied with peeing and pooping
• learning body parts, their names and position on the body
• motor control much improved
• child goes from walking to running—very mobile
• able to manipulate their environment
• is the explorer—into everything—marvels at all the new discoveries

TOILET TRAINING – Child is learning the process of holding on and letting go.
• control over body functions and life
• one of two areas where the child has the ultimate control
• children often use it in one of two ways—they can hold on and not let go, or they can let go constantly—can signify their struggle for autonomy and control

LANGUAGE Child is using language very well now and is constantly improving.
• learns to abstract and therefore learns about time, abstract thoughts, coming and going, grey areas of life
• learns to use language to control impulse—i.e. "I'll hit you" instead of doing it
• not sophisticated in their language—takes many things literally, i.e. Child is anxious about trip because he cannot fly

SELF CONTROL – Child is still the centre of the universe.
• feelings are overwhelming
• difficult to establish control because the child has difficulty accepting the notion of good and bad
• importance of differentiating between the deed and the doer
• still little control over feelings—acts out feelings ie. Screaming, hitting, biting, etc.
• development of language helps
• main reason for the control of behaviour is fear of consequences
• relationship is paramount here—child begins to learn to control behaviour to avoid disapproval of significant adult
• learning the adults' moral code—what is right and wrong
• patience, understanding and encouragement are the keys with this age group

The Child

Childhood is often described as a state of mind. It is also a distinct and mental phase which most agree is experienced between infancy and puberty. The child has a primary need from the very beginning of his or her life to be regarded and respected as the person he or she really is at any given time. This chapter explores the psychological and physical needs of the child along the complex continuum of childhood development. For the maltreated child, a natural progression along this continuum may prove difficult, especially as the child's capacity for *resilience* varies by age and external factors. As discussed earlier, each environment and social interaction experienced plays a large role in a child's development, both socially and physically. By understanding the needs of the child we are able to appropriately address the effects of maltreatment when initiating the healing process and designing the therapeutic space.

Paediatrician and psychologist, *Donald W. Winnicott* developed the concept of *mirroring* whereby a baby looks into the gaze of his mother (primary caregiver) which reflects the mother's perceptions of the baby, which in turn the baby interprets as himself or herself. The child instinctively looks at his mother to find himself, and should expect to do so amidst an atmosphere of respect and tolerance for his feelings, in order to establish *individuation* and autonomy.[2] If no one person is there to be mother, to "mirror" the conditions necessary for healthy development of the child, then the infant's developmental task is infinitely complicated.

During the 1950s, developmental psychologist, *Harry Harlow* required very young monkeys to choose between two surrogate (substitute) mothers, one of which was made of wire and the other of which was covered in cloth. When reared with both a nourishing wire mother and a nonnourishing cloth mother, the monkeys overwhelmingly preferred the cloth mother. Like human infants clinging to their mothers, the monkeys would cling to their cloth mothers when anxious. They also used her as a secure base from which to venture into the environment, as if attached to the mother by an elastic band that stretches only so far before pulling the infant back. Further studies revealed that other qualities—rocking, warmth, and feeding—could make the cloth mother even more appealing (see figures 1.2 - 1.3).

These findings translated to human infants illustrating that attachment is environmentally related and does not depend solely on physiological needs such as feeding. Attachment also consists of one person providing another with a secure base from which to explore the world and a safe haven in times of stress. As we mature, our attachments change and our secure base shifts from parents to peers when we are able to gain a sense of familiarity and strength.

Winnicott conceptualized the psyche of the child as developing in relation to a real, influential parent. For a child to develop a healthy, *genuine self*, as opposed to a *false self*, Winnicott felt the mother must be a *good-enough mother* who relates to the child with *primary maternal preoccupation*. Winnicott felt that a good-enough mother allows herself to be used by the infant so that he or she may develop a healthy sense of omnipotence which will naturally be frustrated as the child matures. His conceptualization of the psychic space between mother and infant, neither wholly psychological or physical, he termed the *holding environment*, which allows for the child's transition to being more autonomous. Winnicott felt that a failure of the mother to provide a holding environment would result in a *false self disorder*. It was
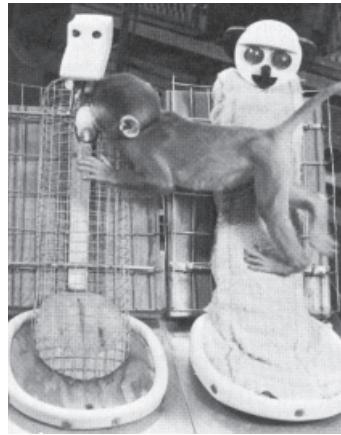
1.2 Harlow's artificial "mothers"—one a bare wire cylinder with a wooden head and an attached feeding bottle, the other a cylinder with no bottle but covered with foam rubber and wrapped with terry cloth. The monkeys much preferred contact with the comfortable cloth mother, even while feeding from the nourishing mother.

1.3 The monkeys in Harlow's study appeared to be more attached to the cloth-covered artificial "mother" than to a wire version.

Winnicott's belief therefore, that it is then the therapist's task to provide such a holding environment for the client, so that the client might have the opportunity to meet the neglected *ego* needs and allow the *true self* of the client to emerge.

> In individual emotional development the precursor of the mirror is the mother's face . . . what does the baby see when he or she looks as the mother's face? Ordinarily what the baby sees is himself or herself. In other words the mother is looking at the baby and what she looks like is related to what she sees there. (Winnicott, P&R p.111)[3]

American psychologist *Abraham Maslow* developed a theory of human motivation. He proposed that basic needs are arranged in a hierarchy, a pyramid in which each overriding level of need has to be met before successive levels of need can be addressed (See figure 1.5)[4]. Maslow described human *Deficiency* or *'Basic' needs* as a hierarchy of needs stemming from *physiological (biological) needs*, to *safety needs*, *love/belonging needs* and *status (esteem) needs*. Once these are met one seeks to meet the 'Being' needs of *self-actualization* and *self-transcendence*.

A person's physiological needs are: the need to breathe, the need for water, the need to eat, the need to dispose of bodily wastes, the need for sleep and the need to regulate body temperature. When these needs are not met, an individual will de-prioritize all other desires and capacities. Physiological needs can control thoughts and behaviours, and can cause people to feel sickness, pain and discomfort.

When the physiological needs are met, the need for safety will emerge. Safety and security rank above all other desires. Security includes physical security (from violence and aggressions), moral and physiological security, familial security and security of health.

After physiological and safety needs are fulfilled, the third layer of human needs is social. This involves emotionally-based relationships such as family. Humans want to be accepted and to belong. They need to feel loved.

Humans also have a need to be respected, to self-respect and to respect others to give the person a sense of self-value. This prompts self-actualization later in life, a term originated by German neurologist *Kurt Goldstein* as the instinctual need of humans to make the most of

Ages and Stages of Development[6]

3 YEARS TO 6 YEARS

3-6 years

Physical/Motor

Can jump a distance of 15 to 24 in (38.1 to 60.1 cm) at 3 years
Climbs stairs alternating feet at 3 years
Can stand momentarily on one foot at 3 years
Body growth slows, more adult proportions develop
At 6, neural development 90% complete
From 4 to 8 years, lymphoid development increases from 40% to 90%
Most children farsighted
Muscle development begins at 4 years, but larger muscles dominate
Washes hands
Can hop on one foot by 4 years
Can jump a distance of 24 to 33 in (61 to 83.8 cm) at 4 years
Throws ball overhand by 4 years
Can use scissors to cut out pictures by 4 years
Can go to toilet alone by 4 years
Skips by 5 years
Can make a running jump of 28 to 38 in (71.1 to 96.5 cm) at 5 years
Dresses and undresses without help by 5 years

Emotional/Mental

Tends to fear imaginary or anticipated dangers
Crying and tantrums diminish, anger can be expressed in words (often by threatening or yelling)
Anger directed at cause of frustration, retained for longer periods of time, but 4-year-olds begin to seek ways to hide it from others
Channelling anger and frustration is important
Combines playthings (sand and water, miniature cars and blocks) at 3 years
Can count up to three objects at 3 years
Builds complicated three-dimensional structures that combine several materials at 5 years
Recognizes specific landmarks, but does not understand geographic relationships between them by 5 years

Language

Age 3: 600 to 1,000 words, simple sentences with grammar close to adult speech
Age 4: 1,100 to 1,600 words, good syntax, plurals used, fluency improves, 4-, 5-, and 6-word sentences, 3- to 4-syllable phrases
Age 5: 1,500 words, nearly perfect syntax, fluency with multisyllabic words, 5- to 6-word complete compound or complex sentences
Can tell a story by 4 years

Social

Accepting of temporary absence of mother or primary caregiver when familiar people are present at 3 years
Begin to understand concept of taking turns and tend to imitate adults
4-year-olds prefer to spend time playing and cooperating with others and can pick up social cues from surroundings
5-year-olds prefer to play with others and for longer periods by 5 years
May create imaginary playmates if deprived of contact with other children, but most will outgrow these playmates by age 5
Extensive role playing by 5 years
Thinks that own point of view is the only one by 5 years

1.4 Social Play

Initiative vs. Guilt

GENITAL STAGE - A time of turmoil for the child.
• grows and learns very rapidly – time when parents get feeling that child is growing up
• their magic is lost, reality starts to sink in, they realize they are no longer all powerful
• super ego development—parents values are internalized
• "why" stage
• period of identification—family, race, sex, religion, etc.

IDENTITY - Child establishes their sexual identity.
• establishes their role as male or female
• curiosity as to "where did I come from?"
• lots of curiosity around differences between boys and girls
• falls in love with the opposite sex parent and feels guilty about wanting to get rid of same sex parent—resolves it by allowing guilt feelings to take over and then identifies with and wants to be like "mommy or daddy"
• establishes "girl" or "boy" behaviour

SOCIAL - Child begins to learn their standing in the community.
• learns the rules of the community—what is/is not acceptable, world is becoming a bigger place

CULTURAL - Child gets a feeling of background and culture.
• knows that he is black, white, native, etc.
• need for identity is great because the child has moved from all-powerful to just another person in this huge world
• child sees themselves in relation to others and the effect that they have on others

SELF CONTROL - Control is becoming familiarized.
• child no longer requires external factors to determine what is right and wrong
• external factor no longer deciding factor on whether child will do the "right thing"
• child feels shame for behaviour that parents or group disapproves of
• is often sorry, ashamed or fearful after "misbehaving"
• child finds other ways of expressing anger or fear, i.e. Talking, drawing angry pictures, yelling at toys, etc.
• children are very rigid and hard on themselves at this age—very un-accepting of "bad" behaviour that they exhibit and that they see in other children
• rules are very rigid
• if child has difficulty accepting "bad behaviour" they may displace feelings and blame others, i.e. "he got me angry," "it was his fault"

6 YEARS TO 12 YEARS

6-8 years

Physical/Motor

Apparent difference between growth rate of girls and boys (girls taller and heavier)

Nearsightedness may begin to develop at 8 years

6-year-olds use whole bodies for activities and large muscles are more developed, 7-year-olds more cautious and show ease with fine motor skills, 8-year-olds develop fine motor skills and increased attention spans

Can play games requiring considerable motor coordination, such as hopscotch and football

Nervous habits begin to appear at age 7

Can hop into small squares with accuracy

Emotional/Mental

6-year-olds begin to assert independence and demonstrate confidence

6-year-olds fear the supernatural

7-year-olds are more stable, narcissistic, polite, responsive, empathetic, less aggressive and can draw connections between cause and effect

8-year-olds demonstrate greater independence, vacillate between moods, and begin to sense how others feel toward them

7-and 8-year-olds discover some of their limitations and may hesitate to try new tasks, but 8-year-olds seek to create an external image of competence and confidence

Understands geographic relationships of landmarks

Begins collections of various types

Social

Family influence decreases, peers are more important, teachers become authority figures

6-year-olds have many internal conflicts, resulting in capriciousness

6-year-olds choose playmates on qualities of age and size (not gender or ethnicity), and 7 year-olds are more aware of social status or ethnicity differences among themselves

7-year-olds are self-critical and often disassociate themselves from frustrations

7-year-olds are well mannered unless bored, and 8-year-olds are more developed socially

7-year-olds are more conscious of position among peers, and boys and girls play separately

8-year-olds prefer company and approval of peers, and exhibit more self-control and modesty

Can play games with rules, such as board games and card games

Plays organized games

Understands that others may have differing points of view

8-12 years

Physical/Motor

More resistance to disease

Steady increases in body measurements: height and weight (girls more than boys), and muscle growth

Have fine motor skills

May feel uncomfortable with scrutiny. Many girls begin showing signs of puberty

Can jump vertically 8½ to 10 in (21.6 to 25.4 cm) by 10 years

Can throw a ball between 40 and 70 ft (12.2 and 21.3 m) by 10 years

Can run approximately 17 ft (5.2 m) per second by 10 years

Can complete a standing broad jump between 4½ and 5 ft (1.4 and 1.5 m) by 12 years

Standing high jump of 3 ft (91.4 cm) is possible by 12 years

Girls become temporarily taller than boys by 12 years

Emotional/Mental

Fear exclusion from peers

Prone to outbursts but try to control them

10-year-olds mild tempered, seek reassurance from others, anger comes and goes quickly

10-year-olds most afraid of heights and dark

11-year-olds fear school, friends, for parents' welfare, strange animals, threatening world events; are more easily angered, often resulting in physical violence, but can control outbursts more appropriately

Social

Socialize in exclusive groups with own sex (boys' groups gravitate toward bravado and competition, and girls' are well structured and more concerned with maturity

Develop important individual friendships, which are often fluid

Ties to family less important than ties to peers; adult shortcomings looked at crucially, often leading to conflicts

Can take into account several different points of view by 12 years

Industry vs. Inferiority

MAGIC IS GONE - the child is now part of the outside world.
- leaves the world of his family and home and goes out to explore the outside world
- child starts to become "reasonable"
- production and producing becomes important—may become quite materialistic
- fairly quiet stage before adolescence
- learns the tools they will need to live—learns life skills, i.e. Responsibility, looking after himself, streetproofing, budgeting, relationships, etc.
- is going through a definite separation from parents—this at times can be very difficult for the parents

ROLE
- usually stick to same sex friends
- role identification is very prominent
- learning to become a parent and a provider
- great emphasis is put on what the child can do—by parents, school, family, child, etc.
- learns to gain recognition by producing things
- is able to do things beside and with others

SCHOOL - Now plays an important role.
- child spends a good deal of their day there
- medium where learning and productivity takes place
- societal expectations and norms are learned there
- mutuality is very important
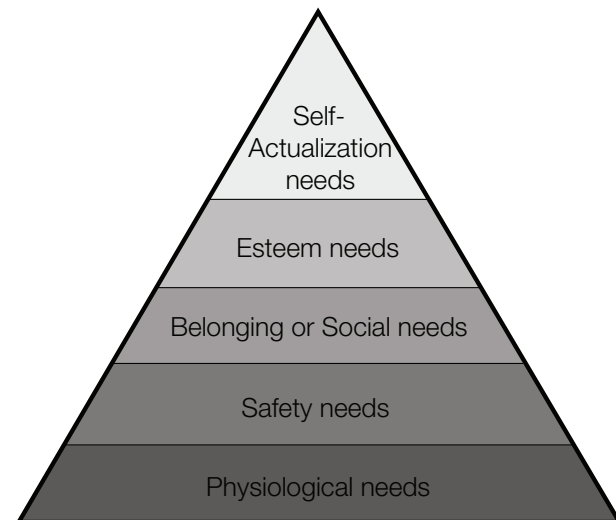
their unique abilities. In his book, *Man's Search for Meaning*, *Viktor Frankl* expresses the relationship between self-actualization and self-transcendence as intertwined.[5] One cannot strive for self-actualization. It is achieved as a side effect of self-transcendence.

The founders of psychology typically worked with adults, not children, making the whole notion of a child's needs a fairly recent phenomenon. In providing the basic needs to a child one must remember that the child's body needs to be tended, nourished and protected. His mind needs to be stimulated and alerted to his environment. He needs assistance in comprehending and organizing his sensations and perceptions. He needs reciprocal affection and models to build up a functioning moral conscience. Most importantly the child needs to be accepted, valued, and wanted.

Perhaps the most integral means of communicating these elements with and for a child is through *play*. Play itself is an integral part of childhood. It is a medium that eases the development of expressive language, communication skills, emotional development, social skills, decision-making skills, and cognitive development in children. Play is an exercise or activity for amusement or recreation, as in children playing

with toys. Unlike Game play which involves rules, child's play has no definitive form, it is whatever the child's imagination creates.

Children actively participate in learning about the world around them. They begin to understand scale by whether they can hold an object in their hands or wrap their arms around it. They learn that things can be soft or hard, smooth or bumpy, through touch, and even through taste. To accommodate this active learning process, the environment should reflect the size of the child and facilitate the child's ability to see and reach objects and navigate within his surroundings. There are *anthropometric* charts that document the physical growth of a child's body used by organizations to set minimum standards for space allocations and accessibility (See Appendix), but perhaps more important is understanding the developmental progress that will occur as a child grows. Although children will progress at different speeds and there will be variations among cultures, different environments tend to strongly impact the development in all areas. It is every child's fundamental need to have their capabilities, social skills and perceptions at various ages, understood and embraced. (See pages 10a-11a and 14a-15a for Ages and Stages of Development)

Summarizing the United Nations Declaration of the Rights of the Child (General Assembly, Fourteenth Session of November 20, 1959), the preamble states that the child, because of his [or her] physical and mental immaturity, needs special safeguards and care, both before and after birth, and that individuals and groups should strive to achieve children's rights by legislative and other means.[7] [Humanity], it says, owes the child the best it has to give to the end that he [or she] may have a happy childhood and enjoy, for his own good and for the good of society, the rights and freedoms in accordance with the following principles:

1. The child is entitled to the enjoyment of the rights mentioned, without any exception whatsoever, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.
2. The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity.
3. The child shall be entitled from birth to a name and a nationality.
4. The child shall enjoy the benefits of social security. He [or she] shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his [or her] mother, including adequate pre-natal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.
5. The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.
6. The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security.
7. The child is entitled to receive free education and full opportunity for play and recreation. These should be directed to promote his general culture and enable him, on a basis of equal opportunity, to develop his abilities, his individual judgment, and his sense of moral and social responsibility, and to become a useful member of society.
8. The child shall in all circumstances be among the first to receive protection and relief.
9. The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.
    The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.
10. The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

Resilience

Development of the child from conception and birth, to adulthood is complex. Depending on a child's stage of development his or her capacity for resilience greatly differs. *Resilience* refers to a child's "ability to adapt effectively in the face of threats to development" (Berk, 2003).[8]

A child's own temperament or personal characteristics, combined with at least one parent or other nurturing adult and social support outside the family, is said to make a child more resilient. The influence of an affirming ethnic and cultural identification, the ability to engage in self-soothing behaviours (as in music, affirming self-talk, or daydreams about a positive future), the ability to choose people who model pro-social behaviours, as well as the development of talents and interests, scholastic aptitudes, and positive peer relationships, all aid in building resilience in children.

We cannot always predict a child's resilience but professionals can identify the above factors in order to more effectively foster these traits and, hopefully, help a child to overcome the residual effects of abuse and threatened development.

According to *Peel Children's Aid*, the following is a description of a Child's Reaction to Separation from Birth to Nine Years:

Reaction to Separation from
Birth to Nine Years (Peel Children's Aid)

Birth to Six Months

Current research concludes that separation is easier and less traumatic for an infant prior to the age of three months.

Symptoms related to the experience of separation that may appear during the first few months of infancy include: excessive crying, digestive disturbances, cessation of vocalization, excessive wakefulness, excessive sleeping and disturbances in the acceptance of routine handling.

From 4 to 6 months, the infant may begin to display an anxiety reaction to separation. Some infants exhibit severe crying, others may become withdrawn, wary and immobile.

Six Months to Two Years

It is during this period of life that the initial stage of protest from separation may be visible, with crying, clinging, cranky behaviour. Following this stage is a phase of despair or depression whereby the child becomes withdrawn, inactive, makes no demands of the environment, may cry intermittently and whose behaviour suggests feelings of increasing hopelessness and sadness. Gradually many infants move out of this phase to one of detachment, in which they begin to interact in a pleasant but shallow manner with caretakers and respond in a rather aloof and detached manner when mother visits.

Other consequences of separation in the under two-year-old will be regression in the area of motor development; he may stop crawling, walking and he may demand to be carried about. Speech may be severely affected with the child becoming very quiet or with garbled incoherent speech or jargon. He may no longer seem to understand simple words to which he formerly responded. Emotional responses become very intense with prolonged and hysterical crying and temper tantrums, even violent rejection of helping overtures from adult figures.

Two to Three Years

The child who experiences disruption during this period may show excessive dependency, with whining, attention seeking behaviour and may show extreme reliance on sameness, on routines or on objects.

He may be over-conforming and compliant or indiscriminate in his approach to people.

He may become over-aggressive and/or hyperactive in his behaviour, striking out at other children and adults around him, flitting from one activity to another, expending himself in restless, purposeless activity.

Preschool Years – Three to Six Years

During this period, all the difficulties already noted may occur, but increasing skills in language and cognition make it possible to deal more verbally with the stresses of separation.

The child may disguise his feelings around separation because he has begun to develop more adequate defenses for his anxiety, such as denial, reaction-formation, and projection, resulting in appropriate feelings of either impotence or omnipotence.

Because of his developing identification with adult models in his life, it is an especially vulnerable time for the separation and loss of these models. He may cling to his former models, no matter how inadequate they may be, or he may make a rapid shift to a new model, especially when earlier identification has been weak or poorly developed.

Six Years

Separation during this period may result in an eruption of new ill-defined fears. These may be new fears or a resurgence of previous fears which the child has earlier learned to master.

The child during this period may also display exaggerated symptoms of bravado and self-confidence. He may want to be the centre of attention and to seek approval through these inappropriate ways. He may be dogmatic and demand that things be done the way he wants them.

The child may show excessive fatigue and emotional exhaustion. He may vacillate between extreme dependency and extreme rejection of parental authority. He may respond more readily to male figures in the home.

He may show extremely hyperactive and restless behaviour—there may be sleep disturbances and bed-wetting.

1.7

Seven Years

Because of the seven-year-old's tendency towards fantasy and thinking through his problems, there may be noted extremes of fantasy and withdrawal.

He may vacillate from silly, acting out behaviour to quiet, withdrawn and passive behaviour.

The seven-year-old in separation may explosively express rejection of rules and regulations, saying that things were not done that way in his home. If inclined to be a dependent and non-assertive child, one may expect these symptoms to increase under the stress of separation.

In general one might expect the seven-year-old to display fewer overt symptoms during separation than during the earlier stage of six. He may be easily moved to tears, however, and will be extremely sensitive to implied or overt criticism or disapproval. He will be reluctant to talk about his feelings and his thoughts.

Eight Years

Once again we find the child who will exaggerate, and with much bravado will attempt to draw attention to himself.

He may be inclined to present as indifferent to his separation experiences and to react with indifference to the rules and regulations of a new home.

On the other hand, he may be fearful and excessively dependent on his new parents.

He will need to help in establishing himself in new relationships in the new school, and may benefit from sensitive assistance in this area from an alert teacher or leader.

Nine Years

Many of the symptoms of separation noted in the eight-year-old will be seen as well in the nine-year-old.

One would expect the nine-year-old to show even more reticence, withdrawal and independence of new parents.

His ability to get around himself and to make choices and decisions for himself will lead him to rely more on his own resources under the stress of separation.

It will be important to attempt to keep open the communications with the nine-year-old. Since he is still vulnerable physically, and prone to fatigue, it is important not to demand perfection or to have too high expectations for this age.

Adjustment in the school situation may be difficult for the nine-year-old for he will be sensitive to the fine differences between his previous experience and the experiences in the new school, and prone to self criticism and sensitive to failure.

Because the nine-year-old is likely to be more integrated in personality it is possible that he may not show such extremes of symptoms during separation. It will be possible to talk to him at a realistic level, and to present some logical explanation for his experiences. His strong sense of right and wrong will make his conflicts more trying, however, and will require sensitive understanding in order to prevent him from developing too strongly, feelings of guilt about his separation.

("Reaction to Separation." Peel Children's Aid. June 2000)[9]

The Youth Leaving Care Research Project[10] was conducted by British Columbia's *Victoria Youth in Care Network*, including interviews of young people who had experienced moving from foster home to foster home or group home or emergency shelter. Youth expressed frustration and concern about not knowing how long they were going to be living somewhere. Regardless of how the change in placement came about, the end result was often the same for youth—they felt confused, rejected, angry and frustrated by the lack of consistency and stability that resulted from the frequent change in living arrangements. Youth told the researchers they needed "a sense of permanence, somewhere where they could feel that they belonged."[11]

One girl's story was as follows:

My Experience in Care . . .
I remember moving into my first foster home. I was so excited. I knew that my life was going to change. I guess I didn't realize how bad it could become. Before everything went sour, there were a lot of positive changes in my life. I had a later curfew than I had ever had in my old controlling family structure, and I didn't have to deal with any abuse. No one really seemed to care about me.

At first all of this seemed really cool, but when school got out for summer vacation it really started to suck. I remember having to be out of the house at 9:30 every morning and not being allowed to return until at least 5:00. Sometimes my foster parent would decide that she wanted to go out for the evening, so then I had to leave again until she came home. I realized then that I no longer had a family. I really felt like my foster parent only wanted me in her home so she could make money off me. After summer vacation was over I decided to try another foster home. This new placement seemed way worse. My social worker reminded me that because I was only a "Temporary Ward", I was able to move back in with my biological family if I wished, but I knew that living with them was just as bad. All of a sudden I felt really out of place. I didn't know where I belonged. I ended up dropping out of school and hitting the streets.

During the time I was living on the streets I was using really hard drugs and I was making some really poor choices. I didn't return to my foster home for about 3 months. When I finally did return I became a "Permanent Ward" and was introduced to my new social worker. Out of the two previous workers I had, this new worker seemed to really care. I told her how I felt about foster care and that I didn't want to be a part of it anymore. She decided to let me try a program call "Independent Living", which means you live on your own. A week after doing this, I started to improve. I quit using drugs and returned to school.

It has been a year since I have been living independently, and I must say that I love it. I feel sad knowing that I will never have a family like I have always dreamed for, but in the same light, all I need is me!!"

(Victoria Youth in Care Network's newsletter "Reality." June 2000)[12]

In a nurturing environment *Child Development* is a natural progression; however developing normally is a difficult undertaking for the abused and neglected child. Two parenting patterns occur in maltreating families, both of which impede the development of the child. One type of family is composed of adults who continually strive to meet their own needs, neglecting those of their child, and eventually force the offspring into the role of nurturing the parents. A second type of family is rigid in its standards with unrealistically high expectations for the child. Although they are able to give the child the nurturing he or she needs, the result of their unmet demands is abuse and confusion for the developing child.[13]

Each developmental period provides new conflicts for the maltreating family. Pregnancy is marked with hopes for an infant who will be miraculously loving and devoted in every way. The relationship between mother and father often determines their ability to accept the infant. Birth and early bonding can be further complicated by the emotional immaturity of the mother, the relationship or lack thereof between the mother and significant others, as well as various other environmental factors. The inadequate bonding that results leaves the child at risk for abuse.

Fathers also have an effect on the child's development. Studies indicate that young children demonstrate affinitive behaviour with their fathers. When fathers are absent or unavailable (whether physically or emotionally), this void can negatively influence their children's cognitive development and self-esteem.[14]

Resiliency is a complex phenomenon involving several social and environmental factors including the child's own temperament or personal characteristics, a close relationship with at least one nurturing adult and social support outside the family.[15] Researchers have been unable to clearly determine the full extent of why abuse and neglect affect some children profoundly and others to a lesser degree, however identification of resiliency factors enables professionals to more effectively foster existing positive traits and help the child to overcome the residual effects of abuse and threatened development.

As illustrated in this chapter, the childhood developmental continuum is complex and progression for the maltreated child is laden with obstacles, which some children are more resilient to than others. Historically these needs were not understood, nor were they always fostered appropriately. Although the concept of child maltreatment has proven controversial, the following chapter will illustrate its historical timeline and the role of the orphanage and foster home system in addressing its concerns. By gaining an awareness of the types of trauma children face in this age, while appreciating their developmental needs, we are able to initiate the healing process within a therapeutic environment.

II   Child Maltreatment

Timeline Headers

Early History — **Middle Ages** — **Industrial Revolution** — **19th Century** — **20th Century** — **Recent History**

Early History

Plato (428-348 b.c.) and Aristotle (348-322 b.c.) both urged the killing of infants born with birth defects.

Egypt - Birth of Moses, the pharaoh ordered the death of all male children.

The Bible cites Abraham's intention to sacrifice his son, Isaac, to God. King Herod ordered infanticide on a large scale when Jesus was born.

In Greek legend, Oedipus was doomed to death until he was rescued by a family retainer.

In early Rome, the father was given complete power to kill, abandon, or even sell his child.

In Rome, the law of the Twelve Tables prohibited raising a child with a defect or deformity.

Early history records the practice of burying infants alive in foundations of buildings and bridges. Excavations of Canaanite dwellings have uncovered jars of infant bones in the foundation of buildings. (Continued into 17th century Europe although outlawed, and children were found buried in the foundations of London Bridge.)

Middle Ages

Children with birth defects, female infants, and the children of poor families were killed as a matter of course several hundred years before the birth of Christ.

In Greece, pederasty (men using boys for sexual relationships) was practiced widely and was the training ground for future soldiers.

In Sparta, infants were examined by a local council of elders who had the power to throw children considered unfit into a canyon.

Some Native American tribes practiced similar rituals where the child was fit to live only if he or she surfaced and cried.

In many cultures, with a father's permission a betrothal could be sealed by intercourse with the underage (under 12 years) daughter.

