A THERAPEUTIC EXPLORATION OF A CHILD WITH AN INSECURE ATTACHMENT STYLE

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ABSTRACT

The extensive amount of research conducted internationally in the field of John Bowlby’s attachment theory indicates that an insecure attachment between a child and the primary caregiver has a detrimental effect on both social and emotional development in childhood, as well as having a profound effect on psychological development and functioning in adulthood. The present study aimed to explore and describe the therapeutic process of a nine year old with an insecure attachment style within a therapeutic framework, namely Theraplay. The therapeutic process was embedded within Ann Jernberg’s Theraplay framework and the case was further contextualized within Bowlby’s attachment theory. The case study method was utilized with a purposive sampling technique employed to select the participant. Irving Alexander’s content-analytic framework in conjunction with Guba’s model of trustworthiness was employed for data analysis. Two needs emerged during the therapeutic process namely the need for nurturance and affection as well as the need for power, control and safety.

Key words: John Bowlby, attachment theory, insecure attachment, Theraplay, non-directive play therapy, case study research
CHAPTER 1

INTRODUCTION AND MOTIVATION FOR THE STUDY

Introduction

My name is Misty, I am but three,
My eyes are swollen, I cannot see.
I must be stupid, I must be bad,
What else could have made my daddy so mad?

I wish I were better, I wish I weren't ugly,
Then maybe my mommy would still want to hug me.
I can't speak at all, I can't do a wrong,
Or else I'm locked up, all the day long.

When I awake, I'm all alone,
The house is dark, my folks aren't home.
When my mommy does come, I'll try and be nice,
So maybe I'll get just one whipping tonight.

Don't make a sound! I just heard a car,
My daddy is back from Charlie's Bar.
I hear him curse my name as he calls,
I press myself against the wall.

I try and hide from his evil eyes,
I'm so afraid now I'm starting to cry.
He finds me weeping, he shouts ugly words,
He says it's my fault that he suffers at work.

He slaps me and hits me and yells at me more,
I finally get free and I run for the door.
He’s already locked it and I start to bawl,
He takes me and throws me against the hard wall.

I fall to the floor with my bones nearly broken,
And my daddy continues with more bad words spoken.
"I'm sorry!" I scream but it’s now much too late,
His face has been twisted into unimaginable hate.

The hurt and the pain again and again,
Oh please God, have mercy! Oh please let it end!
And he finally stops and heads for the door,
While I lay there motionless, sprawled on the floor.

My name is Misty and I am but three,
Tonight my daddy murdered me.

(Ramsey, 1996)

The heartrending description from this poem allows an individual a glimpse into the world of reality of an abused child. It epitomizes the psychological, physical, and emotional abuse, as well as the neglect and maltreatment that some children live with daily.

The family environment, while often seen as a place of safety, where children are nurtured and sheltered, is also the place where many children are at risk of being victimized by their parents. The most significant aspect of child abuse, neglect and maltreatment is that it frequently occurs within the context of the family, committed by those adults upon whom the child relies for protection (Wenar & Kerig, 2000). Early childhood experiences are particularly influential and the extensive amount of research conducted in the field of family violence indicates that child abuse has a detrimental
effect on physical and emotional development in childhood as well as having a profound
effect on psychological development and functioning in adult life (Oberholzer, 1996).

*Prevalence of Child Abuse in South Africa*

According to the 2007 – 2008 South African Police Services (SAPS) annual report, 16,068 children were raped between April and December 2007. According to Childline, females have a one-in-four risk, and males have a one-in-five risk of being raped before the age of 16 (Bureau of Democracy, Human Rights, and Labour, 2008). Based on UNICEF’s Annual Report on South Africa for 2008, it is estimated that 60 children are raped per day. In the period of one year, 2007 to 2008, 1,410 children were murdered, 19,687 children were assaulted with intention to do grievous bodily harm, and 3,517 children were subjected to indecent assault. Four thousand one hundred and six cases of neglect and ill-treatment were reported in South Africa (South African Police Services, 2008). It is believed that these figures represent a small percentage of the actual incidence of child abuse, neglect and maltreatment as many cases are not reported. Most cases involving family members are not reported. A second factor related to the reporting of cases is the low conviction rate of perpetrators. It is estimated that of the reported child abuse cases, only 7% of perpetrators are convicted (South African Police Services, 2008).

**Motivation for the Study**

The quality and character of children’s close relationships with their primary caregiver is proving to be the central concept linking the myriad of factors that have an influence on development. Relationships provide the key experience that connects
children’s personal and social worlds. It is within the dynamic interplay between these two worlds that minds form, personalities grow, behaviour evolves and social competence emerges (Howe, Brandon, Hinings, & Schofield, 1999).

Due to the high rates of crime, unemployment, increasing rates of HIV/AIDS and the resulting increasing number of child headed households in South Africa, there is a growing concern regarding children’s attachment behaviour. Research conducted internationally has shown that many psychological disorders in adulthood, such as depression, anti social personality disorder, the abuse of drugs and alcohol as well as eating disorders, have been linked with an insecure attachment between the mother and child (Bowlby, 1979; Feldman, 2003; Howe et al., 1999).

Much research has been conducted internationally and has contributed to the understanding of the long term effects of abuse on children. This has resulted in many forms of therapeutic intervention aimed specifically at reducing these effects on children. One such therapeutic intervention is play therapy. Play therapy cannot erase the destruction caused by abuse, neglect and maltreatment but it does offer the child an opportunity to heal (Hendricks & Newman, 1995). One form of play therapy, Theraplay, is of particular interest to the researcher as it has been found to increase attachment between the child and mother in international studies (Jernberg, 1979; Jernberg & Booth, 1999; Munns, 2003).

A literature search revealed that limited research has been conducted on children’s attachment styles and the resultant psychological sequelae in the South African setting. This identified gap in knowledge highlighted the importance of conducting a research study which explores the attachment style of an abused, neglected and maltreated
South African child. This research therefore aims to offer a glimpse into the therapeutic processes of an insecurely attached and abused South African child, utilizing Theraplay and non-directive play therapy as the specific therapeutic approaches.

Overview of Chapters to Follow

The presentation of this dissertation includes eight chapters. In Chapter Two a detailed review is given on attachment theory and the resulting effects of an insecure attachment style, the effects of psychological trauma is discussed, followed by developmental psychopathology. Chapter Three provides a detailed description of the therapeutic approaches utilized, namely Theraplay and non-directive play therapy, with the methodology of the study as well as ethical considerations taken into account being discussed in Chapter Four. The client is introduced in Chapter Five with a description of the sixteen therapy sessions conducted. In Chapter Six the findings of the study are discussed. In Chapter Seven, the conclusions, limitations of the research, as well as the recommendations for future research studies are presented.

Throughout this research study, the feminine grammar (for example, she, her) will be utilized to refer to both the female and male gender groups. The use of the feminine terms by no means implies that child abuse or insecure attachment is exclusive to females. It is utilized only in this manner as the client selected in this particular study was female and therefore monotonous repetition of his or her, for example, was avoided to aid in easier reading.
Conclusion

The motivation for the study was discussed in this chapter, and a brief overview of the chapters to follow was included.

The following chapter provides an in depth discussion of Bowlby’s attachment theory. In the chapter the internal working model, the quality of the parent-child relationship as well as the different attachment styles of children is discussed in detail.
CHAPTER 2

ATTACHMENT: A THEORETICAL OVERVIEW

“Children who feel unloved and unattached are often children of rage and rebellion. They become locked in defiant opposition to adults, who reciprocate with counter-aggression. The child becomes ‘adult-wary’, forever biting the hand that didn’t feed him or her.”

(Brendtro, van Bockern & Clementson, 1985, p.38)

Introduction

During the development of the attachment theory, Bowlby was influenced by many different individuals and perspectives such as Klein’s object relations theory, Darwin’s evolutionary theory as well as ethnological and anthropological studies (Bretherton, 1992). One of the major influences in his theorizing of the attachment theory was the work conducted by Mary Ainsworth in Uganda, known as the Ganda project as well as her later work, which resulted in the now famous Strange Situation (Bretherton, 1992). For the purpose of this dissertation, these influences will only be briefly discussed.

Further, Bowlby’s attachment theory including phases of attachment development, internal working models and the quality of the relationship between the parent and child is discussed. The attachment styles are discussed in detail followed by the effects of psychological trauma as experienced by the child. The effects of psychological trauma including a) behavioural, b) emotional, and c) cognitive effects as well as how a child’s life assumptions may be altered are discussed. The stability of the attachment over the
lifespan and, finally, attachment, the effects of trauma on attachment and developmental psychopathology is explored.

**Origins of Attachment Theory**

Bowlby’s interest in working with children began when he volunteered at a school for maladjusted children. From his experiences with the children at the school, Bowlby decided on a career as a child psychiatrist (Bretherton, 1992). Bowlby undertook further training at the British Psychoanalytic Institute where Melanie Klein was a major influence. Klein developed the object relations theory which is briefly discussed below.

*Klein’s Object Relations Theory*

Klein emphasized the infant’s active contribution to the formulation of themselves and their inner worlds of object relations. The term ‘object’, originally used by Freud, meant anything an infant directed drives towards with the goal of satisfaction. Objects can include individuals, such as the mother and father, and things such as objects with which individuals form attachments to. These objects and the developing child’s relationship with the objects are combined with the self to form an internal object (St. Claire & Wigren, 2004).

The infant’s dealings with the external objects continually form the internal world of the infant. The infant experiences feelings of hostility, frustration as well as love in relation to the external objects. This influences and modifies the internal object relating to the child. Klein believed that infants face a constant cycle of gratification and frustration by a constant use of mechanisms of projection and introjections, which the infant utilises to control their intense fears and needs (St. Claire, 2000). The objects of
the infant’s internal world are constructed and come into existence through introjections, which is a process in which an external object is taken in and internalised. The infant can therefore introject external sources of frustration and anxiety. The infant then employs the mechanism of splitting in order to make herself feel safe (St. Claire & Wigren, 2004). This mechanism involves splitting the self and objects into good and bad objects therefore keeping them separate. The complex relationship with the mother is simplified by the infant utilising this mechanism. Instead of having to deal with simultaneous good and bad aspects of the mother (breast), the infant has a relationship with the loving breast and the loved self and the frustrating, hated breast and the frustrated, hating self. In this manner negative feelings are kept separate from positive feelings (St. Claire & Wigren, 2004).

The first object to be introjected is the mother’s breast. Due to splitting, the infant’s experiences with the breast is introjected as two separated experiences. The negative, frustrating experiences are attributed to the bad breast, whilst the positive, good experiences are attributed to the good breast (St. Claire, 2000).

Projection is the process whereby the infant turns her own feelings on to an external object. In this manner, the good breast becomes the blueprint of what is felt throughout life to be good, whilst the bad breast stands for everything that is negative (St. Claire & Wigren, 2004).

Bowlby, though, had doubts regarding certain aspects of Klein’s object-relations approach to child psychoanalysis, specifically Klein’s belief that children’s emotional problems were due to fantasies resulting from internal conflicts between aggressive and libidinal drives, rather than events from the external world (Bretherton, 1992). From his
accumulated experiences with children, Bowlby started moving away from the Kleinian school of thought and started looking at family experiences rather as the cause for emotional disturbance in children. And so the beginning of the attachment theory emerged (Ainsworth & Bowlby, 1991; Bretherton, 1992). During this time Bowlby was also interested in Darwin’s evolutionary perspective and so Bowlby’s emerging theory of attachment was further influenced by anthropological and ethological influences.

**Anthropological and Ethological Influences**

Much of Bowlby’s thinking was influenced by Darwin’s evolutionary perspective which focused on the adaption of organism to environment. This led to Bowlby’s interest in ethnology. He was particularly interested in the concepts of specie-specific patterns of instinctual behaviour and evolutionary adaption, where the ultimate goal was survival of the species through the process of natural selection. The inter-connectedness of the organism, with the environment and instinctual behaviour patterns, influenced what Bowlby termed “the environment of adaptedness” (1977, p.47). Bowlby (1979) highlights this inter-connectedness by stating:

> “This reminds us that in living organisms neither structure nor function can develop except in an environment and that, powerful though heredity is, the precise form each takes will depend on the nature of that environment” (p.28).

Bowlby (1979) referred to numerous ethological and anthropological studies in his writings that influenced his thinking and theorising. One of the most influential ethological studies was Harry Harlow’s (1958) experiment with Rhesus monkeys.
Harlow’s experiment with Rhesus monkeys

In Harlow’s (1958) classic experiment, two groups of baby Rhesus monkeys were removed from their mothers. The first group were placed with a wire-mesh dummy mother that had a feeding bottle and a second dummy mother covered in terrycloth, with no feeding bottle. The second group of monkeys was placed with a terrycloth dummy mother that had a feeding bottle, with the second wire mesh dummy mother having no feeding bottle. Harlow (1958) found that the monkeys clung to the terrycloth dummy mother whether or not it provided them with food and only chose the wire dummy mother when it provided food but once nourished, the monkeys would return to the terrycloth mother. Whenever a frightening stimulus was brought into the cage, the monkeys clung to the terrycloth mother, whether it provided them with food or not (Harlow, 1958; Harlow & Zimmermann, 1959). This experiment greatly influenced Bowlby’s thinking as he saw that the monkey’s needs were not only biological needs but also interpersonal needs, such as the need for security (Bowlby, 1979).

As stated earlier, the work of Mary Ainsworth greatly contributed to the final formation of Bowlby’s attachment theory.

Influences of Mary Ainsworth

Mary Ainsworth met and started working with Bowlby at the Tavistock Clinic in early 1950 (Ainsworth & Bowlby, 1991). Ainsworth had previously conducted research in Uganda where she studied the relationship between mothers and their infants. She was particularly interested in determining proximity-promoting signals and behaviours that the infants displayed towards their mother (Bretherton, 1992). Ainsworth’s analysis of
data from her Ganda project influenced and was influenced by Bowlby’s reformulation of attachment theory (Bretherton, 1992).

Ainsworth, after leaving Uganda, embarked on further research in Baltimore. The Baltimore Project, where 26 families participated, involved Ainsworth observing normal routines of mother-infant engagement for four hour periods, resulting in 72 hours of data collected for each family. The data was in the form of narrative reports and from these narrative reports, Ainsworth noted mother-infant patterns during the first three months, which included crying, feeding, close bodily contact and infant behaviour (Bretherton, 1992). Individual differences were noted regarding the mother’s response to their infant’s signals. Ainsworth also saw that for some mother-infant pairs, some mothers had difficulty in adjusting their behaviour to the infant’s cues with the infant tending to struggle and choke. This did not occur with the mother-infant pairs that were synchronised in their feeding patterns (Bretherton, 1992). From this initial research, Ainsworth went on to develop her now famous Strange Situation (Ainsworth & Bowlby, 1991).

*Strange situation*

In essence the Strange Situation involved eight episodes and lasted approximately 20 minutes in total length. Mothers and their children were observed through a one-way mirror, with all children observed being approximately one year old. The eight episodes were designed to progressively create a more stressful situation for the child, with the observed behaviour being recorded (Ainsworth, Blehar, Waters & Wall, 1978).

The first episode, which lasted 30 seconds, began with the mother and child being introduced to the experimental room, with the mother being asked to carry the child into
the room. The mother was told where to place the child and where to sit after putting the child down (Ainsworth et al., 1978).

In the second episode, which lasted three minutes, the mother was asked to put the baby down with some toys, take a seat in a chair and pretend to read a magazine. The mother was instructed not to initiate contact with the child but to respond to the child if she initiated contact (Ainsworth et al., 1978).

After the three minutes, a stranger entered the room, beginning episode three, which also lasted three minutes. The stranger greeted the mother, then went and sat quietly on a chair for a minute. The stranger then initiated conversation with the mother for a further minute, and for the remaining minute initiated contact with the child. The mother then unobtrusively left the room, whilst leaving her handbag in the room, next to her chair (Ainsworth et al., 1978).

The fourth episode consisted of observation of the child’s reaction to the mother’s absence as well as to the toys and stranger. If the child continued exploring with the toys, the stranger did not intervene. If the child displayed distress the stranger first tried to interest the child with the toys and if that did not work, then picked the child up and tried to console the child. Once consoled, the stranger tried to interest the child in the toys again (Ainsworth et al., 1978).

The fifth episode, which lasted three minutes, began with the mother speaking loudly outside the door. The mother then opened the door, paused for a few seconds to allow the child to mobilise toward her. The mother then comforted the child and placed the child back on the floor to play with the toys. The stranger discreetly left the room. At the
end of the three minutes, the mother made it known to the child that she was leaving by saying “bye-bye” and exited the room (Ainsworth et al., 1978).

The sixth episode, approximately three minutes or less, entailed observing the child’s reaction to exploration with the toys as well as the reaction to the mother’s absence (Ainsworth et al., 1978).

For the seventh episode, the stranger spoke loudly outside the door and then entered, also pausing to allow the child to move towards her. If the child was distressed, the stranger tried to console the child, if the child allowed it, and then tried to interest the child in the toys. If the child started to explore the toys once again, the stranger retreated to the chair. If the child was not distressed when the stranger entered the room, the stranger invited the child to come to her. If the child did not come, the stranger went to the child and initiated play. If the child showed interest in the toys, the stranger retreated to the chair but responded to interactions initiated by the child (Ainsworth et al., 1978).

Episode eight, which is three minutes in length, began with the mother re-entering the room, pausing and then greeting the child. The mother then continued toward the child, picked the child up and spoke to the child. Whilst this interaction took place, the stranger left the room (Ainsworth et al., 1978).

The results were interpreted with Ainsworth defining three attachment styles namely secure, resistant, and avoidant. These attachment styles will be further discussed in more detail later in the chapter.

The anthropological and ethological influences, Harlow’s experiments with Rhesus monkeys, as well as the work conducted by Mary Ainsworth, contributed to Bowlby’s
initial theorizing, which led to his groundbreaking attachment theory which is discussed in the following section.

**Bowlby’s Attachment Theory**

Bowlby’s (1979) final form of the attachment theory states that normal attachment in infancy is crucial to an individual’s healthy development. According to Bowlby (1979) normal attachment occurs when there is a “warm, intimate and continuous relationship with the mother in which both find satisfaction and enjoyment” (p2). Bowlby (1979) viewed attachment behaviour as the product of a biological control system and proposed that evolution ensured that behaviours increasing survival would be genetically inherited. Thus, the relationship between the parent and child is usually instinctive and reciprocal.

Increased separation from the mother, in either, space (too far) or time (too long), increases anxiety. Anxiety therefore activates the attachment system, which increases attachment behaviour, the purpose of which is to get the child back into a close relationship with the mother (Howe et al., 1999). Attachment behaviour brings infants into close proximity to their main carers and it is within these close relationships that infants learn about themselves, other people and social life in general. Therefore, a secure attachment between the mother and infant provides infants with feelings of security, which are critical in allowing an infant the freedom to explore the world (Feldman, 2003; Sadock & Sadock, 2003).
Phases of Attachment Development.

Bowlby formulated four attachment phases in the development of an infant’s attachment. The first phase, termed pre-attachment, occurs from birth to two months of age. During this phase the infant displays ‘prosocial’ behaviour, appearing to become animated by the mother’s efforts to engage with the infant (Bowlby, 1978).

The second phase, termed discriminating responsiveness or attachment in the making, begins to emerge between the ages of three to six months. During this phase the infant becomes familiar with the mother (Bowlby, 1978). Howe et al. (1999) state that during this stage “interaction between infant and caregiver is increasingly attuned, the infant being able to ‘read’ the caregiver’s behaviours and moods better than those of anyone else” (p.20).

During the period of seven months to three years of age, the third phase called clear cut attachment occurs. The infant becomes more involved in pursuing and maintaining communication and proximity with the mother (Bowlby, 1978; Howe et al., 1999). The attachment between the child and the mother becomes increasingly important as the child enters into the second half of their first year as it is during this period that the child learns to organize memories of experience. These memories of experience are what Bowlby (1973) termed internal working models (Cunningham & Page, 2001). These will be discussed in more detail in the following section.

