# A JOURNEY WITH AN ABUSED CHILD:
# A NON-DIRECTIVE PLAY THERAPY PERSPECTIVE

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Submitted in partial fulfilment of the requirements for the degree of

**MAGISTER ARTIUM IN COUNSELLING PSYCHOLOGY**

In the Faculty of Health Sciences
at the Nelson Mandela Metropolitan University

January 2006

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## ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to the following:

My supervisors, Mrs Veonna Goliath and Mrs Lynn Markman: for their professional and competent guidance, enthusiasm, unfailing support and unwavering assistance in the completion of this treatise.

My husband, Grant, for his technical assistance with computer and printer-related matters and my sons, Matthew and Ethan, for their laughter and hugs. Their patience, love and understanding throughout my years of studying are deeply treasured.

My dear friend, Mrs Lynda Allen to whom my deepest gratitude is owed, for being available when the journey was frustrating and also when it was joyful; for offering support, advice and encouragement and walking the treatise road with me.

Another dear friend, Mrs Leigh-Anne Perelson for her consistent treatise accompaniment.

My many friends and family members who offered words of encouragement throughout this process, especially my parents, Tom and Esmé Horne, whose infinite support throughout my numerous years of studying are truly appreciated.

Almighty God

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## SUMMARY

The extensive amount of research conducted in the field of family violence internationally indicates that child abuse has a detrimental effect on both the physical and emotional development of children as well as having a profound effect on an individual's psychological development and functioning in adult life. The aim of this research study was to describe the therapeutic process that unfolded with a seven year old allegedly abused female client within the framework of non-directive play therapy. The case was further contextualised utilising Erik Erikson's theory of psychosocial development. This study served to broaden the body of psychotherapeutic knowledge by means of meaningful qualitative enquiry. The client was referred for therapy because of severe emotional and behavioural problems following the alleged sexual abuse. The client was seen over a period of eight months and this included 11 sessions of non-directive play therapy, three parent interviews and psychometric assessments conducted by a colleague.

The case study method was utilised in this study. To achieve the aim of the research, the methodology of choice was the descriptive dialogic case study. A purposive sampling technique was used in the selection of the research subject for this study. The data collection and analysis were conducted according to Yin's (1994) analytical generalisation, which consists of two main strategies: (a) using a theoretical framework as a guide to determine what data is relevant; and (b) developing a matrix as a descriptive framework for organising and integrating the data. Furthermore, the process of data analysis was aided by the use of guidelines proposed by Irving Alexander (1988) with Axline's non-directive play therapy and Erikson's theory of psychosocial development as the theoretical frameworks.

The findings of this study suggest that plotting the play therapy sessions according to the framework of the four stages of play therapy was a particularly useful tool to monitor Michelle's progression through the therapeutic process. This can be seen as a valuable application of a tool which can be used within the non-directive play therapy approach. Contextualising Michelle's development according to the stages of Erikson's theory of psychosocial development was also found to be a valuable endeavour. According to her chronological age, Michelle should have been in the

fourth stage of industry versus inferiority, but in reality Michelle was still struggling to strike a healthy balance between the terms of conflict of trust versus mistrust issues of the first stage. From a therapeutic point, this was an important exercise as it helped to inform the therapist and consequently, the therapeutic process.

This research undertaking can be recognised as a positive demonstration of the value of non-directive play therapy (Virginia Axline) and Erik Erikson's theory of psychosocial development in the therapeutic process. In addition, this study has served to facilitate a more holistic understanding of the case study approach to research. Recommendations regarding future research undertakings that utilise the case study approach and methodology have been made.

Key concepts: child abuse; family violence; non-directive play therapy; Erik Erikson's theory of psychosocial development; analytical generalisation; case study research

# CHAPTER 1

# INTRODUCTION AND PROBLEM STATEMENT

## 1.1 Introduction

They cry in the dark so you can't see their tears.
They hide in the light so you can't see their fears.
Forgive and forget.
All the while, love and pain become one in the same
In the eyes of a wounded child.
Because hell, hell is for children.
And you know that their little lives can become such a mess.
Hell! Hell is for children.
And you shouldn't have to pay for your love with your bones and your flesh.
It's all so confusing this brutal abusing.
They blacken your eyes and then apologize.
Be Daddy's little girl and don't tell Mommy a thing.
Be a good little boy and you'll get a new toy.
Tell Grandma you fell off the swing.

This poignant description from the lyrics of the song, "Hell is for Children", as recorded by Pat Benatar in the 1980's (Barnett, Miller-Perrin & Perrin, 2005, p.54) emphasises the horror of child abuse. Play therapy cannot erase the past experience for the child, but as will be seen in this study, offers the child an opportunity for healing. In this introductory chapter a motivation for the research is presented and the aim of the study is explained. This chapter concludes with an outline and structure of the study and overview of the chapters that follow in this study.

## 1.2 Motivation

Humans develop within a family context, and family relationships contribute positively to human development at every point in the life span. However, families can also be the source of much anguish and of development gone awry (Sigelman & Rider, 2003). Nowhere is this more obvious than in cases of family violence with the most visible form being child abuse. Multiple forms of abuse often occur within the same troubled family and each day infants, children and adolescents are burned, bruised, beaten, starved, suffocated, sexually abused, neglected and mistreated by their caregivers, and deprived of the basic care and stimulation they need to develop normally (Emery & Laumann-Billings, 1998; Sigelman & Rider, 2003).

There are different kinds of abuse which may have various effects on children's development (Wenar & Kerig, 2000). The different categories of abuse include: physical abuse (beating, scalding, kicking, punching), sexual abuse (fondling, intercourse, exposure to sexual acts), psychological or emotional abuse (failing to meet a child's need for emotional security, acceptance or autonomy) and neglect (failure to provide basic necessities, lack of supervision). Herzberger (1996) states that when a family member suffers one type of abuse, another type of abuse often co-exists in the household. The subject of this research study, Michelle[1], was allegedly sexually abused by her mother's boyfriend and she experienced psychological abuse and neglect by her mother. Lewis (1999) reports that domestic violence is typically associated with the abuse of children by their parents on physical, emotional and sexual levels while Wenar and Kerig (2000) advise that the task of trying to identify the type of abuse is often complicated by the fact that various forms of abuse often occur together.

Child sexual abuse occurs both within and outside families, with research indicating that in most cases, the perpetrator is often someone known to the child rather than a stranger (Barnett et al., 2005). Tragically, family members who are aware of the sexual abuse often choose to remain silent rather than intervene or seek professional help (Hall & Lloyd, 1993). They do this

[1] This is a pseudonym used throughout the research study in order to protect the identity of the client

because of the stigma associated with incest and the threat that exposure of the abuse could potentially isolate families from relatives, friends and communities (Oberholzer, 1996).

Child abuse, particularly child sexual abuse, is currently an area of great concern and Sigelman and Rider (2003) add that child abuse often has damaging long-term consequences for the cognitive, social and emotional development of the child. This is evident in Michelle's life as her interpersonal relationships are characterised by conflict and she has engaged in sexualised play with others. For many children, the abuse occurs at the hands of those whom they trust and love. Research findings in the field of family violence reflect the damaging effects these childhood traumas have on psychological functioning in adulthood, as well as how the abusive behaviour is perpetuated from one generation to another. Bryer, Nelson, Miller and Krol, (1987) found a significant percentage of psychiatric patients to have a history of child abuse, with both childhood physical and sexual abuse more common among adults who develop major mental illness than previously suspected. Literature has begun to address the issue of recurrent abuse for children and the long term implications of this, including the risk of further victimisation in adulthood (Hamilton & Browne, 2002). Effective therapeutic interventions are therefore essential for the psychological health of individuals and also the future of the human race (Oberholzer, 1996).

Michelle was referred for therapy because of severe emotional and behavioural problems and the therapeutic process that ensued was embedded within the framework of non-directive play therapy. This form of therapy provides the child with the opportunity to play out her feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion just as an adult would talk through her problems in adult therapy. Doyle (1990) informs that it is becoming increasingly recognised that abused children need one-to-one therapy. Axline (1989), who developed non-directive play therapy, encourages research and states, "The evidence of the cases which have responded so well to this type of treatment points the way for more intensive research to investigate these areas more thoroughly and more scientifically" (p.55). This researcher is responding to Axline's call for more intensive research and is utilising the case study method as it provides a

suitable discipline in which to give an account of Michelle in a therapeutic situation.

Research strongly suggests that child sexual abuse has a variety of negative emotional, cognitive, physical, behavioural, and social effects on the normal development of the child. Erik Erikson's theory of psychosocial development is also used as an additional theory to further contextualise Michelle's case. Sigelman and Rider (2003) asserted that it is biological maturation and the demands of the social environment that influence the individual's progress through the various stages of Erikson's theory.

Huysamen (1994) describes case study research as being typically directed at gaining an understanding of the uniqueness of a particular case, such as that of Michelle's, in all its complexity. The value of researching an individual case can be rigorous and informative (Bromley, 1986) and is being re-examined to reinstate its rightful place as a research tool in the social sciences (Edwards, 1990).

## 1.3 Aim of the Research

The aim of this research is to describe the therapeutic process that unfolded with a seven year old allegedly abused client within the framework of non-directive play therapy and to further contextualise the case by means of Erik Erikson's theory of psychosocial development.

## 1.4 Overview of Chapters to Follow

The presentation of this treatise is as follows: In Chapter Two, a detailed review of child abuse literature is presented. In Chapter Three, the reader is introduced to the theoretical frameworks of non-directive play therapy (Virginia Axline) and Erik Erikson's theory of psychosocial development. In Chapter Four, the method used in the research study is reported on, and includes a description of the research design, the sample, the procedure followed in the data collection and analysis of the data, in addition to the ethical principles followed in conducting this study. In Chapter Five, the case material, which includes the clinical and therapeutic material, is presented. In Chapter Six, the

findings and discussion are comprehensively covered. In Chapter Seven, the conclusions, limitations of the research study and recommendations for future research studies are presented.

Throughout this research study, the feminine grammar (for example, she, her) will be utilised to refer to both the female and male gender groups. The use of the feminine terms by no means implies that child abuse is exclusive to females, but is used to avoid the monotonous repetition of, for example, he or she, his or her.

# CHAPTER 2

# THEORETICAL BACKGROUND OF CHILD ABUSE

"Child abuse and neglect affect every aspect of human development, sometimes only slightly, and other times dramatically and tragically" (Mayhall & Norgard, 1983, p.67).

## 2.1 Introduction

This chapter provides the reader with a broad and detailed overview of child abuse. The historical context of child abuse is presented initially, followed by a short discussion on the prevalence of child abuse in South Africa. The types of child abuse are then discussed in detail including the possible initial and long term effects on the child, followed by abuse within the family system and factors facilitating coping with the trauma of child abuse. The chapter is concluded with a discussion on the treatment of child abuse victims

## 2.2 Historical Context of Child Abuse

Since the beginning of civilization, child sexual abuse has been in existence (Lachman, 1994; Mrazek, 1987) and has not always been viewed as a problem. Mrazek (1987) informs us that certain types of sexual contacts between adults and children were permitted and sometimes considered a privilege in some ancient civilizations. An example of this can be found in the history of ancient Greece, where most sons of noble families were compelled to take adult lovers who in turn protected and plied the boys with gifts (Crosson-Tower, 1999). Professionals, as well as the general public, have come to acknowledge child sexual abuse as a serious social problem over the past few decades (Haugaard & Reppucci, 1988) and an extensive body of research now exists on the subject (Manion, McIntyre, Firestone, Ligezinska, Enson & Wells, 1996).

The abuse of children is a longstanding problem and, since ancient times, children have been viewed as being under the control of adults. The dynamics of power and control have been closely associated with violence (Bagley & King, 1990) which has resulted in inherent cultural norms that tolerate or approve of violence as a means of social control, including childrearing practices within the family (Bagley & King, 1990; Blumberg, 1974; Gelles & Strauss, 1979). Historical evidence suggests that the family has always been one of society's most violent establishments (Gelles & Strauss, 1979; Newberger, Reed, Daniel, Hyde & Kotglchuck, 1977; Radbill, 1974;) and even the most ancient writings reflect frequent accounts of severe child abuse (Walker, Bonner & Kaufman, 1988). These accounts reflect how many societies throughout the ages have abused, neglected, or tortured children and often killed them by ritual, accident or malicious intent (Blumberg, 1974).

Numerous societies have practised infanticide for population control, and for eliminating children with birth defects; they have offered children as sacrifices to the gods, or mutilated their bodies as part of childrearing practices (Kempe & Helfer, 1980). There are a number of widely known examples of these including the binding of the feet of female children in China, piercing and exaggerating parts of the body amongst African tribes, and the ceremonial mutilation of genitals in various societies (Walker, et al., 1988). Children were regarded as the property of their parents and were commonly treated as virtual slaves by the adults in their family, exploited in the labour market in the form of child labour (Crosson-Tower, 1999), and even sold into slavery. As the Industrial Revolution progressed, children were sent to work for minimal wages as chimney sweeps or in mines (Kempe & Helfer, 1980). Large families, during the times of inadequate birth control, meant that children were often seen as liabilities because of the economic drain on the family. In addition to this, large families were frequently obliterated by disease, and this decreased the bond of affection and concern that parents had for their children (Walker et al., 1988).

Throughout history, and until very recently, abusive acts against children were overlooked by public opinion and religious and legal systems, which supported the view that children were to be regarded as the property of their parents (Blumberg, 1974; Walker et al., 1988). Children's literature, including

fairy-tales and nursery rhymes world-wide reflect the assumption that when a child is mistreated, it is generally by a stranger or step-parent, but when they suffer at the hands of their parents it is because they deserve the punishment, or the parent was acting in the child's best interests (Doyle, 1990).

The development of the current awareness of child abuse started in 1874 when Henry Bergh (founder of the Society for the Prevention of Cruelty to Animals) appealed to the court to protect an eight year old child. This story of Mary Ellen is often recounted when discussing the social history of child abuse. Mary Ellen suffered serious mistreatment at the hands of her adoptive parents who insisted it was their parental right to do so. There were laws in existence in New York in 1874 to protect animals from cruelty, but there were no such laws for the protection of children. Legal action was consequently brought on the basis that Mary Ellen was a 'member of the animal kingdom'. The case was found proved and became a landmark in the legal assertion of child protection over parental rights (Dale, 1999). Eight months later, the Society for the Prevention of Cruelty to Children was established in New York, and in 1883, a similar body was established in England.

Violence within the family has occurred throughout recorded history (Radbill, 1980), but the existence of physical and sexual abuse was largely denied until the early 1960s when the "battered child syndrome" was brought to public attention in 1962 in an article by an American paediatrician, C.H. Kempe (Wenar & Kerig, 2000). This article was instrumental in creating awareness about child abuse in the United States (Haugaard & Reppucci, 1988; Lynch, 1985; Olafson, Corwin & Summit, 1993). Finkelhor (1994) informs that research in the field of child sexual abuse was pioneered in North America in the 1970s, with Europe and Africa following in the 1980s. Corwin (1988) states that sexual abuse has repeatedly surfaced into public and professional awareness in the past century and a half, only to be suppressed by the negative reaction it elicits. As a result, a long history of cultural denial exists about criminal sexual behaviour against children (Summit, 1988). Dale (1999) asserts that at the close of the twentieth century major disputes emulate those occurring a century ago. These disputes include the type and degree of abuse, the appropriateness of intervention into family life, the

dependability of the sexual abuse memories, and whether prevailing influences in society work towards the repression of knowledge of abuse.

For the greater part of the twentieth century, public awareness, social concern and research about sexual abuse of children was dormant while charitable societies, dedicated to the protection of children against gross physical harm and neglect, were gaining momentum (Dale, 1999). In the 1960s, advances in radiology led to an increase in the diagnoses of previously undetected non-accidental bone fractures in children and young babies. As a result child abuse once again became a matter of important social concern. Kempe, Silverman, Steele, Droegemueller & Silver (1962) were motivated by these findings and published the “Battered Child Syndrome” which led to an increase in professional vigilance about the prevalence and dangers of physical abuse. Tzeng, Jackson and Karlson (1991) caution that the boundary between what is considered to be socially and legally acceptable parental chastisement and abuse also remains contentious, reflecting religious, cultural and ideological tensions.

## 2.3 Prevalence

Child abuse and neglect is commonly found in boys and girls of all ages and its presence crosses all racial groups and all socio-economic levels (Lewis, 1999).

The Human Sciences Research Council (HSRC) (2004) states that there is very little research on the incidence and prevalence of child abuse in South Africa as the national data collection systems used by the police and welfare agencies rely on different definitions of abuse, resulting in differing national, provincial and local statistics. Another important reason why it is difficult to obtain accurate statistics on child abuse in South Africa is due to the typical secrecy and the conspiracy of silence that surrounds violence against children. It is only a small proportion of abuse that is actually revealed (Salter, 1988) and Bagley and King (1990) view child sexual abuse as the world’s best kept secret. When the abuse is happening within the family, secrecy is necessary to protect the basic structure upon which the victim’s life is based including the physical, emotional and financial elements (Oberholzer, 1996).

Childline (2005) estimates that one out of three girls and one out of five boys is abused before the age of 18. Child Protection Services also provided identical findings and estimated that in South Africa, one in three girls and one in five boys suffer sexual exploitation in one form or another. The Child Protection Unit of the South African Police Services (SAPS) estimates that only 15% of rapes are reported, indicating that the actual number of rapes of under-18s occurring each year is in the region of 166,500. The Child Protection Unit also indicated that nationally 37,500 incidents of abuse against children were reported during the period 1997/1998. Nationally there were 67,474 counselling calls made on the Childline crisis line from December 2000 to November 2001. Childline estimates that this figure represents only the tip of the iceberg.

R.A.P.C.A.N. (Resources Aimed at the Prevention of Child Abuse and Neglect) indicate in their Annual Report for 2002 that the South African rape and abuse statistics continue to reflect horrifically high levels with the number of reported rapes of under-18s consistently around 25,000 per annum for the past several years. The number of crimes committed against children also showed an increase with 1,800 cases of cruelty reported where the victim was under 18; an estimated figure of over 2 million children were going hungry every day, and 10,000 children were living or working on the streets; and more than 1.5 million children of school age were not attending school. The HIV incidence was also reported as being highest in the 15 - 19 age group, at 65.4%, with adolescent girls four times more likely to be infected than adolescent boys.

The South African Centre for Missing and Exploited Children (SACMEC), a non-profit organisation which functions in partnership with the SAPS Bureau for Missing Persons, indicates that around 1 400 children are reported missing to law enforcement agencies in South Africa each year, but the actual figure is probably significantly higher than the number reported. Similarly, SACMEC (2005) also states that the annual figure of 25 000 reported cases of rape and sexual assault of children in South Africa is undoubtedly underestimated, and in addition to the child abuse statistics, over 2 000 children are murdered each year.

## 2.4 Types and Consequences of Child Abuse

There are different kinds of abuse which may have various effects on a child's development (Wenar & Kerig, 2000). The different categories of abuse include: physical abuse (beating, scalding, kicking, punching), sexual abuse (fondling, intercourse, exposure to sexual acts), psychological or emotional abuse (failing to meet a child's need for emotional security, acceptance or autonomy) and neglect (failure to provide basic necessities, lack of supervision).

For the abused and neglected child, normal development can be problematic (Crosson-Tower, 1999). In addition to learning the necessary motor skills, Helfer, McKinney and Kempe (1976) suggest that children must also learn the following lessons to become healthy individuals:

- "Set priorities and plan ahead
- Trust others
- Make friends
- Develop a good self-image
- Differentiate between feeling and behaviour
- Get their needs met in an acceptable manner" (p.56-57)

Learning the lessons of childhood requires the consistent guidance of caregivers; the inability to provide room for the child's individual growth creates distinct problems in the child's development. As stated by Helfer et al. (1976), children learn in several ways, namely, by association, through outcome, and by observation. These concepts are best explained by way of the following examples: when the child learns by association that her parent's angry voice means she will also be hit, then she may generalise and demonstrate a fear of all adults.

A toddler, who tries to demonstrate her autonomy by running away when called, discovers that the outcome of such behaviour is a hiding, and she learns that autonomy is not encouraged. Finally, a child who observes her parent using violence as a way of expressing anger learns that violent behaviour is acceptable. On this last point, Barnett et al. (2005) are in

agreement with Helfer et al. (1976) and state that evidence suggests that even when children have not experienced abuse directly, they may learn violent interpersonal interaction styles. This happens when children witness negative interactions taking place between significant adults in their lives and learn maladaptive or violent methods of expressing anger or reacting to stress or coping with conflict.

Early childhood experiences are particularly influential (Runyan, 1988) and Wenar and Kerig (2000) advise that abuse in childhood is a significant predictor of depression, low self esteem, conduct disorder and antisocial behaviour in adolescence. Furthermore Dale (1999) informs that adults who were abused as children may experience common difficulties including combinations of physical, emotional, cognitive, self/identity, relational, sexual and social problems. It remains unclear, however, how the various types of abuse, or the severity or extent thereof affects the development and progression of various symptoms and problems.

The extensive amount of research conducted in the field of family violence indicates that child abuse has a detrimental effect on the physical and emotional development in children as well as having a profound effect on psychological development and functioning in adult life, including perpetuating the abusive behaviour from generation to generation (Oberholzer, 1996). A vast amount of research has been conducted over the past twenty years exploring the consequences of childhood abuse in adult life (Dale, 1999). This research provides an accumulation of evidence that significant, lasting problems are more likely for those who, from an early age, were seriously abused on numerous occasions and over an extended period of time, and in the context of a significantly dysfunctional family.

The four types of abuse and their initial and long term consequences will be discussed in detail in the following section.