In Germany, newborns were sometimes plunged into frigid water to test their ability to survive.

In Hawaii, China, and Japan, many female or disabled children were killed to maintain a strong race without overpopulation (as a means of controlling and regulating the population).

The histories of the European school systems are filled with records detailing beatings and abuse that teachers inflicted on their young charges.

In early England, as in many other cultures, infanticide was an unwed mother's solution to her act of shame. Records in England from the 1620s attest to the burial of infants by drowning, burning, and scalding.

During the Middle Ages, families often mutilated or severed limbs from children to make them more effective beggars.

Middle Ages: Europe established a concept of ownership and articulated a hierarchy of rights and privileges placing children at the bottom.

1548: legal protection from sexual abuse was offered to children as England passed a law protecting boys from forced sodomy.

1576: another law was enacted that prohibited the forcible rape of girls under the age of 10.

1601: the Elizabethan Poor Law was one of the first organized attempts to protect children -- although it was enacted more for society to deal with impoverished parents.

Industrial Revolution

African slaves in the early United States were thought of as property and had little control over whether they worked, were sold (often without parents or siblings), or were used sexually by those more powerful.

During the industrial revolution young children were forced to work long hours under inhumane conditions in factories or other heavy industries. Many were beaten, shackled, or starved to force them to work harder at their tasks.

In the 1700s, some educators warned parents to protect their children from abuse by supervising them at all times and by ensuring that they were never nude in front of adults, and in general suggested enforced modesty - the first indication that society was aware that children could be exploited.

Colonial Boston school masters maintained the English tradition of "education through pain" and, if anything added refinements to the flagellant tools they had inherited. One Bostonian invented an instrument called a "flapper" that with every stroke on bare flesh would raise an instant blister.

19th Century

An 1854 Massachusetts law stated: "If any children above sixteen years old and of sufficient understanding shall curse or smite their natural father or mother, they shall be put to death . . ."

Surgery to remove the clitoris, slitting the penis, or cutting the nerves of the genitalia in both sexes was common to curb the practice of self gratification.

Masturbation was vehemently condemned as being a precursor of insanity, growth retardation, and early death for boys; for girls, it was said to promote precocious sexual development, promiscuity, and nymphomania.

1874: In an effort to save an abused child, New York City filed charges against the caretakers using a statute that prevented cruelty to animals. The resulting publicity surrounding Mary Ellen's plight led to the formation of the Society for the Prevention of Cruelty to Children in 1875.

20th Century

In the early 1950s, physicians reported there was strong evidence that parents were responsible for many of the fracture and hematoma injuries that children exhibited in hospital.

1972: the National Center for the Prevention of Child Abuse and Neglect was established.

In 1962 medical revealing abuse were published in the Journal of the American Medical Association by Dr. C. Henry Kempe, as "The Battered-Child Syndrome," soon helping to establish one of the first child protection teams in Denver, Colorado.

Recent History

1998: the Ontario Risk Assessment Model was implemented. This model standardized child welfare services and provided consistent tools to determine and assess eligibility for service, safety, and risk to children in the province.

March 2000: the Child and Family Services Act was amended to expand the definitions for a child to be "in need of protection" due to emotional harm or neglect and also increased the onus on professionals and the public to report situations of maltreatment and risk of maltreatment.

October 2003: the Government of Ontario created the Ministry of Children and Youth Services, the first new Ontario ministry in 20 years and one of the most innovative and dynamic child welfare systems in North America.

Legend

- **LEGISLATED PRACTICE OF MALTREATMENT** (green)
- **SOCIALLY ACCEPTED COMMON PRACTICE** (light blue)
- **NON-SANCTIONED COMMON PRACTICE** (dark blue)
- **SOCIETAL MOVEMENT TOWARDS CHILD PROTECTION** (orange)
- **LEGISLATED CHILD PROTECTION** (red)

Maltreatment of Children
from a Historical Perspective

Maltreatment of children has deeply rooted associations with many historical values and perspectives. Although defining the concept of child maltreatment has proven controversial throughout history, humanity is gradually evolving from viewing children as property, subject to the whims of the family and society, to at least recognizing that children may have rights of their own. The following pages demonstrate each period in history—as well as in each culture—has a concept of how children should be treated and examines the role of the orphanage and foster home system in addressing these concerns. Through a characterization of the types of trauma children face today, we are able to assist the maltreated child in his emotional and physical recovery.

Dating back to ancient Egyptian, Greek and Roman legends, as well as throughout the world, and detailed in early British and German records, the public practice of infanticide is widespread. Reasons varied from outlawing defects, deformities, and female births, to shaming unwed mothers and limiting children of the poor. Around the globe, fathers and councils of elders all exercised their power over "unfit" children as a matter of course. Children's remains were found in the foundations of countless structures ranging from Canaanite dwellings to the London Bridge, having first been killed by drowning, burning or scalding. In
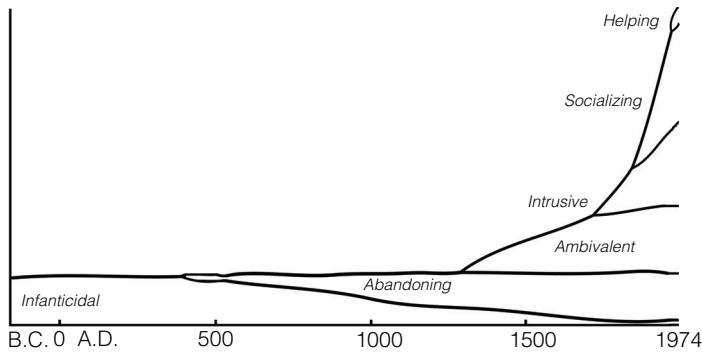
2.2 The evolution of the parent-child relationship according to Psychohistorian, Lloyd DeMause

Germany, newborns were sometimes plunged into frigid water to test their ability to survive and some Native American tribes practiced similar rituals where the child was fit to live only if he or she surfaced and cried. Even in Hawaii, China and Japan, many female or disabled children were killed to maintain a strong race without overpopulation (as a means of controlling and regulating the population).

Those that lived may not have fared much better. In Greece, pederasty (men using boys for sexual relationships) was practiced widely and was common training ground for future soldiers and in many cultures, with a girl's father's permission, a betrothal could be sealed with the underage (under 12 years) daughter. During the Middle Ages, families often mutilated or severed limbs from children to make them more effective beggars and many European school records detail countless beatings and abuse that teachers inflicted on their young charges.

A child's place within society was clearly defined in the Middle Ages where Europe established a concept of ownership and articulated a hierarchy of rights and privileges whereby children were at the bottom, and the children of the poor faring the worst. In 1548 legal protection from sexual abuse was offered to children and England passed a law protecting boys from forced sodomy, a small step in recognizing the exploitation of children. By 1576 another law was enacted prohibiting the forcible rape of girls under the age of 10—although this excluded those betrothed "legally" with the girl's father's consent.

2.3 Mary Ellen Wilson

2.4 Shaken Baby Syndrome

In 1601, the *Elizabethan Poor Law* was one of the first organized attempts to protect children, although it was enacted more for society to deal with impoverished parents. By the 1700s, some educators in England warned parents to protect their children from abuse by supervising them at all times and by ensuring that they were never nude in front of adults, and in general suggested enforced modesty. This change in attitude was the first indication that society was aware that children could be exploited.

Our own history here in North America not only maintained the continued acceptance of certain acts of maltreatment toward children, but also introduced many new and alarming practices. African slaves were thought of as property and had little control over whether they worked, were sold (often without parents or siblings), or were used sexually by those more powerful. The English tradition of "education through pain" continued with added refinements to educators' flagellant tools. One Bostonian went as far as to invent an instrument called a "flapper" that would with every stroke on bare flesh, raise an instant blister and as late as 1854 a Massachusetts law stated: "If any children above sixteen years old and of sufficient understanding shall curse or smite their natural father or mother, they shall be put to death . . ."

In 1874 a social worker discovered eight-year-old Mary Ellen Wilson, beaten and starved by her adoptive parents (see figure 2.3). The social worker referred the case to the New York City Police Department, which refused to take any action because no law yet addressed the abuse of children by their parents or caretakers. In an effort to save the child, the city filed charges against the caretakers using a statute that prevented cruelty to animals. The adoptive mother was sentenced to one year in jail, and the resulting publicity surrounding Mary Ellen's plight led to the formation of the Society for the Prevention of Cruelty to Children in 1875. Over half a century passed before any significant new laws were introduced further protecting children from maltreatment. In the early 1950s, North American physicians reported there was strong evidence that parents were responsible for many of the fracture and haematoma injuries that children exhibited in hospital (See figure 2.4).

After several studies, this phenomenon was published in a 1962 Journal of the American Medical Association by Dr. C. Henry Kempe, as the *Battered-Child Syndrome*, soon helping to establish one of the first child protection teams in Denver, Colorado. A decade later, the National Center for the Prevention of Child Abuse and Neglect was established and in 1998 the Ontario Risk Assessment Model was implemented. This model standardized child welfare services and provided consistent tools to determine and assess eligibility for service, safety, and risk to children in the province. In a great step forward (March 2000), the *Child and Family Services Act* was amended to expand the definitions for a child to be "in need of protection" due to emotional harm or neglect and also increased the onus on professionals and the public to report situations of maltreatment and risk of maltreatment. In October 2003, the Government of Ontario signalled its commitment to children and youth by creating the *Ministry of Children and Youth Services*, the first new Ontario ministry in 20 years and one of the most innovative and dynamic child welfare systems in North America.

Although the maltreatment of children decreased dramatically through the ages and is largely condemned in contemporary industrialized societies, the abuse continues within many homes and even within whole societies in the present day.

According to the *Child Welfare League of Canada* approximately 76,000 children in Canada are under the protection of Child and Family Services and are referred to as *children in care*[1]. Every province and territory has a legislative responsibility for child and family services except for Aboriginal people with status under the *Indian Act of Canada*, who are under Federal responsibility. Each province and territory has its own definitions, policies and services making it extremely difficult to compare children in care nationally. There is no body of research that considers children in care nationwide, through any statistical data or analysis. Even the definition of *child* itself varies from jurisdiction to jurisdiction.

A common symptom felt across the country is the general shortage of placement resources and options, with a growing recognition that children coming into care currently have more problems than foster children a generation ago. Canadian research shows a high prevalence of emotional and behavioural problems of children in foster care rising from 30-40% in the 1970-80's, to 48-80% in the mid-1990's, documented as children with "Special Needs."[1] Some provinces are recognizing the need for more mental health services and secure treatment facilities to deal with these rising numbers (Alberta and British Columbia in particular). While a number of factors may explain this expansion—including increased public awareness, expanded legislation, changes in investigation procedures and a more responsive funding framework—it ultimately represents a dramatic expansion of the types of situations in which child welfare services become involved, in particular with respect to child neglect, emotional maltreatment and exposure to domestic violence. Even the profile of children and families served by child welfare agencies has changed. While the typical case in the early 1990s involved acute problems such a sexual and severe physical abuse, child welfare service providers are increasingly addressing more chronic and multi-layered problems associated with neglect, exposure to domestic

violence and socioeconomic disadvantage.

The current situation for children in care is startling:

> Placements are made in less than ideally-matched settings; children with long-term needs may be temporarily placed in short-term resources while awaiting a vacancy in the long-term resources; increased breakdowns of placements lead to an increased need for replacements; children's placement needs may increase as treatment is delayed; attachment disorders develop with increased disruptions in care.[2]

To address the effects of a lack of permanency in these children's lives, the process of *Permanency Planning* has expanded beyond family reunification and adoption to include options such as *Kinship Care, Customary Care, Guardianship Care, Open Adoption* and *Subsidized or Assisted Adoption*. These alternatives have the capacity to provide consistency, and offer permanence for children—the failure of which leaves children in a state of limbo. The proposed continuum also includes *admission prevention, legal custody, family foster care* and *youth leaving care*.

Often inevitably, children in limbo become *attachment resistant*. Such children pose considerable issues for their caregivers, and consume an inordinate amount of professional time and expertise. They then become vulnerable to further moves because their behaviour is difficult to manage; they tend to exhaust their caregivers and it becomes extremely challenging to devise care plans for them. The *Children in Limbo Task Force* identified that a number of factors exist that, if addressed, have the potential to expedite Permanency Planning, one of which is through "creating a designated or assigned guardianship option that would provide children past the toddler stage with a permanent placement offering greater stability than long-term foster care."[3] A Child-Centered Play Therapy Centre as suggested in this thesis would also be an example of such an option, so crucial to establishing a sense of permanence for children in care.

Rethinking Orphanages

2.6 Typical 20th Century
Orphanage Nursery

Many more than half a million children in the contemporary government-supported child welfare system will be harmed by the system itself, given that all too often the children in the system will have to cope with the profound insecurity that comes from being shipped from one set of foster parents to another, sometimes dozens of times. (McKenzie)[4]

During the 20th century, North America's substitute child care system radically changed. Most significantly is the decline of the traditional American orphanage and its subsequent replacement by a network of foster homes. United States orphanages cared for 144,000 children in 1933, compared to 43,000 by 1977, following decades of steady decline. Three years later, US orphanages were virtually nonexistent. The following pages examine the merits of both the orphanage and foster care system, in an attempt to establish a new approach that would adequately address the emotional and physical needs of the child. A Play Therapy Transitional Centre communicating the scale, dynamics and intimacy of play therapy would offer to children in foster care, as well as those who need an alternative care provider, a safe base where they are able to communicate their emotions and experience childhood through play.

Many child welfare professionals blame orphanages for damaging the children they housed before the 1950s, intellectually, emotionally, and

economically. They denounced the institution for children who a) have a loving parent capable of caring for them and b) have no need for residential care and treatment. Their position may have been syllogistic, but it succeeded in its aim to tarnish the definition of the orphanage.

Were orphanages the problem or did they work? Can they work again? How might they be a more prominent part of the solution to the problems children face? *Marvin Olasky*, in *The Tragedy of American Compassion*, presents a more positive history of orphanages in the US than is commonly presented. Olasky believes that the orphanages that spread in the 19th century to meet genuine needs, from most accounts worked incredibly well. Historians *Cmiel, Goldstein* and *Zmora*'s work on orphanages in Baltimore and Chicago support Olasky's analysis. Cmiel and Zmora found that although issues were plentiful in the group homes they studied, many of the difficulties were endemic to the era and were often related to the standard of living and knowledge of health and well-being of the time.

> If orphanages were having the negative impacts widely claimed and if foster care could be expected to live up to the policy promises, then adoptions should have risen because of the substitution of foster care for orphanage care.[5]

In a US study of the changing adoption rates in the late 1950s, however, *William Shughart* and *William Chappell*, economics professors at the University of Mississippi, found that adoption rates actually decreased with the growth of foster care. They concluded that foster care made children less adoptable, possibly because the children grew older and became more troubled as they were shuffled in and out of numerous placements.

Prior to 1800, children without parents were cared for informally by family members or through the apprenticeship system. As of 1800, there were only seven orphanages in North America.[6] As religious institutions took charge of the issue, the number of orphanages grew over the 19th century. Due to epidemics, war, the social dislocation from the conversion of a rural to an urban and industrialized economy, the number of orphanages grew exponentially by 1850. During this time the mission of orphanages transformed to address not only the needs of truly parentless children,

2.7 Typical dormitory style room

2.8 Boys Town, Nebraska

but impoverished parents and children of neglectful or alcoholic parents. Yet to have any national laws outlining the guidelines of these practices, often their goal expanded from providing life's necessities to the reshaping of their character.

Perhaps this is where the negative connotation of *orphanage* grew from. Evidence became too blatant against orphanages, that once discontinued, revisiting the issue seemed unlikely. Fifty years of research all confirm the same findings: "Long-term institutionalization in childhood leads to recurrent problems in interpersonal relationships, a higher rate of personality disorders, and severe parenting difficulties later in life."[7] *The Child Welfare League of America* (1994) commented that "children experience a great deal of stress and trauma when they are forced to leave their birth parents. Severe emotional, psychological, and behavioural problems result."[8] The conclusion was unanimous: institutions were bad and homes were good. The greater issue was that most of the children who needed help had a surviving parent or parents who had not freed the children for adoption. In these numerous cases, a foster home would be temporary, and the shuffled children would end up with less stability than the orphanages had originally provided. This new system posed new problems; homes were good, but non-farm parents would have to be paid to provide temporary shelter for children since the children could not earn their keep. This responsibility was deemed governmental and individual states began to pay their foster parents. The economic benefits were exaggerated and the focus weakened on placing children in permanent adoptive homes.

Group Care Facilities Today

Today's group care facilities hardly resemble the physically and emotionally barren places portrayed by Dickens and other opponents of orphanages but they also rarely resemble the warm and nurturing Boys Town of Mickey Rooney and Spencer Tracy fame. Traditionally most orphanages employed barracks-style sleeping arrangements with rooms housing eight or more beds, scarcely furnished with more than a quilt. Today's regulations specify a number of required attributes,

especially with respect to the sleeping area and bathroom facilities. The requirements' aim is to reflect the home environment as much as possible in terms of child to space ratios.

It is unfortunate that group care facilities are deemed the last remaining hope in the care plan of a child. There are plausible and cost-effective models of congregate care facilities in the US, such as *Boys Town* in Nebraska and the *Milton Hershey School* in Pennsylvania that provide stability, friends, education, and guidance for children above three years of age. These orphanages operate without removing the child from the interaction and love of his birth family. Birth parents are even given the opportunity to place their children here without the humiliation and delay of the courts. The option of these orphanages seems appropriate when parental rights are not severed but reunification must be deferred frequently or for long periods. It is this type of situation that is of great interest when creating a Play Therapy Centre here in Canada. For so many children in the Child Welfare System today, a grounding point of security and familiarity is desperately needed as an alternative to multiple foster homes and intermittent care.

Alternatively, the foster care system attempts to recreate the maternal bond lacking in many of these children's lives by setting up a surrogate homelife while protective services create a permanency plan for the child. A single family house with temporary substitute parents as caregivers provides a non-institutional environment and therefore should create as little disruption in the child's life as possible. The *maternal deprivation* thought to be the cause of psychological damage in institutionalized children is avoided, in theory. In a series of studies of a small group of children from a New York orphanage, psychologist *William Goldfarb* found evidence from projective, personality, and ability tests that orphans showed deficiencies in speech, intelligence, personality, and social development, concurring with other psychologists that children are seriously damaged emotionally when deprived early in life of maternal contact and affection. The very essence of the institution breaks that mother-child bond that is needed for a child's healthy psychological development. Does the foster home, however, manage to keep this bond intact? Institutions are thought to aggravate the emotional problems of children because of the high turnover rates of their caregivers. Due to

the complex network of services involved in each child's case, as well as the frequent necessity to change placements, creating any sense of stability is difficult. Would the issue of multiple foster placements not then cause the same emotional difficulties associated with institutions?

For children in extremely temperate care or known to return frequently to the care of the system, a Children's Play Therapy Centre would at least offer the stability of a familiar setting to return to where they could communicate their emotions and experience childhood through play. That is not to say we should revisit the idea of the traditional orphanage, as there are numerous negative points in the case against the orphanage model. Researchers have argued that orphanage experiences have led to a relatively high rate of criminal activity, difficulty entering the labour force, and lack of social and parenting skills later in life; all factors the foster care system also cannot escape.

It is difficult to determine what emotional effects were caused by orphanages, or rather the family situations that brought children to them. Another impact on child-rearing methods researchers have since considered is the popularity of child-centred theories, particularly Freudian theories after the 1930s. Psychiatrists with Freudian views recommended self-demand schedules plus liberal weaning and toilet-training methods. The easiest way to experiment with these theories was within orphanages where children lived in great numbers and under constant supervision. A tester of new theories certainly must impact any child. Since the greatest numbers of children studied were located in orphanages, they are thus associated.

In John N. McCall's "A Critical Review,"[9] the following conclusions of the psychological effects of orphanage care may be derived:

1. Theories about the detrimental effects of maternal deprivation receive highly tenuous, indirect support at best from orphanage research. Where psychological deterioration in infants was found, it is not clear whether the mother's absence or simple physical and social neglect was the essential cause. Neither was there any evidence that such neglect was a widespread practice.

2. Some teenagers and young adults with orphanage experience show deficits in language development, intellect, personality, or social skills. It is far from clear, however, that these were caused by their orphanage care. Orphanage care, per se, was almost never directly observed or explicitly manipulated in this research.

3. Most of the research suffers from the overuse of small, opportunistic samples, and there is, a general failure to describe population sources and methods of selection. These limitations make it impossible to generalize findings based on isolated samples to all orphans or orphanages.

4. Most orphanage research is limited to a narrowly focused, clinical search for psychological damage. Very little of it deals with the effects of age at placement. None of it deals with the role of sibling support, the effects of age or gender groupings, the role of work, moral training, and a host of other practical issues in orphanage care.

5. Critics of orphanage care see—overzealous to produce negative evidence—and then generalize their findings to all orphans or orphanages. More consideration should be given to positive orphanage experiences and ways of assessing their effects. Besides the controlled experiments with infants using social stimulation, there was only one developmental study that directly measured change. More developmental research is needed.

It is impossible to determine the cause and effect of every factor in play over the last two centuries. For there to be an intelligent and practical discussion of the value and limitations of congregate care, we need to release the assumptions and myths about orphanages, and focus on safety and permanence. Chiefly, we need to realize that children are not always best when cared for by their biological parents. A child's basic need is to feel safe and protected from harm, and to understand *permanence*. Permanence means that there is an unconditional relationship between child and caretaker which is not achieved when a child is taxied back and forth between abusive and neglecting caretakers and foster care, nor is it moving from foster home to foster home.

Orphanages or congregate care facilities are not the solution to the crisis of the child welfare system. Orphanages and congregate care, however, are an appropriate and underused component of a child welfare system—especially a system that should place safety and permanence as the main goals of child welfare.[10]

One of the Child Welfare System's primary objectives is to provide temporary living arrangements for children without active parents, as a prelude to placing them into stable, traditional family units. How a child adapts to the temporary placement varies greatly with factors such as age, race, and physical and behavioural problems. As such, children may remain within this substitute system for extended periods and some are never placed. The longer a child is within the system, the higher the likelihood that the system itself will influence his or her prospects. By incorporating a Play Therapy Transitional Centre as an adjunct to foster care, as proposed in this thesis, we address the child's temporary situation by providing a place of welcoming familiarity that communicates the values of play therapy through the physical space, as well as the therapeutic programme.

Without any stability, children are unable to establish a sense of permanence. Frequently disadvantaged children in North America grow up to perpetuate the cycles of poverty, abuse, and neglect with their own children. Author Richard McKenzie explains this phenomenon partly because "the children are being held hostage by abusive biological parents who are unloving and irresponsible or by a child welfare bureaucracy that too often uses the count of children in care as a measure of how much is accomplished."[11] Adoption is clearly the best choice when a child's biological family is permanently unable or unwilling to rear the child responsibly but there are times when a child is not yet freed for adoption (in Ontario, not yet a *Crown Ward*). Currently, these children linger in the uncertainty of temperate settings. There is a great urgency surrounding the state of child welfare today. By providing stability and continuity, by allowing children the right to be children, modern orphanages give hope to the prospect of helping children who might otherwise continue to suffer at the hands of the current system.

Today's child protective services are composed of a complex network of organizations, working together to ensure the rights of every child are met, recognizing how a safe and permanent environment can nurture even the most abused or neglected child back to emotional and physical health.

Children's Services Today

Before Mary Ellen Wilson's case brought recognition to the need for child protection laws, statistical information was not collected. Dr. C. Henry Kempe's study documenting *Battered-Child Syndrome* paved the way for government and community agencies to investigate the occurrence of child abuse among families. Not until the 1980s when Children's Aid Societies began operating at a large scale, were such metrics really measured.

For the purposes of contemporary context this thesis utilizes statistical information from *Peel Children's Aid Society* of Ontario. Peel Region is composed of the cities Caledon, Brampton and Mississauga. As one of Canada's 10 largest cities, Mississauga illustrates a cross-section of the current state of Canada's child welfare system.

Now located in Mississauga, in the 2005-06 year alone, Peel Children's Aid served more than 7,700 families and 14,400 children in the Region of Peel. The agency's mission is "to protect and strengthen families and communities through partnership" and its vision is "Every Child Centered." [12] With more than 160 foster homes and 9 residential facilities, in Brampton, Mississauga, and Caledon, Peel CAS provides homes for hundreds of children each year.
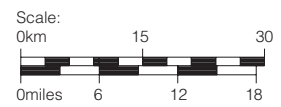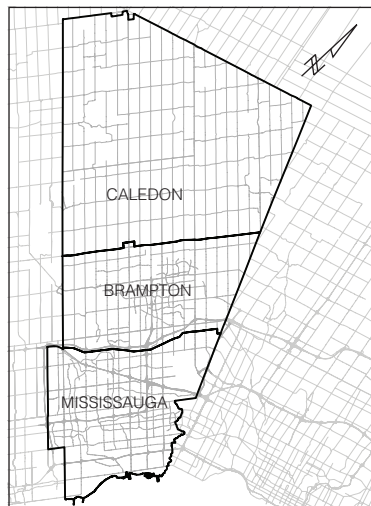
Everyone working with Peel Children's Aid strives to uphold the

2.9 Peel Region within the Greater Toronto Area

Legend:

Greater Toronto Area

Oak Ridges Moraine Conservation Plan Area

Niagara Escarpment Plan Area

2.10 Subdivision of Peel Region

Scale:

following values every day:

Collaboration and Diversity
Accountability to the children, families and community we serve
Respect and compassion
Excellence, learning and innovation

Although the agency is funded by the *Ministry of Children and Youth Services* and special programs for the children are supported by generous donors, 192 volunteers gave more than 20,000 hours of support last year to assist the more than 300 staff working 365 days a year, 24 hours a day.

Not only does Peel Region's population have a higher percentage of children in every age group than Ontario does as a whole, but it also has a higher percentage of children as a region, than Canada does, according to the 2001 Census conducted by Statistics Canada[13]. Although this increase means more children's welfare to account for, Peel Children's Aid is proud to say that this region has a significantly lower number of children per population serviced than other GTA agencies. This is largely due to an attempt at increased awareness of the severity of child maltreatment and the several agencies and programmes that Peel CAS works alongside, including, but not limited to: *S.E.E.D., Challenges, Family Connections, Infant Wellness Program, Interpreter Services, Psychological Assessment Services, Individual Child Treatment, Parenting Capacity Consultations, Parenting Assessments, Play Therapy, Family Treatment, Nursery/Day Care for Children in Care, Family Group Conferencing, Peel Children's Centre, Community Intervention Program, PCC/PCAS Joint Planning, Healthy Babies/Healthy Children, Working Together with Families 0-6 Program, Family Futures Program, Connect* and the *Pathway Program*.

There remains a great need to consolidate many of the services offered to children to create a more seamless existence between childhood and being "in care." In time the hope is to eliminate child maltreatment entirely. In order to understand the difficulties a child must face in overcoming abuse and how we may help make that transition easier in an attempt to end the cycle of that abuse, we must first be aware of the types of trauma children face in this age.

Trauma

According to the *Society for Neuroscience* in Washington, D.C., an increasing amount of research indicates severe maltreatment at an early age can create an enduring, harmful influence on a child's developing brain.[14] As children age, their brains develop; the cells and circuits build and refine. Evidence indicates that many maltreated children later suffer from mental ailments. They appear more likely than healthy individuals to experience learning difficulties, depression and *post-traumatic stress disorder (PTSD)*, a condition marked by intense anxiety that frequently presents after a traumatic experience.

Leading research shows that maltreatment also may affect brain anatomy. Brain areas appear to be smaller in those who experienced maltreatment and have PTSD compared with healthy individuals who have not (see figure 2.11). Included is the cerebral cortex and prefrontal cortex, which help carry out complex actions; the corpus callosum, a collection of fibres that connects the two halves of the brain, allowing them to communicate; as well as the temporal lobes and the amygdala, areas thought to be involved with emotion and memory. Research also finds that a memory area, the hippocampus, is smaller in adult survivors of abuse with PTSD. Although still under investigation, it is possible that experiencing maltreatment during youth harms overall brain development

and may contribute to the disorders common in abused and neglected children.

The stress associated with maltreatment may be at the root of these complications. After the experience of a stressful situation, the brain's stress system activates numerous biological actions preparing the body to fight or flee. Perpetual or intense stress, especially during the brain's sensitive development time in childhood, may harm this system. Research measuring various stress molecules indicates brain abnormalities in maltreated children and adult survivors. In another example, young rodents were separated from their mothers for a few hours each day (a source of significant stress); as adults, they showed signs that their stress systems did not function normally.

In extremely stressful situations, the altered stress system appears to cause brain cell death in rodents and may also do so in humans. Studies showing infant monkeys raised individually develop with a smaller corpus callosum, which was also found to be smaller in some maltreated children. More recently researchers discovered a group of monkeys that will better assist them in testing the effects of stress in child abuse. The mothers naturally act abusive to their offspring. Early findings indicate that the poor parenting alters the stress systems of the abused.

Scientists are also examining maltreated children who do not seem to suffer from mental ailments and are functioning normally, in an attempt to correlate the brain's development with resiliency. In addition, scientists are testing ways to block or reverse abuse-related biological alterations; including early findings that indicate that some medications used for depression can reverse problems with the stress system in rats raised in stressful environments which may also aid abused children.

