A CASE STUDY OF CHILD-CENTRED PLAY THERAPY WITH A CHILD SUFFERING FROM POSTTRAUMATIC STRESS DISORDER

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Declaration by the student

I, Kanyisa Nyanga, student number 207052626, for the qualification Magister Artium in Clinical Psychology, hereby declare that:

In accordance with Rule G4.6.3, this treatise is my own work and has not previously been submitted for assessment to another university or for another qualification.

Signature: **_____**

Date:_____

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Abstract

Child-centred play therapy is not the preferred treatment approach for Posttraumatic Stress Disorder (PTSD), because of the limited research demonstrating this treatment as a proper approach for childhood trauma. The purpose of this case study was to explore and describe the process of child-centred therapy with a four-year-old child with PTSD. An exploratory descriptive case study approach was utilised as it allowed for an in-depth description of a phenomenon in its therapeutic context. Data was collected through multiple sources to establish a comprehensive database. The data was analysed through Alexander's content analysis and Guba's model of trustworthiness. Findings included themes observed in the research participant dealing with PTSD of perfectionism, control, shame, mistrust, needing control, and perfectionism. The therapist's application of Axline's principles indicated these principles being enough for treating PTSD in a child. Some of those principles had immediate impact while others were cumulative in their effect.

Keywords: Autonomy; case study; child-centred play therapy; play; Posttraumatic Stress Disorder; trusting relationship

Chapter 1

Introduction and Problem Statement

1.1 Introduction

Traumatic events can have a dramatic impact on the social, psychological, and physical development of a child (Litz, 2004). According to Kaminer and Eagle (2010), research has indicated increasing numbers of children who experience trauma. They state that the exact numbers of children exposed to trauma due to the difficulties in assessing exposure levels, as often the trauma experienced by young, particularly pre-school age children is not reported. They further state that due to the high incidence of crime in South Africa it can be expected that the rate of children who experience trauma is high. A study was conducted in Khayelitsha, in the Cape Town area by Ensink, Robertson, Zissis and Leger (1997) using self-report measures to determine rates of exposure to violence, and used structured questionnaires to elicit symptoms and make psychiatric diagnoses in children aged six to 16 years old. They found that all the children had been exposed to indirect violence, 93% of the children had witnessed violence, 56% had experienced direct violence, and 22% met the criteria for Posttraumatic Stress Disorder (PTSD).

In early childhood, developmental tasks such as developing attachment relationships and learning to self-regulate emotions are of great significance. For example, at ages between three and six years, children learn to become autonomous and a traumatic life experience may compromise this developmental task and result in a child becoming more dependent (Kaminer & Eagle, 2010). The developmental tasks are important because they affect the child's future ability to form trusting relationships (Erikson, 1972). Trauma often compromises the ability of young children to master the tasks required for healthy development (Kaminer & Eagle, 2010).

1.2 Purpose of the Study

The purpose of this study was to explore and describe how Axline's principles of Child-Centred Therapy (CCPT) unfolded with a four-year-old male child with PTSD. This was realised by conducting a single case study of [1]Lizo, who had undergone such a therapy process.

5.1 Motivation

Play in children can be thought of as a language as it allows children to express themselves without using words. Therapy approaches that are advocated for PTSD in children, particularly in the preschool age group, are Trauma Focused Cognitive Behaviour Therapy (TF-CBT) and Parent-Child Relationship Therapies (P-CRT) (Cohen, 2008). Psycho-educating the child's parents on how to assist the child with the trauma also helps to provide effective support to the child (Kaminer & Eagle, 2010). CCPTis not the preferred approach for PTSD due to insufficient published research(Joseph, 2004). Joseph (2004) further states that "Client-centred therapists have not always valued the ideas underlying evidence-based practice and what they see as the inappropriate medicalisation of therapy" (p.111). Further, research regarding psychotherapy is limited as it often cannot be generalised to a larger population due to small sample sizes(Bratton, Ray, Edwards & Landreth, 2009). Case study research has the benefit of providing details of a case that can inform other clinicians regarding the process of CCPT with a child with PTSD. This is because the knowledge gained from case study research can be used by clinicians to apply the therapeutic method more efficiently in their own cases (VanFleet, Sywulak & Caparos, 2006).

1.4 Overview of Chapters to Follow

The treatise has been presented in the manner discussed here. In Chapter 2, the literature review regarding PTSD in children is provided. Chapter 3describes CCPT which is the therapeutic approach utilised for the study. Chapter 4 presents the research methodology used in the current research study. The clinical picture which consists of the collateral and

background information about Lizo is provided in Chapter 5. Chapter 6describesthe research findings and discusses the case in relation to the literature reviewed. Chapter 7is the final chapter of the treatise where the conclusion is covered, and limitations and recommendations emanating from the research are made.

1.5 Conclusion

This chapter has provided the purpose of and motivation for the study and the outline of the treatise chapters. The following chapter comprises a literature review of PTSD in children.

Chapter 2

Literature Review: Posttraumatic Stress Disorder in Children

2.1 Introduction

According to Litz (2004), trauma is defined as a sudden event that overpowers one's coping mechanisms and challenges one's ability to manage the reactions that result from the event. He further states that the event involves feelings of fear, panic, a possibility of physical injury or death, and emotional injury. Posttraumatic Stress Disorder (PTSD) symptoms can be summarised into the following four clusters:

1. Persistent re-experiencing of the event or stressor
2. Persistent avoidance of triggers or reminders of the event
3. Numbing of general responsiveness
4. Persistent symptoms of arousal (American Psychological Association, 2000, 2013).

In this chapter, the researcher presents a comprehensive discussion of PTSD in children, the moderating factors of PTSD in children, and the factors relating to the treatment of PTSD in children.

2.2. The Nature of Posttraumatic Stress Disorder in Children

PTSD became a psychiatric diagnosis in 1980 through recognition by the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III) (APA, 1980). In those early years there was not enough information regarding the presentation of PTSD in children and adolescents (Scheeringa, Zeanah, & Cohen, 2011). However, the recent version which is the DSM 5(2013), acknowledges that children and adolescents may develop PTSD and has features that are age-specific for PTSD in children(APA, 2013). The DSM 5 (2013) relays that PTSD develops consequent to an individual experiencing an event that threatened the individual's life or safety and that made the individual feel fear, and helplessness. Various events can cause PTSD in children, adolescents and adults and Coffeng*et al.*(2011) states two

kinds of potentially traumatising events (PTEs), type I and type II. Type I PTEs result from a single traumatic event and often lead to developing PTSD. Type II PTEs include those experiences from childhood or those that occur repeatedly and often lead to developing complex PTSD.

The DSM 5 (2013)criterion for PTSD in children is attached in appendix 1**.** The diagnostic criteria prior to the DSM 5 (2013) publication had the limitation that very young children were erroneously presented with fewer PTSD symptoms than they possessed (Scheeringa, 2008;Scheeringa, Zeanah, & Cohen, 2011). This was due to fact that eight symptoms of PTSD in the DSM IV-TR (2000) and ICD-10 (1992) required verbal articulation of the individual's experiences, and young children cannot adequately verbalise their experiences (APA, 2013; Kaduson & Schaefer,2006; WHO, 1992). A brief description of the age specific symptoms for children with PTSD that are relevant for the current research participant is provided below. Appendix 1provides a full list of the age specific symptoms for PTSD.

A child may lose an already acquired developmental skill like toilet training because of PTSD and may also have sleep difficulties, become emotionally dependant onhis or her parent, andbecome fearful (Kaduson& Schafer,2006; Sadock & Sadock, 2003). Mash and Wolfe (2005) corroborate the above facts and state that young children with PTSD may regress in development and this may be demonstrated through age inappropriate behaviour such as fear of strangers.

Kaduson and Schaefer (2006) and Hamblen (2008) state that clinical reports suggest that school-aged children may experience time skews and omen formations instead of flash backs and memory lapses. Kaduson and Schaefer (2006) describe time skews as the re-arranging of the sequence of trauma related events and the inability to recall events in the order they occurred. Hamblen (2008) adds that time skews are uncommon in adults but occur often

in children. Omen formation is described as the belief that certain things are associated with the event and the child avoids those things on the belief that trauma will be prevented from re-occurring. Kaduson and Schaefer (2006) and Sadock and Sadock (2003) add that school-aged children with PTSD display posttraumatic re-enactment of the trauma through play, drawings, or verbally. They define posttraumatic play as a literal representation of the trauma, which involves compulsively repeating the aspect of the trauma that does not relieve anxiety. In posttraumatic play, the child may for example, play excessively with shooting games after exposure to a shooting traumatic event. Posttraumatic re-enactment, is described as recreating a certain part of the traumatic event, for example; a child may carry a knife after experiencing a violent traumatic event at knife point (Sadock & Sadock,2003; Terr, 1991).Hamblen (2008) states older children of adolescent age display the same symptoms of PTSD as seen in adults. There may be a few differences in features of PTSD in adolescents and adults, such as, adolescents having the likelihood of impulsive and aggressive behavioural problems.

2.3. Causes of PTSD in Children

Children and adolescents are most vulnerable to trauma because of their youthfulness, which is associated with a lack of sophisticated coping skills and lack of social influence (Boyden & Mann, 2005). As mentioned, trauma in children can be due to various potentially traumatic events which are grouped as either type I or type II PTEs. Hamblen and Spiegal (1999) further categorise PTEs experienced by children as either natural or man-made, such as floods and violence as kidnapping, rape or murder of a child's parent, school shootings, motor vehicle accidents, severe burns, exposure to community violence, peer suicide, and sexual and physical abuse. Life threatening illnesses do not necessarily qualify as traumatic events as they have to be sudden and catastrophic to be considered as traumatic, for example, waking up during surgery (APA, 2013).

Each individual reacts to PTES differently, andit is the event and the individual's resources that determine whether PTSD develops (Mash & Wolfe, 2008). It is important to consider studies indicating how thePTEs are related to causation of PTSD in children. Saxe et al (2005) identified the PTSD causal pathway for children who suffered burns. Seven children between the ages of seven and 17 admitted to hospital for an acute burn were utilised for the study. An assessment of the PTSD symptoms was undertaken with the Child PTSD Reaction Index and the Multidimensional Anxiety Scale for Children at admission to the hospital and at three months after the burn. The findings suggested that two pathways for developing PTSD existed: 1) from the magnitude of the burn and severity of the pain after the burn, the child's severity of acute separation anxiety, and then to PTSD, and 2) from the magnitude of the burn to the child's level of acute dissociation following the burn, and then to PTSD. Both pathways accounted for about 60% of the variance in PTSD symptoms in the children.

Another study conducted by Kaplow, Dodge, Amaya-Jackson, and Saxe (2005)to identify pathways for PTSD in children who experienced sexual abuse identified three pathways to PTSD symptoms; avoidant coping, anxiety or arousal and dissociation.

The children were assessed during or immediately after disclosure of sexual abuse. Age and gender predicted avoidant coping, while life stress and age at abuse onset predicted symptoms of anxiety or arousal. These three pathways accounted for about 57% of the variance in PTSD symptoms.It is important to consider the numbers of children affected by PTSD to highlight PTSD in children significantly.

2.4. Statistics on PTSD in Children

Several researchers have demonstrated the rates of PTSD in children as described here.Studies were conducted by Giacona *et al*. (1995) and Cuffe *et al.*(1998) on the general population in the United States of America to examine rates of exposure and PTSD in children. Giacona *et al.*(1995) found that 15–43% of girls and 14–43% of boys had experienced at least

one PTE in their lifetime. Cuffe *et al* (1998) further established that those children and adolescents diagnosed with PTSD comprised about 3–15% of girls and 1–6% of boys. This indicates that not all children who experience PTEs will develop PTSD. Hamblen (2004) as cited in Kaduson and Schaefer (2006), states that children who have experienced sexual abuse have been shown to have a greater likelihood for developing PTSD compared to other PTEs. According to Childline-Kwazulu Natal (2014), it is estimated that one in four children in South Africa will experience abuse during their childhood. They further state that with children under the age of ten, there is an equal rate of abuse across both sexes. Suliman, Kaminer, Seedat and Stein (2005) conducted a study to assess PTSD in South African grade 11 adolescents from Cape Town. They utilised a self-report scale which indicated that 91% of the youth had been exposed to a traumatic event in their lives and only 38% reported symptoms severe enough to be classified as PTSD. On interviewing the participants, they found that 86% reported exposure to a traumatic event and only 19% met the criteria for PTSD. These statistics imply that not every child that experiences PTEs will develop PTSD, and it follows factors that affect developingPTSD, are discussed below.

2.5Moderating Factors for Developing PTSD in Children

Moderating factors are variables that act to increase or decrease an individuals' susceptibility to developing psychopathology, and they can cause either vulnerability or protection against developing of psychopathology (Boyden & Mann, 2005). Trauma researchers highlight the importance of individual differences in moderating factors as key determinants of whether one develops PTSD symptoms and the duration thereof (Peres, Moreira-Almeida, Nasello & Koenig, 2007)**.** Numerous variables that have been identified as moderating the development of PTSD (Kaminer & Eagle, 2008; Webb, 2007) exist. These moderating factors are grouped by Kaminer and Eagle, (2008) and Webb (2007) into individual characteristics and environmental factors; whereas La Greca, Silverman, Vernberg,

and Prinstein (1996) and the DSM 5 (APA, 2013) categorises the moderating factors according to the time they occur in relation to the PTE, such as; pre-traumatic, peri-traumatic, and posttraumatic factors. According to Brewin (2000) a number of studies identified risk factors for PTSD. His findings suggested that, peri-traumatic factors, like the nature of the trauma, and post-trauma factors, such as family support, are more predictive fordeveloping PTSD than pre-trauma factors, such as previous psychological difficulties. Below is a discussion that incorporates both approaches of viewing moderating factors.

2.5.1Pre-traumatic moderating factors

The pre-traumatic factors exist before the PTE, and comprise according to Blaustein and Kinniburgh (2010), Van der Kolk (2005) and Webb (2007) of individual factors as follows;

1. Temperament
2. Physiology
3. Intelligence
4. Self-confidence
5. Ability to form relationships and seek support
6. History of psychiatric illness

According to Van der Kolk (2005)environmental factors such as;

7. The attachment relationship
8. Socio-economic status
9. Cultural influences
10. Social support

*Individual factors.*Children's individual characteristics shape to a large extent the strategiesused to manage PTEs and to defend themselves against painful experiences (Boyden & Mann,2005; Van der Kolk, 2005).

Temperament. It can be described as the child's disposition or inherited mental strength for approaching life and coping with challenging circumstances (Mash & Wolfe, 2005). Boyden and Mann (2005) emphasise that, due to difference in temperament, the children can manage stress better whereas others may find it difficult. Temperament encompasses such things as resourcefulness, curiosity, having a life goal, and an ability to help others. Children who possess hopefulness, flexibility, and adaptability, and have a sense of control over their lives are less vulnerable than those who feel hopeless on the adverse circumstances (Punamaki, 1987).Barbarin and Richter(2001) report research with South African children showing that those who possessed the ability to adapt to and tolerated frustration were protected against the negative impact of violence. Children who have emotional problems and prior mental disorders prior to age six are more likely to have a temperament that makes them susceptible to developing PTSD (APA, 2013).

*Physiology.*According to the DSM 5(2013),factors such as female gender and younger age are said to affect the development of PTSD in adults (APA, 2013). In children, different studies do not seem to be consistent onthe relationship of gender with PTSD development (Boyden & Mann, 2005). Deykin (1999) reviewed literature on gender and PTSD and the findings indicated thatthe rate of PTSD is higher in females than males, even when there is control for rape. Some suggest that younger children have greater susceptibility to develop PTSD compared to older children (Sadock & Sadock, 2003).Other studies though, find no relationship of age to PTSD development(Hamblen, 2008).

Self-confidence.High self-confidence is a good prognostic indicator for PTSD in children (Webb, 2007). A longitudinal study on 698 children born in 1955 on the Hawaiian island of Kauai on children's susceptibility to develop PTSD consequent to experiencing PTEs, found that, those toddlers that were not susceptible to developing PTSD were responsive. These children had a sociable manner, and had advanced self-help abilities (Research, Policy, and Practice in Children's Mental Health, 2005).Boyden and Mann (2005) add that children who experience approval, acceptance, and are encouraged to master their fears are more likely to be resilient than those who experience humiliation, rejection, and failure to master their fears.

Intelligence.High intelligence is a protective factor, since lower intelligence is a vulnerability factor for PTSD (APA,2013). The study on Hawaiian children of Kauai, found that the children who were not susceptible to PTSD had higher intelligence compared to those that were vulnerable and developed PTSD. The children's intelligence was demonstrated through assessments of language and motor development in childhood (Research, Policy, and Practice in Children's Mental Health, 2005). Boyden and Mann (2005) and Roberts (2011), state that children who display low intellectual functioning are more susceptible to developing PTSD due to either poor judgement, which leads to placing themselves in risky situations, or poor problem solving skills.

Ability to self-regulate emotions.In early childhood, infants learn to regulate emotions from parental interactions, where the parent gives them attention and soothing from difficult emotions (Blaustein & Kinniburgh, 2010). As they grow older, they begin to understand that difficult emotions do not last forever, and develop skills to regulate these emotions. The ability to self soothe emotions is a good prognostic indicator for PTSD (Webb, 2007).Traumatic events may create an overwhelming situation for a child and challenge the child's emotion regulation skills, often resulting in the child either disconnecting from his or her feelings, or utilising unhelpful coping skills and withdrawing from social interactions (Blaustein & Kinniburgh, 2010).

Ability to form and trust in relationships. Webb (2007) states that the age of children also determines which factors may act as protective factors in pre-school age children when autonomy and social orientation are important tasks to be achieved. A pre-school child, who has achieved a sense of self-worth and can seek support in an age-appropriate manner, is more protected against developing PTSD (Blaustein & Kinniburgh, 2010). Supportive relationships play an important part in mediating against PTSD (APA, 2013; Sadock & Sadock, 2003). A child needs to have such relationships to cope with challenging situations. Boyden and Mann (2005) add that children with the ability to form peer relationships can access support outside their own family, where they can be nurtured and encouraged. Peer relationships in children provide a sense of competence and esteem and act as protective factors against adversity.

Environmental factors.Environmental factors include availability of needed resources, a support system, type of attachment with the caregiver, parent's reaction to the trauma, cumulative stress, the nature of the trauma, and socio-economic status (Kaduson & Schaefer 2006; Litz, 2004; Webb.2007).

The attachment relationship.TheAPA (2013),Boyden and Mann (2007),and Sadock and Sadock (2003) identified that the relationship between a parent and child is influential in

determining how a child deals with trauma. They state that a secure attachment or relationship with a parental figure serves as a protective factor and is protective against developing PTSD. However, a poor relationship between the child and a central parental figure increases the vulnerability to PTSD (Kaduson & Schaefer, 2006). Developmental psychology identifies the quality of an attachment relationship between the child and care-giver as essential for healthy development (Mann, 2001).A secure attachment relationship between a child and a care-giver provides a supportive environment for the child and assists the child to adapt from victimisation and develop effective emotion regulation and coping skills (Kaminer & Eagle, 2008; Van der Kolk, 2005).Van der Kolk (2005) identified characteristics of disorganized attachment as (1) an increased vulnerability to stressful situations, (2) an inability to self-sooth emotions resulting in greater dependence on external assistance, and (3) the child's help-seeking behaviour becomes either over-dependent or disengaged.