### 2.4.1 Physical Abuse

Physical abuse involves the presence of injuries resulting from acts of commission or omission in which the child’s life, health or safety are endangered (Wenar & Kerig, 2000). In terms of severity, the injuries range

from being relatively minor to serious and include the Munchausen by proxy syndrome. This is where, as Sadock and Sadock (2003) state, the child is subjected to repeated and unnecessary medical procedures, which result in the caretaker indirectly assuming the sick role or being relieved of the caretaking role while the child is hospitalised. Barnett et al. (2005) add to this by stating that adults falsify physical and / or psychological symptoms in the child in order to meet their own psychological needs.

Barnett et al. (2005) assert that child physical abuse is often associated with other problems within the family, for example, family violence, substance abuse, parental depression, psychological abuse and low socio-economic status. Sadock and Sadock (2003) state that the perpetrator of physical abuse is more often the mother than the father and that one parent is usually the active perpetrator while the other passively accepts the abuse.

#### 2.4.1.1 Possible effects of physical abuse

According to Barnett et al. (2005), possible effects associated with physical abuse include: medical and neurological complications, cognitive difficulties, behavioural problems, socio-emotional deficits, psychiatric disorders, physical disfigurements, disabilities and death.

One of the most common physical injuries associated with physical abuse are bruises which are found in uncommon sites, for example, the buttocks, back, abdomen, and thighs (Schmitt, 1987). The child may also have other marks as a result of being struck by a belt or other object, or as a result of being grabbed or squeezed. Myers (1992) adds that a series of unusual injuries on the child’s body is often an indicator of physical abuse. Head injury is one of the most dangerous types of injury and is sited as the most common cause of death in abused children (Barnett et al., 2005). Injuries to the head are caused by either a blow to the head by a fist or object, or as a result of throwing the child against a hard surface. Shaking the child violently can also result in a serious head injury leading to coma or death.

Other physical injuries include chest and abdominal injuries, burns, fractures and dislocations (Myers, 1992). Chest and abdominal injuries are caused by the child being struck by objects, being grabbed too tightly or by

being punched or kicked and can result in injuries to the underlying organs in the chest and abdominal cavities (Barnett et al., 2005). Burns are often inflicted as a form of punishment whereas dislocations and fractures of bones in various parts of the body often result from the child being punched, kicked, shaken, twisted or squeezed.

The consequences of child physical abuse are not only limited to the visible signs of physical trauma (Barnett et al., 2005). As stated by Hamilton and Browne (2002) and Sigelman and Rider (2003), research indicates that this type of abuse has detrimental effects on the psychological, social and intellectual functioning of the victim. These effects include psychological dysfunction, eating disorders, conduct disorders, poorly learned parenting skills and poor relationships with significant others (Bagley, Wood & Young, 1994). Barnett et al. (2005) expand on the behavioural problems stating that physical aggression and antisocial behaviour are most commonly associated with physical abuse. In contrast, however, Sadock and Sadock (2003) caution that physically abused children may also appear withdrawn and frightened.

Neurobiological complications associated with physical abuse include compromised brain development and alteration of the biological stress system within the body (Barnett et al., 2005). Research conducted by Miller (1999) suggests that abuse-related injury to the brain can result in impaired neurological functioning while research conducted by Miller (1999) and De Bellis (2001) suggests that the experience of physical abuse can result in impaired physiological functioning with a disruption in neurotransmitters and hormones. Changes in the neurobiological system can impact negatively on the physical and cognitive development of children as well as their ability to regulate their emotional and behavioural responses (De Bellis, 2001).

Possible cognitive difficulties associated with physical abuse and identified by Barnett et al. (2005) include: decreased intellectual and cognitive functioning, deficits in verbal abilities, memory, problem solving and perceptual-motor skills, decreased reading and mathematical skills, poor scholastic achievements and increased need for special education services.

With regard to their social and emotional functioning, Barnett et al. (2005) report that physically abused children suffer from problems related to attachment to caregivers and impaired parent-child relationships. This is

because the caregiver is both the child's source of safety and protection and the source of danger and harm (Hesse & Main, 2000) and these early patterns of parent-child interaction may lay the foundation for difficulties in social interactions later in life (Barnett et al., 2005).

Research conducted by Kaplan, Pelcovitz and Labruna (1999) concluded that children who have been victims of physical abuse are at an increased risk for specific psychiatric disorders. These include: major depressive disorders, oppositional defiant disorders or conduct disorders, attention-deficit/hyperactivity disorder and borderline personality disorder. The presence of posttraumatic stress disorder (PTSD) in victims of child physical abuse has also been documented in separate studies conducted by Famularo, Fenton, Kinscherff, Ayoub and Barnum (1994) and Dubner and Motta (1999).

### 2.4.2 Sexual Abuse

As stated earlier, sexual abuse includes incest, sexual assault, fondling, exposure to sexual acts, and involvement in pornography. In most cases the perpetrators are adult men and the victims are female children (Lewis, 1999), however, any grouping of sex, age and number of persons may be involved. The sexual act may range from penetration to no physical contact, and it may be sudden and violent, as in rape, or it may involve a period of grooming. The perpetrator may be a family member or a stranger, and it may be a single act or may occur over a period of years. Usually, however, the perpetrator of sexual abuse is commonly someone known to the child with fathers, step-fathers, uncles or family friends being the ones most often responsible for the sexual abuse of children (Lewis, 1999).

Although less common, females are also perpetrators of child sexual abuse and most offenders are either accomplices to male perpetrators, adolescent babysitters, lonely and isolated parents, or adult women who develop romantic relationships with adolescent boys (Saradjian, 1996). As stated by Barnett et al. (2005) female perpetrators tend to abuse younger children than male perpetrators do, and are more likely to be caretakers of their victims. Child rearing is accompanied by closeness and touching, which

in most families serves to provide the child with a sense of security and the feeling of being loved. In some families, however, touching is not confined to the appropriate limits and sexual abuse of children often occurs (Crosson-Tower, 1999).

#### 2.4.2.1 Possible effects of sexual abuse

The consequences of sexual abuse are classified as either initial (occurring within two years following the abuse) or long term (consequences occurring beyond the two years following the abuse) (Barnett et al., 2005).

The initial consequences of sexual abuse include a range of emotional, cognitive, physical and behavioural effects taken from the following literature sources (Barnett et al., 2005; Browne & Finkelhor, 1986; Kendall-Tackett, Williams & Finkelhor, 1993; Mayes, Currie, Macleod, Gillies, & Warden, 1992). The emotional effects reported in the literature include fears, anxiety, depression, anger, hostility, aggression, clinging, nightmares, guilt, tantrums, phobias, obsessions, tics, family and peer conflicts, and low self esteem.

The cognitive effects reported in the literature include learning difficulties, poor concentration, poor attention, declining grades in school-going children, negative perceptions and dissociation. The physical effects reported in the literature include bruising in the genital area, genital bleeding, genital pain, genital itching, genital odours, difficulty walking or sitting, sleep disturbance, eating disturbance, enuresis, encopresis, stomachache and headache.

The behavioural effects reported in the literature include regressive behaviour, social withdrawal, self-injurious behaviour, inappropriate sexual knowledge, sexualised behaviour, seductive behaviour, excessive masturbation, sex play with others, sexual language, genital exposure, sexual victimization of others, conflict with family members, poor relations with peer group, hyperactivity, delinquency, stealing and antisocial behaviour. As stated by Friedrich (1993) sexualised behaviour is believed to be the behaviour most predictive of the occurrence of sexual abuse.

Barnett et al. (2005) and Kendall-Tackett et al. (1993) suggest that there are two common patterns of psychological responses: one is associated with the symptoms of PTSD and the other with an increase in sexualised

behaviours. The PTSD symptoms most likely to occur are recurrent re-experiencing of the abuse through inappropriate play, dreams, flashbacks, using denial or repression as defence mechanisms to avoid strong emotions, or evidence of hyper-arousal manifested in sleep disturbances, aggression or other externalised symptoms. The sexualised behaviour may take the form of mimicking sexual intercourse, inserting objects into the anus or vagina, excessive or public masturbation, seductive behaviour, and knowledge and behaviour which is inappropriate for the age of the child.

It is estimated (Bagley & King, 1990; Davenport, Browne & Palmer, 1994; Finkelhor, 1988) that a minimum of a quarter male and female child sexual abuse victims carry an inheritance of serious long term psychological effects. As each person's experience of the abuse differs and their responses to it are determined by their personal resources and perspectives of life, a broad range of long term effects are observed (Davenport et al., 1994).

The long term effects are also varied and include depression and anxiety disorders, poor self esteem, suicidal behaviour, guilt, poor self-image, fears, phobias, somatic complaints, migraine, feelings of isolation and stigma, difficulty in trusting others, a tendency towards re-victimization, difficulty forming and maintaining relationships, suicidal behaviour, borderline personality disorder, self-mutilation, eating disorders, substance abuse, and sexual maladjustment (Browne & Finkelhor, 1986; Mayes et al., 1992; Peters & Range, 1995). The presence of PTSD symptomatology is also documented as a possible long term effect associated with child sexual abuse (Barnett et al., 2005). Areas of psychological damage include the self-concept, the sense of self, interpersonal relationships, sexuality and aggression. In the case of adult survivors of child sexual abuse, symptoms include sexual dysfunction, suicidal tendencies, depression, anxiety, guilt and disturbed interpersonal relationships (Walker et al., 1988; Coleman, Butcher & Carson, 1984).

### 2.4.3 Psychological Abuse

Psychological abuse is the least reported and usually the least visible form of child abuse (Barnett et al., 2005). It is the most difficult form of child abuse to define as it often coexists with other forms of child abuse and rarely occurs

in isolation (Iwaniec, Herbert & Sluckin, 2002). It has been recognised as possibly the most pervasive and damaging form of child abuse (Barnett et al., 2005).

Psychological abuse involves conveying messages to the child that she is worthless, inadequate, unloved, endangered or valuable only when she meets someone else's needs (Hart, Binggeli & Brassard, 1998). Abusive acts include rejecting, degrading, terrorising, isolating, incorrectly socialising or corrupting, exploiting, denying emotional responsiveness to a child and confining a child. Research also indicates that a child suffers psychological abuse indirectly when exposed to violent behaviour between family members, in particular, parents (Barnett et al., 2005). This violent behaviour may be directly observed or overheard, or the child may see the results of the violent acts in the form of the physical injuries.

Early research studies show a link between psychological abuse and low income. In addition to this, the female parent is identified most often as the perpetrator of psychological abuse. Barnet et al. (2005) inform that the psychologically abusive parent often exhibits interpersonal and social difficulties, poor problem-solving skills, substance abuse and psychiatric maladjustment (for example, depression).

#### 2.4.3.1 Possible effects of psychological abuse

Researchers have documented the following short term effects associated with psychological abuse: insecure attachment to caregiver, lower levels of social competence and social adjustment and difficulties with peer relationships. Possible intellectual deficits include: academic problems, decreased cognitive ability, decreased problem solving and intelligence and a lack of creativity. A variety of affective and behavioural problems are also associated with psychological abuse and include aggression, conduct problems, attention difficulties, low self esteem, lack of impulse control, disruptive classroom behaviour, self-abusive behaviour, eating disorders, hostility, anger and anxiety (Barnett et al., 2005; Hamilton & Browne, 2002).

The potential long term effects of psychological abuse that could extend through to adulthood include: a greater risk for the development of personality

disorders including borderline, narcissistic, obsessive-compulsive, and paranoid personality disorders. In addition to this, the presence of difficulties such as a perpetuating poor self esteem, substance abuse, anxiety, depression, suicidal behaviour, dissociation, and interpersonal sensitivity (Barnett et al., 2005).

Researchers have started evaluating the long term consequences of psychological abuse in comparison to other forms of child abuse. Many of these studies reportedly confirm that, relative to other forms of abuse, psychological abuse is the strongest predictor of negative long term impacts on psychological functioning (Barnett et al., 2005).

### 2.4.4 Neglect

Neglect is described as an act of omission rather than commission and as such is difficult to detect (Wenar & Kerig, 2000). It may exist independently of other forms of abuse, however, neglect frequently co-exists with psychological, physical or sexual abuse (Glaser & Prior, 2002) When the provision of caregiving, such as nourishment, shelter, health care, personal hygiene, household safety, household sanitation, supervision and education is lacking and compromises a child's physical and/or psychological health, this then constitutes neglect. Barnett et al. (2005) add that physically deserting a child, failing to provide a child with emotional support and security and encouraging delinquent behaviours also constitute areas of child neglect. Herzberger (1996) states that alcohol abuse has been observed among child abusing parents, with the most common forms of abuse being neglect and psychological abuse. In addition, alcoholic parents have commonly been found to refrain from disciplining their children (Herzberger, 1996).

#### 2.4.4.1 Possible effects of neglect

There are short term and long term effects associated with this form of child abuse. Barnett et al. (2005) assert that one of the most frequently occurring problems is a social and attachment difficulty. There is a disturbed parent-child attachment, generally reflecting an anxious attachment style (in

which the child is overly dependent, clingy and prone to crying). There are also indications of disturbed parent-child interactions with deficits in communication and poor involvement between the mother and her child. Neglected children also show deficits in peer relationships and many exhibit more socially withdrawn behaviour.

Possible cognitive difficulties associated with neglect and identified by Barnett et al. (2005) include: poor scholastic achievement and grade repetitions, deficits in general intelligence, deficits in language comprehension and verbal abilities, receptive and expressive language deficits, low level of creativity and flexibility in problem solving.

The victims of neglect frequently display emotional and behavioural problems such as: apathy, withdrawal, low self esteem, ineffective coping, difficulty recognising and discriminating emotion, physical and verbal aggression, attention problems and conduct problems (Barnett et al., 2005). There are also physical consequences of neglect. These include a clinical condition known as failure to thrive, and the most serious consequence of all, death.

The long term effects associated with neglect include: lower intelligence scores and reading ability, increased criminal and delinquent behaviour, and increased likelihood of running away from home (Kaufman & Widom, 1999). In addition, Horwitz, Widom, McLaughlin and White (2001) state that dysthymia, PTSD, major depressive disorders, antisocial personality disorder and alcohol problems have also been linked to neglect in childhood.

Sigelman and Rider (2003) add that many neglected and abused children turn out fine, especially if they have a close relationship with at least one non-abusive adult. An important point was made by Feinauer (1989) that literature concerning the successful adjustment in life following childhood abuse is extremely limited. Child abuse cannot be spoken about in over-simplistic terms as a single phenomenon likely to have similar negative effects for those who have experienced it. People (and different cultures) experience and define the same events in different ways, react in different ways and ultimately make sense of their experiences in different ways (Janoff-Bulman, 1989).

## 2.5 Abuse Within the Family System

One of the ways in which being part of a family helps individuals to develop is by allowing them to participate in a number of different relationships simultaneously (Wenar & Kerig, 2000). This approach to the family system, known as structural family theory, is associated with Salvador Minuchin (Becvar & Becvar, 2003). According to Minuchin, there are naturally occurring subsystems within the larger family system that serve to join some family members and differentiate others. There is the marital subsystem, the parent-child subsystem and the sibling subsystem. These subsystems are all separated by invisible boundaries which define the amount and kind of contact allowable between subsystems in the family. The interpersonal boundaries between subsystems fall into three categories: clear, rigid and diffuse. Clear and appropriate boundaries allow family members to meet their developmental needs and change as family members grow and develop (Wenar & Kerig, 2000). Boundaries that are too rigid result in little interaction between family members who may appear unresponsive to each other. In contrast, diffuse boundaries are unclear or too flexible and also present problems within the family (Crosson-Tower, 1999). The clarity of the boundaries within a family is a useful indicator for the evaluation of healthy family functioning.

If appropriate boundaries are not maintained as with rigid and diffuse boundaries, this can result in families becoming confused and dysfunctional. The family environment, while often seen as a place where children are nurtured and sheltered, is also the place where many children are at risk of being victimised by their parents (Lewis, 1999). The most significant aspect of child abuse, according to Wenar and Kerig (2000), is the abuse which frequently occurs within the context of the family, committed by the adults on whom the child relies for protection.

Bagley and King (1990) add that sexual abuse is likely to occur in family settings in which the biological father is replaced by a stepfather/cohabiter, has a drinking or mental problem, or where the child is subjected to vacillating emotional support, authoritarian control or rejection. An abusing parent, regardless of the age of the child, destroys the expectations of love, trust and

dependence that are so crucial to healthy personality and social development (Craig, 1999). As indicated in Minuchin (1974), parentification (where the child is expected to assume a parental role) is partly due to the inability of the family to establish and maintain effective boundaries.

Parents or caregivers under the influence of alcohol or drugs frequently physically, sexually or emotionally abuse the children in their care (Crosson-Tower, 1999) and the influence of the substance hampers the parent's ability to be fully available to the child, thus implying neglect. Furthermore, Hamilton and Browne (2002) state that child behavioural problems have been linked to both growing up in a violent household and one in which a parent is a substance misuser.

Often the incestuous family has unclear generational boundaries. Relationships, especially those that are sexual and normally kept to the older generation begin to involve the rest of the family. Abusive parents have inappropriate expectations of their children and there is a reversal of the dependence needs. The parent will, for example, turn to the child for reassurance, nurturing, comfort and protection and expect a loving response (Sadock & Sadock, 2003).

The presence of poverty, unemployment, stressful living conditions and overcrowding, lack of social support and substance abuse all add to the potential for children to be abused and neglected as these issues may increase the stress levels in susceptible families (Lewis, 1999). In addition to these factors, the unequal power relations between men and women, as well as the interpersonal and individual factors such as growing up in a dysfunctional and emotionally abusive family, also constitute causes of child sexual abuse.

Wurtele (1997) states that the characteristics of a child's family may themselves constitute risk factors and increase the likelihood of sexual abuse. These include: the emotional neglect of the child, inappropriate expectations regarding the child's responsibilities, children who lack supervision, marital discord, lack of privacy, situations in which offenders have access to victims, stressors in the family, the presence of a father substitute, exploitation of children to meet the needs of adults, and the absence of the natural parent.

## 2.6 Coping With the Trauma of Child Abuse

When children have to cope with traumatic experiences, they employ the following mental coping mechanisms as discussed in Wilson, Kendrick and Ryan (1992):

- Repression (where the child attempts to block all spontaneous thought to avoid the traumatic content)
- Fixation to the trauma (where the child repeatedly gives an incomplete and journalistic retelling of the traumatic event)
- Displacement (where the child transfers feelings about the trauma to fearful feelings about her own future harm)
- Denial-in-fantasy (where the child imagines a positive outcome rather than the traumatic one)
- Identification (where the child identifies herself with the police or with one of her parents)
- Detachment (where the child becomes withdrawn, numb, or mute about the traumatic event)
- Heightened anxious attachment (where the child shows clinging attachment behaviour to a caregiver)
- Dissociation (Which can be described as an extreme form of denial and a coping mechanism highly relevant to sexually abused children)

When the child is directly involved in a sexual abuse experience, the child may split her motor actions away from her feelings and mental activity as a means of coping with the recurring abuse. Various motor coping strategies may also occur. These include: repetitive, unsatisfying traumatic play which could involve other children, as well as the re-enactment of the traumatic event in real life.

Cognitive coping mechanisms develop gradually in children in keeping with their general level of mental development, and are more basic and transparent than in adults, as are lies and emotional understanding, (Ekman, 1989; Harris, 1989; Wilson et al., 1992). Children use coping mechanisms to deal with abnormal anxieties as well as everyday, normal anxieties.

The degree of support a child receives from her parents and others following the disclosure of sexual abuse has been shown to moderate the negative long term effects of abuse (Coffey, Leitenberg, Henning, Turner & Bennett, 1996). In addition, depending on the individual coping styles and mechanisms of different individuals, the effects of sexual abuse will be experienced to different degrees. Research suggests that coping strategies play an important role in the adjustment of the victim and survivor (Coffey et al., 1996). Children's perceptions of parental responses are also likely to have a significant impact on their ability to cope and adjust following the disclosure or discovery of child sexual abuse (Conte & Scheurman, 1987). The degree of trauma and adjustment of the child will also be affected by a number of factors such as: the degree and type of abuse, the age of the child, the duration and extent of the abuse (Crosson-Tower, 1999), the identity of the perpetrator and the conviction of the perpetrator and the availability of support structures.

## 2.7 Treatment of Child Abuse Victims

When children who have been abused enter the therapeutic process, they present a challenge for the therapist as Wieland (1997) points out, they are likely to have a damaged or distorted sense of self due to the various messages they have internalised about themselves. Childhood sexual abuse victims carry intrapsychic scars, of which the symptoms could persist for many years into adult life (Killian & Brakarsh, 2004).

Treatment methods for dealing specifically with psychological abuse have, as yet, not been well developed (Iwaniec et al., 2002), but it does lend itself to established therapeutic methods such as family therapy, cognitive-behavioural methods, attachment work, filial therapy and techniques that improve the parent-child relationship (Barnett et al., 2005; Iwaniec et al., 2002). These are some of the ways of working with parents which can help them become more effective in child-rearing practices and by so doing, help psychologically abused and neglected children.

Killian and Brakarsh (2004) recommend individual play therapy and group therapy as models of therapeutic intervention for victims of child abuse, however group therapy is only advocated as a suitable model for the older

child or adolescent. Individual play therapy has been widely advocated as the preferred method of intervention for abused children with sand play therapy, anatomical dolls, drawings, story telling and narrative being documented as useful means to enable sexually abused children to communicate (Davis, 1989; Hansen, 1992; Kelley, 1984; Miller & Boe, 1990; Pistole & Ornduff, 1994; Reidy, 1980; Steward, 1989).