Childhood trauma comes in many forms and with the help of information from both Peel Children's Aid and Cynthia Crosson-Tower's text on *Understanding Child Abuse and Neglect*[15], the following attempts to categorize Childhood Trauma into: *Physical Abuse, Sexual Abuse, Emotional Abuse/ Psychological Maltreatment,* and *Neglect*.
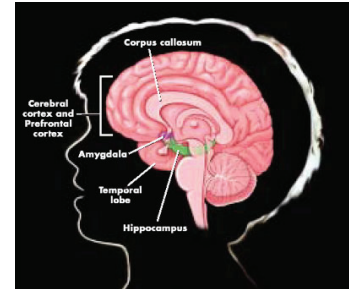
2.11 The human brain

2.12 Introverted child

Physical Abuse

Numerous authorities have defined child abuse. Part of the problem is that many of the definitions are vague, contradict each other or are inconclusive. Physical Abuse encompasses those situations where a caregiver having charge of a child has used inappropriate or excessive force on a child resulting in physical injury. Physical abuse ranges from situations where physical punishment has been inappropriate to excessive, resulting in injuries that can range from scrapes and bruises to cuts, burns, broken bones, shaking, internal injuries, and in extreme situations, death.[16]

Physical Indicators of Physical Abuse[17]

- Unexplained bruises or welts that may be in various stages of healing, in clusters or unusual patterns, or on several different areas
- Unexplained burns in the shape of a cigarette, rope, or iron or caused by immersion, which may appear sock- or glove-like
- Unexplained lacerations to mouth, lips, arms, legs or torso
- Unexplained skeletal injuries, stiff swollen joints, or multiple or spiral fractures
- Missing or loosened teeth
- Human bite marks
- Bald spots
- Unexplained abrasions
- Appearance of injuries after school absence, weekend, or vacation

Behavioural Indicators of Physical Abuse[18]

- Easily frightened or fearful of adults and parents, physical contact, or when other children cry
- Destructive to self and/or others
- Extremes of behaviour: aggressive or withdrawn
- Poor social relations
- Learning problems, poor academic performance, short attention span, delayed language development
- Runaway or delinquent behaviour
- Reporting unbelievable reasons for injuries
- Complains of soreness or moves awkwardly
- Accident-prone
- Wears clothing that is clearly meant to cover the body when not appropriate
- Seems afraid to go home

Sexual Abuse

Sexual Abuse includes any sexual contact between a child and caregiver. Sexual abuse may include sexual suggestiveness, voyeurism, sexual acts, or sexual penetration. Researcher *David Finkelhor* presents the most convincing argument against adult-child sexual involvement. He contends that our society is based on consent and free will, and in order to consent one must have knowledge and authority. Children do not have knowledge of the meanings of sexuality, information to enable them to anticipate the direction of the sexual relationship, or any idea of how others will react to their sexual involvement.[19]
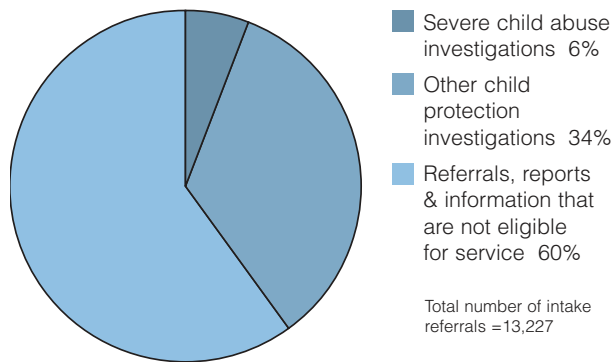
How Society "Sets Up" Children as Victims[20]

Girls
Taught by society to be "vulnerable"
Taught to feel guilt and shame
Taught to be clean and attractive
Taught to be manipulative
Taught to please others

Boys
Taught to believe they are "powerful"
Taught not to be seen as victims
Taught molestation may lead to homosexuality or others to question manhood
Taught to think it "cool" to be initiated by a female
Taught to fear no one will believe them
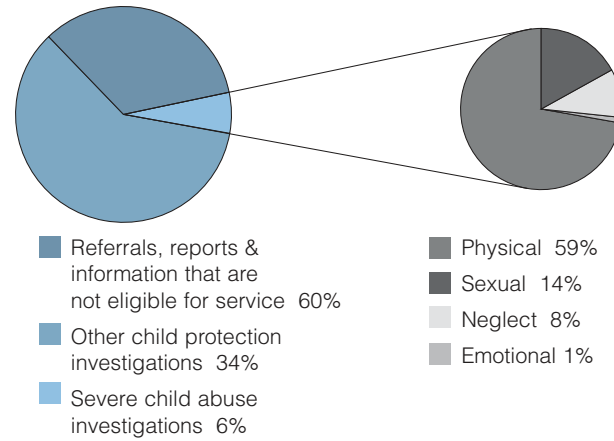Taught to be "free" and "freedom" repressed if molestation reported to parents

2.13 Peel Children's Aid

All Intake Referrals
2003-2004

Severe child abuse investigations 6%

Other child protection investigations 34%

Referrals, reports & information that are not eligible for service 60%

Total number of intake referrals =13,227

2.14 Peel Children's Aid

Intake Referrals and Types of Severe Child Abuse Investigations
2003-2004

Referrals, reports & information that are not eligible for service 60%

Other child protection investigations 34%

Severe child abuse investigations 6%

Physical 59%

Sexual 14%

Neglect 8%

Emotional 1%

2.15 Peel Children's Aid

Intake Referrals and Types of Moderately Severe Investigations
2004-05

RRFINFs

Severe child abuse investigations 6%

Moderately Severe 33%

Minimally Severe 1%

Physical 26%

Sexual 3%

Neglect 16%
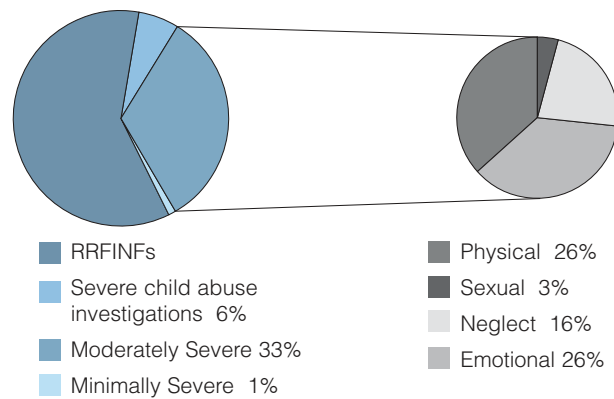
Emotional 26%

Emotional Abuse/ Psychological Maltreatment

Emotional harm underlies all types of maltreatment and is not an isolated incident. Emotional or psychological maltreatment is a pattern of negative caregiver behaviours or repeated destructive interpersonal interactions by the caregiver to the child. A repeated pattern of extreme incidents of emotional harm may include spurning, terrorizing, isolating, exploiting/ corrupting, and denying emotional responsiveness. Emotional harm can be the most difficult type of harm to define and often a clinical diagnosis needs to precede a legal intervention by Children's Aid. Survivors tell us that the results of the physical blows do not last as long as the messages of the perpetrator of sexual abuse that creates and/or intensifies the scars for their victims. Although the definition of emotional maltreatment is controversial and was only introduced to many child welfare agencies fairly recently, the consensus today is that emotional or psychological maltreatment is not an isolated event, but rather a pattern of psychically destructive behaviour that may include any of the following:[21]

2.16 Blocking out emotional maltreatment

> **Rejecting** – The adult refuses to acknowledge the child's worth and the legitimacy of the child's needs.
>
> **Isolating** – The adult isolates the child from normal social experiences, prevents the child from forming friendships, and makes the child believe that he or she is alone in the world.
>
> **Terrorizing** – The adult verbally assaults the child, creates a climate of fear, bullies and frightens the child, and makes the child believe that the world is hostile and unsafe.
>
> **Ignoring** – The adult blocks the child from having stimulation, stifling emotional growth and intellectual development.
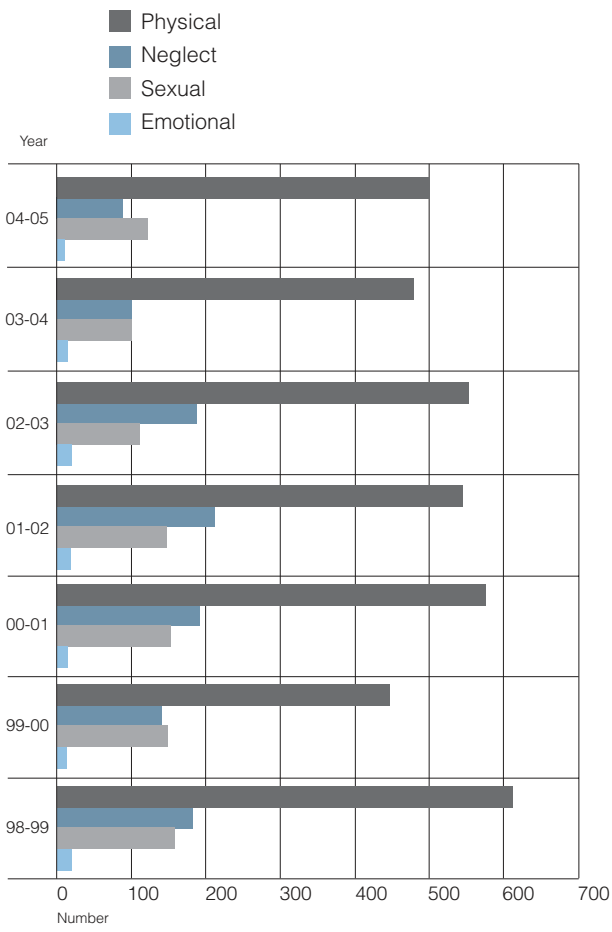>
> **Corrupting** – The adult encourages the child to engage in destructive and antisocial behaviour, reinforces the deviance, and makes the child unfit for normal social experience.

Children who are emotionally maltreated suffer feelings of being inadequate, isolated, unwanted, or unloved. Children respond by either fighting back, becoming hostile, aggressive, and exhibiting behavioural problems, or they turn their anger inward, becoming self-destructive, depressed, withdrawn, or suicidal. Some children also develop somatic complaints (e.g. headaches, asthmas, colitis, nervous habits, etc.) or sleep disturbances.
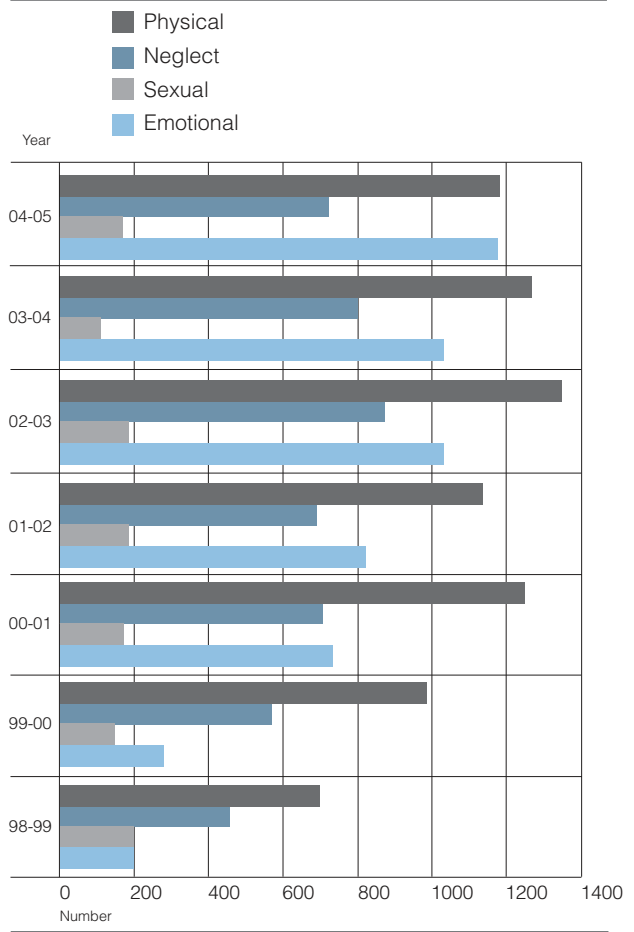
Types of Severe Child Abuse Investigations Opened 1998-99 to 2004-05

Legend:
- Physical
- Neglect
- Sexual
- Emotional

Year

Number (x-axis: 0, 100, 200, 300, 400, 500, 600, 700)

Years (y-axis): 04-05, 03-04, 02-03, 01-02, 00-01, 99-00, 98-99

2.17 Peel Children's Aid

Types of Moderate Child Abuse Investigations Opened 1998-99 to 2004-05

Legend:
- Physical
- Neglect
- Sexual
- Emotional

Year

Number (x-axis: 0, 200, 400, 600, 800, 1000, 1200, 1400)

Years (y-axis): 04-05, 03-04, 02-03, 01-02, 00-01, 99-00, 98-99

2.18 Peel Children's Aid

Neglect

Neglect of a child's basic needs means that the child's caregiver either deliberately or through a lack of knowledge and/or lack of motivation, fails to provide a child with adequate food, shelter, clothing, safety, medical treatment, or treatment services, which results in the child experiencing injury, harm, or illness. Neglect is often seen as an act of omission which some divide into three categories: physical neglect, educational neglect, and emotional neglect. Consequences of neglect can be far-reaching and long-standing. They can impact a child's physical, social, intellectual, and emotional development, and have an incredible cost for families and for society. Neglect is a type of maltreatment which is so dependent on cultural child rearing values as well as variations in the neighbourhood, the community, and indeed by the cultural, economic, and political values of society itself.

Children who have been neglected demonstrate numerous symptoms including those described by physician *Vincent Fontana* in his 1976 report on rounds at the New York Foundling Hospital in the 1960s:[22]

> What my associates and I saw were dull-eyed children who turned their faces to the wall, who could not respond to a friendly touch. Children with infections that had gone untreated. Children who had lice removed from their hair. Children who were slightly bruised, perhaps had a minor dislocation or two, whose eyes were big in hollow faces. Children who had been dehydrated almost to the point of death. Small children barely capable of speech who used the most incredible gutter language. Children who had been fed totally unsuitable foods. Children who showed traces of medication never intended for children. Children who gave every appearance of being physically healthy, yet looked terribly lost and who never laughed and seldom cried.

Some physical symptoms are not obvious, but others are—to a painful degree.

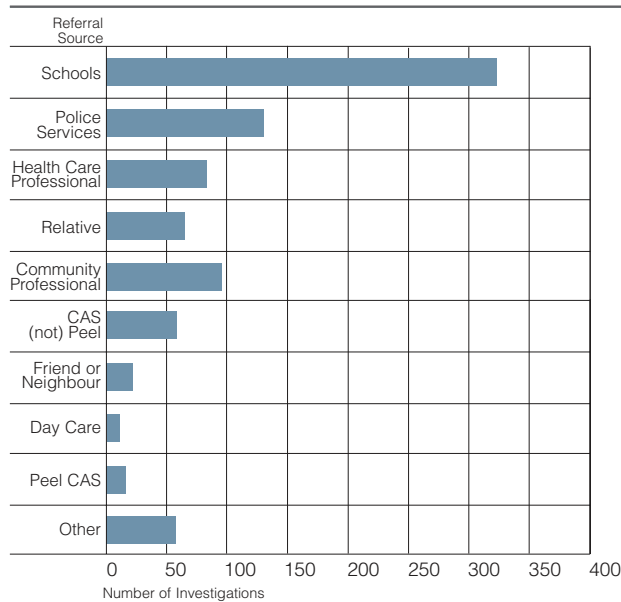**2.19** An environment of neglect discovered by Protective Services.

2.20 Distress

Referral Source

According to Peel Children's Aid, referrals from schools, police services and health care professionals are the primary sources of referrals for child abuse investigations.

Sources of Referral for Severe
Child Abuse Investigations
2004-2005

2.21 Peel Children's Aid

Sources of Referral for Moderate
Child Abuse Investigations
2004-2005
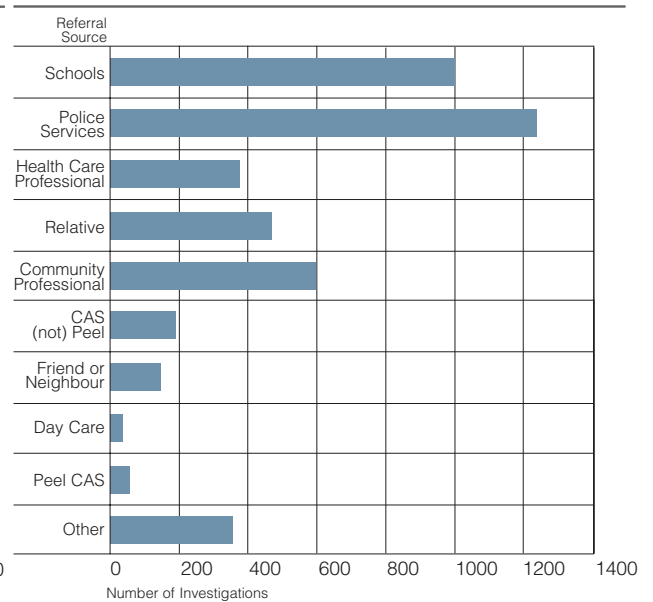
2.22 Peel Children's Aid

Outcome of Child Abuse Investigations

Once investigated, Children's Aid will either close the case, take some action to rectify the situation, categorize the case as requiring ongoing intervention or will place the child in care. It is Peel CAS's intention that ongoing child protection services ensure the safety of children under the supervision of caregivers through various interventions that can include individual and/or family counseling and child management training. Placement may be permanent or may be temporary pending the initiation of assessments, counseling and/or court processes. It is Peel Children's Aid Society's policy to "actively work with the caregivers to reduce risk factors in an effort to work towards a safe reunification."[23]

Types of Child Abuse Investigations Transferred
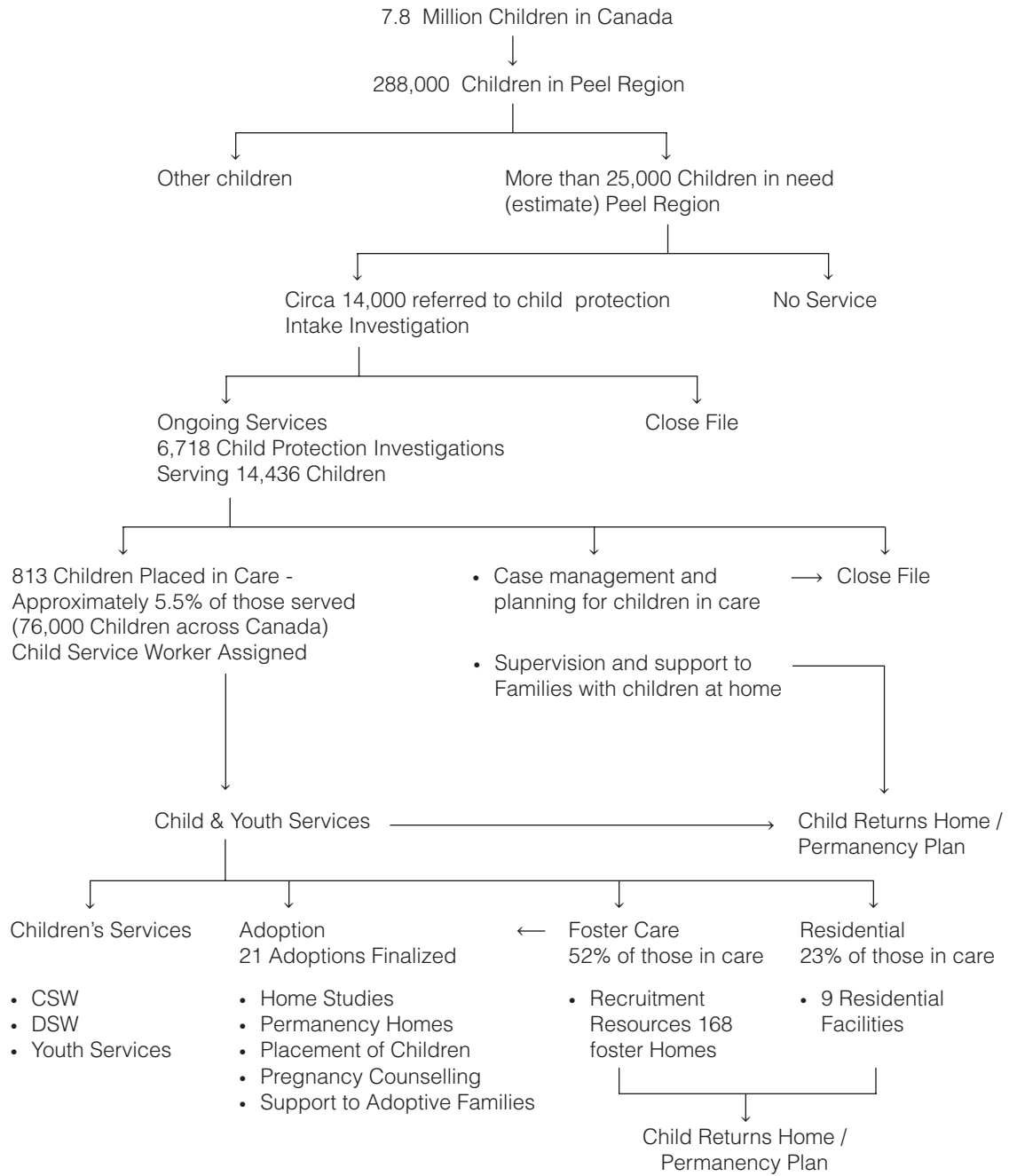for Ongoing Service 2004-05
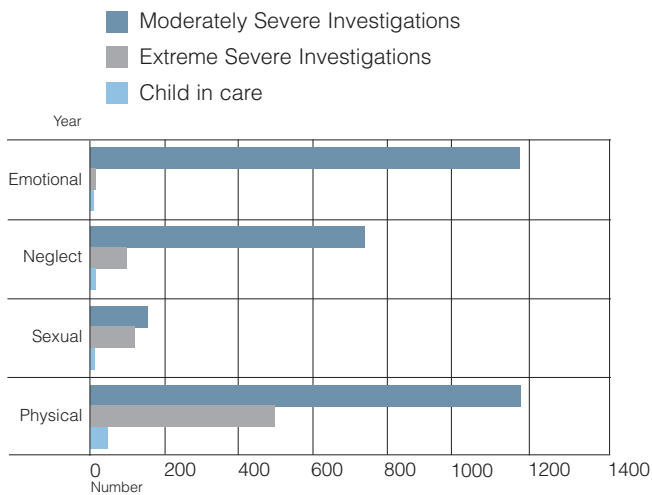
- Moderately Severe Investigations
- Extreme Severe Investigations
- Child in care

Today child abuse is addressed by three ideologies—judicial, medical, and social welfare. Child protective agencies like Peel Children's Aid, are responsible for direct intervention and their efforts can be hampered if there is not community and public support for their work, which is only possible through a more extensive community awareness and education. Until such time that we are able to eliminate child maltreatment entirely, the focus must also include helping the maltreated child to recover physically as well as emotionally.

Chart of Care

7.8 Million Children in Canada

↓

288,000 Children in Peel Region

Other children   More than 25,000 Children in need
(estimate) Peel Region

Circa 14,000 referred to child protection   No Service
Intake Investigation

Ongoing Services   Close File
6,718 Child Protection Investigations
Serving 14,436 Children

813 Children Placed in Care -   • Case management and   → Close File
Approximately 5.5% of those served   planning for children in care
(76,000 Children across Canada)
Child Service Worker Assigned   • Supervision and support to
     Families with children at home

Child & Youth Services ⟶ Child Returns Home /
Permanency Plan

Children's Services   Adoption   ←   Foster Care   Residential
     21 Adoptions Finalized   52% of those in care   23% of those in care

- CSW
- DSW
- Youth Services

- Home Studies
- Permanency Homes
- Placement of Children
- Pregnancy Counselling
- Support to Adoptive Families

- Recruitment
  Resources 168
  foster Homes

- 9 Residential
  Facilities

Child Returns Home /
Permanency Plan

III Healing of the Childhood Trauma

Play Therapy

Cleverness in a child will not make up for a delay in the
maturing of the personality. If emotional development
had been blocked at some spot, a child has to go
back, whenever certain circumstances recur and act
as if still an infant or a little child.

<div align="right">- D.W. Winnicott (1957)</div>

This chapter illustrates the importance of Play as a means of
communication for the child and explores the values of Play Therapy.
By integrating the dynamics, scale and intimacy of Play Therapy into
the architectural strategy of the Play Therapy Centre, architecture and
therapeutic practice are able to act in essence, as a transitional object
for the maltreated child.

       A child looks at his mother to find himself, and often in situations
of maltreatment, instead of finding a mother gazing back, allowing herself
to act as a function of the child's development, she instead projects
her own expectations, fears and plans for the child. If this state is not
altered, the child remains without a *mirror*.[1] Although not a replacement

for a parental figure, the temporary environment that a maltreated child is placed in, does play a role in supporting the same basic needs of a child. The intention of the Play Therapy Centre is to mirror the authentic needs of the child, the crucial elements necessary to re-establish the lost trust. If their essence is mirrored, we need to be able to teach them to receive these qualities.

The centrality of the experience of play as the child's manner of creative expression makes it a dynamic form of therapy especially for those children who have been abused. Jung (1931) wrote:

> The creative activity of imagination frees man from his bondage to the 'nothing but' and raises his to the status of one who plays. As Schiller says, man is completely human when he is at play.
>
> - C.G. Jung, 1931

Play in the form of therapy allows children to tell us what is going on inside their minds, even if they do not know themselves. It not only allows us to clarify what the child has experienced; it can help the child to recover from the trauma and regenerate natural processes of social interaction. As Dr. Donald W. Winnicott said:

> It is by playing and only playing that the individual child is able to be creative and to use the whole personality and it is only in being creative that the individual discovers the self.
>
> - Winnicott, 1971

A space designed for Play Therapy must be a "safe place" where, as Winnicott suggested, a child can dare to reach back for what he lost or was never given, or for what was too painful to be absorbed.[2] Relating on a basic level to the four elements and the five senses will be an integral part of the spaces, both within and surrounding the facility. The core intention of the centre is healing, and allowing a child to access his imagination as a vehicle to his very essence. The centre will communicate the declaration of Yes! To the Spirit of a Child! The centre should also honour the child, and hold child development with the highest regard, allowing children to express their pain in an appropriate way.

Dr. Clark Moustakas believed child Play Therapy to be "a private world where two people may live fully behind closed doors without fear of judgement, surveillance or retaliation. . . [where he could see] the unfolding journey of the child engaged in imaginative play and in a dialogue that represented natural means of coming alive again and restoring a sense of self."[3] Dr. Moustakas considered three basic attitudes in child-centered Play Therapy: faith, acceptance, and respect. Faith is an element expressed between therapist and child in both subtle and direct ways where the child is able to sense the faith the therapist has for him. "The child who feels faith knows what he wants to do, what he can do, and what he will do. He trusts his own feelings."[4] Acceptance was thought to be more clearly differentiated and better understood; it implies a commitment on the part of the therapist that is made known to the child through body language, feelings, and verbal indicators. The third of Moustakas' attitudes, respect, is a quality the therapist communicates to the child by attempting to see him as he is, at his own level.

3.2 Play Therapy at Amani
Children's Home, Tanzania

Play itself is an integral part of childhood. By the time children reach the age of six, they are likely to have spent more than 15,000 hours playing.[5] It is a medium that eases the development of expressive language, communication skills, emotional development, social skills, decision-making skills, and cognitive development in children. *Dr. Charles Schaefer* said play is the most complete form of self-expression developed by the human organism. He expressed that play is also a medium for exploration and discovery of interpersonal relationships, experimentation with adult roles, and understanding of one's own feelings.[6] Dr. Schaefer articulated that play is easier to recognize than to define, partly because it changes its form as young children mature; in that way it is like other psychological constructs such as love and happiness. Piaget (1951) and others distinguished four stages of cognitive development in play: practice play, construction play, symbolic play, and games with rules.[7]

Schaefer defines practice play as the sensorimotor play seen in infants during the first year of life; involving non-goal oriented actions with objects, stemming from the infant's pleasure in having actions and objects under his own control, for example, banging or dropping a rattle.[8] Construction or combinatorial play continues to twenty-four months and involves putting things together such as shapes into a shape box, stacking blocks and grouping objects by function or shape. Symbolic or pretend play is most common from two to six years and is thought to be one of the most interesting and creative forms of play. Children "act if," allowing themselves to change into people, objects, or situations other than themselves through verbal expression and/or motor movements. The fourth stage of play, games with rules, involves adult recreation sports, such as basketball or baseball, but does not exclude play with board games.

Communication is the key factor of child Play Therapy. "Play is to the child what verbalization is to the adult – the most natural medium for self-expression."[9] Before the teenage years, children have difficulty using words to express their feelings, needs, and thoughts. Schaefer postulated that toys are a young child's words, and play is his natural language.[10] According to Piaget (1951), fantasy play "provides the child with the live, dynamic, individual language indispensable for the

3.3 Sensorimotor play

3.4 Imaginative play

3.5

expression of his subjective feelings for which collective language alone is inadequate."[11] Play, as a form of communication is more fantastic and full of image and emotions. Schaefer explained the communication process as one that operates on two levels. On the conscious level, play allows children to enact those thoughts and emotions of which they are aware but are unable to verbalize. Children are also able to use play to express their unconscious wishes and conflicts, revealing feelings of which they are completely unaware. Sigmund Freud was the first therapist to realize the value of play in uncovering a child's unconscious conflicts. By interpreting the symbolic content of child's play, clinicians are able to understand the emotional difficulties of children.[12]

In her book on *Play Therapy with Abused Children*, **Ann Cattanach** outlines the essentials of the optimum Play Therapy environment as including: a safe place for the child, which the child recognizes as a play space; play materials which facilitate embodiment, projective and symbolic play; and a therapist capable of providing an empathic relationship with the child, which means that she is able to be the adult who listens, acknowledges and stays with the feelings of the child. The therapist watches and sometimes can offer these skills to the child without intruding on the child's own creativity.[13] She, along with other therapists believe that ideally, the play space should be sound-proofed and should have a sink with both hot and cold water, sand trays, water trays, and should have walls and floors able to withstand sand, water, clay, paint and other projections which may materialize from the child's person occasionally! An element found to be universal among therapists' requirements is that children must have access to the same toys each session, as they will be disturbed if objects or the space itself changes in any way. As an aside to this condition, it is also recommended that the toys be categorized and arranged in a discreet manner, so that a child is not overwhelmed with the entirety of the collection. Other common tools in Play Therapy include: puppets; family dolls; dolls; representational toys; sensory play materials, as in tactile and jelly-like materials for modelling, smelling, touching, ripping, throwing, where colour is extremely important; stage makeup, as it's colour is more vibrant and textures more varied; and of course, drawing material.