The fourth phase, from the age of three onwards, termed goal-directed partnership occurs. The child continues pursuing and maintaining communication with the mother. With an awareness of self and other, the child has the benefit of managing and adjusting the mother’s behaviour as well as her own (Bowlby, 1978; Howe et al., 1999).
As stated earlier, the memories the child experiences, or rather the internal working models, regarding the mother are vitally important for later development. These internal working models are discussed in the following section.

*Internal Working Models*

Attachment theory holds that, within close relationships, young children acquire mental representations of their own worthiness based on other people’s availability and willingness to provide care and protection. Bowlby (1979) referred to this process as internal working models (Howe *et al.*, 1999). These mental representations have three elements namely, the self, other people and the relationship between the self and others. Bowlby (1973) highlighted the difference between the child’s working models of self and others. A working model of the self is regarded as an internal representation of how the child views herself based on her role in the attachment relationship. In essence, the internal working model of self is the belief about one’s worthiness and competence as an individual (Lyddon & Sherry, 2001). Internal working models of others result directly from the original working model the child has based on the relationship between herself and her mother. The child, as she grows older, utilizes this internal representation to generalize to a broader base of expectations of others (Lyddon & Sherry, 2001). The internal working model of the self and of others that the child has then mirror each other as the child grows older (Cunningham & Page, 2001; Lyddon & Sherry, 2001).

According to Bowlby, the most influential relationship for the child is with the mother, as it is in this relationship that the child learns how to integrate the three components. However, essentially the child learns that it is in relationships with other people in
general that one learns to understand oneself. And, furthermore, by understanding one’s self, one begins to understand other people (Howe et al., 1999). Therefore, based on the internal working model, children develop behavioural strategies, such as crying, smiling and laughing, in order to ensure that their various needs are met.

Internal working models tend to retain their essential qualities over time, though they are always subject to updating and revision. With an internal representation of the mother as responsive and reliable, the child can explore the environment and by doing so, create new social relationships (Cunningham & Page, 2001). This healthy internal working model is then carried forth into adulthood. If the child’s internal representation of the mother is characterized by inconsistency and fear, as with many maltreated, abused and neglected children, the child lacks the secure base from which to explore their environment. These children therefore are typically deprived of opportunities to learn social skills (Cunningham & Page, 2001; Lyddon & Sherry, 2001). Poor regulation of emotions, anxiety, hyper-vigilance, distrust of others, hostility, as well as social non-engagement is commonly reported behavioural strategies of maltreated and abused children (Green & Goldwyn, 2002). As with the child with a healthy internal working model, these inner representations are carried forth into adulthood, placing the child at risk for psychopathology and psychopathological behaviour (Green & Goldwyn, 2002).

Crucial to the internal working model is the quality of the attachment between the mother and the child.

Quality of the Parent-Child Relationship

Children’s attachment behaviour is activated when they feel distress or anxiety. This propels them into a relationship with their mother, where they look for comfort,
soothing and understanding. It is important to distinguish between the presence of an attachment and the quality of that attachment (Newman & Newman, 2003). According to the attachment theory, if an adult is present to interact with a child, an attachment will be formed. However, individual differences emerge in the quality of the attachment between the adult and the child, which depends on the child’s accumulation of information over many instances when the child seeks reassurance, comfort or protection from a threat (Newman & Newman, 2003). An important factor in forming a secure attachment is the adult’s acceptance of the child and their ability to respond to the child’s communications and needs (Newman & Newman, 2003).

Rutter (1991) states that the quality of a parent-child relationship constitutes a central aspect of the role of parenting. Rutter (1991) also adds that the development of social relationships occupies a crucial role in personality growth, and that the abnormalities found in relationships are important in understanding identified psychopathology.

Ainsworth formulated two attachment categories, secure attachment and insecure attachment, based on the quality of the attachment relationship between the primary caregiver and the child (Ainsworth & Bowlby, 1991; Alexander, 1992; Brisch, 1999). The insecure attachment category can be further divided into three attachment styles: a) avoidant attachment, b) ambivalent attachment, and c) disorganized attachment which are discussed in more detail in the following section.
Attachment Styles

Secure Attachment

Secure attachment occurs when there is a synchrony between the mother and the child, and involves well timed, reciprocal, rewarding interactions. In times of distress or anxiety, the primary caregivers comfort their child, therefore allowing their child to know that they are being responded to in a positive, caring manner (Alexander, 1992; Brisch, 1999; Feldman, 2003). A securely attached child learns that their expressions, such as crying, produce an appropriate response from the mother such as comfort. These children when in an unknown environment will explore but will repeatedly visually or physically give reference to the mother. If stressed, a securely attached child will show a clear preference for the mother and will easily be soothed (Anderson & Alexander, 2005). The child therefore uses the mother as a secure base from which to explore the environment, develop the capacity for self-soothing and see themselves as worthy of attention and love. A securely attached child views the world as a safe place and sees others as trustworthy and responsive to their needs (Anderson & Alexander, 2005).

Children who are securely attached tend to be more socially and emotionally competent later, others view them more positively (Alexander, 1992; Brisch, 1999; Feldman, 2003), and they are often resourceful and empathic toward others (Anderson & Alexander, 2005).

The child’s failure to gain comfort from the mother produces feelings of anxiety and anger. Despite the child’s inherent need to stay in proximity to the mother during times of distress, these painful emotional states would be prominent during situations of heightened attachment distress (Anderson & Alexander, 2005). These children would
be classified in the insecure attachment category. The insecure attachment category is divided into three distinct attachment styles namely avoidant, ambivalent and disorganized.

**Insecure Attachment**

**Avoidant attachment**

Children with avoidant attachment styles experience their primary caregiver as rejecting, interfering and controlling (Alexander, 1992). When these children display distress, it may annoy or agitate the caregiver. The result is a rebuff or an aggressive attempt to control or deny the child the comfort it seeks (Howe et al., 1999). Displays of attachment behaviour such as crying seem to elicit the opposite of what they were designed to achieve. Instead of the primary caregiver giving comfort and reassurance to the distressed child, the primary caregiver does the opposite therefore teaching the child to minimize the attachment behaviour (Brisch, 1999). The child then either denies or does not communicate distress and emotional self-containment is established (Brisch, 1999). The child learns to blunt their emotions and remain detached from the mother in order to maintain access to the mother during periods of heightened emotional distress. This results in the child’s increasing lack of awareness of the internal states. Avoidantly attached children are characterized by overreliance on emotional detachment, the maintenance of affective neutrality and “compulsive self-reliance” (Bowlby, 1973).

As a toddler, the child will show little or no distress during separation from the mother. Avoidant attachment has been associated with emotional insulation, lack of empathy, hostile and antisocial behaviour, attention seeking, eating disorders as well as
drug and alcohol abuse (Alexander, 1992, Sroufe, 1988). Avoidantly attached individuals are less empathic and have been found to minimize any expression of distress (Anderson & Alexander, 2005).

**Ambivalent attachment**

Ambivalent attachment occurs when primary caregivers are insensitive, unreliable and inconsistent in their responses to their children. The child feels the need to maximise their attachment behaviour in order to break through the parent’s emotional neglect, unavailability and lack of responsivity (Alexander, 1992; Brisch, 1999). The child may try to gain proximity to the mother by displaying angry, demanding behaviours or conversely, dependent and coy behaviours when the mother responds to the child (Anderson & Alexander, 2005). Therefore these children do not feel that they are worthy of automatic interest as the mother is seen to be inconsistent and not always able to provide comfort (Brisch, 1999). Ambivalently attached children often strongly protest separation, desperately seek contact with the mother upon return, only to angrily resist contact once it is achieved. As an ambivalently attached child is unable to use the mother as a secure base, the child is unable to adequately explore the environment. These children who display hostile, self-destructive and apparently deliberately irritating behaviours may use these actions or behaviours to gain parental attention as well as an expression of resistance or anger (Anderson & Alexander, 2005).

Ambivalent attachment has been associated in adulthood with neediness, impulsivity, helplessness, jealousy, poor social skills, antisocial behaviour, relationship difficulties and oppositional defiance disorder (Alexander, 1992; Anderson & Alexander, 2005; Brisch, 1999).
Disorganized attachment

Children who cannot organise their behaviour, or who develop a defensive strategy to achieve proximity, have a heightened and unregulated arousal and fall into the disorganized attachment style (Alexander, 1992). These children find it difficult to maintain a functional and positive relationship with their primary caregiver and therefore any behavioural strategy that they utilize fails to bring them into proximity with their primary caregiver. Their attachment behaviour becomes increasingly incoherent and disorganized, sowing a mix of avoidance, angry responses and behavioural disorientation (Booth & Koller, 1998; Brisch, 1999).

Dissociation, post traumatic distress disorder, depression, elevated levels of anger, rage and violence, aggressive anti social behaviour and alcohol and drug abuse have been linked with the disorganized attachment style (Alexander, 1992; Brisch, 2002).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM IV-TR) (American Psychiatric Association, 2000) the only pathology that is related to attachment is reactive attachment disorder of infancy or early childhood (RAD) which is discussed in the following section.

Reactive Attachment Disorder (RAD) in Infancy or Early Childhood

As previously stated, the only pathology related to attachment in the DSM IV-TR is Reactive Attachment Disorder (RAD) (American Psychiatric Association, 2000). The DSM IV-TR (2000) lists two types of RAD, namely the inhibited type and the disinhibited type (see Appendix A for diagnostic criteria). Both types of RAD have been linked to, but not limited to, children who were abused, maltreated and neglected by their family or caregivers.
caregivers (Hardy, 2007; Haugaard & Hazan, 2004; Marvin & Whelan, 2003), to children who have been hospitalized for prolonged periods of time, as well as to children whose primary parent (i.e., mother) has been hospitalised or institutionalised for a prolonged period of time (Minnis, Marwick, Arthur, & McLaughlin, 2006). Since the diagnostic criteria for RAD are relatively nonspecific, the diagnosis may be given to children from a range of different backgrounds (Hardy, 2007).

The inhibited type of RAD has been described as a pattern resulting from experience with caregivers who do not provide emotional support and comfort when needed by the child (Haugaard & Hazan, 2004). As children who have been treated in such a manner expect to be rejected by others, they avoid social contact and interaction. Inhibited children are therefore often withdrawn, avoid comforting gestures, are often aggressive and are awkward in social situations (Hardy, 2007).

In the disinhibited type, behaviours are believed to be related to the child's experience with caregivers who are not responsive but who can be coerced into providing affection. Children with disinhibited RAD have often had multiple caregivers or have repeatedly lost attachment figures and therefore the child superficially accepts anyone as a caregiver (Hardy, 2007). Behaviours displayed by children in this diagnostic category include inappropriate familiarity and comfort-seeking with strangers, exaggeration of needs for assistance, chronic anxious appearance and inappropriate childishness (Haugaard & Hazan, 2004).

While diagnosis and treatment of disordered attachment patterns are vitally important, Marvin and Whelan (2003) emphasize some of the difficulties associated with diagnosing a child with RAD. Attachment has typically been studied by applying Bowlby
and Ainsworth’s four attachment styles, a RAD diagnosis does not fit neatly into the categories laid out by Bowlby and Ainsworth (Marvin & Whelan, 2003). The only clear cut RAD subtype that fits into a specific attachment style is the inhibited type of RAD, which has been found to closely correlate to the disorganized attachment style (Minnis et al., 2006). With regard to the inhibited subtype, characteristics include a mixture of Bowlby’s avoidant and ambivalent attachment styles (Minnis et al., 2006).

As RAD and many attachment difficulties may be a result of trauma experienced by the child, much research has been conducted on children who have experienced trauma during the last two decades. This research has led to the recognition that unresolved trauma experienced in childhood, not only affects the parent-child relationship, but may also increase the child’s risk for the development of adult psychopathology (Hendricks & Newman, 1995).

**Psychological Trauma in Childhood**

A traumatic event differs from stress or a crisis. A trauma is a sudden, horrifying experience, where an individual feels fear, is helpless and out of control. The event is so terrifying that it overwhelms the individual’s ability to cope (Lewis, 1999). Trauma can be defined as a physical or psychological threat or assault to the child’s physical integrity, sense of self, safety or survival (Moroz, 2005). Pearlman and Saakvitne (1995) have defined psychological trauma as:

“The unique individual experience of an event or enduring conditions in which the individual’s ability to integrate her
emotional experience is overwhelmed or the individual experiences a threat to life, bodily integrity or sanity” (p.60).

Children may experience psychological trauma as a result of a number of different circumstances such as abuse, neglect, exposure to violence, natural disaster, or war (Moroz, 2005; Pearlman & Saakvitne, 1995; Trickey & Black, 2000). Psychological trauma may occur during a single traumatic event, known as an acute traumatic event, or as a result of repeated chronic exposure to overwhelming stress. Children exposed to repeated chronic trauma have been found to have greater negative outcomes than those exposed to single traumas (Moroz, 2005).

Effects of Psychological Trauma

The range of reactions displayed by children following a trauma is very broad and may include behavioural, emotional and cognitive components. Changes to a child’s assumptions about life also play a role in the effects of the trauma.

Behavioural effects

Clinical studies as well as empirical research revealed that many survivors of childhood victimization experienced negative behavioural effects (Moroz, 2005; Trickey & Black, 2000). The behavioural effects include sleep disturbances, which includes sleepwalking, nightmares, restlessness and talking in their sleep. Trickey and Black (2000) found that flashbacks are less common in children but found that the trauma was often re-experienced in repetitive play. The child’s play may involve themes of the trauma experienced, if not repetitively playing out of the actual trauma.

Regression is a common behavioural effect, where the child regresses and seems to forget developmental skills previously mastered. Possible reactions of the regression
include enuresis, encopresis, loss of language skills previously mastered and feeding problems (Lewis, 1999; Trickey & Black, 2000).

An exaggerated startle response has also been linked to traumatic events. The child may startle easily to loud or sudden noise, with the effects lasting longer than would ordinarily be expected. The child may also experience hyperarousal, where the child feels as though she is constantly in danger and may be jumpy and experience sweating and a rapid heartbeat (Hendricks & Newman, 1995; Lewis, 1999).

**Emotional effects**

Children experiencing psychological trauma often become tearful, withdrawn, suffer from mood swings, and may become clinically depressed (Trickey & Black, 2000). Separation anxiety, even in teenagers, is common. The child may seem clingy and become distressed when separated from the parent (Lewis, 1999; Trickey & Black, 2000).

Children who are traumatised may develop various types of fears. The child may have specific fears around the trauma and also around the reminders of the trauma. A fear of the dark or fears of being alone are common in children (Lewis, 1999).

The child’s self-esteem may also be affected. Young children often come to believe after the trauma that something is inherently wrong with them and that they are unlovable, helpless and unworthy of protection (Moroz, 2005). The child may constantly be fearful of other individuals, potential danger and generally may see the world as a threatening and dangerous place (Lewis, 1999).

Dissociation may occur when there are prolonged traumatic incidents, such as abuse. The child may suppress her thoughts and feelings by denying that the abuse is
happening and therefore block it out of her mind. In this way the child is protecting herself and mentally escaping from the traumatic situation. Children that dissociate may have a withdrawn, ‘frozen’ expression on their faces (Lewis, 1999).

**Cognitive effects**

If the child is not suffering from full-blown flashbacks of the trauma, she may have intrusive thoughts regarding the trauma (Lewis, 1999). Concentration difficulties are common and the child may become forgetful and have difficulty following instructions. These difficulties with memory and concentration may affect the child’s performance at school and often there is a marked decrease in academic performance (Hendricks & Newman, 1995; Lewis, 1999; Trickey & Black, 2000).

**Life assumptions**

A child assumes that most people are nice most of the time and that they basically have control over what goes on around them. A trauma often shatters this assumption resulting in the child trying to make sense of what has happened. Following a trauma some children have a foreshortened future and no longer make plans for the future (Lewis, 1999). The child may come to expect that life is dangerous, that she may not survive, and as a result the child may give up hope and expectations for themselves that reach into the future (Moroz, 2005).

Bowlby (1969) implied that the onset of attachment patterns was accomplished and grounded in early childhood. He described internal working models as persistent, yet also implied that these internal representations were open to revision, and may therefore change and evolve in light of experience and significant changes in the family environment. Therefore, if psychological trauma is experienced by a child and not
adequately worked through or dealt with by the child, the child may form an internal working model of this event, which may be carried through into adulthood.

**Stability of Attachment**

The stability of attachment across the lifespan has been widely researched with differing, and at times, inconsistent findings. Research conducted by Waters, Merrick, Treboux, Crowell and Albersheim (2000) as well as by Hamilton (2000) found that the majority of their participants maintained the same attachment status over time. Waters et al. (2000) found that changes in attachment styles were attributed to lifestyle changes, which in turn changed the individual’s internal working models. Research conducted by Bar-Haim, Sutton and Fox (2000) as well as Watkins (1987) had inconsistent, mixed results.

One of the most widely researched models of adult attachment was developed by Bartholomew (1990). Based on Bowlby’s (1973) concept of internal working models of self and others, Bartholomew (1990) developed a four-category system of adult attachment, depicted below, which organises an individual’s working models along two dimensions, namely, the distinction between self and others and positive versus negative. The intersection of these dimensions lead to four styles of adult attachment, namely secure, preoccupied, dismissing and fearful (Bartholomew & Horowitz, 1991).
Research conducted by Bartholomew and Horowitz (1991) as well as others (Bartholomew, 1993; Griffin & Bartholomew, 1994) found that the four adult attachment styles strongly corresponded to the four attachment styles in childhood. In other words, adults that fell into the preoccupied category displayed many behaviours similar to children categorized with ambivalent attachment. For example, Bartholomew (1990) found that secure individuals have a sense of self-worth and an expectation that others are generally trustworthy, accessible and responsive; which correlates with Bowlby’s characteristics of a securely attached child. Individuals displaying a preoccupied attachment style are excessively vigilant of attachment relationships and are emotionally dependent on others’ approval due to their positive view of others. Their emotional dependency often manifests in ‘clingy’ behaviour (Bartholomew, 1990). These adult manifestations are similar to those behaviours displayed by ambivalently attached children.
As internal working models developed in childhood may be carried over into adulthood, it increases an adult's risk for pathology if the adult was insecurely attached as a child. Attachment and psychopathology will therefore be explored in the following section.

**Attachment and Psychopathology**

In Bowlby’s (1977) attachment theory he stressed the importance of attachment in understanding both normal and psychopathological development. In Bowlby’s (1977) writings he explains how internal working models in childhood may lead to psychopathology. Bowlby (1977) states:

“The many forms of emotional distress and personality disturbances, including anxiety, anger, depression, and emotional detachment, to which unwilling separations and loss give rise” (p.201).

In Bowlby’s (1977) view, childhood attachment underlies “the later capacity to make affectional bonds as well as a whole range of adult dysfunctions” including “marital problems and trouble with children as well as...neurotic symptoms and personality disorders” (p.201). Bowlby therefore postulated that early childhood experiences have long lasting effects that can persist across the lifespan (Bowlby, 1977).

Bowlby’s (1977) view on psychopathology encompassed insecure attachment in childhood as the foundation of disordered personality traits. He linked ambivalent attachment to “a tendency to make excessive demands on others and to be anxious and clingy when they are not met, such as dependent personalities” (Bowlby, 1977,
p.14). Bowlby (1977) linked avoidant attachment to “a blockage in the capacity to make deep relationships, such as is present in affectionless and psychopathic personalities” (p.14). Bowlby did not state that an insecure attachment automatically leads to psychopathology but believed that an insecure attachment increased an individual’s vulnerability to psychopathology (Bowlby, 1977; Bowlby, 1978).