Wilson et al. (2002) are of the opinion that it is helpful to offer each child who has been the victim of sexual abuse a short sequence of non-directive play therapy with the option to continue if the child so wishes. Through the use of play therapy the child can process and integrate the experiences of abuse and develop an understanding of the world. Play therapy enables the child to practise new ways of expressing emotions within the safety of the playroom. Non-directive play therapy will be discussed at length in the following chapter.

## 2.8 Conclusion

In this chapter, various aspects of child abuse were discussed, including the historical context of child abuse, followed by a discussion of the types of abuse and the possible initial and long term effects associated with abuse. Abuse within the family system was discussed as well as factors facilitating coping and the treatment of child abuse victims.

In the following chapter, the researcher will discuss the theoretical frameworks used in this research study. These include non-directive play therapy and Erik Erikson’s theory of psychosocial development.

# CHAPTER 3

# THEORETICAL FRAMEWORKS:
# NON-DIRECTIVE PLAY THERAPY (VIRGINIA AXLINE)
# THEORY OF PSYCHOSOCIAL DEVELOPMENT (ERIK ERIKSON)

"…to *play it out* is the most natural self-healing measure childhood affords" (Erikson, 1963, p.222).

## 3.1 Introduction

This chapter introduces play therapy as a therapeutic approach for working with children. Initially, a discussion covers Carl Roger's theory of personality structure upon which his person-centred therapy was based. Thereafter, a comprehensive discussion ensues covering Virginia Axline's non-directive approach to play therapy, followed by a detailed discussion of Erik Erikson's theory of psychosocial development. The chapter concludes with a discussion of the first four stages of Erikson's theory and the impact of child abuse at these stages.

## 3.2 Play Therapy

The emphasis in play therapy work is to enable the individual to move from a sense of being at the mercy of hidden feelings to gaining some mastery over them. Play therapy offers the child a unique relationship with an objective and accepting adult, who is not involved in other aspects of the child's life (West, 1992). The therapist creates a safe and trusting environment in which the child is free to explore her feelings which might be expressed either directly in words, or indirectly through behaviour and play. The therapist's task is to listen, understand and respond to these communications in such a way as to help the child towards a greater awareness of feelings, which, when expressed and experienced in a non-judgemental and accepting relationship, lose their negative power (Wilson et al., 1992). "Play therapy offers children an opportunity to work through their problems, to learn to know themselves, to

accept themselves as they are, and to grow more mature through the therapy experience" (Axline, 1989, p.54).

Play therapy may be in the form of directive or non-directive therapy. In directive play therapy, the therapist assumes responsibility for guidance and interpretation, whereas in non-directive play therapy, the therapist leaves responsibility and direction to the child (Axline, 1989). The non-directive approach is indicated by Wilson et al. (1992) to be an effective and non-intrusive way of working with a sexually abused child as it emphasises the child's choice and control of issues and the pace at which therapy progresses.

Developed from the work of Carl Rogers by Virginia Axline, play therapy draws from the humanistic school and is essentially child-centred (West, 1992). Before proceeding with a description of non-directive play therapy, it is important to understand the theory of the personality structure upon which it is based. The underlying philosophy of the approach is that each human being, whether adult or child, is motivated by a drive for self-realization. Given the opportunity and the right climate, the individual has the ability to solve her problems satisfactorily (Wilson et al., 1992).

## 3.3 Theory of Personality Structure

Meyer, Moore and Viljoen (1997) describe Carl Rogers' fundamental view of humankind as humanistic-phenomenological. With regard to the humanistic approach, Rogers emphasises the study of the individual as a whole as well as the active role the client plays in actualising her own intrinsic potential. With regard to the phenomenological approach, Rogers emphasises the part played by the client's subjective experience of her world and how this impacts on the client's view of herself (Meyer et al., 1997).

According to Rogers, the purpose of psychotherapy is to provide clients with the opportunity to get to know themselves fully and to reveal their potential (Meyer et al., 1997). This process takes place in a therapeutic environment in which the therapist accepts the client unconditionally with the emphasis being on the quality of the relationship between the client and therapist. The basis of Rogers' theory is the self-actualising tendency, which means that each person has a potential to develop, grow and change in a

basically positive way. Rogers' theory places a high value on the experience of the person and the importance of her subjective reality. The person-centred approach also challenges the individual to accept responsibility for her life and to trust in her inner resources as she journeys along the path of self-awareness and self-acceptance (Mearns & Thorne, 1988).

Roger's (1951) personality theory is derived mainly from his practical experience in the field of psychotherapy and is based on three central assumptions. These are that the individual has constructive potential; that the nature of the individual is basically goal-directed, and that the individual is capable of changing. There are 19 propositions underlying Roger's theory which are fundamental to his approach and these are listed in Meyer et al. (1997, p.464) as follows:

1. All individuals exist in a continually changing world of experience of which they are the centre.
2. The organism reacts to the field as it is experienced and perceived. The perceptual field is *reality* for the individual.
3. The organism reacts as an organised whole to this phenomenal field.
4. A portion of the total perceptual field gradually becomes differentiated as the self.
5. As a result of the interaction with the environment, and particularly of evaluational interaction with others, the structure of the self is formed.
6. The organism has one basic tendency and striving to actualise, maintain and enhance the experiencing organism.
7. The best vantage point for understanding behaviour is from the internal frame of reference of the individual.
8. Behaviour is basically the goal-directed attempt of the organism to satisfy its needs as experienced in the field.
9. Emotion accompanies and in general facilitates such goal-directed behaviour, the kind of emotion being related to the perceived significance of the behaviour for the maintenance and enhancement of the organism.
10. The values attached to experiences, and the values which are part of the self structure are, in some instances, values experienced directly by the organism, and in some instances are values interjected or taken

over from others, but perceived in distorted fashion, as if they have been experienced directly.

11. As experiences occur in the life of the individual, they are either: (a) symbolised, perceived, and organised into some relationship to the self, (b) ignored because there is no perceived relationship to the self structure, or (c) denied symbolisation or given a distorted symbolisation because the experience is inconsistent with the structure of the self.
12. Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self.
13. In some instances, behaviour may be brought about by organic experiences and needs which have not been symbolised. Such behaviour may be inconsistent with the structure of the self, but in such instances the behaviour is not *owned* by the individual.
14. Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.
15. Psychological maladjustment exists when the organism denies the awareness of significant sensory and visceral experiences, which consequently are not symbolised and organised into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension.
16. Any experience which is inconsistent with the organisation or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organised to maintain itself.
17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived and examined, and the structure of self revised to assimilate and include such experiences.
18. When the individual perceives and accepts into one consistent and integrated system all her sensory and visceral experiences, she is

necessarily more understanding of others and is more accepting of others as separate individuals.

19. When the individual perceives and accepts into her self-structure more of her organic experiences, she finds that she is replacing her present value system – based so largely upon introjections which have been distortedly symbolised – with a continuing organismic valuing process.

Within each individual there appears to be a powerful force that continuously strives for complete self realization. This force may be regarded as a drive towards maturity, independence and self-direction. It is, however, necessary for the individual to be given the permission to be herself, to receive complete acceptance of herself, by herself and others, and the right to be entitled to the dignity befitting each individual in order to achieve a satisfaction of this growth impulse (Axline, 1989). Growth is described as a spiralling process of change and the individual's perspective and focus is changed by her experiences. Everything is constantly evolving, interchanging, and assuming varying degrees of importance to the individual as her attitudes, thoughts and feelings are constantly reorganised and integrated. Every experience, attitude and thought of every individual is constantly changing in relation to the interaction of psychological and environmental forces upon each and every individual. There are certain basic needs within each individual and she is constantly trying to satisfy these needs.

Carl Rogers was influential in defining a type of association with people based on nurturance, warmth, genuineness, respect and authenticity (Kottler, 2004). During the 1950s and 1960s, Rogers conducted a series of research studies to develop empirical evidence for his early theorizing about the importance of the counselling relationship. This resulted in the three core conditions upon which the person-centred therapy is based, namely, empathy, unconditional positive regard and congruence/genuineness (Kottler, 2004).

### 3.3.1 Empathy

This requires active listening and attending to the client and understanding what it means to be the client and to be in her unique life situation. Empathy is, "attempting to see the world through the client's eyes" (Mabey & Sorensen, 1995, p.25). To achieve this, the therapist must be willing to engage on an

emotional level. Mearns and Thorne (1988) describe empathy as a way-of-being-in-relation to the client rather than simply a technique of responding to the client. Mabey and Sorensen (1995) further clarify this as being willing to recognise the client's feelings by recognising and acknowledging in themselves the emotion being described or felt, while simultaneously focussing on the client and being aware of the separateness between them.

An example of how the play therapist can reflect empathy is by reflecting verbally her observation of what the child is feeling or experiencing based on the child's behaviour. This in turn serves to increase the child's level of self-awareness and the impact that her behaviour might have on others.

### 3.3.2 Unconditional Positive Regard

This is described in Mabey and Sorensen (1995) as, "the intrinsic valuing of the client without imposing conditions of worth" (p.26). This value is especially important when working with a young client as her self-worth is often low. When the young person is with a therapist providing unconditional positive regard, she will begin to challenge her self-concept and pay attention to the prompting of the organismic self (Mabey & Sorensen, 1995). The process of intrinsically valuing clients enables the therapist to challenge or confront the client in such a way that the client will tolerate the challenge.

In the play room, the therapist can communicate this core condition by allowing the child the freedom to engage in the type of game of her choice without fear of being judged by the therapist.

### 3.3.3 Congruence /Genuineness

This is the core condition that requires a therapist to be real and authentic within the therapeutic relationship. A therapist who is congruent allows for the child to meet a professional who is not hiding behind a role, but promoting equality in the relationship. This type of relationship is empowering to the young client (Mabey & Sorensen, 1995). Rogers proposed that it is the realness of the encounter that is important and his insight-orientated theory encourages naturalness, genuineness and humanness in the relationship between therapist and client. The core of the person-centred approach is

rooted in a profound regard for the wisdom and constructive capacity in the human organism (Mearns & Thorne, 1988).

A child who has been abused may not know appropriate boundaries between herself and other adults or children and may act in a way which makes the therapist feel uncomfortable. It is important for the therapist to reflect this back to the child because it is through the genuine setting of boundaries that the child will learn to identify her own.

Person-centred therapy has an optimistic philosophy which emphasizes the potential of humans to learn, grow, and heal themselves when given the opportunity within a nurturing therapeutic relationship (Kottler, 2004). The person-centred approach elevates the importance of the individual's experience and the significance of her subjective reality (Mearns & Thorne, 1988). The central tenet of person-centred therapy as described in Wilson et al. (1992) is that individuals have within themselves a basic drive towards health and better functioning, and that they possess the ability to solve their problems satisfactorily if provided with the opportunity and right climate to do so.

## 3.4 Non-directive Therapy

Non-directive therapy is based upon the assumption that the individual has within herself the ability to solve her own problems as well as the growth impulse that makes mature behaviour more satisfying than immature behaviour (Axline, 1989). This form of therapy starts where the individual is, and bases the therapy process on the current formation, allowing for change depending upon the reorganisation of the individual's accumulated experiences, attitudes, thoughts and feelings to bring about insight during the therapeutic contact (Axline, 1989). Boy and Pine (1982) assert that the basic propositions regarding Roger's personality theory can be summarized as viewing the child as:

1. being the best determiner of a personal reality
2. behaving as an organised whole
3. desiring to enhance the self
4. being goal directed in satisfying perceived needs

5. being behaviourally influenced by feelings that affect rationality
6. being best able to perceive self
7. being able to be aware of the self
8. being valued
9. being interested in maintaining a positive self-concept
10. behaving in ways that are consistent with the self concept
11. not owning behaviour that is inconsistent with the self
12. producing psychological freedom or tension by admitting or not admitting certain experiences into the self-concept.
13. responding to threat by becoming behaviourally rigid
14. admitting into awareness experiences that are inconsistent with the self if the self is free from threat
15. being more understanding of others, if a well-integrated self concept exists
16. moving from self-defeating values toward self-sustaining values.

Non-directive therapy allows the individual to be herself, to accept that self and to learn to know herself completely without evaluation or pressure to change. This fundamental assumption is carried through to the non-directive play therapy relationship as well.

### 3.5 Non-directive Play Therapy

Based on the principles of Roger's person-centred therapy, also known as non-directive psychotherapy, the non-directive approach to play therapy was developed most fully by Virginia Axline who is regarded as the approach's chief advocate (Wilson et al., 1992). The non-directive play therapy approach, also known as child-centred play therapy, involves a special one-to-one relationship in which the therapist creates a safe and trusting environment in which the child is free to express herself and explore some of her feelings, if she so chooses. These feelings may be communicated directly in words or indirectly through her behaviour and play (Wilson et al., 1992). Therapy is a gradual process and the therapist cannot hurry the child into it as any attempt to hurry therapy along will cause her to withdraw. Axline (1989) explains this as the law of readiness operating in the therapy session and indicates that the

child will express her feelings in the presence of the therapist when she is ready to do so. “By nature [she] is slow. This world is a big place, and [she] needs time to take it all in” (Axline, 1989, p.119).

> Non-directive play therapy may be described as an opportunity that is offered to the child to experience growth under the most favourable conditions. Since play is the natural medium of self expression for the child, she is given the opportunity to play out accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion. By playing out these feelings, she brings them out in the open, faces them, learns to control them, or abandons them. When the child achieves emotional relaxation, she begins to realise the power within herself to be an individual in her own right, to think for herself, to make her own decisions, to become psychologically more mature and by so doing, realise selfhood. (Axline, 1989, p.15)

This form of therapy provides the child with the opportunity to play out her feelings and problems just as an adult would talk out her problems in adult therapy. Landreth (1991) supports this by stating that the process of play is viewed as the child’s effort to gain control of the environment. Each child possesses a personal perceptual view of self and the world that is reality for the child. This view of self provides a basis for individual functioning in whatever daily experiences occur in the child’s life. This view of self and the unlimited potential within each child form the basis for the theory of personality structure on which the child-centred approach to play therapy is based (Landreth, 1991). This will be described in greater detail below.

The child-centred theory of personality structure is based on three central concepts: (a) the person, (b) the phenomenal field, and (c) the self (Rogers, 1951). Explaining these concepts in more detail, *the person* is everything the child is: thoughts, behaviours, feelings and physical being. Every child exists in a continually changing world of experience of which she is the centre. *The phenomenal field* is everything the child experiences, whether or not at a conscious level, internal or external, and forming the basis of the internal reference from which life is viewed. It is the personal, subjective interpretation

of the positive and negative experiences of life that influences the child's self esteem and self image. Life is a constant process of personal dynamic experiences and the child is constantly experiencing an internal reorganization of thoughts, feelings and attitudes. In other words, whatever the child perceives to be occurring is reality for the child and her behaviour is determined by the subjective perceptions and experiences as well as her perceptions of self in the world. *The self* is the totality of those perceptions the child has of herself. As defined in Mabey and Sorensen (1995) the self concept is, "the constructed, internalized, sense of self based on the expectations of significant others and the denials and adjustments the individual makes to gain the approval and positive regard that are essential for emotional well-being" (p.25). The self grows and changes as a result of continuing interaction with the phenomenal field.

A child brings her thoughts and feelings encountered in her relationships with others into her play world. Words are inadequate and awkward things for a child especially when there are feelings which cannot be put into words, but play is something the child can handle adequately (Axline, 1989). The play materials in the therapy room are the mediums through which the child expresses her feelings and there are many different types of toys available upon which the child can vent her feelings. Children do play out the feelings that are very close to them; when they experience the permissiveness of the therapy hour however, the therapist should not expect each moment in the play room to be filled with deep feelings as these emerge as therapy progresses (Axline, 1989). The needs of each child are not the same and a valuable procedure for one child may be harmful to another. The therapist needs to be flexible, adaptable and sensitive to each individual situation (Axline, 1989).

The therapist allows the child to integrate her mental activity in a safe and non-threatening environment. Wilson et al. (1992) states that the therapist attempts to help the child to make conscious and give symbolic representation to thoughts which are largely outside conscious awareness. According to Axline (1989) successful therapy is the release of feelings that lead to the development of insight, resulting in more positive self-direction. This author further states that the therapy session is a growth experience for the child and

through the vivid experiences in the playroom, the child discovers herself as a person and finds new ways of relating to others in a healthy, realistic manner. This is done by the establishment of limitations which must be consistently followed.

These limitations serve to attach therapy to the world of reality, and to make the child aware of her responsibility in the relationship. These limitations include: limiting the wilful destruction of play materials and the play room, an attack on the therapist and limitations necessary for the protection of the child. Limitations also include the length of the sessions and the frequency of the appointments. In non-directive play therapy, the length of the session is usually one hour long, however it may be shorter for a young child, and the appointments usually take place on a weekly basis.

The role of the therapist is to create the right conditions in which this self-actualisation can take place, namely, congruence, positive regard and empathy. An essential characteristic of non-directive therapy is that the therapist is responsive to what the client is saying and accurately reflects back to the client an understanding of what the client has said. Through this process the client is helped to a better understanding and recognition of feelings and by so doing, begins to master them. Reflection mirrors the feeling and affect of the client, it is also non-interpretive, remains in the present and is communicated within the same metaphor as that used by the client (Wilson et al., 1992).

In the formulation of non-directive play therapy, Axline incorporated the principles of Roger's person-centred therapy, namely the development of a trusting accepting relationship between therapist and client; an acceptance that the client chooses the direction of the session; reflection rather than interpretation; non-intrusiveness and a respect for the client's defences; and the setting of appropriate, therapeutic boundaries to the relationship (Wilson et al., 1992). When the individual is left to take the initiative, she will select the ground upon which she feels her greatest security (Axline, 1964).

### 3.5.1 Eight Guiding Principles in Non-directive Play Therapy

Axline (1989) discusses eight basic principles to guide the therapist in non-directive play therapy. These principles of non-directive play therapy are interwoven and interdependent (Wilson et al., 1992) and are based on the non-directive client-centred approach developed by Carl Rogers and are as follows:

1. The therapist develops a warm, caring relationship with the child, in which a good rapport is established as soon as possible.
2. The therapist accepts the child exactly as she is and does not wish that the child were different in some way.
3. The therapist establishes a feeling of safety and permissiveness in the relationship so that the child feels free to express her feelings completely.
4. The therapist is sensitive to recognize the feelings the child is expressing and reflects those feelings back to her in such a manner that she develops self-understanding.
5. The therapist maintains a deep respect for the child's ability to solve her own problems if given the opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way in all areas of the relationship; the therapist follows by trusting the child's inner direction.
7. The therapist does not attempt to hurry the therapeutic process along and appreciates its gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that help the child accept personal and appropriate relationship responsibility.

According to Axline (1989) the relationship established between the therapist and the client is of utmost importance in determining the success or failure of therapy. Landreth (1991) states that the child-centred therapist is concerned with developing the type of relationship which facilitates inner emotional growth and the child's belief in herself.

### 3.5.2 The Four Stages of Play Therapy

Children in play therapy characteristically move through four therapeutic stages (West, 1992) although the order of the first three stages may vary occasionally. The four stages as stated by West (1992) are as follows:

#### 3.5.2.1 Stage One:

This stage is characterised by prolific and extensive behaviour which may occur appropriately or inappropriately. The behaviour of the child may appear extreme at this stage. For example, some children display hostility, expressing this in the play room by attacking the toys and the therapist. Other children display anxiety and are afraid of everything and everybody and want to be left alone.

#### 3.5.2.2 Stage Two:

It is during this stage that the child begins to focus her anger or fear on definite things or people outside herself. This is dependent on the child's trust in the play therapist and the certainty of being accepted and respected in the playroom. For example, the child begins to take out her anger or fear at school or at home. She takes her fears out on the objects that caused the problem and her anger is usually targeted at a sibling or parent, however, the play therapist may be targeted first. At this stage, the child's behaviour appears to worsen and may be a source of concern to the parent.

#### 3.5.2.3 Stage Three:

This is a stage of acute ambivalence as the child starts to build positive feelings and begins to feel worthy, accepted and good inside. The child may love and hate at the same time, which can be confusing and painful. The child may tentatively test out good feelings, but not yet trust what will happen if she shows her true feelings, resulting in violent mood swings. For example, in the play room, the child may ask for something and then throw it back. This may

be very intense at first, but gradually subsides as it is repeated in the therapeutic relationship. The child may try to involve the therapist more actively or differently as she works through issues of trust and mistrust, dependence and independence.

#### 3.5.2.4 Stage Four:

This is the stage at which play therapy ends. The positive, realistic feelings emerge more strongly and the child feels worthy and secure. The child has consistently been accepted throughout the first three stages, so at this stage the child has introjected a good-parent image from the adult play therapist and feels a good self image inside. The child is able to carry with her the therapist's acceptance and respect which leads to self-acceptance and self-respect. For example, the child appears to take some self-responsibility, namely, to own and to respond to her feelings. As Rogers asserts, "One of the most characteristic and perhaps one of the most important changes in therapy is the bringing into awareness of experiences of which heretofore the child has not been conscious," (1951, p.147).

West (1992) further stated that these therapeutic stages are linked with periodic feedback from people in the child's outside world so that a meaningful evaluation of the progress of the child can be made.

Hook (2002) highlights the importance of theory as tools that enable practitioners to organise and understand a diverse range of developmental information that may otherwise have remained disorganized. However, he advised that theories are only useful as long as they accurately, usefully and ethically expand our ability to explain, predict and analyse critically. If a theory fails in these regards, then it is time to reformulate or adapt the theory. By utilising more than one theory, we are able to look at behaviour from more than one angle. Similarly, one theory may be well suited to the explanation of one aspect of behaviour, but it may be necessary to incorporate additional theories if various aspects of behaviour are to be properly accounted for (Hook, 2002). In this study, the researcher utilizes Erik Erikson's theory of psychosocial development to further contextualise the case.