3.6 Play therapy room at Indian Health Council Clinic, California

3.7 *Opposite* Hoyle Early Years Centre, Bury, UK
The interior uses the play of light and shade to soften the severity of its design

3.8 Child and Therapist

3.9 Painting

3.10 *Top Left* Water play

Each child prefers her environment a certain way, depending on her emotions during the Play Therapy session. Taking comfort in private spaces such as tents or under tables, or concealed within crevices created between furniture, is universal among children. The aim is to design a space, with differing qualities incorporated into the space itself, to allow children to expand on their feelings and creativity.

There are many different types of Play Therapy, with differing styles within them again. *Non-directive Therapy* emphasizes that play is in itself a healing process; where the child is able to "play out" her feelings and problems and to learn about herself in relation to the therapist. Play itself is the therapeutic intervention in this method; it is not used to stimulate other forms of therapy, but rather to focus on the process of play, which heals the child.[14] Piaget rather, examined play as part of the whole intellectual development of the child and relates it to the process of *assimilation* and *accommodation*. Assimilation occurs whenever the individual is able to recognize and give meaning to new components encountered in the environment. Accommodation then occurs when the individual is altered by the surrounding conditions in which he finds himself. Piaget regarded play as an assimilation of new experience and

3.11 Group Play Therapy session; drawing and clay exploration

classified play into types.[15]

Anna Freud and Melanie Klein laid the theoretical foundations of psychoanalytic systems of child analysis using play to interpret the child's unconscious motivation, through their work with neurotic children. Anna Freud developed a system which uses children's play in a similar fashion to the examination of dreams in adult psychoanalysis, whereby she looked for the unconscious motivation behind imaginative play, drawings and paintings, emphasizing the relationship between the therapist and the child.[16] Melanie Klein postulated that Play Therapy furnished direct access to the child's unconscious, where the spontaneous play of the child was a substitute for the free association of the adult.[17] These two systems of analysis use the medium of play to reveal the source of the problems, rather than as a curative factor, which is a point of controversy amongst present day therapists. (See figure 3.12, right)

Dr. Charles Schaefer described thirteen factors of child Play Therapy, communication being the foremost aspect. Also a factor is mastery, whereby a child, by engaging in play, satisfies his innate need to explore and master his environment.[18] As previously stated, play encourages children to improve their problem-solving skills; it promotes creativity and flexibility with its atmosphere of reassurance that alleviates fear of negative consequences. Sherrod and Singer, in their 1989 study found pretend play in childhood has links to adult creativity and innovative problem solving; the flexible and original thinking inherent in play helps children find alternate and more effective solutions to real life social and emotional difficulties.[19]

Catharsis is another core therapeutic factor shared by many schools of psychotherapy as it provides clients comfort through the release of tension and affect on such inanimate objects as "punching bags, and bobo dolls. The safety of the playroom allows children the opportunity for emotional release without fear of retaliation or censure."[20] An example of this arousal and discharge of strong emotions was documented by Ann Cattanach in a session with Andrew. Andrew was given the rules of play on Ann's blue mat; on the mat he could say anything he wished. On their first meeting, with one toe on the mat, Andrew greeted Ann with a hard, thoughtful stare and stated, "You fat
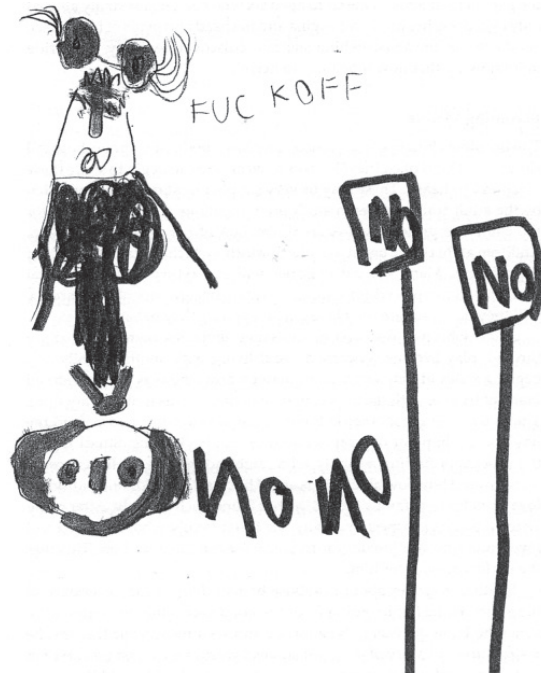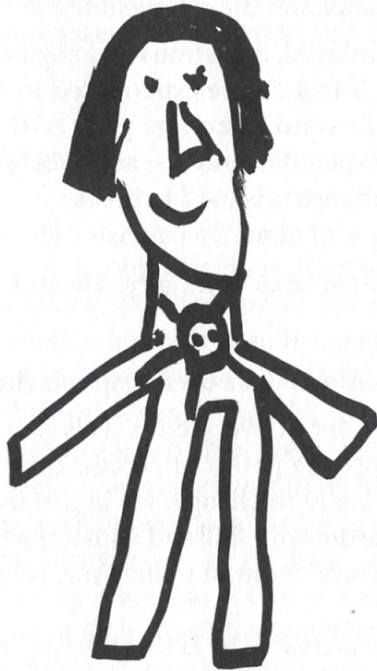
3.12 Interpreting the child's unconscious motivation through drawing analysis, examples from Ann Cattanach's sessions with abused children. *Top left* Lionel's Juggler: Juggling with Knives; *top right* This is a mummy monster—she hits you; *bottom left* This monster is a boy—he kicks people; *bottom right* This is how I draw myself. I have a head and a vagina. My brother has a head and a penis. I shout 'No, no!'

old bag. You said I could say what I liked on the mat and my foot is on the mat so it's alright." Ann assured him that yes she did say that, so he was following their contract. After testing Ann for several weeks in a similar manner, Ann told Andrew that while she thought he could say what he wanted, and would survive it, she did find it hurtful; but if he needed to speak that way, then it was fine because he was keeping the rules since he had his foot on the mat when he spoke. Ann went on to reassure Andrew that she liked him even though he was rude to her and that he was interesting and made up exciting stories. The week after there was no challenge and after play he looked at Ann and said, "I think children who swear are very immature."[21] Andrew was able to test out his anger towards adults on Ann and was not reprimanded; he was given the chance to understand the affect his words had on others and was able to alter his behaviour himself.

3.13 Child and Therapist in 'safe space'

Schaefer explains *abreaction* as the reliving of past stressful events and the emotions associated with them. It is a more heightened process than catharsis in that the release of affect is greater. In play, children are able to process and assimilate traumatic experiences by reliving them with an appropriate discharge of affect; in time, achieving mastery over them.
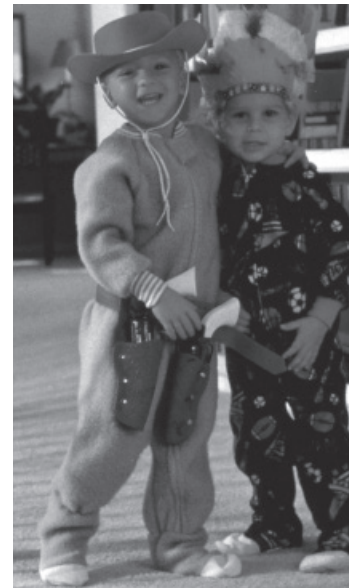
Role-play is a mode of play that is universal among children; it offers children an opportunity to try out alternate behaviours. Widely regarded as an advanced form of pretend play, is the creation and maintenance of interactive fantasy play, or sociodramatic play. This stage of play begins as children reach their third birthday. In Play Therapy, children are encouraged to try out new actions they may have never have thought of, to experience what it is like to behave in this way, and to consider the pros and cons.

3.14 Role Play

According to Garvey (1976), the major roles assumed by children in play are:

1. Functional roles (unnamed roles represented by the actions of the players, e.g., driver-passenger).

2. Relational roles (such as family roles of mommy, daddy, baby).

3. Occupational roles (including doctor, teacher, policeman).

4. Fantasy roles (which encompass fantastic characters, e.g., Superman, and TV characters, e.g., Flintstones).[22]

3.15 Attachment formation established through sensorimotor play

Through role-playing, a child develops her powers of empathy, and is able to step outside herself and view herself from another's perspective. In doing so, *Mead* (1967) concluded that children's pretend role-play contributes to the development of the self as a separate identity.[23]

Play enhances the varied use of one's imagery capacities. Fantasy play gives a child control over his environment, even when he does not have much power in real life. Children are able to pretend that reality is conforming to their wishes.

Schaefer noted that we are myth making beings that create reality by belief in stories we have told about it. He described that myths help shape belief systems that structure, energize, and give meaning to life. *Watzlawick* (1978) explained this power of myths partly because they go directly through to the right side of the brain; therefore messages can be directly communicated to the child's unconscious by stories, fantasy play, and drawings.[24] Using this knowledge, a therapist can provide children with new myths that address the sources of conflicts, fears, and hostilities and offer more adaptive solutions; new myths can diminish unrealistic expectations and existing aggressive solutions to those conflicts.

Attachment formation is another factor in Play Therapy whereby the child gains a sense of self as someone whose skills and

body boundaries are well known and who can have fun with another person —feelings many abused children are not familiar with. One way the therapist may establish this secure attachment is by replicating the positive parent-infant relationship through sensorimotor play, as in itsy-bitsy spider and other such games involving touch and smiling. The therapy is fun-filled and includes elements of surprise, an example Schaefer uses is putting a shoe on a child's head, and a hat on his feet.[25]

3.16 Overcoming fear of darkness

Once that attachment is formed, enhancing the relationship is important. This is achieved through playful interactions that are for enjoyment rather than achievement. Through play, a pleasure bond is formed that makes the child identify more with the therapist and her behaviours and values. Crucial to all of these factors is that children should enjoy the play. Play should be enjoyable in its own right and does not need incentives. "Research indicates that children do better work under the influence of strong emotion, that enjoyment of a task enhances striving and persistence at it, and joy provides motivation in unrelated activities."[26]

A technique designed by *Wolpe* (1958), called systematic desensitization is implemented to treat emotional behaviours such as anxiety, irrational fears and phobias. The technique uses the processes of counter-conditioning. By exposing a child to a fearful situation while the child is relaxed in play and having fun, the pleasure can counteract and neutralize the fearfulness so the child is able to continue with the desired behaviour. This is used with phobias such as fear of the dark, whereby the fear can be overcome by repeatedly playing games with the child in a dark room. At first the room is darkened only briefly and eventually the time is extended making the strange and scary become familiar and no longer frightening.[27]

The 1980s opened up the field of Play Therapy for use with older children, adolescents and adults through the creation of a wide variety of therapeutic board games. Game play allows children to develop social skills because of the prearranged rules involved in play. These regulations prepare children for respecting the rules of life, as in fair play, taking turns and gracious winning and losing. Game play is a useful factor in Play Therapy as the possibilities are endless and can be advanced or changed depending on the client.

Ann Cattanach dissected the four basic concepts of the Model of Play Therapy which help focus the therapy towards healing the abused child:

1. A crucial concept is the centrality of play as the child's way of understanding her world. Play becomes the child's way of making contact with her environment.

2. Play is a developmental process and in therapy the child moves back and forth along a developmental continuum as a way of discovering individuation and separation. Embodiment play, projective play and role play are commonly thought to be developmental stages of play.

3. Play is a symbolic process through which the child can experiment with imaginative choices appropriately distanced from the consequences of those choices in 'real life.' Play with objects develops from simple action patterns compatible with objects through more complex play until the child can transform objects and make dramatic representations whereby they engage in problem solving through the fictional present.

4. Play happens in a therapeutic space, the transitional space between child and therapist, the space to define what is 'me' and 'not me', the place where our creative life starts, where we experience for the first time the psychological significance of art.[28]

This last concept of therapeutic space is of utmost importance in the quest to design the physical environment for children in therapy. Cattanach describes this space as being two realms, the physical place where therapist and child meet and the psychic space developed between the child and therapist. There must be clear physical boundaries to the therapeutic space, safe enough, and free from disruptions from the outside world.

Gersie (1987) found that as children we play most easily "in the fringes of structured time and in the borderland of common space."[29] Places described earlier such as in an attic, beneath a table, behind the garden shed are desirable to children. It is there we are able to make choices regarding public and private, the personal and the collective. In designing a therapeutic environment we must allow for easy transformation into apparent seclusion, through the creation of actual boundaries, or into the approachable by granting access to others.

The psychic space between child and therapist represents the transitional space described by Winnicott as the potential space between child and mother figure.[30] First, baby and mother are merged with one another; the baby's view is subjective and the mother is oriented towards making actual what the baby is ready to find. Second, the object is rejected, re-accepted, and recognized objectively. The last stage is being alone in the presence of someone, whereby the person reflects back what happens in the playing. The child plays on the assumption that the person who loves them and who is available, will be there when called upon. This is in preparation for two kinds of play: first mother and child play together, but the mother fits into the child's activities; then the mother introduces her own playing allowing the child to discover the ideas are not her own; thus forming a relationship.

It is this transitional space that is present in Play Therapy as the child moves along the developmental continuum to find, perhaps for the first time, "a relationship which will enable her to meet and separate from

a caring adult, a relationship which is not bound by the pathology of an abuser and victim."[31]

The essential ingredients a child centre should invoke include, but are not limited to: *mirroring, receiving, permanence, security, privacy, trust, belonging* and *delight*. These qualities should translate architecturally, not in the sense that "security" would establish fear or literal boundaries of shelter, but rather a calming realm that encourages safety in knowing themselves, and expressing themselves.[32]

In order for the maltreated child to transition on the developmental continuum to the next stage of adulthood, we must appropriately address his emotional and physical needs. The final chapter illustrates and surveys the practical and aesthetic concerns of what makes a Play Therapy Centre.

3.18

# IV   Space for the Imagination

Making the Child's World

Although it is true that psychologists have grasped the major developmental stages of human perception and cognition, most architects have yet to use that knowledge in their designs. This is perhaps due to the historic failure to validate an architecture designed specifically to the needs of the child. Nursery and pre-school facilities were, and still are, often dealt with as merely additions to existing locations or as renovations to box spaces.

Evaluating the built environment's impact on the child, as well as their spatial needs and desires, creates the necessary communication between the realms of architecture and psychology. This communication is especially critical to integrating the values of Play Therapy into the architectural strategy when designing for the maltreated child. The following pages illustrate and survey the practical and aesthetic concerns of what makes a Play Therapy Transitional Centre.

Kindergarten Roots

It was child-centered innovators from the time of *Pestalozzi* and *Froebel* that lead the way in demonstrating an architecture of new ideas because radical educational ideas begged for radical settings. As early as the 18th century, philosophers and psychologists began to analyze the stage of childhood as distinct. Philosopher *Jean-Jacques Rousseau* advanced the notions that children are innately noble and good, that their way of learning is different from that of adults, and that they should be removed from the corrupting influences of society for their early education. Rousseau was not an early childhood educator, nor did he work with children, but his ideas influenced the field, initiating an early childhood education reform that would flourish in the 20th century. Rousseau's theories intrigued educational reformer, Johann Pestalozzi, who believed that young children learned actively, from concrete experiences and observation. He espoused the need for active learning and education for the whole child, influencing educators in later years, including Froebel. Although an admirer of Pestalozzi, German educator Friedrich Froebel was concerned with Pestalozzi's inability to articulate his methods. Like his predecessors, Rousseau and Pestalozzi, Froebel believed in the child's developing mind. He also advocated that education should harmonize with the child's inner development, recognizing that childhood is a separate stage with great intrinsic value in its own right, not merely a transition into adulthood. Froebel's programme centered on play and sensory awareness. His classes were not held in a traditional classroom but in a "garden for children," thus establishing the German "*Kindergarten*."

  Maria Montessori, the first female medical doctor in Italy, also developed a successful method of early education widely followed today. Through her work with both impoverished and developmentally challenged children, Montessori concluded that children's difficulties were often educational more than medical. In her "casa dei bambini" Montessori explored her teaching methods with average children, establishing the Montessori Method for early childhood education which considers how young children grow. Today there is great variation among Montessori programmes which for the most part are attended
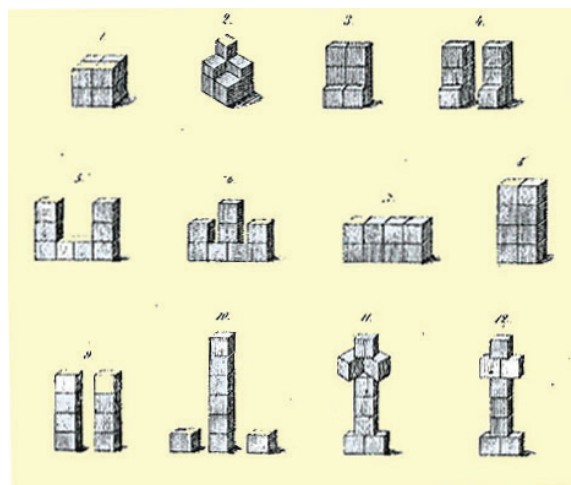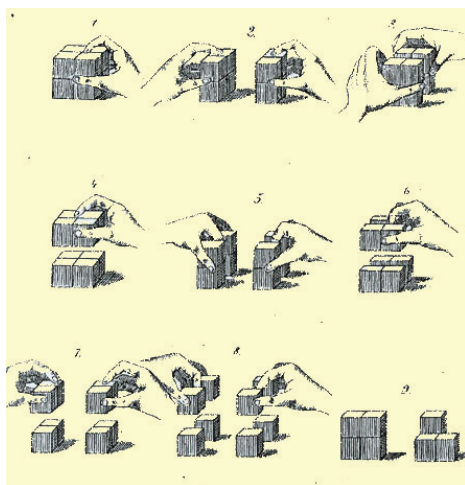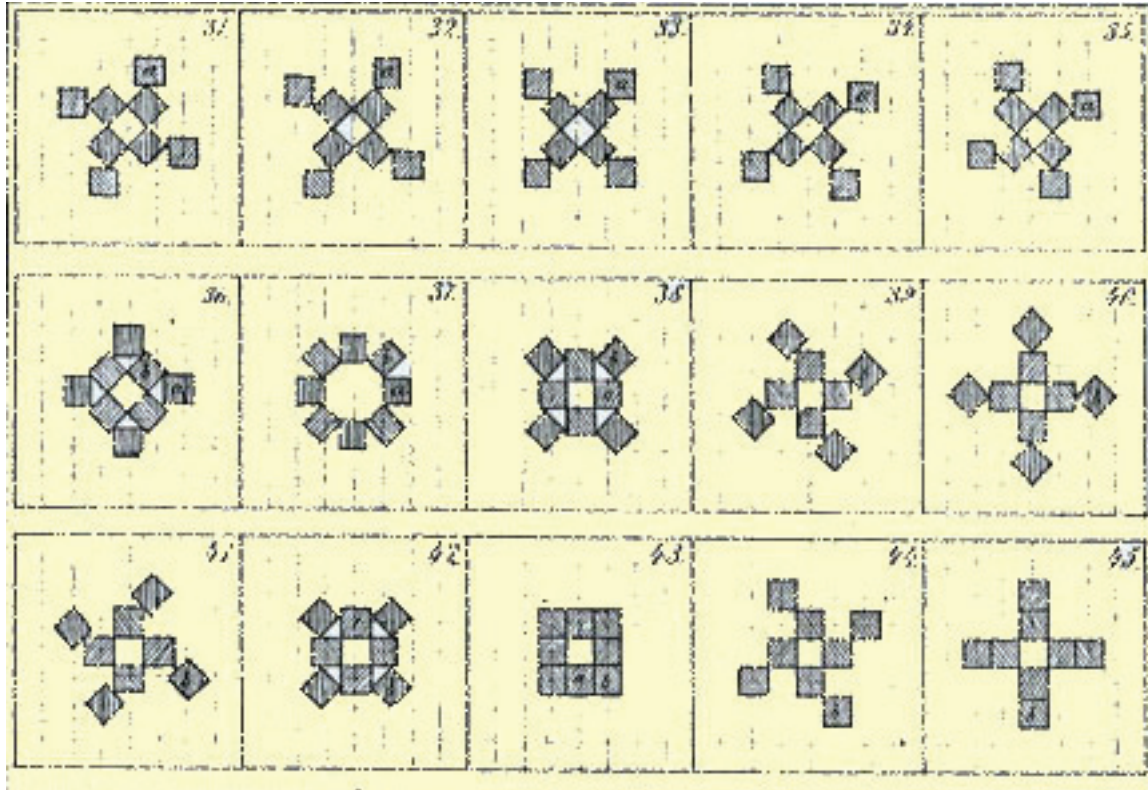
4.2 One of Froebel's educational tools, popularly known as Froebel Gifts, or Fröbel Gaben, included geometric blocks that could be assembled in various combinations to form three dimensional compositions.

by children from more affluent homes. In a traditional Montessori classroom (as seen in figures 4.3-4.5) there is a sense of order inherent in the room. Child-size equipment and materials are clearly organized on shelves that are easily accessible to children. There are distinct areas, each containing materials unique to promoting the tasks to master in that area.

During the same period in the early 20th century, Russian psychologist *Lev Vygotsky* originated his socio historic theory, stressing the importance of the social environment to development, spurring considerable interest in recent years, decades after his death, in cross-cultural studies of child development and child rearing practices. A follower of Sigmund Freud, *Erik Erikson*, like Vygotsky, stressed the importance of the social context of child development. Erikson's psychological theory, which spans childhood and adulthood, focuses on specific social tasks that need to emerge for healthy development in each of eight stages. The first four stages experienced by the young child are paraphrased in chapter I, pages 10a and 14a as Ages and Stages of Development. Erikson emphasized the importance of play in meeting the tasks of autonomy and initiative during the early years of childhood and the balance we must provide to help children achieve healthy development. A stage theorist (like Erikson), *Jean Piaget* also conceived of qualitatively different characteristics and accomplishments in cognitive ability during various stages of development. His cognitive development theory was one of the most influential on early childhood education, transformed into models by more educators than any other childhood development theory, even though Piaget did not suggest specific educational applications of his work.

Rousseau, Pestalozzi, Froebel, and Montessori all felt that, given appropriate instruction by understanding adults, children will naturally develop into healthy, responsible adults. Behaviourist *B.F. Skinner* believed conversely, children are not shaped by inherent forces but rather those emanating from the environment. Skinner was a behaviourist whose ideas have had widespread influence on all aspects of education. The application of his theories operates on the underlying principle that behaviour can be modified by manipulating

4.3 Montessori Classroom 'home centre,' Montessori Schools Association, London, UK

4.4 Montessori Classroom activity area, Montessori Schools Association, London, UK.

4.5 Montessori Classroom, organized activity zones Association Montessori Internationale

the environment which includes both physical and social components. This period of educational reform was also the birth place of *Waldorf* education, based on the educational philosophy of *Rudolf Steiner*. Waldorf education incorporates a balance of physical activity, artistic creativity and academic work against the backdrop of its well-defined stages of child development. Viewing child development as a process of incarnation of the child's soul and spirit, the Waldorf curriculum focuses on the arts, social skills, spiritual values, as well as practical and integrated learning.

Although these theories were the basis upon which the roots of kindergarten architecture can be viewed and assessed, it is puzzling how little the key educationalists of the times had to say about the role of architecture and architects, except in the spiritualist educational theories exemplified by spaces created by Rudolf Steiner. The Steiner approach to early education includes architecture as an element of the method, although the healthy holistic environment and the healthy holistic programme are not codependent. The alternative philosophies of last century left a significant impact on child-centered environments, yet they have proven limited in the wider humanization of mankind. Instead of continually drawing connections or barriers between mankind, nature and the external world in an attempt to recompense as adults, we should also be creating architecture that reflects the natural spirit of childhood for the children that will inevitably become adults.

Crow Island School

Of course acceptable child-centered programmes can and do exist in less than wonderful buildings, as do cold and insensitive programmes within state of the art buildings. However, there is no doubt the building itself should be a player. A building can reflect and perpetuate ideas about how children develop, emotionally, physically, intellectually, socially. Beyond the purely physical sense, a building can also communicate to children a great many subtle messages about their life experiences. An example of architecture that communicates consistent humanistic messages to children is Crow Island School in Winnetka, Illinois. Now over sixty-five years old, Crow Island is a designated National Historic Landmark. Whilst briefing architects *Eero Saarinen* and *Larry Perkins* in 1938, Director of Activities at Crow Island, Francis Presler, proclaimed the school was to be:

4.6 Front entrance of Crow Island School, Winnetka, Illinois

> A place that permits the joy in small things of life and in democratic living . . . a place for use, good hard use, for it is to be successively the home, the abiding place for the procession of thousands of children through the years. . . . The school must be obvious to childish eyes as to its structure, its purpose, its use, its possibilities. Strength shall be evident. Genuineness shall be visible. Materials shall say "things are as they seem." . . . It must be inspiring, with a beauty that suggests action, not passiveness on children's part . . . It must be democratic. That above all is necessary. School must not create an illusion, otherwise children will fail in more mature life. The classrooms shall express inner tranquility that can be sustained. The atmosphere of these rooms, which particularly are the school homes, should give the feeling of security. These are especially the places of living together and should give feeling of inviting home-likeness.[1]

Crow Island consciously, and to a rare degree, has always offered an education catered specifically to the emotional and cognitive needs of the younger child where the building itself plays a vital role in that education. For the fiftieth anniversary of the school in 1990, four hundred Crow Island alumni completed a questionnaire that probed the effect of the building design on their early learning. The outside play areas are accessible directly from the classrooms. The close proximity of each classroom to the outside areas extends a sense of space and light. One

4.7 *Top* Outdoor lecture theatre, framed y the school building on three sides, Crow Island School
4.8 *Bottom* Exterior view of individual courtyards accessible from classrooms
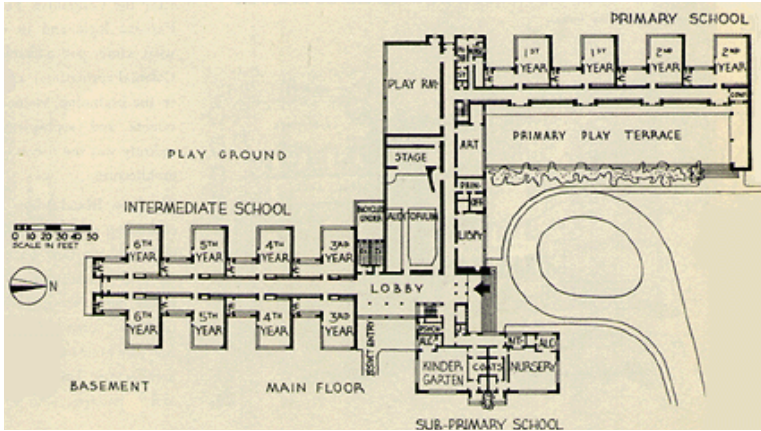
4.9 Original Plan, Crow Island School

4.10 Open meeting area

person remarked, "The windows to the courtyards and the wings gave the feeling of endless space."[2] Sixty Years after Crow Island School first opened its doors, it was discernible how it had sustained itself through the decades. It is still a successful representation of an environment for children that encourages an appropriate, nonverbal, symbolic and long lasting learning that an academic education alone cannot possibly accomplish.

The plan of the building is designed to bring an abundance of light and air into the classrooms. In every way possible—through lighting and ventilation as well as texture and colour, the architects provided for the welfare of the children who spend their hours of work and play in these rooms. Each of Crow Island's L-shaped "one-room school" modules contains large sections of glass to admit light into all the rooms and the hallways. Each also has its own small courtyard of flagstone, walks, and shrubs, contributing to a sense of spaciousness. Each classroom has a glass-paneled transom door opening onto a courtyard, linking outdoors and indoors. The low nine foot classroom ceilings are finished in acoustical plaster and the recessed lighting offers a calming variation to the typical fluorescent lighting used in classrooms elsewhere.

Following the philosophy that the school should fit the child, everything is scaled to children's needs, from the height of door handles


4.11 Custom furniture

4.12 Auditorium

4.13 Outdoor gathering space,
Crow Island School

and blackboards, to the size of benches under the windows. Also designed by Saarinen are the classroom chairs of bonded plywood (see figure 4.11) as well as the auditorium's plywood benches, which vary in size from front to back, with seating for the smallest children at the front and for adults at the back (see figure 4.12).

4.14 Current aerial view,
Crow Island School
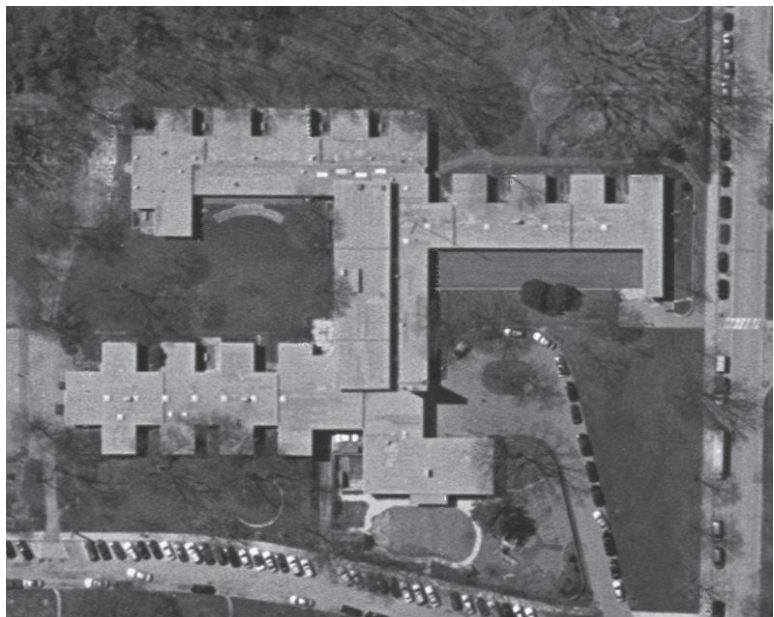
Tools for Culture Building

Proposing a set of design standards and qualities necessary of a building type is a concept explored by many. Most notably perhaps is architect and theoretician, Christopher Alexander. Alexander along with Sara Ishiwaka and Murray Silverstein, attempted to provide tools for culture building in a three volume work answering design problems. A Pattern Language was one of the first coherent attempts to link the observations of Environmental Psychology to Architecture.