The importance of a secure attachment between the parent and child cannot be emphasized enough. A secure attachment bond between a parent and child is vitally important for the well being of a child that has suffered a trauma. This attachment bond serves as primary defenses against trauma-induced psychopathology in children, with the quality of the bond between parent and child being the most important determinant of long term damage to children who have been exposed to severe stressors (McFarlane, 1988). Children who lack a secure attachment relationship are at risk for the development of long-term post-traumatic stress symptoms. Conversely, the presence of a secure attachment has been found to buffer the adverse effects of trauma as this bond provides the safety and nurturance the child needs, which allows the child to process the traumatic events (McFarlane, 1988).

Attachment theory holds that, within close relationships, young children acquire mental representations of their own worthiness based on other people’s availability and willingness to provide care and protection (Bowlby, 1979). These mental representations are known as the internal working model. Children form an internal working model of themselves and of the world around them through their experiences within their attachment relationships. The child’s internal working models are therefore
defined by the internalization of the affective and cognitive characteristics of their relationship with their parents (van der Kolk, 2005)

Children that are insecurely attached may have learned, through their interactions with a parent, that they are unworthy of care and nurturance (Bowlby, 1979). This may result in the child having limited abilities in which to cope with trauma as they do not have the feeling of safety and nurturance from the emotionally unavailable parent. With their limited coping abilities, the child is more likely to be completely overwhelmed by stress (Perry, 2001).

When the parent is emotionally absent, inconsistent, violent or neglectful, the child is likely to become distressed and therefore unlikely to develop a sense of the external environment as able to provide relief (van der Kolk, 2005). This results in a child with an insecure attachment style having difficulty relying on others to help them, while simultaneously being unable to regulate her emotional state herself. The child may then experience excessive anxiety and anger. These feelings may become so extreme that the child may dissociate (van der Kolk, 2008). Perry (2001) has found that younger children and young females are more likely to respond to trauma with dissociation while older children and males are more likely to respond with hyperarousal.

The child’s initial psychological response to overwhelming stress establishes a pattern of responding to the threat that will be triggered again and again, at lower and lower thresholds of threat. In this way a patterned, learned response, linked to the child’s survival, becomes embedded in the child’s internal working model (van der Kolk, 2008).
An emerging area of research in developmental psychopathology is concerned with mapping how early childhood experiences may act as risk factors for later diagnosable psychological disorders. By mapping these childhood experiences, attempts have been made to describe the pathways by which early experiences may cause adult psychological disorders such as major depression, personality disorders, somatoform disorders, dissociative disorders, and eating disorders.

**Developmental Psychopathology**

Personality disorders in adulthood have been recognized as being, in part, due to earlier experiences. Derksen (1995) states: “depending on the precise nature of the trauma and the age of the child, the disturbance exerts itself on the development of the person” (p.280). Research has found that if the child had a predisposition to a personality disorder, the personality disorder could possibly be activated by the trauma the child experienced. For example, children who responded to the trauma by being socially withdrawn were more likely to develop avoidant personality disorder in adulthood (Moroz, 2005).

Winje and Ulvik (1998) found that children who feared for their lives had an increased risk for psychopathology. Similarly, Pynoos, Steinberg and Goenjian (1996) demonstrated a link between a child’s feelings of guilt regarding the trauma and later psychological functioning. Pynoos *et al.* (1996) stated that the child’s perception of the trauma may predict future psychological problems rather than the degree of the trauma itself.
Parents play an important role in the way the child copes with the trauma. Winje and Ulvik (1998) suggest that parents who are preoccupied with dealing with their own reactions to the trauma are less able to tend to the needs of the child. If the parents are emotionally unavailable at the time the child needs them the most, this increases the likelihood of psychological difficulties in the child as well as having an impact on the relationship between the parent and child.

A number of routes linking childhood psychopathology to adult mental health problems have been found. Firstly, the simplest relationship is where the childhood disorder persists into adulthood in the same form. For example, childhood anxiety or depression develops into experienced anxiety and depression in adulthood (Davey, 2008). Farrington, Loeber and van Kammen (1990) also found that antisocial behaviour in childhood often continued into adulthood in the form of antisocial personality disorder.

A second route is that childhood psychopathology may have an adverse affect on a child’s development and indirectly may lead to different forms of maladjustment in adulthood (Davey, 2008). For example, children who fail to form adaptive relationships with their parents early in life often exhibit disruptive behaviour in late infancy. Further, Caspi, Newman, Moffit and Silva (1996) found that preschool behaviour problems predicted psychopathology in later life.

Thirdly, childhood psychopathology may represent a cognitive precursor of a related adult disorder. For example, Davey, Menzies and Gallardo (1997) found that a phobia of heights in adolescence proved to be a risk factor for full-blown panic disorder in adulthood.
Fourthly, a childhood disorder may not necessarily extend into adulthood but may cause the individual to be vulnerable to later life stressors.

**Conclusion**

This chapter introduced the reader to the major influences that led to Bowlby formulating his attachment theory, such as ethnological and anthropological influences as well as the influence of Mary Ainsworth. The attachment theory was then explored in detail, which included internal working models, the phases of attachment development as well as the importance of the relationship and quality of the relationship between mother and child. The different attachment categories were explored, namely secure and insecure attachment, as well as the differing subtypes of insecure attachment. Further, the effects of psychological trauma on the attachment relationship were explored. The stability of attachment over the life span was briefly explored followed by Bowlby’s (1977) view on attachment and psychopathology.

In the following chapter the therapeutic approaches utilized in the study, namely Theraplay and non-directive play therapy, are explored and discussed in detail.
CHAPTER 3

THERAPEUTIC APPROACHES: THERAPLAY AND NON-DIRECTIVE PLAY THERAPY

“You rock a sobbing child without wondering if today’s world is passing you by, because you know you hold tomorrow tightly in your arms”

(Neil A Maxwell, n.d.)

Introduction

A child’s natural medium of self expression is through play. By playing, a child is granted the opportunity to express their accumulated feelings in an age appropriate manner, at their own pace (Axline, 1989). Play therapy therefore allows the child the opportunity to ‘play out’ their feelings and problems just as adults ‘talk out’ their problems (Axline, 1989). Play therapy may be divided into two categories, namely a) directive play therapy, and b) non-directive play therapy. In directive play therapy, the therapist assumes responsibility for guiding, directing and interpreting the play, such as Jernberg’s Theraplay (May, 2005). In contrast, the therapist in non-directive play therapy, such as Axline’s therapeutic approach, plays more of a passive role in the therapeutic process, with the client guiding the session (Axline, 1989).

The following chapter includes an overview of play therapy, highlighting the objectives of play therapy as well as what a child learns during the course of play therapy. The chapter is then divided into the two types of play therapies utilized in the study, namely, a) Theraplay, a directive play therapy developed by Jernberg (1979),
and b) non-directive play therapy, developed by Axline (1989), each of which is discussed in detail.

Objectives of Play Therapy

Play therapy is a learning experience for a child and is therefore viewed from a developmental perspective with an overall goal of assisting the child to learn about themselves and their world (Landreth & Bratton, 1998). Axline (1989) states that play therapy enhances the development of the child by helping the child to learn to know and accept herself. The primary objective of play therapy is therefore not to solve the child’s problem but to rather help the child grow. When the focus is on solving the child’s problem, the child as a person usually gets lost in the process (Landreth & Bratton, 1998). The focus is rather on the child and not on the problem, as the child is most important. The objectives of play therapy outlined by Landreth and Bratton (1998) are as follows:

To Establish an Atmosphere of Safety for the Child

Although the play therapist cannot 'make' the child feel safe, she can create the space to allow the child to feel safe in the developing therapeutic relationship. Safety for the child is also conveyed to the child through the therapist’s consistency.

To Understand and Accept the Child’s World

Understanding is accomplished by the therapist abandoning adult reality and seeing things from the child’s perspective, therefore actively trying to understand the child. This is conveyed by the therapist being genuinely interested in whatever the child chooses to
play with in the playroom. Acceptance also means being patient with the child’s exploration of the playroom.

To Encourage Expression of the Child’s Emotional World

Although the play therapy materials and toys are important they are of secondary importance to the child’s feelings and the feelings they promote in the child. Play therapy requires the therapist to stop evaluating the child’s feelings and rather to accept whatever the child feels without judgment.

To Establish a Feeling of Permissiveness

The child needs to feel or sense the freedom available in the play therapy setting. In order for the child to develop the feeling of permissiveness, the therapist allows the child to make choices for herself.

To Facilitate the Child’s Decision Making

This is accomplished by the therapist refraining from providing the child with answers. The opportunity to choose what toy to play with, how to play with it or what colour to choose creates decision-making opportunities for the child and with decision-making comes self-responsibility.

To Provide the Child an Opportunity to Assume Responsibility and to Develop a Feeling of Control

The child may not always be in control of their environment but it is important for the child to feel as though she is. The child is responsible for what she does for herself in the playroom. When the therapist does things for the child that the child can do for herself, the child is deprived of the opportunity of experiencing what self-responsibility feels like.
A child’s development is assisted in play therapy by helping the child to learn and to know themselves. The majority of what is learned in the therapeutic relationship is not cognitive learning but rather experiential, intuitive learning about self that occurs over the course of therapy (Landreth & Bratton, 1998).

**What a Child Learns in Play Therapy**

As play therapy is a learning experience for the child, Landreth and Bratton (1998) highlighted some important aspects of what the child learns during the therapeutic process. Even though Landreth and Bratton detailed what a child learns during this process from a non-directive stance, these experiences can be learned during both directive and non-directive therapies.

During the therapeutic process the child learns to respect themselves as the therapist communicates constant positive regard and respect for the child regardless of the child’s behaviour (Landreth & Bratton, 1998). The child will internalize respect when she senses the therapist’s respect, feels respected and because of the therapist’s absence of evaluation and continuous acceptance. Most importantly, once children have respect for themselves, they learn how to respect others (Landreth & Bratton, 1998).

The child also learns that her feelings are acceptable. As she plays out her feelings in the presence of an understanding adult who accepts the intensity of the feelings, she learns that her feelings are acceptable. As the child begins to experience that her feelings are acceptable, the child will then begin to be more open in expressing her feelings (Landreth & Bratton, 1998).
Once the child has learned to express her feelings openly and has been accepted, the child learns that their feelings lose their intensity and can therefore be more easily controlled. The child has therefore learned to express her feelings responsibly (Landreth & Bratton, 1998).

In the natural process of development, the child strives towards independence and self-reliance but the child is often dissatisfied in her efforts by adults who take charge by doing things for the child, resulting in depriving the child of opportunities to experience how being responsible for self feels (Landreth & Bratton, 1998). In the therapeutic process the therapist believes in the child’s abilities and resists doing anything that would deprive the child of the opportunity to discover her own strength. In this way the child learns to assume responsibility for self (Landreth & Bratton, 1998).

As the child is enabled to figure things out for herself, to derive her own solutions to problems and to complete her own tasks, her creative resources are released (Landreth & Bratton, 1998). When the frequency of this is increased, the child will learn how to solve her own problems and in so doing, experience the satisfaction of doing things by herself. In this manner, the child learns to be creative and resourceful when confronting her problems (Landreth & Bratton, 1998).

The child will also gradually learn to accept herself. As the child experiences acceptance from the therapist just as she is, the child will gradually begin to accept herself as worthwhile (Landreth & Bratton, 1998). The therapist’s behaviour in everything that she does, conveys to the child the therapist’s acceptance of the child. The child first needs to feel that she is accepted and then know that she is accepted for who she is without judgement, with no desire from the therapist that she is different. A
major contributing factor to the development of a positive self-concept is this increased self-acceptance (Landreth & Bratton, 1998).

Keeping in mind the objectives of play therapy as well as the learning that takes place, the reader is introduced in detail to directive play therapy followed by non-directive play therapy.

Directive Play Therapy

As previously stated, directive play therapy is a therapeutic approach guided and interpreted by the therapist. The directive approach utilized in this study was Theraplay, which is discussed in detail in the following section.

Due to the relationship between insecure attachment and psychosocial dysfunction in later life, researchers have been exploring therapeutic interventions to help children and their parents to reconnect in a healthy manner (May, 2005). One such method that has been found to increase attachment is Theraplay, developed by Ann Jernberg (1979). Theraplay is a form of directive play therapy that is gaining wide recognition as a treatment method for individuals with attachment disorders (Munns, 2000).

Origins of Theraplay

As a response to the challenges in providing psychological treatment to pre-school children in Chicago’s Head Start Program, Ann Jernberg created and developed Theraplay in the 1960’s (Booth & Koller, 1998). Many children were in need of psychological services and Jernberg, realizing that the number of children requiring psychological services far exceeded what was available, began to formulate strategies
that could be utilized by paraprofessionals (Jernberg, 1979). Jernberg’s approach was to take a model of healthy parent-child interaction and add elements from the work of Austin Des Laurier and Viola Brody (Jernberg & Booth, 1999).

The work of Des Lauriers focuses on the here-and-now in the therapist-client relationship, and incorporates a physical and more intrusive approach to the therapeutic process (Booth & Koller, 1998). Brody introduced the model of developmental play therapy, involving structured sessions with an emphasis on physical contact as well as touch between the client and therapist (O'Connor, 2000). Like Theraplay, Brody’s method also sets out to treat the child at his developmental and not chronological level (Jernberg, 1979). Jernberg’s Theraplay approach, whilst incorporating elements from both Des Lauriers and Brody, focuses specifically on enhancing the interactions and relationship between the child and the parent through play (Jernberg & Booth, 1999), where one of the main goals is to allow the child to feel ‘normal’ and to become aware that no matter how ill behaved, unattractive or how rejected by everyone else, there are certain things about her that are lovable (Jernberg, 1979).

Theraplay differs from Des Lauriers’ and Brody’s therapies in its vigor, intensity, perseverance and its regressive dimension (Jernberg, 1979). Also, whilst retaining its spontaneity and fun, Theraplay sessions are carefully planned and structured. Therapists do not wait to see what the child will do and will not wait for the child to lead the way. The therapist lets it be known that she is in charge of the session (Jernberg, 1979).
Definition of Theraplay

Theraplay is an active, intrusive and physical therapy aimed at increasing attachment between a child and the parent (Booth & Koller, 1998). It is a playful, short term treatment method modelled on the interaction between a parent and child and is an intensive, goal-orientated approach that involves both the child and the parents (Booth & Koller, 1998). The technique includes the elements of Structure, Challenge, Intrusion/Engagement and Nurture where each session is set to meet the needs of each individual child. These elements will be discussed in more detail later in the chapter.

Underlying Theraplay Principles

The principles underlying the Theraplay approach are based on the core components of the mother-infant relationship during the first 18 months of the infant’s life (Ammen, 2000). It is during this crucial period that attachment bonds are first formed between the mother and the child (Jernberg, 1979).

During the first four months of the infant’s life, the mother’s sensitivity enables her to respond to her infant’s needs. By crying, smiling, babbling and sucking, the infant learns that the world can respond to his needs (Ammen, 2000).

The interaction between the mother and the infant becomes more reciprocal from the age of four to eight months, with the mother and infant beginning interactive play (Ammen, 2000). The infant learns that she can influence her mother to respond to her needs and therefore the infant’s development of seeing herself as attractive and lovable begins (Ammen, 2000).
Clear evidence of discriminated attachment appears during the period of nine to 18 months (Ammen, 2000). During this period of development, the baby cries in the presence of strangers and clings to the mother, in whose presence the baby feels safe, secure and comforted (Booth & Koller, 1998).

As the normal interactions between mother and child are playful, warm and delightful experiences, Theraplay has incorporated the elements of Structure, Challenge, Intrusion/Engagement and Nurturance (SCIN) which is based on this relationship between the mother and child. These principles are combined in a setting that is playful, physical and fun and are tailored to meet the specific needs of the child.

**Structure**

In an infant’s life there is a routine and rhythm in terms of feedings and nap times, with the child’s life being structured in terms of time and space by the parent, therefore providing the child with a sense of predictability and safety (Jernberg, 1979).

In a normal mother-child relationship, certain boundaries are set, which ensures the child’s safety and helps the child to understand the world in which she lives (Munns, 2000). For example, a mother teaches her child that it is dangerous to touch a hot stove.

The principle of Structure is addressed through clearly stated safety rules as well as through activities that have a beginning, middle and an end (Booth & Koller, 1998). The therapist plans the activities and leads them and in this way the child learns that the therapist is in charge (Munns, 2000).

Structuring activities can include activities such as drawing around hands and bodies or counting the amount of freckles the child has on her face (Jernberg, 1979).
Challenge

The purpose of this principle is to allow the child to master new behaviours by providing the child the opportunities for success (Perry & Gerretsen, 2002). By taking risks and mastering skills enables the child to build a sense of competence and increased self-confidence (Munns, 2000). It is important to note that the new activity for the child to master will be an age appropriate activity and within the capabilities of the child, therefore the child will not experience failure but rather an accomplishment (Munns, 2000).

Challenging activities should be fun and allow for tension release in a safe, direct, controlled and playful manner for the child (Jernberg, 1979; Jernberg & Booth, 1999; Munns, 2000). Activities that are challenging include a thumb wrestle or for the child to remember a clap pattern that progressively gets more difficult.

Intrusion/Engagement

In a normal relationship, mothers engage their child in many playful ways, and in doing so, intrude in their child’s world (Munns, 2000). As this happens in sync with the child’s needs, it is a mutually enjoyable experience for both the mother and child (Munns, 2000). However, some children give off a superficial message that they want to be left alone, while others have had such bad experiences that they truly do not want to engage (Booth & Koller, 1998). Booth and Koller state that these children need to be ‘enticed’ out of their withdrawal with activities specifically suited to the child in order to engage them in a pleasurable relationship. Such activities would include playing peek-a-boo, the mother may blow on the child’s stomach or may softly whisper in the child’s ear (Jernberg & Booth, 1999).
Through Intrusion/Engagement activities the child gradually learns who they are, becomes aware of body boundaries and senses that she is a source of delight and pleasure (Munns, 2000). The activities often have an element of surprise in order for the child to learn that life can be adventurous and fun, with the therapist engaging the child in many stimulating ways (Booth & Koller, 1998).

**Nurturance**

In the mother-child relationship a great deal of time is spent on nurturing activities. Mothers demonstrate their love in a number of day-to-day activities including feeding, bathing and cradling a child (Munns, 2000). For an infant, nurturing activities provide comfort and reassurance and in this way the infant learns to self-soothe (Munns, 2000; Perry & Gerretsen, 2002).

The purpose of nurturing activities is that through these activities the child learns to feel valued, loved, wanted and secure (Munns, 2000). These activities are essential in Theraplay and they usually incorporate the use of touch, which is important to the development of a secure attachment (Perry & Gerretsen, 2002).

**Treatment Phases**

Theraplay treatment has six general phases namely a) Introduction, b) Exploration, c) Tentative acceptance, d) Negative reaction, e) Growing and trusting, and f) Termination. The termination phase has three sub-phases namely a) Preparation, b) Announcement, and c) Parting.
**Introduction Phase**

Upon first meeting the child the therapist approaches the child in a fun manner, encouraging the child to join the therapist in an activity. An example of an approach the therapist may utilise may be by the therapist giving the child a piggyback ride to the therapy room or by hopping to the therapy room. The action is swift, with a high level of excitement, thereby giving the child little opportunity to dwell on doubts or to verbalize reservations (Jernberg, 1979).

The therapist establishes through her behaviour that the sessions will be fun and active and allows the child to understand that the therapist is in charge by directing all the activities (Perry & Gerretsen, 2002).

**Exploration Phase**

During this phase the child and therapist actively get to know each other. The therapist notices and points out, in a playful manner, some of the child’s interesting physical characteristics such as counting how many freckles the child has on her face (Perry & Gerretsen, 2002).