## 3.6 Erik Erikson's Theory of Psychosocial Development

Erik Erikson was concerned with the inner dynamics of personality and proposed that the personality evolves through systematic changes that confront people with different challenges (Sigelman & Rider, 2003). His theory focuses on human development and can be described as a process covering the total lifespan and consisting of eight stages ranging from birth to old age (Meyer et al., 1997). Craig (1999) states that Erikson's theory of personality development concentrates mainly on the effects that social interactions have on shaping personality. Sigelman and Rider (2003) support this by adding that both maturational forces and social demands push individuals everywhere through these eight psychosocial stages and if early conflicts are not successfully resolved, then later conflicts may prove difficult to resolve.

Erikson's theoretical framework shows how the individual progresses through various emotional stages throughout the life cycle and how this normal progression is reflected in therapeutic work with children. In addition, Erikson's theory gives coherence and added meaning to the therapist's clinical experience with children in non-directive play therapy as well as to the understanding of all children (Wilson et al., 1992). The core concept of Erikson's theory is ego identity which can be described as a basic sense of who we are as individuals in terms of self-concept and self-image.

Craig (1999) states that a distinct part of all individuals is based on the culture they were raised in, starting with interactions with caregivers during infancy and continuing through adulthood with interactions with others outside the home. Erikson's stages organize the individual's development of emotions based on social interactions, as well as the maturational processes within the individual, into a general overview of normal emotional development. For optimal development, a healthy balance must be struck between the terms of conflict. For example, in infancy, trust of caregivers should outweigh mistrust, but an element of skepticism is needed as well (Sigelman & Rider, 2003).

### 3.6.1 The Eight Stages of Psychosocial Development

The eight stages of Erikson's theory will be presented in the following format: The stage of development will be described first, followed by the developmental crisis to be resolved, followed by the ego strength which develops as a result of a successful resolution of the stage. The eight stages as stated in Corey (2001) are as follows:

- Infancy: Basic trust versus mistrust: Hope

  This stage covers the first year of life and during this time, the quality of the caregiving environment contributes to the child's sense that the world is either a safe and loving place, or a disappointing one (Corey, 2001). If their caregivers are responsive to their needs, infants learn to trust other people; otherwise the balance of trust versus mistrust will tip in favour of mistrust (Sigelman & Rider, 2003). It is during this stage that infants begin to distinguish themselves from others and recognize themselves as separate from the caregivers who respond to their needs. The ego strength which develops from a successful resolution of this stage is hope.

- Early childhood: Autonomy versus shame and doubt: Will-power

  This stage covers the second year of life and is characterized by the child wanting to exercise autonomy (Corey, 2001). According to Erikson, as toddlers struggle with the psychosocial conflict of this stage, they acquire an even clearer sense of themselves as individuals and assert that they have wills of their own (Sigelman & Rider, 2003). If dependency is promoted by the parents, then the child's autonomy is inhibited and a sense of self doubt ensues. The ego strength which develops from a successful resolution of this stage is will-power.

- The play age: Initiative versus guilt: Purpose

  This stage covers the third to sixth year of life and is characterized by the child needing to select and achieve meaningful tasks in order to develop a positive view of self and purpose (Corey, 2001). Preschoolers

define themselves predominantly in terms of their physical activities and accomplishments and they develop a sense of purpose by devising bold plans and taking great pride in accomplishing the goals they set (Sigelman & Rider, 2003). If this is not allowed, children will develop guilt when using their initiative and will rely on others for direction and purpose. The ego strength which develops from a successful resolution of this stage is purpose.

- The school age: Industry versus inferiority: Competence

This stage covers the sixth to twelfth year and children focus on mastering important cognitive and social skills (Sigelman & Rider, 2003); they are confronted with learning the basic skills required for school success, learning the tools of their culture, as well as developing appropriate gender-role identity during this stage (Corey, 2001). During this stage, children evaluate their competencies and engage in more social comparison leading to a sense of either proficiency or inadequacy, depending on the outcome of the comparison. Sigelman and Rider (2003) advise that if it is a favourable outcome, then the child is likely to acquire a sense of industry rather than inferiority. Successful resolution of this stage leads to the development of competence. Children who successfully master each of the childhood psychosocial conflicts gain new ego strengths, learn about themselves and position themselves to resolve the next stage relating to the adolescent crisis of identity versus role confusion.

- Adolescence: Identity versus role confusion: Reliability

This stage starts at approximately twelve years of age and ends at the beginning of early maturity (anywhere between 18 and 25 years of age). The tasks in this stage are for the adolescent to form a clear identity and purpose in life (Corey, 2001) and by so doing, paves the way for forming a truly intimate relationship with another person in the next stage of intimacy versus isolation (Sigelman & Rider, 2003) . Failure to do this will result in

role confusion. The ego strength which results from a successful resolution of this stage is reliability.

- Early adulthood: Intimacy versus isolation: Love

This stage covers the ages of approximately 18 to 25 years and involves the forming of intimate relationships which, if not achieved, can result in the individual isolating and alienating themselves (Corey, 2001). Erikson theorized that before an individual is able to commit to a shared identity with another individual, she must first achieve a sense of individual identity (Sigelman & Rider, 2003). The ego strength which develops from a successful resolution of this stage is love.

- Adulthood: Generativity versus self-obsession and stagnation: Care

This stage covers the ages of approximately 25 to 65 years of age. The matter of generativity versus stagnation involves gaining the capacity to generate or produce something that outlives you and to genuinely care about the welfare of future generations (Sigelman & Rider, 2003). It is during this stage that the adult has the need and ability to be involved in helping the next generation; failure to achieve a sense of productivity will result in psychological stagnation (Corey, 2001). The ego strength that develops from a successful resolution of this stage is care.

- Maturity: Ego integrity versus despair: Wisdom

This final stage, which begins somewhere between 60 and 70 years of age, is characterized by the individual looking back over their life. Elderly adults try to find a sense of meaning in their lives that will help them face the inevitability of death (Sigelman & Rider, 2003). If the journey seems to have been personally worthwhile, then ego integrity is the result. If ego integrity is not achieved, then despair is the result (Corey, 2001). The ego strength which results from a successful resolution of this stage is wisdom.

In addition to successfully resolving the crises at each of the stages, Erikson describes development as occurring holistically and according to the

epigenetic principle. This means that to develop optimally, an individual will not only successfully resolve the crisis of the particular stage she is in, but also work through each crisis afresh at each stage and experience the positive aspects of each developmental crisis as appropriate to the developmental stage (Meyer et al., 1997).

### 3.6.2 The Impact of Abuse on the Child's Psychosocial Development

The first four stages of Erikson's theory will be discussed here in more detail as these are the stages most relevant to this study. More specifically, the possible effects of abuse on the child's development according to the first four stages of Erikson's theory will be discussed.

- Trust versus Mistrust

The child's development of trust versus mistrust may be interrupted at this stage if she experiences abuse during this time (Wilson et al., 1992). The child requires the presence of an attachment figure and the consistent quality of parental care to achieve a feeling of basic trust. Even when the establishment of basic trust has been laid as a foundation, it may not be a lasting achievement. Trust can also be impaired during later development if the child experiences sexual abuse. The child is physically and emotionally dependent on her caregivers and their ability to protect her from harm. When the abuse has been committed within the context of the family, the child is likely to feel a sense of deprivation and abandonment by her carer even when this person has not been directly involved in the abuse. In addition, the sexually abused child may also have a sense of mistrust in herself, of her feelings and of her body. When the child has felt some physical pleasure during the sexual abuse, or if the child has a strong emotional attachment or sense of loyalty to the abuser, then this mistrust in herself may be particularly apparent.

The therapeutic relationship, to a significant degree, mirrors the child's functioning in other relationships. To this end then, the child may have an insufficient level of trust in the therapist to engage meaningfully in the process of therapy. Wilson et al., (1992) inform that this may be mitigated, however, by

the therapist's attitudes of empathy, acceptance and congruence and lead to a decrease in the child's defensiveness, enabling her to establish a feeling of trust with the therapist. In contrast, the abuse may have led to a deprivation of the child's emotional needs over a prolonged time and the child may enter therapy with a desperate need for attention and affection. Consequently, the child may be too willing to place her trust in the therapist; relating this to other relationships, the child may be vulnerable to further exploitation as she will not have developed sufficient mistrust to protect herself against further abuse.

The child's experience of the therapist as a consistent, warm and trustworthy adult offers her the opportunity to explore more appropriate ways of relating to others. The child's deep sense of mistrust can be moderated by a relationship with an adult who does not invade or abuse her, as the perpetrator has done, and does not blame her or offer inadequate protection as the non-abusing parent has done. Within the therapeutic relationship, the child is valued for herself, without any expectations, and this will provide the child with an experience against which to compare the abusive relationship.

- Autonomy versus Shame and Doubt

When a child is sexually abused, she feels both the loss of self control, and experiences control from others, leading to a lasting feeling of shame and doubt (Wilson et al., 1992). The sexually abused child has usually been given many false messages about her autonomy as she has no real choice at any stage about rejecting the abuse and has no control over the feelings of shame and doubt that ensue. In addition, the sense of responsibility for having allowed the abuse to take place and a feeling of having been an active participant is frequently used by the perpetrator to silence the child. Wilson et al., (1992) caution that damage at this stage of development can lead to a sense of compulsive self-doubt which can become particularly acute during adolescence, if not resolved by therapeutic help. Often the child has no choice as to whether she attends therapy or not; however, within the non-directive play therapy approach, she has choices regarding activities and conversations during the therapy session. This re-establishment of choice and autonomy is exceptionally important, especially for victims of sexual abuse and can be therapeutically addressed by way of non-directive play therapy.

- Initiative versus guilt

Sexual abuse at this stage of development is likely to lead to a sense of overwhelming guilt as the child feels responsible for some, if not all of the sexual abuse that has occurred. The professional response to the child's sexual abuse, particularly the investigatory stage where she is physically examined, interviewed and questioned about the abuse which took place, may exacerbate the child's feeling of guilt. The therapist provides a containing relationship for the child where she can play out her feelings in the safety of the play room, if she chooses to. The therapist does not judge the toys the child chooses to play with, or the games the child chooses to engage in, nor does she add to the guilt feelings experienced by the child, but allows her to establish a sense of purpose in the play room.

- Industry versus inferiority

Wilson et al., (1992) advise that this stage of development may also be distorted by the experience of child abuse and lead to a prevalence of feelings of inadequacy and inferiority. The child may feel inferior in several ways. Firstly, a sexually abused child is likely to feel isolated and different from her peer group resulting in separation from other children. Secondly, the perpetrator may strive to keep the child away from peer group friends because of jealousy or fear that the child might disclose the sexual abuse to her friends. She then loses or fails to develop her sense of identity in relation to them. If the child's normal emotional development is interrupted at this stage, the child may become an under-achiever at school as she is unable to establish the emotional space required for her intellectual growth. She may also experience feelings of stress, anxiety, fear, dread and avoidance (Wilson et al., 1992). In contrast, the child may become an overachiever at school as she attempts to regain some control over her life. Recognition of her intellectual abilities and achieving academic success provides a way for the child to become or feel superior and compensates for the trauma created by the sexual abuse.

## 3.7 Conclusion

In this chapter, the reader was introduced to play therapy. The non-directive approach to play therapy was followed in this study and the origins of this approach, namely, Carl Rogers' approach were discussed in detail. This was followed by a discussion of Erik Erikson's theory of psychosocial development and the chapter was concluded with a more detailed discussion of the first four stages of Erikson's theory and the impact of child abuse at these stages.

In the following chapter, the methodology of this case study will be reported on.

# CHAPTER 4

# METHODOLOGY

## 4.1 Introduction

In this chapter the case study approach to research is discussed in detail. It will deal specifically with how the case study research design and methodology was utilised in this research study. In addition to this, the ethical principles, data collection and analysis procedures followed in this study are discussed.

## 4.2 Case Study Research

### 4.2.1 Definition of Case Study Research

Bromley (1986) defined a case study as any singular case, example or incident that, when described and analysed, is thought to contribute to our understanding of an area of enquiry. Case studies are thorough investigations of individuals, single families, units, organisations, communities or social policies (Lindegger, 1999). Case study research can further be defined as ideographic research whereby individuals are studied as individuals and not as members of a population (Lindegger, 1999).

A psychological case study or case history refers to a detailed account of an individual. It consists of a comprehensive compilation of information about a person, including, for example his/her history, background, test results, ratings or interview details (Reber, 1985).

### 4.2.2 Issues Relating to Case Study Research

Edwards (1990) explained that the objective of case study research is the development of an accurate description of a single case which should ultimately lead to the development of theory and general principles. Case

studies frequently generate hypotheses that could be more meticulously tested by other research methods (Lindegger, 1999).

Historically, within the field of psychology, an inappropriate focus has been on quantitative methodology which was modelled on physics and diverted the psychology profession away from ecological, naturalistic research approaches and away from the intensive study of single cases (Edwards, 1990). In the 1950's, linked to the advances of computer technology, a decisive shift towards quantitative research took place and the result was a marked decline in the use of and respect for case studies. This resulted in the case study methodology and its underlying rationale becoming neglected. The case study method, having been used in the fields of clinical and developmental psychology in addition to anthropology and sociology, is being re-examined to re-establish its rightful place as a research tool in the social sciences (Edwards, 1990).

As stated in Yin (2003), social science research continues to make extensive use of case studies. This researcher goes on to say that the case study method is also frequently used in thesis and dissertation research in the traditional disciplines (of which psychology is one), as well as in the practice-orientated fields such as urban planning, social work or education. Finally, Yin (2003) states that case studies are increasingly commonplace and continue to be a relevant method of research. This researcher further explained that case studies are the strategy of choice when there is little control over events by the researcher and when the focus of the research is on contemporary phenomena within a real-life context.

> The intensive, largely retrospective study of individual cases can be as rigorous and informative as the extensive, prospective study of samples of people, whether in surveys or experiments. One can generalise from individual cases, and many important real-life human problems cannot be studied effectively, or at all, by experimental methods of enquiry. (Bromley, 1986, p.286)

### 4.2.6 The Practitioner as Scientist

Edwards (1990) proposes the adoption of the practitioner-as-scientist model of psychotherapy. Within this approach, psychotherapy is seen as a fundamental research endeavour, and the therapist is seen in the role of scientist. There are three parts to this model. Firstly, the therapist has access to privileged information about the life world of the client which is not easily obtained in other settings. The depth of the information obtained in the therapeutic setting is not readily accessed by quantitative methods. Secondly, the professional context of psychotherapy is an essential method of furthering knowledge through the development and testing of theory. This is achieved through case conceptualisation, supervision, peer discussion, seminar work, conferences and publications. Thirdly, the practice of psychotherapy can be perceived as an exercise in applied science as each case is unique and requires systematic and careful observation and conceptualisation. Clinical decisions and management or intervention strategies are made using similar criteria to that used in research development.

### 4.2.7 The Principles of Case Study Research Methodology

It is necessary that certain principles be adhered to, in order to ensure that the case study method retain its value as a scientific endeavour. The case study method is idiographic in that an individual case is studied in depth. This is different to most experimental methods where large samples are utilised.

Case study research does not use statistical inference. Validity is established by a logical process termed *analytic induction* or *analytic generalisation* (Yin, 2003). The case study researcher aims to develop a conceptualisation to reveal the important qualities of the case being investigated. The conceptualisation will make assumptions about the constructs or theoretical perspectives used to frame it, as well as the relationship that is assumed to exist between them. These assumptions are then tested against further cases (Edwards, 1990).

The process of analytic induction or analytic generalisation is summarised as follows:

1. Develop a rough definition of the phenomenon to be explained
2. Formulate a hypothesis to explain the phenomenon
3. Study one case to see the fit between the case and the hypothesis
4. If the hypothesis does not explain the case, either reformulate the hypothesis or redefine the phenomenon
5. Actively search for negative cases to disprove the hypothesis
6. When negative cases are encountered, reformulate the hypothesis or redefine the phenomenon
7. Proceed until one has adequately tested the hypothesis by examining a broad range of cases.

In the words of Edwards (1990), case study methodology is not “the mathematico-deductive model of positivist metatheory… rather a framework of understanding” (p. 15-16).

### 4.2.8 Types of Case Studies

Edwards (1990) refers to four types of case studies that can be seen as falling on a continuum, ranging from studies that are mostly descriptive to studies that are concerned with testing specific aspects of existing theory. It should be noted that these four types of studies represent points on a continuum rather than exclusive categories. As such, specific case studies may well have characteristics of more than one category.

The four types of studies as described by Edwards (1990) are as follows:

#### 4.2.8.1 Exploratory-Descriptive Case Studies

The aim of this type of case study is to provide a rich and accurate account of an individual case without attempting to generalise to other cases. The function of this type of study is essentially exploratory and serves to provide an in-depth understanding of something that is as yet largely unknown. There is little emphasis on developing theory or in using the case to test existing theory.

#### 4.2.8.2 Descriptive-Dialogic Case Studies

The aim of this study is to provide an accurate description and portrayal of a phenomenon. The case is not regarded as unique, however, and the case study is situated within existing theory, or used to argue conflicting points in existing theory. For this reason the descriptive-dialogic case study can also be seen as representing an early phase in the process of theory development.

#### 4.2.8.3 Theoretical-Heuristic Case Studies

The focus of this study is on the development of theory or the testing of existing theory. Not all cases are suitable for this type of research as the focus of this type of study is to test the adequacy of precise concepts in existing literature. Cases are therefore specifically chosen depending on the aspects to be studied.

#### 4.2.8.4 Crucial or Test Case-Study

In this type of study, the case is specifically selected to provide a crucial test of a theoretical proposition. The theory needs to have been well-developed and operationalised and the selected case needs to allow the researcher to argue convincingly regarding the theoretical construct in question.

The material of the current research study falls within the ambit of a descriptive-dialogic case study and thus attempts to provide a rich and accurate account of Michelle, an individual case, and to situate the case within the existing theoretical frameworks of non-directive play therapy and Erik Erikson’s theory of psychosocial development. Hook (2002) stated that theories serve the purpose of giving a certain amount of explanatory power, but are not foolproof and require constant testing, revising and updating. The existing case conceptualisations will be examined in the light of the case study material to discover whether the theories are rigorous or exact enough.

## 4.3 Preliminary Methodological Considerations

A number of difficulties relating to the effective execution of the case study approach have been identified. Before commencing with a case study, the researcher needs to be aware of the possible shortcomings and limitations of this approach. The shortcomings for the current study as well as the mechanisms for reducing their influence are discussed under the following subheadings:

### 4.3.5 Researcher Bias

Yin (2003) cautions that case study researchers may make use of the case study approach to substantiate a preconceived position. One possible way to counteract the danger of subjectivity is for researchers to examine their feelings about the subject and to develop empathy with the subject (Anderson, 1981). Objectivity can also be achieved through case conceptualisation, supervision, peer discussion, seminar work, conferences and publications (Edwards, 1990). The researcher tried to counteract researcher bias by conceptualising the case, discussing the case on numerous occasions with two clinical supervisors, and presenting the case at both a departmental proposal meeting and a clinical group supervision session at the tertiary institution where the researcher studied.

### 4.3.6 Cross-cultural Differences

Anderson (1981) suggested that the researcher needs to develop a culturally empathic understanding of the subject in order to minimise cross-cultural differences. As the researcher and research subject were of different ethnic backgrounds and cultural origins, the researcher interviewed the client’s mother to gain a deeper understanding of the client’s world, the client’s teacher and school environment, and the various health professionals who work in the community where the client lives and is currently being reared. The researcher also discussed the case in an additional group supervision session with colleagues of varying cultural origins.

### 4.3.7 Inflated Expectations

According to Anderson (1981), case study researchers should remain aware of the limitations of their approach. The current researcher recognises that this study has been conducted primarily from a psychological approach and is aware that psychological explanations do not replace other explanations, but rather compliment them. This researcher has maintained a realistic view of the limitations of the case study approach and is aware that she has interpreted this case study from two specific theoretical perspectives which have provided only some of many potential psychological interpretations.

### 4.3.8 Validity and Reliability Criticisms

Criticisms regarding validity and reliability form the most widespread criticisms of the case study design and methodology because of perceived ‘lack of controls’ in the case study approach and the difficulty in generalisation (Runyan, 1988). The quality of a case study design, as stated by Yin (1994), can be measured by four tests common to all social science methods, namely: construct validity, internal validity, external validity and reliability. These are each discussed in more detail below.

#### 4.3.8.1 Construct validity

This term refers to establishing correct operational measures for the concepts being studied (Yin, 2003). In case study research, this form of validity is addressed by using multiple sources of evidence and establishing a chain of evidence. Rudestam and Newton (1992) suggested that multiple sources of data should be utilised and in-depth research conducted with the material in order to check for distortions and ensure construct validity. The current researcher has obtained data from multiple sources of evidence including the case material, interviews with the client’s mother, collateral information from professionals involved in the case, as well as the results of psychometric assessments conducted on the child.

#### 4.3.8.2 Internal validity

This term refers to establishing a causal relationship, whereby certain conditions are shown to lead to other conditions. This is only a concern of causal or explanatory research and is not applicable to descriptive or exploratory research (Yin, 2003). As has been discussed previously, this research study can be referred to as descriptive research.

#### 4.3.8.3 External validity

This term refers to establishing the domain to which a study's findings can be generalised (Yin, 2003). Case studies rely on a process termed analytic generalisation by Yin (2003), or analytical induction by Edwards (1990), where the researcher strives to generalise a particular set of results to some broader theory. The current researcher aims to relate the findings to the theory and not to other case studies or the general population. In this way the results of this study will be compared with the previously developed theories of non-directive play therapy and Erik Erikson's theory of psychosocial development. The case study method retains external validity by investigating people or events in, or as close as possible, to their natural contexts.