Socio-economic status.A high socio-economic status is associated with decreased vulnerability sincea low socio-economic status is associated with increased susceptibility for developing PTSD (Kaduson & Schaefer, 2006). Socio-economic status is also linked to cumulative stress, in that, those who live in a low socio-economic environment are likely to experience more financial stress and consequently have increased susceptibility to PTSD (Kaduson & Schaefer, 2006). A low socio-economic status is associated with exposure to extreme stress as poverty, lack of resources such as, health care, housing, and nutrition, which all act to increase vulnerability to developing PTSD (Moroz,2005). Impoverished and disempowered communities may cause children to have a sense of helplessness, pessimism, and increase their risk for developing PTSD (Pat-Horenczyk *et al.*, 2009).

***Cultural characteristics*.** Some cultures have their own meaning on occurrence of PTEs and this influences the whether PTSD results (APA, 2013). According to the DSM 5 (APA, 2013) cultures that encourage fatalistic or self-blaming coping methods are associated with increased susceptibility to PTSD. For example, in some cultures, being raped or abused as a child, creates feelings of shame for the child and his or her family (Olive,2007). Minority racial and ethnical status is normally associated with increased risk for developing PTSD (APA, 2013). According to Nqweni and Van Rooyen (2012) the impact of culture in the causation of PTSD cannot be avoided, thus, they proposed a model of incorporating cultural influences on the symptoms of PTSD. This model focused specifically on the formation and expression of intrusive memories in PTSD. They proposed a framework that incorporates culture concerning the formation of intrusive memory, whether the memory becomes pathological, and how the PTSD symptoms were expressed. The intrusive memory is formed as a result of exposure to an event deemed as not being the norm in the culture; coping strategies that are employed are influenced by culture; and the expression of symptoms, specifically avoidance, depends on the language of the culture.

Cumulative stress. Cumulative stress increases susceptibility to developing PTSD. The more stressors a child experiences, the poorer the prognosis will be for PTSD (Kaduson & Schaefer, 2006). Experiencingdifficulties such as family dysfunction, deprivation or any of the other factors already discussed, adds to stress in a child, increasing the risk of PTSD (APA, 2013). Pre-existing psychiatric conditions are reported to increase the effects of PTEs (Sadock & Sadock, 2003).

2.5.2 Peri-traumatic Factors

Peri-traumatic factors occur with the PTE or at the time of the PTE and are clustered as individual factors such as, dissociation, and perceived threat and environmental factors such asthe nature of the event (APA, 2013; Eth, 2001).

Individual factors. Whether dissociation occurs during the trauma and continues afterwards is a significant indicator of increased susceptibility to later developing PTSD (APA, 2013). Child sexual abuse is associated with dissociation and higher likelihood for developing PTSD because dissociation hinders the processing of the traumatic event and prevents the resolution of PTSD symptoms (Kaplow*et al.*, 2005). The perceived threat of the traumatic event is a mediator for the development of PTSD: the greater the perceived threat, the more likely it is that the child will develop PTSD (APA, 2013). A traumatic event perceived as uncontrollable and unpredictable and creates fear in the child increases susceptibility to developing PTSD (Olive,2007).

Environmental factors.These occur outside of the individual and are essentially the nature of the event.

Nature of the event. Man-made disasters lead to developing PTSD more often than natural disasters. In addition, human aggression, as abuse leads to more severe PTSD symptoms (Kaduson & Schaefer, 2006). Traumas that involve physical injury are more likely to result in PTSD than those that do not involve injury. The extent of emotional and physical closeness to the trauma is associated with PTSD development (Eth, 2001). This means experiencing the trauma secondarily is linked with lower susceptibility (Eth, 2001), whereas being a victim or perpetrator of a traumatic event is linked to greater likelihood of developing PTSD (Litz, 2004). A study conducted in Cape Town by Shields, Nadasen, and Pierce (2009) to distinguish the effect of direct victimisation and that of witnessing violence and its relation to trauma in children, found that direct victimisation had a stronger effect on psychological well-being compared with witnessing violence. Greater severity of the PTE is linked to increased susceptibility for PTSD (APA, 2013). Severity can be conceptualised according to chronicity or frequency, and the extent to which the PTE is perceived as a threat to life (APA, 2013; Brown,2009). This means trauma endured over a prolonged period can be expected to

lead to PTSD symptoms but that which is of a lesser duration has a lesser effect in terms of PTSD symptoms. Eth (2001) states that experiencing sexual abuse, particularly, has been demonstrated to be associated with subsequent psychiatric illness. Sexual abuse that involves physical aggression, genital penetration, or a perpetrator who is a trusted male authority figure, is associated with increased vulnerability to PTSD (APA, 2013; McLeer, Deblinger, Atkins, Foa & Ralphe, 1988). Trauma that occurs through interpersonal relationships is linked to increased susceptibility for PTSD, particularly where a caregiver is the perpetrator of the trauma (APA, 2013).

2.5.3 Posttraumatic Factors

Posttraumatic factors are those that occur after the traumatic event has occurred. They include individual factors like coping strategies and environmental factors like parental reaction, support systems, and exposure to reminders (APA, 2013; Olive, 2007; Webb, 2007). Brewin *et al.* (2000) conducted an analysis of studies in child PTSD to identify risk factors for PTSD. Their findings suggested that post-trauma factors were more predictive of PTSD than pre-trauma factors. There are both individual and environmental factors which moderate for PTSD after the PTE has occurred.

Individual factors.The child's appraisal and coping strategies to the PTE play a large part in whether or not PTSD develops (APA, 2013; Olive,2007). The presence of an acute stress disorder after experiencing trauma is linked to an increased likelihood of developing PTSD (APA, 2013).A child's response to a PTE is influenced by the type of coping skills they have been 'nurtured' to utilise by their parents in dealing with adversity (Brown,2009). Children who maintain a hopeful stance about the future are less susceptible to PTSD (Boyden & Mann, 2006). The family, parents, and community provide a template for how a child negotiates a PTE.

Environmental factor. The environmental factors occurring after PTEs are significant in determining whether a child develops PTSD. These are; parents' reaction, support system, and exposure to repeated upsetting reminders.

Parents' reaction. The more severe the parents react to the PTE, the more likely the child will develop PTSD symptoms (Kaduson & Schaefer 2006). Webb (2007) states that young children are most vulnerable to PTEs because they lack sophisticated coping skills. They require assistance from adults to buffer the stress they experience and to learn effective coping skills. Where the parents or caregivers under-estimate the child's experience with PTE there is greater likelihood that the child will not receive treatment and will develop PTSD (Webb, 2007).

*Support system.*A good support system characterised by open communication between the child and the parents about the trauma results in a better prognosis for PTSD and acts as a resilience factor. Avoiding talking about the trauma, leads to a poor prognosis in PTSD symptoms (Kaduson & Schaefer 2006; Litz, 2004). For most families impoverished, experiencing PTEs increases the risk of punitive parenting styles and lack of support for the child (Krenichyn, Saegert & Evans, 2001).

*Exposure to repeated upsetting reminders.*Experiencing repeated upsetting reminders of a PTE can increase the chances for developing PTSD and worsen Acute Stress Disorder (ASD) if it exists (APA, 2013).A child exposed to neglect, poverty, lack of health care, and parental substance abuse may be subjected to stressors that may include repeated trauma reminders (Moroz, 2005). Exposure therapy is one of the therapeutic treatments for PTSD that utilises exposure to trauma reminders that are not inherently dangerous as a therapeutic strategies to reduce unrealistic anxiety by addressing anxiety-provoking thoughts, situations, activities, and people that are erroneously been viewed as harmful (Cahill, Foa, Hembree, Marshall &

Nacash, 2006). Certain reminders may be inherently dangerous and exposure to such reminders, or activities would not be helpful to reduce the individual's PTSD symptoms (Brown,2009). Repeated reminders such as being in the same house as a perpetrator can be expected to increase vulnerability to PTSD (Brown, 2009).

For each child exposed to PTEs, environmental and individual factors interact and their interaction determines whether a child will become resilient or develop PTSD (Webb, 2007). Webb (2007) explains the interaction between the environment and individual and states thata child who lives in a supportive, stimulating or structured environment will overcome PTEs and gain self-confidence.

The DSM 5(2013)criteria for PTSD specify for dissociative symptoms, it is for this reason that the concept of dissociation is discussed.

2.6Dissociative Symptoms

Webb (2007) states dissociative symptoms may occur as a part of PTSD as flash backs. Further, he states that dissociation may be pathological or non-pathological. The innocuous symptoms may include such things as daydreaming, whereas the extreme symptoms may include dissociative identity disorder (DID). According to Steinberg (1995), dissociation occurs as five major symptoms. These he lists as amnesia, depersonalisation, derealisation, identity-confusion, and identity alteration.

Steinberg (1995) describes amnesia as memory lapses or gaps that can last from minutes to years. Depersonalisation he describes as a feeling of being detached from yourself and feeling unreal and being separated from your own body. Derealisation conversely, is a sense of being detached from the world. Identity confusion, he explains as a sense that you are fragmented from yourself. Identity alteration includes observable changes in one's identity and presentation of more than one ego state and is often associated with amnesia (APA, 2013; Steinberg, 1995). Pathological dissociation is defined as a disturbance in the integration of

identity, memory, and consciousness (APA, 2000, 2013). The DSM (2000,2013), identifies DID as characterised by the existence within a person of two or more distinctly different identities or personality states that from time to time take executive control of the person's behaviour, with accompanying amnesia (APA,2000,2013). Chronically traumatised children are likely to experience dissociation as flashbacks, amnesia, depersonalisation, and derealisation (Van der Kolk,2005). The dissociation may lead to disorientation about time and space, and difficulty in attention regulation.

Webb (2007) states that besides PTSD, there is a condition known as complex PTSD thatmay result from traumatic events.

2.7Complex Trauma

Complex PTSD is usually attributed to interpersonal trauma, which is experienced early in life and over a prolonged time (APA, 2000). Complex trauma can also occur due to single incident PTEs such as natural disasters (Van der Kolk *et al*., 2005). Van der Kolk(2005) states, children who have been traumatised over prolonged periods, if untreated, may develop difficulty in emotional self-regulation. This has a consequence of creating difficulty with self-identity by ; 1) lacking a stable sense of self, 2) poor regulation of affect and impulse control, with aggression directed at self and others, and 3) feeling insecure about the reliability and predictability of others,expressed as distrust and suspiciousness, and problems with intimacy that may cause social isolation. Herman(1992) categorises 27 symptoms of complex trauma into the following seven categories;

(1)Emotion and increased risk taking behaviours, such as suicidal ideation, and sexual activities.

(2) Attention and consciousness including amnesia, and dissociative episodes.

(3) Self-perception such as guilt, shame, minimising, feeling alone, ineffective, and feeling hopeless

(4) Perception of the perpetrator such as idealization of, or possessing intentions to hurt the perpetrator.

(5) Relationships with others, such as lack of trust, and becoming a perpetrator to others.

(6) Somatisation of the trauma through chronic pain, and conversion symptoms

(7) The beliefs previously held such as hopelessness.

The DSM 5 (2013) makes no mention of Complex PTSD but the diagnosis of PTSD makes allowance for dissociative symptoms and is inclusive of symptoms that are a closer fit to complex PTSD. A complementary diagnostic system, the ICD-10 (1992) does not make mention of dissociative symptoms for PTSD or complex PTSD.

PTSD is often found in association with other mental health problems and these will be focussed on in the next section.

2.8Psychological Conditions Comorbid with PTSD in Children

In children, psychological disorders often comorbid with PTSD include attention deficit or hyperactivity disorder (ADHD), major depressive disorder (MDD), oppositional defiant disorder (ODD), phobic disorders, and other anxiety disorders such as separation anxiety, and panic disorder (Roberts 2011). In addition, developmental and behavioural problems are found because of trauma in children (Kaplan, Pelcovitz & Labruna, 1999).Perfectionism is an effect familiar in PTSD survivors that may feel that they must get things precisely right or something terrible will happen. This leads to tasks often being unfinished, as they focus on every small detail and small tasks can become unnecessarily complex (Roberts,2011).

Children in the preschool age group, who have experienced PTEs as sexual or physical abuse, may have frequent temper tantrums and developmental milestones - such as toilet training may regress (Olive, 2007). When these abused children enter preschool, learning

problems and low self-esteem isevident in their scholastic performance. A physically abused child will often withdraw from others or may show physical aggression towards others (Olive,2007). Children who have experienced PTEs may easily become frustrated in the face of challenges (Blaustein & Kinniburgh, 2010). Blaustein and Kinniburgh (2010) state, children with PTEs have a higher risk for school disciplinary problems and dropping out.

Research has documented neurobiological changes in the brain volume following traumatic experiences (Bremner, 2003). Webb (2007) further states that these neurobiological changes can affect cognitive, behavioural and emotional functioning and the development of children. The structural, biological, and functional levels of the brain may all be affected and this can manifest as lags in receptive and expressive language, and difficulty with sustained attention and concentration (Blaustein & Kinniburgh, 2010). Blaustein and Kinniburgh (2010) further state that if these are left untreated, over time impairments in executive functioning may result in children. Impairments in children's memory concerning consolidation of experiences may also be present due to altered states of consciousness in the experiencing and re-experiencing of the trauma anddifficulties with attention inhibition (Blaustein & Kinniburgh, 2010; Moradi, Doost, & Yule, 1999).

Since the research participant in the current study developed PTSD symptoms consequent to experiencing sexual abuse, the interaction of sexual abuse and PTSD a discussion is provided below.

2.9Sexual Abuse and PTSD in Children

Krug (2002) defines sexual abuse as;

> "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work"(p. 149).

The particular type of abuse relevant for this study is indecent assault described as an unlawful and intentional act of a sexual nature involving bodily contact between two or more people (Lev-Wiesel, 2008). Indecent assault covers such acts as penetration of objects other than a penis into genital organs, molestation, and anal rape (Lev-Wiesel, 2008). A study by Van Den Bosch, Verheul, Langwland and Van Den Brink (2003) on females with Borderline Personality Disorder, found that a greater number of female borderline patients who had experienced childhood sexual abuse had experienced dissociation and posttraumatic stress symptoms more than those who experienced other forms of traumatic events. Findings by McLeer *et al.* (1988) indicated that sexually abused children have increased PTSD symptoms when the abuse has been perpetrated by a close person such as the father or stepfather, and when the abuse involved physical force. Sexually abused children can have sub-threshold symptoms of PTSD but they should still receive treatment, as the symptoms are likely to impair their functioning (King *et al.*, 2000). Saxe *et al.*(2005) state that children who experience dissociative symptoms immediately after disclosing abuse, have a greater probability for developing PTSD symptoms. They found that dissociation was the strongest predictor for developing PTSD in children. This high probability for PTSD is explained as due to the fact that dissociative experiences hinder processing of the traumatic event and prevent the resolution of PTSD symptoms (Kaplow*et al.*,2005).

Whether a child receives treatment for PTSD often depends on whether the child's teachers or parents seek professional help (Cohen, 2004). It is important to consider the factors that contribute to seeking therapeutic intervention.

2.10Factors that Affect Seeking Therapeutic Intervention for PTSD in Children

Moroz (2005) identifies the importance of secondary prevention for PTSD in children. He states that psychological screening and early identification of exposure to PTEs leads to early treatment and recovery from PTSD but screening requires specialised training of

healthcare professionals and can be costly (Moroz**,** 2005). Children receiving treatment is often affected by parental involvement, cultural beliefs, family coping strategies, and forensic factors (Cohen, 2008; Daniels &Jenkins, 2000;Roberts, 2011).

2.10.1 Parental Involvement

According to Cohen (2008), children depend on parents to seek or receive treatment for PTSD. This means the parent has to recognise that there is something wrong and relates to exposure to the PTE. Cohen (2008) states that, where the PTE is due to interpersonal abuse, children may not wish to disclose the trauma due to fear of the abuser. Children should be allowed to freely disclose their trauma and where a child is prevented from disclosing due to religious, educational, and family cover ups, the PTSD symptoms may be perpetuated (Brown,2009). Cohen (2008) also states that there may be further delays on therapeutic intervention, as the therapist needs to ensure that an independent evaluator for the abuse has evaluated the child who alleges abuse. This practice aims at avoiding a dual relationship between the therapist and the child. Parents' attentiveness to changes in behaviour such as sleep problems, irritability, avoidance of other children or certain situations, changes in school performance, and difficulties with peers is important in determining whether psychological help is sought (Hamblen,2008).

2.10.2Family coping strategies

According to Roberts (2011), families with PTSD have a poor communication that results in a lack of cohesion between the members. He states that avoidance of emotional topics is often characteristic of PTSD families. Individual and family counselling can help members to learn effective communication skills (Roberts, 2011). The families whom have previously experienced trauma are likely to avoid therapy and the child victim may not reach psychological interventions and recovery from PTSD (Weisaeth, 1998). Caregivers of children who have experienced PTEs need to possess skills of emotional tolerance, emotional

regulation, and coping for their own emotional responses to be able to seek help and to provide this to their children (Blaustein & Kinniburgh, 2010).

2.10.3 Cultural beliefs

Culture affects whether treatment will be sought and the type of treatment that will be sought (Roberts, 2011). Roberts states that, depending on the child's culture, the caregivers may feel that medicine men, priests or elders are the only suitable persons to deal with the trauma. She further states that mental health problems often present as physical problems such as stomach-aches or headaches, since mental health problems might be considered shameful in many cultures. Cultures often have their own behavioural and cognitive templates of understanding trauma symptoms and cultural syndromes of stress (APA, 2013; Nqweni &Van Rooyen, 2012) often influence these templates. Hinton and Lewis-Ferna´ndez (2010) add that PTSD is valid trans-culturally they acknowledge that there is cross-cultural variability in certain areas of symptoms expression, particularly on prevalence of somatic symptoms. Many mental health professionals may be unfamiliar with other cultural backgrounds and may unknowingly offend their clients. For example, a family may come with the client expecting to be part of the therapy but the mental health professional may ask them to leave the room (Roberts, 2011).

Cultures are often categorised as either collectivistic or individualistic. Collectivistic cultures are those in which functioning as a group is more important than the individual, while individualistic cultures value an individual's functioning over that of the group (Gelfand & Christakopoulou, 1999). A person presenting with PTSD in a collectivistic culture will be viewed with less importance as the goal is the group functioning and such things as getting along with others and maintaining social harmony are valued more than individual needs (Roberts, 2011). Consequently, these individuals are less likely to seek psychological intervention. Roberts (2011) mentions that in contrast to collectivist cultures, individualistic

cultures consider a person with PTSD as requiring assistance. In addition, the concept of PTSD identifies with the individualistic culture as it focuses on a single individual's symptoms and may be difficult to define in a collectivistic culture without considering cultural influences (Nqweni & Van Rooyen, 2012). Roberts (2011) advises the clinician working with PTSD, then, to be sensitive and aware of different cultures' view of PTSD. This, he says, can be done by looking at each culture from within and not to compare it to one's own culture. Unger (2004) agrees with Roberts' argument and mentions that many prescribed methods of protecting and intervening with children emanating from outside the child's social and cultural context are challenged for their effectiveness.

2.10.4Forensic factors

Where the clinician needs to evaluate whether abuse has occurred and whether the child is at risk, he or she needs to consider the Guidelines for Psychological Evaluations in Child Protection Matters (APA, 2013), listed in Appendix 2. Play Therapy with children whom have PTSD due to abuse needs to occur when the child is no longer experiencing the trauma; ensuring the safety of the child is the priority. Amongst other reasons, the child who is experiencing abuse needs to have his or her defence mechanisms to survive and will not be receptive to therapy (Daniels &Jenkins,2000). Moroz (2005) proposes that the first stage of treatment for every child who has experienced PTEs is determining and re-establishing their safety and this is done by firstly assessing their current living circumstances.