The child may have a variety of responses. Negativistic behavioural responses can be turned around to show a more lovable side to the child. As Jernberg (1979) points out:

“She may never have been told what a skilful ‘rag doll’ she is when she defiantly goes limp. She may never have been asked to “Be sure never to look at me” when she turns her head to avoid eye contact” (adapted, p. 37).
The therapist is in this manner allowing the child to know that even though she is resistant, she is still lovable and that this is not conditional on good or polite behaviour. The therapist therefore is unconditionally loving the child (Jernberg, 1979).

At the end of the exploratory phase the child has become aware of the therapist as a person; their facial features and the sound of their voice. The therapist has become a familiar figure in the child’s life and is no longer a stranger (Perry & Gerretsen, 2002).

**Tentative Acceptance Phase**

In the early sessions the child pretends or attempts to ‘play the game’ the therapist has chosen for the therapy session. The child may participate in the activities but may do so with apprehension and the child’s participation may be superficial rather than genuine involvement. The underlying tone expressed by the child is tentativeness and apprehension (Jernberg, 1979; Perry & Gerretsen, 2002).

During this phase, the therapist continues to be intrusive, insistent, challenging, surprising and fun. The child’s response may vary from enthusiasm to defensiveness as there is not yet a genuine relaxed engagement between the child and therapist. The child’s behaviour in this phase is to purposefully keep the intruding therapist at bay (Jernberg, 1979; Perry & Gerretsen, 2002).

**Negative Reaction Phase**

This phase is characterised by the child’s clear resistance to any form of intimacy or affection that the therapist may display (Jernberg, 1979). In this phase the child, who previously seemed enthusiastic and eager to cooperate, may become negativistic and resist participation in activities (Jernberg, 1979). The therapist’s response continues to be intrusive and insistent conveying to the child that what they are about to do would be
enjoyed by other children. With the therapist’s continued enthusiasm and perseverance, the child’s behaviour will diminish in intensity and eventually disappear (Jernberg, 1979; Perry & Gerretsen, 2002).

Growing and Trusting Phase

A genuine enjoyment of the activities is experienced by the child in this phase and the child begins to participate in a satisfying relationship with the therapist. Booth and Koller (1998) describe this stage by saying:

“This is the time when much therapeutic work is accomplished. Longer periods of intimacy occur between the therapist and child; reciprocal play begins; eye contact improves; in short, there is a feeling of true partnership between therapist and child” (p.327).

As the child begins to develop more confidence in herself and the world, the child and therapist increasingly become partners in a plan to try out new variations on old themes or activities in order to enjoy longer periods of intimacy. The child and therapist genuinely enjoy each other’s company (Booth & Lindaman, 2000; Jernberg, 1979).

At this point the parents are brought into the sessions and begin to participate and engage in the activities with their child, with the therapist directing these activities (Perry & Gerretsen, 2002).

Termination

In Theraplay the termination date is planned from the start, when the therapist first contracts with the parents for a certain number of sessions. Even though this phase is relatively short to the previous phases, it consists of three sub-phases.
**Preparation**

In the preparation phase of termination the therapist starts preparing the child for the eventual dissolution of the therapy contact. While the partnership between the therapist and child has become more meaningful, the termination of therapy does not need to be seen as a negative experience (Jernberg, 1979).

**Announcement**

The therapist announces the termination of the therapy sessions to the child within the context of gains the child has made (Jernberg, 1979). For the next few sessions, the emphasis lies on the skills the child has learned throughout the therapeutic process. As Jernberg (1979) states:

“The object is to redirect her cathexis away from the therapist and onto the people who will comprise her post-therapy environment. The behaviour of patients reflects more and more feelings of independence and need to belong to a family” (adapted, p.41).

After each session the therapist reminds the child of how many more sessions remain. During the second last session the therapist reminds the child that the following session will be their last and may enquire if the child would like to replay some of his favourite activities from previous sessions (Jernberg, 1979; Perry & Gerretsen, 2002). A party may also be planned for the last session and the child and therapist together plan for the final party (Jernberg, 1979).

**Parting**

The theme of the last session is that of a future-orientated reaffirmation of the child's strengths (Jernberg, 1979). The therapist, in a general discussion with the child,
reminds the child of all the events that she still has to look forward to, such as a birthday or the holidays still to come. In this way the therapist is keeping with the future-orientated theme and is gently reminding the child of all that he has accomplished (Perry & Gerretsen, 2002). Souvenirs, for example handprint pictures, from previous activities can be distributed for the child to keep as a memento of their time together (Jernberg, 1979).

At the end of the final session the child is reminded of how much she has accomplished in the time spent together and the therapist once again enthusiastically reminds the child of all the exciting events still to come (Jernberg, 1979).

In the directive play therapy section of the chapter, the reader was introduced to Theraplay. The origin of Theraplay, the principles of Theraplay and the treatment phases was explored and discussed. In the second section of this chapter, non-directive play therapy is explored and discussed in detail.

**Non-directive Play Therapy**

Non-directive play therapy, as discussed earlier, allows for the child to lead the way in the therapeutic process whilst the therapist takes more of a passive role. The non-directive play therapy approach utilized in this study is Axline’s non-directive play therapy (1989). Axline’s approach is discussed in more detail in the following section.
Introduction to Roger’s Person-centered Therapy and the Origins of Non-directive Play Therapy

Carl Rogers (1951) originally developed the client-centered therapy model for adults, later termed person centered therapy, which focuses on an individual’s self-actualizing tendency. Rogers (1951) believed that every individual has a potential to develop, grow and change in a positive manner (Meyer, Moore & Viljoen, 1997). Rogers developed 19 propositions, which are fundamental to his approach (See Appendix B) (Meyer, Moore & Viljoen, 1997).

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 three core conditions upon which the person-centered therapy is based. These conditions are (a) empathy, (b) unconditional positive regard, and (c) congruence/genuineness (Rogers, 1951).

Empathy

Empathy in essence is “attempting to see the world through the client’s eyes” (Mabey & Sorenson, 1995, p.25), which 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 (Currin, 2006). In order for this to be achieved, the therapist must be willing to engage on an emotional level and be able to recognise the client’s feelings by recognising and acknowledging in themselves the emotion described or felt, whilst simultaneously focussing on the client and being aware of the separateness between the therapist and client (Mabey & Sorenson, 1995).
Unconditional Positive Regard

This is described as the “intrinsic valuing of the client without imposing conditions of worth” (Mabey & Sorenson, 1995, p.26). This value is especially important when working with young clients as their self worth is often very low. When the young person is with the therapist providing unconditional positive regard, she will begin to challenge her self-concept and pay attention to the prompting of the organismic self (Mabey & Sorenson, 1995).

Congruence/Genuineness

This is a core condition that allows the therapist to be real and authentic within the therapeutic relationship. A therapist who is congruent allows for the client to meet the therapist who is not hiding behind a role, but promoting equality in the relationship. This type of relationship is empowering to the client (Mabey & Sorenson, 1995). Rogers proposed that it is the realness of the encounter that is important and encouraged genuineness, naturalness and humanness in the relationship between the therapist and the client (Rogers, 1951).

Virginia Axline, a student and colleague of Rogers, later adapted Rogers’ model to be used for children and termed it child-centered play therapy (Sweeney & Landreth, 2003). Child-centered play therapy or non-directive play therapy is based on the same principles as Rogers’ client-centered therapy, such as the development of a trusting and accepting relationship between the client and therapist; an acceptance that the client chooses the direction of the session; reflection rather than interpretation; non-intrusiveness and a respect for the client’s defenses; and the setting of appropriate, therapeutic boundaries in the relationship (Wilson, Kendrick, & Ryan, 1992). Therefore
non-directive play therapy involves a journey with the child to engage in self-discovery and self-exploration (Sweeney & Landreth, 2003). The principles of non-directive play therapy will be discussed in greater detail later in the chapter.

The Child-centered Theory of Personality Structure

According to Axline (1989) 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 the child’s individual functioning in everyday experiences occurring in the child’s life. The view of self and the unlimited potential within each child forms the basis for the theory of personality structure on which the child-centered approach to play therapy is based (Landreth & Bratton, 1998).

The theoretical constructs of child-centered play therapy are not related to the child’s age, physical and psychological development or presenting problem. Instead they are related to the inner dynamics of the child’s process of relating to and discovering the self that the child is capable of becoming (Sweeney & Landreth, 2003). The child-centered approach holds the belief that a child can grow and heal in the correct environment which is free from agenda and constriction.

The child-centered theory of personality structure is based on three central concepts derived from Roger’s theory, namely (a) the person, (b) the phenomenal field, and (c), the self.

The Person

The person is all that the child is, which consists of self-perceptions including thoughts, feelings, behaviours as well as physical being. Every child exists in a
continually changing world of experience of which she is the centre and children interact with and respond to this personal and continually changing world (Sweeney & Landreth, 2003). This results in continuous dynamic intrapersonal interactions occurring in which the child, as a whole, is striving towards actualizing the self. This process is an internally directed movement towards becoming a more positively functioning individual, towards positive growth and towards enhancement of self as a person (Sweeney & Landreth, 2003). The behaviour of the child is therefore goal-directed in an effort to satisfy personal needs as experienced in the unique phenomenal field, that for the child, is reality (Sweeney & Landreth, 2003).

The Phenomenal Field

The phenomenal field is everything the child experiences. It includes everything happening in the child at a given time, whether at a conscious or unconscious level, including perceptions, thoughts, feelings and behaviours (Sweeney & Landreth, 2003). Essentially, the phenomenal field is “the internal reference that is the basis for viewing life; that is, whatever the child perceives to be occurring is reality for that child” (Landreth & Sweeney, 1999, p.41).

This points to the basic principle in child-centered play therapy, namely, the child’s perception of reality is what needs to be understood if the child and the behaviours of the child are to be understood (Sweeney & Landreth, 2003). Whatever the child perceives in the phenomenal field therefore assumes primary importance as opposed to the actual reality of the events. As this reality is subjective to the child, the therapist intentionally avoids judging or evaluating even the simplest of the child’s behaviours and
rather tries to understand the child’s internal frame of reference (Sweeney & Landreth, 2003).

The Self

The self is the totality of the perceptions that the child has of herself. The self is the differentiated aspect of the phenomenal field that develops from the child’s interactions with others. The formation of the child’s concept that she has of herself develops from how others perceive the child’s emotional and behavioural activity and accordingly react (Sweeney & Landreth, 2003). This is a natural and continuous process in which the child positively values those experiences that are perceived as self-enhancing and places a negative value on those that threaten or do not enhance the self.

The child-centered play therapy process provides the opportunity for the child to be seen by the therapist as a positive and growing self in an atmosphere of acceptance and permissiveness (Sweeney & Landreth, 2003). The self therefore grows and changes as a result of continuing interaction with the phenomenal field (Sweeney & Landreth, 2003). The play therapy process then becomes a phenomenal field through which the child can discover self. Not only is the child’s behaviour consistent with concept of self, but the play therapy experience facilitates postive change in the self-concept (Sweeney & Landreth, 2003).

Definition of Non-directive Play Therapy

Non-directive play therapy is based on the assumption that the child has within herself the ability to solve her own problems. Non-directive play therapy therefore grants the child permission to be herself, whilst accepting the self completely without judgment
or pressurizing the child to change (Axline, 1989). This form of play therapy recognizes and clarifies the emotions expressed by the child by the therapist reflecting on the child’s actions. Most importantly, non-directive play therapy offers the child the opportunity to be herself and to learn to know herself. Axline (1989) describes non-directive play therapy as:

“...an opportunity that is offered to the child to experience growth under the most favorable 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 realize 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, realize selfhood.” (p.15)

Axeline (1989) identified eight guiding principles for the therapist to be aware of before and during the non-directive therapeutic process which are discussed in the following section.

**Principles of Non-directive Play Therapy**

Axline (1989) highlights eight basic principles to guide the therapist in non-directive play therapy. These principles are interwoven and interdependent (Wilson, Kendrick, &
Ryan, 1992). Through these principles, therapists communicate an attitude of love and create an atmosphere of belonging that reaffirm the child’s value. Axline’s (1989) principles are as follows:

1. The therapist must develop a warm, friendly relationship with the child, in order to rapidly establish rapport.
2. The child is accepted exactly as she is by the therapist.
3. A feeling of permissiveness in the relationship is established by the therapist in order for the child to express her feelings freely.
4. The therapist is alert to recognize the feelings of the child and reflects those feelings back to the child in such a manner that the child gains insight into her behaviour.
5. The therapist maintains a deep respect for the child’s ability to solve her own problems. It is the child’s responsibility to initiate change and to make choices.
6. The therapist does not attempt to direct the child in any manner regarding actions or conversation. The child leads the way with the therapist following.
7. The therapist does not attempt to hurry the therapy as the therapy is a gradual process.
8. The only limitations established by the therapist are those necessary to anchor the therapy to the world of reality and to make the child aware of her responsibility in the relationship.

The non-directive play therapy approach 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 her feelings. These feelings may be communicated directly or indirectly through her play (Wilson, Kendrick, & Ryan, 1992).

Axline (1989) emphasizes the importance of the initial contact between the therapist and the child as this sets the ground for the success of the therapy. Landreth (2002) adds that the therapist is more concerned with forming the therapeutic relationship with the child rather than focusing on the child’s problems, symptoms and diagnosis. Landreth (2002) states that when a therapist focuses solely on the child’s problems or diagnosis they lose sight of the child. It is the therapeutic relationship that sets the foundation for change.

According to Axline structuring is vitally important and it is during the initial contact between the therapist and child that structuring takes place. Axline (1989) explains structuring as “the building up of the relationship according to the principles so that the child understands the nature of the therapy contacts and is thus able to use them fully” (p.70). Structuring in this instance is not planning a therapy session but rather a carefully planned method whereby the child is introduced to the medium of self-expression which brings with it a release of feelings. Structuring is not a verbal explanation of what the therapy is all about but is the establishment of the relationship between the therapist and the child (Axline, 1989).

The structuring of the relationship begins with the initial interactions between the child and therapist in the waiting room where the therapist’s task is to place full attention on the child (Landreth & Bratton, 1998). It has been suggested by Landreth and Bratton that the therapist and parents meet for a session beforehand in order for the therapist to explain the therapy process and to focus entirely on the parents’ needs and concerns.
In this way, if the therapist has met with the parents before the child’s therapy session she will be free to focus all her attention on the child. The therapist may approach the child at the child’s level, attain eye contact and greet the child. The therapist may then say “We can go to the playroom now. Your mom will wait here so she will be here when we come back from the playroom” (Landreth & Bratton, 1998). The relationship can further be structured by how the child is introduced to the playroom. Landreth and Bratton (1998) advise that verbal communications at this point should be kept to a minimum as no amount of words will convey to the child that the playroom is a safe place.

As toys are considered to be the child’s words and play is their language, carefully selected toys and materials are essential in facilitating the therapy process and relationship (Axline, 1989; Landreth & Bratton, 1998; Sweeney & Landreth, 2003).

The Playroom and Materials

Axline (1989) suggests that it is desirable to have a room set aside and furnished as a playroom but this is not absolutely necessary. A portable playroom can be just as meaningful for a child as long as the necessary toys are included. The atmosphere of the playroom is of critical importance. The therapist must create an environment that conveys to the child that the playroom is a safe haven for the child where the child is in charge and accepted completely (Landreth & Bratton, 1998; Sweeney & Landreth, 2003).

Axline (1989) suggests that the playroom should be sound-proofed as well as have a one-way mirror so that observations can be made without the child being aware of this.
Axline (1989) also suggests that the floor should be protected with material that is easily cleanable and that can withstand paint, clay and water. A sink with running water is recommended as it provides for water-play activities and also facilitates the clean-up of mess. Axline (1989) recommends that all pictures and clay work should be removed from the playroom at the end of each session so that the room is free from suggestive use of materials.

As toys and materials are part of the communication process for a child, careful attention needs to given to the selection of appropriate toys. Simple, easy to use toys encourage success and mastery and provide opportunities for the child to express a wide variety of experiences and feeling (Axline, 1989; Landreth & Bratton, 1998). Highly structured materials and mechanical toys should be avoided as they may interfere with, rather than facilitate, children’s expressions as the child may become frustrated with the workings of the toy (Landreth & Bratton, 1998).

Landreth and Bratton (1998) state that therapists should be careful when selecting toys and consideration should be given to which toys facilitate the following goals:

1. Establishment of a positive relationship with the child
2. Expression of a wide range of feelings
3. Exploration of real-life experiences
4. Testing of limits
5. Development of a positive image
6. Development of self-understanding
7. Opportunity to redirect behaviours unacceptable to others.
Landreth and Bratton (1998) place toys in three categories and suggest that the following toys and materials represent the minimum requirements. These toys are recommended as they encourage a wide range of expressions and can easily be transported for therapists who do not have access to an equipped playroom.

1. Real-life toys, such as dolls; a bendable doll family; a doll house and doll house furniture, a plastic feeding bottle; play dishes, cups and spoons; a small car; an aeroplane; a telephone and toy animals.

2. Acting-out or aggressive release toys such as handcuffs, a dart gun, rope, toy soldiers, aggressive puppets (such as crocodile or dragon), a rubber knife and an inflatable punching bag.

3. Toys for creative expression and emotional release such as crayons, paper, blunt-nosed scissors, an assortment of craft materials; Play-Doh and hand puppets. It is also suggested that if space permits, a sandbox is a desirable addition to this category (Axline, 1989; Landreth & Bratton, 1998; Sweeney & Landreth, 2003).

The treatment phases outlined for Theraplay are very similar to those for non-directive play therapy and therefore, to avoid repetition, were not included in this section.

**Play Therapy and Attachment**

Psychotherapy, as explained by Bowlby, can be viewed as a relationship in which clients’ internal models of experiences based on past and current attachment relationships are influenced by their newly developing relationship with their therapist (Ryan, 2004).
Therapeutic work with maltreated children, abused children and children with attachment difficulties and their families is increasingly recognized as a priority in clinical practice (Ryan, 2004). This is because new environments alone can be insufficient for changing the child’s internal models of attachment relationships and their behavioural strategies for maintaining and engaging attachment figures (Ryan, 2004). In order for these internal models of experience and the resulting strategies to change to healthier attachment relationships, the child needs to be allowed to work through their attachment issues. This can be accomplished in play therapy, as important attachment properties seem to be inbuilt in the therapeutic relationship (Ryan, 1999). Patterns of interactions between the therapist and child can be viewed as similar to the restoration of normal parent-child interaction patterns (Ryan, 1999).

According to attachment theory the first relationship a child has is crucial, as it is this relationship which forms the prototype for all other relationships throughout the lifespan. If the first relationship is not a positive relationship, subsequent relationships can therefore go awry, resulting in a multitude of problems (Munns, 2000). Theraplay goes back to the original relationship and attempts to make it a healthier, more secure relationship. Theraplay is therefore based on the belief that the relationship between a parent and child can be enhanced through play. As attachment occurs at a young age, within the first three years of the child’s life, the play activities are often adaptations of the activities a parent would usually perform with their young child (Perry & Gerretsen, 2002).

In Theraplay, interactions between the parent and child are replicated which delve into the roots of interpersonal connectedness. Early emotions are relived and re-
experienced in a caring and accepting atmosphere, first provided by the therapist and later by the parents themselves with the help of the therapist (Munns, 2000).

Theraplay and non-directive play therapy can be complementary when working with abused children. Non-directive play therapy is a well established therapeutic approach for working individually with children and being able to address a multitude of problems simultaneously. Non-directive play therapy’s use of non-verbal communication and it’s flexibility to adjust to the child’s changing developmental needs point to it’s suitability for children with attachment difficulties (Ryan, 2004).