A Pattern Language explores more than 250 patterns, each consisting of a problem statement, a discussion of the problem with an illustration, and a solution, in theory enabling a person to make a design for almost any kind of building (shown right). Although it has its limitations, A Pattern Language was successful in initiating a communication of architectural ideas to the average person. Alexander's intent was to develop a language that would allow anyone to articulate and communicate an infinite variety of designs within a formal system which gives them coherence.

Alexander's spaces for children such as "Child Caves," shown here, depict an architecture for children from an adult's point of view of remembering childhood and assigning physical guidelines to recreate exact experiences. Distinct from Alexander's prescriptive method, the following pages illustrate the qualitative and attitudinal guidelines for the design of a children's Play Therapy Transitional Centre. By evaluating the impact of the built environment on children, as well as allowing children to express their own needs and desires, we create the necessary communication between architecture and psychology, enabling us to stimulate the emotional and physical growth of the child.

203 CHILD CAVES

4.15 'A Pattern Language' example of 'Child Caves'

. . . the places specially devoted to children's play—ADVENTURE PLAYGROUND (73), CHILDREN'S HOME (86), CHILDREN'S REALM (137)—and THICK WALLS (197)—can be embellished with a special detail.

❖ ❖ ❖

Children love to be in tiny, cave-like places.

In the course of their play, young children seek out cave-like spaces to get into and under—old crates, under tables, in tents, etc. (For evidence see L. E. White, "The Outdoor Play of Children Living in Flats," *Living in Towns*, Leo Kuper, ed., London, 1953, pp. 235–64.)
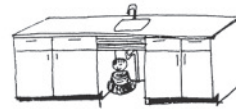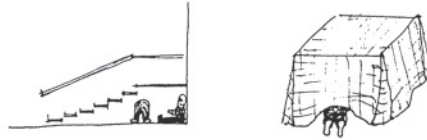

They try to make special places for themselves and for their friends—most of the world about them is "adult space" and they are trying to carve out a place that is kid size.

When children are playing in such a "cave"—each child takes up about 5 square feet; furthermore, children like to do this in groups, so the caves should be large enough to accommodate this: these sorts of groups range in size from three to five—so 15 to 25 square feet, plus about 15 square feet for games and circulation, gives a rough maximum size for caves.

Therefore:

Wherever children play, around the house, in the neighborhood, in schools, make small "caves" for them. Tuck these caves away in natural left over spaces, under stairs, under kitchen counters. Keep the ceiling heights low—2 feet 6 inches to 4 feet—and the entrance tiny.
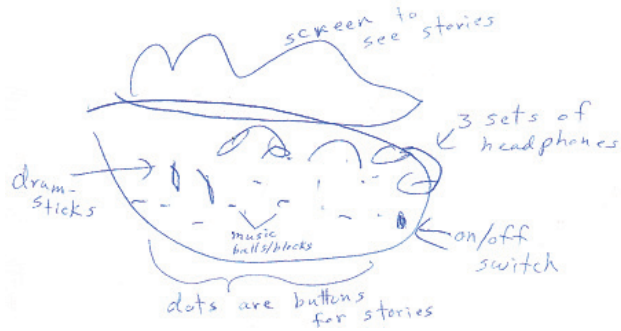

3 to 4 foot ceiling

❖ ❖ ❖
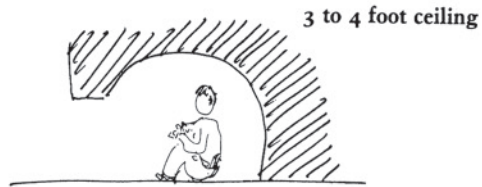
Build the caves right into the fabric of the walls—THICKENING THE OUTER WALLS (211). Make the doors very tiny to match the caves—an extreme version of LOW DOORWAY (224). . . .

Evaluating the Built Environment

We have accomplished little in the way of evaluating the impact of the built environment on children; even now two decades after psychologists like *John C. Baird* made statements declaring the need. Only in the last few decades has advocacy for the child become a worldwide priority. As recently as a hundred years ago children were not granted any protection at all. To this day their safety and welfare depends on others. Although it is not practical to believe that children will ever have a political voice, it is important that society be sensitive to the rights and needs of children, as well as aware of their ability to voice their own desires. We must bridge the gap between theoretical knowledge and applied practice within the fields of environmental psychology and developmental architecture under the common perception that physical environments exert powerful influences over the perceptual and social development of children. Crucial to this partnership is recognizing how children assess their own environments and identifying ways in which children can exert influence over these environments.

Listening to young children holds particular challenges for everyone. When designing a child's space, the more considered process of consultation with the users is less likely, given the constraints of limited

4.16 Sketch by five-year-old, Claire, showing design of future music room. University of Maryland project working with children to design 'The Classroom of the Future'
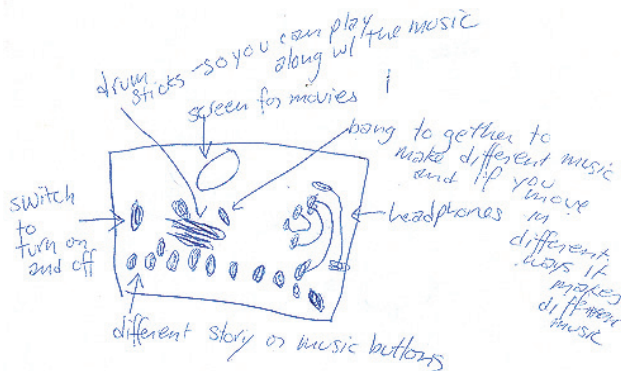

screen to see stories

3 sets of headphones

drum-sticks

music balls/blocks

on/off switch

dots are buttons for stories

4.17 *Left* Children working with prototype of a future classroom. University of Maryland, 'Kids Design the Future'

4.18 *Far Left* Child's concept of a new digital library. University of Maryland, 'Kids Design the Future'


4.19 Sketch by five-year-old, Samantha, showing design of future music room. University of Maryland project working with children to design 'The Classroom of the Future'

drum sticks - so you can play the music along w/ the music

screen for movies

bang together to make different music and if you move

switch to turn on and off

headphones

different ways it makes different music

different story on music buttons

budgets and health and safety standards as well as the obvious communication challenges that exist between adult and child. Dividing the design into manageable elements that can be explored in tandem by architect and child speaks to the sensitivity of the situation. Of particular importance within the design of child-centered environments are the details. These features enable a child to experience the space not only with comfort and ease, but also as a place of exploration, discovery and environmental awareness. Crucial to creating a child-centered environment is the concept of "voice" by allowing the child to act as a credible witness and expert in their own lives. The insights of children add an important dimension to the conventional adult view of what constitutes a place.

Students and teachers at New End School in Hampstead, London established a working relationship in 1988, to re-design the near century old school they had outgrown. Pupils were asked to draw and model spaces within the school building and suggest improvements. Each session was concluded with a discussion on the ideas generated (see figure 4.20).[3] Although each child's "Bubble Room" was quite fantastical, common elements noted include personal space and places for relaxation and socializing. Figures 4.16-4.19 and 4.21-4.22 are further examples of design exchanges with children.

Comprehending both a child's desires and needs within the built environment as well as appropriately evaluating the impact of the environment on children is not an easy feat. Professionals have conducted years of investigation, creating many theories and methods of observation, surveys and collaborative work, in an attempt to establish a mode of evaluation. For children, who have limited communication skills and even more limited physical resources with which to alter their physical surroundings, establishing a way to read their needs and desires is fundamental to creating enriched child-centered spaces; spaces meant to accelerate the development of perceptual, motor, and cognitive abilities. John Baird and Anthony Lutkus developed a schematic diagram to represent this continuum of evaluation necessary in designing a child-centered environment (see figure 4.23). Although
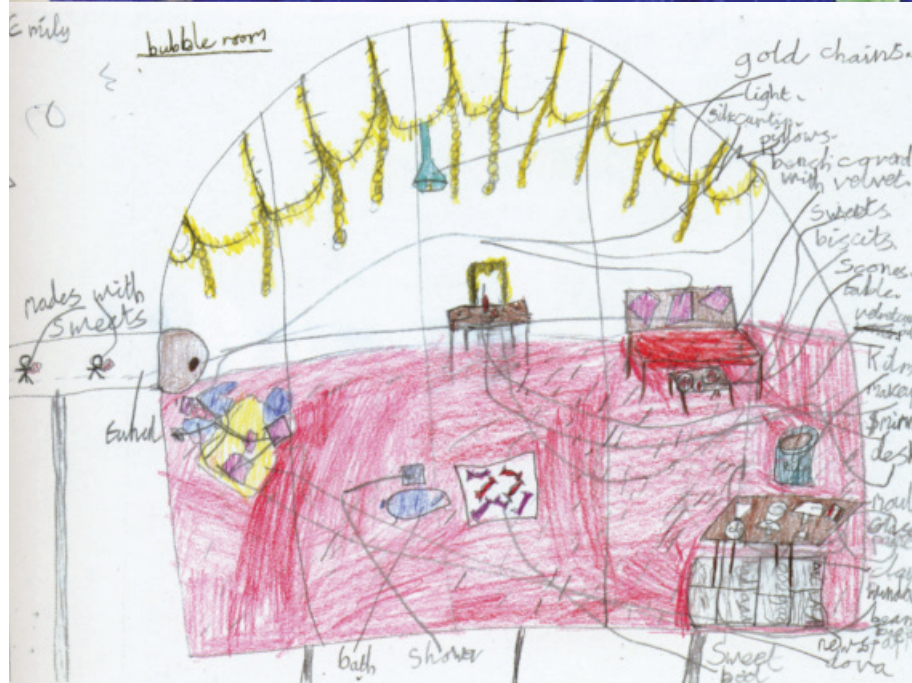
4.20 *Top* A small personal pod equipped with sofa, beanbag and cushions; supplied with a video game console and rack of board games; *bottom* Room concept for a new children-only space
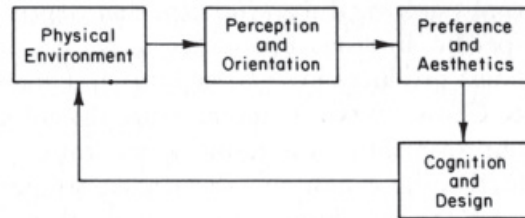
4.21 Brian, 9 years. Bedroom. Storyboard Toys

4.22 Breanna, 8 years. 'Reading in my Room'
Michigan State University Children's Art Gallery

4.23 Schematic diagram for Mind
Child Architecture overview

not quite scientific theory, their diagram effectively illustrates how built
structures (even when constructed by adults) reflect back onto the
physical environment, changing it accordingly, and thereby stimulate
new situations that initiate the cycle of perception, preference, and
design.[4]

Once we are aware of the effects of the physical environment on
children as well as their needs and desires, and are well versed in their
physical, emotional and cognitive development, we must re-calibrate the
fundamental qualities that will speak to the child appropriately at each
stage.

Dimensions in Learning Environments

In accordance with leading environmental psychologists, a framework of five dimensions is used to describe the ideal early childhood learning/play environment and is already a standard set of guidelines used in Sweden.[5]   This framework incorporates the following dimensions: hard/soft, open/closed, intrusion/seclusion, low mobility/high mobility and simple/complex/super.   Early childhood researchers often refer to these dimensions as a means of observing adults' and children's use of an environment for evaluation.   The table (see right) provides brief descriptions and examples and should be used not as a measure of its extremes but on a continuum, constantly assessing how each dimension assists or detracts from the program's philosophy and goals. All environments should have somewhat of a balance in each dimension, although at times, either end may be appropriate.

The following pages illustrate the author's vision of the spatial qualities of the proposed Play Therapy Transitional Centre.

4.24 *Opposite* Dimensions in Learning Environments

'Environmental Impact: What We Can Learn From Swedish Early Childhood Settings*,'* Blaska (1994)

Hard/Soft: Responsiveness and physical comfort of the environment

HARD	SOFT
Hard tables/chairs, tile floors, sinks and countertops, cement and tar, harsh lighting, unattractive colours	Cozy furniture, carpets/scatter rugs, grass and sand, curtains, plants and flowers, lamps/shades

Open/Closed: The degree to which materials, storage, programme, and adults restrict children.

OPEN	CLOSED
Toys, manipulatives, art supplies, stored on shelves open to children's choices	Materials stored in a closed manner teacher decides what children will do and which toys will be used

Intrusion/Seclusion: Who and what penetrates the child's boundaries

INTRUSION	SECLUSION
Activities that involve all of the children (e.g., free play activities in one large room)	Spaces for child to be alone (e.g., hiding places, boxes, draped table) Separate rooms

Low Mobility/High Mobility: Level of physical involvement and motion

LOW MOBILITY	HIGH MOBILITY
Sedentary activities (e.g. painting, water play)	Activities that require movement (e.g., outdoor play)

Simple/Complex/Super: Describes the ways that materials and equipment hold children's interest

SIMPLE	COMPLEX	SUPER
Have one obvious use (e.g., tricycles, puzzles, trucks)	Have two parts or materials that can be played with together (e.g., art materials, books, building blocks)	Have three or more materials (e.g., draw highway on playground surface with chalk, and road signs and tricycles)

Complex toys hold children's interest 4 times longer than simple toys; super toys hold children's interest 8 times longer than simple toys.

Play Therapy Transitional Centre

Having discussed the goals and principles of a therapeutic play environment for children previously, the following programme is organized here according to different purpose-specific zones.

SIZE

The site must be large enough to accommodate the building programme, with a 100 child maximum, in groups of 10-12, built in stages worked out from a master plan. The site should also accommodate several enclosed courts or gardens, vehicular and service access, and parking.

LOCATION AND IDENTITY

The site should be located in an established community (for catering facilities, doctors, cultural contacts, access, community interaction). The grounds should have open areas as well as more "private" areas, and should have varying degrees of shade (both with landscaping and artificial shading). The main building and connecting houses should have their primary accesses separate from each other. Insofar as possible, the site should have a clear, distinct, and non-institutional character which would foster easy recognition.

SECURITY AND ENCLOSURE

All outdoor areas of the site, excluding the entrance way, should be easily enclosed and secured and should be private from the outside community. Each "house" should have its own enclosed yard for safety and the houses and community buildings should be connected via pedestrian-only streets. The site areas as a whole should be developed so that security is effective, but discreet, and non-institutional in character.

Following these criteria, a site may be selected in any town or city. Examples below demonstrate three different sites, all meeting location requirements within Peel Region (Mississauga, ON).
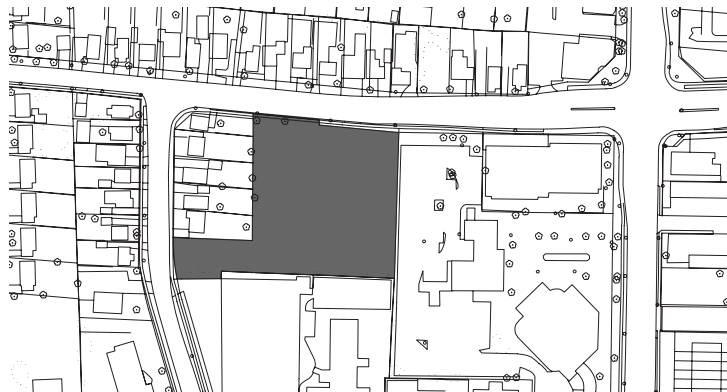
4.25 Residential/Naturalized
Landscape
(Author)
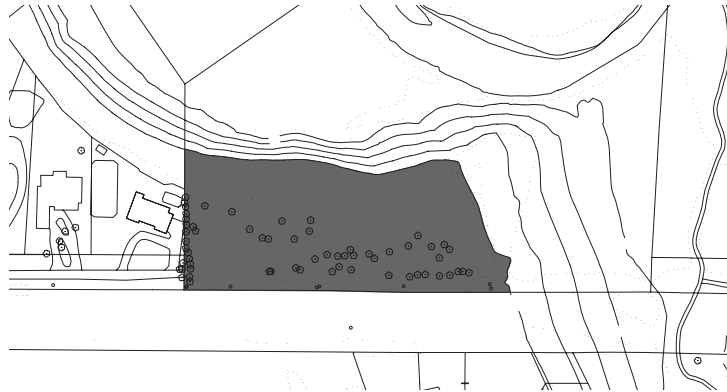
4.26 Residential/Institutional
(Author)
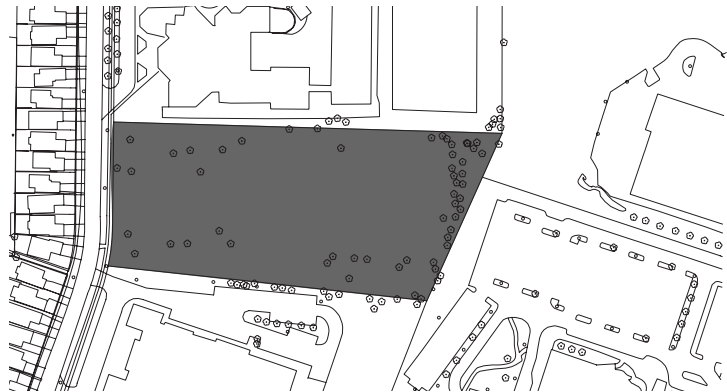
4.27 Residential/Commercial
(Author)

Programme

Site Requirements/ Outdoor Spaces

Play area connected to each 'house'

Each house's gardens should be tended by children, inhabitants

Outdoor water area

Grounds should have different zones for group play, quiet individual play, as
well as traditional play equipment and ample material for 'creative' building
(boards, planks, poles, etc.)

Use natural land formations/terrain for exploring; trees, rocks, grade variations
for running, climbing and sliding

Vary surfaces for play—asphalt, concrete, grass, sand, or synthetic resilient
matting beneath climbing/swinging equipment; avoid gravel

Provide varied outdoor lighting conditions; use shade structures

Provide storage space for all outdoor play equipment, if possible accessible
from both outside and inside the facility

Garbage and custodial area.

Play Therapy Centre

Create areas for distinct activities (individual sessions, group play therapy, quiet
reflection space, open space for active play, private hideaway spaces).
These areas are best created through the use of moveable furnishings,
shelves, bookcases and subtle architectural gestures.

Provide a soft area for visiting/relaxation/puppet play

Space should meet both children's and adults' physical needs with adequate
seating, tables, and storage to suit both.

Every part of the architecture should be thought of as potential display space:
walls, ceilings, floors, and furnishings, throughout the facility

Where possible, lower sills of windows to within 18 to 24 inches above floor to
conform to a child's scale

Take advantage of areas below windows for quiet seating nooks or play areas

Provide a play area specifically suited to wet or messy activities with sink -
accessible by both adults and children, sand trays, and water trays with
walls and floors able to withstand sand, water, clay and paint

Provide ample storage for toys that allows for categorization and discreet
organization so the variety of toys is not overwhelming to a child

Provide ample daylight, with good shade/blind control

Provide flexible lighting levels/types to accommodate various activities/moods

A range of textures friendly to a child's skin and body adds another aspect to
a child's experience with the physical environment: wood, stone, various
plaster surfaces, metal or wire screens, fabric, rubber, various metal
surfaces, safety mirrors and glass

Incorporate a child-accessible drinking fountain (incorporated with sink)

Provide a toilet room directly adjacent to the room with child-accessible fixtures

Provide areas/closets for storage of supplies, games, mats/blankets

Provide direct access to exterior space from each therapy room

Play therapy rooms should be soundproofed and where possible should have
    one-way mirrored glass for observation rooms.
Acoustically isolate observation rooms to allow for discussion
May be a space shared by therapy rooms
Entry/exit should be possible without view from observed area

Residential Neighbourhood
May be incorporated in main building or as distinct units
Zoning within houses to distinguish activity functions
Kitchen not too large, that it is cafeteria-like, pantry not too small that it is
    traditional family proportioned
Basement equipped with spacious storage rooms, for household seasonal
    storage and children's belongings
Bicycle garages
Mud room
Adequate laundry facilities for household essentials
Smaller 'rec' rooms in addition to main communal space, for individual and small
    group play of different ages
Design bedrooms to differ, to offer less institution-like feel and allow for
    individuality, and allowing children to form natural groups
Lots of built in storage
Safety precautions taken for windows, staircases, heating vents, doors
Additional in-house residential unit, consisting of single or double rooms, could
    be used for short term stays, or weekend visitors, or people attending a
    seminar, or also the parents of children in certain short-term circumstances

Support Spaces
Light-filled open lobby
Controlled Entry Reception Area
Sectioned Reception Waiting Areas (3)
Restaurant/Kitchen (supplying meals to staff, visitors, former "children," parents,
    people attending a seminar, etc.), as well as drinks and snacks
Bathrooms near outdoor play area

Administrative/Service Space:
Administrative Offices (4)
File Room
Central collective Laundromat
Custodian's apartment (one live-in accommodation)

Transitional Spaces
Viewed as extensions of activity space
Avoid long, straight hallways; provide nooks and alcoves for sitting, play, and
    display
Open corridor spaces with interior glass windows looking into adjacent therapy/
    activity spaces; take advantage of borrowed light
Avoid designing corridors so they have no other use but circulation
Use of varied colours and textures is desirable, as in the therapy rooms

In many cases, the functions described in association with the different departments of the programme may overlap. In other instances, functions from one department would benefit by being adjacent to others, but without overlap; others should remain quite discrete. Given the complexity of all of the possible interconnections and relationships, the principle of overlapping or integrating functions can be understood best by identifying major zones in the building programme, and then arranging the other departments in relation to them.

The first major zone is the **Play Therapy Centre**, which must remain somewhat discrete from the public areas to maintain a sense of privacy for the children and families. This zone includes Play Therapy rooms, observational rooms, group session rooms, interview rooms and private waiting areas. The Play Therapy classrooms should have direct access to exterior space. Functional relationships should also be established between this zone and the Residential Neighbourhood.

The second major zone is the **Residential Neighbourhood**. This zone could be entirely distinct from the main building or separated via different wings or floors. It is essential that this area remain discrete from the support spaces and be accessible through a secured reception area.

The last major zone is a cluster of different departments, the **Support Spaces** – Administration, Education and Research, and the Lobbies and Waiting Areas. Linked directly to this area are the Open Play Area, and Courtyard.

The following site plan proposes a building arrangement for a Play Therapy Transitional Centre. Incorporating courtyard clusters and division of buildings into wings to create a more intimate scale—popularized by Crow Island School in Winnetka, IL—has proven successful for countless early learning classrooms, providing direct connections to individual outdoor spaces. More recently, W. Ross Macdonald School for the Blind in Brantford, ON, also deploys the same strategy, with transitional spaces acting as rooms themselves.

■ Residential Neighbourhood   ■ Support Spaces   ■ Play Therapy Centre

4.28 Site Plan (Author)

The Playroom

By Ann Cattanach[6]

The door opens to reveal what seems at first glance to be an ordinary room equipped for play: all manner of familiar things; sand, water, art materials, crayons, pencils, dolls, cars. The toys representing the familiar alphabet of the child waiting for them to string together a word, a sentence, a story.

The room is prepared for a session. The child's personal box, a sturdy cardboard container holding the artwork, models and stories the child has created in previous sessions awaits them. The room, tidy in a casual way shows no evidence of other children having played there today and yet it is apparent that the room is well used. A space has been created for them.

There is something magical about the playroom. Large enough to provide a fair space, small enough to feel cosy and boundaried . . . it manages to be as big as you need it to be . . . It is tidy in an untidy way, allowing the child to be free while providing secure boundaries.

A single glance encompasses the room. There is an impression of order which reassures rather than bombards the senses . . . A carpeted area, covered in a rug, scattered with cushions indicates that it is acceptable to stop in this room, to rest, to be. Equally a tiled area suggests that is permissible to be messy, to create, to do. Separating the two areas is a bookcase, housing not only books, but a few games, jigsaws, and a variety of stationary. Interesting small boxes sit atop along with an inviting selection of pens, crayons and brushes.

Puppets, dolls and soft toys lie inert on a cot and bed, waiting for life to be breathed into them. A selection of five sided wooden boxes are stacked and look like an empty cupboard, or could they be a dolls house or a garage? A low table holds a container of dry sand, beneath are drawers which when opened reveal various small objects; people, animals, vehicles, furniture, stones, fir cones, acorns, etc. Another table shows evidence of being used for painting and what's this underneath? More sand, a great container of wet sand. A large cupboard holds the promise of more to come.

4.29 'The Comfy Area'
A small rag rug, with a few
cushions to soften the impact
of the hard floor. A child is
able to choose a book from
the selection of myths and
fairy tales and can sit in the
comfy area, to read or to
be read to. Play Therapist
Ann Cattanach suggests
this often happens before a
break, when children naturally
prepare themselves for the
separation.
Moreland Hills Elementary
School, Pepper Pike, Ohio,
USA

Play Therapy Centre

The Play Therapy Room's purpose is to provide a safe zone for children to undergo Play Therapy. Whether a child is in a transitional state of care, and is temporarily living in the residential neighbourhood; has a foster home placement; was recently adopted; or is participating in family therapy with his biological parents; the Play Therapy Centre provides an escape into the world of play and allows the child to reach back for what he lost or was never given, or for what was too distressing to comprehend.
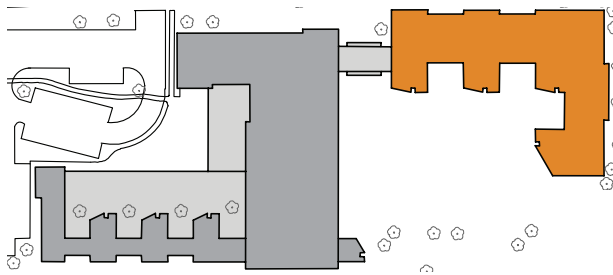

4.30 Play Therapy Zone
(Author)
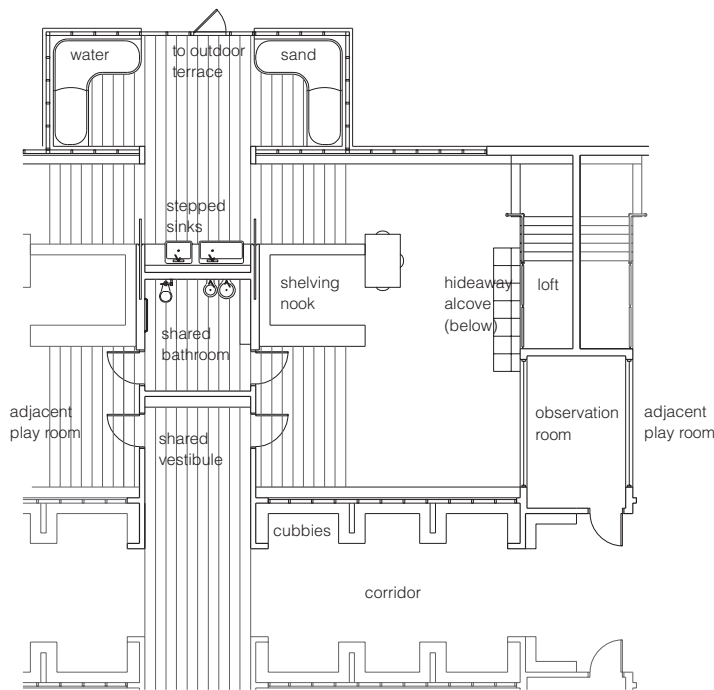
4.31 Typical Play Therapy Room
Large enough to move about in and small enough to feel safe. The walls are neutral and though children are free to put up their pictures while they are there, none remain after the session ends. Play Therapist Ann Cattanach explains this condition relieves pressure to compare, to be good enough or to be reminded of other children that attend.
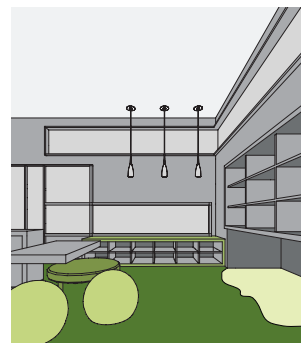(Author)

4.32 Play Therapy Room
View of therapist and child in
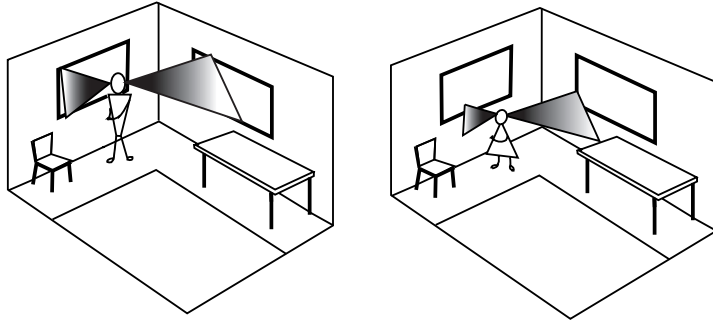session
(Author)
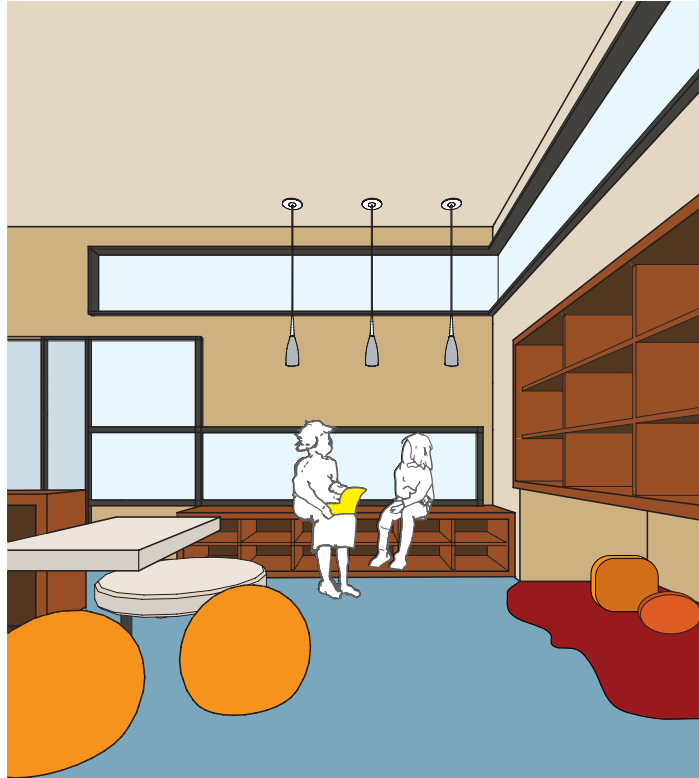
4.33 *Right* Highlighted features
illustrate a variety of play
material storage spaces for
access by child and therapist.
(Author)
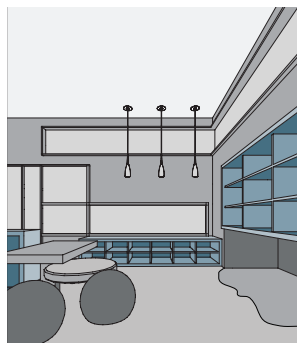
4.34 *Far right* Highlighted features
illustrate seating surfaces
from hard (dark) to soft (light).
(Author)

An adult's concept of a room is usually proportional to their body with respect to ceiling height, furniture, headroom, sightlines, window views. In an adult-centered room, a child's concept is usually cavernous, even if miniature furniture is incorporated (which then do not function for adults). Establishing a balance is important in order to make both adult and child feel welcome, thereby translating the feelings of receiving, trust and belonging as well as giving the designer the opportunity to establish delight. Windows serve as more than openings to allow natural light into a room; they provide views. When considering placement of windows it is important to consider the scale of both children and adults. A standing child has a different line of sight than does an adult; in addition to the varying sightlines when a child is laying down or sitting, whether in a chair or on the floor.