Assessing and diagnosing PTSD in children can be challenging as PTSD may differ in the way it presents from adults, also the process of diagnosing a child depends largely on the child's developmental stage. The factors known to affect the assessment of PTSD in children are defined below.

2.11 Factors affecting assessment and evaluation of PTSD in children

Eth (2001) mentions several factors that may affect assessment and evaluation of PTSD in children such as developmental changes, the nature of the PTE, psychosocial factors, and the assessment tools. Early and correct assessment and diagnosis of PTSD symptoms is necessary for administering a proper treatment approach that meets the needs of the child with PTSD (Newman, 2002).

2.11.1 Developmental changes

Children and adolescents are undergoing developmental changes and a therapist needs to be cognisant of the child's developmental stage when undertaking an assessment for features of PTSD (Eth, 2001). Eth (2001) further mentions that the child's developmental stage is significant, more so for young children, as their emotional development can be disrupted by PTSD. In addition, as already mentioned above, presenting PTSD symptoms in children differs slightly from adults due to developmental factors. Further, developmental factors, such as the type of attachment between a child and caregiver are influential and should be considered during assessment as it influences which type of intervention should be undertaken (Cloitre *et al.*, 2009; Van der Kolk, 2005). Assessment should include a full developmental and medical history to provide a full picture of the functioning of the child as diagnosing a child who has not developed language or verbal skills, or the cognitive ability to express him or herself can be challenging (Brown, 2009).

2.11.2Factors related to the PTEs

Eth (2001) mentions factors such as the time since the trauma occurred as significant in the assessment process. The effects of the traumatic experience, particularly if recent, can limit the evaluation process itself because of resistant and defensive behaviours. Newman (2002) identifies that disorders that are co-morbid with PTSD need to be identified as they interact with PTSD and affect the treatment required for the child. These co-morbid disorders can exert

stress on the child's adaptation systems and lead to an overwhelming of the coping strategies of the child (Cohen *et al.*,2002).These co-morbid disorders can be identified and diagnosed through a careful history taking of the individual's adjustment both prior to and after the PTE (Newman,2002). Further, PTSD has been shown to affect memory of traumatic events and this can affect validity of the assessment tools used (Bremner *et al.*, 2002). Assessment of the trauma can be done by allowing the child to express what he or she recalls to have happened, and what he or she considers to be the worst aspects of the traumatic event can also be utilised (Newman,2002).

2.11.3Psychosocial factors

These include factors such as cultural background, gender, social competence, and family support, and can influence the diagnosis, manifestation, and treatment of PTSD (APA, 2013; Brown, 2009). Families who place value on children based on their social attributes such as gender and personal attributes such as temperament, appearance, or cognitive ability are likely to treat children with certain preferences. This means those that are not preferred are not likely to receive treatment (Boyden & Mann, 2006). The parents' account of the trauma's effect on the familial structure provides a context from which the assessment and intervention should be conducted (Eth, 2001). Pynoos, Goenjian and Steinberg(1998) caution therapists that parents often underreport the level of distress experienced by their child during interviews. Children are likely to underreport the severity of the PTSD if the parents are present during assessment. This is said to be due to children not wanting to worry their parents (Newman, 2002).

2.11.4Assessmenttools

Eth (2001) mentions that literature focusing on the clinical assessment of PTSD in children and on adolescents is rather limited. Most PTSD measures were developed in the context of research and very few contain validity scales and can be challenged in forensic

settings. Low numbers of validated, published, and accessible measures specifically designed to diagnose PTSD in children and adolescents based specifically on DSM-IV-TR (2000) criteria have been a challenge in forensic settings (Hawkins & Radcliffe,2005).

Measures have been developed with validity, such as the Trauma Symptom Checklist for Children, the Child and Adolescent Psychiatric Assessment, Life Events Section and PTSD Module (CAPA-PTSD), the Clinician-Administered PTSD Scale for Children and Adolescents for DSM-IV-TR (CAPS-CA), and the Children's PTSD Inventory (CPTSDI) (Eth, 2001).

2.12Conclusion

In this chapter trauma as pertaining to children was elaborated on and issues relating to trauma and the treatment thereof were discussed. Considering this study is conducted on a play therapy with a child suffering from PTSD, in the following chapter the researcher provide an understanding of play as a mechanism by which children work through difficult emotions. The researcher providesa discussion of child centred play therapy that was the therapeutic approached utilised in this study.

Chapter 3
Play Therapy

3.1 Introduction

Play therapy allows children to express themselves and to process difficult emotions (Schaefer, 2011). In Chapter 3study seeks to discuss the nature of play as a method of therapy. Rogers' Person Centred Therapy (PCT) will be discussed as the fundamental theoretical background to Child Centred Play Therapy(CCPT). A discussion of Axline's(1947)CCPT as the therapeutic approach that was usedi n the current study will also be concluded.

3.2 Play

As evident in the name, play therapy relies on play. To contextualise play therapy the different forms of play and the functions of play as described by developmental psychologists and according to child-centred therapists, are discussed. Thereafter the two major play therapies are discussed.

3.2.1 Defining play

Play can be defined as children's natural world that allows them to learn about themselves, others, and the world (Homeyer & Morrison, 2008). McMahon (1992) further elaborates that;

> "Play is not a mindless filling of time or a rest from work. It is a spontaneous and active process in which thinking, feeling and doing can flourish since they are separated from the fear of failure or disastrous consequences"(p. 1).

With play defined, in the next session different forms of play are discussed, focusing specifically on the person centred framework. Various developmental psychologists from different theoretical frameworks have offered descriptions of different forms of play. The main focus for the current study is on describing forms of play from a child centred perspective.

3.2.2Forms of child play

Developmental psychologist such as Erikson (1972) and Parten (1933) have described different play and stages of play in children which the researcher described briefly. A children's play description according to a child centred framework (Landreth, 2002) is provided.

Erikson (1972) described play in children as occurring in three spheres that include the auto-sphere, the micro-sphere and the macro-sphere. The auto-sphere refers tothe child's play which occurs on his or her body. For an example, a child plays with the buttons of his or her jacket. In the micro-sphere, a child becomes part of a miniature toy world, and uses these toys as substitutes for real objects. The macro-sphere (conversely),is the sphere where a child plays with objects from the real world. The child goes beyond just the toys and uses objects in the environment.Parten (1933) describes five plays for two to five year old children, that included; unoccupied, solitary, onlooker, parallel, associative, and co-operative play. Unoccupied play is play where the child appears to play random and without purpose. Solitary play is characterised by the child being completely absorbed by the play and hardly notices others and is often seen in two to three year old children. Onlooker play is the type of play where a child shows interest in the play of other children without participating. Parallel play is characterised by the child mimicking other children's play without participating with them. Associative play is when the child becomes interested in playing socially with each other. Co-operative play is the characterised by a level of goal direction and may include adoption of roles.

According to Landreth (2002), a child-centred play therapist two plays observed in children are adjusted and maladjusted play. He describes adjusted play where a child is free, comfortable, uses various toys in a playroom, is comfortable to engage with the therapist, demonstrates an ability to self-regulate emotions, self-directs the play, and has little fantasy and repetitiveness. Maladjusted play he describes as being cautious as the child tends to play

with fewer materials, utilising a small area of the room, and demonstrates increased fantasy, aggression, and intense emotional display. Landreth (2002) states that children who engage in maladjusted play often have low self-esteem, depend more on the therapist, and experience anxiety during play therapy. Because play requires problem solving ability and the mastering new ideas, it can lead to a feeling of power, accomplishment, and confidence (Kaduson &Schaefer, 2006). Landreth (2002) further identifies repetitive playas repeated engagement with either the same toys or activity, or the same play theme, over a period. This repetitive symbolic play behaviour is understood to be an expression of painful past experiences (Findling, Bratton,& Henson, 2006). These repetitive activities have the purpose of attempting to make meaning from previous difficulties (Findling, Bratton, and Henson, 2006).

Children dealing with trauma may exhibit either posttraumatic play or posttraumatic re-enactment (APA, 2013; Kaduson & Schaefer 2006). Kaduson and Schaefer (2006) explain that posttraumatic and re-enactment play is symptomatic of PTSD as the child is displays ruminative re-experiencing of the traumatic event. They further distinguish posttraumatic play as not facilitating relief of anxiety associated with trauma but rather worsening it. Since, posttraumatic re-enactment involves recreating themes or aspects of the trauma and helps relieve the anxiety of trauma and is therapeutic because it elaborates the memory of the traumatic event.

3.3 The functions of play

Play serves many functions in children. The main functions include communication, development, and creativity (Kaduson & Schaefer, 2006; Landreth, 2002; VanFleet,Sywulak&Sniscak, 2010).

3.3.1 Communication

VanFleet, Sywulak and Sniscak, (2010) states play is a medium of communication as children do not have the vocabulary to express themselves fully in a verbal manner. According to Kaduson and Schaefer (2006) play allows children the space for communication without

using words and permits both conscious and unconscious content to surface. This means that the thoughts, feelings, and conflicts that a child experiences, can be revealed, often through projection onto the toys in a playroom, and the emotions associated with the trauma can be re-experienced and processed.

Webb (2007) reports that, a child does not often admit to having a problem and it is often the parent or teacher who reports complaints about a child's behaviour. In this regard, it is no surprise then, that when children are taken to therapy that they are often unwilling to discuss their problems. According to Webb (2007), play offers a non-threatening way for children to express themselves. This she states, is because in play the child can review his or her experiences symbolically plan ahead, and learn how to solve problems. In addition, role rehearsal occurs in play and a child's perspective becomes broadened to situations beyond the play. Webb (2007) further attributes to play the provision of a sense of relief from distress and hope for the future. Schaefer (2011) states that play also offers a means to release strong emotions, and creating relief from these emotions in children. The catharsis can be brought about using toys and materials.

3.3.2Development

Play may be used by children to developmentally transition from the level of concrete understanding to abstract thinking (Porter, Henandez-Reif, & Jesse, 2007) Schaefer (2006) states that in older children playing games allows them to learn rules, take turns, and be a gracious winner or loser. Children learn to focus and sustain attention by playing a game and following the rules and pacing required in a game with others. Alvarez (1992) views play in children as encouraging curiosity and development through exploration and discovery. Ginsburg (2007) and Schaefer (2006) both state that play helps in developing the child's imagination, and fine and gross motor skills, physical, cognitive, and emotional strength. Ginsburg (2007) adds that play is important for healthy brain development and that this is accomplished through engaging and interacting with the world around the child.

3.3.3Creativity

Vygotsky (2004) relays that "Creativity exists not only where it creates great historical works, but also everywhere human imagination combines, changes, and creates anything new." (p.54) Play also encourages developing creative thinking and it is creative thinking that forms the foundation of problem-solving skills and the ability of the child to consider alternative ways of play (Schaefer, 2011).Vygotsky elaborates that creativity facilitates actualisation of the child's inherent and latent abilities such as being flexible, inventive, and make a contribution towards environment. Chazan (2002) corroborates that play is a sign of creativity and encourages action and transformations and represents the child's autonomy.

Play therapy is discussed above serves to promote the functions of play and assist with expression and overcoming emotional difficulties.

3.4 Play Therapy

In this section, play therapy is defined and the two major approaches of play therapy are described, being the directive and the non-directive play therapy.

3.4.1 Defining play therapy

Play therapy can be defined as "the systemic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (www.playtherapy.com,2008).Mulherin (2001) adds that for play to be therapeutically effective, it needs to have; (1) an opportunity for diagnostic assessment, (2) establish a relationship between therapist and client, (3) defences of the client need to be removed, (4) encourage expression from the client, (5) provide an opportunity for catharsis and (6) equip the child for future life events. Winnicott (1968) said about play therapy that at times the therapist may not comprehend the child's intention for play, attempting to understand a child is more meaningful than deciphering the child's play.

3.5 Play therapy approaches

Play therapy consists of two major approaches; the non-directiveand the directive approaches to play therapy(Mcmahon, 1992; VanFleet *et al.*, 2010). The main difference in these two approaches is in the role the therapist plays during the therapy process (Andrews, 2009). These two approaches are discussed to highlight their differences and their use in treating PTSD in children.

3.5.1 The directive approach

Kirschenbaum and Henderson (1989), and Menassa (2009) state that in directive play therapy, the therapist chooses the toys, the procedure, and the goals for therapy. Menassa (2009) further statesthe directive approach of play therapy views the therapist as the creator of scenarios in the playroom, and has a goal for the therapy. The therapeutic relationship is important but is not solely responsible for therapeutic change. The use of psychological techniques to reach the goal of therapy is inherent to the directive approach.

3.5.2The non-directive approach

The non-directive play therapy approach allows the child to lead the process of therapy, the child chooses the items he or she wants to play with and the therapists takes a facilitating role (Vanfleet *et al.*, 2010). Child-centred play therapy, which is a type of non-directive play therapy that was developed by Axline(1947). She viewed the therapeutic relationship as enough in offering the conditions within which a child could psychologically grow and change without being directed (Axline, 1947). Axline (1947)further emphasised that the child's engagement within the therapeutic relationship is an important predictor of the therapeutic success. McMahon (1992) states that non-directive play therapy utilising Axline's (1947) principles of play therapy can be effective for reaching feelings that were out of awareness for the child, bringing them to consciousness to process them. In CCPT, play may be symbolic or easily understandable to the play therapist, but may, at times, also seem random and without

aim (VanFleet *et al.*, 2010).Carl Rogers' (1951)Person-centred therapy (PCT) which served as the foundation of CCPT is discussed below.

3.5 The Foundation of Child-Centred Play Therapy: Person-Centred Therapy

Carl Rogers' (1951) Person Centred Therapy (PCT) is the foundation on which child centred play therapy was built. Rogers' (1951) work included a theory of personality development and the PCT approach to therapy. For this study,a discussion of his PCT has been done as it provides a background to CCPT. According to Rogers (1957), PCT in its most basic form consists of six necessary and sufficient conditions for therapeutic change**.** Rogers (1957) formulated his necessary and sufficient conditions for therapeutic change from his experience in psychotherapy with adult clients.

3.6 The sixnecessary and sufficient conditions for therapeutic change

Rogers (1957) states, for therapy to be successful, these conditions are essential. The process of change can often commence with only these minimal conditions, and he hypothesised that it never commences without these conditions being met. It is often necessary for the contact or relationship to extend over a period before the therapeutic process is effective and the conditions can be met.

3.6.1 Two persons are in psychological contact

Rogers (1957) described this as a psychological relationship between a client and a therapist that implies that a client has sought psychotherapy from a therapist. The fact that each person makes a difference in the other's experiential field is important to this condition as the basis for psychological intervention. Rogers further stated that significant positive personality change could only happen within the context of a relationship. This first condition of therapeutic change can be seen as a foundational assumption because the following conditions depend on the existence of this condition (Goldfried & Davila, 2005).

Rogers (1957) emphasised therapeutic relationship significance for effective change and subsequent researchers and psychological approaches agreed with the importance of the

therapeutic relationship. Goldfried and Davila (2005)state that some psychologists view the therapeutic relationship and not the therapeutic techniques as being responsible for most of the change in therapy, Goldfried (2007), Watson (2007),and Norcross (2002) argue that the therapeutic relationship and the therapy techniques influence each other and cannot be effective on their own. Goldfried (2007) further states that a therapeutic relationship needs establishment before any form of therapy can progress, and both the relationship and the techniques contribute to psychological change. For example in other approaches such as Cognitive Behavioural Therapy (CBT), a client needs to have a trusting relationship with the therapist before he or she will be willing to undergo therapy and the successful implementation of techniques will also influence the therapeutic relationship. Watson (2007) argues that Rogers (1957) communicated the intricate interplay between the relationship and technique by stating that any techniques could be communicated in a manner that demonstrates acceptance of and empathy for the client.

3.6.2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious

Rogers(1957) explained that the client must have been experiencing a form of incongruence in his or her life resulting in psychological maladjustment. Rogers (1957**,** p. 241) stated that incongruence is "a discrepancy between the actual experience of the organism and the self-picture of the individual insofar as it represents that experience". The incongruence resulting from experiences that are incompatible with our self-concept becomes threatening and manifests as anxiety (Schultz and Schultz, 2009).Watson(2007)argues that Rogers' view of incongruence refers to clients who have difficulty being aware of and labelling their inner affective experience.

Rogers (1959) further added that the process of therapy was more likelyto proceed if the client was anxious and not merely vulnerable. Biermann-Ratjen (1998) explained

incongruence as a necessary defence that serves to protect the organism from the inconsistency between experience and an externally based self-concept.

3.6.3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship

Rogers (1951, p.513) defined congruence as; "the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of the self". The therapist needs to be aware of his or her own organismic experiences in relation to the client to remain congruent (Mearns & Thorne, 2000; Rogers**,** 1957). Mearns (2004) states that counsellors highly congruent and self-accepting appear to practice what they preach and their words and actions match up. Conversely, an incongruent counsellor is, essentially, not fully aware of some of his or her own reactions and this leads to inconsistencies and can lead the client to mistrusting the counsellor, and may hinder the client from experiencing the therapist's empathy. Rogers(1961) elaborated on the concept of congruence to include a communicational aspect. He stated that congruence is a matching of experience, awareness, and communication. In addition, he elaborated that communicating congruence between experience and awareness by one person facilitates the other to also communicate in a congruent manner. Mearns (2004) emphasises the importance of the therapist's congruence for clients with a pluralist conception of themselves. He states that the therapist needs to manifest the therapeutic conditions, of which congruence is one, to all parts of the self that are expressed by the client. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996)state that, based on the reflection of most therapists, therapists realise that with experience they become more themselves in their therapeutic interactions instead of being constrained to a learnt role. Further, they bring aspects of their personal life together with their professional and become more genuine with clients.

3.6.4 The therapist experiences unconditional positive regard for the client.

Rogers (1957)relayed unconditional positive regard as the therapist's experiencing a warm acceptance of each aspect of the client's experience. Unconditional positive regard

communicates acceptance of the client as he or she is and facilitates the client's growth towards self-actualisation (Mearns, 2004). Mearns and Thorne (2000) state that unconditional positive regard ensures that a client receives the utmost respect and acceptance (Goldfried, 2007) found that in a group of well-seasoned clinicians of different orientations that one of the major aspects of therapy was patience. This, they attributed to the fact that clients do not always perform what the therapist would like nor do they change at the pace the therapist would like, and the therapist needs to accept their clients as they are. Mearns (2004) distinguishes unconditional positive regard from mere liking. Unconditional positive regard he states is related to the therapist placing value on the client instead of liking what the client does. Kircheubum and Henderson (1989) add that what Rogers meant by unconditional positive regard was valuing the client completely instead of in a conditional way.

3.6.5.The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client

Rogers (1951) viewed empathy as the therapist is experiencing and communicating an accurate understanding of the client's awareness of his or her own experience. Sharf (2010) describes empathy in therapy as a way of responding to experience as the client perceives it. It is not a technique but a way of being and not a single event but a process. It involves appreciation of client's feelings by the counsellor as if the feelings were his or her own, while not getting lost in these feelings, and giving empathic responses, and walking along the client. Rogers (1951, p.243)illustrates empathy by stating it as "sensing the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it". Rogers (1975) elaborated on empathy and stated that it is a process of frequently checking with the client on the accuracy of your understanding feelings, and using his response to guide you further.