Incorporation of the Two Therapeutic Approaches

As Theraplay is intrusive and involves a great deal of touch between the client and therapist, it was originally not recommended by Jernberg (1989) for sexually abused children. Since then numerous research has been conducted (Booth & Koller, 1998; Booth & Lindaman, 2000; Munns, 2003) and has shown that Theraplay has been effective in working with sexually abused children in conjunction with other forms of treatment (Rumley, 2008). It is recommended that when utilizing Theraplay with sexually abused children, changes need to be made regarding some of the games. For example, the use of body lotion may not be encouraged as it involves a great amount of touch, which the child may not be comfortable with (Rumley, 2008). An extensive amount of research has been conducted on Axline’s (1989) non-directive play therapy, which has been found to be a suitable and effective approach when working with sexually abused children (Ryan, 1999; West, 1992; Wilson, Kendrick, & Ryan, 1992).
In combining these two approaches, the child is afforded the opportunity to guide the therapist and the therapy and ‘show’ the therapist the areas or issues that need to be focussed on through non-directive play therapy. Further, the child is granted the opportunity to change internal working models of parent-child relationships through Theraplay as it is an attachment enhancing therapeutic apporach. For these reasons, a combination of these two approaches were utilised in the present study.

**Conclusion**

In this chapter the reader was introduced to play therapy. The chapter outlined the objectives of a play therapy session as well as what the child learns during the therapeutic process. Two therapeutic approaches were discussed namely, Theraplay and non-directive play therapy, including their origins, followed by their principles, and the method of conducting sessions.

In the following chapter the methodology of the study is discussed. The aim, research design, data collection method and Alexander’s method of content analysis will be discussed. Furthermore, methodological as well as ethical considerations are discussed.
CHAPTER 4
METHODOLOGY

Introduction

The present chapter provides an overview and description of the case study research design and methodology employed in this study. The chapter explores the methodology applied by looking at the research design, sampling methods, procedures, and data analysis methods that were employed. Finally, it reflects on the ethical as well as methodological considerations that were maintained within the investigation.

Primary Aims of the Study

The aim of the study is to broaden psychotherapeutic knowledge by means of meaningful qualitative enquiry. More specifically, the aim will be to describe the therapeutic process of an eight year old girl (Cindy) with an insecure attachment style. Both Theraplay and a non-directive play therapeutic approach were explored in this regard.

Research Design

The choice of which research method to utilise, either quantitative or qualitative, is dependant on the nature of the research problem (Noor, 2008). Both qualitative and quantitative research methods have their own advantages and disadvantages.
Quantitative methods have the advantage of allowing researchers to measure and control variables with the disadvantage being the resulting theory often failing to take into account the unique characteristics of individual cases (Edwards, 1998).

An advantage of qualitative studies is they provide detailed descriptions and analyses of quality or substance of human experience (Marvasti, 2004). Denzin and Lincoln (1994) state that qualitative research emphasizes processes and meanings that are not rigorously examined and measured in terms of quantity, intensity or frequency. Qualitative researchers are interested in insight, discovery and interpretation rather than hypothesis testing. One disadvantage of qualitative research is that it may be time consuming and may be costly (De Vos, Strydom, Fouche & Delport, 2005).

As the qualitative method takes into account the individual characteristics and experiences of human experiences, it was selected for the present study. The case study approach was selected as it provides a suitable research design in which to give an account of the subject in a therapeutic situation (De Vos et al., 2005; Fouche & De Vos, 1998). Furthermore an exploratory-descriptive case study was employed, which is discussed further in the chapter.

*Case Study Research*

The objective of case study research is the development of an accurate description of a single case which leads to the development of theory and general principles and therefore case studies often generate hypotheses that could be tested by other research methods (Edwards, 1990). Yin (2003) states that case studies continue to be a relevant method of research and are the strategy of choice when there is little control
over events by the researcher and when the research focuses upon a contemporary phenomena within a real-life context.

**Definition of a Case Study**

Yin (2003) defined a case study as:

“An empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p.13).

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

In order for case study methods to retain its value as a scientific endeavour, certain principles need to be adhered to which are discussed in the following section.

**The Principles of Case Study Research Methodology**

As the case study method is generally utilized in qualitative research, statistical inference is not utilized (Yin, 2003). Rather, validity is established by a logical process namely analytic generalization, analytic induction or content analysis (Yin, 2003). The case study researcher aims to develop a conceptualisation in order to reveal the important qualities of the investigated case. The conceptualisation will make
assumptions regarding the constructs or theoretical perspectives utilised to frame it as well as the relationship assumed to exist between them (Edwards, 1990).

**Types of Case Studies**

Edwards (1990) describes four types of case studies and points out that some case studies may fit into more than one of the categories outlined. The four types are a) exploratory-descriptive case studies, b) descriptive-dialogic case studies, c) theoretical-heuristic case studies, and d) crucial or test case studies.

*Exploratory-descriptive case studies*

Exploratory-descriptive case studies aim to provide a rich and accurate description of an individual case, whilst providing an in-depth understanding of the case. This type of case study represents the details of an individual case without attempting to generalize to other cases (Edwards, 1990).

*Descriptive-dialogic case studies*

This type of case study’s emphasis is placed upon the description of a phenomenon. However, the case is not regarded as unique but rather one that is situated within existing theory. Another use for the descriptive-dialogic case study is to debate conflicting points in existing theory (Edwards, 1990).

*Theoretical-heuristic case studies*

Theoretical-heuristic case studies are primarily concerned with developing or testing existing theory. As the focus of this type of case study is on testing aspects of existing theory, not all cases are suitable for this type of research. Cases are therefore specifically selected depending on the aspects to be studied (Edwards, 1990).
Crucial or test case studies

For this type of case study a case is selected which provides a crucial test of a particular 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 (Edwards, 1990).

The exploratory-descriptive case study was selected for the purpose of this study as exploratory-descriptive case studies provide rich and accurate descriptions of an individual case, such as Cindy’s story, whilst simultaneously providing an in-depth understanding of the case. The researcher aimed to provide an accurate representation of the case of Cindy without generalizing her case to other cases but rather to generalize her case to existing theory.

Participants and Sampling

A purposive sampling technique was utilised for the selection of the participant in the study. In purposive sampling, the researcher uses her judgment to select the membership of the sample based on the specific goals of the research. Participants are included based on characteristics such as specific knowledge or experience related to the purpose of the study (Neuman, 2003). An advantage of this type of sampling is that the researcher uses it to select unique cases that are especially informative (Neuman, 2003). However, in this type of sampling, the chances of selection bias are high, which result in difficulties related to the generalization of results to the population (Cozby, 1997; Neuman, 2003). The researcher of this study however did not attempt to generalize the case to the population but rather to existing theory.
For the selection of the client, the researcher utilised an inclusion criteria in order to select the best possible client for the study. The inclusion criteria included:

(a) the participant must be in a family unit, currently living in the same residence as the primary caregiver
(b) the child should be between the ages of eight to ten years of age
(c) the child must be able to read and write
(d) the child should be fluent in either the English or Afrikaans language
(e) the primary caregiver must be the parent or legal guardian of the child
(f) the child must display signs of attachment difficulties such as poor social relationships, disruptive behaviour, aggressiveness and clinginess.

Cindy was the single subject selected as she complied with the inclusion criteria for the study. She represented a typical case of a child with an insecure attachment; she was in the age bracket, spoke English, was able to read and write as well as resided with her primary caregiver.

Procedure and Data Collection

Permission to conduct the study was gained from the institution at which the researcher studied. Once the client was selected, written informed consent was obtained from the client's primary caregiver and assent gained from the client. Once written informed consent and assent were gained, the researcher scheduled therapy appointments with the primary caregiver.

For the study, the three principles of data collection as proposed by Yin (2003) were adhered to. The three principles are: a) use multiple sources of information, b) create a
case study database, and c) maintain a chain of evidence. These three principles are discussed below.

*Use Multiple Sources of Evidence*

A major strength of case study data collection is the opportunity to utilise many sources of evidence (Yin, 2003). Cozby (1997) states that 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. The use of multiple sources of evidence allows the researcher to address a broader range of historical, attitudinal and behavioural issues (Yin, 2003). The greatest advantage of using multiple sources of evidence is that any finding in the case study is likely to be more accurate as it is based on several different sources of information (Yin, 2003).

In order to combat researcher bias, triangulation of data sources was ensured. Triangulation of data sources entails a researcher utilizing more than one source of data (Fitzpatrick & Wallace, 2006). The data sources for the study included archival data, which included existing information in the client file, case material from the 16 therapy sessions, detailed records in the form of process notes, direct observation through taped videos of three therapy sessions as well as from interviews from the client’s primary caregiver, the social worker and teacher. Furthermore, investigator triangulation was utilized, which is defined by Fitzpatrick and Wallace (2006) as the utilisation of more than one data collector and data analysts. The data was analysed by the researcher as well as by an independent registered psychologist and two research supervisors.
Create a Case Study Database

A case study database is the practice of developing a formal and presentable database including the researcher’s case study notes (Yin, 2003). The case study database for the present study included process notes, electronic media in the form of video tapes, collateral information from the primary caregiver, social worker, General Practitioner as well as from the teacher.

Maintain a Chain of Evidence

The importance of maintaining a chain of evidence is that it 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 researcher ensured that a chain of evidence was adhered to throughout the study by dating the evidence as it was collected. For example, each therapy session and interview was dated.

Data Analysis

The data was analyzed utilizing content analysis. Content analysis is a method for analyzing communication after it has been produced. There are no boundaries to the form of communication and can be applied to behaviour as behaviour has a communicative dimension (Haslam & McGarty, 2003).

The content analysis technique employed was that of Irving Alexander (1988), where core identifying units, in the form of “themes”, were extracted. In Alexander’s (1988) model the data is approached in accordance with two routes, namely, a) letting the data reveal itself, and b) asking the data questions.
Letting the Data Reveal Itself

This involves the researcher sorting through the raw data and identifying what in the material demands further scrutiny due to its importance. The sorting through the data serves two purposes namely reducing the data into manageable proportions and to break the conscious communicational intent of the content (Alexander, 1988). When breaking the conscious communicational intent of the content, the researcher must be directed away from the judgement of the content and rather focus on the awareness of what in the content signals importance to the individual in what has been communicated (Alexander, 1988).

Alexander (1988) proposed nine guidelines for the extraction of salient data which includes the following:

1) Primacy: This refers to the association that is made between the concepts of first and importance. According to Alexander (1988) people tend to speak or write first about what is most on their minds.

2) Frequency: This refers to speech or writing that occurs often and frequently (Alexander, 1988). Certainty and importance is attributed to the frequency with which information is reported.

3) Uniqueness: This refers to that which is singular or odd (Alexander, 1988). 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 not only refers to verbal expression but also the content of what is being expressed. Alexander (1988)
advises that the therapist should look for unique verbal as well as nonverbal cues from the client.

4) Negation: Negation statements are statements which are denied or turned into its opposite (Alexander, 1988) and are indicators of possibly repressed or unconscious material (Fouché, 1999).

5) Emphasis: That which is overemphasized, underemphasized or mistakenly emphasized should be noted by the researcher. Overemphasis is usually noted when something which is widely held to be commonplace, receives excessive attention (Alexander, 1988). Underemphasis is noted when something that seems important receives little attention, while misplaced emphasis occurs when an apparently irrelevant aspect of a crucial event is emphasised (Elms, 1994).

6) Omission: This refers to what is missing. Alexander (1988) stated that a therapist should pay special attention to affect which is commonly omitted while description of actions and events abound.

7) Error or Distortion: This is 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 (Alexander, 1988).

8) Isolation: This refers to that which is alone or doesn't fit (Alexander, 1988). If this leaves one asking the question “Does this really make sense?” or “Where did that come from?” it is highly likely that important material is contained in this isolated communication (Alexander, 1988).

9) Incompletion: This refers to that which is not finished (Alexander, 1988). This may happen when an individual's story may follow a course but then ends before
closure is reached. Alexander (1988) points out that the individual may sometimes be aware of what is happening and may abruptly stop with her story, which may indicate that it is too painful to continue. Other forms of incompletion may include subtle changes, where distraction serves to interrupt the narrative flow and there is no return to the original story line (Alexander, 1988).

Asking the Data Questions

The researcher extracted all relevant information from the data by systematically categorizing the information into ‘core identifying units' also known as themes. The researcher asked the data questions that served to highlight the core identifying units of relevance to achieving the objectives of the study. The following questions were asked:

Question 1: What section of the data will allow for the exploration and description of the process of Theraplay followed with Cindy?

In the process of answering the first question, it was decided that information would be obtained from process notes and video recordings of therapy sessions.

Question 2: What section of the data will allow for the description of Cindy’s attachment style?

In order to answer this question, it was decided that process notes, video recordings of therapy sessions as well as collateral information gathered would be utilized.

Question 3: What section of the data will allow for the contextualization of Cindy’s play therapy process whilst simultaneously incorporating Cindy’s attachment style?
In order to answer question four, it was decided that process notes, video recordings of therapy sessions, collateral information gathered as well as notes from supervision would be utilized.

Question 4: How will a dialogue be created between the extracted data, the content of Theraplay and Bowlby’s attachment theory?

An attempt to answer question five has been made through the process and implementation of analytical generalization, where the theory of Theraplay as well as Bowlby’s attachment theory were utilized as a template with which to compare the results of the case study.

Furthermore, Guba’s model of trustworthiness was utilised in order to make every effort to remain objective whilst analysing the data (Krefting, 1991). The model outlined credibility, transferability, dependability and confirmability as the criteria for assessing qualitative research.

Credibility refers to whether the researcher has established confidence in the truth of the findings. This can be achieved by presenting accurate descriptions of human experience that people, who are familiar with the experience, would instantly recognize the description (Willig, 2001). Transferability refers to the degree of which the findings can be generalized to other contexts. Research meets this criterion when the findings from a study fit into contexts outside of the study situation (Krefting, 1991). Dependability addresses the issue of whether the findings would be consistent if the study were replicated (Krefting, 1991). Confirmability refers to freedom from bias in the research procedures and results (Krefting, 1991).
Preliminary Methodological Considerations

Before commencing with a case study, the researcher needs to be aware of the possible shortcomings and limitations of the case study approach. The shortcomings relating to the current study as well as their influence are discussed in greater detail below.

Researcher Bias

Yin (2003) cautions that case study researchers may make use of the case study approach to substantiate a preconceived position. A possible way for researchers to counteract the danger of subjectivity is for the researcher to examine their feelings regarding the subject and to develop empathy with the subject (Anderson, 1981). Objectivity can also be achieved through case conceptualization, supervision and peer discussion (Edwards, 1990).

The researcher endeavoured to counteract researcher bias by conceptualising the case and by discussing the case on numerous occasions with two supervisors as well as with an independent registered psychologist. The case was also presented at a Psychology Department proposal meeting and the case was further reviewed by the Faculty of Health Sciences Research Technology and Innovations Committee and Research Ethics Committee (Human) at the institution where the researcher studied.

Validity and Reliability Criticisms

Runyan (1988) stated that the most widespread criticisms of the case study method are those regarding validity and reliability due to the perceived ‘lack of controls’ and the difficulty in generalisation. Yin (2003) stated that the quality of a case study design can
be measured by four tests common to all social science methods, namely: a) construct validity, b) internal validity, c) external validity, and d) reliability.

**Construct validity**

Yin (2003) describes construct validity as “establishing correct operational measures for the concepts being studied” (p.34). This issue can be addressed in case study research by using multiple sources of evidence such as interviews, documentation and archival records, psychological testing and direct observation (Yin, 2003). Establishing a chain of evidence allows an external observer to follow the source of any evidence and therefore trace the steps taken by the researcher in either direction such as from the conclusion to the initial research question or vice versa.

The issue of construct validity was dealt with as the researcher obtained multiple sources of evidence including the case material, interviews with the client’s primary caregiver, social worker, general practitioner as well as from video recordings and process notes.

**Internal validity**

Internal validity has been described as establishing a causal relationship, whereby certain conditions are shown to lead to other conditions. This is only a concern for explanatory research and is not applicable to exploratory or descriptive research (Yin, 2003).

**External validity**

External validity is establishing the field to which the study’s findings can be generalised. Case studies rely on analytical generalisation where the researcher strives to generalise a particular set of results to some broader theory. The case study method
maintains external validity by investigating people or events in, or as close as possible, to their natural contexts (Yin, 2003).

The researcher aimed to relate the findings to the theory and not to other case studies or the general population. In this way the results of the study were compared with theories previously developed. The findings of the study were related to Bowlby’s attachment theory, Jernberg’s Theraplay and Axline’s non-directive play therapy.

Reliability

The term refers to demonstrating that the operations of the study can be repeated with the same results. The objective is that if later researchers followed the same procedures and conducted the same study, they would arrive at the same research findings and conclusions (Yin, 2003). The goal of reliability is to minimise the errors and biases of the study.

The case study protocol is an effective way of dealing with the overall problem of increasing the reliability of case studies as it guides the researcher in carrying out the data collection. The case study protocol keeps the researcher focused on the subject of the case study and forces the researcher to anticipate problems that may arise. A second tool in increasing the reliability of the study is by creating a case study database. A case study database is where the researcher organizes the data collected and in this way allows other investigators to review the data directly. This increases the study’s reliability greatly (Yin, 2003).

The researcher has addressed the issue of reliability by clearly stating the steps in the data collection process as well as all the procedures followed in the research process have been clearly laid out in the dissertation. A case study database was
created whereby all sources of data, such as process notes and videos were methodically organized. A case study protocol was also employed as the study has been clearly laid out in the form of a dissertation, with a detailed contents page as well as methodology chapter.

**Ethical Considerations**

In any form of research, the researcher faces a myriad of ethical choices and dilemmas and must decide how to act in an appropriate and professional manner.

Ethical guidelines according to Vorster (2002) serve as a standard and base upon which the researcher should evaluate their own conduct. In order to maintain good ethical practice and a level of professionalism and accountability a number of ethical guidelines were followed. This involved seeking and gaining approval of both the University’s Faculty Research, Innovation and Technology Committee as well as the Ethics Committee (Human).

Furthermore, as mentioned earlier, written informed consent was obtained from the client’s primary caregiver.

As the protection of the client is of utmost importance and in order for confidentiality to be maintained, a pseudonym was chosen and utilised throughout the study. Any data that could be used to identify the client or the primary caregiver was disguised.

Participation was on a voluntary basis and the clients (the child as well as the primary caregiver) were informed that they had the right to withdraw from the study at any stage, without fear of discrimination.
Mouton (2001) discussed certain ethical principles that are of utmost importance to the research process. These include:

Objectivity and Integrity in Research

The highest possible technical standards were adhered to in the study. The theories, methods and research design utilised in the interpretation of the collected data have been disclosed as well as the limitations of the study were discussed.

The Fabrication of Data

None of the data utilised in the study was fabricated in any form and was an accurate reflection of the information obtained from the various sources.

Ethical Publishing Practices

All sources of information utilised in the study have been acknowledged.

Conclusion

The methodology of the research was discussed including the research design, sampling method, data collection method as well as the data analysis method. Furthermore, methodological considerations as well as ethical considerations were discussed.

In the following chapter, the clinical material will be discussed and the therapy case will be presented.
CHAPTER 5

CLINICAL PICTURE AND PRESENTATION OF THERAPY CASE

“Inside each child there is a story that needs to be told - a story that no-one else has yet had the time to listen to”

(Winnicott, 1984, p.21)

Introduction

A child’s natural medium of self expression is through play. By playing, a child is granted the opportunity to express their accumulated feelings in an age appropriate manner, at their own pace. Play therapy therefore allows the child the opportunity to ‘play out’ their feelings and problems just as adults ‘talk out’ their problems (Axline, 1989).