#### 4.3.8.4 Reliability

This term refers to demonstrating that the operations of the study, such as data collection procedures, can be repeated with the same results (Yin, 1994). The objective is that if later researchers followed the same procedures as described by an earlier researcher and conducted the same study, they would arrive at the same research findings and conclusions. Yin (2003) emphasised the importance of making as many steps in data collection as operational as possible. Yin suggested that the case study researcher could compile a case study protocol that specifies all the operational steps in the data collection process. The current researcher has clearly operationalised all steps in the data collection process and all procedures followed in the research process

have been clearly stated in this detailed research treatise. The focus will now turn to the research design and methodology used in this study.

## 4.4 Research Design and Methodology

### 4.4.5 Research Design

The present study is qualitative in nature and utilises a single case (holistic) research design (Yin, 2003). The single case study is described by Yin (2003) as an appropriate design in five particular situations. These are as follows: (a) when the single case represents a critical case, when it is (b) an unique/extreme case, or conversely, (c) a typical/representative case, (d) a revelatory case, or (e) a longitudinal case.

The case study method provides a suitable research design in which to give an account of the subject in a therapeutic situation. The strategy of this research method is to provide a thorough description of a single unit during a specific period in time. This can lead to the researcher developing insights, ideas, questions and hypotheses (Fouche & De Vos, 1998) that can be further tested using other research methods (Cozby, 1997). To achieve the aim of this research study, the methodology of choice is the descriptive dialogic case study method. The descriptive dialogic case study method seeks to provide an accurate description and portrayal of a phenomenon. This method is utilised when the case is not regarded as unique, and the case study is situated within existing theory, or used to argue conflicting points in existing theory (Edwards, 1990). In the current study, the case study method was used to trace the process of therapy of a seven year old female client over a period of 15 sessions.

### 4.4.6 Research Subject

The purposive sampling technique was used in the selection of the subject of this study. This type of sampling is dependent on the researcher's judgement according to the characteristic attributes desired in the sample (Strydom & De Vos, 1998). Michelle was the single subject selected for this

study as she represents a typical case of an abused child in terms of her gender, age, socio-economic status and apparent dysfunctional family relationships (Barnett et al., 2005; Lewis, 1999). These factors have been presented and discussed in Chapter Two. An important point to be borne in mind is that the case study researcher does not try to select a “representative” case (Yin, 1994) as she does not aim to generalise to other case studies or to the larger population. Instead she attempts to generalise the findings to the theory (i.e., analytical generalisation).

### 4.4.7 Research Procedure and Data Collection

The following procedure was employed to achieve the aims of the study: Written informed consent was obtained from the client’s mother. The researcher did not discuss the issue of consent with the client as she was younger than eight years of age. The three principles of data collection as proposed by Yin (2003) were adhered to for this study. These are discussed as follows:

- Principle one: Use multiple sources of evidence

Yin (2003) stated that a major strength of case study data collection is the opportunity to use many different sources of evidence. Depending on the purpose of the research, the individual’s history, symptoms, characteristic behaviours, reactions to situations and responses to treatment may be presented in the case study (Cozby, 1997). The researcher made use of archival data (existing information in the form of the client file) regarding the research subject; as discussed by Cozby (1985), archival data constitutes a useful data collection method.

Triangulation of data sources was ensured as the researcher used multiple sources of evidence which were obtained through the direct observation of the client, case material from 15 sessions conducted between April and December 2003, detailed records in the form of the researcher’s process notes, clinical supervision of the case, interviews with the client’s mother, collateral information from various sources such as the client’s teacher, the

social worker, and the registered psychiatric nurses, and from psychometric assessments conducted on the subject by a colleague in August 2003.

- Principle two: Create a case study database

This refers to the practice of developing a formal and presentable database (Yin, 2003) and includes the researcher's case study notes. This consisted of the process notes, interviews with the client's mother, collateral information obtained from the client's teacher, social worker and registered psychiatric nurses, and the data from the psychometric assessments that were conducted on the client. In addition to this, the notes from the clinical supervision sessions and the clinical group supervision session were included in the database.

- Principle three: Maintain a chain of evidence

This principle serves to increase the reliability of the information in a case study and enables the readers of the case study to move from one part of the case study process to another, following the source of evidence from initial research question to conclusions (Yin, 2003). The current researcher ensured that a chain of evidence was maintained throughout this study. The research supervisors of this study provided comments and feedback on the data collection and analysis procedures, and as such, a form of investigator triangulation was employed.

Possibly one of the most difficult tasks confronting the case study researcher is the examination, extraction, categorisation and analysis of the collected data or material (Alexander, 1988; McAdams, 1994). The following section is a discussion of the procedures followed for the extraction and analysis of the research data.

### 4.4.8 Data Extraction and Analysis Procedures

The data that was collected for this study was analysed according to the content-analytic framework proposed by Irving Alexander (1988) whereby core identifying units, also referred to as themes or schemes, have been

extracted. According to this model, the data is approached in accordance with two major routes, namely, letting the data reveal itself, and asking the data questions.

#### 4.4.8.1 Letting the data reveal itself

This method involves sorting the raw data according to a set of rules that are designed to identify *what in the material* demands further scrutiny because of its importance. Alexander (1988) proposed nine guidelines for the extraction of salient data. These guidelines provided the current researcher with an overall indication or impression of what information, or which descriptions were most significant in terms of this study. Each guideline is described below, and an example is provided of how the researcher applied the guidelines to the data of this particular study.

- Primacy. That which comes *first*. This refers to the association that is made between the concepts of first and importance. People tend to speak or write first about what is most on their minds (Elms, 1994). In psychotherapy the importance of primacy or ranking is illustrated by therapists who will treat the opening communication in any hour as salient information that forms the cornerstone to unravelling what ensues (Fouché, 1999).

  The subject of this study, Michelle, started most sessions by drawing a picture for the therapist. Her conversation was mostly nonverbal, but her opening communication was through her play and her drawings.

- Frequency. This refers to that which appears often and *frequently*. The frequency with which information is reported is usually a sign of certainty and importance. Fouché (1999) clarifies that therapists are tuned to frequency or repetition as increasing signs of certainty and of importance; when a message is repeatedly imparted, people are more likely to assign importance to that message.

As has been discussed in Chapter Three, play is a child's natural medium of expression, and for this reason the therapist looked more carefully at the behaviour that Michelle repeated frequently. For example, throughout a number of the therapy sessions Michelle pretended to prepare food and feed the dolls; there was thus a strong theme of nurturance present.

- Uniqueness. This refers to that which is *singular* or odd. As an indicator of importance, uniqueness is related to a variety of normative assumptions, and the various baselines that the examined material is being compared with must be kept in mind. Uniqueness refers not only to verbal expression, but also to the content of what is being expressed. As the therapist, one must look for unique verbal and nonverbal cues from the client.

  An example of uniqueness as an indicator of salience is illustrated in session six of this case study when Michelle removed her shoes in the playroom and tentatively started a peek-a-boo game with the therapist. This was the first time she initiated a game with the therapist in the playroom and can thus be seen as an indicator of importance.

- Negation. This refers to that which is denied or turned into its *opposite*. Negation statements made by clients in psychotherapy, are indicators of possibly repressed or unconscious material (Fouché, 1999).

  An example of negation occurred during one of the therapist's interviews with the client's mother wherein the therapist was informed that the mother had not touched a drop of alcohol since her previous boyfriend had left her. This was contrary to and thus negated the information reported by collateral sources.

- Emphasis. This refers to that which is highlighted either by being overemphasised, underemphasised or mistakenly emphasised. Overemphasis is usually noted when something which is widely held to be commonplace, receives excessive attention. Underemphasis arises

when something that seems important receives little attention. Misplaced emphasis occurs when an apparently irrelevant aspect of a crucial event is emphasised (Elms, 1994).

There was a general consensus amongst all data sources regarding Michelle's behaviour; information from all sources emphasised her aggression towards other children, her destructiveness of property, and her self- injurious behaviour.

- Omission. This refers to that which is *missing* from the picture. Alexander (1988) stated that attention to affect is commonly omitted while ample description of actions and events abound.

  The therapist's interviews with the client's mother as well as information from the teacher, social worker and professional nurses all revealed descriptions about Michelle's behaviours and the events surrounding the alleged abuse. There was, it seemed, very little attention paid to Michelle's inner life or emotional well-being.

- Error or Distortion. This refers to that which is a *mistake* or error. Mistakes can occur in a variety of forms, for example, they can be related to general facts about the case or to facts about the individual.

  The researcher never obtained any information about the alleged abuse from the client as this was not the goal of the therapeutic process. These facts were relayed to this researcher via the client's mother and the collateral information obtained from the professionals.

- Isolation. This refers to that which is *alone*, or does not fit. This leaves one asking the question: "Does this really make sense?" Fouché (1999) states that if in reading or listening, one finds oneself asking the question, "Where did that come from?" or "Does that really follow?", it is highly likely that important material is contained in such isolated communication.

  In two consecutive sessions in the playroom, Michelle started crying while seated at the table. These two sessions were neither the first nor

the last sessions and there did not appear to be a reason for her crying in the playroom. The therapist was left asking the question, “Where did that come from?”

- Incompletion. This refers to that which is not *finished*. This can often be seen when closure has not been achieved.

  The therapeutic process was concluded by Michelle’s mother and did not reach the final stage of therapy. The therapist did not have the opportunity to prepare the child adequately for the termination of therapy and was thus of the opinion that closure was not achieved.

These nine identifiers of salience provided the researcher with guidelines to approach all sources of evidence for this case study in a relatively consistent and systematic fashion.

4.4.8.2 Questioning the data

The second route of the model proposed by Alexander (1988), namely that of asking the data questions, has been used as a complementary source of revealing critical information about the process of therapy and the psychosocial development of the subject. The researcher extracted all relevant information from the data by the systematic categorisation of information into core identifying units also referred to as themes or schemes. The researcher asked the data questions that served to highlight core identifying units that have relevance to achieving the objectives of the study. The following questions were asked:

- Question One: What section of the data will allow for the description of the process of non-directive play therapy followed with Michelle?

  In the process of answering question one, it was decided that the information obtained from the therapy process notes would be utilised in this regard as well as the discussions from clinical supervision and group supervision sessions.

- Question Two: What section of the data will allow for the contextualisation of Michelle's psychosocial development according to Erik Erikson's theory?

  In the process of answering question two, it was decided that information obtained from the interviews with the client's mother and collateral sources, the therapist's clinical observations, process notes, and data from the psychometric assessments would be used. In addition to this, the notes from the clinical supervision sessions and the clinical group supervision session would be included in the database.

- Question Three: How will a dialogue be created between the extracted evidence from the collected data, the content of the non-directive play therapy and Erik Erikson's theory of psychosocial development?

  An attempt has been made to answer question three through the implementation of analytical generalization, in which the theory of non-directive play therapy and Erikson's theory are used as a template with which to compare the results of the case study. In this process the researcher has critically compared the information extracted from the collected data with the stages explored in answering both questions one and two.

By following the nine guidelines for the extraction of salient data, and by asking the data questions related to the content of the theory and the research aim, the researcher attempted to establish a consistent approach in order to enhance the study's trustworthiness and auditability (Fouchè, 1999).

### 4.4.5 The Conceptual Framework

This refers to the development of a descriptive framework for organising and integrating the data of the case study. In order to facilitate the process of the data revealing itself, the researcher needed to categorise the most salient available data. This was achieved by developing two conceptual matrices by

which to categorise the core data. A dialogue was created between the extracted themes of analysis and the content of the two theoretical approaches utilised in this study. The technique of analytic generalisation was employed by the researcher to critically compare or pattern-match the themes extracted in the collected data, with the conceptualisation of the two theories, namely that of Axline's non-directive play therapy and Erik Erikson's theory of psychosocial development. These matrices, represented graphically below, assisted the researcher's efforts to remain systematic and consistent in the analysis of the content of the material.

Table 4.1 below schematically represents the matrix of the therapeutic process of non-directive play therapy. The vertical columns were used to represent the therapeutic sessions. The horizontal columns were used to represent the four stages of play therapy.

Table 4.2 below schematically represents the matrix of Michelle's psychosocial development. The vertical columns were used to represent periods in Michelle's life. The horizontal columns were used to represent Erikson's theory of psychosocial development.

Table 4.1

**Matrix of the therapeutic process of non-directive play therapy**

The four stages of play therapy

| Therapeutic Sessions | Stage 1 | Stage 2 | Stage 3 | Stage 4 |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |

Table 4.2

**Matrix of Michelle's psychosocial development**

The eight stages of Erik Erikson's theory of psychosocial development

| Periods in Michelle's life | Infancy | Early childhood | The play age | The school age | Adolescence | Early adulthood | Adulthood | Maturity |
|---|---|---|---|---|---|---|---|---|
| 0 - 1 year | | | | | | | | |
| 1 - 2 year | | | | | | | | |
| 3 – 6 year | | | | | | | | |
| 6 - 7 year | | | | | | | | |

The researcher made use of Guba's model of trustworthiness of qualitative research (Krefting, 1991) to ensure the trustworthiness of the study. This model is used extensively in qualitative research and is based on four aspects that enable the researcher to establish trustworthiness, namely: truth value, applicability, consistency and neutrality.

The first aspect, truth value, involves the researcher establishing confidence in the truth of the results or findings for the participants, and in terms of the context in which the study was conducted. According to Krefting (1991), the second aspect of trustworthiness is concerned with applicability, which refers to the extent to which findings can be applied to other settings and contexts. Durrheim and Wassenaar (1999) refer to this phenomenon as reliability. Ensuring reliability in a descriptive study is virtually impossible and highly undesirable. Durrheim and Wassenaar (1999) advise that researchers undertaking this type of research "expect that individuals, groups and organisations will behave differently and express different opinions in

changing contexts" (p. 64). Given the fact that this research study aims to describe an individual's experiences makes it highly unlikely that exactly the same results would be generated if this study were to be repeated with different participants. This research study does not aim to generalise the findings to other situations or settings; however it will be reflected against the background of similar and related research.

The third aspect of trustworthiness outlined by Guba is concerned with the issue of data consistency and attempts to determine whether the findings would be similar if the study were to be replicated. As has been discussed under the section covering reliability, the current researcher has made as many steps in data collection as operational as possible. The objective is that if later researchers followed the same procedures as described by an earlier researcher and conducted the same study, they would arrive at the same research findings and conclusions. The fourth and final aspect of Guba's model has to do with neutrality. This refers to the extent to which outside influences, biases, perceptions and motivations impact on the findings of the study. The current researcher used the techniques of triangulation of data sources and triangulation of investigators to ensure neutrality in this study.

## 4.5 Ethical Considerations

The researcher in the field of psychology uses human subjects as the objects of study. For this reason, the importance of ethical considerations and the upholding of ethical principles are essential to ensure correct conduct towards, and protection of the research subjects.

Ethical considerations have been taken into account in this study. As stated earlier, written informed consent was initially obtained from the client's mother prior to the commencement of this study. To ensure patient confidentiality, pseudonyms were chosen and have been used throughout this study. Any identifying data, whilst maintaining its relevance to the case, was disguised in order to respect the client's confidentiality. All information was treated as strictly confidential. The client's mother was aware that participation in the study was voluntary, that no payment was expected for the therapy, and that no written report would be provided to her. Consent was voluntary and

the client's mother was told that she had the right to withdraw the client from the study at any stage of the process without fear of discrimination.

The researcher was not in a therapeutic relationship with the client while the study was conducted. As the client was younger than 18 years old, consent to participate in the research was given by the client's mother. The client's father was deceased and the mother was the only legal parent. It is recommended in the guidelines for submission to the Human Ethics Committee (of the Nelson Mandela Metropolitan University), that when the client is eight years or older, the child's willingness to participate in the study should also be obtained. As the client is younger than eight years of age, the researcher did not discuss the issue of consent with her.

Mouton (2001) discussed certain ethical principles that are imperative to the research process. These are: objectivity and integrity in research, fabrication of data, recording of own data and ethical publishing practices. These principles were applied to this research study and are discussed in greater detail below.

### 4.5.1 Ethical Principles

#### 4.5.1.1 Objectivity and integrity in research

The researcher adhered to the highest possible technical standards in her research. The theories, methods and research design used in the interpretation of the data have been disclosed and the limitations of the methodology and findings have been reported on in this study. Furthermore, the researcher acknowledges that her view is but one view of reality.

#### 4.5.1.2 The fabrication of data

The data that was utilised in this study was an accurate reflection of the information obtained from the various sources and of the process followed in therapy. The researcher did not fabricate or falsify any data.

#### 4.5.1.3 Recording of own data

The researcher recorded data in an appropriately referenced manner and was at all times prepared to disclose the methodology and analysis techniques used in the study to other social research scientists.

#### 4.5.1.4 Ethical publishing practices

All sources of information used in this research study have been acknowledged.

## 4.6 Conclusion

This chapter has provided a description of the research design and methodology of this study. The data collection and analysis process were described in detail and the conceptual matrices were systematically presented. The two matrices which form the main organising structure of the data collection and analysis have been provided in tabular form. In addition, attention was also given to the strategies utilised to improve reliability and validity. The ethical principles and considerations followed in this research study were also discussed in this chapter.

The following chapter provides the reader with a discussion of the clinical material and presentation of the therapy case for this study.

# CHAPTER 5

# CLINICAL MATERIAL AND PRESENTATION OF THE THERAPY CASE

"Inside each child there is a story that needs to be told – a story that no-one else has yet had time to listen to"
(Winnicott, 1984, p.21 in West, 1992, p.56).

## 5.1 Introduction

This chapter consists of two sections. Firstly, the clinical material is presented, which includes biographical information, developmental history, psychometric assessments, the presenting problem as well as relevant detail obtained during the intake interview with the client's mother, collateral information obtained from the professional nurses, social worker, and teacher. Thereafter, relevant case material, obtained from the process notes, is presented and lastly an analysis of the drawings completed by Michelle during play therapy is provided.

## 5.2 Presenting Problem

Michelle, aged 6 years 11 months, was referred by psychiatric professional nurses for therapy as she was presenting with a range of emotional and behavioural problems. She had allegedly been sexually abused by her mother's boyfriend who had been living with them for four years. Michelle shared a bed with her mother and the boyfriend. At the start of her grade one academic year, Michelle's mother noticed a change in her daughter's behaviour. Michelle also showed her mother a rash she had in her genital area. Her mother took her to the local clinic where she was treated and sexual abuse was confirmed.

The emotional and behavioural problems which precipitated her referral for therapy included the following: nightmares, sleepwalking, restlessness and a fear of the dark. In addition to this, Michelle was manifesting temper outbursts, biting her nails, and experiencing a loss of appetite. She was unhappy at

school and would regularly wander away from school and home. Michelle displayed regressive behaviour and suffered from enuresis and encopresis, in addition to demanding to breastfeed from her mother. Her behaviour was generally restless and she would sometimes be found rocking her body. Michelle displayed self-mutilating behaviour (using a drawing pin and a knife) and physical aggression towards the family dog and other children (especially her three year old nephew). She stole money, smoked cigarettes, told lies and swore excessively. On one occasion she set her teddy bear alight and engaged in sexualised play with other children. She also tried to touch her mother sexually.

A few months after Michelle commenced therapy, her mother engaged in a new relationship. Collateral sources reported that Michelle's mother was being physically abused by her new boyfriend and that she had started abusing alcohol again. A psychiatric nurse, Sr Pam, described taking Michelle home after a therapy session, to find Michelle's mother in an intoxicated state, lying on the floor asleep in a pool of her own excreta. Michelle refused to go to school or interact with neighbourhood children. Michelle's school attendance had been very poor as she had been absent from school on 18 out of 54 school days in term one of her grade one school year. Her mother described her as being "clingy" and wanting to stay inside the house with her and her latest boyfriend.

Michelle's interpersonal relationships with neighbourhood children and adults were characterised by conflict. The school, as well as friends and neighbours had been told about the alleged sexual abuse by Michelle's mother. As a result, she had to contend with children who teased her by saying she had slept with a man. Michelle's mother's description of her behaviour is that "she is not always like a child".

The therapeutic interventions (from intake interview through to the final session) took place over a period of 15 sessions which were spread over an eight month period. The case material for this current study is taken from these sessions and includes the play therapy sessions, the psychometric assessments, the intake interview conducted with Michelle's mother, three parent consultations held with Michelle's mother throughout the course of

therapy, discussions with the psychiatric nursing sisters, Michelle's teacher and the social worker involved with Michelle's case.

## 5.3 Biographical Information

The researcher has chosen the name of Michelle to be used as a pseudonym in this study.

| | | |
|---|---|---|
| Age | : | 6 years 11 months to 7 years 7 months |
| Academic year | : | Grade One |
| Mother's age | : | 43 years |
| Father's age | : | Deceased at age 43 years |
| Siblings | : | 18 year old sister |
| | | 2 deceased sisters |

Michelle is the youngest of the children

## 5.4 Developmental History

With regard to Michelle's developmental history, she was reportedly born at full term and was a normal vertex delivery. According to her mother, Mrs B, Michelle reached her developmental milestones age appropriately. She admits to consuming alcohol and smoking cigarettes throughout the pregnancy and is currently 43 years old. All four children were fathered by different men and Michelle was the last born. Michelle's oldest sister is 18 years old and has a three year old son. Her second oldest sister died when she was just one month old and the third sister died when she was three years old. Michelle's biological father, whom she seldom saw, died in December 2002.