4.36 *Far left* Upper and lower glazed panels in the doors allow the young to see through as well as the adults. Jigsaw Day Nursery, London, UK

4.37 *Left* This area of the playroom provides contrast to intimate low ceiling spaces, and allows plenty of light and space, while the corrugated aluminum creates texture and the floor provides colour. Windows are placed low to the ground for a child's gaze. De Kleine Kikker Day Care Centre, Utrecht, Holland

4.38 Windows consider the scale of both the small child and adult to provide both ambient natural light, as well as vistas to the outside. Hoyle Early Years Centre, UK
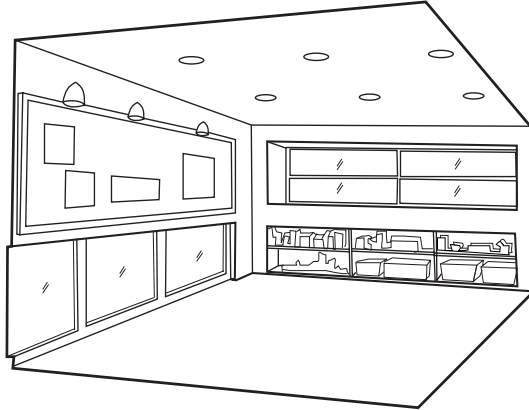
4.39 Glazing
(Author)

Windows can add natural light and or ventilation without providing a clear view into the room from the exterior or of the exterior from the play room depending on the room's needs. For instance, a blackboard area could benefit from a line of windows at the floor level but clear glazing might distract children from the instructor's lesson. Or within a therapy room, natural light is important but security may be an issue if the room faces a public place at grade. Clerestory windows or slits of glazing may be useful to allow natural light or views out, without providing access to sessions inside. Shade control is of utmost importance, with ability to close out light completely.

4.40 Glazing

This little boy is concentrating on expressing himself with paint with the total absorption characteristic of children. Aided by the light from outside, this interior is sympathetic to creativity.

4.41 Different activities are possible in an open, yet connected play space.
Jigsaw Day Nursery, London, UK

A variety of artificial lighting is necessary for any play therapy room, given the variety of activities held within. Bright ambient lighting should fill the room with a base lighting level, replicating daylight throughout the main area of the play room. This can vary from direct recessed lighting to indirect diffused lighting.

Task lighting is important over areas needing directional lighting to illuminate a specific task, as in table work or painting, as well as in tucked away areas that the overhead ambient light does not fully illuminate. Task lighting can also add to the general illumination of the room and has the potential to improve the dynamics of a space, create divisions within it and link items of furniture into groups.

If possible, accent lighting can break up the evenness of general lighting in the form of spotlights, table lamps with opaque shades to channel light downwards, picture lights and up-lights to wash walls in light.

All lighting should have individual controls as well as dimmers to change the light levels to suit the session's activity.

4.42 Lighting example - Family Life Center, Children's Memorial Medical Center, Chicago, Illinois, USA

4.43 Lighting
(Author)

Direct Recessed
Ambient Lighting

Indirect Diffused
Ambient Lighting

Task Lighting
over Workspace

Task
Lighting

Accent
Lighting

Secluded
Space

Soft Surface

Hard Surface
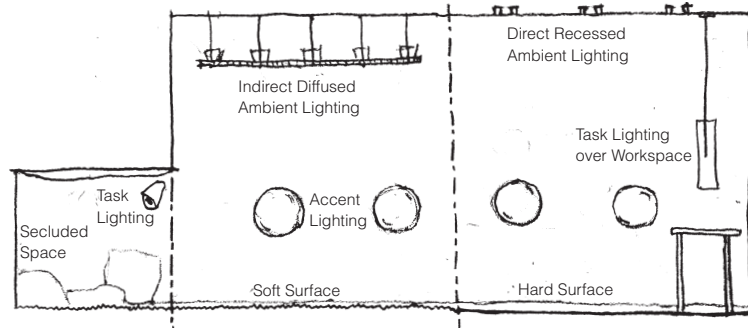
4.44 Lighting

Children desiring alone
time have varying levels of
seclusion in this stacked
structure. What is missing
in this image is both task
and accent lighting to subtly
illuminate spaces if the child
so chooses.
Swiss School Kindergarten,
Barcelona, Spain

4.45 Varied surface levels, as shown in this example from Mark Dudek's early childhood observational study[1]
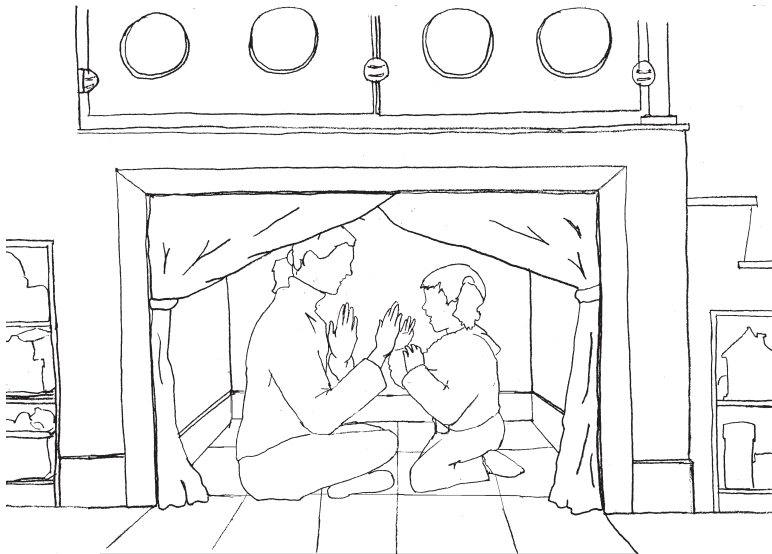
4.46 Therapist and child engaged in sensorimotor play in the seclusion of a hideaway alcove. Shelving on either side of alcove is at a child's level, as are circular portholes at loft level. Floor surfaces change from hard to soft when transitioning from activity space of play therapy room to private alcove. (Author)

All aspects of a child-centered environment should be designed to the same level of detail, including service spaces such as washrooms. It is important to provide direct access to toilets from each Play Therapy room so as not to interrupt the flow of the session by having to leave the safety of the play space to walk down a corridor where contact with other people is possible. Establishing a healthy sense of personal hygiene without the pressures of line ups or having to make washroom trips with buddies is possible by using child-accessible fixtures in a friendly and functional toilet room directly adjacent to the play room as shown in the example below.

4.47 Child-accessible individual washrooms
Ballifield Community Primary School, Sheffield, UK

Support Spaces

Lobby and waiting spaces should be friendly and welcoming without being forced and should avoid the gathered waiting spaces typical of doctor's waiting rooms. Separate waiting rooms beyond the lobby will provide the sense of privacy necessary of a Play Therapy centre, which can be accomplished with alcove seating areas or entirely separate rooms. Soft indirect lighting with soft surfaces in private waiting areas will assist in transitioning children and families from their lives outside, to the therapy space. See examples below.

Clockwise from top left **4.48** Bentley College, Lobby; **4.49** Reception area, New York University Child Study Center; **4.50** Waiting area, NYU Child Study Center; **4.51** Waiting area, NYU Child Study Center.
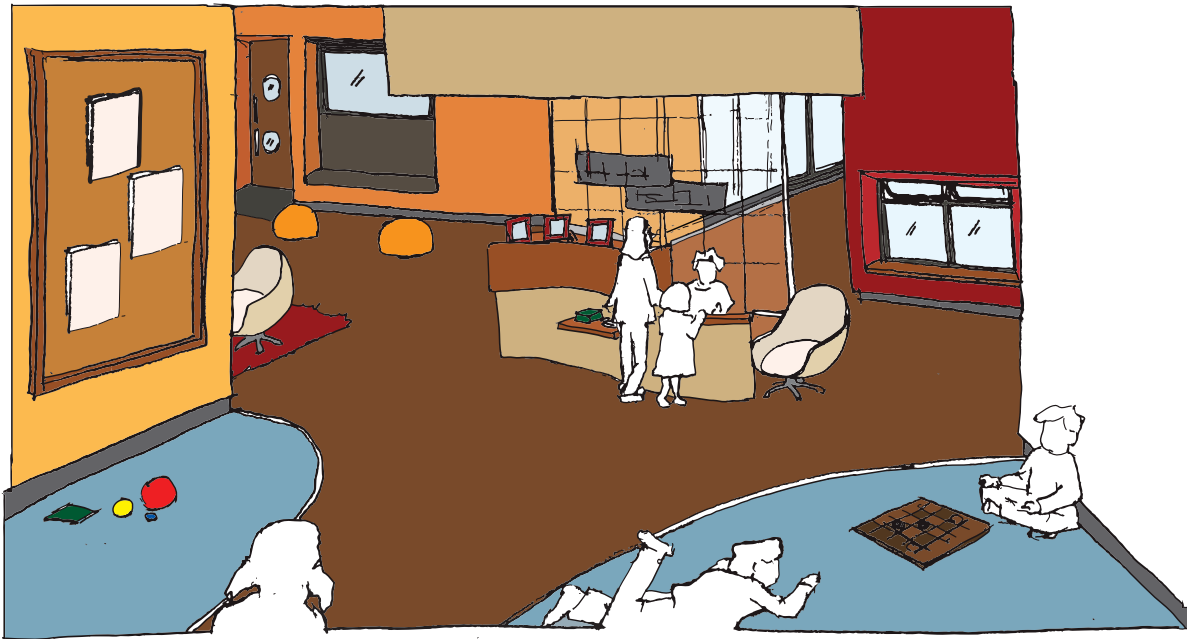
4.52 The experience of entering the building through the main lobby space into a waiting area from a child's perspective. Polished concrete, hardwood and rubber, paint and glass; the juxtaposition of surface materials and textures translate a sense of scale for the child as well as clarify wayfinding. Soft, indirect and natural lighting, varying ceiling heights and division of zones ease the child into a realm of familiarity by enhancing the feeling of receiving, permanence, security and trust; it is a space where the child feels he or she belongs. (Author)

Corridors and other transitional spaces should be viewed as extensions of activity space, complete with nooks and alcoves for sitting, play, small gatherings, and display, not only for circulation. Interior glass windows looking into adjacent therapy/ activity spaces open corridor spaces by taking advantage of borrowed light. Varied colours and textures are desirable, as in the play therapy rooms. Children are made to feel safe and welcome when in spaces that are not intimidating or overwhelming, as long corridors with high ceilings and rows of doors often are. This can be achieved with varying floor materials, ceiling heights, lighting and wall textures.

4.53 Corridor, W. Ross Macdonald School for the Blind, Brantford, Ontario. Large dark porcelain tiles laid in a brick pattern constitute most of the flooring in the classroom corridors, but critical junctures are differentiated by blonde maple hardwood flooring, which not only contrasts with the tile in colour but in tonal quality underfoot.

4.54 *Top* Santa Monica College Library

4.55 *Bottom* Corridor, Harold G. Fearn Elementary School

4.56 *Right* Corridor, Harold G. Fearn Elementary School. Light-filled wide corridors with benches and cubbies to call their own, encourage children to find a spot, stop and socialize. This is a space where the child feels he or she belongs, and is secure.


Privacy and security are a major concern in child welfare facilities and often appear overly authoritative to children (and adults). One way to overcome this is to create oversized thresholds between zones and rooms within them using bridges and screens, while maintaining visual connections to spaces above and below (see figure 4.54).

Residential Neighbourhood

The Residential Neighbourhood may be incorporated in the main building or as distinct units, depending on site size and location. These "houses" are for children in transition within the child welfare system, such as Children's Aid. Meant for children in highly indeterminate situations, who may stay the night, a few days or a few weeks. Both an apartment-like zone within the main building, as well as a separate neighbourhood of houses is proposed. All houses should have direct access to outdoor garden play space, whether at grade, on a terrace or a rooftop.

Kitchens are to be proportioned to house size (typically five to ten children); not too large that they are cafeteria-like, with a pantry large enough to accommodate the number of residents. Bedrooms should differ from one another to offer less institution-like feel and allow for individuality, as well as follow the same design criteria of the play therapy rooms in terms of lighting, materials and finishes. Houses should have smaller rec rooms in addition to a main communal space, for individual and small group play of different ages.
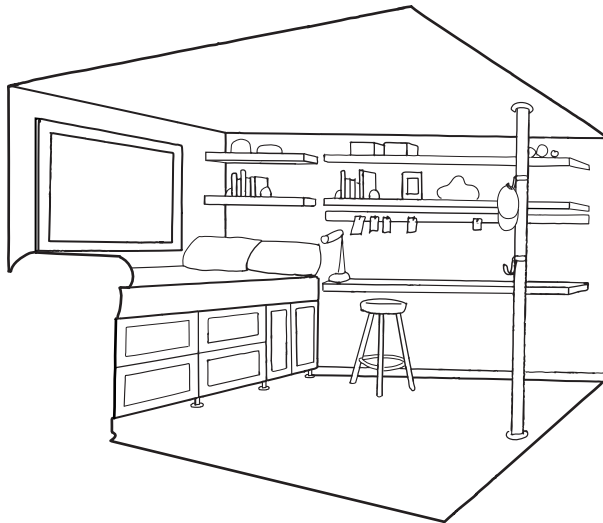
4.57 Main communal space University of Washington, Nordheim Court student housing, Seattle, Washington, USA

4.58 *Left* Child's bedroom Raising bed over storage unit is efficient use of space, as well as fun. Open shelving provides space to personalize the room during the child's stay. (Author)

4.59-4.63 *Opposite* Kids' Studioworks, California, USA *Clockwise from Top Left* Modular desk/shelf unit adjusts as child grows; Adjustable desk, wall unit; Shelving unit; Trundle bed with wheels; Credenza and trundle bed.

The Residential Neighbourhood should have individual access to the outdoors, with terraces or stoops acting as semi-private threshold spaces between the pedestrian only "streets" and the private residences. Varied cladding materials, shading, and landscaping offers added textures and layers to the transition between interior and exterior and creates a village atmosphere rather than an institutional presence. Below is an example of an urban arrangement of residential units, with family friendly entrances.

4.64 *Opposite* Transitional space between Public zones and Residential Neighbourhood. Natural materials with bright accents, artwork, flowers and books contribute to the welcoming 'home-like' atmosphere as well as mirror the qualities of acceptance and confidence for children in residence.
Harvard University Center for the Study of World Religions, Massachusetts, USA

4.65 *Right* Stoops at street edge University of Washington, Nordheim Court student housing, Seattle, Washington, USA

Outdoor Spaces

The site's façade and entrance should have a clear, distinct, and non-institutional character which would foster recognition. The entrance way should be easily enclosed and secured and should be private from the outside community. The residential neighbourhood as well as the play therapy rooms should all exit out into an enclosed garden with pedestrian-only "streets." Alternative thresholds should be considered when buffering public and private realms.

4.66 Library entrance across pond, Evangelical School in Gelsenkirchen, Germany. A 'moat' is bridged marking the entrance to the library (as well as an alternate exit), limiting access to one set of doors while creating a sense of fantasy for young patrons.

4.67 Massey Centre for Women. Residential-Infill and Daycare Centre, Toronto, Ontario Level changes, hard and soft landscaping and fencing all assist in enclosing this private courtyard.

4.68 *Right* Rooftop garden at St. Louis Children's Hospital, St. Louis, Missouri, USA. Design is alive with colour, sound and texture, inviting visitors to use all their senses

4.69 *Bottom Right* St. Louis Children's Hospital, St. Louis, Missouri 'Moon Windows' provide intimate seating with views of the city while protecting the plaza gathering space

4.70 *Bottom Left* St. Louis Children's Hospital, St. Louis, Missouri Garden view

4.71 *Below* St. Louis Children's Hospital, St. Louis, Missouri Garden swing and pergola

4.72 *Opposite* Classroom building, Montessori School, Ingolstadt, Germany. Green roofs, exterior first and second storey corridors and both hard and soft landscaping transform the outdoors into exterior rooms.

Individual buildings are grouped around a central green area, linking the 'inside' of the site with the 'outside' of the bordering green area. The 'green' classrooms and common rooms have wooden decks which are further protected by hedges and high shrubs, allowing classes to be held outside if weather permits.

4.73 *Top Right* Atrium, Waldorf School, Cologne, Germany The glass roof is supported by tree-like columns, affording skylight and sunlight and serving as the main ventilation shaft using the 'stack effect.'

4.74 *Bottom Right* Central Court, Evangelical School, Gelsenkirchen-Bismarck, Germany Designed as a village, the complex ends in this court used by both students and the local community.
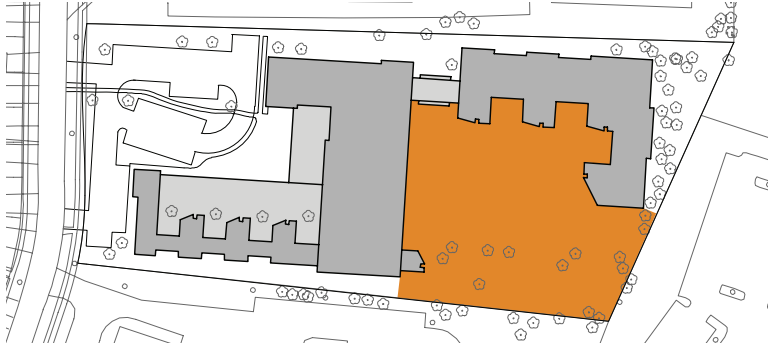
Providing exterior elements within the public spaces, such as natural landscaping and water elements, allow for use year-round and are an option for courtyard spaces adjacent to play rooms when site space, climate or location limit exterior placement.
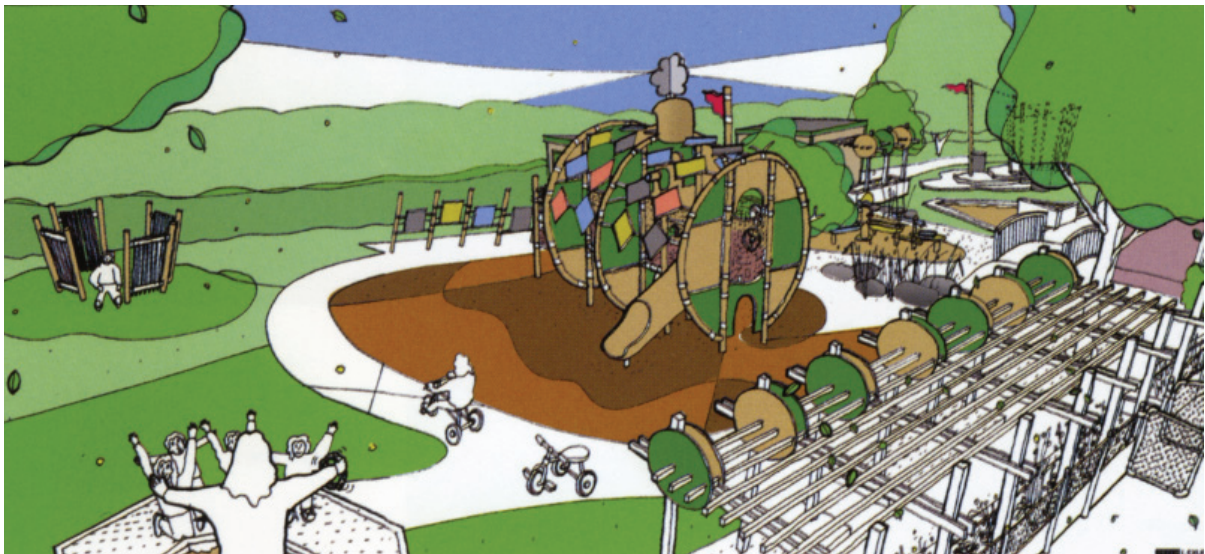
4.75 Outdoor learning environment
(Author)

4.76 Outdoor learning environment. Winnetka Public School Nursery, Winnetka, Illinois, USA

Different zones of enclosed exterior space should accommodate areas for group play, quiet individual play, as well as traditional play equipment and ample material for "creative" building. Landscaping should incorporate natural land formations/terrain for exploring; trees, rocks, grade variations for running, climbing and sliding. Use of varied surfaces is beneficial—asphalt, concrete, grass, sand, or synthetic resilient matting beneath climbing/ swinging equipment. Lighting and shading allows for safe play in most weather conditions at various times of the day. Adjacent to each play room, the wet/sand area can be extended outdoors for use during warmer months (see figure 4.88).
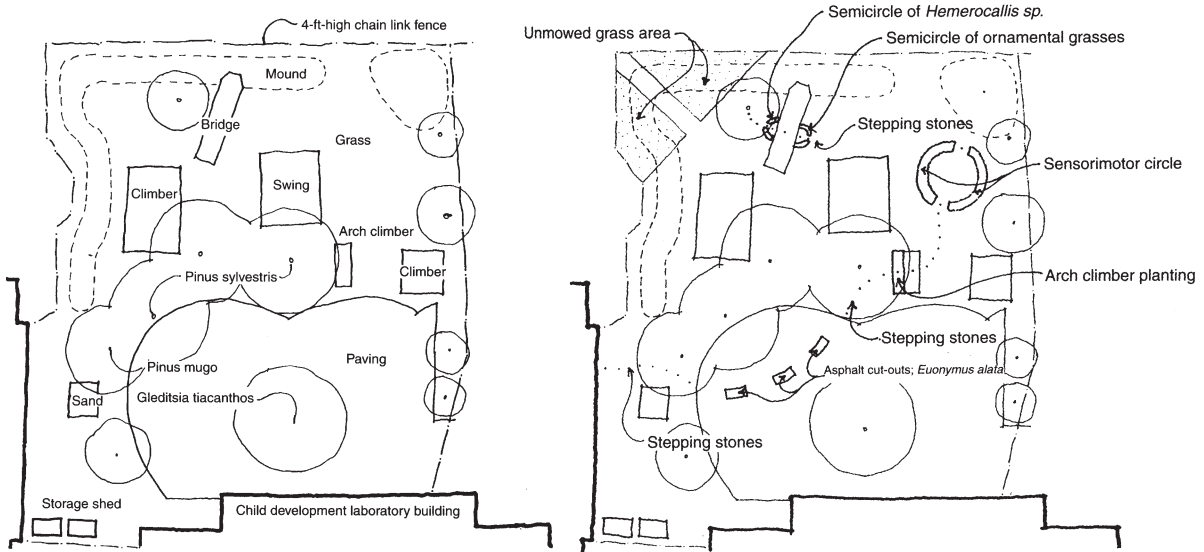
Clockwise from top right

4.77 Outdoor easels for art-making and letter writing

4.78 Emotionally secure environment where children progress at their own pace

4.79 Platform is both a stage and music-making station

4.80 Elevated play area for reflection or small group play

Labels on left diagram (before): 4-ft-high chain link fence, Mound, Bridge, Grass, Climber, Swing, Arch climber, Climber, Pinus sylvestris, Pinus mugo, Paving, Sand, Gleditsia tiacanthos, Storage shed, Child development laboratory building

Labels on right diagram (after): Unmowed grass area, Semicircle of *Hemerocallis sp.*, Semicircle of ornamental grasses, Stepping stones, Sensorimotor circle, Arch climber planting, Stepping stones, Asphalt cut-outs; *Euonymus alata*, Stepping stones

4.81 Iowa State University's Yard to the Garden intervention project *before* and *after*. The research project involved the placement of temporary and permanent landscape elements in the existing play yards to assess the effects that the interventions had on the use of the existing play structures. The results suggested that when simple landscape elements were introduced into the yards, different types of development were encouraged, providing insight into how designers and people who work with children can fine-tune the design of existing outdoor play spaces to match the specific developmental goals of their programmes.

Iowa State University's Yard to the Garden intervention project involved child development specialists who collaborated with the architect to design landscape situations that would fulfill specific developmental milestones of children (as described in the first chapter of this thesis, Needs of the Child).[7] Simple landscape elements were introduced into these yards creating play opportunities spanning the spectrum of learning dimensions (see figure 4.24).
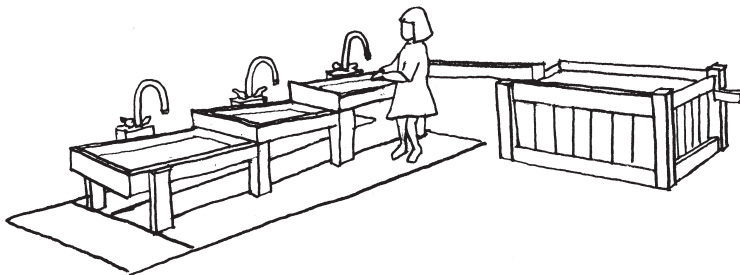
4.82 *Left* Stepped water feature for use by children of varying stages of development (Author)

4.83 - 4.88 *Opposite, clockwise from top left* Children engaged in outdoor play

4.89 *Opposite* Water and sand structure, Winnetka Public School Nursery, Winnetka, Illinois, USA

This portrayal of the practical and aesthetic concerns of what makes a Play Therapy Centre, along with a continued discourse with the needs of the child, will assist in establishing much needed stability for children in care. This dialogue is especially critical to integrating the scale, dynamics and intimacy of Play Therapy into the architectural strategy when designing for the maltreated child. By giving a voice to children in the evaluation and creation of child-centered spaces we are able to stimulate their emotional and physical growth within an environment of familiarity and permanence. A place that invokes mirroring, receiving, permanence, security, privacy, trust, belonging and delight, this is a centre that encourages healing of the childhood trauma by initiating communication through play and engaging the senses.

Conclusion

For thousands of years the patriarchal relationship between adult and child was one of employer or controller and raising children was instead considered the matriarchal role. Also a feminine concept is that of relatedness, as in child to therapist, child to environment. In contrast, the architectural, construction and political worlds have traditionally been patriarchal. Due to the clear division between these masculine and feminine realms, the concept of relatedness was not at the top of architecture's agenda.

During the mid 20th century there was a shift to a child-centered focus. The newly discovered awareness of the long-term physical and emotional effects of child maltreatment generated interest in establishing what the needs of the child are, how to meet those needs, and how to help heal childhood trauma, with notable advancements by psychoanalysts such as Anna Freud and Donald W. Winnicott. Doctors including C. Henry Kempe recognized the need for child protection with the identification of the battered-child syndrome, soon helping to establish one of the first child protection teams in North America.

Early childhood education philosophies flourished with the theories of Montessori, Erikson, Piaget and Skinner, broadening our understanding of healthy child development and initiating a discourse on an appropriate environment to engage young minds. By evaluating

the impact of the built world on young children and continuing a communication between the realms of architecture and psychology, we are able to stimulate their emotional and physical development. This interdisciplinary dialogue draws to light the one universal aspect of architecture is its capacity to take care of our basic needs for shelter and security, in a sense to mother us. Therefore we must gauge a balance between the patriarchal and matriarchal perspectives when designing for children in order to adequately meet their developmental needs.

Children within the child welfare system are in a state of transience with a great need for a grounding point to take in their anxieties, hold them, and give them back in a more manageable form at an appropriate time; an environment that allows the child to express himself unconditionally without fear of rejection, in order for him to establish a sense of permanence. This thesis attempts to redefine and re-calibrate the planning of child-centered architecture for children in care by allowing the dynamics, scale and intimacy of Play Therapy to infiltrate the architectural strategy, which is especially critical to the maltreated child. Making the Child's World proposes the qualitative and attitudinal guidelines necessary of spaces for children overcoming tremendous emotional and physical trauma, who seek a place that is safe, reassuring and stimulating.