In the following chapter the client’s therapeutic process is presented. It introduces the reader to the client and her mother. The client’s biographical information, developmental history, family, and social background are described. The presenting problem and reason for referral are discussed. This information was obtained from the intake interview with the client’s mother as well as from collateral sources such as the social worker and District Surgeon. This is followed by a summary of the client’s 16 therapy sessions.
Biographical Information

Name: Cindy
Age at start of therapy: 8 years, 0 months (estimated according to date of birth)
Grade: 2
Gender: Female
Home Language: English
Nationality: South African
Primary Caregiver: Mandy, 42
Biological mother: Name unknown, deceased, unknown age
Biological father: Name unknown, deceased, unknown age
Siblings: Two older sisters, deceased, unknown ages
Older brother, Robert, 14

Developmental History

Limited details of Cindy’s background and developmental background before the age of two are available. Cindy’s date of birth is unknown but it was estimated based on her size and development. Cindy’s caregivers during her first year of life were her terminally ill biological mother, ill and alcoholic father, terminally ill older sister, and alcoholic aunt. The quality and quantity of care that Cindy received in her first year of life was likely to have been inconsistent and lacking due to her mother’s illness’ symptoms, such as fatigue, depression, and cognitive symptoms such as forgetfulness and confusion. Cindy’s biological mother and sisters passed away due to AIDS related illnesses when Cindy was approximately 12 months old. Due to economic restraints and alcoholism the
care given by her other adult caregivers was likely to have been equally inconsistent and lacking. Cindy’s biological father passed away approximately a year after her mother and sisters’ deaths, also due to AIDS related illnesses. Cindy was approximately two years old at the time. Cindy and her older brother Robert became wards of the State and were placed in a child and youth care centre.

Mandy, as part of a church group that visited the child and youth care centre, met Cindy at the centre and soon was granted permission to take Cindy home for weekend visits. When Mandy started fostering Cindy over the weekend, she reported that Cindy had an ‘institutionalized’ face, void of any facial expression and displayed a blunted affect. She also reported that Cindy was hypervigilant, didn’t make her needs known, and was extremely distrustful of men.

When Cindy was three years old Mandy noticed that it was painful for Cindy when her genital area was washed. Mandy took Cindy to the community nurse, who referred them to the District Surgeon. It was established by the District Surgeon that Cindy had a severe vaginal infection. The District Surgeon also revealed that Cindy had been vaginally as well as anally penetrated over a prolonged period of time. Cindy also tested positive for HIV and had Tuberculosis. Mandy then decided to formally start fostering Cindy.

Cindy displayed a number of behavioural difficulties between the ages of three and five. She was reportedly obstinate, defiant, and stubborn. Up to the age of five, Cindy had regular episodes of nocturnal Enuresis and Encopresis. Based on Robert’s physical features and borderline intelligence and known history of Cindy’s biological mother’ alcoholism, Cindy’s medical practitioner diagnosed Fetal Alcohol Syndrome, even
though Cindy did not show the typical signs of the syndrome. Cindy exhibited regressive behaviours such as speaking with the tone of a younger child. Cindy was also reportedly extremely clingy towards Mandy. She struggled to communicate her negative feelings such as anger, hurt and jealousy and rather coped by ‘walling’ these emotions and being over-compliant. Mandy sensed that Cindy molded herself into whatever expectation she believed Mandy had of her.

**Family and Social Background**

Mandy is a 42 year old Grade 1 teacher, who is also a volunteer counselor at Lifeline. She therefore has a reasonable amount of psychological knowledge. Mandy is friendly, intelligent, and family orientated. Her family lives in other cities but they are very close and converse weekly telephonically. Mandy is single, has never been married, and has no children. She has a strong support system through her family and church, where she is an active member.

Mandy started fostering Cindy when she was approximately two years old. Cindy’s brother, Robert, who is 14 years old, lives in the child and youth care centre. Robert was also scholastically assessed and it was found to be of Borderline intellectual functioning. Robert and Cindy share a very close relationship and he often comes to stay with Mandy and Cindy over weekends and every school holiday. Mandy’s adoption of Cindy was formalized three years ago.

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1 As Cindy has been legally adopted, Mandy will be referred to as Cindy’s mother.
Presenting Problem and Reason for Referral

Mandy brought Cindy to the University psychology clinic as she found Cindy to be ‘extremely clingy’ and was concerned with some of Cindy’s behaviour. Cindy reportedly displayed inappropriate affection towards strangers. For example, Cindy would start a conversation with a stranger and would then soon start kissing their hands and stroking their arms. Mandy was also concerned about Cindy’s attention seeking behaviour and her fascination with her reflection in the mirror.

Course of Psychotherapy

The therapeutic process with Cindy was conducted over a period of 16 therapy sessions in the form of Theraplay and non-directive play therapy. The therapeutic process was spaced over a period of eight months. Twelve sessions out of the 16 were a combination of both Theraplay and non-directive play therapy. Four of the 16 sessions were Theraplay focused sessions. The combination sessions consisted of 30 minutes of Theraplay followed by 30 minutes of non-directive play therapy.

The Theraplay part of each session was usually conducted in an empty room in order for there to be no distractions, while the non-directive play therapy part of the session was conducted in a fully equipped playroom. Table 1, Summary of Cindy’s Therapeutic Process, represents a tabular format of the therapy sessions and the type of therapy utilized in each session. This is followed by Table 2, which is a breakdown of the type of Theraplay activities utilized in each session.
Session One

The session consisted of an hour of Theraplay and was introduced utilizing touch activities in order for the therapist and Cindy to get to know one another. At the beginning of the session, parts of the body, such as head, neck, legs and arms, were greeted and welcomed. For example, the therapist greeted Cindy’s hands and fingers by touching and holding them and saying “Hello hands…hello fingers”. Cindy initially appeared a little surprised at the amount of touch she received but soon became deeply involved and accepting and found great pleasure in the therapist’s affection.

Another activity named the ‘oven’ was then introduced. This activity involved Cindy and the therapist, where together they would make ‘cookies’. Cindy was the ‘cookie’ and various ingredients were added to the cookie such as imaginary body parts, as well as imaginary ingredients such as flour, milk, and sugar. This activity involved touch, where the therapist would touch the certain parts of Cindy’s body, such as limbs, face and neck, which were then added to the cookie mixture. The cookie would then be placed in the oven where Cindy would then curl up in the therapist’s lap and together they would sing songs or talk. Once the cookie was baked she would then be ‘eaten’ by the therapist. The therapist would use an imaginary cookie cutter and would press a shape formed by the therapists’ fingers on her arms and legs. These were then ‘cookies’ that the therapist ‘took’ and pretended to eat. The therapist would then smack her lips and exclaim ‘yum yum’ and would ‘ooh and aah’ at how nice the cookies were. The therapist noted that Cindy seemed passive during the games but once she grasped what the game entailed, she enjoyed participating.
Cindy’s behaviour during the oven activity had become more ‘baby-like’; her tone of voice grew higher and ‘smaller’ and she displayed baby-like laughter. It was estimated, based Cindy’s language use, that she regressed to an approximate age of a child of two to three years of age.

**Session Two**

The second session was a combination session, with 30 minutes of Theraplay and 30 minutes of non-directive play therapy.

During the first part of the session, which consisted of Theraplay, the oven activity was played. Cindy seemed less passive during this activity and made more effort to direct the play. The therapist resisted her direction but allowed Cindy to decide what type of cookie she wanted to be, whether the cookie was baked, and for how long it was baked. Cindy preferred ‘eating’ half of the ‘Cindy cookie’ herself, whilst allowing the therapist to ‘eat’ the other half. During the oven activity, Cindy once again displayed regressive behaviour to the approximate age of a child of two to three years of age. Her voice once again became ‘smaller’ and she displayed baby-like laughter.

During the non-directive part of the session, Cindy’s play revolved around the horse-zebra family with a horse-mother, zebra-girl and zebra-boy. The family searched for food together. Another element was added to the play, where the horse-mother and zebra-boy protected the zebra-girl from the possible danger of lion play animals.

**Session Three**

This session consisted of an hour of Theraplay.

During the oven activity, the therapist noticed that Cindy displayed resistance to being eaten. This was expressed by Cindy as being ticklish. In the previous two
sessions which included this activity, Cindy enjoyed being eaten and found pleasure in this activity. Cindy’s regressive behaviour during this session was less obvious, but still present.

Session Four

This was a combination session, with both Theraplay and non-directive play therapy. New activities such as thumb, arm, and leg wrestling were introduced during the Theraplay part of the session, much to Cindy’s enjoyment.

During the oven activity, Cindy wanted to make a zebra cookie and also wanted to eat the therapist. The therapist noticed that even though Cindy was excited and enthusiastic to begin each activity, she seemed distracted, which was not typical behaviour of Cindy’s. The therapist, after 20 minutes of Theraplay, felt that Cindy was eager to symbolically play out an emotion or significant experience and therefore cut the Theraplay time short and immediately allowed Cindy to start non-directive play therapy in the playroom.

During the remaining 45 minutes of the session, Cindy played with the punching bag. Cindy expressed a great deal of anger, yet it was observed by the therapist that while Cindy was venting her anger, she did not show appropriate facial expression. Rather, her eyes were glazed over, void of any emotion and Cindy had a smile-like grimace. It was ascertained that Cindy’s anger was directed at Mandy as she didn’t have money for things Cindy wanted and told Cindy to clean her room.

After Cindy finished with the punching bag she played with the animal family. The zebra-girl in this scenario continually ‘saved’ the horse-mother from the lion family and continually fed the horse-mother. A lion cub was later introduced as a friend of the
zebra-girl. It was noted that in this family scenario the zebra-girl had more power and abilities than during previous non-directive play sessions.

**Session Five**

This combination session started with a Theraplay session. However, as soon as the oven activity was introduced, Cindy immediately regressed. Her voice rose and her language became simpler and more infant-like. Cindy, more than ever before, didn’t want to get out of the oven and spent the majority of the Theraplay part of the session in the therapist’s lap. The therapist decided to extend the oven activity and cut short other activities.

In the playroom, the same animal family was played with during the non-directive part of the session. The horse-mother was under threat from some unknown force and the zebra-girl helps the horse mother.

**Session Six**

This session consisted of an hour of Theraplay. At the beginning of the session a new game was introduced which involved a boat and a storm. This activity involved Cindy sitting on the therapist’s lap facing forward and together they would pretend they were sailing a boat. At times it would be quietly sailing and at other times they would be in a storm. During the storm, the therapist and Cindy would rock from side to side and Cindy would hold on to the therapist in order to keep her safe. Towards the end of the boat game, Cindy unexpectedly turned around and grasped both of the therapists’ breasts. Cindy was clearly embarrassed at her behaviour, yet could not stop herself from touching, grabbing and squeezing the breasts. The therapist removed Cindy’s
hands from her breasts and distracted her with another activity. Cindy expressed the reason that she loves breasts so much was because they were soft and motherly.

Session Seven

This session was a combination session, which began with 30 minutes of Theraplay. During the Theraplay part of the session, as part of the oven activity, a baby’s bottle filled with milk was introduced. Cindy regressed and communicated even further with baby-like gurgles and ‘cried’ for her bottle. She displayed infant-like facial expressions and laughed in a baby-like manner.

Cindy was then taken to the playroom for the non-directive part of the session. In order to fulfill Cindy’s fascination with breasts, the therapist introduced an activity where, together they made breasts out of clay. The therapist noticed that Cindy tried to suckle from the clay breast that she had made.

In another game, the therapist was handcuffed as she was a ‘bad person’. The therapist was then ‘starved for a week’.

Session Eight

At the beginning of the session, Cindy was very excited as she had remembered to bring milk for her bottle.

The Theraplay part of the session began with the greeting activity, where parts of the body were greeted and welcomed. This was followed by the oven activity. Cindy wanted a lot of ‘mixing’ which entailed the therapist softly kneading Cindy’s stomach. Each time the therapist announced she was finished mixing, Cindy was not satisfied and wanted more mixing. During the mixing there was regression in Cindy’s laughter. In the ‘oven’ two songs were sung. Cindy then wanted her bottle and ‘cried’ as if she were an infant,
for her bottle. She then pretended to sleep, awoke and resumed drinking her bottle. Whilst drinking her bottle, Cindy touched the therapist’s breast in an infant-like manner. Once the oven activity was completed, the therapist allowed Cindy to select the next activity. She requested, in a baby-like manner, to thumb wrestle.

For the non-directive part of the session, Cindy was taken to the playroom. The following activity involved making ‘breasts' out of shortbread and smarties. Cindy was extremely enthusiastic during this activity. Cindy made a breast for the therapist and ate the other breast herself. She requested balloons filled with milk for the following session and was excited and keenly anticipated the next session.

Cindy, in the following activity, pretended to be a princess. She pretended that she had been given a large sum of money to buy tickets for a show for herself and her family to attend. In her play she made reference to her father, the king, who was very strict. The king didn’t allow the princess to play outside the castle as ‘men might hurt her’. The princess was also very angry with her father as he didn’t give her enough money. She would like more money to buy things for her friends.

Session Nine

The session was a combination session, with 30 minutes of Theraplay followed by 30 minutes of non-directive play therapy.

Cindy brought milk to this session and upon seeing the therapist, she immediately wanted to know if they were still going to play with the balloons filled with milk as breasts. Once Cindy and the therapist were in the Theraplay room Cindy regressed immediately. She wanted to make ‘booby cookies’ during the oven activity. Cindy pretended to cut off the breasts of an imaginary lady and ‘added’ this to the cookie
mixture. Later she felt sorry for cutting off the lady’s breasts. She then removed the breasts from the mix and using Pritt ‘stuck’ them back on the lady and said “sorry lady”. During this activity Cindy had a wild, spontaneous child-like laugh.

During the oven activity, Cindy was excited to sing songs, which were age appropriate for a young child of two to three years of age. She asked for her ‘bottie’ (bottle) in simple two word sentences. Later during the activity Cindy could put together simple sentences such as “I want to walk, mommy”.

The following activity involved hand wrestling. The therapist’s as well as Cindy’s hands were covered in body lotion in order for it to be slippery while they hand wrestled. Cindy enjoyed this activity.

On the way to the playroom, Cindy pretended that she was learning how to walk. As she got closer to the playroom she got better and better at ‘walking’ and said to the therapist “Look mommy, I can walk”. Cindy was proud of herself that she had learned how to walk.

During the non-directive play therapy, Cindy started playing with the horse and zebra family. During her play, the horse-mother was run over by a truck. The zebra-girl helped the horse-mother escape, and then sent the horse-mother away in order to be safe from the truck.

Cindy then moved on to the doll section of the playroom and pretended to feed a doll her bottle. She repeated this with a second doll.

Towards the end of the therapy session, the balloons were taken out. Together the therapist and Cindy filled the balloons with milk but before they could be used, the balloons burst.
Mandy reported to the therapist that Cindy’s teacher had suddenly passed away during the week and that Cindy had been sad and tearful since her passing. Cindy told the therapist at the end of the session that she is allowed to be angry and sad.

Session Ten

Mandy reported at the beginning of the session that it was Cindy’s teacher’s funeral on the past Tuesday and that it had been an open casket. Cindy had therefore seen her teacher’s body in the coffin. Mandy said that Cindy had since had a nightmare.

The therapy session began by Cindy telling the therapist about her nightmare. It involved Cindy inside a coffin. The ‘bogeyman’ then closed the coffin lid, trapping Cindy inside. She couldn’t escape and tried kicking her way out. There were sharp thorns on the inside of the coffin that pierced her heart and she died. Cindy was very scared and sad. Cindy said: “I don’t want to die.”

During the Theraplay part of this combination session Cindy immediately regressed with baby-like language. The therapist began by greeting Cindy’s body parts, with Cindy in turn greeting the therapist’s body parts. She enjoyed this activity.

Cindy couldn’t wait for the oven activity. Cindy told the therapist “People don’t know our secret in the oven – that we sing”. Together they sang songs. When ‘twinkle twinkle little star’ and ‘Mary had a little lamb’ were introduced, Cindy immediately regressed again. She cried for her bottle and sang in a baby-like manner, replacing words such as ‘lamb’ with ‘wamb’. When Cindy was in the oven, she pretended that the bogeyman was coming to fetch her and that the therapist, whom she called ‘mom’ when she regressed, protected her. She was then ready to come out of the oven.
In the non-directive part of the session, ice cream breasts were made, using raisins as nipples. The ice cream melted and Cindy wanted to be fed the ice cream. She hated the raisins and spat them out. The therapist introduced feeding Cindy good things such as a princess, fairy and puppy. When bad things were fed to Cindy she said: “When I eat bad things, I become bad”. The therapist introduced eating a good bogeyman in order to change Cindy’s view, Cindy refused. The therapist also introduced eating ‘mommy’ as mommy was good. Cindy didn’t want to eat ‘mommy’ as mommy’s ‘wee’ and ‘pou pou’ (faeces) would be inside her stomach. She later said: “When mommy’s inside me I can protect her”.

Cindy played with the horse-mother and girl-zebra. The play revolved around the horse-mother saving the girl-zebra from danger. The girl-zebra was, in this session, able to find her own food.

Cindy then drew a picture. The picture was of herself and her mother, which she wanted to give to Mandy. She wrote on the picture “I lovue mom from Cindy. Lovue to mom. Do you lovue me to.” She was excited to give the picture to her mother.

Session Eleven

At the beginning of the session, Cindy told the therapist that she didn’t want to play ‘baby games’, meaning Theraplay games such as the oven activity. Cindy and the therapist then went to the playroom. The session began with the therapist and Cindy playing with puppets. The first puppets Cindy chose were a princess puppet and a Xhosa girl puppet. The two puppets were friends and the play revolved around the friends having fun on the playground. The following puppets Cindy chose were the
princess puppet and a devil puppet. The devil puppet chased the princess puppet and the princess then fainted. The mood with both puppet scenes was playful.

The next activity, which was a Theraplay activity conducted in the playroom, involved drawing Cindy’s life size outline on a large sheet of newsprint. The therapist and Cindy together then coloured in the outline. Cindy added blue eyes and added yellow hair. She drew long fingernails on the hands, whereas her own fingernails were bitten to the quick. She named this drawing Cindy. The therapist noticed that this drawing was different to Cindy’s true identity, as her biological mother was Xhosa and biological father was Coloured. Cindy then started communicating her fears to the therapist through the Cindy-drawing which was pasted to the wall. The therapist asked the Cindy-drawing questions, such as “what makes Cindy scared?” Cindy would then whisper in the therapist’s ear what the Cindy-drawing told her. She spoke of her fear of dying and her fear of the bogeyman. She said she imagined the bogeyman breaking into the house and stealing her and then killing her by sticking a knife in her heart. She told the therapist that she plays music to forget the scary thoughts and dreams. The conversation then moved on to her deceased teacher. Cindy was upset and said: “she was like a mother to me too” and was upset “because I never could say goodbye to her”. The therapist and Cindy then painted the teacher’s house. Cindy seemed to find comfort in this activity.

Outside Cindy and the therapist spoke about what scared her. Cindy was afraid of each person that walked past them. She was afraid that they would catch her and hurt her. The therapist taught Cindy to ‘roar’ in her head at anything that scared her and together they practiced this.
Session Twelve

This session was a combination session. Cindy began the session by telling the therapist about a dream that she had. In the dream there was a girl that had sharp teeth that sucked blood and brains from children. There was also a boy that hypnotized the teacher. The boy then told the children to go to the girl’s bedroom. Cindy ran to her own bedroom and locked herself inside. She thought that she was safe but when she turned around she found the girl with the sharp teeth behind her. The girl sucked at her neck and sucked some of her blood. Cindy then got spots all over her body and died. The other children were also hypnotized to clean their bedrooms. A man arrived and broke the spell. All the other children get their blood back except Cindy. After she died she said she was happy because she went to heaven and she knew God would protect her. She said nobody could help her, “not even mom”.

Cindy then said that she wasn’t scared to die anymore as she was “roaring in her head” and by roaring in her head she “scared the baddies away”. She confessed to the therapist that she doesn’t tell her mother about the dreams as she then constantly thinks about the dreams.

Cindy and the therapist went straight to the playroom. Together they made doughnut ‘boobies’ and used caramel as the nipple. Cindy’s eyes grew large when the therapist took a big bite out of her own doughnut.