## 5.5 Psychometric Assessment

The following assessment measures were utilised in assessment sessions conducted by a colleague of the current researcher:

- Junior South African Individual Scales (JSAIS)
- Beery Test
- Bender-Gestalt Test
- The following measures were completed by Michelle's teacher: Stress Response Scale (SRS), Teacher Temperament Questionnaire (TTQ), and Conners Teacher Rating Scale: 39 item.
- Children's Apperception Test (C.A.T.) Card One was attempted

Michelle was assessed on the **JSAIS**, an IQ battery utilized to assess general intellectual functioning. Her performance on this measure indicates that her general intellectual functioning falls within the *borderline* range. Furthermore, both her performance on the verbal scale and on the nonverbal scale falls within the *borderline* range. There was no significant difference between Michelle's verbal and nonverbal scores on this measure.

On the **Beery**, a developmental test of visual motor integration, Michelle obtained a score that is equivalent to the performance of a child of 5 years 10 months. This is 16 months below the level expected of Michelle's chronological age.

On the **Bender**, a developmental test of visual-motor perception, integration and coordination, Michelle obtained a score that is equivalent to the performance of a child of 5 years 6 months to 5 years 8 months. The category description for her score is poor. There are three emotional indicators and four neurological indicators. In addition, Michelle took 25 minutes to complete the Bender and this falls outside the critical time limit.

Michelle's teacher completed the **Conners Teacher Rating Scale : 39 item** (a rating scale used to assess hyperactivity). A T-score of 70 and above is considered a significant score. Michelle's scores on the various rating scales were as follows: Hyperactivity = 87, Emotionally Indulgent = 95, Asocial = 91, Conduct Disorder = 89, Anxious Passive = 90, Daydreaming = 114. Michelle

thus scored significantly high on all of the rating scales; this included her score on the Hyperactivity Index of T= 95.

Michelle was assessed by her teacher on the **Teacher Temperament Questionnaire (TTQ)**. This is a measure that seeks to determine how the child interacts with her environment and yields a temperament score on three subscales: task orientation, personal-social flexibility and reactivity. On the TTQ, Michelle showed the following temperament: Her task orientation score is *below average*, indicating that Michelle's ability to complete tasks and to remain focussed in the midst of distracting stimuli is below average. Michelle's personal-social flexibility score is *low average* and indicates that she may experience some difficulty with changes in routine, does not always approach new experiences with a positive outlook and does not always respond positively to others in the environment. Michelle's reactivity score is *average*, indicating that she is not excessively perturbed by the external environment.

Michelle was also assessed on the **Stress Response Scale (SRS)**. This is a measure that provides an estimate of the impact of stress on Michelle's behavioural adjustment. The overall total score is the best measure of the magnitude of maladjustment and Michelle scored significantly high on this total score. In addition, the SRS reflects the response styles commonly used by children under stress. Michelle scored significantly high on most of the scales, including the *impulsive (acting out)* scale, the *passive-aggressive, repressed and dependant scales*. Michelle might typically adopt these responses to stress, which may be manifested in behaviours such as being demanding and prone to selfishness and a tendency to fight and pick on other children. She may respond by underachieving, procrastinating, having a poor attitude towards school, not caring about schoolwork, appearing detached, daydreaming, having a tendency not to complete assignments, and sometimes being uncooperative and stubborn.

When presented with **C.A.T. Card One**, Michelle looked at the card, but did not respond to the examiner's cues. She sat, and thoughtfully chewed the back of the pencil. She looked around her and gazed at the interior of the office where we sat. We were seated opposite each other at a children's table. She occasionally looked up at me and then traced the picture on the C.A.T.

card with the back of the pencil. She watched me write, but did not say anything. Michelle lay her head down on one arm and continued to watch me.

This continued for 15 minutes, after which I realized that Michelle was not going to tell me a story about the C.A.T. card. We went to the playroom, but Michelle just surveyed the room, not playing with the toys. She started to cry and said, “Ek wil daar voor sit.” (“I want to go and sit in front”), implying that she wished to go to the waiting room.

## 5.6 Course of Psychotherapy

The researcher’s therapeutic intervention with Michelle was in the form of non-directive play therapy and was conducted over a period of 11 play therapy sessions. The first six sessions took place on a weekly basis at the same time every week. Sessions Seven and Eight were spaced with a two week interval. Session Nine took place a month later than the eighth session and was followed by three consecutive weeks of psychometric assessments. Thereafter, Michelle missed five sessions and unexpectedly arrived with her mother, for Session Ten, two months later. Six weeks after Session Ten, Michelle and I held our final play therapy session.

The current researcher will now discuss the sessions as they occurred in the therapeutic process with the client.

Session One

When Michelle walked down the passage with me to my office, she was wide eyed, looked around, and stuck her fingers in her mouth. Michelle spent the entire session drawing in my office. She appeared quiet and spoke very softly, in a "whisper voice". She seemed to enjoy the drawing activity.

She held the pencil crayon with a mature pencil grip and handled it confidently. During the session, she drew four pictures: (a) a pencil drawing of herself, (b) a coloured crayon drawing of her nephew, (c) a coloured crayon drawing of her house, (d) a coloured crayon drawing of her family. The drawings of herself, her nephew and her family are attached in the appendices and discussed in greater detail in section 5.8.

Michelle did not show much emotional expression during the session. After the session, she went running and playing with other children in the waiting room and laughed with them. She appeared to be a very different child to the one I had seen in my office moments earlier. According to Sr Jean, at the time of the first session, Michelle was on antibiotics for an upper respiratory tract infection and was taking Imipramine 10mg at night.

Session Two

Michelle sat at the little table in my office and spontaneously drew a picture for me with coloured crayons. The picture was one of herself, two friends and their teacher. This picture is included in the appendices and is discussed in detail in section 5.8. Michelle had not yet recovered from her illness and was still coughing and sniffing occasionally. After she had completed her drawing, Michelle moved to the playroom tote bag. She spent 45 minutes playing with the toys, however most of the time was initially spent arranging the toys in groups. The toy soldiers were arranged according to colour, followed by the plastic firemen which were placed together in a row behind the toy soldiers, thereafter the cowboys and Indians were arranged in their respective groups.

Michelle seemed to relax after arranging the small groups of toys as mentioned above and she played with the doll and pretended to feed it and give it a bottle. She prepared food with the utensils in the toy bag. She peeled potatoes, and worked very skilfully with the plastic potato and knife. Michelle then put the potatoes in a pot, added salt to another pot and stirred the imaginary food, tasted it, and added a little more salt. It became apparent to me that she had done this before with real food and real utensils as she appeared very adult-like in the way she was involved in preparing the food.

She did not express emotion and seemed to ignore me and once again, spoke to herself in a whispering voice. Her voice was barely audible and it was not possible to hear what she was saying.

Session Three

Before the playroom session, as we were walking down the passage, Michelle initiated conversation with me by telling me that she did her homework that week. We spent the first 15 minutes of the session in my office

and the rest of the session (45 minutes) in the playroom. Michelle drew two pictures for me (one of her house and one of her older sister, Maree). In the playroom, Michelle appeared restless and moved from one toy to the next. She played mostly with the dolls and the telephone; she made food and ate with the utensils, and sat at the dressing table and adorned herself with the jewellery accessories and perfume.

Michelle spoke in whispers to herself while playing, and showed little emotion throughout the session. Furthermore, she ignored me as she played and did not initiate conversation or interaction. Michelle was still sniffing throughout the session.

Sr Pam reported that Michelle's mother had not been consuming alcohol recently and was involved with a new boyfriend, George (a chokka boat fisherman). She further reported that Michelle was still taking Imipramine at night.

Session Four

The first 15 minutes of the session saw Michelle drawing in my office. She drew (a) a picture of herself standing in front of her house and (b) a drawing of her cousin, Belinda and friend, Tandi.

The following 45 minutes were spent in the playroom. Michelle played with various toys such as: the telephones, the plastic wild animals, the wheelbarrow, and she played at the dressing table and with playdough. She would whisper sometimes to herself as she played. At other times, she asked me the following questions in an audible voice, "Wat is dit?" (“What is this?”), referring to a lizard-like toy and "Kan ons teruggaan na die klaskamer?" (“Can we go back to the classroom?”) referring to my office.

She looked happy when she was naming the wild animals and packing them into the wheelbarrow. She wheeled them around the playroom a few times before packing them out again. She requested to go back to my office after 40 minutes in the playroom. I allowed this as I was curious about why she would want to go back to my office. The answer, I discovered, was that she had left three toy spinners on the table and she played with these in silence for the next few minutes.

After the session, in the waiting room, Michelle was interacting with another little girl, but there was a language barrier so this was short-lived. Michelle took a book from the bookcase in the waiting room and as she paged through it, she made up a story according to the pictures. She came across a picture where a group of people were being chased by a swarm of bees and one person had fallen to the ground and another was staggering around and the rest of the group had raised their hands. Michelle's interpretation of the picture was "Die mense is dronk" ("The people are drunk"). She spoke in a soft, but audible voice and not a whisper.

Session Five

Today was Michelle's seventh birthday. She was brought to the session by Mrs Daniels, a retired social worker, who had promised to take her to the Wimpy after the session.

Michelle showed no emotion during the play therapy session. She sniffed continually and did not communicate verbally. Michelle appeared to be deep in thought. In the playroom, she painted initially, and then played briefly with two squeaky toy dolphins, the telephone and a plastic construction set. She became frustrated with the construction set and threw the parts back into the box. Her body language appeared angry, but she showed no facial or verbal expression of anger. She played at the dressing table, and then in the kitchen, preparing food and making tea. She whispered to herself, but not as much as in previous sessions.

She spoke to me on three occasions saying, "Maak hom oop" ("Open it"), instructing me to open a hairclip "Wat is die?" ("What is this?"), referring to a piece of broken toy, "Ek wil uit gaan!" ("I want to leave!"), she wanted to go to the waiting room. When I asked her why, her reply was "Ek voel lam" ("I feel weak"). She filled the sink with water and washed her hands several times with soap. After that she collected the paint brushes and washed them thoroughly. Later, while waiting for Mrs Daniels in the waiting room, she once again "read" me a story. Her voice was soft, but audible. She also spent a long time sitting and rocking on the rocking horse and she seemed happiest when she was doing this.

Session Six

Mrs Daniels brought Michelle to the play therapy session once again. I noticed that Mrs Daniels was very affectionate towards Michelle and although this was only the second time she had brought Michelle to therapy it seemed that Michelle was very comfortable with her. Mrs Daniels was physically affectionate as they arrived, with Michelle holding her hand while Mrs Daniels stood talking to me. Mrs Daniels touched Michelle on the head and cheeks and then held both her hands. Michelle smiled and looked happy and comfortable. She appeared to be thriving on the physical affection given to her by this “granny” figure. Mrs Daniels reported that on the way home, after the Wimpy outing, Michelle sang a song to her called "Visvang vir Jesus" (Fishing for Jesus).

During the session, Michelle drew a grid on the chalkboard with numbers as represented below.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |

She appeared more "playful" in the playroom. She picked up a rope and seemed to want to skip, but changed her mind. She smiled more and seemed happier than before. She took her shoes and socks off. Michelle still whispered, but occasionally an audible sound could be heard. She hid from me (behind the chalkboard), but in a playful way, almost as if she was playing peek-a-boo. She washed her hands, but only once after drawing with the chalk.

Session Seven

Michelle was brought to therapy by Mr Bob, the school principal. She sat down at the table in the playroom and spontaneously drew a picture of herself, a friend and her mother. She was extremely quiet and subdued, not whispering at all. She covered her eyes with her arms and sat motionless for a short while. She began to cry softly. I fetched tissues and sat next to her

and reassured her of my presence. I asked if I could put my hand on her back. She did not respond to this so I did not touch her, but sat at the table with her. She cried softly for 30 minutes. At the end of the session, I asked her if she would like to wash her face, and blow her nose and then I offered her some tea or coffee. She chose coffee and came with me to make it.

When she left the psychology clinic, she spontaneously turned back to smile at me and wave. This was the first time she had ever done this. After this I attempted to contact her mother to ask about her progress and conduct at home. Her behaviour today was very different in comparison to the days when the social worker or psychiatric nurses brought her to therapy. I wondered whether she was possibly feeling very anxious because of the long trip with the school principal.

Session Eight

Michelle was brought to therapy by one of the male teachers at the school. As before, Michelle was very quiet and did not show emotion, and did not speak. She did not return my greeting. We entered the playroom and she looked around briefly and sat down at the table. I also sat down at the table. Michelle did not say anything.

A short while later she started rubbing her eyes and started to cry, as she had done in the previous session (Session Seven). I reflected on this, but did not move closer nor touch her in any way. Eventually she told me "My maag is seer," (“My stomache hurts”). I glanced at the wall clock and after enquiring, I realized she was hungry and wanted to eat. I indicated that she could eat if she wanted to and she took a clear plastic packet from her schoolbag. The packet was full of fruit approximately six or seven bananas, pears and apples. She chose a banana, but before she peeled it she took a pear out of the packet and put it in front of me. She did not say anything, but her intention was clear. She wanted me to have the fruit. This was her school lunch that she was sharing with me. She finished her banana, threw the peel away and started crying softly again. She eventually told me, "Ek wil buite gaan", (“I want to go outside”). I explained that she could go outside towards the end of the session however she sat crying for the rest of the session. By the end of the session, she had stopped crying. As with the previous session I asked her

if she would like to wash her face, and blow her nose and I once again offered her some tea or coffee. She took a while to respond, chose coffee and came with me to make it.

When she left with the teacher, she waved to me from the doorway as she had done in the previous session. I was left wondering if there was a connection between the fact that she appeared anxious and cried throughout the session when brought to therapy by a male teacher who is in a position of authority over her.

Session Nine

Mrs B accompanied Michelle on her visit to the psychology clinic. I had requested a parent consultation meeting with her to monitor Michelle's progress. We met in a room where Michelle could observe us through the glass. Mrs B reported an improvement in Michelle's behaviour and reported three main remaining concerns: enuresis, encopresis (she has had a medical examination to exclude a possible organic reason for their existence) and difficulty with concentration.

As we spoke, Michelle was quite animated through the glass, waving and laughing at her mother and showing her mother some of the toys through the glass. Mrs B told me about a recent incident in which Michelle set fire to the neighbours' grass; fortunately no serious harm was done. Mrs B reported that she has a new boyfriend, called George, and Michelle sometimes refers to him as her father.

In the play therapy session, Michelle was busy in the kitchen corner. She took the pots and pans as well as the plastic plates, cutlery and food out from the little cupboard and she proceeded to prepare a meal. She picked up a baby doll, undressed it and then dressed it again. She then wrapped it in a baby blanket and took it to the table to feed it. She left the doll and picked up a broom and dustpan and started to clean. She swept the kitchen corner and part of the playroom floor.

She then moved to the dressing table and put the jewellery on. She placed the toy tiara on her head and studied herself in the mirror. She reached for the bottle of perfume and pretended to spray perfume onto herself. She ignored me and my reflections.

Session Ten

Michelle and her mother arrived unexpectedly at the psychology clinic. Mrs B gave me the envelope from Michelle's teacher and requested to speak to me alone. Mrs B said they spent the weekend in Port Elizabeth having heard on Friday that D, the man who allegedly sexually abused Michelle, had been released from custody. Mrs B was returning home today and would leave Michelle behind in Port Elizabeth with George's sister. Mrs B would fetch Michelle on Friday afternoon. Mrs B did not mention that she was being physically abused by George (as reported by Sr Jean and Sr Pam). She also said that she had only had one beer since the beginning of the year, when she had stopped drinking alcohol. I wondered if she was seeking my approval with that statement as I had not asked about her alcohol consumption. She also told me that Michelle's older sister, Maree, had received a bursary and had been accepted to study pharmacy at a Western Cape university from 2004.

Mrs B expressed a concern about Michelle's behaviour. She said Michelle was displaying very "clingy" behaviour. Mrs B said she had to walk Michelle to school everyday and when they arrived at the school gate, Michelle would not let go of her mother. She also reported that Michelle did not have any friends and that she hurt other children. She fought with them, swore and used bad language towards children and adults alike. Mrs B reported that she would occasionally play with her nephew, but on many occasions she hurt him, threw something at him (for example, a stone) and caused him to bleed. At home she also did not want to play outside with the other children and preferred to be inside with her mother and George. Mrs B said some of the children in the neighbourhood teased Michelle saying "Sy het met 'n man gelê" ("She has slept with a man"). Mrs B reported that Michelle was not like a child and said that she must grow up and stop being so "clingy". The behaviour described by Michelle's mother in this session was very different from that described in Session Nine where her mother had reported an improvement in her behaviour.

Mrs B said Michelle still woke up during the night and would not fall asleep unless Mrs B was with her. If she awoke during the night, she would get into bed with Mrs B and cohabitant, George. George had told Mrs B that Michelle

had tried to touch and rub his genital area. Mrs B had wondered whether it would be better for Michelle to be at a boarding school and to come home once a week, or once a month. She did not know of a school like this, but seemed to be contemplating the idea. Mrs B said she did not want to give her child up. She loved her, but wanted to do what was best for Michelle. She said Michelle would be in Port Elizabeth for the week and would be staying with George's sister who would bring Michelle to her next therapy session.

Michelle didn't speak to me as we walked down the corridor to my office. As I had not prepared for the session, we sat at the little table and I asked her to draw me a picture of how she was feeling today. She proceeded to draw a picture of herself and a friend and then drew her nephew, Tristan, as a worm. She also wrote her name, her mom's name and her sister's name above the drawing. The drawings were rotated on the page. She proceeded to start sharpening the green pencil crayon, but remained silent and did not speak to me or tell me about her drawing. She appeared to become absorbed in sharpening the pencil crayons and she even sharpened some more than was necessary, thus breaking the points off, and having to re-sharpen them. She continued with this activity for quite some time.

When she had sharpened more than half of the pencil crayons, I asked her again about the picture as I wondered whether the pencil figure was her mother or her sister. She told me it was Angelique, her friend. I asked her about the "figure" below the drawing and she wrote "wirim Tristan" ("worm Tristan"). When I reflected on Tristan being drawn as the worm, Michelle said it's because he is always on the move. Although my asking her about the figures in the pictures was not a non-directive technique, it did seem to stimulate some conversation. We spoke briefly about the children Michelle hurts. She said she hurts them and fights with them because they make her angry. She seemed to withdraw after this, not wanting to continue the conversation. I respected her silence, but realised the significance of the moment, knowing that we had shared a dialogue in a therapy session. She finished sharpening the pencil crayons and picked up the water-paints, looked at them, touched them and held the paintbrush. I asked her if she would like to paint when next she came to therapy and she nodded. As we left my office she said she wanted to look at my cell phone. I handed it to her and let her

walk to the waiting room with it. Along the way she was silent, but she looked at the cell phone and pushed the buttons as we walked.

Session Eleven

I met with Mrs B briefly before the final session with Michelle. Mrs B reported that Michelle was going to repeat Grade One and that she would remain in Mrs Adam's class. She said Michelle had started to like her teacher and believed that it was a positive thing that Michelle was remaining in her class. Mrs B reported that she was happy with the progress made by Michelle over the year. She was going to be taking leave from work over the Christmas holiday period and would be spending time with Michelle, baking biscuits and going for walks together.

Michelle had missed the previously scheduled appointment, as had been happening for most of the second half of this year, but I needed to have the final session with Michelle today as the clinic would be closed for the remainder of the year. I explained to Michelle that today would be our last session together. Michelle did not respond in any visible way to this information. This was not the ideal way to terminate therapy with her and I wanted more sessions to prepare her for this, but due to the fact that Michelle had been missing her scheduled appointments, this was not possible.

In the playroom Michelle decided that she would paint. She started by painting the numbers one through to ten, but then told me she was going to wash the paint brushes. She proceeded to put the plug in the basin and to fill the basin with some water. She then took the liquid soap and began to wash the paint brushes. There were two paint-mixing trays and a scrubbing brush at the basin which she incorporated into this washing ritual. The trays and brushes were washed and rewashed several times. Michelle seemed totally engrossed in her game. She looked neither happy nor sad. She just washed and washed. She ignored me and seemed to pay no attention to my verbal reflections of her behaviour. Towards the end of the session, I informed her there were five more minutes left in the playroom; still Michelle did not interrupt her game. When the session came to an end, Michelle did not seem to want to leave and continued washing the paintbrushes and paint-mixing trays. I reflected on the fact that she did not seem to want to leave the

playroom even though the session had ended, but I could sense that she was not ready to leave.

Eventually Michelle did leave the playroom and seemed happy when she joined her mother in the waiting room. As she left the psychology clinic with her mother, Michelle turned and waved to me from the door.

## 5.7 Discussions with Collateral Sources

Discussions were held with Sr Pam (Professional Psychiatric Nursing Sister), Mrs Adams (Michelle's teacher) and Ms Julies (Social Worker) during the second half of the year when Michelle missed a number of scheduled play therapy appointments. These discussions elicited the following information:

Sr Pam reported that Michelle's mother was being physically abused by her new boyfriend. She also reported that Mrs B was abusing alcohol again and had not been attending work regularly and that there was a disciplinary hearing pending against her. Sr Pam also reported that Michelle had not been attending school and that this information was brought to their attention by Michelle's sister. The psychiatric clinic had enlisted the assistance of their social worker, Ms Julies.

Mrs Adams, Michelle's teacher, reported that Michelle had in fact not attended school for an entire week and had been absent previously from school on numerous occasions. Her mother had brought her to school on the day of these discussions and Mrs Adams added, with reference to Michelle, "Sy lyk verwaarloos", ("She looks neglected").

A telephonic conversation with the social worker, Ms Julies, revealed that an auxillary worker had visited Michelle's house and confronted the mother. According to the auxillary worker, the children were not living there and would be placed in the care of the mother's sister. I found this statement to be confusing as Michelle was the only child living at home; however this is what Michelle's mother told the auxillary worker. The nursing sisters were also not aware of this information.