A Play Therapy Transitional Centre provides much needed stability in the care continuum, which involves myriad family and child protection services of ongoing therapy, child care and supervision. As an adjunct to the current foster home model, this centre acts as a central location, where children may sleep, eat, play and interact with service providers and family or may be a place to return to at various stages of a child's permanency plan. A centre of this nature aims to initiate communication through play, allowing the maltreated child to work through emotional uncertainties and experience childhood.

If there is one piece of knowledge that architects might learn from a child-centered view of the world, it is that we all share the need for architecture to mother us, to provide for us our basic needs and to mirror our potential.

Appendix

Anthropometric Measurements of Children

In *Design Standards for Children's Environments*, Linda Cain Ruth provides charts with guidelines from which to design. The data is based largely on studies of children from the United States and the United Kingdom. The date for boys and girls was combined for all measurements except height and weight, which are shown for boys and girls, separately and together. When available, the 5th, 50th, and 95th percentiles are presented and noted on each chart.

Height (Including Infant Length)—Boys and Girls
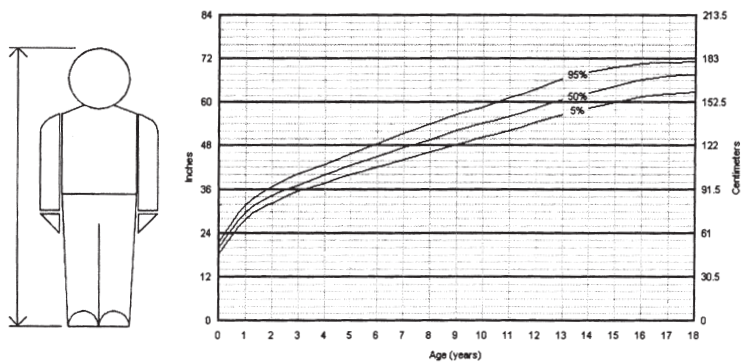
Height (Including Infant Length)—Boys
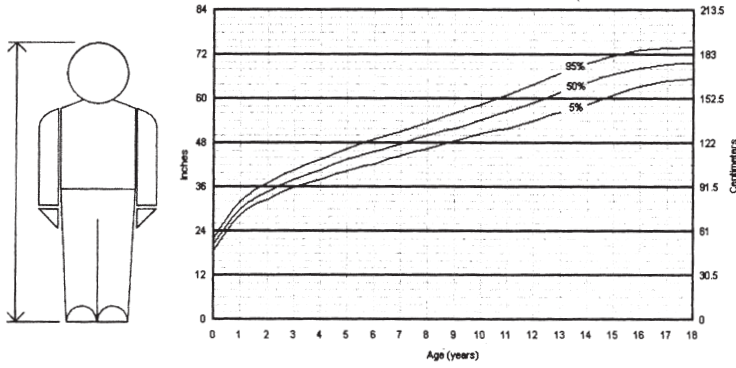
Height (Including Infant Length)—Girls
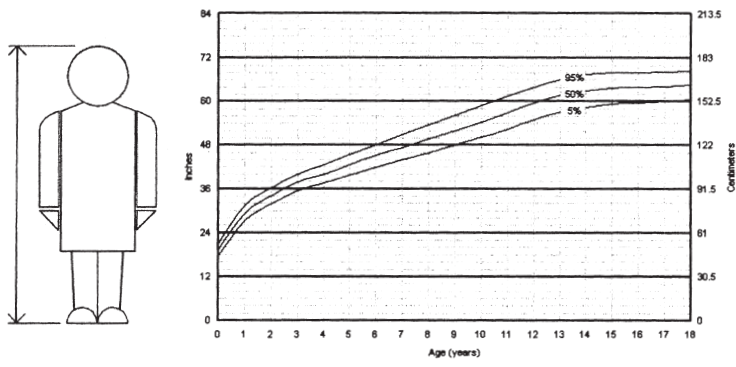
Weight—Boys and Girls
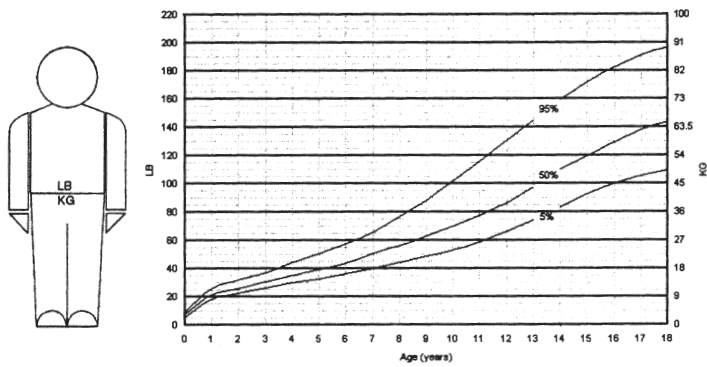
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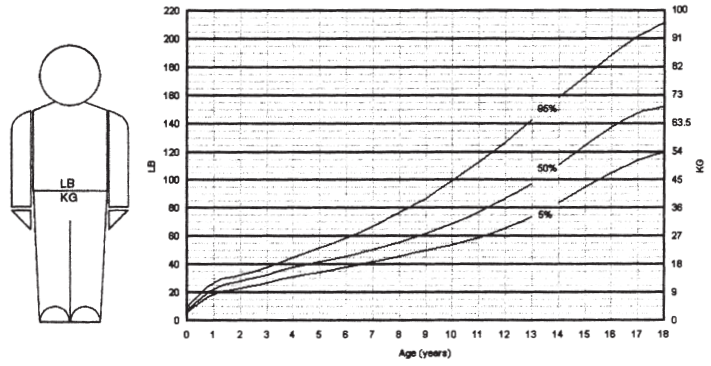
Weight—Girls
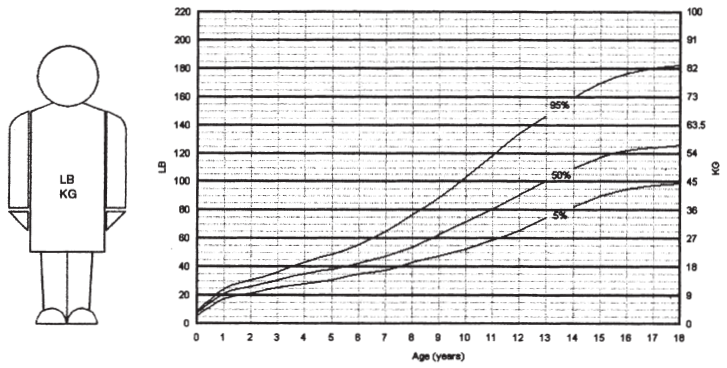
Standing Eye Level
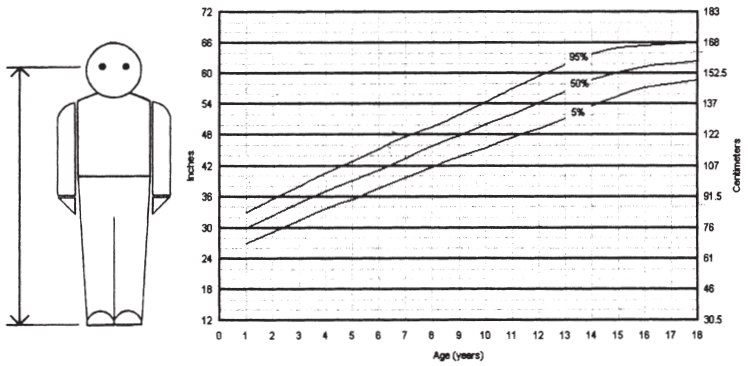
Shoulder Width
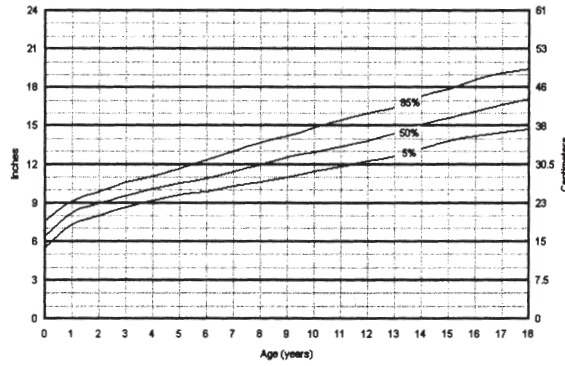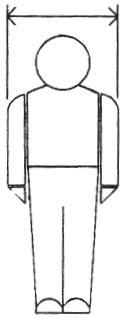
Crotch Height
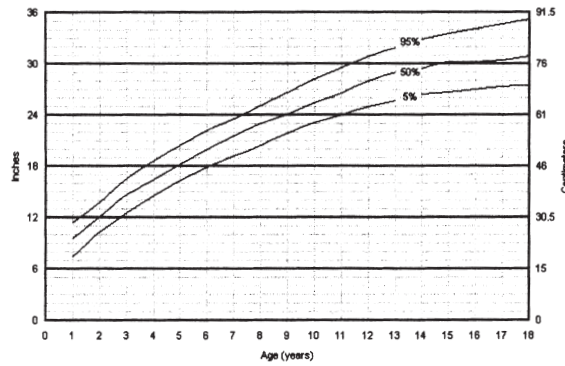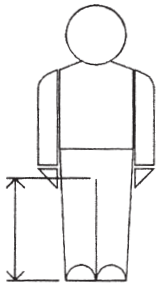
Standing Center of Gravity
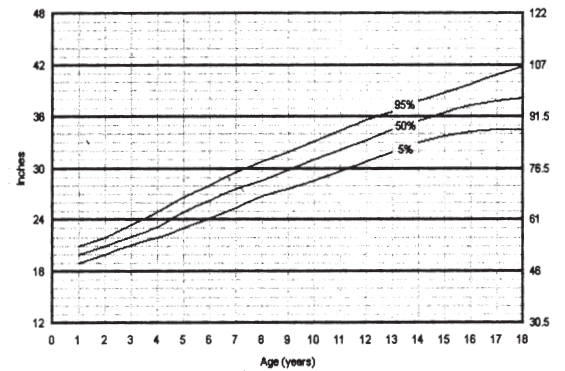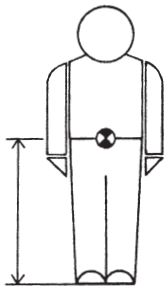
Vertical Reach to Grip
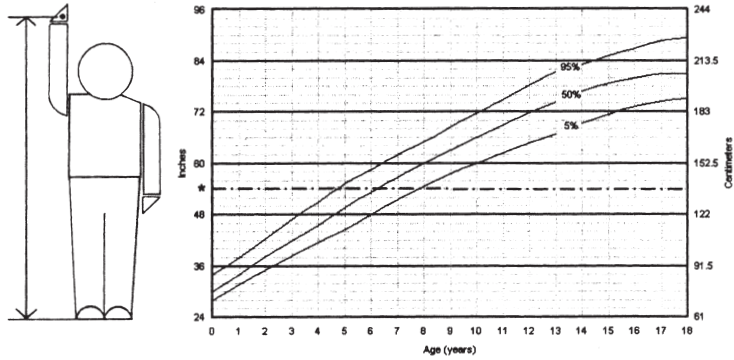
* This is the maximum height at which elements may be mounted and still meet ADA accessibility standards for adults.

Accessible High and Low Reach to Grip—Forward and Side
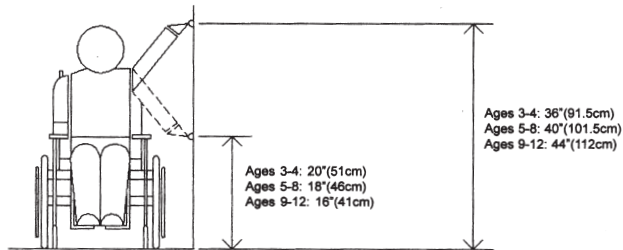
The entire range of 16 to 44 inches (41 to 91.5 cm) is considered accessible. The age divisions are additional suggestions included in the Americans with Disabilities Act Accessibility Guidelines' (ADAAG's) *Building Elements Designed for Children's Use.*

Span
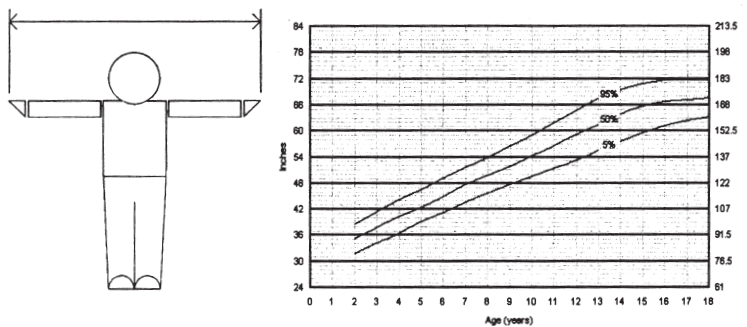
Seated Height
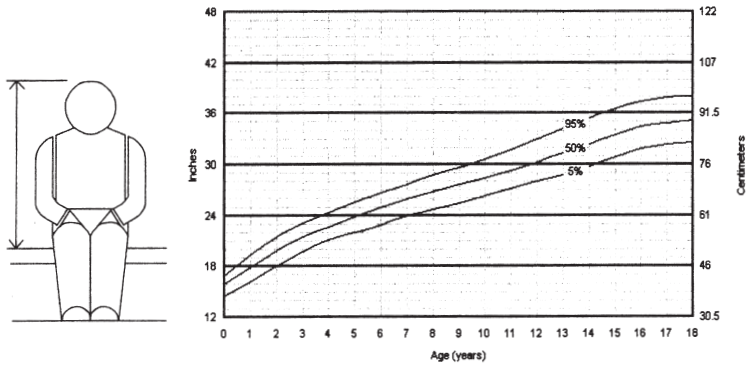
Seated Eye Level
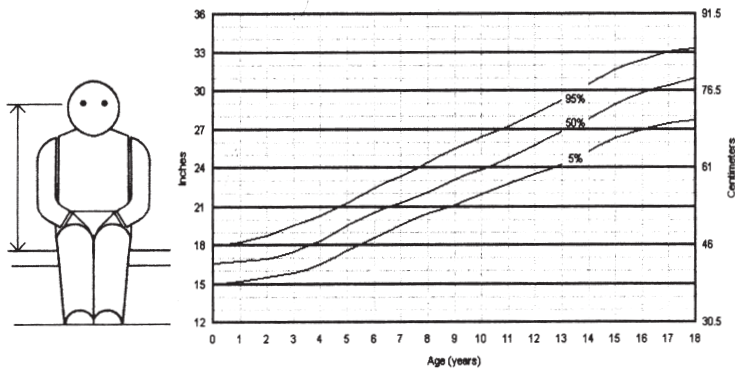
Seated Back-to-Knee Length
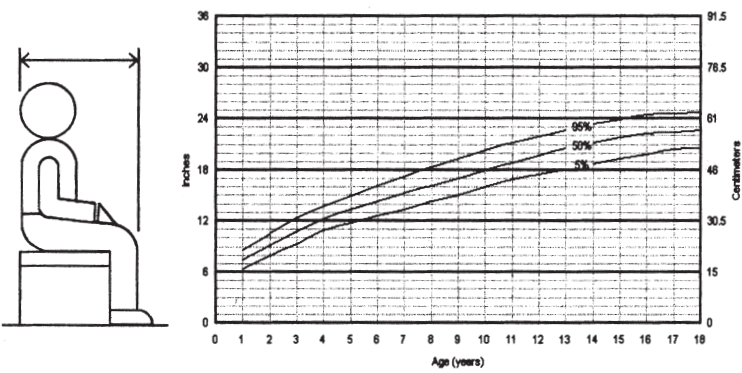
Seated Back-to-Sole Length
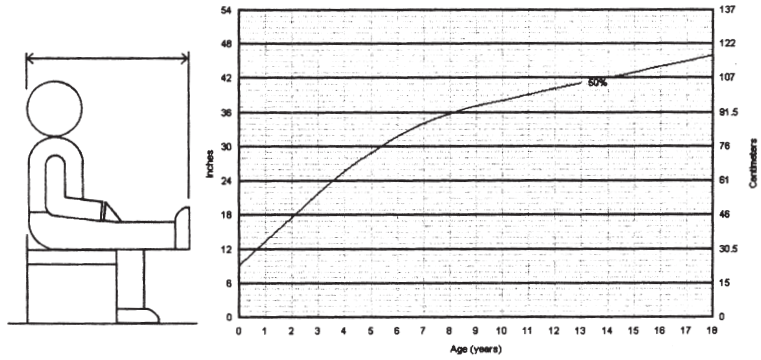
Seated Knee Height
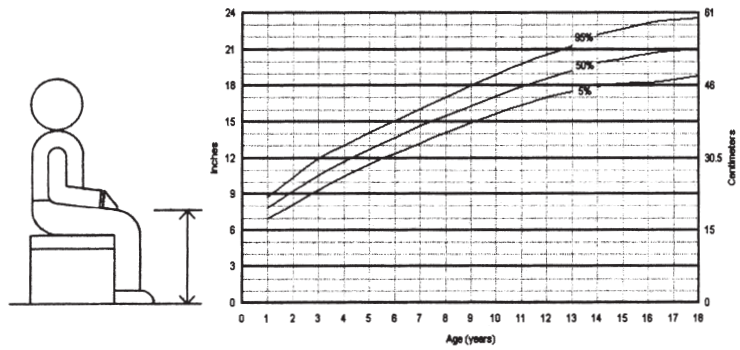
Head Width
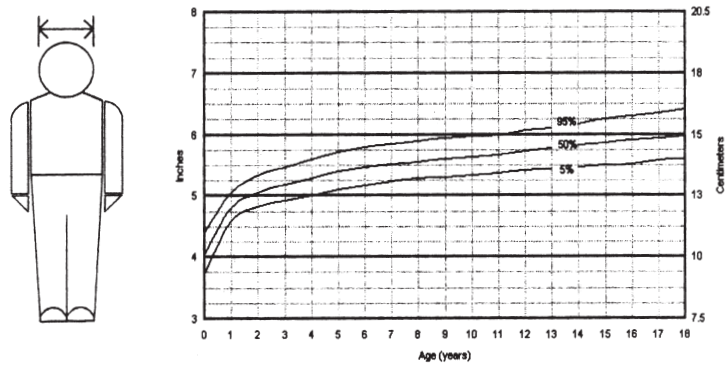
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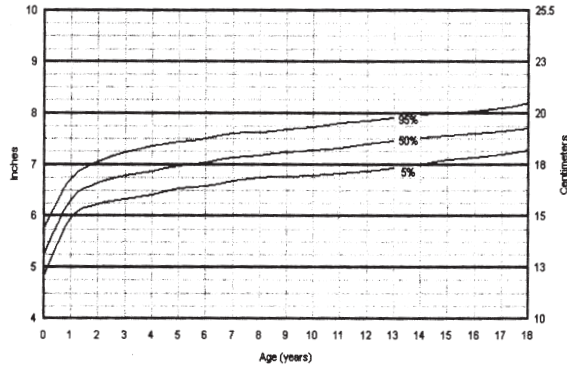
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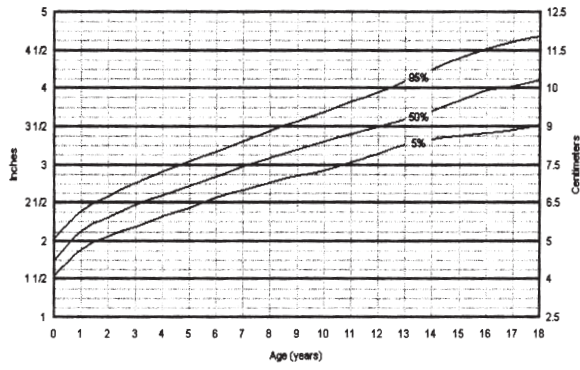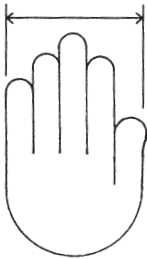
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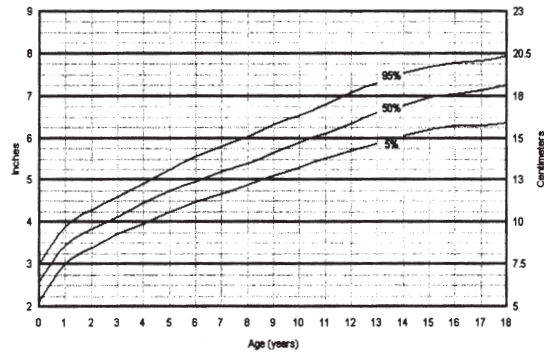
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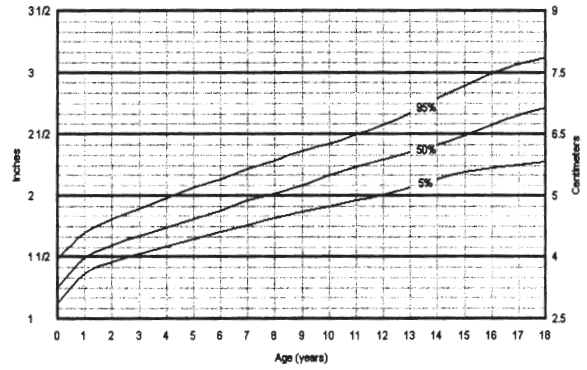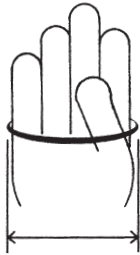
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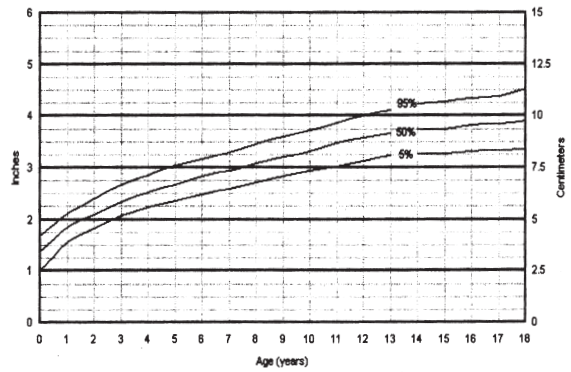
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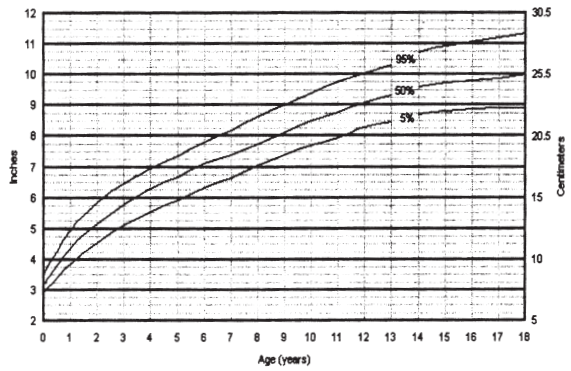
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Glossary

Abreaction

The release of emotional tension achieved through recalling a repressed traumatic experience. This release may take the form of acting out the situation causing the conflict, with words, behaviour, or the imagination. Dr. Charles Schaefer describes the process of abreaction with children when they are able to process and assimilate traumatic experiences by reliving them with an appropriate discharge of affect; in time, achieving mastery over them.

Accommodation

Developmental psychologist Jean Piaget referred to accommodation as the modification of internal representations in order to accommodate a changing knowledge of reality. Piaget examined play as part of the whole intellectual development of the child and relates it to the process of assimilation and accommodation. Accommodation occurs when the individual is altered by the new components in the surrounding conditions in which he finds himself.

Admission Prevention

Initiative to assist children and families before admission into care is required.

Adoptive Care

Permanent family, legal guardianship rests with adoptive parents. Contact with birth family is dictated by terms of adoption; open or closed adoption

Alexander, Christopher	(1936-) Austrian born Architect and theoretician, noted for his collaboration with Sara Ishikawa and Murray Silverstein, producing the architectural system, A Pattern Language.
Anthropometric	The measurement of the size and proportions of the human body.
Assimilation	A sociological term referring to amalgamation and modification of newly perceived information and experiences into the existing cognitive structure. Developmental psychologist Jean Piaget explained Play as part of the whole intellectual development of the child and relates it to the process of assimilation and accommodation.
Attachment Resistant	An insecure attachment of a child or infant to the caregiver combined with a resistance of contact with her when she returns after and absence, and a wariness of the stranger.
Baird, John C.	Professor of Psychological and Brain Sciences, Dartmouth College, New Hampshire, USA. Co-editor of Mind Child Architecture (1982), Author of Psychophysical Analysis of Visual Space (1970) and co-author of Fundamentals of Scaling and Psychophysics (1978).
Battered-Child Syndrome	A medico legal term coined by Dr. C. Henry Kempe in 1961, that describes the diagnosis of a medical expert based on scientific studies that indicate that when a child suffers certain types of continuing injuries, those injuries were not caused by accidental means.
Belonging	A fundamental human social need to belong, to be loved and accepted; the need to avoid loneliness and alienation, as described in Maslow's hierarchy of needs (1970). Also, one of the main ingredients that a Play Therapy Transitional Centre should evoke.
Belonging/Love Needs	see Love/belonging needs
Boys Town	A village in Douglas County, Nebraska, USA. The headquarters of the Boys Town organization, now known as Girls and Boys Town, founded by Edward J. Flanagan, which is dedicated to the housing and education of at-risk children. Featured in Oscar winning 1938 film Boys Town, starring Spencer Tracy and Mickey Rooney.

Bruno Bettelheim

1903-1990 An American writer and child psychologist predominantly known for his disproven theory on autism.

Cattanach, Ann

A play therapist and dramatherapist in private practice. She has a wide experience of teaching and lecturing in drama, dramatherapy and speech communication, and has also worked as a child psychotherapist, family therapist and dramatherapist for Social Services. Author of Introduction to Play Therapy (2003) and Process in the Arts Therapies (1999).

Challenges

Peel CAS Associated Service: A core child management program for children 2-12 years and their families. Provides intensive home based intervention to mandated families. Primary focus is the provision of education and skill development to parents.

Child

A young human being below the age of puberty.

Child and Family Services Act

Ontario government funding of services for children including child development, child treatment, child welfare, community support, young offenders, and child and family intervention services. It also governs the operation of children's aid societies and other agencies approved to provide these services and the licensing of residential programs. The Act is currently changing to strengthen Ontario's child protection system. (Child and Family Services Act, R.S.O. 1990, Chapter C.11)

Child Development

Is the study or examination of processes and mechanisms that operate during the physical and mental development of an infant into an adult.

Child Protection Services

Delegated authorities empowered to provide mandated intervention, based upon legislated definitions of children in need of protection; i.e. children exposed to maltreatment, suspected or confirmed child abuse or neglect.

Child Welfare League of America

The United States of America's oldest and largest membership-based child welfare organization. Committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

Child Welfare League of Canada	A membership-based, Canadian national organization, dedicated to promoting the well-being and protection of all children, especially vulnerable children and youth (0-18 years). CWLC plays a significant role in promoting best practices among those in the field of child welfare, children's mental health and youth justice.
Child Welfare System	Operates to protect children and ensure a safe permanent home for children. It is a set of government services to protect children and encourage family stability. These typically include investigation of alleged child abuse and neglect; foster care; adoption services; and services aimed at supporting at-risk families so they can remain intact.
Child-Centered Architecture	An architectural type where children's ideas, interests and abilities are integrated into the design process. The architectural strategy is geared towards the child's physical, social and emotional needs.
Childhood	The state or period of being a child. A distinct and mental phase experienced between infancy and puberty.
Children in Care	Children under the protection of Child and Family Services within provincial jurisdictions.
Children in Limbo	Children in care who are experiencing ongoing discontinuity in their care and are in a perpetual state of uncertainty regarding their future.
Children in Limbo Task Force	A Sparrow Lake Alliance Task Force based in Toronto's Hospital for Sick Children. Advocates for continuity of care in the nurture and development of children and teenagers with the main goal of ensuring that children who must be apprehended by a Children's Aid Society spend as little time as possible in limbo. Members include representatives from the child welfare system, the family court system, and the children's mental health system.

Cmiel, Kenneth J.	(1954-2006) Historian of the idea of human rights, and author of Democratic Eloquence: The Fight over Popular Speech in Nineteenth-Century America and A Home of Another Kind: One Chicago Orphanage and the Tangle of Child Welfare (1995). Until his death in February, 2006, Cmiel was a professor of History and American Studies at the University of Iowa and director of the UI Center for Human Rights.
Community Intervention Program	An integrated counselling and parent/child support service offered by Peel Children's Centre in collaboration with Peel Children's Aid (and others) for children/youth who are experiencing moderate to severe mental health concerns.
Connect	Peel CAS Collaborative Initiative/Service. Provides 4 month sessions of intensive service to children/youth (7-15 years) with mental health needs who are at risk of coming into CAS care or have been in CAS care and are being reintegrated into the family home. Will provide support in every aspect of the child's life (i.e. in school, home, after school, community). Will provide the family with education, parenting skills and treatment.
Crown Ward	A Canadian legal term used to describe a child who is in the permanent care of a children's aid society.
Customary Care	Care provided in the custom of the particular band or community.
Day Care Services	Peel CAS Collaborative Initiative/Service for pre-school children requiring day care.
Deficiency (Basic) needs	A hierarchy of human needs as described by psychologist Abraham Maslow, stemming from psychological needs, to safety needs, to belonging or social needs and esteem needs. Once these are met one seeks to meet the "Being" needs of self-actualization and self-transcendence.

Delight

One of the essential ingredients of a child play therapy centre, evoking great pleasure and well-being, promoting human flourishing.

Ego

One of the three divisions of the psyche according to psychoanalyst Sigmund Freud's "structural theory." The ego mediates between the super-ego (containing internalized norms, morality and taboos) and the id (containing the "primitive desires" of hunger, rage, and sex) and may include or give rise to the sense of self.