The Theraplay part of the session was then conducted in the playroom. Cindy then requested to draw another life size picture. She named this picture Candy. In this picture she drew black hair, black eyes, and a crown on the picture’s head. She said the crown gives Candy courage. She mentioned to the therapist that she imagined wearing
a crown in her dreams. When Cindy finished the drawing she told the therapist that the Cindy-drawing would be jealous of the Candy-drawing because she was a new girl and because she was wearing a crown. She said the Candy-drawing would have to bring ‘things’ for the Cindy-drawing. Cindy then mentioned to the therapist that she is the mother of these two girls and “will make both of them feel good.”

After this activity, the non-directive part of the session began. Cindy chose to play with ‘Peter Pan’ figures. During her play she mentioned that she was scared of the dark because the dark can “eat her up.” She said she wasn’t afraid of something in the dark but of the darkness itself. She then started playing with a ‘Tigger’ toy. During the play Tigger ate his own ‘pou pou’ (faeces) as he thought it was food. Tigger thought it tasted ‘disgusting’ and vomited the ‘pou pou’ and ‘a little bit of blood’ out. Tigger was then very sick. Cindy, pretending she was Tigger’s mother, fed the sick Tigger.

The therapist thought Cindy seemed a bit distracted and even wary during this session. Cindy would look at the therapist out of the corner of her eye, which Mandy noted was the same way Cindy looked at her when she first started fostering her.

Session Thirteen

This session was a combination session. The session began with Cindy enthusiastically telling the therapist about her dream. Cindy once again had a dream about the boogeyman but in this dream she killed him. She told the therapist “I killed him this time”. She said she killed the boogeyman by ‘roaring at him’. The therapist felt that Cindy was a bit resistant and distant towards her during this discussion.

Cindy wanted to play ‘baby games’ during this session. As soon as the therapist started feeding Cindy with her bottle Cindy immediately regressed. Cindy placed her
arms around the therapist’s neck and laughed in a baby-like manner. The therapist started greeting Cindy’s body parts. Cindy did not respond to each part being greeted besides showing baby-like satisfaction at being shown affection. When the oven activity was introduced Cindy was very excited. She decided that she wanted the imaginary ingredients for the cookie to be ‘milkies’ and ‘dolly’. When the cookie was baking in the oven Cindy suddenly changed to an older baby and wanted to be called ‘Princess’. She then sang songs. She enjoyed being ‘eaten’ by the therapist.

In the second part of the session, the non-directive part, Cindy was impatient to begin playing. She chose the horse and the two zebras. Her play with the animals seemed ‘rough’ and Cindy’s eyes seemed ‘hard’. When the therapist queried if the animals were fighting Cindy replied that no, they were only playing. The zebra-girl went to the horse-mother to feed from her udder when a snake appeared. The girl and boy-zebras were both afraid and went and hid behind the horse-mother. The snake then went away. The zebras then climbed on a train. When the train accidentally fell over during the play, Cindy was visibly irritated and said “It’s her fault [the zebra-girl]. She went too fast.” Cindy explained, with an institutionalized face with glazed eyes and a frozen expression, that zebras did dangerous things, such as climbing up high objects, they struggled and they then fell. Cindy then pretended that the zebra-boy struggled to climb on to the table but eventually reached the table. The same was done for the girl-zebra. Whilst she did this, her face had the glazed expression. The horse-mother reached the top easily and Cindy was satisfied when all three were at the top of the table. A hunter appeared, Cindy whispered “Is he going to kill them?” and replied to
herself “no, not really”. ‘Skater Snoopy’ arrived and scared the hunter away. After the hunter was gone Skater Snoopy became a friend.

During this session the therapist sensed resistance from Cindy, as if Cindy was keeping the therapist at bay. During this session the therapist also felt that Cindy was nearing acceptance regarding the therapy sessions coming to an end but was not yet ready.

**Session Fourteen**

During the first part of this session, Cindy was very adamant that she did not want to play baby games. The session started with the punching bag. Cindy punched with conviction but with not much intensity. She asked the therapist to join her in punching the bag.

During the second part of the session Cindy played with the horse and zebra family. During this play a lion attacked the two zebras. They ran to the horse-mother and hid behind her. The lion attacked the mother and bit her. The girl-zebra fought the lion and the lion fell down, hurt. The girl-zebra was also hurt during the fight and was bleeding. The boy-zebra carried her to safety. The zebra-girl’s friend, the lion cub, arrived and was very angry at her father. The lion cub angrily said to her father “I want nothing to do with you!” and chased the father lion away. The lion cub put her father in a truck and pushed him away.

To end off the session, a goodbye song was introduced. It involved the therapist and Cindy taking turns to sing a funny goodbye to one another.
Session Fifteen

The Theraplay part of the session started with Cindy punching the punching bag in the playroom. She displayed a lot of anger and fury towards the punching bag. She told the therapist that the punching bag says to her that he wants to destroy her and that the punching bag is stronger than she is. This intensified her anger and Cindy directed all her anger at the punching bag. While she was punching, she was screaming loudly. Cindy imagined that she was 'karate girl'. Karate girl is highly skilled and is able to defeat the punching bag. When the punching bag was defeated and dead, Cindy felt bad. She then tried to wake the bag up and make the punching bag better and gave it 'some power'.

During the second part of the session Cindy played with the puppets and the puppet theatre. The characters in the activity are Mary, who was a good, compliant girl, Nick, and Pupeza. Mary and Nick were controlled by Cindy, with Pupeza controlled by the therapist. Mary taught Nick to eat vegetables. Mary was wary of Nick but she wanted to get to know him better. She wanted to trust him but did not yet trust him. Pupeza was in the wing of the theatre and was hiding behind the curtain with her head down. Mary said that Pupeza was shy. Pupeza then started crying. Mary said that Pupeza was crying because she didn't like her name. Mary decided to rename Pupeza and Nixi was chosen as her new name. Pupeza was very happy to now be called Nixi. The therapist sensed that Cindy was feeling sad as she grew quiet, with her eyes down cast. Nixi, still played by the therapist, asked Mary why she was so sad. Mary hit Nixi on the head and laughed hysterically saying "Sad? I'm not sad!" When Cindy started laughing the
therapist noticed that she had glazed over eyes and the laughter was not genuine laughter. Once this happened the game abruptly ended.

Cindy then started playing with rag dolls and chose a black and white rag doll. She told the therapist that she must be the white rag doll, which Cindy named Ann Marie. Cindy told the therapist that Ann Marie must sit and cry. The black rag doll comforted the white doll. Cindy asked Ann Marie if she wanted to be friends. Ann Marie cried and told Cindy that she is her mother’s slave and that she always has to work. Cindy asked Ann Marie to be her daughter. Ann Marie expressed fear. Cindy ignored this, took on a harsh persecutory tone of voice and took the doll, Ann Marie, away from the therapist.

Session Sixteen

The final session began with Cindy requesting to play outside instead of in the playroom. The session therefore began with non-directive play therapy.

While walking outside Cindy spoke in baby-like language. She conveyed to the therapist that the therapist needed to walk to the opposite side to catch her, then gestured the therapist back to her side. The therapist then had to catch her when she jumped. Once outside Cindy decided that she wanted to dance. She danced for a while singing ‘Goodbye, farewell’ but soon lost interest.

Together the therapist and Cindy sat on a climbing structure. Cindy told the therapist about her upcoming school concert and the songs they would sing. She said she didn’t think she would be able to go as her and her mother would be away. The therapist reminded Cindy that the holidays were arriving and that the clinic would therefore be closed. Cindy grew quiet and changed the subject. Cindy wanted a lot of hugging and comfort and together they sat quietly for a while.
Throughout the session Cindy had a bottle filled with water with her. At the beginning of the session Cindy used the bottle in a baby-like manner, along with her language but towards the end of the session she started making patterns with the water in the sand, in the manner a child her age would with a bottle.

With three minutes left of the session, the therapist suggested they play the goodbye game. While playing the game there was a feeling of acceptance, companionship and pleasure.

Table 1: Summary of Cindy’s Therapeutic Process

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<th>Session</th>
<th>Theraplay</th>
<th>Non-directive Play Therapy</th>
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Table 2 represents a breakdown of the four types of Theraplay activities, namely a) Structure, b) Challenge, c) Intrusion/Engagement, and d) Nurturance, included in each session.

Table 2: Breakdown of Theraplay Activity Type Utilized during the Therapeutic Process

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<tr>
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<th>Structure</th>
<th>Challenge</th>
<th>Intrusion/Engagement</th>
<th>Nurturance</th>
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Conclusion

This chapter introduced the client, Cindy and her mother, Mandy. It included the biographical information, developmental history as well as the client’s family and social background. This was followed by the presenting problem and reason for referral.
Finally the sixteen therapy sessions were described. In the following chapter the results of the study will be discussed.
CHAPTER 6
RESEARCH FINDINGS AND DISCUSSION

“Play is the highest expression of human development in childhood, for it alone is the free expression of what is in the child’s soul”

(Froebel, 1903, p. 22)

Introduction

The results of this study are presented in this chapter. The 16 therapy sessions were contextualized utilizing the theoretical frameworks of Bowlby’s attachment theory and Jernberg’s therapeutic approach, Theraplay. Further, the connection of an insecure attachment and developmental psychopathology is examined.

In order to enable the reader to follow the results in a logical, sequential order, the researcher devised a model in which to present the results, which also assists in easier reading. The model encompasses a visual representation of Cindy’s therapeutic process as depicted on the following page, with each of the headings in the model being further discussed in the chapter.
Cindy’s first two years of life were marred by inconsistent caregiving with Cindy’s biological mother having passed away when Cindy was approximately 12 months old. The care that she received from her other caregivers, her biological father and aunt was likely to be equally as inconsistent due to alcoholism, illness and economic constraints. Cindy’s biological father passed away when Cindy was approximately 22 - 24 months old.
old and shortly thereafter she was removed from her aunt’s care and placed in a child and youth care centre.

**Attachment Style**

The first 18 months of an infants life is crucial for the formation of a secure attachment between parent and child (Ammen, 2000). It is during this period that the parent responds to the child’s needs, offers nurturance and comfort in times of distress and thereby forming a secure attachment with the child, where the child feels loved, cared for and protected. If the care an infant receives during this period is lacking and irregular, where the mother does not meet the infant’s needs, an insecure attachment will form (Alexander, 1992; Bowlby, 1979; Howe et al., 1999).

*Insecure Ambivalent Attachment*

Cindy was classified as having an insecure attachment style as the care she received in her first 18 months of life was inconsistent and lacking. Cindy did not have the opportunity to form a secure attachment with her biological mother as she was terminally ill, with severe symptoms such as fatigue, depression, forgetfulness and confusion and was emotionally as well as physically neglectful towards Cindy. Cindy’s biological mother passed away when Cindy was approximately 12 months old. Cindy’s other caregivers, her biological father and aunt, were both alcoholics therefore the care she received was equally inconsistent and lacking. Her biological father was also terminally ill, with similar symptoms as her biological mother, and passed away when Cindy was approximately 24 months old.
Cindy was further classified in the insecure attachment category as having an ambivalent attachment style. An ambivalent attachment style occurs when caregivers are unreliable and inconsistent in their responses to the child. The child then feels the need to maximize the attachment behaviour in order to break through the parent’s emotional neglect, unavailability and lack of responsivity (Alexander, 1992; Brisch, 1999). The usual attachment behaviours a child displays, such as crying when hungry, elicited ambivalent responses from Cindy’s biological parents. At times Cindy’s needs were met, whilst at other times they were ignored. Due to the inconsistent care that Cindy received it resulted in Cindy’s need to maximize her attachment behaviour in order to have her needs met by her biological parents.

Cindy’s present behaviour, at the age of eight years of age, further suggests an ambivalent attachment style. She is extremely clingy towards her mother, Mandy, and demands a vast amount of attention and is excessively needy.

Cindy also meets the diagnostic criteria for Reactive Attachment Disorder (RAD) of Infancy or Early Childhood (see Appendix A). RAD is associated with pathological care, with a constant disregard for the child’s basic emotional needs such as the need for comfort, stimulation and affection. There is also a disregard for the child’s basic physical needs as well as repeated changes in a primary caregiver thereby preventing the formation of a stable attachment (American Psychiatric Association [DSM-IV-TR], 2000).

Cindy specifically fits into the Disinhibited Type of RAD as she displays indiscriminate sociability and a lack of selectivity in choice of attachment figures (DSM-IV-TR, 2000). Cindy is reportedly inappropriately affectionate towards strangers. It is
reported that she would start a conversation with a complete stranger and shortly thereafter start kissing the stranger’s hands and stroking their arms. Further, shortly after her second birthday she was placed in a child and youth care centre. In her first three years of life Cindy had approximately four caregivers before Mandy started fostering her. Due to the constant change in caregivers in a short period of time, Cindy had never had the opportunity to form a secure, stable attachment. Cindy’s only constant caregiver has been Mandy, who legally adopted Cindy.

As previously highlighted, Cindy experienced a great deal of trauma in her short life span. Research indicates that an insecure attachment between the parent and child may impact upon the severity of how the child experiences traumatic events, which is discussed in the following section.

Trauma Experienced

The trauma Cindy experienced in her first two years of life may have been exacerbated by her ambivalent attachment style, as a secure attachment between mother and child serves as a buffer to the effects of the trauma (McFarlane, 1988).

Cindy’s trauma included abuse, maltreatment and neglect by her biological parents, as well as the loss of both her biological parents at a young age. Further, Cindy was also sexually abused, whilst in a place of safety. The most noticeable traumatic effects of Cindy’s trauma included behavioural and emotional effects. Literature shows that behavioural effects may vary but the most common effects are sleep disturbances and regression (Trickey & Black, 2000), both of which were experienced by Cindy.

Cindy experienced sleep disturbances in the form of nightmares. The nightmares extended over a period of time and took the form of a bogeyman who was continually
trying to harm or kill Cindy. The second prominent behavioural effect was regression. Throughout the therapeutic process, in almost every session, Cindy regressed to the age of approximately two to three years old. She regressed in tone of voice as well as displayed baby-like laughter and wanted to drink from a bottle, as an infant would. The researcher found this significant as the majority of Cindy’s trauma was experienced during her first three years of life.

The emotional effects Cindy experienced varied. Literature states that after a traumatic incident children may become clingy and may experience separation anxiety (Lewis, 1999; Trickey & Black, 2000). Fears are also common, whether it be specific fears related to the trauma or generalised fears, such as a fear of the dark (Lewis, 1999). One of the reasons for Cindy’s referral was her clinginess towards her mother. Cindy also experienced other fears; she was extremely wary and afraid of men. She feared that the individuals that walked past her would catch her and hurt her.

Cindy’s internal working model of care may have incorporated adult parental figures as unstable and untrustworthy due to her first experiences involving ill and alcoholic parents. The present researcher is of the opinion that Cindy felt unsafe and abandoned by her parents which was integrated into her internal working model. The present researcher is of the impression that as Mandy was the only constant caregiver in Cindy’s life, Cindy may have been afraid that she would abandon her, as Cindy’s internal working model of parental care suggests that. Cindy may therefore have been maximizing her attachment behaviour in the form of clinginess. As ambivalently attached children tend to maximize their attachment behaviour in order to regain
proximity to their caregiver, Cindy may have been trying to gain proximity to Mandy in the only manner she knew how to, by clingy behaviour.

Cindy’s fear of men was regarded as a specific fear, as it was only men that she was afraid of. This was interpreted to be as a result of the sexual abuse she experienced. Cindy also had other fears which materialized in her dreams, such as dreams involving death and the bogeyman. As mentioned earlier, the bogeyman continually tried to harm Cindy and she feared for her safety. The specific fear of dying may be as a result of Cindy’s many experiences of death in her eight years, including both her parents, her sister and her teacher. Cindy’s fear of death was also interpreted as an expression of her concerns regarding her own mortality due to her HIV status.

Dissociation is an emotional effect of prolonged trauma. The child may suppress her thoughts and feelings by denying that the abuse is occurring and in essence, blocks it from her mind. A common indication of dissociation is a ‘frozen’ or ‘institutional’ facial expression (Lewis, 1999). Mandy reported that when she started fostering Cindy over the weekends, Cindy had an ‘institutionalized’ face, devoid of any facial expression. Over the course of time, once Cindy became accustomed to Mandy, this became less noticeable.

The present researcher interpreted Cindy’s dissociative symptoms as a coping mechanism. As Cindy was so young when her many traumas occurred in addition to not having a caring relationship with her biological parents, Cindy never was given the opportunity to process the traumatic events. The present researcher is of the opinion that Cindy built up a ‘protective wall’ as not to experience her feelings, therefore leading to dissociation.
Due to Cindy’s insecure attachment style, Theraplay was selected as the therapeutic approach of choice as research conducted internationally found this treatment method increased attachment between primary caregiver and child. Theraplay was combined with non-directive play therapy in order for Cindy to guide the therapist to the issues that were most pertinent to her and therefore to work through these issues. Cindy’s therapeutic intervention is discussed in the following section.

**Therapeutic Intervention**

The therapeutic approach utilized was Theraplay. A total of 16 therapy sessions were held. For 12 of the total 16 therapy sessions, a combination of Theraplay as well as non-directive play therapy was employed. The therapist felt that in order to work through to the crux of Cindy’s needs, Cindy needed to guide the therapist as to what was most troubling for her. In order for this to occur, Cindy was given the opportunity to ‘play out’ her needs in non-directive play therapy.

The six treatment phases Cindy encountered during her therapeutic journey, as laid out by Jernberg (1979), are discussed in detail below.

*Introduction Phase*

During the introduction phase of the treatment phases, the therapist introduces herself to the client (Jernberg, 1979). Axline (1989) emphasizes the importance of the first meeting between the therapist and child and encourages that the therapist places their full attention on the child. Structuring is extremely important and involves the building of the relationship between the therapist and child (Axline, 1989). Upon first meeting Cindy, the therapist introduced herself and led Cindy to the playroom.
**Exploration Phase**

The exploration phase entails the therapist and client actively getting to know each other. Jernberg (1979) points out that the child may have a variety of responses to this stage, the child may love the attention she is receiving or may conversely have a negative response. Jernberg (1979) advises that if a negative response is experienced, it should be turned around to show a more lovable side of the child, which is discussed in more detail in Chapter Three. At the end of the exploration stage the child has an understanding and awareness of the therapist as a person, with the therapist becoming a familiar figure in the child’s life (Jernberg, 1979; Munns, 2000).

Cindy’s exploration phase lasted for the first two sessions. During these sessions the therapist and Cindy got to know each other through Nurturing activities. Nurturing activities were introduced as, through these activities, the therapist conveyed to Cindy that she is wanted and valued. Nurturing activities further encourage a feeling of security for the child. The oven activity was introduced and whilst Cindy was in the oven, Cindy and the therapist got to know each other more intimately. Cindy at first was a little surprised by the amount of attention she received but soon enjoyed and thrived on all the attention and affection she received.

Intrusion/Engagement was utilised in the first session as these types of activities mirror the playful side of the parent-child relationship. Structuring activities have a clear beginning, middle and end, which sets boundaries in the therapeutic relationship thereby increasing the child’s feeling of security. By combining Intrusion/Engagement and Structuring into one activity, such as greeting body parts, the therapist actively engaged Cindy and together they got to know each other, whilst the therapist
simultaneously set boundaries in a playful manner thereby fostering a sense of security for Cindy.

**Tentative Acceptance Phase**

The tentative acceptance phase is characterized by the child participating in activities but the participation is a superficial, rather than, genuine involvement. The underlying tone of the child’s involvement is apprehension (Jernberg, 1979; Perry & Gerretsen, 2002). By doing this, the child tries to keep the therapist at bay and out of ‘her world’. The apprehension on the part of the child may manifest in the child pretending to partake in activities.

Cindy never entered this phase. Cindy, in the beginning, seemed hesitant and passive during some of the new games that were introduced. The therapist noticed that this was due to Cindy at first not knowing what the game entailed but once she grasped the concept of the game she joined in and participated fully.