## 5.8 Human Figure Drawings

My instructions to Michelle were for her to draw a picture of a whole person (a boy or girl, a man or woman). She was given an A4 sheet of white paper and an HB pencil. She drew a portrait of herself. This is discussed under heading 5.8.1. I then removed the pencil and placed the coloured crayons on the table with a clean sheet of paper and asked her to draw a whole boy. She drew a portrait of her nephew, Tristan. This is discussed under heading 5.8.2. Following this, she received another clean sheet of paper, and I asked her to draw a picture of her family doing something together. This drawing is discussed under heading 5.8.3. The final drawing was during a non-directive session and she spontaneously drew a picture of herself with two friends and her teacher. This is discussed under heading 5.8.4.

On every picture Michelle has baselined (drawn lines or grass under the figures). Klepsch and Logie (1982) indicate that this is suggestive of a child requiring security or support. In a number of the figures, the eyes are vacant and non-seeing. The lack of pupils in the eyes may be an indication that Michelle is not making sensory contact with the world.

It became evident to me that drawing was an activity that Michelle enjoyed. In almost every session she drew a picture for me. In my very first session with Michelle, she drew me a picture of herself, her nephew, and a picture of her family, on request. During the second session, she spontaneously drew a picture of herself, two friends and her teacher, for me. I have included these four drawings as appendices and give possible explanations according to the literature. The drawings do appear to coincide with what is happening in Michelle's life.

### 5.8.1 Portrait of Self

Looking at the overall drawing (refer to Appendix A), Michelle has drawn herself as a very small figure on the page. This small size may be a reflection of her insecurity and feeling insignificant with a poor self-image (Klepsch & Logie, 1982).

Michelle has allocated big ears to her portrait. This could be that she perceives that others are talking about her (which they are doing in light of what has happened in her life recently). She has drawn arms of unequal length (one large long arm, the other a more appropriate size). Large arms are drawn by children who want to control, or those who want strength and power. If I relate this to Michelle, perhaps it is an unconscious desire to have the strength and power to control what has happened to her.

Michelle has drawn hands and feet on the figure, but they are misshapen. The feet look almost like flowers. Hands and feet are suggestive of security issues and in Michelle's case, I interpret this to be a sign of insecurity and possibly also regression.

The crown on the head is possibly an unconscious desire to be a "princess" and to feel important and worthy. No clothing is apparent. It may be that she feels bare. She was examined intimately by strangers (nurses and doctors) and has had her privacy violated.

A tick and a star for the drawing possibly indicate Michelle's need for praise, recognition and approval and the baselining of the figure is present.

### 5.8.2 Portrait of Nephew

The portrait of Tristan (refer to Appendix B) is an eery one. Once again she has drawn a very small figure with grass as a baseline under it and the tick and star appear again.

Tristan does not wear a crown, but has spiky hair. The omission of the nose is viewed as a feeling of powerlessness and the omission of the mouth can be interpreted as a problem in the area of communication. In Michelle's case, this may be that she desperately wanted to tell someone about what was happening, but could not do so.

Once again the long arms are drawn and these end in very large spiky hands, possibly indicating aggressiveness and once again the need to control the environment. Tristan is drawn without feet and the figure is not touching the ground. This is suggestive of a child lacking security and feeling helpless.

### 5.8.3 Family Drawing

With reference to the family drawing in Appendix C, the family is drawn doing the dishes (washing up after a meal). The first figure drawn was Aunt Katie, then Aunt Barbara and then the cupboard with shelves and cutlery and crockery. She numbered the pots on the top shelf 1, 2, 3. Michelle then drew her cousin, herself and her mother (in this order and in pencil). She then added Maree, the clouds and Jesus. She added an ice-cream in a cone below the clouds. Once again she ticked each item in the drawing and allocated a star.

Everyone in the picture is smiling except for Aunt Katie whose mouth is open. As the therapist, I had the opportunity to meet this woman when she accompanied Michelle's mother to the intake interview. I found her to be a very talkative and verbally expressive person. Perhaps Michelle sees her in the same light, hence the open mouth.

Why did Michelle include Jesus in her drawing? Perhaps spirituality is an important facet of her community or she has been exposed to religion at home or at school. Michelle had positioned herself next to her mother in the drawing indicating that this is the person she feels closest to. All of the figures have the same hairstyle and the same vacant eyes. Michelle's mother has a small, disproportionate body and no feet. She has been drawn virtually the same size as Michelle. Possibly indicating that she sees her mother as no more powerful than she is.

### 5.8.4 Drawing of Friends

With reference to the drawing of Michelle and her friends in Appendix D, Michelle first drew herself, then Belinda, then Candice. The sun was drawn next and then Mrs Adams, the teacher. Once again, Michelle ticked the picture and allocated a star for each tick. Underneath the stars she numbered 1 to 11 working from right to left. Michelle, Belinda and Candice are wearing crowns.

In this drawing, Michelle has drawn herself very differently to the characters of her two friends and teacher. She has depicted herself as a

disjointed figure with short spindly arms, spiky hands, no legs and big, grotesque feet. The small arms could indicate that Michelle is experiencing feelings of inadequacy, seeing herself as weak and ineffective. The spike-like hands are ineffective tools to handle the environment and this possibly reiterates her feelings of inadequacy. The lack of legs could be indicative of a lack of support and the big feet indicative of a need for security. The head is separated from the body by a long, thin neck and looks as if it has been pinned on. This is possibly indicative of someone not being able to control her impulses (Di Leo, 1973).

The other three figures in the drawing are shorter and have a broader stance than Michelle's figure; possibly indicating that she feels they are more stable. Once again the theme of the ticks and stars comes across. Seemingly, this is a need for recognition and approval of her work. Probably indicative of a deeper need for self-recognition and self approval.

Michelle's figure slants 20 degrees. Klepsch and Logie (1982) inform us that a figure slanting 15 degrees from the vertical is suggestive of feelings of imbalance and the lacking of secure footing.

Yellow is an appropriate colour for the sun, however, Michelle has drawn her teacher entirely in yellow. Information obtained during the intake interview from Mrs B was that Michelle felt her teacher did not like her. Yellow is a nurturing colour and it is possible that Michelle feels she needs more nurturance from her teacher.

## 5.9 Conclusion

In this chapter the clinical material pertaining to the case was discussed. This included biographical information, developmental history, psychometric assessments, the presenting problem, as well as relevant detail obtained during the intake interview with the client's mother, collateral information obtained from the professional nurses, social worker, and teacher. Thereafter, relevant case material, obtained from the process notes, was presented and lastly an analysis of the drawings completed by Michelle during play therapy was offered. In the following chapter, the researcher will discuss the findings to this research study.

# CHAPTER 6

# FINDINGS AND DISCUSSION

## 6.1 Introduction

The results of the study are presented in this chapter. The data is looked at in relation to the theory and salient information has been extracted. The findings of the psychometric assessment and human figure drawings are briefly discussed followed by a discussion of the dominant themes which presented in the play therapy sessions. These discussions are imbedded in the discussions of the stages of the therapeutic process of Axline's non-directive play therapy and Erikson's theory of psychosocial development. This has been achieved by utilising the conceptual matrices described in Chapter Four of this study.

## 6.2 Psychometrics

The results of the psychometric measures were discussed in greater detail in Chapter Five. As assessed on the JSAIS, Michelle's intellectual functioning falls within the borderline range of functioning. In addition, her results on the Bender and Beery indicate scores ranging 16 to 20 months below her chronological age. These results are aligned with the literature on abuse which indicates that there are possible cognitive difficulties associated with neglect and as identified by Barnett et al. (2005) include: poor scholastic achievement and grade repetitions, deficits in general intelligence, deficits in language comprehension and verbal abilities, receptive and expressive language deficits, low level of creativity and flexibility in problem solving. It is however, important to note that there have been no previous developmental or scholastic assessments conducted with which to compare results and it is with caution that these psychometric results are interpreted. Her scholastic performance collaborates with her IQ, however she has been absent for one third of the number of school days of the first school term and, in addition to

this, the presence of test-taker anxiety should also be considered as a possible contributing factor.

Michelle scored significantly on all the rating scales of the Conners Teacher Rating Scale including the Hyperactivity Index. As assessed on the Teacher Temperament Questionnaire, Michelle's task orientation is below average and her personal social flexibility is low average. With regard to the Stress Response Scale, Michelle scored significantly high on the overall total score indicating the magnitude of her maladjustment. Victims of neglect frequently display emotional and behavioural problems such as apathy, withdrawal, low self esteem, ineffective coping, difficulty recognising and discriminating emotion, physical and verbal aggression, attention problems and conduct problems (Barnett et al., 2005).

It was stated that if the child is unable to establish the emotional space required for intellectual growth because her normal emotional development has been interrupted, she may then become an underachiever at school. Michelle's mother has a history of alcohol abuse and Michelle was allegedly sexually abused by her mother's boyfriend and these factors would be reason enough for interruption of her normal emotional development.

It seemed as if the demand to perform on the C.A.T. was, in some way, too much of an expectation for Michelle. She was unable to make up a story relating to the C.A.T. card stimulus or passively refused to, however after two play therapy sessions, while waiting to be fetched, she paged through books in the waiting room and created stories by looking at those pictures. The interpretation of the picture and story created by Michelle, namely that the people in the picture were intoxicated and falling over, offered the therapist a glimpse of the possible home circumstances that Michelle was regularly exposed to.

## 6.3 Human Figure Drawings

With reference to the discussion on the human figure drawings in Chapter Five, themes that come through in her drawings are a need for security and support, self-recognition and approval. She feels inadequate and has a poor self-esteem and self-concept. As evidenced in her drawing, she sees herself

as different from her friends. These emotional and behavioural manifestations coincide with Erikson's theory which suggests that the experience of child abuse may cause the child to feel inferior to her peers.

As Wieland (1997) pointed out, the sexually abused child is likely to have a damaged or distorted sense of self due to the messages she has internalised about herself. This is evident in Michelle's drawings as mentioned above.

## 6.4 Theme Discussion

A theme of nurturing was evident when Michelle played with the doll. She fed it, dressed it, tried to put it on her back, held it and rocked it and this behaviour with the doll reoccurred in a number of sessions.

Michelle was also attracted to the telephone and this behaviour was repeated over a few sessions. She pretended to phone somebody, but because of her whispering the therapist could not always hear what she said or to whom she was speaking. The therapist's reflections also did not elicit a response from her. This reflected a need for communication, but perhaps also a difficulty in interacting and communicating with others.

The theme of whispering which is reflected in almost every session may be reflective of the secrecy of abuse and/or it may be indicative of Michelle's lack of trust in adults.

In some of the sessions, a theme of ritualistic cleansing seemed to emerge, where Michelle appeared to be symbolically ridding herself of the *dirt* associated with the abuse.

Michelle seemed to enjoy sitting at the dressing table and putting on the perfume and jewellery including the toy tiara. She looked happy while doing this and would often return to this activity during the sessions. This theme reflected a self esteem need which was also reflected in her drawings. With reference to Appendix A and D, it can be seen that Michelle drew crowns on her head and on the heads of her friends.

Michelle played out a theme of food preparation and cooking in a number of sessions, and it usually ended with her feeding and nurturing the doll. This theme of nurturance was also subtly displayed in her family drawing (refer to

Appendix C), where Michelle included a cupboard in the drawing with cutlery, crockery and pots.

The therapist's observation of Michelle was that she appeared very capable and practised at working in the kitchen by the way she pretended to peel potatoes, add salt to the pot, and stir and taste the food. She was also very capable at handling a broom and dustpan. It is possible that she was involved in the preparation of the food and housekeeping activities at home. With reference to Erikson's stages, Michelle appeared to have comfortably resolved the age-appropriate conflict of industry versus inferiority and have developed the ego strength of competence in terms of housekeeping activities. This contrasts so dramatically to other areas in her life where she was still struggling with issues from Erikson's first stage of trust versus mistrust.

Michelle was not a verbal client in therapy and the therapist's reflections did not elicit a response from her. Michelle seemed to ignore the therapist in the playroom unless she made a specific verbal request. Outside the playroom she was inclined to communicate more on a verbal level and to show more emotional expression in the form of happiness and laughter when she interacted with other children. This was a function of her usual interaction with adults and she was simply treating the therapist as she did all other adults in her life. She did not trust most adults, but would acquiesce with their requests. For example, she cooperated with the psychometric assessments however, the current researcher is certain that Michelle would have preferred a session in the playroom.

## 6.5 The Therapeutic Process

The non-directive approach is indicated by Wilson et al. (1992) to be an effective and non-intrusive way of working with a sexually abused child as it emphasises the child's choice and control of issues and the pace at which therapy progresses. The therapist applied Axline's eight guiding principles in non-directive play therapy along with the core conditions of empathy, congruence and unconditional positive regard.

The therapist had eleven sessions of play therapy with Michelle. The physical distance between Michelle and the therapist in the playroom did not seem to be of significance to her. She played close to the therapist and further away with no obvious preference. This could be as a result of a learnt mistrust of the adult world. Michelle did not involve the therapist in her play and she played alone whispering to herself. Initially, the only time she spoke to the therapist was if she had a particular need or request, saying for example, ”Maak dit oop!” (“Open this!”), when she instructed the therapist to open something for her. She spoke in an audible voice when making specific requests during the session and when she spoke before and after the sessions.

She shut the therapist out of her play when they were in the playroom. Her verbal expression was reduced to a whisper during the session when she whispered a running commentary to herself (for example, naming the objects she was looking at).

Toys that Michelle avoided in the playroom were the doll house and the puppets and she never showed any interest in these two areas of play. Reasons for this could be that Michelle was not yet ready to play with these toys and was still enjoying the other playroom toys or she was specifically avoiding them as they were too emotive for her.

Michelle was a neat child in the playroom and did not make a mess with the toys and usually put the toys back where she found them. This seemed to contradict the description of the destructive and aggressive child as described by her mother in the intake interview.

The only limitation that the therapist found necessary to enforce was the time limit of the session. In Session Four, Michelle requested to leave the playroom after 40 minutes. The therapist allowed this, but then realised the error. Michelle wanted to leave because she had left three small toys in the therapist’s office and she wanted to play with them. The following session, Michelle again requested to leave the playroom before the end of the sessions. This time the therapist processed the need with her. In Session Eight, the request came again from Michelle during a session in the playroom and the therapist reminded her of the limitation. In Session Eleven, the final session, Michelle did not want to leave the playroom and delayed the end of

the session as she continued to wash the paintbrushes and paint mixing trays. The child's feeling of security and reality was enhanced by the therapist enforcing the limitation.

There seemed to be small progressive steps with Michelle. She gradually became more verbal with the therapist before and after the sessions. On one occasion she told the therapist that she had done all of her school homework (perhaps she was seeking approval), and she began to smile and wave spontaneously when leaving - something she never did in earlier sessions. Her mother reported that towards the end of the therapeutic journey, Michelle was calmer than before and no longer wanted to touch the mother inappropriately.

As discussed in Chapter Two, literature suggests that there are two common patterns of psychological response to sexual abuse, the first being associated with the symptoms of posttraumatic stress disorder, the second being associated with an increase in sexualised behaviour. Michelle's symptoms appeared to come from both response patterns; however, it is important to bear in mind that Michelle was not only a victim of alleged sexual abuse, but had also suffered psychological abuse and neglect.

The following section discusses the four stages of the therapeutic process as described by West (1992) and portrays Michelle's therapeutic journey through the various stages.

Stage One:

As discussed in Chapter Three, Stage One is characterised by the following behaviour: Profuse, diffuse behaviour targeted appropriately and inappropriately, and behaviour which may appear extreme. The child may have lost contact with the real self and the resultant unease may be widespread, indiscriminate and unattached. Hostility may be displayed indiscriminately towards the self, the toys or the therapist. Anxious children are afraid of everything and want to be left alone (West, 1992). Michelle remained at this stage in Sessions One, Two, Three and Four, and appeared to revert back to this stage in Session Nine. The predominant themes of this stage were nurturing, self esteem, ritualistic cleansing and secrecy.

In Session One, Michelle was very anxious and the entire session was spent drawing in the therapist's office. Michelle complied with the therapist's instructions because she was used to complying with adult requests, but her anxiety level was high and she did not speak to the therapist; she occasionally whispered a barely audible response to a question posed by the therapist.

In Session Two when she was presented with a variety of toys, she displayed heightened anxiety and did not engage in play immediately. Michelle appeared to have lost contact with the real self and there was widespread unease and unattached behaviour when she began arranging and grouping the toys rather than playing with them. She indicated that she wanted to be left alone by ignoring the therapist and whispering to herself.

Initially, the reflections made by the therapist to Michelle were more content-based as opposed to feeling-based. This was due to the relative inexperience of the therapist and the fact that the client was not verbal and showed very little emotion. The therapist persevered and maintained her presence within the therapeutic space even though there were periods of silence at times.

In Sessions Three and Four, Michelle's behaviour seemed very restless and she indicated wanting to be left alone by ignoring the therapist and not involving the therapist in her play. In addition to this, she whispered into the phone to prevent the therapist from overhearing her imaginary conversation. By Session Four, Michelle had started to develop a certain amount of trust in the therapist because she asked to go back to the office. It was in the very next session that she moved on to Stage Two.

It is interesting to note that Michelle seemed to revert back to Stage One in Session Nine after a break in therapy of one month, where she once again presented with restless behaviour and ignored the therapist. However, there was a parent consultation attached to this session and Michelle's mother reported that Michelle had set fire to the neighbour's grass the previous week. This could be regarded as having elements of Stage Two in it, as this stage is characterised by the child beginning to focus her anger and fear on things or people outside herself. However, this behaviour could just as easily be described as "profuse behaviour" which may appear extreme and could be categorised as belonging to Stage One.

Stage Two:

As stated in West (1992), the greater the child's trust in the therapist and the certainty of acceptance and respect in the playroom, the greater the child's ability to focus anger or fear on definite things or people outside themselves. Initially, this anger may be focussed on the toys in the playroom or the therapist because the child can trust enough to test the therapist in this way. At home, the focus may be on siblings or parents, and at school, on peers.

As stated in Craig (1999), an abusing parent destroys the expectations of love, trust and dependence that are crucial to healthy personality and social development. This can be mitigated by the consistent application of the therapists' attitudes of empathy, acceptance and congruence and can lead to a decrease in the child's defensiveness, enabling her to establish a feeling of trust with the therapist.

Session Five showed elements of Stage Two as Michelle showed her anger towards the plastic construction set toys when she aggressively threw the parts back into the box. This was the first time that Michelle attempted playing with the construction set, which can be interpreted as being symbolic of her trying to reconstruct her life and integrating her life, but with immense frustration. Michelle felt safe enough within the playroom and within the presence of the therapist to show her frustration and anger. As previously mentioned, Session Nine may have elements of Stage Two of the therapeutic process; however the current researcher has opted to place these events at Stage One.

Although Michelle appeared to only spend one session at Stage Two, the themes that emerged during this stage seemed to be similar to Stage One, with the exception that Michelle whispered less. The ritualistic cleansing concentrated on washing her hands and the paintbrushes repeatedly.

Stage Three:

At this stage, the child begins to build positive feelings towards others and is no longer quite so negative in her expression of emotion; however, there may also be acute ambivalence. The child tentatively tests out good feelings

of love and trust, but does not yet trust the outcome of showing true feelings with the resultant ambivalence (West, 1992).

In Session Six, Michelle smiled at the therapist reflecting the building of positive feelings. She also tried to involve the therapist in a different manner to earlier sessions when she playfully hid behind the chalkboard and tentatively attempted a very short-lived game of peek-a-boo. In addition to this, Michelle also removed her shoes and socks in front of the therapist and picked up a skipping rope in an attempt to skip. It was in this session that the value of additional consistent people in Michelle's life was clearly demonstrated. Mrs Daniels, the retired social worker, who drove Michelle to therapy for Sessions Five and Six, kept her promise of an outing and was also consistently affectionate and a warm, motherly-type person. The current researcher is of the opinion that this consistency of affection and dependability shown by Mrs Daniels towards Michelle assisted the therapeutic process.

In Session Seven, Michelle once again involved the therapist differently by crying throughout the session. In Session Eight, Michelle also cried throughout most of the session; however, this was interrupted when she ate a fruit and she shared her fruit with the therapist. This was the first time during the therapeutic process that the therapist saw Michelle perform any self-nurturing activity and this was seen as a positive reflection of an increase in self-worth. Michelle also invited the therapist to do the same when she shared the fruit with her. This could be seen as the building of positive feelings. At the end of both Sessions Seven and Eight, as she left the building, Michelle spontaneously turned back to wave at the therapist and thus tentatively expressed or tested out good feelings of love and trust.

Session Ten started off with the ambivalence that was evident in Stage Three where the child can simultaneously love and hate the same object or person. Michelle initially ignored the therapist and engaged in drawing, followed by repetitive sharpening of the pencil crayons. Midway through this activity, she engaged in a brief conversation which was clearly audible, unlike her previous whispering tone. The content thereof was the expression of her anger towards other children. She then became engrossed in sharpening the pencil crayons, once more shutting the therapist out. Thereafter, she started

to test good feelings of love and trust and asked to look at the therapist's cellular phone. Michelle spoke openly to the therapist, as opposed to whispering, and by so doing involved the therapist differently, possibly providing the tentative beginnings of a more age-appropriate relationship.

During the final session, Session Eleven, Michelle started to work on issues of trust and independence as she told the therapist that she was going to paint. She also spent most of the session washing the paint brushes and paint mixing trays. The current researcher is of the opinion that this was Michelle's way of coming to terms with the news that this was to be her last session. It appeared as if she did not want to play, but wanted to keep busy with some activity rather than just chat to the therapist.

Over time, Michelle had whispered less and started to speak to the therapist during the play therapy sessions. The themes of ritualistic cleansing and nurturing persisted throughout the therapeutic process, however.