3.6.6 The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved

Rogers (1951,p. 484) stated that "the organism reacts to the field as it is experienced and received. This perceptual field is, for the individual, reality." From the above statement, clients need to perceive that the therapist has unconditional positive regard and empathic understanding for them for the therapy process to be initiated(Rogers,1951). Unconditional positive regard can be communicated to the client through the therapist's attitude of genuine caring, respect, acceptance, support and understanding(Mearns, 2004). This enables the client to be able to reduce his or her defences and rigid perceptions, and symbolise his or her experience, and subsequently change and grow towards full functioning (Rogers, 1957). Tudor and Worrall (2006) add that the client's experiencing of unconditional positive regard and empathy from the therapist is the most important of the six conditions for therapy to progress. They further state that therapy is not dependent on the skill of the therapist or techniques but on whether the client perceives the therapist to be offering unconditional positive regard and empathy. Mearns and Thorne (2000) and Sharf (2010) would agree that the above statement is congruent with the person-centred approach as commitment to the client's frame of reference is of primary importance. Rogers (1957) emphasises that each condition is enough to effect change on its own, and that all the conditions are needed for change to occur.

Roger's (1951) person-centred approach is the basis of Axline's (1947) CCPT approach, which is the focus of this study. In the 1940s, Virginia Axline began to develop non-directive play therapy, which was based on Carl Rogers' (1951) then newly emerging person-centred approach. In her first published work, she established the eight basic principles of nondirective play therapy.

3.7 Axline's Child-Centred Play Therapy

Axline (1947) described child centred therapy as an opportunity for the child to master his or her difficulties using play. She stated that the child plays out difficult emotions and anxieties and subsequently learns how to control and abandon them. CCPT is based on the central belief that children have the ability to resolve and master their own problems (Axline, 1947; Landreth, 2002)**.** Axline (1964) stated the following onCCPT;

> "The therapeutic value of this kind of psychotherapy is based upon the child experiencing himself as a capable, responsible person in a relationship that tries to communicate to him two basic truths: that no one ever really knows as much about any human being's inner world as does the individual himself; and that responsible freedom grows and develops from inside the person"(pp. 57–58).

Axline formulated the following eight principles that a child centred play therapist needs to follow during play therapy with children.

3.8 The principles of child-centred play therapy

Axline (1947) stated that if these eight principles are adhered to by the therapist and followed consistently and intelligibly they would be effective in bringing about positive change in the child.

3.8.1 Establish a warm and friendly relationship with the child

Axline (1947) stated that the therapist needs to be attuned to the child's needs and feelings and to communicate this, as this would aid in building rapport with the child. Axline (1947) added that a child who has been referred for play therapy is not likely to be engaging on initial contact. Axline (1947) provided an example of a child who may be unwilling to engage with the therapist and that the therapist needed to accept the child's feelings and accurately reflect them back to the child's to facilitate relationship building with the child. Cattanach (2013) suggests initiating rapport building with the child immediately as the therapy commences.VanFleet *et al.* (2010) explains that establishing rapport with a child requires time,

although the amount of time varies for each child. Landreth (2002) also had a similar view and stated that warm caring for another exists in a relationship with the other, involves getting to know the other, and is expected to take time. It is important for the therapist to remain consistent in his or her manner so that the child will trust the therapist(VanFleet *et al.*, 2010). Cochran, Nordling, and Cochran (2010) state that establishing rapport with a child requires the therapist to be patient with the child and allow the child time to feel comfortable in the relationship at his or her own pace.

3.8.2. Accept the child unconditionally for who he or she is.

Axline (1947) encouraged acceptance of the child's behaviour, although limits that ensure safety of the child may be required. The therapist remains non-judgemental regarding the child's play and this is demonstrated by the therapist's attitude. An attitude of acceptance may be communicated through accurate reflection of the child's behaviour at the present moment, not demonstrating impatience with the child, and maintaining a friendly relationship with the child. Moustakas (1953) stated that a child requires a relationship of acceptance from an adult to facilitate the process of emotional growth in the child. Wilson, Kendrick, and Ryan (1992) further suggest that to have unconditional acceptance of the child during play therapy, the therapist avoids providing advice to the child. Cochran, Nordling, and Cochran (2010) encourage avoiding making judgements of the child or diagnosing and evaluative feelings towards the child. Valuing the child for who he or she is and not focusing on symptoms, creates an atmosphere that encourages the child on the path to change as the child's defences are lowered.

3.8.3Create an atmosphere of permissiveness in the relationship to encourage the child's expression of feelings

According to Axline (1947) permissiveness means allowing the child to do and be all that they need to be in play. An atmosphere of permissiveness is created when the therapist is non-judgemental, genuine, non-directive in play, and accepting of the child. VanFleet *et al.*,

(2010) add that permissiveness requires the therapist to use a non-judgemental facial expression and voice tone, show interest in the child's play and behave in a nondirective manner. Landreth (2002) states that allowing a child's experiences, without evaluating them, is emotionally rewarding to the child. The therapist needs to be consistent in creating an atmosphere of permissiveness with the child. Cochran *et al.* (2010) state that maintaining an atmosphere of permissiveness allows the child to exercise decision-making on how he or she wishes to play.

In a study Carroll (2002) interviewed 14 children, aged nine to 14, to determine the value of their experience of play therapy and the relationship with their therapist. The findings indicated that, out of the 14, eight said that just being with the therapist was helpful, seven stated that they appreciated the confidentiality offered by the therapist, and two appreciated that the therapist was unlikely to get upset about their behaviour in play. These findings indicate the importance of trust and being permitted to be who they are in a therapeutic relationship with children during play therapy.

3.8.4. Recognise the feelings which the child is expressing in speech and play and reflect these back so that the child can get insight into his or her behaviour

According to Axline (1947), the therapist uses empathic and reflective listening to recognise the child's feelings. Reflecting the child's feelings entails recognising the child's feelings, and stating the recognised feelings to the child while remaining non-judgemental. The child's thoughts and feelings may be demonstrated by his or her non-verbal behaviour, voice tone, or the type of play in which the child engages (VanFleet *et al.*, 2010). Moustakas (1953) was of the opinion that listening for children's feelings is not always simple because children may express their feelings in an unclear or subtle manner, which may be difficult to comprehend. Landreth (1991) added that empathy for the child is essential for accurate reflection of the child's feelings. Empathy means that the therapist can see things from the frame of reference of the child. According to Kelly and Odenwalt (2008) providing a child with

empathic understanding validates the child's feelings and provides the child with a sense of safety in the relationship with the therapist. Robinson (2011) argues that the experience of a trusted relationship is synonymous with Bowlby's (1988) describing a secure attachment between mother and child. Children who have a secure attachment to a caregiver, can own, express, and regulate their own feelings (Schaefer, 2011).

3.8.5 Deep respect for the child's ability to solve his or her own problems when given the opportunity and that the responsibility to make changes belong to the child

The actualising tendency is the central tenant of CCPT and a child is expected to be able to direct his or her own play towards self-actualising (Axline, 1947). The child is expected to be able to solve his or her own problems if provided with an environment that support this. According to Axline (1947), deep respect given to the child allows the child to develop trust in self, self-acceptance, and self-responsibility. She elaborated that any meaningful change requires the individual to come to insight, and needs to come from within the individual. VanFleet *et al.* (2010) further explain that any type of play the child engages in is viewed as what the child needs to deal with his or her challenges and solve his or her problems. The therapist's role is to create an atmosphere conducive to the child's utility of play to become insightful and overcome about his or her challenges (Cochran *et al.*, 2010). They describe a facilitative atmosphere as one of acceptance, being empathic, and permissive towards the child.

3.8.6. No attempt to direct the child's actions or conversation during play but to allow the child to lead

In CCPT, children are allowed to play as they please and are not directed by the therapist. Axline (1947) mentioned that the therapist should avoid probing questions or suggestions as these are directive. Being non-directive means the therapist does not lead the play therapy process but allows the child to lead (VanFleet *et al.*, 2010). Schaefer (2011) relates that since no goals are set in CCPT, the focus is in relating to the child as a person

instead of achieving a goal. There is great belief in the child's innate actualising tendency and the child being able to direct and lead play. Cochran *et al.* (2011) add that attempting to lead the therapy may inhibit the child from self-expression and further lengthen the process of therapy. Landreth (2002), and Paone and Maldonado (2008) elaborate that when children are allowed to find their own way, they develop responsibility for themselves, and they learn creative methods to confront their problems.

3.8.7. Make no attempts to hurry the therapy process but recognise that the process is gradual

Axline (1947) relayed that the law of readiness is what should be followed in CCPT, which means that children will express what they are ready to express and this cannot be hurried. The play therapist should be patient with the child and allow the child's leading and allow the child to spend the duration of the therapy session the way he or she pleases (VanFleet *et al.*, 2010).Moustakas (1953) relayed that the child should not be pressured to use certain toys during play or how to use these toys. The child's meaning of play is unique to the child and the child should be allowed to use toys as he or she pleases. Axline (1947) added that during the hour of play therapy, some children take time to start play and the therapist may be tempted to become impatient with the child. Not playing immediately does not mean the child is not experiencing but that the child may be getting ready to play. Schaefer (2011) mentions that movement in CCPT starts emerging as the child experiences unconditional acceptance from the therapist and that this process cannot be hurried. Further, it is important to remember that children in CCPT are essentially learning self-direction and self-evaluation and this requires that the therapist allow them the time and independence to do so.

3.8.8. Establish only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility

Axline (1947) defined limits as boundaries relating to play therapy, which include, time, duration of the play, and rules relating to harmful behaviour in therapy. VanFleet *et al.*

(2010) states that the most necessary limits in therapy should be established during CCPT. These limits are set up to maintain safety in the playroom and help the child, who may be feeling out of control of their lives, to experience a sense of security. A lack of limits makes children feel anxious and insecure, as they do not know what to expect. Landreth (1991) added that limits should be based on clear criteria and should facilitate psychological growth. A clear statement of a limit should be given to the child at initiation of therapy and when a limit has been broken. Limits such as time, place and duration of the therapy should be provided during initial contact, sincelimits relating to behaviour in the playroom are provided when they are being broken. Limits should be communicated using Landreth's (1991) ACT model:

- A stands for acknowledging the child's feelings and ensuring that the child feels acknowledged
- C stands for communicating the limit to the child
- T stands for targeting two choices that will be appropriate to the therapist and meet the child's need

Limits that have been set accurately provide alternatives that are functional for the process of therapy (Landreth, 2003).O'Sullivan and Ryan (2009) state, that limit setting encourages children to experience a containing environment and consequently more lasting therapeutic change.

Building on the above-mentioned work of Axline (1947), Landreth (1991, 2002) formulated tenets for relating to children in a CCPT framework described below.

3.9 Tenets for Relating to Children in a Child-Centred Play Therapy Framework

Landreth (1991) identified tenets which can be followed by therapists when working with children in a child-centred frame of reference. He believed that the person of the therapist had a great influence on developing the play therapy process; as the child's ability to bring and resolve their feelings is affected by the relationship with the therapist.

3.9.1Children are not miniature adults

Landreth(1991, 2002) views children as individuals in their own right, and therapists should not respond to them as if they are miniature adults. Similar to all persons, children also have a desire to be heard, understood and valued. Boyden and Mann (2010) state that, the manner in which children deal with difficulties may be different to adults. Often children's strategies are not acknowledged in dealing with challenging. It is of great importance to acknowledge children's coping resources because they are the methods by which children's beliefs, feelings, competencies, and actions, are expressed. Axline (1947) identified play therapy is an effective method for children to express themselves and play out difficult feelings due to play being a preferred way of expression by children. Van der Kolk (2005) encourages therapists to be specifically attuned to children's coping mechanism, and not in accordance with adult standards.

3.9.2. Children are people

It is important to recognise that children have emotions and can experience deep emotional joy and pain and their feelings should not be underestimated (Landreth, 1991). Landreth (1991) further explained that children do not become people after a certain age, they are already individuals. Blausten and Kinniburgh (2010) indicate that children are persons by stating, children develop a sense of the self and the other, and the self in relation to others as they grow. They further state that the child learns through interactions, the interpersonal skills such as communication and interpretation of non-verbal expressions. Brown (2009) adds that children are affected by distress as any other person and they may develop a host of psychological problems if they do not receive treatment. For example, experiencing trauma may lead to fears and anxieties associated with the trauma.

3.9.3. Children are unique and worthy of respect

This means that the therapist values the uniqueness of children in therapy and shows respect for their unique features (Landreth, 1991). This implies that the therapist does no attempt to change the child but accepts the child as and for whom the child is. This has a closer link to principle two of Axline's principles, a child should be appreciated for who he or she is without judgement and by not judging the child, the environment that encourages change is created (Axline, 1947; Cochran *et al.*, 2010). The child is viewed not as a problem to be fixed but as an individual to be respected and understood (Landreth, 1991). Schaefer (2011) corroborates this and adds that the CCPT therapist believes not only what the child is but also what the child can become under a supportive environment.

3.9.4 Children are resilient

Landreth (1991) viewed children as having the capacity to overcome the difficult circumstances they experience in their lives. This is due to the actualising tendency, as children can overcome difficulties surrounding them and grow towards actualisation. Children are not purely a result of their home environment; due to their inner strength, they often overcome difficulties. For example, some children with alcoholic parents grow up to become independent and emotionally adjusted. Werner and Smith (2001) define a resilient child as possessing self-confidence, is goal directed, have self-control, are self-directed and maintain competence in the midst of stress. Agaibi and Wilson (2005) identify resilience because of an interaction between internal psychological such as temperament and perception of an event; and the environmental pressures such as, the type and intensity of the difficulty.

3.9.5. Children have an inherent tendency towards growth and maturity

According toLandreth (1991) this is the central tenet of CCPT that means that children possess an inner wisdom that leads them towards growth. The belief in this inherent actualising tendency is central to CCPT as proposed by Axline (1947). Cochran *et al.* (2010) elaborate on

actualising tendency and state, all individuals possess it and if provided with the correct environments they will grow in maturing ways. Children often do not grow in the correct environments and the result is blocks in their actualising. The function of CCPT is to provide the correct environment for the actualising tendency to be fully fulfilled (Rogers, 1951).Rogers(1951)stated of the actualising tendency;

> "Often it is true that the immediate reward involved in taking a few steps is in no way commensurate with the pain of falls and bumps. The child may, because of the pain, revert to crawling for a time. Yet the forward direction of growth is more powerful than the satisfaction of remaining infantile. Children will actualise themselves, in spite of the painful experiences of doing so"(p. 490).

3.9.6 Children are capable of positive self-direction

Children can deal with their world in creative ways (Landreth, 1991) and they discover their inner resources when they are treated with patience and respect by adults. Axline (1947) identified that, in therapy, where a child is allowed to lead, that allows the child to take initiative and leads to positive self-direction, because the child plays in the manner determined and needed by the child. CCPT offers children an opportunity to play in a manner, which they choose, and this allows children to explore, through play, various ways of being and how they feel about these alternatives (Cochran *et al.*, 2010). Rogers (1951) stated that, goal-directed behaviour in the child is a result of interactions with the child's reality as influenced by theactualisingtendency. Goal-directed behaviour by the infant is an attempt to satisfy the perceived needs of the actualising tendency.

3.9.7 Children's natural language is play

As previously mentioned, play in children is compared with talking in adults. It is the most preferred method of self-expression for children (Landreth, 1991). Axline (1947, p.9)states the originator of CCPT relays that; "play therapy is based upon the fact that play is the child's natural medium of self-expression". Drewes (2006) relays that play are common to children across all cultures as it transcends language and ethnicity although it may look

different in different cultures. Gill and Drewes (2005) attribute differences in how play looks to cultural norms and beliefs associated with play in each culture. These cultural influences determine such things as, whether children are allowed the freedom to explore and practice adult roles through play; and whether there is availability of play materials for creative play (Edwards, 2000).

3.9.8. Children have a right to remain silent

In interacting with a child, Landreth(1991) stated that the therapist needs to accept that a child may choose to be silent. Some children require more time, and are careful in their approach to play but this should not be mistaken for lack of movement in the therapy process. Empathic listening, which is paying close attention to the child's verbal and nonverbal behaviours is important to understanding the child (VanFleet *et al.*, 2010).As Axline (1947) stated, it is important for a CCPT therapist to demonstrate, at all times, acceptance of the child, by avoiding criticism or encouragement of certain behaviours.

3.9.9 Children will take the therapeutic experience to where they need to be

The therapist maintains faith in the child's ability to decide on the direction of therapy and remains non-directive in play (Landreth, 1991). The only structuring provided by the therapist in the play session is inviting the child into a place of acceptance where he or she can freely express feelings (VanFleet *et al.*, 2010). Schaefer (2011) states the importance of the therapist allowing the child to play in a self-determined way, and states that, offering suggestions, encouragement or solutions for the child hinders the process of self-direction and responsibility. The therapist only participates in the play provided the child asks for this.

3.9.10. Children's growth cannot be speeded up

This means the therapist recognises the developmental process which a child has to undergo and does not attempt to hurry the process but accepts where the child is developmentally (Landreth, 1991).It implies that the interaction with the child is at the child's

level without expectations of the child but accepting the child unconditionally (VanFleet *et al.*, 2010).

With the tenets for relating with children having been described, it is important that the researcher consider how play themes observed in CCPT are interpreted. Ryan and Edge (2011) state that no enough methods of classifying play themes exist for non-directive play therapy practice. This motivated them to undertake the task of classifying play themes in non-directive play therapy. VanFleet *et al.*(2010) also undertook to identify categories of play themes relevant to CCPT.

3.10Play Themes in CCPT

Play themes or play patterns are defined by Ryan and Edge (2010, p. 356) as "inferences made by play therapists about children's main emotional issues."They can be viewed or categorised in various ways, but in CCPT, VanFleet *et al.* (2010) proposed six categories of play themes; Since Ryan and Edge (2011) proposed two categories, whether the themes are individual or relational. The six categories are content, feeling, intention, psychological meaning, relationship to previous session, and relationship to life events. Ryan and Edge (2011) state that the individual themes are those that relay the child's emotional sense of self; since the relational themes express the child's feelings on relationships with others. Most themes may be seen as belonging to both the individual and relational categories, but one category may represent the theme more accurately than the other may do. It is important to bear in mind that interpretation of play themes should occur through holistic consideration of the child. The child's family and experiences should be considered (VanFleet,2010). The researcher described below both approaches of categorising themes.

3.10.1 Content

VanFleet *et al.*(2010) describe this as observing a child's overt behaviours and activities in play therapy. This level of play interpretation requires very little psychological

background as it is direct interpretation of what is observed. Landreth (2002) adds that to understand a child's inner thoughts, an observation of the child's behaviour as demonstrated in play is essential.

3.10.2Feeling

The interpretation of feeling themes refers to the child's emotional expressions during play (VanFleet *et al.*, 2010). VanFleet *et al.*(2010) add that the therapist exercises a degree of interpretation to understand the feelings expressed by the child as these emotions may not always be overtly expressed. Describing these emotions comprises reading nonverbal cues, facial expressions, and voice intonations. In interpreting emotions, Ekman (2007) adds that most primary emotions, such as happiness, sadness, excitement, disappointment, anger, jealousy to mention a few, are expressed in a similar way by all humans; Only emotions that are subtle or unusual may be difficult to identify as they differ according to culture.