**Negative Reaction Phase**

This phase entails the child displaying clear resistance to any form of intimacy or affection from the therapist and resists participation in activities (Jernberg, 1979). Cindy entered this stage during session three where, during the oven activity, Cindy resisted being eaten.

Cindy resisted affection from the therapist by resisting participation in a Nurturing activity, which they called the oven activity. The oven activity entailed making a ‘Cindy cookie’ by adding imaginary ingredients. The cookie would then be ‘baked’, which involved Cindy sitting in the therapist’s lap. The Cindy cookie would then be ‘eaten’ by the therapist, which entailed the therapist using an imaginary cookie cutter and ‘cutting’
parts of the Cindy cookie which she would then pretend to eat. Cindy expressed her resistance as being ticklish, which she had not displayed in the previous two sessions; in fact she enjoyed being eaten and the affection she received from the therapist.

Axline (1989) points out that the child’s perception of reality needs to be understood if the child’s behaviours are to be understood, Cindy’s resistant behaviour could therefore be an indication, based on her perception of reality that she may be unworthy of affection due to her previous history of maltreatment and neglect.

Growing and Trusting Phase

During this stage a partnership between the therapist and child develops. There is genuine enjoyment of the activities and the child begins to participate in a satisfying relationship with the therapist (Booth & Koller, 1998).

The therapist and Cindy entered this stage during the fourth session and it continued through to the fourteenth session. Cindy and the therapist enjoyed each other’s company and once Cindy realised that the therapist accepted her as she is, the trust in the relationship increased. Cindy slowly started allowing the therapist to enter her world and once she understood that she was not being judged, she opened up to the therapist and accepted and gave affection more freely. One specific instance of where Cindy let the therapist see the world through her eyes involved a life sized drawing in session eleven. An outline of Cindy was drawn and the therapist and Cindy coloured in the outline and added in characteristics such as eyes and hair. The therapist noticed that Cindy’s drawing was different to her true identity; in the drawing Cindy had blond hair and blue eyes, with beautiful long fingernails, the ‘real’ Cindy in contrast had dark hair and dark eyes, with fingernails bitten to the quick. This could be interpreted as who
Cindy wanted to be, an image that she had of being beautiful with long fingernails. Once Cindy felt secure enough to be herself, she had the opportunity to learn more about herself. Cindy’s trust in the therapist was clearly demonstrated when she began telling the therapist about her recurring nightmares, which were very frightening for her, which she wouldn’t tell her mother about.

**Termination Phase**

The termination phase of therapy consists of three sub-phases; preparation, announcement and parting. During the preparation sub-phase the therapist starts preparing the child for the eventual end of the therapy, whilst during the announcement sub-phase the therapist starts counting down the remaining sessions with the child. The final sub-phase, parting, involves the final therapy session where the therapy sessions come to an end.

The therapist started preparing Cindy for termination from session thirteen. This was done in such a manner that the eventual parting would be exciting for Cindy. At the end of each of the three remaining sessions, Cindy was reminded that therapy would be ending soon. The final session, session sixteen, was a special session where Cindy was allowed to choose which activities she wanted to play. Towards the end of the session Cindy was once again reminded that this was the final session, with the session ending off on a positive note, with a feeling of acceptance and companionship.

Throughout the 16 therapy sessions many themes emerged during Cindy’s play. The most prominent themes included play revolving around family settings, themes revolving around danger and safety as well as themes revolving around her need for love and affection. These themes were then incorporated by the researcher into two main needs,
Cindy’s need for nurturance and affection and her need for power, control and safety, which are discussed below.

**Identified Needs**

Whilst the therapist was working Cindy two major themes became evident, namely that of Cindy’s need for nurturance and affection as well as her need for safety, control and power.

*Nurturance and Affection*

Cindy’s need for nurturance was repeatedly displayed during her therapy sessions, where she continually regressed, in almost all of the 16 sessions, to an infant of approximately 2 to 3 years of age. She regressed in tone of voice, where her voice became ‘smaller’ and higher pitched and Cindy also displayed baby-like laughter. Her regression also included learning how to walk and talk and drinking from a bottle. The need for nurturance and affection was accommodated in therapy through Nurturing activities based on the Theraplay approach. Through Nurturing activities the child learns to feel valued, loved and secure. Nurturing activities incorporate touch and are generally very soothing activities (Munns, 2000).

The Nurturing activity that Cindy enjoyed the most was that of the ‘oven’ where she and the therapist together would make ‘cookies’. Cindy was the ‘cookie’ and various ingredients were added to the ‘cookie’ such as body parts, as well as imaginary ingredients such as flour, milk and sugar. This activity involved a great amount of touch, where the therapist would touch the parts of Cindy’s body that were added to the
mixture. The ‘cookie’ would then be placed in the ‘oven’ where Cindy would then curl up in the therapist’s lap and together they would sing songs or talk.

In this activity Cindy was given the opportunity to regress and be cared for as an infant would be cared for by the mother, which is critical for the development of a secure attachment. Regression allows a child to access deep, genuine and intense emotions associated with certain events and people who created those events. By the therapist allowing the child to regress it enables the child to express feelings and needs and resolve those conflicts (Levy & Orlans, 1998). By the therapist allowing Cindy to experience the need for regression combined in a Nurturing activity it allowed for Cindy to relive her infant need for love, nurturance and comfort, whilst simultaneously giving Cindy the opportunity to experience these needs in a safe environment.

As Cindy clearly displayed a need for nurturance and affection, another activity involving a boat in a storm was introduced. Cindy would sit in the therapist’s lap and together they would pretend they were sailing a boat. At times it would be calm and at other times it would be rough and stormy. This activity included Nurturance as well as Challenge which involved a great amount of touch as the therapist needed to ‘protect’ Cindy during the storm as well as challenge Cindy as she needed to stay on the boat.

Cindy’s fascination with breasts was interpreted as a further expression for comfort and nurturance. A common voice from Kleinian thinking lends its voice to Theraplay regarding Cindy’s fascination with breasts. In Kleinian terms, objects can include individuals, such as the child’s mother and father, or things such as objects that the child may attach to. These objects and the relationship the child develops with them are combined with the self to form an internal object (St. Claire, 2000). Cindy’s internal
objects can be viewed as attributions from all her caregivers, good and negligent as well as aspects of herself.

The child’s experiences with external objects, such as the mother’s breasts, form the inner world of the child. The child experiences feelings of hostility, frustration and love relating to the breasts which is the external object. These feelings influence and modify the internal object relating to the child (St. Claire & Wigren, 2004). As Cindy experienced more negative, painful experiences rather than good experiences, her internal objects were continually modified in order to cope with the many negative experiences.

Klein believed that infants utilized introjections and projection to control their needs and fears. Through introjections an external object is taken in and internalized, thereby the child can introject external sources of frustration (St. Claire, 2000), which in Cindy’s case included deprivation and danger. The child may utilize a defense mechanism termed splitting to make herself feel safe. This defense mechanism involves the child splitting self and objects into good and bad, thereby keeping them separate as the child cannot comprehend that an object can be both good and bad. The child splits the object, which at this point in the child’s life is the mother’s breast, into good breast and bad breast. Projection involves the child turning her own feelings on to an external object, the good breast. The good breast then becomes the model of what is felt to be good and pleasurable (St. Claire, 2000).

Cindy’s fascination with breasts could be related to the desire to introject the good breast. Through ‘baby games’ Cindy was allowed the opportunity to regress, where the good experiences, such as nurturance and affection, could be introjected by Cindy. A
significant example of Cindy’s introjections took place during session ten, where the therapist and Cindy together made ice cream breasts. Cindy refused to eat the raisin nipples, with her reasoning being that when she ate bad things, she became bad. Later during the game, the nipples were substituted with other objects such as her mother, Mandy. Cindy didn’t want to ‘eat’ her mother. After the therapist reassured her that her mother was good, Cindy was willing to eat her mother and said “When mom’s inside me I can protect her.”

Cindy’s breast fascination was accommodated in therapeutic activities, where many forms of breasts were made from different materials such as doughnuts, balloons, clay and cookies. The breast activities lasted for four sessions, which seemed to have satisfied Cindy’s fascination with breasts.

A theme that emerged through Cindy’s non-directive play therapy part of the session revolved around family. Through her play she continually chose a zebra and horse family that hunted together. Cindy throughout the therapy sessions chose a zebra toy to portray herself, a zebra-boy to portray her brother, whilst selecting a horse to portray her mother. The researcher found the selection of these toys significant as a zebra symbolically represents something that is unique but also limited in power. The horse in contrast symbolizes power, beauty and is a supportive figure. The selection of these toys could further be seen as Cindy’s way of differentiating herself and her brother from her mother as Cindy’s ethnicity is black, whilst Mandy’s is white. The symbolism of these figures could further be interpreted in that Cindy views herself as unique yet lacking in power, whilst Mandy, as seen through Cindy’s eyes, is the powerful, supportive figure that protects her. The family theme was interpreted as a need for
nurturance and affection as well as a need for power, control and safety. The second need of power, control and safety is discussed below.

**Safety, Control and Power**

The second theme that emerged during therapy was that of the need for safety, power and control. During the 12 combination therapy sessions, through non-directive play, Cindy constantly played out various scenes with toy animals. The animals were usually a girl-zebra with a horse-mother and occasionally a zebra-brother. One theme that was continually reenacted involved the animal family hunting to provide food for the girl-zebra. This was interpreted as Cindy’s expression of insecurity and feelings of being unsafe. Similarly, in session four the girl-zebra, sometimes with the help of the zebra-brother, continually fed and ‘saved’ the horse-mother. This was similar to the scene in session two with the exception that the girl-zebra had more power and abilities. This was interpreted by the present researcher as an increased sense of control over the world that Cindy experiences through play therapy.

Cindy’s nightmares involving the bogeyman trying to kill her was also interpreted as a need for safety. Once Cindy was taught to ‘roar in her head’, she felt that she had gained strength and power and could scare the bogeyman away, which she successfully did.

Theraplay activities involving Challenge were incorporated into the therapy sessions to accommodate Cindy’s need for control. Challenging activities allow the child to master new skills and help to increase the child’s self-confidence, whilst simultaneously allowing the child to release tension and anger in a safe environment (Jernberg, 1979). Activities such as thumb wrestling and leg wrestling were introduced which addressed
Cindy’s need for control as she could choose which activity she wanted to play, whilst simultaneously allowing Cindy to release tension in a safe, controlled environment.

In the following section attachment in relation to developmental psychopathology is explored.

**Attachment and Developmental Psychopathology**

Research has shown that an insecure attachment in childhood does not necessarily cause pathology in adulthood but rather lays the foundation for disturbances in developmental processes which can lead to psychopathology (Sroufe, Carlson, Levy, & Egeland, 1999).

In terms of a childhood ambivalent attachment style, research has shown that the child grows up with faulty beliefs, and lack trust in themselves as well as in others. A strong feeling of unworthiness, intense fears of rejection coupled with a longing for social contact are common in adults who were ambivalently attached. These feelings result in the individual being constantly on alert to signs of disapproval or rejection by others and are likely to interpret and evaluate events in ways which confirm their fears (Bartholomew & Horowitz, 1991).

The present researcher is of the opinion that throughout Cindy’s therapeutic journey the beginning of a secure attachment was fostered between Cindy and her mother. This attachment will need to be nurtured and developed in order for a stable, secure attachment to form. Once a secure attachment has been formed, Cindy will be less likely, according to the attachment theory, to develop psychopathology in adulthood but will still have risk factors for pathology due to her history of insecure attachment. These risk factors such as neediness and jealousy may manifest in Cindy’s adult romantic
relationships where she could develop relationship difficulties. As poor social skills are also a risk factor, Cindy many have difficulty in relating to individuals and therefore experience difficulty forming relationships, both platonic and romantic. Trust in relationships is vitally important and as Cindy’s early experience with her parents led to Cindy’s lack of trust, Cindy would need to constantly work on her ability to trust and not expect rejection.

**Conclusion**

In this chapter the results of the study were discussed following a model devised by the researcher, incorporating Cindy’s biological parents’ caregiving style, her attachment style as well as the impact of Cindy’s trauma experienced on her attachment style. Furthermore, the therapeutic intervention, Theraplay, was discussed as well as Cindy’s needs, which emerged during the course of her therapy, were explored. Finally the connection of an insecure attachment to developmental psychopathology was explored.

In the following chapter the limitations, recommendations and conclusion of the study will be explored.
CHAPTER 7
CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

“Every end is a new beginning”

(Proverb)

Introduction

In the previous chapter an in depth discussion of Cindy’s therapeutic process was explored and contextualized utilizing attachment theory as well as Theraplay. Cindy’s identified needs, the need for nurturance and affection as well as her need for power, control and safety were explored and discussed.

In this chapter, the final chapter of the study, a summary of Cindy’s progress is presented followed by the possible limitations of the study. Finally, recommendations for future research are outlined.

Value of the Study

This study has provided a detailed account of Cindy’s therapeutic journey and allows the reader a glimpse of the world through her eyes. The value of a single sample case study should not be underestimated as it allows for the researcher to give a detailed account of an individual in a therapeutic situation and in doing so, allows the researcher to add the unique findings to the existing knowledge base.

Contextualizing Cindy’s therapeutic process within attachment theory as well as Theraplay proved to be valuable, firstly as the two are complementary in that Theraplay aims to increase attachment and secondly, it allowed the researcher to put into
perspective Cindy’s needs that arose throughout the therapeutic process. The researcher is of the opinion that Cindy’s needs were met as the therapist understood where those needs arose from, from an attachment perspective, and was able to accommodate those needs during Theraplay sessions.

**Summary of Cindy’s Progress**

Significant progress was made by Cindy during the course of her 16 therapy sessions. The elimination of her disinhibited behaviour towards strangers was achieved as Mandy reported that Cindy has not displayed this behaviour since the termination of therapy. Further, Cindy’s attention-seeking behaviour towards adults, especially Mandy, has decreased dramatically. Cindy’s destructive biting habits have also ceased. Mandy as well as Cindy’s teacher have both reported a remarkable increase in Cindy’s self-confidence.

Cindy’s future prognosis therefore is good as she has learned, throughout the therapeutic process, healthy coping skills. As Mandy continues to build a stronger attachment relationship with Cindy, the researcher is of the opinion that Cindy’s attachment style will change from an insecure-ambivalent style to a healthy, secure attachment.

**Possible Limitations of the Study related to the Case Study Approach**

In the methodology chapter, Chapter Four, the researcher noted possible methodological limitations followed by a discussion of the methodological considerations together with methods that were employed to minimize their influence in
this study. These possible limitations included aspects such as, researcher bias as well as validity and reliability criticisms. Retrospectively viewing the research process, the researcher is able to comment and provide insight into her experience of conducting the case study in terms of these preliminary methodological considerations.

**Researcher Bias**

Regarding researcher bias, no difficulty was experienced in empathizing with the subject. The researcher is of the opinion that objectivity was achieved in the study through case conceptualization and research supervision with the supervisor, co-supervisor as well as with a registered Counselling Psychologist.

**Validity and Reliability Criticisms**

The researcher is of the opinion that the required standards were strictly adhered to, as discussed in Chapter Four, and that the study is valid and reliable. One major criticism of case studies is that the findings are not generalizable to the population. A case study can be generalized to theory, as the researcher did in this study.

**Specific Limitations of this Study**

One possible limitation of the study is that not all scheduled, weekly appointments could be kept due to hospitalizations or illness as a result of Cindy's HIV status. This resulted in 'gaps' in the therapeutic process where, at the most, three weeks passed between therapy sessions. The researcher is of the opinion that this did not have an effect on the relationship between the therapist and the client but may have had an effect on the flow of the therapeutic activities.
A second possible limitation is that the researcher was not actively involved in the therapy sessions; instead an independent Registered Counselling Psychologist conducted the therapy. The researcher feels that, if she was an active co-therapist for the Theraplay activities, she may have experimented with other Theraplay activities, which may have had a meaningful impact on Cindy.

**Recommendations for Future Research**

A recommendation would be to analyze the data utilizing an object-relations perspective in conjunction with Bowlby’s attachment theory as this may afford the researcher the opportunity to more deeply explore the client’s identified needs. In the present study this was only briefly explored; in hindsight a more in-depth analysis utilizing object-relations would have been beneficial in the present study.

A further suggestion is that if the study were to be repeated, it is recommended that during the course of Theraplay, the parent(s) and sibling(s) should become involved in the therapeutic process. This would aid in strengthening relationships between the members of the family outside the therapeutic setting, as the client’s healing is based on the family’s holistic healing as a whole.

**Conclusion**

This study aimed at broadening psychotherapeutic knowledge by means of a qualitative, single sample case study. More specifically, the aim was to explore and describe the therapeutic process of an eight year old with an insecure attachment style
within the Theraplay therapeutic framework. The researcher is of the opinion that the aim of this study has been accomplished.

In conclusion, below is a poem which represents the essence of this research, written by a mother for her child.

To My Child
Just for this morning,
I'm going to smile when I see your face and laugh when I feel like crying.
Just for this morning,
I'll let you choose what you want to wear, and smile and say how perfect it is.
Just for this morning,
I'm going to step over the laundry, and pick you up and take you to the park to play.
Just for this morning,
I'll leave the dishes in the sink, and let you teach me how to put that puzzle of yours together.

Just for this afternoon,
I'll unplug the telephone and keep the computer off and sit with you in the back yard and blow bubbles.
Just for this afternoon,
I'll not yell once, not even a tiny grumble when you scream and whine for the ice cream truck and I'll buy you one if he comes by.
Just for this afternoon,
I won't worry about what you are going to be when you grow up, or second guess every decision I have made where you are concerned.
Just for this afternoon,
I'll let you help me bake cookies and won't stand over you trying to fix them.
Just for this afternoon,
We'll go to McDonald's and buy us both a Happy Meal so you can have both toys.
Just for this evening,
I'll hold you in my arms and tell you a story about how you were born and how much I love you.
Just for this evening,
I'll let you splash in the tub and not get angry.
Just for this evening,
I'll let you stay up late while we sit on the porch and count all the stars.
Just for this evening,
I'll snuggle beside you for hours and miss my favourite TV shows.
Just for this evening,
When I run my fingers through your hair as you pray, I'll simply be grateful that God has given me the greatest gift ever given.
I'll think about the mothers and fathers who are searching for their missing children, the mothers and fathers who are visiting their children's graves instead of their bedrooms, and mothers and fathers who are in hospital rooms watching their children suffer senselessly, and screaming inside that they can't handle it anymore.
And when I kiss you good night,
I will hold you a little tighter, a little longer. It is then that I'll thank God for you and ask him for nothing, except one more day.
Author Unknown
REFERENCES


APPENDIX A

Diagnostic Criteria for Reactive Attachment Disorder of Infancy or Early Childhood.

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):

(1) persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent or contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)

(2) diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)

B. The disturbance in criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

(1) persistent disregard of the child’s basic emotional needs for comfort, stimulation and affection

(2) persistent disregard of the child’s basic physical needs
(3) repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)

D. There is a presumption that the care in Criterion C is responsible for the disturbed behaviour in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type:

**Inhibited Type:** if Criterion A1 predominates in the clinical presentation

**Disinhibited Type:** if Criterion A2 predominates in the clinical presentation
APPENDIX B

Roger’s 19 propositions underlying his theory which are fundamental to his approach. These propositions are listed in Meyer, Moore, & Viljoen (1997, p.464).

1. All individuals exist in a continuously changing world of experience of which they are the centre.
2. The organism reacts to the field as it is experienced and perceived.
3. The organism reacts as an organized 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, striving to actualize, 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 introjected 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) symbolized, (b) ignored because there is no perceived relationship to the self structure, or (c) denied symbolization or given a distorted symbolization 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 been symbolized. 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 symbolized and organized 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 organization 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 organized 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 the 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 symbolized – with a continuing organismic valuing process.