Stage Four:

As stated in West (1992), it is at this stage that positive and realistic feelings emerge more strongly within the child and she appears to experience an improved image inside of her. The therapist feels that Michelle did not, unfortunately, reach Stage Four of the therapeutic process at the time of termination of therapy.

The current researcher is of the opinion that the long interruptions in the therapeutic process, from Session Nine through to Session Eleven, had a negative effect on the progression of therapy to Stage Four. Another factor which could have impacted upon the progression was the psychometric assessments which were conducted between Sessions Nine and Ten. Combined with this, and possibly the greatest factor, was the continued lack of stability in the family home. It was during this time that the collateral sources reported Michelle's mother being physically abused by her boyfriend, and the reports of alcohol abuse occurring in the home. The reports of Michelle not attending school and appearing neglected also emerged. As research indicates, a child suffers psychological abuse indirectly when exposed to violent behaviour between family members (Barnett et al., 2005).

In addition to this, Herzberger (1996) informs that neglect and psychological abuse are the most common forms of abuse associated with alcohol abuse.

## 6.6 Erik Erikson's Theory of Psychosocial Development

As discussed in detail in Chapter Three, Erikson's theory (Craig, 1999) concentrates mainly on the effects that social interactions have on shaping personality. The core concept of which is the ego identity, the basic sense of who we are in terms of self-concept and self-image. As Michelle is seven years old and in her Grade One year of formal schooling, this places her within the fourth stage of Erikson's developmental stages namely, industry versus inferiority. The researcher will therefore describe Michelle's psychosocial development in terms of her current and preceding developmental stages according to Erik Erikson's theory.

Stage One: Infancy (Trust versus mistrust)

In creating a trusting relationship, the therapist needed to consider, inter alia, Michelle's use of personal space. The therapist attempted to meet this by remaining *still* in the playroom and not following Michelle around the room as she moved from toy to toy. Michelle appeared vigilant of the therapist, but at the same time, tried to ignore her during many of the sessions.

The therapeutic relationship, to a significant degree, mirrors the child's functioning in other relationships. To this end then, the child may have had an insufficient level of trust in the therapist to engage meaningfully in the process of therapy. Wilson et al. (1992) inform that this may be mitigated, however, by the therapist's attitudes of empathy, acceptance and congruence and lead to a decrease in the child's defensiveness, enabling a child like Michelle to establish a feeling of trust with the therapist. In addition, the abuse she experienced may have deprived the child of her emotional needs over a prolonged period of time and the child may enter therapy with a desperate and exaggerated need for attention and affection.

This need for attention and affection was seen by the therapist when Michelle was brought to therapy by Mrs Daniels, the retired social worker, who was physically affectionate to Michelle. As described in Session Six of the

therapeutic process, Michelle appeared to respond well to the physical touching of Mrs Daniels and seemed to enjoy the affection being afforded her. Mrs Daniels' consistent approach towards Michelle over the two sessions also helped to increase her sense of trust. It was Michelle's birthday on the day of the fifth session and Mrs Daniels had promised to take her to the Wimpy after the therapy session to celebrate this occasion. She honoured her promise to Michelle, thus increasing Michelle's trust in her. This trust and joyfulness seemed to be carried through to the playroom with the therapist where Michelle was seen removing her shoes and socks and attempting to skip in the playroom in Session Six. She also started to engage more with the therapist on a playful level wanting to play a game of peek-a-boo, during the session.

Overall it can be said that Michelle's experience of the therapist as a consistent, warm and trustworthy adult offered her the opportunity to explore more appropriate ways of relating to others. Her deep sense of mistrust was moderated by a relationship with an adult who did not invade or abuse her, as the perpetrator had done, and did not blame her or offer inadequate protection as the non-abusing parent had done. Within the therapeutic relationship, the child was valued for herself, without any expectations, and this provided the child with an experience against which to compare the abusive relationship.

Stage Two: Early Childhood (Autonomy versus shame and doubt)

Michelle had no choice as to whether she attended therapy or not; however, within the non-directive play therapy approach, she was given choices regarding activities and conversations during each therapy session. In addition to this, Michelle's choice and freedom to take control in the playroom and the choice to set the pace at which therapy progresses (Wilson et al., 1992) were all effective and non-intrusive ways in which the therapist worked with Michelle. An example of this is taken from Session Seven, where Michelle spent 30 minutes of the session crying at the table. The therapist stayed with her without attempting to stop her from crying, or attempting to distract her with toys.

The therapist ensured the availability of toys and painting and drawing materials in the playroom, but Michelle chose the activities she wished to

engage in and the toys she wanted to play with. She decided if and when she wanted to draw, or paint, or play with playdough, or pretend to cook, or put on jewellery. This re-establishment of choice and autonomy is exceptionally important in therapy, especially for victims of sexual abuse and can be therapeutically addressed by way of non-directive play therapy as seen in this study.

Stage Three: The play age (Initiative versus guilt)

Sexual abuse at this stage of development is likely to lead to a sense of overwhelming guilt as the child feels responsible for some, if not all of the sexual abuse that has occurred. The professional response to the child's sexual abuse, particularly at the investigatory stage, where she is physically examined, interviewed and questioned about the abuse which took place, has also been found to exacerbate the child's feeling of guilt.

The therapist provided a containing relationship for Michelle wherein she could play out her feelings in the safety of the playroom, if she chose to. The therapist did not judge the toys she chose to play with, or the games she chose to engage in, nor did she add to any guilt feelings that may have been experienced by the child. As advocated by Axline (1989), in non-directive play therapy, the therapist left responsibility and direction in the playroom to Michelle and this allowed her to establish a sense of purpose in the playroom.

It is interesting to note that Michelle never played with the dolls house or the puppets, both of which were large items in the playroom; these seemed to be consciously avoided by Michelle as she chose not to play with them. The therapist respected Michelle's decision and never tried to encourage her to play with these items. The toys most frequently selected by Michelle to be played with were the kitchen corner with its utensils and plastic food, the dolls, the dressing table and the jewellery.

Stage Four: The school age (Industry versus inferiority)

Wilson et al. (1992) advise that the experience of child abuse may cause the child to feel inferior to her peers. The sexually abused child is likely to feel different and isolated from her peer group. As has been discussed, in the case of Michelle, neighbours and neighbourhood children were aware of the

alleged ongoing sexual abuse in her world and thus Michelle's relationships with the children were characterised by conflict. Michelle felt isolated from her peer group, and this was also reflected in her drawings where she drew herself differently to her friends.

There were two examples of this noted throughout the therapeutic process engaged in with Michelle. Firstly, the therapist noted that after Session Four, Michelle started interacting with a girl of a similar age in the waiting room, but there was a language barrier so Michelle discontinued the interaction. Secondly, in Session Ten, Michelle verbalised to the therapist that she hurts and fights with other children because they make her angry. Thus her interpersonal relationships with her peers could be described as dysfunctional and disturbing for her.

Stages Five to Eight: These stages commence at adolescence and end with the final stage of the lifespan and are therefore not yet applicable to Michelle.

## 6.7 Conclusion

This chapter discussed the results of this study. The psychometric assessment results, human figure drawings and the numerous themes emerging from the play therapy sessions were presented. Thereafter, discussions of the stages of the therapeutic process of Axline's non-directive play therapy and Erikson's theory of psychosocial development were presented. The following chapter will house the conclusion, limitations and recommendations of the study.

# CHAPTER 7

# CONCLUSION AND RECOMMENDATIONS

## 7.1 Introduction

This chapter commences with a summary of the findings of this study. The value of the study is then presented, followed by a discussion of the possible limitations related to the case study approach and the specific limitations of this study. The chapter concludes with recommendations for future research.

## 7.2 Summary of the Findings of this Study

Michelle's general intellectual functioning as assessed on the JSAIS fell within the *borderline* range of functioning. In addition, her results on the Bender and Beery Tests indicated scores ranging 16 to 20 months below her chronological age. Michelle scored significantly high on all of the rating scales of the Conners Teacher Rating Scale: 39 item, including the Hyperactivity Index. As assessed on the Teacher Temperament Questionnaire, Michelle's task orientation was below average and her personal social flexibility was low average. With regard to the Stress Response Scale, Michelle scored significantly high on the overall total score indicating the magnitude of her maladjustment. The results of the psychometric assessment were aligned with the literature on abuse which indicated that there are potential cognitive, emotional and behavioural problems associated with abuse.

Themes that were evident in Michelle's drawings included a need for security and support, self-recognition and approval. In addition to these, a sense of inadequacy, poor self-esteem and self-concept were also evident and she saw herself as different from her friends.

During the play therapy sessions the following themes emerged: Michelle played out a theme of food preparation and cooking in a number of sessions, and it usually ended with her feeding and nurturing the doll. This theme of nurturance was also subtly displayed in her family drawing, where Michelle included a cupboard in the drawing with cutlery, crockery and pots. Michelle

was also attracted to the toy telephone and this behaviour was repeated over a few sessions. This reflected a need for communication, but perhaps also a difficulty in interacting and communicating with others.

The theme of whispering which is reflected in almost every session may be reflective of the secrecy of abuse and/or it may be indicative of Michelle's lack of trust in adults. In some of the sessions, a theme of ritualistic cleansing seemed to emerge, where Michelle appeared to be symbolically ridding herself of the *dirt* associated with the abuse. Michelle seemed to enjoy sitting at the dressing table and putting on the perfume and jewellery including the toy tiara. This theme reflected a self esteem need which was also reflected in her drawings.

Michelle was not a verbal client in therapy and the therapist's reflections did not elicit a response from her. Michelle seemed to ignore the therapist in the playroom unless she made a specific verbal request. Outside the playroom she was inclined to communicate more on a verbal level and to show more emotional expression in the form of happiness and laughter when she interacted with other children. This was a function of her usual interaction with adults and she was simply treating the therapist as she did all other adults in her life. She did not trust most adults, but would acquiesce with their requests.

The physical distance between Michelle and the therapist in the playroom did not seem to be of significance to her. She played close to the therapist and further away with no obvious preference. This could be as a result of a learnt mistrust of the adult world. Michelle did not involve the therapist in her play and she played alone whispering to herself. There seemed to be small progressive steps made with Michelle and she gradually became more verbal with the therapist before and after the sessions.

With regard to the four stages of play therapy, Michelle remained at Stage One in Sessions One, Two, Three and Four, and appeared to revert back to this stage in Session Nine. The predominant themes of this stage were nurturing, self esteem, ritualistic cleansing and secrecy. Michelle appeared to spend only one session, Session Five, at Stage Two. The themes that emerged during this stage seemed to be similar to Stage One, with the

exception that Michelle whispered less. The ritualistic cleansing concentrated on washing her hands and the paintbrushes repeatedly.

In Sessions Six, Seven, Eight and Ten, Michelle tried to involve the therapist in a different manner which is characteristic of Stage Three of the therapeutic process. Over time, Michelle whispered less and started to speak to the therapist during the play therapy sessions. The themes of ritualistic cleansing and nurturing persisted throughout the therapeutic process, however. During the final session, Session Eleven, Michelle started to work on issues of trust and independence as she told the therapist that she was going to paint. The therapist felt that Michelle did not reach Stage Four of the therapeutic process at the time of termination of therapy.

With regard to Erik Erikson's theory of psychosocial development, Michelle's chronological age placed her within the fourth stage of Erikson's developmental stages namely, industry versus inferiority. In the non-directive play therapy approach, Michelle was afforded the opportunity to revisit the developmental crisis of each stage. Initially she appeared vigilant of the therapist, but at the same time, tried to ignore her during many of the sessions. Gradually, Michelle started to work through the conflict of trust versus mistrust and progressed from making barely audible whispers during the first therapy session to holding a brief dialogue with the therapist in Session Ten.

Michelle was given the choice and freedom to take control in the playroom. When she chose to cry for two sessions, the therapist did not attempt to stop her from crying or distract her with toys. This was an important step in the re-establishment of choice and autonomy for Michelle. When the responsibility and direction in the playroom was left to Michelle; it was interesting to note that there were certain toys that she seemed to be consciously avoiding, namely the dolls house and the puppets.

The experience of child abuse may cause the child to feel inferior to her peers and the sexually abused child is likely to feel different and isolated from her peer group. As has been discussed, in the case of Michelle, her relationships with other children were characterised by conflict. She felt isolated from her peer group, and this was reflected in her dysfunctional

relationships with them, in addition to her drawings, where she drew herself differently to her friends.

## 7.3 Value of this Study

The case study method has provided a suitable research design in which to give an account of the subject in a therapeutic situation. This study has provided a detailed account of the life of Michelle and the value of this lies in allowing the reader to look at Michelle's world through the eyes of the researcher, and by so doing, see things that may otherwise have gone unnoticed.

The value of the application of Axline's eight guiding principles and the three core conditions in the non-directive approach to play therapy cannot be overemphasized; this was seen in action in this research study. Plotting the play therapy sessions according to the framework of the four stages of play therapy was a particularly useful tool to monitor Michelle's progression through the therapeutic process. This can be seen as a valuable application of a tool which can be used within the non-directive play therapy approach.

Contextualising Michelle's development according to the stages of Erikson's theory of psychosocial development was found to be a valuable endeavour. According to her chronological age, Michelle should have been in the fourth stage of industry versus inferiority, but in reality Michelle was still struggling to strike a healthy balance between the terms of conflict of trust versus mistrust issues of the first stage. From a therapeutic point, this was an important exercise as it helped to inform the therapist and consequently, the therapeutic process.

As was discussed in Chapter Four, this study falls into the ambit of the Descriptive-Dialogic Case Study and the current researcher provided a valuable addition to this research method in the form of Michelle's case study. This study is therefore a prime example of the type of study which is able to take up its rightful place amongst the qualitative methods of research.

As the current researcher was a relatively inexperienced therapist at the time of the therapeutic process described in this study, the strategy of this research method has allowed her to retrospectively learn and grow in her

therapeutic approach with children, through the in depth nature of this case. The intensive study of this single case has helped develop within the current researcher an increased wisdom and competence as she has passionately searched for greater mastery in personal and professional skills.

## 7.4 Possible Limitations of the Study as Related to the Case Study Approach

As was noted in Chapter Four, the case study approach has possible limitations related to the methodology. The current researcher presented a discussion of the preliminary methodological considerations together with methods that were employed to minimize their influence in this study. These possible limitations included aspects such as researcher bias, cross-cultural differences, inflated expectations, validity and reliability criticisms. The researcher is now able to discuss these issues retrospectively, and is able to provide insight into her experience of conducting the case study in terms of the preliminary methodological considerations.

### 7.4.1 Researcher Bias

With regard to researcher bias, no difficulty was experienced in empathising with the subject. Furthermore, the researcher is of the opinion that objectivity was achieved through case conceptualisation, clinical supervision, group supervision with colleagues and research supervision with the supervisor and co-supervisor.

### 7.4.2 Cross-cultural Differences

The researcher did not experience the cultural divide between herself and the subject as a significant limitation, as she took adequate steps to minimise cross-cultural differences and gain a culturally empathic understanding of the subject. The researcher facilitated this process by interviewing the client’s mother to gain a deeper understanding of the client’s social world, and she also interviewed the client’s teacher and various health professionals who all work in the client’s community. The researcher also discussed the case in a group supervision session with colleagues of varying cultural origins.

### 7.4.3 Inflated Expectations

This researcher maintained a realistic view of the limitations of the case study approach and remained aware that this case study had been interpreted from two specific theoretical perspectives which have provided only some of the many potential psychological interpretations.

### 7.4.4 Validity and Reliability Criticisms

The validity and reliability criticisms discussed in Chapter Four were implemented as described. The current researcher is of the opinion that she adhered to the required standards and that this study has acceptable levels of validity and reliability. Case study research has often been criticised on the grounds that its findings are not generalisable; however, it must be borne in mind that case studies rely on the process termed analytic generalisation, as discussed in Chapter Four, and that the current researcher generalised the findings to theory and not to other case studies or to the general population.

## 7.5 Specific Limitations of this Study

The researcher believes that it is a limitation that the therapy sessions were not video-recorded, as more detailed data could have been obtained had all sessions been video-recorded and transcribed. Instead, detailed transcriptions of the therapeutic process were made after each session.

There were additional limitations which were specifically related to the therapeutic process. These included the child’s difficulty in keeping all scheduled appointments as she was reliant on others to bring her to the psychology clinic. The therapist also felt it was a limitation that the therapeutic process did not reach the final stage, but was terminated by factors beyond the control of both the client and the therapist due to the annual end-of-year closure of the community clinic, which provided Michelle’s transport to the therapy sessions, and the end-of-year closure of the psychology clinic.

## 7.6 Recommendations for Future Research

This study could be repeated using additional psychological theories, such as Piaget's Cognitive Development Theory and Kohlberg's Six-Stage Theory of Moral Reasoning, both of which would illuminate additional areas of Michelle's life. The current researcher has experienced the case study approach to research as a challenging scientific undertaking. It is therefore recommended as a valuable addition to other enthusiastic researchers' repertoires. Furthermore, the current researcher is of the belief that research in the area of therapeutic interventions for victims of child abuse is a critically important endeavour as there appears to be a paucity of research in this arena.

## 7.7 Conclusion

The current researcher adhered to the highest possible ethical and technical standards in her research. Client confidentiality has been maintained throughout the study. The theories, methods and research design used in the interpretation of the data have been disclosed and limitations of the methodology and findings have been reported on in this study.

Taking into account the limitations noted earlier in this chapter, the researcher is of the opinion that this study has nonetheless proved to be a valuable research undertaking. This research undertaking can be recognised as a positive demonstration of the value of non-directive play therapy (Virginia Axline) and Erik Erikson's theory of psychosocial development in any therapeutic process. In addition, this study has served to facilitate a more holistic understanding of the case study approach to research.

The general aim of the study was to broaden psychotherapeutic knowledge by means of meaningful qualitative enquiry. More specifically it aimed to describe the therapeutic process that unfolded with a seven year old allegedly abused client within the framework of non-directive play therapy. The case was further contextualised by means of Erik Erikson's theory of psychosocial development. From this perspective, the researcher is of the opinion that the aim of this study has been accomplished.

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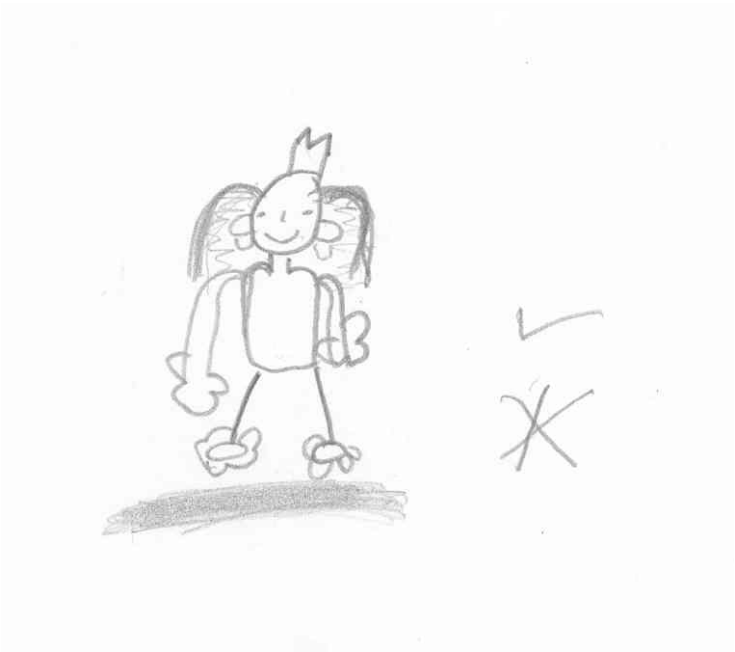
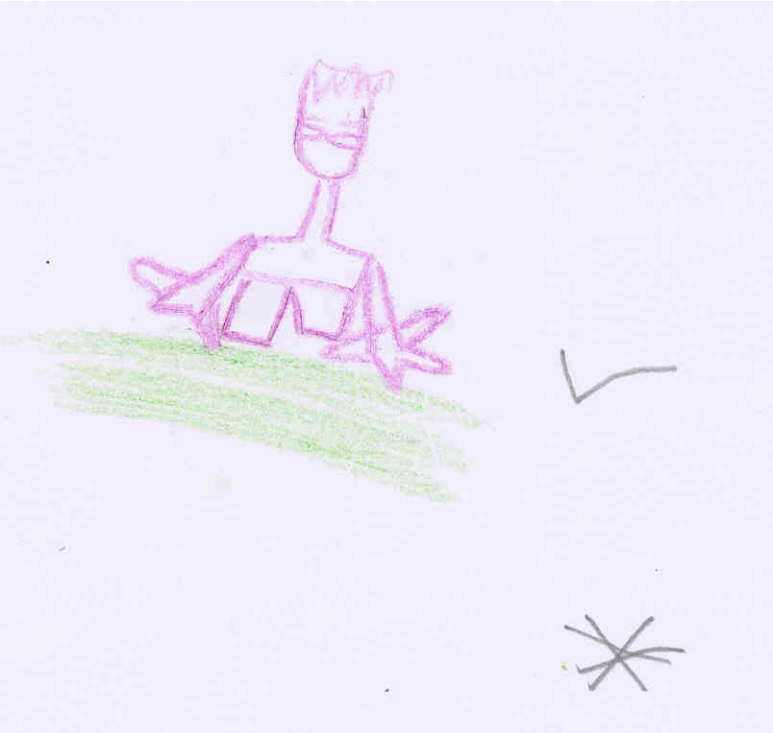
# Appendix A

Portrait of Self



# Appendix B

Portrait of Nephew



**Appendix C**

Family Drawing

# Appendix D

Drawing of Friends