3.10.3 Intention

Intention refers to the motive behind the child's chosen play technique(VanFleet *et al.*, 2010). This category of interpretation requires the therapist to make a close observation, and extensive interpretation of the child's motives behind the play activity, and often requires observation of more than one play behaviour (VanFleet *et al.*, 2010). While interpreting the intention of a child's play theme, non-directive play therapists maintain a non-deterministic manner and avoid own biases (Ryan & Edge, 2011).

3.10.4 Psychological meaning

According to VanFleet *et al.*(2010),this level of interpretation requires explanations of psychological driving forces of the observed play. These deeper level explanations of play themes are based on psychological theory that serves to explain the intra-psychic forces at work. Ryan and Edge (2011) explain that themes observed from play behaviour are indicative of underlying emotional issues that children then express spontaneously in their play therapy.

3.10.5 Relationship of the play to prior sessions

VanFleet et al.(2010) view this level of interpretation as requiring a comparison between sessions to see how one session is connected to the previous session (s). From the comparison, a play pattern becomes evident, and the therapist discerns the meaning of the child's play. This interpretation level consists of both overt and covert themes observed in therapy.

3.10.6 Relationship of the play to daily life or events

VanFleet et al. (2010) state that, this level of interpretation links the child's play to the child's real life events outside the play session. The link may be clear or it may require substantial interpretation by the therapist. The child may use metaphors in his or her play and accurate empathic reflection from the therapist may encourage further expression from the child (Schaefer,2011).

3.10.7 Individual and relational themes

Ryan and Edge (2011) view play themes in CCPT according to individual and relational themes in relation to developmental theory, specifically, according to Erikson's (1950) psycho-social developmental stages. The individual and relational themes are synonymous with the psychosocial stages of development. These stages are described below according to Ryan and Edge (2011) on spanning early childhood.

Trust versus mistrust. Ryan and Edge state that this category is indicative of the extent of children's development of attachment within intimate relationships and is mostly evident in very young children. This category on the positive end has themes of trust such as; safety or protection, nurturing, comfort, rescued, exploration, rebirth, full, satisfied, having enough, and hopefulness. On the negative end, children may portray themes of mistrust such as; distancing or rejection of relationship, chaos, relationship ambivalence, death or destruction, loss of self or others of importance, dying, emptiness, despair, never having enough.

Autonomy versus shame.Ryan and Eagle state that this category as demonstrating of the extent that children are developing a sense of self as worthwhile individuals through interactions with others and are mostly found in the two to three year old children. On the positive end, the themes indicate autonomy and they are; power, mastery, sense of completion, satisfaction. The negative end, with shame has the following themes; control or victimisation; weakness or helplessness; limit testing, aggression, over-compliance and high approval seeking, defiance, and dominance or submission.

Initiative versus guilt. This category identifies themes associated with the children's need to take age-appropriate responsibility for their actions and is mostly found between the fourth and sixth years of life. Themes associated with initiative are; goodness, helping, age appropriate risk taking, compliance with social rules. Themes associated with guilt include; harming self or others, damage to objects, noncompliance with social rules, believing they are evil, over concern for own safety.

Competence versus inferiority. This is often found in children between the seventh and eleventh years and is indicative of the extent of a sense of competence for them-selves. Themes indicative of attainment of competence include; friendship, persistence, learning, enjoying social recognition for skills and accomplishments, pleasure in own achievements, and interest in sharing with peers and adults the negative end is characterised by themes of inferiority such as; over conformity to social rules, lack of persistence at tasks, preoccupation with winning, alienation of peers and adults, inability to seek assistance, low self-esteem, approval seeking.

Because children to a large extent are dependent on parents, it is to be expected that parents have influence the success of CCPT (VanFleet *et al.*, 2010). This influence is worth a mention as the therapist also experienced its importance during the process of CCPT.

3.11 Parental Influence on CCPT

Parents may act in a manner that encourages or undermines the process of CCPT with children, often unintentionally (VanFleet *et al.*, 2010). Lack of good parenting skills may exacerbate the child's problems(Rye, 2010). VanFleet *et al.*(2010) suggests regular consultation work with the parents to help them use more effective parenting skills in the home environment. Resistance from the parents who may feel inadequate can be dealt with through sensitivity to the parents' concerns and listening empathically. Rye (2010) states that, parents influence the process of CCPT because they provide the context in which the child lives. This context includes parental emotional availability that can influence whether the child receives support while undergoing CCPT.

3.12 Conclusion

In this chapter, a thorough discussion of child-centred play therapy have been provided, being the therapeutic approach used in this study; its foundational background which is person-centred therapy, and describing how play is efficaciously used in play therapy with children. The following chapter focuses on the research methodology used in the current study.

Chapter 4
Research Methodology

4.1 Introduction

In this chapter, a discussion of the case study research design and relevant aspects associated with this approach is provide. A discussion of the research method followed in the current research, and the ethical considerations for the study is explained.

4.2 Research Design and Methodology

The research method used for this study is qualitative research, utilising a case study design. Creswell (2007) mentions that research methods may be distinguished as either qualitative or quantitative in nature and the main difference between the approaches is that the qualitative method presents data as a narration, and views phenomena in their natural settings, since the quantitative method views data numerically and presents results statistically.

4.3 Case Study Research

The assumption is often that case studies can only be qualitative in nature.This is not accurate as quantitative and mixed method case studies are present(Gerring,2007). Case study research produces the type of context dependent knowledge particularly valuable to the human sciences (Flyvbjerg, 2006). It is important that there is an attempt to define a case study, and this is provided below.

4.4 Defining a Case Study

It is challenging to define case study research that encompasses all fields and paradigms because most definitions of case studies tend not to be generic but rather fit a particular field of study or paradigm (Mills, Durepos, & Wiebe, 2010). A comprehensive definition for a case study is provided by Yin (2003) who states that it is an in-depth study of a unit to understand a phenomenon in a larger set of units. He further explains that a case study can be a representation either of the norm or an example of an extreme case or outliers. Certain

researchers regard a case study as the first stage of research as it often focuses on the exploratory aspect of research while an experimental research design is often considered more appropriate to explore causal links in research study (Baxter & Jack,2008). This is a misconception as case studies can be exploratory, descriptive, and explanatory just as any of the other research approach can be (Baxter & Jack, 2008; Yin,2003).

With the case study research defined, the focus shifts to describing the common components often found in all case study research.

4.5 Components of a case study research

Case study research according to Yin (2003) consists of the following components, also common in most research methods: they are; the research question; the propositions for the research; the unit of analysis; the conceptualisation of the link between the propositions and data; and the method of interpreting the data.

4.5.1The research question

Yin (2003) identified the type of research question asked in a study as important in determining the type of research design suitable. According to Yin (2003) five forms of research questions exists; 'how?' 'what?' 'when?' 'who?' 'why?'. Further he states that the research questions of the form 'how?' and 'why?' are most suited for case study research because these questions facilitate context dependent and in-depth investigations, offered by a case study. It was found that Yin (2003) describes research questions as consisting of a form, such as; 'why' or 'how' and a substance, which is, the content of what being investigated in the research.

4.5.2 The propositions for the research study

According to Yin (2003) propositions provide direction about what should be examined in a study and where to look for evidence. Certain studies, particularly exploratory studies, do

not have propositions but instead have research aim and criteria by which the research will be judged as successful.

4.5.3 The unit of analysis

Yin (2003) states that the unit of analysis seeks to define the case which is being investigated and can be an individual, an entity or an event which the researcher is concerned with investigating. Gillham (2000) adds that the unit of analysis does not only apply to single cases but can include multiple cases as well. Yin (2003) further states, that deciding on a unit of analysis is influenced by the research question and is essentially the substance part of the research question.

4.5.4 The conceptualisation of the link between the data and the proposition

The conceptualisation of the link consists of a method of viewing data in their relationship to the stated propositions (Yin, 2003). Yin (2003) sees the conceptualisation of the link between data and the propositions as setting the foundation for data analysis. It is unfortunately the least well developed aspect of case study research. Yin (2003) mentions the various ways of ensuring that data can be linked to propositions. He mentions pattern matching the process of identifying patterns in the data to match a predetermined pattern as one approach.

4.5.5 Method of interpreting the data

This component is influenced by the previous component, interpretation occurs according to the framework utilised for linking data to propositions. Yin (2003) states that, for example, if the pattern matching approach was used to link propositions to data, this stage would require the researcher to decide on what percentage of match indicates a true match.
Case study research has facets that are unique to the design and these are discussed below.

4.5 Fundamentals of Case Study Research

A case study encompasses the investigation of a unit to answer specific research questions by utilising a range of valid evidence (Gillham, 2000; Yin, 2003). For this reason, using multiple sources of evidence is a key characteristic of case study research, as no single source of evidence is likely to be sufficiently valid (Creswell, 2007 ;Gillham, 2000).Deciding on the case study research approach requires the researcher to carefully consider its appropriateness for the phenomenon being studied (Gillham, 2000). Yin (2003) and Gillham (2000) argue that case study is best suited for complex, context dependant, real-life phenomena. Research (where the aim is not to generalise the results to a population)is more suited to a case study approach. This does not mean the researcher ignores relevant literature but rather reviews the context in which the other research studies were conducted.

Gerring (2007) states that case study research often utilises the subjectivity of the researcher, which implies that the researcher is not neutral in the research process. Recognising that the researcher influences the research is part of doing good research.

Although case study research is not usually used for generating theory, it is important to acknowledge that it can be utilised for abduction. Abduction was formulated by Charles Peirce (1880), and is viewed as the third form of inference, besides deduction and induction, and valuable for a more thorough understanding of the processes of research inquiry. The process of abduction entails explanations of new and surprising data through pre-existing concepts and is often used when expectations or hypotheses of the research undertaken fall short in some way (Richardson & Kramer, 2006).Abduction is further explained by Mills, Eerepos, and Weber (2010)as the process of formulating theory to explain research outliers or deviant cases discovered during research which indicates that a new variable is evident and demands to be heard. Abduction is a major strength of case study research considering that quantitative

research methods may only identify deviant cases but lack clear means of actually formulating new hypotheses. Various types of case study research as discussed below.

4.6 Types of case study research

There are different types of case studies, whose names are linked to their research purpose and they are; exploratory, descriptive, and explanatory case studies and multiple case studies (Baxter & Jack, 2008; Yin 2003). Stake (1995) included two other types of case studies: intrinsic and instrumental case studies.

4.6.1 Exploratory case study

According to Yin (2003), exploratory case studies are utilised to explore real life settings where the interventions being assessed do not have clear single outcomes. Exploratory cases are sometimes the initial phase of research study in social research but are not limited to this use. Exploratory case studies are often used to explore a phenomenon that does not have enough theoretical background information and offer an opportunity to learn about a phenomenon (Stake, 1995).In the current research, exploration was used to learn how the process of CCPT unfolded in treating a four-year-old male child with PTSD.

4.6.2Descriptive case study

Descriptive cases require a descriptive theory, prior to conducting the research, to describe the phenomenon observed in the research (Yin, 2003). A descriptive case study is useful in describing a phenomenon and the real life context in which it occurs (Yin, 2003). A descriptive case study differs from an exploratory case study because a descriptive case is based on theory, since an exploratory case often has enough theoretical background about the phenomenon under study although it can generate theory (Baxter &Jack, 2008). For the purpose of this study, an exploratory-descriptive case study was chosen as a proper research design because it allowed for an in-depth account of the case in its therapeutic context.

4.6.3 Explanatory case study

This is a third type of case study according to Yin (2003). Yin (2003) states this type of study is useful in explaining an established causal link in a real life intervention in a more in-depth manner than an experiment or a survey would. It seeks to explain the link between the intervention and the observed effects.

4.6.4 Intrinsic case study

Stake (1995) explains that this case study type is utilised when the researcher has an interest in the case with the intention of improving the understanding of the case. The researcher views the case as interesting merely for its characteristics and does not choose the case for representativeness or to illustrate a phenomenon. This type of case, although it may be used for generating theory, is not chosen based on its use for generating theory but rather for its interest value(Baxter & Jack, 2008). This means that an intrinsic case study is aimed at a better understanding of the particular case and not on generalising (De Vos, Strydom, Fouche &Delport, 2005). De Vos, *et al*.(2005) further add that findings from this type of case study are available to be used by other researchers to formulate theory although the case was primarily conducted for interest.

4.6.5 Instrumental case study

According to Stake (1995), an instrumental case study is aimed at providing a deeper understanding than what is immediately obvious to the observer. It provides insight into an area and this insight can be used to refine a theory. Baxter and Jack (2008) add that the case itself is not of primary importance but its use in facilitating understanding of a concept is more significant. The case may be examined in detail for assessing its usefulness in the area of interest.

4.6.6 Multiple case studies

Multiple case studies are utilised to compare and explore differences between and within cases and are chosen for their suitability for comparison, such that a researcher can predict results across different cases (Baxter & Jack, 2008).Case study research has advantages and disadvantages linked to the approach as discussed below.

4.7 Advantages of Case Study Research

Case studies allow for in-depth exploration of a phenomenon in its natural context which can be difficult to undertake in other research (Flyvbjerg, 2006; Yin, 2003). Although case studies are criticised for lack of generalisability, they are useful in gaining knowledge about a variety of phenomena and this is of equal salience to the ability to generalise from research project (Flyvbjerg, 2006). Instead of generalising from one case to others, case studies can be generalised to theory through the process known as analytical generalisation(Richardson & Kramer 2006).

4.8 Disadvantages of Case Study Research

The main criticism of case study as research approach is that it lacks scientific rigour as it does not have specific procedures and relies on the investigator who may be erroneous in his or her findings (Yin, 2003). The lack of scientific rigour in the case study research method leads to the limitation of tending to confirm the researcher's pre-conceived ideas (Flyvbjerg, 2006). Gerring (2004) states another disadvantage as being inadequate methodological literature focusing on case study research in comparison to other research strategies. This lack of literature, he suggests, has led to the case study research strategy often being undervalued. Certain researchers argue that it is difficult to make generalisations from case studies as they cannot be replicated (Yin, 2003). Gerring (2004, 2007) states that the assumption from most research is that there is difficulty in testing theories utilising a case study research design and this often undermines the usefulness of case studies. The current case study addresses this

disadvantage of trustworthiness in case study research, by applying Guba and Lincoln (1985) model of trustworthiness. This model entails strategies to improve trustworthiness in qualitative research, such as; a) credibility (internal validity); b) transferability (external validity); c) dependability (reliability); d) confirm-ability (objectivity). This model is detailed in a separate section further below.

The following sections seek to describe the research methodology followed in the current research, starting with describing the research aim.

4.9 Research Aim

The aim of the study is to explore and describe how the process of Axline's (1947) principles of CCPT unfolded in treating a four-year-old male child with PTSD.

4.10 Defining the Current Case Study Research Question

The research question for the current case study sought to explore and describe how Axline's (1947) principles of CCPT unfolded in treating a four-year-old male child with PTSD. The researcher was focused on answering research question of the form 'how?' and substance of the research question consisted of the CCPT process with a male child with PTSD.

4.11 The Propositions of the Current Case Study

For the current study, research aim was preferred to propositions as the study was exploratory-descriptive in nature. The aim of the study as already mentioned was to explore and describe how Axline's principles of CCPT were applied and unfolded in treating a four-year-old male child with PTSD.

4.12 The unit of analysis

In the current study, the unit of analysis is the therapeutic process of Axline's CCPT that unfolded in treating a four-year-old male child suffering from PTSD.

4.13 Conceptualising the link between the data and the propositions

Yin (2003) states that this aspect is the least well developed in case study research. In the current study, a data extraction and analysis grid that consists of Axline's (1947) eight principles of CCPT was constructed by the researcher to extract the relevant data from the existing documents as process notes that recorded the therapy process of the case in question, and interviews of the research participant's mother, and the research participant's medical doctor and teacher. This allowed the researcher to link the data to the aim of the study that was to explore and describe how the process of Axline's principles of CCPT unfolded in treating a male child with PTSD.

4.14 Method of Interpreting the Data

The data collected through the grid, as mentioned above, was interpreted by exploring and describing how each of Axline's (1947) principles of CCPT unfolded during the child-centred play therapy process. This was done while attending to the reflexivity of the researcher. Denzin and Lincoln (2005) define reflexivity as a process of ensuring that the researcher explicitly examines how his or her research beliefs and emotions affect the research. It is particularly important for qualitative inquiry as it acknowledges the impact of the researcher in the creation of knowledge, particularly during qualitative data interpretation. The specific techniques for ensuring reflexivity that were followed in the current research are described in the section on ensuring trustworthiness. Data interpretation was made possible by utilizing Alexander's (1988) content analysis model of data extraction. The model approaches data through two strategies, namely, a) letting the data reveal itself, and b) asking the data questions. The process of data interpretation is described further in the section on data analysis.

Conducting research requires careful observation of ethical issues and below are the ethical issues relevant to the current study.

4.15Ethical Considerations

Research ethical considerations are available to provide standards for research conducted on humans (Mills, Durepos & Wiebe, 2010). The ethical considerations for the current research included receiving permission from the Faculty Research, Technology and Innovation Committee to conduct the study and ethical approval from the Research Ethics Committee-Human at the Nelson Mandela Metropolitan University before commencing the research. Further ethical considerations of the current study included informed consent, confidentiality and anonymity, and non-maleficence and beneficence that are discussed below.

4.15.1 Informed consent

Written informed consent ensures that the research participant has a clear understanding of what the research entails and is not coerced into participating in the research (Mills, Durepos & Wiebe, 2010). In the current study, informed consent was requested from the mother of the research participant as the participant was a minor. The informed consent information letter which described the aim of the research, the possible risks and benefits of the research, who will have access to the research, and informing the participant and the parent that they can withdraw without penalty from the study whenever they so wish was provided. The written informed consent information letter was provided to the participant's mother prior to providing the consent form, and conducting data analysis, it was provided to the mother by the researcher. This allowed the research participant's mother an opportunity to clarify any misunderstandings onthe research. A consent form was utilised to obtain written informed consent from the participant's mother. The consent form was then kept confidential and private by the researcher.

4.15.2Non-maleficence and beneficence

Creswell (2007) defines beneficence as the principle of ensuring that the research benefits the participant. Further, he describes non-maleficence as the principle of ensuring that no harm comes to the research participant. These principles are important to consider when conducting research and to be aware that harm includes physical, social, and psychological aspects (Mills, Durepos & Wiebe, 2010). The participant in the current study was protected from harm and the researcher could not foresee any harm from the study as the therapy had already been completed under supervision of a psychologist and only archival case data and interviews were used. As the process of therapy with the participant had been completed and terminated, no simultaneous dual relationship existed in accordance with the Health Professions Council of South Africa (HPCSA) requirement. The rule of the HPCSA ethical code of conduct for psychologists states that;

> "A psychologist shall refrain from entering into multiple relationships if that multiple relationship could reasonably expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her function as a psychologist or cause a risk of exploitation of or harm to the person or organisation with which the relationship exists".(p.21)

4.15.3 Confidentiality and Anonymity

The research participant's privacy was maintained through anonymity and confidentiality (Mills, Durepos & Wiebe, 2010).The identifying details of the client were excluded from the research report and a pseudonym was utilised to protect his identity. Confidentiality was maintained according to the Ethical Guidelines of the Professional Board for Psychology (Health Professions Council of South Africa, 2004). Ethical guidelines on keeping client files were adhered to by ensuring that the case content was only accessible to the researcher and the supervisor for purposes of the current research study and will be kept securely at the Psychology Clinic for a maximum duration of five years.