Elizabethan Poor Law

Enacted in 1601, one of the first organized attempts to protect children and families by dictating that relief must be offered to the destitute. The poor were separated into three categories: 1. The able-bodied poor—those who were considered capable and were, therefore, forced to work; 2. The impotent poor—those who were old, disabled, or mothers, who were excused from work and for whom aid was provided by the state; and 3. Dependent children—those who were orphaned or abandoned and for whom aid was provided.

Emotional Abuse / Psychological Maltreatment

Underlies all types of maltreatment and is not an isolated incident. Emotional or psychological maltreatment is a pattern of negative caregiver behaviours or repeated destructive interpersonal interactions by the caregiver to the child. A repeated pattern of extreme incidents of emotional abuse may include rejecting, isolating, terrorizing, ignoring and corrupting.

Erikson, Erik

(1902-1994) A developmental psychologist and psychoanalyst known for his theory on social development of human beings. Erikson's psychological theory, which spans childhood and adulthood, emphasizes the importance of play in meeting the tasks of autonomy and initiative during the early years and the balance we must provide to help children achieve healthy development.

False Self	Dr. W. Winnicott described the False Self as a split off part of an individual who, for a variety of reasons, is unable to express his True Self. In Winnicott's view, this False Self functions as the reactive protector of the true core of the individual. The False Self is reactive instead of proactive and responsive instead of generative or creative. The false self constantly seeks to anticipate demands of others as in when a person has to comply with external rules and social codes. For persons in whom a False Self predominates, there is minimal possibility for developing potential space and almost no capacity for creativity and play.
False Self Disorder	Winnicott felt that a failure of the mother to provide a holding environment would result in a false self disorder where the false self protects the hidden true self and reacts to the adaptation failures and develops a pattern corresponding to the pattern of environmental failure.
Family Connections	Peel CAS Associated Service: Home support to families in crisis when placement of children is imminent. "Booster" sessions to families who require brief additional support following termination.
Family Foster Care	A planned, goal-directed service in which the temporary protection and nurturing of children takes place places in the homes of agency-approved foster families.
Family Futures Program	Peel CAS Collaborative Initiative/Service. Parenting Group Program for parents of newborns to 6-year-olds in eight week sessions. Learn new skills to help with everyday parenting challenges.
Family Group Conferencing	Peel CAS Fee for Service Program. Facilitates permanency planning for children in collaboration with family and extended family while ensuring child safety.
Family Treatment	Peel CAS Fee for Service Program for families requiring family counselling. Referrals are for ongoing protection cases only.

Family-Based Care   Adoptive, Foster, Kinship, Customary, Guardianship care

Finkelhor, David   Author, and professor of sociology at the University of New Hampshire. Specializing in Youth and Crime and Family Violence, Finkelhor is Director of the Crimes against Children Research Center, which is dedicated to studies about the nature and impact of a wide variety of offences against juveniles, including conventional crimes (e.g. homicide, rape, robbery), child abuse, peer violence, family abductions and the exposure of children to domestic and community violence.

Fontana, Vincent J.   (1924-2005) A pioneer in the prevention of child abuse and the care of abused children, he spent forty-three years as medical director and chief paediatrician of New York Foundling Hospital. In 1963, he wrote "The Maltreatment Syndrome in Children," a groundbreaking article that appeared in the New England Journal of Medicine.

Foster Care   Provision of care by a family, other than a parent or guardian of a child, approved and arranged by a child welfare authority, to provide care and supervision of a child in care.

Foster Home   An agency-appointed household in which a child is raised by someone other than its biological or adoptive parent.

Frankl, Viktor Emil   (1905-1997) An Austrian neurologist and psychiatrist. Frankl was the founder of logotherapy and Existential Analysis. His book, Man's Search for Meaning (1946) chronicles his experiences in a concentration camp and describes his psychotherapeutic method of finding meaning in all forms of existence, and thus a reason to continue living.

Freud, Anna   (1895-1982) The sixth and last child of Sigmund and Martha Freud. The formation of the fields of child psychoanalysis and child developmental psychology can be attributed to Anna Freud. Freud developed different techniques of assessment and treatment of child disorders, thereby contributing to our understanding of anxiety and depression as significant problems among children.

Froebel, Friedrich Wilhelm August	(1782-1852) A German educator who coined the term "kindergarten" for the Play and Activity Institute he founded in 1837 for young children. Trained originally in architecture, Froebel is known for his educational tools, popularly termed Froebel Gifts, or Fröbel Gaben, which included geometric blocks that could be assembled in various combinations to form three dimensional compositions. Froebel's great insight was to recognize the importance of the activity of the child in learning. Activities in the first kindergarten centered on play and sensory awareness and included singing, dancing, gardening and playing with the Froebel Gifts.
Genuine Self	see True Self
Gersie, Dr. Alida	Born in the Netherlands, Alida Gersie developed the story making approach to complex change. Gersie has worked in training and management roles in the arts therapies, the arts in health, higher education and organizational development.
Goldfarb, William	American psychologist who tested small groups of children from a New York City orphanage. Golfarb found evidence from projective, personality, and ability tests that orphans showed deficiencies in speech, intelligence, personality, and social development, concurring with other psychologists that children are seriously damaged emotionally when deprived early in life of maternal contact and affection, leading to the term "maternal deprivation."
Goldstein, Howard	Social Science professor and author of The Home on Gorham Street and the Voices of its Children (1996).
Goldstein, Kurt	(1878-1965) A German neurologist who created a holistic theory of the organism based on Gestalt theory. Originated the term "self-actualization" as the instinctual need of humans to make the most of their unique abilities. Goldstein's most notable book, "Der Aufbau des Organismus" (1934) was translated and published in English in 1995 as "The Organism."

Good-Enough Mother	A term coined by Donald W. Winnicott who felt the child's mother must be a good-enough mother who relates to the child with primary preoccupation. Winnicott felt that a good-enough mother allows herself to be used by the infant so that he or she may develop a healthy sense of omnipotence which will naturally be frustrated as the child matures.
Group Care	Non-family based group care (staffed), usually limited to six to nine residents in a home/facility.
Guardianship Care	Known family or specified friend provides care indicating permanency, with legal guardianship status retained by the government
Harlow, Harry	(1905-1981) An American psychologist best known for his studies on affection and development using rhesus monkeys and surrogate wire or terrycloth mothers.
Healthy Babies - Healthy Children	Peel CAS Collaborative Initiative/Service. In-home educational service for 0-6 years provided by Public Health (Nurses/Family Visitors).
Holding Environment	A concept developed by Donald W. Winnicott of an environment the mother creates to take in the anxieties of the child, hold them, and give them back in a more manageable form at an appropriate time, an environment that allows him to express himself unconditionally without fear of rejection, in order for him to establish permanence.
Indian Act of Canada	(1876) A Canadian federal Act which deals with registered Indians, their bands, and the system of Indian reserves. The Act is administered by the Minister of Indian Affairs and Northern Development. The Act is upheld under Canada's Constitution Act of 1867 which enables the Federal Government to legislate in relation to "Indians and Lands Reserved for Indians." The Indian Act also includes rights for Indians.
Individual Child Treatment	Peel CAS Fee for Service Program for children and youth in care.

Individuation	The process in the analytic psychology of Carl Jung by which the self is formed by integrating elements of the conscious and unconscious mind.
Infant Wellness Program	Peel CAS Fee for Service Program for birth to 18 months—children in the community and in care. Program intends to enhance the safety and well-being of high-risk infants in the Region of Peel as well as to support CAS front-line workers in their child protection work.
Institutional/Residential Treatment Centre	Facility with common treatment focus providing prescribed, often time-limited large-group care. Focus may be on specific maladjustment behaviours, mental health conditions, young offenders, youth, children.
Institutionalized	To place a child in a building housing an organization dedicated to providing care for children unable to live with their biological families.
Interpreter Services	Peel CAS Fee for Service Program for all clients—children, youth and families, requiring interpretation and translation. Program intends to better service clients from diverse ethno-cultural communities.
Kindergarten	The concept of "Kindergarten" was developed by Friedrich Froebel in 1837 as a Play and Activity Institute. The European Kindergarten was traditionally built as a distinct institutional building for pre-school children between 3 and 6 years and is now used as a generic term in Europe relating somewhat to the Steiner school system.
Kinship Care	The full-time nurturing and protection of children by relatives, members of their bands, tribes, clans, sects, or god-parents or to whomever a child, a child's parents or family members ascribe a "family" status.
Klein, Melanie	(1882-1960) An Austrian born British psychoanalyst who built on Sigmund Freud's ideas concerning children, developed through work with mainly adult patients, by instead allowing children to express their own emotion. Klein attempted to interpret the specific meaning of play as a mode of communication and possible site of therapeutic intervention.

Legal custody
A court order granting Legal Custody of a child means that the awarded persons, or Children's Aid Society, has the legal right to make decisions about the child's health, safety and education.

Love/Belonging Needs
The third level in the hierarchy of human needs as described by psychologist Abraham Maslow, stemming from psychological needs, to safety needs, to belonging or social needs and esteem needs. Once these are met one seeks to meet the "Being" needs of self-actualization and self-transcendence. Belonging needs are social needs involving emotionally-based relationships such as family. Humans want to be accepted and to belong. They need to feel loved.

Maslow, Abraham
(1908-1970) An American psychologist notable for his theory of human motivation with his proposal of a hierarchy of human needs. Maslow proposed that basic needs are arranged in a hierarchy, a pyramid in which each overriding level of need has to be met before successive levels of need can be addressed.

Maternal Deprivation
The psychological theory that deviating conditions of maternal care in early life tend to be associated with later disturbances in intellectual and personal-social functioning. Four types of deviation were categorized as 1. institutionalization; 2. separation from a mother or mother-surrogate; 3. multiple mothering (with no one specifically fulfilling major functions); and 4. distortions in the quality of maternal care (overprotection, ambivalence or rejection). This concept was central to the arguments against orphanages.

Mead, George Herbert
(1863-1931) An American philosopher, sociologist and psychologist, primarily affiliated with the University of Chicago, where he was one of several pragmatists. Mead is regarded as one of the founders of social psychology. Author of Mind, Self, and Society: From the Standpoint of a Social Behaviorist (1967).

Milton Hershey School	A private philanthropic (pre-K through 12) boarding school founded by Milton S. Hershey of The Hershey Company and his wife Catherine "Kitty" S. Hershey. The school was originally a home and school for fatherless or orphaned boys opened by the Hershey's who were unable to have children of their own. Now students live in family-like homes, each of which is overseen by a married couple who are the houseparents for the home. More than just caretakers, houseparents take an active, nurturing interest in MHS students' development and well-being, serving as the primary contact for the children in their care, in partnership with a biological parent or guardian.
Ministry of Children and Youth Services	Ministry responsible for the legislation and funding under which child welfare services are provided in Ontario. The Child and Family Services Act gives the Minister of Children and Youth Services the authority to develop policies and programs for the range of services provided by the Act, including the establishment and monitoring of Children's Aid Societies and other approved agencies.
Mirror	see Mirroring
Mirroring	A concept developed by Donald W. Winnicott whereby a baby looks into the gaze of his mother (primary carer) which reflects the mother's perceptions of the baby, which the baby sees as himself or herself. In early stages of the emotional development of the human infant a vital part is played by the environment which in fact is not separated from the infant by the infant. Gradually the separating off of the not-me from the me takes place, and the pace varies according to the infant and according to the environment. The major changes take place in the separating-out of the mother as an objectively perceived environmental feature. If no one person is there to be mother, to "mirror" the conditions necessary for healthy development of the child, than the infant's developmental task is infinitely complicated. Also one of the essential ingredients of a child play therapy centre, whereby the centre itself refects the needs of the child, allowing the child to feel at ease and secure.

Montessori, Maria	(1870-1952) The first female medical doctor in Italy, Montessori was an Italian educator and psychologist who developed the Montessori method in the early 1900s at her "Casa dei Bambini." The Montessori method is both a methodology and educational philosophy developed as a way to educate poor children in Italy. The Montessori method is based on observing young children and learning from them about their characteristics and needs. Universal characteristics of children are recognized for each level of development. The goal of Montessori is to provide a stimulating, child-centered environment in which children can explore, touch, and learn without fear, thus engendering a lifelong love of learning as well as providing the child the self-control necessary to fulfill that love. Montessori achieves this through encouraging children to develop their observation skills by doing many types of activities. These activities include use of the five senses, kinetic movement, spatial refinement, small and large motor skill coordination, and concrete knowledge that leads to later abstraction.
Mother figure	The primary caregiver of an infant or child who evokes the feelings usually reserved for a mother. The person who serves as a mirror to the child as described by Donald W. Winnicott.
Moustakas, Dr. Clark	Psychologist and president of Columbia University's Educational and Clinical Psychology's Union Institute. Moustakas is one of the leading experts on humanistic and clinical psychology. He is the author of numerous books and articles on humanistic psychology, education and human science research.
Neglect	Condition when a child's caregiver either deliberately or through lack of knowledge and/or lack of motivation, fails to provide a child with adequate food, shelter, clothing, safety, medical treatment, or treatment services, which results in the child experiencing injury, harm, or illness. Neglect is often seen as an omission which some divide into three categories: physical neglect, educational neglect, and emotional neglect.

Non-Directive Play Therapy

A type of therapy that centres solely on the child, helping them to make connections between events in their life and to understand these events. The therapy is non-directive in that the child leads and the therapist follows. The therapist watches what the child does and interprets its actions in terms of their knowledge of that child.

Nursery/ Daycare for Children in Care

Peel CAS Fee for Service Program for pre-school children experiencing difficulty in their foster placement—part time daycare funding offered for up to three years, half weeks.

Olasky, Marvin

(1950-) Professor of journalism at the University of Texas, a leading conservation columnist and the editor-in-chief of World magazine. Olasky is noted for his most famous work, The Tragedy of American Compassion (1992) in which Olasky argues that care for the poor must be the responsibility of private individuals and organizations, particularly the Christian church, instead of government programs like welfare. He suggests that government programs are ineffective because they are disconnected from the poor, while private charity has the power to change lives because it allows for a personal connection between the giver and the recipient.

Open Adoption

An adoption arrangement in which contact between the adoptive and biological parents is allowed or maintained.

Orphanage

An institution for the care and protection of children without parents, as well as those abused, abandoned and neglected. Orphanages may be privately or publicly funded, or run by religious organization. Since the 1950s, after a series of scandals involving the coercion of birth parents and abuse of orphans, North America has moved to de-institutionalize the care of vulnerable children in favour of foster care and accelerated adoption. Today, the orphanage remains common and necessary in most parts of the world, now more commonly termed "group home," "children's home," or "rehabilitation centre."

Parenting Assessments	Peel CAS Fee for Service Program. Case related assessment to be determined by the worker and Supervisor for ongoing protection cases. For parents whose children are in the care of the society.
Parenting Capacity Consultations	Peel CAS Fee for Service Program for families with complex service issues or needs, involved in contested court proceedings.
Parents' Care	Biological family (receiving in-home supports as children in need of protection)
Pathway Program	Peel CAS Affiliated Program. Access programming for children in care.
PCC/PCAS Joint Planning	Peel CAS Collaborative Initiative/Service. To avert admission of children who present with mental health issues to PCAS care.
Peel Children's Aid (Society)	A child protection agency funded by the Ministry of Children and Youth Services along with donor supported special programs and volunteers. Located in Mississauga, Peel Children's Aid aims to protect and strengthen families and communities through partnership with a vision of Every Child Centered. Peel CAS provides homes for hundreds of children exposed to maltreatment or without suitable homes each year, in more than 160 foster homes and 9 residential facilities throughout Mississauga, Brampton and Caledon.
Peel Children's Centre	Peel CAS Collaborative Initiative/Service. Integrated counselling and parent/child support service for children between the ages of 4 and 12 who are experiencing social, emotional and/or behavioural difficulties and/or are experiencing moderate to serious mental health concerns.
Perkins, Larry	(1907-1997) Son of Prairie School architect, Dwight Perkins (1867-1941). Founding Partner of architectural firm Perkins, Wheeler and Will (now Perkins+Will). In a joint venture with Eliel and Eero Saarinen, gained international recognition as architects of Crow Island School in Winnetka, IL.

Permanence	A concept felt when there is a consistent and unconditional relationship between child and caretaker. Also an essential ingredient of the Play Therapy Centre, creating a consistent, stable environment of familiarity.
Permanency Planning	The effort to create a plan for children entering care to create the quickest permanent and consistent solution, limiting the time spent in care to as short a period as possible. Permanency options have expanded beyond family reunification and adoption to include Kinship Care, Customary Care, Guardianship Care, Open Adoption, and Subsidized or Assisted Adoption.
Pestalozzi, Johann Heinrich	(1746-1827) Swiss pedagogue and educational reformer. Pestalozzi argued that children should learn actively, from concrete experiences rather than words. He felt children should be free to pursue their own interests and draw their own conclusions, thereby educating the whole child. Pestalozzi looked to balance, or keep in equilibrium, three elements: hands, heart and head.
Physical Abuse	Encompasses those situations where a caregiver having charge of a child has used inappropriate or excessive force on a child resulting in physical injury. Physical abuse ranges from situations where physical punishment has been inappropriate to excessive, resulting in injuries that can range from scrapes and bruises to cuts, burns, broken bones, shaking, internal injuries, and in extreme situations, death.
Physiological (Biological) Needs	The first level in the hierarchy of human needs as described by psychologist Abraham Maslow, followed by safety needs, to belonging or social needs and esteem needs. Once these are met one seeks to meet the "Being" needs of self-actualization and self-transcendence. Physiological needs are the need to breathe, the need for water, the need to eat, the need to dispose of bodily wastes, the need for sleep and the need to regulate body temperature. When these needs are not met, an individual will de-prioritize all other desires and capacities. Physiological needs can control thoughts and behaviours, and can cause people to feel sickness, pain and discomfort.

Piaget, Jean   (1896-1980) A Swiss natural scientist and developmental psychologist, well known for his work studying children and his theory of cognitive development that focuses on how children's intelligence and thinking abilities emerge through distinct stages: 1. Sensorimotor Stage; 2. Preoperational Stage; 3. Concrete Operational stage; and 4. Formal Operational Stage.

Play   An exercise or activity for amusement or recreation, as in children playing with toys. An integral part of childhood and medium that eases the development of expressive language, communication skills, emotional development, social skills, decision-making skills, and cognitive development in children. Charles Schaefer explained that "Play is to the child what verbalization is to the adult—the most natural medium for self-expression."

Play Therapy   Defined by the Association for Play Therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein a trained play therapist uses the therapeutic powers of play to help clients prevent or resolves psychosocial difficulties and achieve optimal growth and development." Play Therapy is a form of therapy that allows children to express what is going on inside their mind, even if they do not know themselves, through engagement in play. It allows the therapist to clarify what the child has experienced and can help the child to recover from the trauma and regenerate natural processes of social interaction. As described by Dr. Clark Moustakas, the three basic attitudes in child-centered play therapy are: faith, acceptance, and respect. Common tools of play therapy can include sand and water trays, puppets, family dolls, representational toys, sensory play materials, stage makeup, and drawing material.

Play Therapy Centre

As proposed in this thesis, a Play Therapy Centre is a centre for children in transition within the child welfare system that would operate alongside foster homes and would express the values, that is the dynamics, scale and intimacy, of Play Therapy through it's architectural presence as well as social programme, allowing the physical environment to act in a rehabilitative role. A place to learn, play, eat, sleep and interact with all persons involved in each child's case, a Play Therapy Centre is a children's facility evoking the essential ingredients of mirroring, receiving, permanence, security, privacy, trust, belonging and delight, thereby speaking to children as conscious beings, as developing children, as well as for their unconscious selves, harbouring repressed desires, traumatic memories and painful emotions.

Play Therapy Services

Peel CAS Fee for Service Program for children in care with abuse/neglect histories, children exposed to traumatic events aged 3-12 years.

Post-Traumatic Stress Disorder (PTSD)

A condition first identified when some Vietnam War veterans began experiencing flashbacks of events that occurred during combat. PTSD is defined as the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. The characteristic symptoms involve re-experiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased agitation. This mental disorder is also experienced by children who have experienced maltreatment or have witnessed family violence, and is a frequently observed symptom of sexually abused children.

Primary Maternal Preoccupation

As described by Dr. W. Winnicott as the mental state of the mother in the perinatal period that involves a greatly increased sensitivity to, and focus upon the needs of her baby. Winnicott indicated that this state begins near the end of pregnancy and continues for a few weeks after the birth of the baby. A mother then needs nurturing support and a protected environment to develop and maintain this state. This special preoccupation and the openness of the mother to her baby are key factors in the bonding process. Winnicott believed that the mother who relates to the child in this state must be a "good-enough mother."

Privacy	For children in play therapy, it is important to be able to provide privacy. Privacy can take the form of anonymity, as in the child not knowing the other children and not being known. Allowing the child to hang paintings or drawings but having none remain after the session conveys a sense of privacy for the child, where he is not compared to others. Privacy can also take the form of window coverings so that the child feels that no one else can see her. Also one of the essential ingredients of a child play therapy centre whereby the centre itself coveys a sense of privacy, allowing the child to feel his identity, experiences and fears are protected.
Psychological Assessment Services	Peel CAS Fee for Service Program for child victims of abuse and/or neglect.
Psychological Maltreatment	see Emotional Abuse
Receiving	The quality of receiving in therapy and as one of the essential ingredients of a child play therapy centre, involves taking in, holding and containing the child's thoughts, fears, and anxieties. A sense of receiving emits the sense that the child is welcome and she is free to relax and let go of her inhibitions.
Resilience	Resilience refers to a child's ability to adapt effectively in the face of threats to development, such as through maltreatment. Many factors including other nurturing adults, social support and activities, as well as personal characteristics, influence resilience in children.
Rousseau, Jean-Jacques	(1712-1778) A Swiss philosopher, Rousseau highlighted the importance of childhood by advancing the notions that children are innately noble and good and that their way of learning is distinct from that of adults. Rousseau was not an early childhood educator, did not work with children and abandoned his own five children to orphanages.
S.E.E.D.	Peel CAS Associated Service for children 10-12 years & at risk of admission to care. A community based intervention—support services to both youth and caregivers with focus on youth's needs.

Saarinen, Eero	(1910-1961) Son of Eliel Saarinen, a Finnish-American architect and product designer of the 20th century famous for his simple, sweeping, arching structural curves.
Safety Needs	The second level in the hierarchy of human needs as described by psychologist Abraham Maslow, preceded by physiological needs and followed by belonging or social needs and esteem needs. Once these are met one seeks to meet the 'Being" needs of self-actualization and self-transcendence. Safety and security rank above all other desires. Security includes physical security (from violence and aggressions), moral and physiological security, familial security and security of health.
Schaefer, Dr. Charles	Professor of Psychology at Farleigh Dickinson University in New Jersey. An expert in the field of play therapy, he is the cofounder of the Play Therapy Training Institute in New Jersey and author of several works on play therapy including The Therapeutic Powers of Play (1993).
Security	A freedom from anxiety, or doubt. As an essential ingredient of a child play therapy centre, a calming realm that encourages safety in the children knowing themselves, and expressing themselves.
Self-Actualization	A term originated by German neurologist Kurt Goldstein (1878-1965) as the instinctual need of humans to make the most of their unique abilities. Along with self-transcendence, self-actualization are the highest level of human needs as described in Maslow's hierarchal theory of human motivation, after physiological needs, to safety needs, to belonging or social needs, to esteem needs.
Self-Transcendence	At the top of Maslow's hierarchy of human needs with self-actualization, described together as spiritual needs. Maslow believed that we should study and cultivate peak experiences as a way of providing a route to achieve personal growth, integration, and fulfillment. Peak experiences are unifying, and ego-transcending, bringing a sense of purpose to the individual and a sense of integration. Individuals most likely to have peak experiences are self-actualized, mature, healthy, and self-fulfilled. All individuals are capable of peak experiences. Those who do not have them somehow depress or deny them.

Sexual Abuse

Sexual abuse includes any sexual contact between a child and caregiver. Sexual abuse may include sexual suggestiveness, voyeurism, sexual acts, or sexual penetration.

Sherrod, L.R., & Singer, J.L.

Psychologists and researchers in the area of play, especially the concept of pretend play.

Shugart, William & Chappell, William

Economics professors at the University of Mississippi who made correlations between adoption rate and foster care.

Skinner, B.F.

(1904-1990) Behaviourist whose ideas have had a widespread influence on all aspects of education. Skinner believed that children are not shaped by internal forces but rather by external ones, specifically those emanating from the environment. The application of his theories operates on the underlying principle that behaviour can be modified by manipulating the environment, which includes both physical and social components.

Society for Neuroscience

Formed in 1969, a non-profit membership organization of basic scientist and physicians who study the brain and nervous system. At more than 37,500 members, it is the world's largest organization of scientist devoted to the study of the brain. The Society's primary goal is to promote the exchange of information among researchers and is devoted to education about the latest advances in brain research.

Spacial Needs

Children perceive the environment holistically, storing information in a non-sequential fashion, revealing the strength of their right-brain processing. A child's acute awareness of space, the orientation of their body and others, allows them to notice subtleties and details, unnoticed by most adults. In order to satisfy these spatial needs, children need to have accessibility to activities that exercise skills in drawing, doing puzzles, mazes and tasks requiring fine-motor manipulation. A child's imaginative spatial needs include the hunger for visual stimulants that continually present new information.

Spatial Play

A keen eye for form, design, colour, size, shape and space will enable a child to appreciate patterns and form at varying scales, which is proven encourage healthy child development.

Status (Esteem) Needs

The fourth level in the hierarchy of human needs as described by psychologist Abraham Maslow, after physiological needs, safety needs, and belonging or social needs. Once these are met one seeks to meet the "Being" needs of self-actualization and self-transcendence. Esteem needs describe the human need to be respected, to self-respect and to respect others, giving the person a sense of self-value, promoting the final level in Maslow's hierarchy, self-actualization and self-transcendence.

Steiner, Rudolf

(1861-1925) An Austrian philosopher, literary scholar, architect, playwright, educator, and social thinker. He is the founder of anthrosophy, a movement based on the notion that there is a spiritual world comprehensible to pure thought but accessible only to the highest faculties of mental knowledge and many of its practical applications, including Waldorf education, biodynamic agriculture, anthrosophical medicine, and new artistic impulses, especially eurythmy. Steiner advocated a form of ethical individualism, to which he later brought a more explicitly spiritual component.

Subsidized or Assisted Adoption

When an adoption is approved under the Children and Family Services Act for subsidy to assist with services or care associated with the adopted child.

Technical Guides

Publications outlining anthropometric data, standards and sources for building products, furnishings, fixtures, recreational items, and amenities for children's environments. A framework of dimensions that meet children's physical needs in varying spaces and activities.

Treatment Foster Care

Caregivers with specialized skill-set providing therapy/treatment specific to individual child's care needs

True Self   Discovery of the True Self, is the state where one becomes self-aware and self-accepting, secure in the sense of who he is.

Trust   The belief in the good character of a person or place. Trust makes social life predictable, creates a sense of community and makes it easier for people to work together. Trust allows us to form relationships with others and to depend on others—for love, for advice, for help. A child able to trust is one willing to let down a guard, exposing his vulnerability without fear of rejection. A centre conveying the feeling of trust, shows a vulnerability to children so they feel there is a compatibility and collaboration between them and the facilitators of the centre.

Victoria Youth in Care Network   Peer service providing assistance and support to youth in care: advocacy, recreation planning, education events, etc. for youth 16-19 years of age in Victoria, British Columbia.

Vygotsky, Lev   (1896-1934) A Russian psychologist and originator of the "Sociohistoric Theory" which stresses the importance of the social context of development.

Waldorf   Waldorf education's aim is to educate the "whole child: mind, body, and heart," incorporating a balance of physical activity, artistic creativity and academic work against the backdrop of well-defined stages of child development. Child development is viewed as a process of incarnation of the child's soul and spirit. Its curriculum focuses on the arts, social skills, spiritual values as well as practical and integrated learning. Waldorf schools are commonly described as schools of the head, heart and hands.

Watzlawick, Dr. Paul   (1921-) Austrian born. Is one of the world's leading theoreticians in Communication Theory and Radical Constructivism. His work has made a great impact in the field of family therapy and general psychotherapy.

Winnicott, Donald W.

(1896-1971) A British paediatrician and psychoanalyst. Winnicott's treatment of psychically disturbed children and their mothers gave him the experience on which he built his most influential concepts, such as the "holding environment" so crucial to psychotherapy, and the "transitional object." He had a major impact on object relations theory, particularly in his 1951 essay "Transitional Objects and Transitional Phenomena," which focused on familiar, inanimate objects that children use to stave off anxiety during times of stress.

Wolpe, Joseph

(1915-1997) A South African born American psychiatrist best known for developing theories and experiments about what is now called systematic desensitization. He also conducted studies indicating that sexual orientations can change spontaneously. Wolpe was professor of psychiatry at Temple University Medical School from 1965 to 1988. One of his best known books is The Practice of Behaviour Therapy (4th ed. in 1991).

Working Together with Families 0-6 Program

Peel CAS Collaborative Initiative/Service for children 0-6 years who are at risk of developing emotional/ developmental lags due to parent issues. Initial assessment completed within two weeks of referral. Intervention period is generally six months and program provides a range of community based and home based services.

Youth Leaving Care

The Ministry of Children and Youth Services supports the development of social and life skill programs that will help prepare youth for living on their own as the transition from being in care to living independently can be difficult for youth leaving care and requires support and planning. Specifically, the ministry supports the development of a guide to best practices for the preparation of youth for independence and will explore further opportunities for financial assistance for post-secondary education.

Zmora, Nurith

Historian and author of Orphanages Reconsidered: Child Care Institutions in Progressive Era Baltimore (1994). Assistant Professor of History at the University of Delaware.