4.16 Participant Recruitment

The participant chosen for this case study was selected specifically for achieving the aim of the current study, which is a four-year-old male child with PTSD who had been treated through CCPT informed by Axline's (1947) principles. He was purposively chosen due to meeting the criteria for the research aim.

4.17 Procedure

Permission to conduct the current research study was obtained from the Faculty Research, Technology and Innovation Committee, and the Research Ethics Committee-Human at the Nelson Mandela Metropolitan University. As the therapy process had been completed, written informed consent was obtained from the research subject's mother to conduct the current case study as the participant is a minor. This ensured that the participant's mother had a comprehensive understanding about the research study and her rights and those of her child concerning the study. The main data source for the study consisted of relevant data extracted from the case file and will continue to be stored at the University Psychology Clinic situated in the Department of Psychology at the Nelson Mandela Metropolitan University for a maximum period of five years.

The case file consists of data as therapy process notes, medical and academic records, and interviews with the mother and a teacher to the participant. Upon receiving permission to conduct the research from the Faculty Research, Technology and Innovation Committee, and the Research Ethics Committee-Human at the Nelson Mandela Metropolitan University, further, permission to access the file was sought from the University Psychology Clinic Manager.

With the research procedure that was followed described, a discussion of the method applied for data collection follows.

4.18 Data Collection Method

The data was collected according to Yin's (2003) three principles of data collection; using multiple sources of data, creating a case study database, and maintaining a chain of evidence.

4.18.1 Using multiple sources of evidence

According to Yin (2003) the ability to utilise multiple sources of evidence is a major strength of case studies. Triangulation of sources of evidence allows the researcher to address a variety of issues such as historical, attitudinal and behavioural facets. The current case study utilised, upon termination of therapy with the client, the archived process notes, detailed data gained from the parent and the teacher, and the medical doctor who was involved with the participant during the process of his treatment.

4.18.2Create a case study database

Creating a database serves to improve reliability of the research study and to develop a form a representation of relevant data from the researcher's case study notes (Yin, 2003). The case study database for the present study consisted of the case file that contained all collected therapy process notes, interviews with the client's mother and collateral information obtained from the client's teacher and medical doctor.

4.18.3 Maintain a chain of evidence

Yin (2003) defines this as maintaining a chain of evidence means making a clear trail of the data collection process. The importance of maintaining a chain of evidence is that it enables an external reader of the case study to move from one part of the case study process to another, following the source of evidence from the research question to the conclusions (Yin, 2003). The researcher ensured that a chain of evidence was created through the systematic collection,

analysis, and interpretation of the data. The data kept in the file was ordered in chronological order.

The data that was collected through Yin's data collection principles and utilising the conceptual grid (appendix 3) for analysis and the process of analysis undertaken is described below.

4.19 Data analysis

The method of data analysis utilised in this study was Alexander's (1988) content analysis which looks at data in two ways; letting the data reveal itself, and asking the data questions. In addition, a CCPT conceptual framework grid (appendix 3) with a list of Axline's principles was constructed by the researcher and utilised as a data analysis tool. Investigator triangulation was used during the data analysis, by enlisting a psychologist in training, who has competency concerning CCPT, to check the data extracted and analysed by the researcher following the same method utilised by the researcher. Alexander's content analysis is described in the following section.

4.19.1 Letting the data reveal itself

Alexander (1988) defines the process of letting data reveal itself as sorting through the raw data and identifying the material that relates to the research aim. Sorting through the collected data accomplishes two purposes, namely, reducing the data into manageable proportions and revealing the unconscious communicational intent of the research participant. This is done by utilising nine principles of salience identified by Alexander, which are; primacy, frequency, uniqueness, negation, emphasis, omission, error, isolation, and incompletion. These are discussed below.

Primacy.Primacy is based on the principle of associating importance with what comes first and goes back to histories of folklore and customs (Alexander, 1988). The first is often seen as important in unfolding meaning of intended communication. It has been shown by Freud that primacy is critical in psychotherapy of psychoanalytical frame.

Frequency.Alexander (1988) identifies a link between frequency and importance although it is not a directly linear link. To determine whether a frequent variable is significant, it has to be examined in corroboration with other salience indicators. The general trend is that importance increases as frequency increases until a certain point and then salience plateaus, from this point a decrease in frequency increases salience again and this increase in salience can be explained by the importance one places on an entity when it becomes scarce.

Uniqueness.Alexander (1988) states that uniqueness as an indicator of importance refers to those things that are new or different. It can be observed in non-verbal behaviour or in verbal language by observing behaviour that departs from commonly held norms in language and is often identified through statements that are unusual.

*Negation.*Negation refers to the statements that are relayed by a person as denial of something (Alexander, 1988). Freud argued that negation statements in therapy are indicators of the unconscious repressed material coming to the surface. Alexander (1988) adds that negation as an identifier of salience often occurs with frequency or uniqueness indicators. Freud suggests that a statement of negation can be clarified by removing the negative or the 'not' in the statement.

Emphasis.Emphasis refers to those events or things that are given focus by a person, often statements that direct one to focus on or give little focus on a certain aspect (Alexander, 1988). This salience factor may be identified by over-emphasis, under-emphasis, or misplaced emphasis on a specific subject (Alexander, 1988).

Omission. Alexander (1988) states that this signifier refers to what is omitted from the content and is often determined by using logic. There often needs to be establishment of criteria for what the complete story is to determine what is omitted, also, the omission may refer to either emotion or fact.

Error. Errors as indicators of salience identify those things that are distortions, that are slips, and those that are factual errors (Alexander, 1988).

Isolation. Isolation as a saliency identifier refers to things that can be seen not to fit or follow the context of what is being discussed and may seem irrelevant to the context (Alexander, 1988). Alexander (1988) adds that isolation could be an indication of an important fact surfacing in association to what is being communicated or due to compulsiveness.

Incompletion. Alexander (1988) identifies incompletion as a saliency indicator that refers to those statements that have an incomplete sequence; they begin, follow a sequence, but end without closure being reached in the content of the story. Alexander (1988) adds that the incompletion may be due to distraction or may be due to the content being too difficult for the person.

4.19.2 Asking the data questions

According to Alexander (1988), the researcher extracts all relevant information from the data by systematically categorizing the information into themes. In the current study, data was asked questions derived from the CCPT principles that highlight the core themes relevant to achieving the aim of the research study**.** The questions asked in to data were;

1. Whichof Axline's (1947) eight principles of CCPT is being expressed by the data segment?
2. How did the above principle of CCPT unfold**?**

These two questions were asked to facilitate data analysis, and the constructed CCPT conceptual grid was utilised for this purpose to identify and describe the CCPT principles.

The main critique on case study research is the trustworthiness of the approach (Yin, 2003) and thus below a method of ensuring trustworthiness in qualitative case study research is discussed.

4.20 Trustworthiness of case study research

Shenton (2004) corroborates that trustworthiness of qualitative research is the main criticism by positivistic researchers. It is important to discuss ways of ensuring trustworthiness in qualitative research. Lincoln and Guba (1985) formulated four tests, parallel to the positivistic approach for ensuring trustworthiness in qualitative research and preferred the following terms; a) credibility (internal validity) ; b) transferability (external validity); c) dependability (reliability); d) confirm-ability (objectivity),described below.

4.20.1 Credibility

This criterion assesses confidence in the truth of the findings on the research subject and the context in which the study was undertaken (Lincoln & Guba, 1985). Shenton (2004)highlights the following ways of increasing credibility in qualitative research.

The adoption of well-established research methods. Shenton (2004) describes this as ensuring that qualitative research is conducted through trusted methodology. Adoption of trusted methods should be applied in all the components of the research process, beginning in data gathering sessions, to the methods of data analysis. These methods should be based on previously successfully utilised methods for a similar case study as has been done in the current case study. The data collection was conducted utilising Yin's (2003) data collection principles for a qualitative case study that include using multiple sources of data, creating a case database, and maintaining a chain of evidence. Data analysis was conducted utilising Alexander's (1988) content analysis which is a trusted data extraction and analysis method that utilises two approaches to data analysis, that is, letting the data reveal itself, and asking data questions.

The researcher familiarises him- or herself with the culture of the participant. Shenton (2004) states that to be familiar with the culture of the participant the researcher should partake

in document study regarding the particular culture, and engagement with the participant regarding his or her culture. In the current study, the researcher established a familiarity with the culture of the participant through interactions in therapy that lasted a period of seven monthsand through information provided by the mother of the participant during interviews and discussions with the researcher. It was advantageous that the researcher belonged to the same culture as the participant.

Utilising random sampling,Case selection in qualitative research is often purposive and this may lead to selection bias(Shenton, 2004). The researcher may select a case that has variables that portray the favoured hypothesis, and ignore cases that appear to contradict the hypothesis, and over generalise to the population (George & Bennett, 2004). Random sampling limits selection bias (Shenton, 2004). Bias in purposively selected case study, research can be countered by ensuring that the case study findings are generalised to the theory through the process of analytical generalisation and not to a wider population (George & Bennett, 2004). The current case study was selected purposively but to counter the effect of selection bias analytical generalisation was utilised to generalise to the theory of CCPT and not to a population.

Employing triangulation in the research. Shenton (2004) recommends that triangulation is used by using different data gathering methods, of observation and interviews, the major data collection strategies for qualitative research. The current researcher utilised triangulation during data collection. This means that multiple sources of evidence were utilised, which included process notes, collateral from the mother of the participant, the teacher, and the medical doctor of the participant. Investigator triangulation was utilised in data analysis by allowing a psychologist in training with competence in CCPT to check the data utilising the data analysis method that was utilised by the researcher.

Employing tactics to ensure that participants are authentic in their responses. Shenton (2004) highlights that researchers should ensure that the participant is informed that he or she is not obliged to participate in the research, that the participant knows no right or wrong answers in an interview exists, and establish rapport with the participant. In the current study, the participant was a play therapy client and there was no need to have concern about the participant's authenticity. Children in play therapy express their inner thoughts, feelings and difficulties, through play and can deal with them through play to gain mastery over them (Landreth, 2002). Concerning interviews with the mother, the researcher provided unconditional positive regard, and was non-judgemental on the abuse of her child and her parenting skills.

Utilising iterative questioning .During data collection, the participant may be asked a question in different phrasing to ensure truth and uncover lies (Shenton, 2004). The current study did not rely only on interviews and iterative questioning was not used on the research participant. The interviews conducted with the participants' mother were subjected to probing questions to ensure that the information provided was consistent.

Negative case analysis.This involves identifying and discussing elements of the data that do not fit the patterns or predicted explanations during the data analysis (Lietz & Zayas, 2010). Negative case analysis is done through the refining of the research hypothesis until it accommodates all the elements of the data (Shenton, 2004). The current research does not have research hypothesis as it is exploratory-descriptive in nature, this means there is no expected pattern based on a hypothesis. Relevant data was extracted and analysed according to the aim of the research, the analysis was conducted, as already mentioned, by utilising Alexander's content analysis and a CCPT conceptual grid(appendix 3).

Attending debriefing sessions. Shenton (2004) identifies debriefing sessions between the researcher and his or her supervisors as essential in expanding the vision of the researcher

through discussions with superiors or the project director. As the researcher in the current study, supervision has been received and debriefing from her research supervisor from the start to the completion of the research study and this interaction allowed for the widening of her perception regarding the research.

Engaging peers in scrutinising the research project. The researcher should allow opportunities for the research to be scrutinised by colleagues, peers, and academics and feedback should be offered to the researcher at these presentation (Shenton, 2004). The current research was presented to the psychology department proposal meeting, the Faculty Research, Technology and Innovation Committee and the Research Ethics Committee-Human at the Nelson Mandela Metropolitan University prior to commencing the study. Feedback, scrutiny and recommendations were offered and addressed by the researcher concerning the theoretical, methodological, and ethical considerations of the study.

***The researcher ensures reflexivity*.** Besides the outside scrutiny discussed above, the investigator should seek to evaluate the project again as it develops to ensure reflexivity (Shenton, 2004). Reflexivity is defined by Horsburgh (2003) as "active acknowledgement by the researcher that her or his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation" (p.308). Morrow (2005) identified the following ways to ensure reflexivity in qualitative case study research: researcher journaling, and debriefing with peers and other academics. Journaling of the research process is conducted from the inception to the completion of the research and entails identifying assumptions, beliefs, and biases of the researcher and recording the understandings that emanate from these reflections (Johnson & Waterfield, 2004; Morrow, 2005). Lietz and Zayas (2010) suggest that debriefing sessions with peers or supervisors may be conducted to provide wider and alternative views of the case. The emerging self-understandings can then be re-examined and put aside from the research or consciously incorporated into the analysis,

depending on the frame of the researcher. The researcher's rigorous engagement with the study was addressed through explicitly examining how her research agenda and assumptions, personal beliefs, and emotions affected the research (Given, 2008) as recorded in her research journal. An example of a journal entry regarding the bias was the fear by the researcher of the possibility an inclination to view the research data as the therapist, instead of an objective researcher. Through considerable reflection on this bias, the researcher came to the realisation that, the research would not merely reflect positive outcomes of therapy but that the 'failures' were also of significance. This is important in qualitative research because it acknowledges the role of the researcher in knowledge production instead of seeing a researcher as only a bystander (Camic, Rhodes, & Yardley, 2003).

Adequate qualifications and experience of the researcher. Adequtequalification of the researcher serves to improve credibility of the researcher in qualitative research as the research depends on the researcher's subjectivity (Shenton, 2004). The researcher has competency in the research phenomenon under study (CCPT), as the researcher have completed her internship in clinical psychology, where CCPT was one of the therapeutic approaches she was taught and practiced under the supervision of a qualified clinical psychologist. The research was also conducted under the supervision of a clinical psychologist with extensive experience in research and supervising research.

Implementing member checks.Shenton (2004) identifies member checking as entailing participants conducting a check of the data collected to ensure that the data are accurate. These member checks may be conducted at various points of the research that includes during the course of the research process and at the end of the data collection. The research did not depend on interviews but on observations of a therapeutic intervention, and member checking was not feasible. Regarding the information provided by the participant's mother, a summary report was provided prior to submitting the research thesis and an opportunity to check facts was offered to the mother through a feed-back session. The summary report entailed information on; the research aim; the context of the research; the information obtained from the mother, the teacher, and the medical doctor; the process of therapy; the research findings; and conclusions.

***Thorough description of the phenomenon being investigated*.** Detailed descriptions of the phenomenon under study provide the reader with the context and the situation being investigated and this adds to credibility as it allows the reader to make his or her own decision regarding the truthfulness of the findings (Shenton, 2004). Creswell and Miller (2000) add that thorough descriptions add to the readers, the experience that they have been through or could go through the event being described. The researcher in this study went to great lengths to detail the background to the phenomenon under study, the methodology followed, the case details, and the research findings. The research findings were viewed from the data extracted through Alexander's (1988)content analysis and the CCPT conceptual grid through a process of analytical generalisation.

The researcher is familiar with previous research findings. The researcher needs to be familiar with other research findings of similar investigations to assess the similarity or contradiction to past studies (Shenton, 2004). The researcher of the current study engaged in a review of the literature regarding CCPT for treating PTSD and was able to consider the current research findings in context of this literature. The literature reviewed has indicated that CCPT can be used with traumatized people as it provides an understanding of trauma, post-traumatic growth processes, and how the therapist can conduct therapy with a traumatised individual (Joseph, 2004). Joseph (2004) person-centred therapists do not often subscribe to the terminology of pathology with regards to prescribing certain treatment approaches for certain disorders such as, for example, PTSD. This, he argues, has also contributed to the marginalisation of this therapeutic approach with regard to its use for treating disorders such as PTSD.

A recent study that utilised CCPT with children who suffered from sexual abuse was Ryan and Needham's (2001) case study of CCPT with a nine year old with PTSD. The research identified various themes during play, the role of the family and therapist, and came to the conclusion that CCPT was an effective therapeutic approach for treating PTSD in children.

4.20.2 Transferability

Lincoln and Guba (1985) state that transferability assesses whether research study findings can be generalised to the larger population and that research meets this criterion when the findings fit into contexts outside the study situation as determined by the degree of similarity between the two contexts. Lincoln and Guba (1985) further elaborated that transferability is the responsibility of the individual wishing to transfer the findings to a population other than that of the original study. They argued that as long as the original researcher presents enough descriptive data to allow comparison, transferability has been addressed. In case study research transferability depends on analytical generalisation (Yin,

2003) which is a process of generalising to theory. In the current research study the aim was not to generalise to a larger population, enough description of the research context and methodology was provided for other researchers or therapists to determine whether the current findings can be applied in their own contexts.

4.20.3 Confirmability

Confirmability refers to the extent to which the findings are a result of the informants or participants and conditions of the research and not due to other biases, motivations, and perspectives (Lincoln & Guba, 1985). Creswell (2007) adds that this is a measure of the accuracy of the operationalised construct being researched. For research to be considered confirmable it must meet two conditions. The first condition is to select a specific type of change to be measured and related to the objective of the study. Secondly, it should illustrate that the measure of the change demonstrates the type of change that has been selected. Lietz and Zayas (2010) state that keeping audit trails and observer triangulation allow persons external to the research team an opportunity to evaluate or corroborate the research procedures. The strategies that the researcher used to ensure confirm-ability in the current case study include establishing a chain of evidence during data collection and utilising investigator triangulation to evaluate or corroborate the data extraction procedure followed through content analysis and the conceptual grid.

4.20.4Dependability

The criterion of dependability assesses whether research study can be replicated with findings remaining the same (Lincoln & Guba, 1985). Yin (2003) adds that dependability of a case study can be improved by ensuring that a comprehensive record or protocol of the case material is kept. In the current study a comprehensive database as a client file has been kept in order to improve dependability. Further, an audit trail of the process followed during data

extraction and analysis was kept and will be kept in safe storage for a period of five years to ensure dependability.

5.21 Conclusion

The chapter has provided a thorough discussion and description of the research design and methodology and related issues. It provided information that ensures that an external reader can be able to understand the research process followed, and the trustworthiness and ethical standpoint of the research.

Chapter 5
Clinical Picture and Presentation of the Research Participant

5.1 Introduction

This chapter focuses on the details of the research participant. Details are presented onthe case regarding; biographical information, developmental history, presenting problem, collateral information from the teacher and the medical doctor, and the therapy sessions process notes and interviews that occurred telephonically and face to face, and observations made by researcher as the therapist. It is worth noting that researcher as the therapist, conducted the intake interviews with both the grandmother, and the mother of the client.

5.2 Presenting Problem

Lizo was referred by a clinical psychologist from a public hospital to receive play therapy. The referral letter stated that Lizo had experienced sexual abuse and is experiencing encopresis. The psychologist at the hospital could not assist with play therapy due to a lack of resources at the hospital. Upon intake, Lizo's mother reported that the sexual assault had occurred two months prior to the consultation. She further reported that this trauma was inflicted by a seven-year-old boy from the neighbourhood who had inserted a plastic object into Lizo's anus. This trauma was subsequently discovered when Lizo complained of pain during defecation she told me. Initially, Lizo did not reveal the traumatic event that had occurred but with further probing by his grandmother, and the doctor, he disclosed Lizo was reported as experiencing encopresis since this traumatic event occurred. Lizo's grandmother stated that she initially took him to consult a medical doctor at the hospital for his encopresis and Lizo was subsequently referred to the hospital's clinical psychologist who then referred him to the University Psychology Clinic for play therapy. Lizo's mother reported that he was, since the event, aggressive towards other children in the neighbourhood and at school. His

teacher also confirmed that he was aggressive towards other children. Lizo's mother further reported that he recently had a poor appetite, and when he had eaten, he would have encopresis. He was 'moody' and would cry easily and become clingy particularly to his grandmother. He was also experiencing headaches since the event occurred and he would frequently complain of this pain.

5.3 Biographical Details

Lizo was a boy between the ages four years and eight months and five years two month at the time of the therapy in grade R at a public school. His mother was 41 years old and his father was 43 and their home language is Xhosa.

5.4 Family History

Lizo was born as the second child to his mother and it is not known how many children his father has with various women. His mother's first born child passed away due to a sudden attack of seizures at the age of three years, two years prior to Lizo's birth. Lizo's mother was diagnosed and has been under treatment for Major Depressive Disorder (MDD) since then. Lizo's parents were never married to each other and Lizo's mother is single, while Lizo's father was undergoing a divorce from his marriage of approximately four years. Lizo lived with his mother in her two-bedroom house and sometimes lived with his grandmother in her two-bedroom house. At his grandmother's house, he lived with his maternal uncle-who is sick, uses illicit drugs, and is unemployed, and his grandmother who receives old age pension. The researcher, as his therapist, observed Lizo to be very emotionally close to his grandmother, while his relationship with his mother was more like that of a sibling and he often referred to her by her first name. Lizo's relationship with his father was reported to be strained and this was reportedly due to his father not maintaining a close emotional relationship with him. Lizo's father was reported to not see him often and failing to provide for him financially. His father has been employed as a schoolteacher for many years and his mother is unemployed,

although she often volunteered at a victims support centre aligned with South African Police Service (SAPS) as a counsellor.

5.5 Developmental History

Lizo's mother reported that he was born full term in a normal birth with no complications. She was on anti-depressants while pregnant with him due to experiencing depression since the death of her first born child who passed away two years prior to her falling pregnant with Lizo. No other illness was reported by Lizo's mother from the first trimester of the pregnancy to delivery. Lizo's mother reported no use of alcohol, no smoking and no illicit drug use during pregnancy.

Lizo's sleeping patterns as reported by his mother reflected normal diurnal rhythms. Lizo had no developmental delays as he reached all developmental milestones age appropriately. He sat at five months, crawled at seven months, walked at ten months and was able to run and balance at one year. His speech development indicated that he was able to speak comprehensible words at age two. In addition, his fine motor skill development was reported as age appropriate. Prior to the presenting problem, Lizo had no problem behaviours reported by his mother or grandmother. He had been toilet trained at age two years and slept throughout the night without wetting his bed. Prior to the presenting problem he had, no significant physical illness has been reported and he had never been hospitalised. Since the reported traumatic event, he reported frequent headaches. Lizo's grandmother reported that he often slept when he came back from school complaining of a headache for which there was no known cause.

Socially, Lizo was reported to have many friends and most of whom were older than him, usually around age seven. His social skills reflected a young boy who preferred to be seen as older than he is. This was evident in his language, which reflected that of a 'macho' young boy.

5.6 Scholastic History

Lizo started attending preschool at age three years and was at the time of therapy at the clinic, four years eight months old and in grade R. The therapist (and researcher) was informed by his teacher that he was ‘troublesome’ in class and fought with other children. Interestingly, the teacher informed that at school, he did not experience encopresis. His grandmother corroborated that he was aggressive towards other children since the traumatic event happened. Academically, his teacher advised that he was a bright child and was able to write his name.

A series of 15 play therapy sessions were conducted byLizo’s therapist(the researcher) and are attached as Appendix 4. In addition, interviews were conducted with his mother and grandmother; written input of the medical doctor who examined Lizo and his teacher. Data from all these sources were included in the description of the case. Below is the working diagnosis regarding Lizo’s symptoms is provided to aid in providing a clear picture of the PTSD diagnosis.

5.7 Diagnosis

Based on the interviews with Lizo’s mother and grandmother, and collateral information, from the teacher, the doctor and the clinical observations, Lizo met the criteria for PTSD with dissociative features.

5.8 Conclusion

In this chapter, a description is provided of the background information with regards to Lizo’s presenting problem, his family structure, his functioning and written collateral information from his doctor and collateral information from his teacher. This wasintended to provide a clear picture of the context of the case for a reader of the treatise.

Chapter 6
Research findings and discussion

6.1 Introduction

In this chapter the researcher provide the research findings according to the themes extracted through Axline's principles of CCPT and include a discussion of how each of the identified principles unfolded in the play therapy process. The discussion follows the principles as they emanated from each session of play therapy from the first to the last of the 15 sessions in the play therapy process and relates them to the literature reviewed in the previous chapters. Appendix4 that provides the details of the play therapy sessions with Lizo is attached to the treatise for the reader's perusal and is often referred to in this chapter.

6.2 Axline's principles and the research themes

The eight principles of Axline's CCPT that were applied in the play therapy process of the current study and the themes that were extracted from the process are discussed in the sections that follow. Axline's principles of CCPT are discussed in detail in Chapter 3.

6.2.1 Establish a warm and friendly relationship and good rapport with the child

An attempt by the therapist, to establish rapport as soon as therapeutic contact was made with Lizo, as Axline (1947) recommends establishing rapport begins during the initial contact with the child. On the initial contact, the researcher observed that while Lizo was waiting at the waiting area with his grandmother, Lizo was anxious at being at the Clinic. He was approached in a non-threatening manner by the therapist firstly introducing herself through stating hername and then engaging him regarding the toys that could be found in the playroom by stating that in the playroom she had various toys for his use. This can explained as attemptng to engage him in a language and area of interest that he could relate to as a young child, namely, play and toys Lizo responded to this invitation by agreeing to go to the playroom with me. Engaging Lizo regarding play would be corroborated by many play therapists as play in children is thought of as their natural language as children are not

miniature adults but have their own manner of expression (Axline, 1947; Landreth,1991; VanFleet, Sywulak& Sniscak 2010).

The process of establishing rapport continued in the second session when Lizo arrived late with his grandmother. The therapist explained to Lizo after speaking to his grandmother regarding the importance of maintaining punctuality. The therapist explained to Lizo that the session would consequently be shorter in duration which was intended to encourage openness and congruence in the therapeutic relationship which Rogers (1951) explains aids in developing a relationship of trust between a therapist and a client. As evident from Lizo's willingness to go into the playroom with therapist after this conversation, it was evidence of an emergence of trust in the relationship. It was important to be aware that the process of building a relationship requires getting to know each other and that requires time (VanFleet,Sywulak& Sniscak 2010) and the therapist did not expect grand acts of trust from Lizo but appreciated small things such as his willingness to go to the playroom.

In the third session, the therapist initiated a humorous conversation with Lizo while shefetched him from the waiting area about the wooden horse he was riding in the waiting area. She enquired if he had ever seen a red horse before, to further develop friendliness in the relationship. Lizo humorously responded that he had only seen one on television. During the play therapy session on the day, Lizo suddenly sang a song and smiled nervously. The therapist sensed that Lizo was feeling slightly silly about his song. Consequently, the therapist responded by engaginging dancing along with him to provide him with an experience of a supportive relationship. Lizo's sudden singing was suggestive of him feeling secure in the relationship as he was able to engage in free play and self-direct play behaviour and Landreth (2002) identifies the self-directed play as emergence of self-confidence in the child. Further, as the same session continued Lizo requested therapist's participation in kicking the ball back

between the two of them. This self-direction was also indicative of developing rapport between themand his sense of confidence as mentioned above.

During the fifth sessions he engaged Lizo in the waiting area where he was sitting on a wooden horse. She greeted him in his mother tongue (the same as hers) and started a humorous conversation about whether he had used a horse, bus, or taxi to travel to the clinic. Lizo responded by laughingly stating that he had used a bus. This encouraged Lizo to become more comfortable in our relationship as evident from his response of laughing while responding to the question she posed. Evidence that lizo was beginning to feel secure in the relationship with therapist was seen further along during session five, when he suddenly verbalised to her the details of the traumatic event of the abuse he had experienced. He relayed to her that his perpetrator had told him to take his pants off, and inserted a plastic object inside his anal opening, and that he had cried and ran away. The details of the traumatic event he endured are provided in appendix4. My response regarding Lizo's sharing of this experience is discussed in the section further down which discusses Axline's principle three. Lizo's verbal expression of his trauma corroborates what Kaduson and Schaefer (2006), and Sadock and Sadock (2003) stated, school-aged children with PTSD may express their trauma verbally. As Lizo was for the duration of the play therapy process in grade R, she considered him to fit the school-aged category.

As the play therapy process progressed to the sixth session, Lizo expressed excitement at seeing therapist and screamed her name excitedly when she approached him in the waiting area. The level of warmth and excitement expressed by lizo at seeing her was reflective of an established warm relationship between him and her. Asthe therapeutic relationship developed; Lizo began engaging more frequently in adjusted play (Landreth, 2002) where he sought involvement from her as the therapist during play, which was also accompanied by more toys to play; instead of maladjusted play(Landreth, 2002). This was characterised by fewer toys and

restricted play that consists of a great deal of fantasy play, aggression, and not engaging others in the play process. Another instance demonstrating Lizo's engagement in adjusted play occurred further along during the session when he requested that she participate in playing with bubbles. He asked herto blow the bubbles for him while he chased and then burst the bubbles. Axline (1947) identified that, in therapy, when a child leads the process it provides the child with initiative and leads to positive self-direction, because the child self-determines the manner of play as was evident with initiating co-operative play with me. Lizo also asked her to accompany him to the toilet, a further indication of developing trust and a level of comfort within our relationship.

Axline (1947) and VanFleet et al.(2010) mentioned that accurate empathy and consistency from the therapist aid in facilitating trust in a therapeutic relationship. In the current case, researcher as the therapist expressed empathic understanding for Lizo's need for re-assurance regarding the time left in therapy as he frequently enquired if he still had time left in the playroom. Empathy was expressed by understanding that he needed to be re-assured and it was sought to consistently inform or re-assure Lizo regarding the amount of time left whenever he enquired about it. This occurred in sessions five, nine and ten when he asked "do I have time left?"and in Session 13 when he asked "do I have time to play a lot?"and this he was viewed indicating a need for security as he was aware that the therapy process is finite.

The therapist had by the eleventh session, viewed the relationship with Lizo as having matured as evidenced by the moment of non-verbal communication that was shared, which signified a better understanding of each other as persons. This moment consisted of Lizo simply smiling at mean while he was playing with a ballto non-verbally communicate his desire for co-operative play with her and she then smiled back at him signifying an empathic understanding of his intention and engaged him in co-operative play as we started kicking the ball he was playing with back and forth. In the above-mentioned instance there was non-verbal

communication of empathy by therapist and this corroborates Rogers (1951) assertion that accurate empathy facilitates a relationship of trust between therapist and client.

During session 12, which took place three weeks after the previous session due to lack of funds by his mother to bring Lizo to the clinic as explained in appendix, Lizo ran towards the therapist excitedly as she approached him in the waiting area where he showed her his school report stating he had done well at school. She received and read the report and stated that he had indeed done well! Lizo wanted to share his moment of achievement with her and this reflects the level of comfort and warmth he had come to know in the relationship they shared. As Lizo had not been to therapy again for a further three weeks after session twelve, the concern she had was that the relationship between him and her may have been negatively affected and that Lizo may have thought the relationship was lost. Literature suggests that an abrupt break in therapy can have effects on the child of feeling abandoned by the therapist (Wittenberg,1999).

As she approached Lizo in the waiting area for session 13, there was concern if a relationship would need tore-established from the existing. She approached and hugged Lizo as she had previously done when greeting him in the waiting area to communicate to him that their relationship was still intact and to be warm towards him, and he reciprocated the hug. In this instance, she was not certain whether the relationship had been negatively affected. She made the above attempts to ensure consistency in behaviour for Lizo to experience an enduring warm relationship. Consistency in behaviour is viewed as important in assisting the client to trust the therapist as a congruent person (Cochran, Nordling,& Cochran, 2010).

Unfortunately, a further one month passed before Lizo was brought back for the therapy termination session and this has been discussed in detail in appendix. It was observed that the relationship between Lizo and researcher did not appear to be negatively affected by the one-month absence. This was evident as he interacted non-verbally, and he began smiling while he

was playing with his truck and the therapist reciprocated by smiling back at him.An Axline (1947) relay, a smile is an indication of warmth and friendliness; and in the interaction, both Lizo and therapist xchanged smiles. Further, he then requested she join him in play and she obliged him in playing a cards game with him. The request from Lizo to play with her further indicates that a relationship of rapport was established between them.

6.2.2 Accept the child unconditionally for who he or she is

In the first session Lizo was objectively dissociating while in the waiting area and in the playroom. The dissociation was observed by his 'blanking out' and staring into space and initially being unresponsive as the therapist attempted conversation with him in the waiting area although he ultimately responded and came to the playroom with her. Secondly, in the playroom he had a moment where he suddenly appeared to be 'blanking out', staring into space and not engaging with any activity. I, as the therapist unconditionally accepted Lizo with his experience of dissociation by not asking him probing questions about it but allowing him to undergo his experience. This was intended to foster a feeling of being worthwhile from Lizo and that he is not seen merely for his problems. Lizo was receptive of the acceptance the therapist offered as he was able to move away from the state of dissociation to play activity. As Landreth (1991)states, in CCPT the child is viewed not as a problem to be fixed but as an individual to be respected and understood.

During the second session Lizo became frustrated at the puzzle, he was playing with which he could not piece together and subsequently gave up on it. The therapist was unconditionally accepting of his frustration and his unwillingness to confront it. The therapist did not insist that he try harder but accepted that he was deciding to quit and play with a different toy. This highlighted Lizo's need to have control, which was indicative of feeling shame. In addition, Lizo could not confront his feelings of frustration and this is in agreement

with literature that suggests that in children with PTSD, the ability to process difficult emotions may be thwarted and results in unhelpful coping such as avoiding difficult emotions.

In Session three, the therapist unconditionally accepted Lizo's thumb sucking and dissociating, which were evident while she approached him as he sat in the waiting area. Lizo further engaged in thumb sucking in session four while she approached him when he was waiting in the waiting area. His dissociation was understood as a part of his response to the traumatic experience he had encountered and his thumb sucking was a regressive behaviour, which may have emanated from a sense of helplessness associated with the trauma (APA,2013;Mash and Wolfe, 2005). Accepting Lizo unconditionally allowed him to rebuild his confidence and to become autonomous and overcome this regressive behaviour and dissociation. Lizo experienced acceptance of his behaviours and further on in session three and four he began engaging in self-directed play and did not dissociate or engage in thumb sucking and according to Ryan and Edge (2012) self-directed play is indicative of autonomous behaviour. Literature suggests that children who experience approval, acceptance, and encouragement to master their fears are likely to overcome trauma than those who experience humiliation, rejection, and failure (Boyden & Mann,2005).

In Session 5, Lizo was at the playroom startled by the slight noise that came from outside as he was playing in the playroom, the therapist accepted his startled reaction and did not attempt to dismiss his fear but rather re-assured him that the sound was without threat and was made by people outside the playroom. As expected with children that experience PTSD, fearfulness often results in being startled easily(APA, 2013). The therapist had to be patient concerning Lizo's startled response to provide him with an opportunity to work through this aspect of trauma at his own pace by not imposing on him that he not be fearful.

As Lizo and the therapist had not seen each other for a month, explained in detail onAppendix4, at the beginning ofsession eight Lizo was approached at the waiting area and he

did not speak and the therapist accepted the silence and did not attempt to force a conversation. Landreth (1991) states that children have a right to remain silent and be accepted as such.By accepting Lizo's withdrawal and empathically listening to his need for silence, and recognising the silence as a form of expressing his dissatisfaction and mistrust, a relationship of trust towards the therapist was further facilitated as evidenced by Lizo, after following her to the playroom.

During Session 9, Lizo erroneously stated to therapist that a young girl who was his neighbour was his younger sister. The therapist unconditionally accepted this error and did not attempt to correct Lizo. More than understanding the meaning behind the error, it was more valuable and meaningful to accept Lizo's error than to probe regarding it. As literature suggests that asking questions in CCPT is not advised as it can be leading (VanFleet et al.,2010)

In Session 10 Lizo disclosed that at school the teacher was disciplining him with a duster. This revelation of corporal punishment was indicative of the level of trust Lizo had on the relationship with the therapist. She communicated acceptance of Lizo's experience and did not criticise or blame Lizo for not behaving in a particular way and subsequently receiving this punishment, but rather verbally reflected an empathic understanding of his feelings of the unfairness and uncontrollable nature of the punishment he was receiving. Lizo responded by moving on to a different play activity of painting.

In Session 13, the therapist provided acceptance of Lizo's experience of encopresis which had occurred earlier before the session,and the remnant odour from his grandmother's attempt of cleaning it up. It is known that young children who experience PTSD may have regressive behaviours such as loss of bowel and urinary control (Mash &Wolfe, 2005). The unconditional acceptance of Lizo and this experience provided him with a secure base as an accepting relationship from which to exercise effective coping skills as observed in his play

that consisted of chaotic play. This culminated in the resolution of his shame as evident by his statement “that’s much better”.

As literature suggests (including the cultural beliefs of the child and his family), is essential for treating PTSD as both the culture and the family contribute to the understanding of how the PTSD is conceptualised and alternate treatment practices(Landreth,2002: VanRooyen& Nqweni,2012). In this case Lizo’s parents chose at the 13th session to discontinue therapy andpursue a traditional route of treatment, which entailed slaughtering for Lizo’s paternal ancestors as a ritual to introduce Lizo to these ancestors. As part of unconditionally accepting Lizo, the therapist accepted the preferred cultural treatment by Lizo’s family.

During the termination session, Lizo became silent and appeared sad when therapist informed him that it was his final session of play with her. The therapist accepted his reaction to the ending therapy of sadness, and this was communicated to him through an empathic reflection of his sad feelings by stating that it was understandable that he was sad, and congruently expressing the therapist’s own feelings of sadness at the ending of the play sessions.

6.2.3 Create an atmosphere of permissiveness in the relationship to encourage the child’s expression of feelings

During the process of introducing Lizo to the playroom, the therapist informed him that in the playroom he could play in any way he wished and that immediately created an atmosphere of permissiveness. This was the opening statement recommended by VanFleet *et al.*(2010) to facilitate the process of free play that occurs in CCPT. In thef irst session, in an isolated event, Lizo stated that he wished the plastic sword he was carrying had a blade so that he could stab someone with it. This was a violent statement, but the therapist offered permissiveness and held no judgement or attempt to change him or his verbal behaviour. Lizo

subsequently moved away from the verbal aggression on his own will and asked to go to the toilet.

In Session 2, an attitude of permissiveness was created in the relationship Lizo's request was accepted when he asked therapist to accompany him to the toilet because he was scared.It is expected that children with PTSD become fearful and often have clinginess to people (APA, 2013; Boyden andMann, 2005). Providing Lizo with permissiveness to express his need for the therapist's company and providing him such company to encourage him to feel secure and become autonomous was expected. Just as a secure attachment relationship with a care-giver provides a supportive environment for the child and assists the child to adapt from victimisation and develop effective emotion regulation and coping skills the relationship with the therapist can act in a similar manner(Kaminer & Eagle, 2008; Van der Kolk, 2005).

During Session 8, Lizo was engaged in a permissive manner and encouraged to play in a chaotic and aggressive manner. In this session Lizo's chaotic and aggressive play was through driving small car toys against each other, against the wall and against the door and then throwing balls all over the playroom. Chaos during play as a theme is often indicative that the child is experiencing mistrust instead of trust in the relationship Ryan& Edge, 2012). In this instance Lizo was chaotic in play and he was mistrusting as consequent to having missed a month of therapy as described in Appendix4. Aggression during play was indicative of the emotions of shame, associated with loss of control resulting from trauma (Ryan& Edge, 2012).In Session 9,Lizo again demonstrated aggressive play when he pushed toy cars against each other and the walls. On this instance,t he therapist further engaged him permissively by not interrupting this play and he subsequently moved to play in a relaxed manner. Allowing Lizo to work through and express his emotion of shame and mistrust in both Session 8and 9,encouraged developing trust in the therapeutic relationship. Lizo's developing a sense of positive self-esteem as the therapist demonstrated to him that his emotions were worthwhile.

Lizo's developing trust was evident as he self-directed his play from chaotic to calm. CCPT encourages self-direction in play and further states that children will play in a manner best for them as seen with Lizo (Landreth, 2002).

Session 10 saw the therapist creatinga permissive environment when she allowed Lizo to engage in aggressive play as abig doll hitting a small doll. This aggressive play demonstrated a theme of victim and perpetrator. This became evident as posttraumatic re-enactment, reflecting the violence that Lizo had experienced when the perpetrator (who is an older child), used force on him. Permissiveness allowed Lizo to play in a manner that encouraged processing and elaborating the memory of the trauma, essential to overcoming the PTSD,as avoidance worsens PTSD (Kaplow et al., 2005).

In Session 11, the therapist encouraged an atmosphere of permissiveness again by allowing Lizo to recite his poem in the hallway, as he was excited to do so. Lizo was very proud of his poem and needed to recite it tothe therapist and he could not wait to go to the playroom. This meant that the therapist maintained a non-directive approach as suggested by Axline (1947) and allowed Lizo to make his own decision regarding when to recite his poem. Lizo in turn, appreciated the attention he received from the therapist, his mother, and the people passing by in the hallway. The attention provided a sense of achievement for him, evidenced by himsmiling proudly when people complemented him.

During session12, Lizowas allowed to climb on top of the plastic toy box. Therapist did not attempt to control or direct Lizo's play. She refrains to request that he unengaged in climbing on top of the plastic box. By allowing Lizo to experience his play without an evaluative input from her, allowed him to be autonomous and value his own experience(Landreth,2002). Lizo's play was essentially testing of limits as he climbed a toy box (not meant for climbing). The testing of limits further confirms that Lizo was confronting his helplessness emanating from PTSD and was further developing autonomy (APA,2013;

Ryan&Edge,2012). Lizo was eventually satisfied with this play, and endure by asking therapist if he could go to the toilet. This action indicated a resolution of a sense of helplessness and an emergence of autonomy.

Session 13the therapist further engage Lizo permissively as he poured water into the bubbles container until it overflowed. The therapist sensed the feeling of being emotionally overwhelmed from Lizo through the pouring of water into the bubbles container until it overflowed. The therapist permitted this behaviour by Lizo and did not attempt to re-direct his play away from pouring the water. This was emotionally rewarding to Lizo as he eventually stopped pouring the water by himself, signalling a resolution of the overwhelming emotions he was experiencing. During the same session,Lizo's aggressive play of pushing the train against the door emerged. This play was permitted as it was resurfacing once again the feeling of a lack of autonomy Ryan& Edge,2012). Lizo's aggressive play was at his direction, as he needed this, and because he was permitted his own expression and was not judged. He stopped in his own time.

6.2.4 Recognise the feelings which the child is expressing in speech and play and reflect these back so that the child can get some insight into his or her behaviour

In the first session, the therapist was able to recognise and reflect Lizo's non-verbal behaviour. He removed the miniature toy people out of the cars and she sensed that he was unhappy with the miniature persons. She signalled to him that he was removing them. Lizo responded: "they do not drive anyway". By reflecting Lizo's behaviour back to him, he was able to confront and express the intention behind his non-verbal behaviour, being essentially that he needed to have control over the toy cars and the miniature people were not useful for that purpose. In addition in the session, the therapist recognised a feeling of anxiety from Lizo. He began talking about his friend who had sexually assaulted him, by revealing the friend's name and that he was his "buddy". Due to this anxiety, Lizo attempted to re-assure and provide him-self with a sense of safety, by suddenly stating that he had ten friends! The therapist

acknowledges the statement by coinciding hat he had many friends. This indication facilitated a reduction of the anxiety as Lizo suddenly moved on to play a counting game.

During the second session, the therapist reflected Lizo's feeling of frustration when the puzzle pieces did not fit together and he could not fulfil his need for perfectionism and competence. His response to the reflected feeling of frustration was to avoid confronting the emotion and change his play. Literature indicates that children who have PTSD often express perfectionism, linked to the belief that if things are not done perfectly, something bad may occur (Roberts,2011). Lizo subsequently avoided the reflected feeling of frustration at not achieving perfection. He could not at the time confront that he had not achieved perfection and competence.

In the third session Lizo named each colour from the painting he was making. The therapist sensed that he was seeking approval and acknowledgement of his competence by demonstrating to herhis knowledge of colours. The therapist agreed that Lizo knew the colours and was naming all the colours he was using, complementing him. This allowed Lizo to recognise what he needed without therapist overtly expressing approval. CCPT encourages no judgement or praise of the child's play by the therapist (VanFleet*et al.*,2010). The need for approval is a theme that was frequent in Lizo's play and signalled a sense of insecurity and shame. It is common for a child with PTSD to have these feelings as their sense of security and autonomy has been compromised by the overwhelming experience (Moroz,2005).

Another instance where therapist assisted Lizo to gain insight through reflection, was during Session 4 when Lizo narrated a story about a character who told children to take off their pants and hit them if they did not comply. The therapist reflected the sense of fear emanating from Lizo's story by stating that the children were scared of the character. The theme of fear in the story and the content relating to taking pants off was indicative of posttraumatic play as it related directly to the traumatic event experienced by Lizo. From the therapist's reflection from

his story, Lizo became aware of his own fear. This fear was evidenced by him looking at therapist for a moment then engaging in play that was non-absorbed and characterised by moving from toy to toy.

Session 5involved empathic reflection by therapist of the feelings of fear Lizo expressed. He surprisingly related the traumatic event to her. He told her of the trauma and that he cried and then went on to tell the boy's mother who reprimanded the boy. The therapist reflected Lizo's feelings stating that he must have felt scared and that yet he further had strength to run and tell the boy's mother. After this reflection, Lizo suddenly enquired if he had time still left in play. This indicated that he had accepted the therapist's empathic response towards him and wished the session would not end.

In session 6, the therapist empathically identified and reflected the shame expressed by Lizo's critical talk towards the doll, which had encopresis. The therapist communicated an understanding of the doll's encopresis as a mistake due to its involuntary nature. The reflection facilitated insight by Lizo into the doll's encopresis as involuntary. The statement made that the doll made a mistake, could be argued by some CCPT therapist such as VanFleet et al.(2010) as being leading. The therapist considered that an accurate empathic reflection would involve the reflection of the deeper intention of Lizo's critical talk, which was a need for acceptance of the 'doll' with the encopresis and it was offered. Lizo confronted his feelings of shame at the doll with encopresis and was able to relay eventually that the doll had made a mistake.

During Session 8, therapist recognised aggression and uncontained emotions expressed by Lizo during his play with cars, as he was driving them into each other and the wall. Therapist allowed him this play and reflected that he was really having "a go" at the cars. The reflection of Lizo's aggressive play facilitated the process of developing a healthy sense of self

and valuing himself as worthwhile instead of viewing himself shamefully(Ryan &Edge,2012). This was evident when Lizo at his own discretion moved on to less aggressive play.

Session 9consisted of Lizo relaying that the boy who had perpetrated the abuse was gay. The therapist engaged Lizo in an attempt to understand him and enquired what he meant by "gay". Her enquiry essentially reflected Lizo's confusion regarding the term, to which` he simply responded; "That boy, that gay" and could not describe what gay meant. Lizo stated that there was a character who was a liar and touched people's bums. The therapist replied that this character should not be touching people's bums. This was done to bring clarity to Lizo regarding acceptable and non-acceptable behaviour. The therapist empathically sensed Lizo expressing confusion in this regard and it was important for his future safety and security.

During Session 10, Lizo made a painting, folded it, and threw it in the bin stating it was ugly. Lizo then made another painting, folded it and threw it in the bin again. The therapist recognised Lizo's feelings of dissatisfaction regarding his paintings and reflected it back to him. The theme of perfectionism had emerged again in Lizo. Perfectionism (as mentioned) is found often in traumatised children indicating a fear that if things are not perfect, something bad may happen. Therapist' sreflection facilitated a process of Lizo confronting his fear as he became aware of it and stated that his mother was boss and no one could mess with her. This indicated that he provided himself with protection as he realised the fear he was experiencing.

In session 12, Lizo again played with the two dolls and the therapist recognised that it was repetitive behaviour and intuitively sought empathic understanding by enquiring about the doll's ages. Lizo responded that the smaller doll was four and the bigger doll was seven. This facilitated insight into the identity of the 'dolls', as Lizo was four and the boy who had perpetrated the trauma was seven. The conflict between these two dolls represented the shame emanating from the trauma. Insight into the identity of the dolls initiated the resolution of the trauma and developing a sense of self-worth and autonomy. The evidence that Lizo was

resolving his trauma was clear when subsequent to him gaining insight on the doll's identities. He began placing toy animals in pairs and each pair consisted of a big and a smaller animal.

Session 13involved Lizo speaking about his friend who was proud of his dancing skills; and his teacher who was proud of his work skills. The therapist recognised the feeling of shame in Lizo and the need for acceptance and approval and she reflected that there were many people proud of Lizo. This provided Lizo with a sense of acceptance, but also reflected the need within him for acceptance and approval so that he may be able to confront it. Consequent to this reflection and as a sign of resolution of shame, Lizo made a painting and once again folded it. The therapist considered the previous time he had done so stating the painting was ugly, but this time he said he was taking the painting home. During Session13, the therapist recognised the feeling of shame expressed by Lizo when he said, "It smells good here, like food". The therapist empathically understood his shame at his earlier experience of encopresis and reflected that he was distracted and concerned about the smell and Lizo started to recognise his real feelings and went on to aggressively play by driving a train against the door. As previously mentioned aggressive play is seen as indicating shame and Lizo was consequently gaining insight on his feeling of shame confronting and working through it by aggressively playing with the train. Additionally in this session,therapist recognised that Lizo was feeling emotionally overwhelmed when he suddenly stated that he was busy while playing with numerous toys. The therapist responded to him that he was very busy and that helped Lizo become aware of his emotions of being overwhelmed. Lizo worked through feeling emotionally overwhelmed by continuing to play with numerous toys and eventually stated, "That's much better". Towards the end of the session, Lizo became nurturing towards the small doll and stated that he liked the doll. The therapist recognised and reflected the feeling of love and nurturing towards the small doll. This theme of nurturing the small doll emerged in subsequent sessions and was a sign of the resolution of shame and emergence of self-worth.

In Session 14the therapist realised and reflected Lizo's need for approval which was expressed by Lizo when he wrote his name with coloured pens for herto see. She responded that shecould see that he was able to write his name. This made Lizo aware of his intentions and provided him with the sense of validation he needed.

During the last session, Lizo had a sad countenance as the therapist informed him that it would be the last time theyplay together. The therapist reflected his non-verbally expressed sadness and shared her own emotion about how she enjoyed playing with him. This confirmed significance of the relationship and an acceptance of Lizo's sadness at it ending.

6.2.5 Deep respect for the child's ability to solve his or her own problems when given the opportunity and that the responsibility to make changes belong to the child

In the first session Lizo suddenly and compulsive expressed a wish to stab someone with the sword if only it was real. The therapist reflected that he wished to stab someone but he could not confront his feelings and responded that he did not wish to stab anyone. Lizo was not forced to confront what he meant but thetherapist had deep respect for his ability to resolve the conflict in his own manner and time. This theme of interpersonal violence indicated a feeling of mistrust and of been harmed personally.

In the second session, Lizo was pre-occupied with packing away toys after playing with them. The therapist respected his pre-occupation with order, which were a theme related to perfectionism as previously mentioned and a necessary part of his problem solving process. By the fifth session, Lizo had become absorbed in his play and not pre-occupied with packing toys away. This adjusted play was initiated as the therapist showed unconditional respect for Lizo's ability to take responsibility for his own change and thus facilitated Lizo's own problem solving and resolution of the conflict and he eventually became absorbed in his play.

In session six Lizo spoke to the small doll with encopresis in a nurturing manner and cleaned it up with tissue paper, and continued to take more and more tissues from the box to clean the doll. The therapist respected Lizo's need to take more and more tissue paper and saw

it as engaging in creative problem solving process. The theme of nurturing the ‘doll’ is reported to describe a positive growth towards autonomy and was a resolution of the feeling of shame (Ryan & Edge,2012).

Session 8,followeda month of not having therapy and Lizo’s play was aggressive and chaotic as he drove cars into each other and the wall. The therapist showed respect for Lizo’s problem solving ability and understanding that he was spending his time in play as he needed to resolve his conflict which he eventually resolved as his play became non-aggressive and chaotic. Chaotic play (previously mentioned)signals a feeling of mistrust while aggression signals an emergence of shame.

Session 9indicatedLizo’s play to reflect theme of aggression and chaos. He drove the small toy cars into each other and the wall and threw the balls all over the playroom. The therapist respected his play process and allowed him to work through his chaotic and aggressive play without interruption. In the session, he confronted his feelings of mistrust and shame creatively through play and with their resolution was able to initiate a conversation regarding the boy who had perpetrated the trauma.

The play initiated by Lizo in session ten included him making a painting, folding it and then throwing it away. The therapist did not attempt to resolve the problem for Lizo by informing him the painting was beautiful but believed in his ability to resolve his own problem. When he had completed this activity, he moved to talk about his mother.

In session 13, Lizo decided to break a limit regarding only being allowed to go to the toilet once. He decided to leave the playroom for a second time and that had a consequence of ending the session. The therapist showed Lizo respect and did not attempt to enforce he stays and she recognised his decision as indicative of a developing sense of autonomy.

Session 14 and 15indicatedLizo being unhappy with ending the therapy process. The therapist’ belief in Lizo’s problem solving ability was communicated as she stated that Lizo

would be able to play with his friends at home and at school and be able to do so in a healthy manner.

6.2.6 No attempt to direct the child's actions or conversation during play and allow the child to lead

From the first session, Lizo's play was self-directed as he started playing immediately as he entered the playroom in the first session and the therapist did not attempt to direct him. His natural ability to direct himself can be understood as being due to the actualising tendency that governs growth in positive manner if provided with a positive environment. As Axline (1947) has highlighted; the environment of a child can facilitate the process of fulfilling the self-directed actualising tendency.

Session 2signified Lizo becoming frustrated at the puzzle pieces that did not fit and consequently changed his play. The therapist did not coerce Lizo to continue playing with the puzzle or confront his feeling from failing to achieve perfection or competence, but instead she allowed him to play, as he preferred. As previously mentioned, the theme of perfectionism is prevalent in children with PTSD; allowing Lizo to decide on his play encouraged him to confront feelings of needing perfection and to overcome them at his own pace.

In session 3,Lizo described a painting he had made only stating the colours while omitting to describe the form of the painting. Lizo was allowed to describe his painting in the restrictive manner he chose. Lizo's restricted focus regarding his painting can be seen as a form of restrictive play which is associated with PTSD in children (Landreth,2002).

Perpetually in session 4,Lizo played with cards and puzzle pieces by piling them on top of each other. The therapist did not attempt to direct his play by correcting him or informing him how a game of cards is played and informing him how to make a puzzle. He was allowed self-direction in his play with his cards.

During session six Lizo spent a considerable period playing with small toy cars and talking to the small figures inside the cars that he had on the first session taken out stating they could not drive anyway. During the session, he was able to direct his play to talking to the miniature toy people without an attempt by the therapist to direct him. The theme of control was being confronted as the miniature toys had moved from being unable to drive and being taken out of the car to being spoken to. It is important to note that this occurred in a self-directed manner and was not influenced by the therapist.

In session eight Lizo's play was for the most part chaotic, the therapist did not attempt to direct him and Lizo subsequently moved on to a narrative about a comedian who was going into people's houses and taking people's food. The movement from chaotic play to a narrative was at his self-direction and was indicative of working through his experience of mistrust indicated by the chaotic play to a resolution indicated by non-chaotic play.

Session 10 had Lizo engaged in adjusted play Landreth (2002)as he played with a ball and requested the therapist tokick the ball with him; then he went on to play with the big and the small dolls; and then lastly went on creating a painting. Lizo engaged in collaborative play and when he was satisfied with the play he went on to play with the dolls engaging the big and the small doll in conflict and using critical and nurturing talk towards them. Lizo directed his play and spent time on each play activity as he chose. The conflict between the dolls involved a victim and perpetrator, and was essentially posttraumatic re-enactment that needed to be resolved. As he played with the two dolls fighting each other, Lizo was psychologically processing his own struggle to overcome his own trauma.

During session 12 Lizo directed his play and began playing with the small toy cars, then he played with the two dolls, where after he placed the animals on the floor in pairs, and climbed on top of a plastic box. The therapist allowed him to express himself in the play as he wished and engage in various play activities. Play with the small toy cars was brief as he

quickly moved on to play with the dolls. The play involved the small doll hitting the big doll which was an indication of an emerging sense of autonomy for the small doll as the dolls had been previously identified as the perpetrator and victim. Play as climbing the plastic box was a testing of limits as the plastic box was not for climbing but it allowed Lizo to confront his feelings of shame as a testing of limits is associated with shame and a need for agency (Ryan & Edge,2012).

During session 13 Lizo covered the small doll with plastic covers and bags and this was done at his own direction. This identified a theme of protection and nurturing for the small doll and can be argued to signify a feeling of protection and nurturing for Lizo as he identifies with the small doll. A resolution of the conflict between mistrusting and trusting resulted in Lizo becoming trusting. The relevant literature identified an ability to form trusting relationships as a moderating factor to PTSD, (2012).

6.2.7 Make no attempts to hurry the therapy process but recognise that the process is gradual

In the first session Lizo's play consisted of rapidly moving from one toy to the other, and he was not absorbed in each play activity. The therapist did not attempt to insist thatLizo become involved in one form of players hurry the process of developing in-depth play. With time,Lizo's play began to become increasingly involved as he included the therapist and utilised more toys but this was achieved at Lizo's pace.

The theme of perfection was evident from packing away each toy when moving to another in the second session. The therapist made no attempt to hurry the process and to redirect Lizo's play. The perfectionism was in time resolved at Lizo's own pace, as evident in session five where he did not engage in packing away each toys. As literature reports that perfectionistic preoccupation may be a result of irrational fears associated with PTSD, and resolution of the perfectionistic tendency signals a resolution of the irrational fear associated with PTSD, (2012).

Session 4 consisted of Lizo narrating a story about a character that was taking people's pants off and hitting the children who did want to comply. When the therapist reflected the children were hurt by and scared of the character in the narrative, Lizo avoided any emotions as evident from moving away from the narrative. The therapist did not insist he confront his feelings of fear and hurt but allowed him to follow his own pace to resolve these feelings.

In Session 5,Lizo expressed a need to go to the toilet, this meant he would need to leave the playroom and delay the play process. The therapist did not attempt to hurry the process of therapy by encouraging Lizo to stay in the playroom and continue the process but she allowed him to be excused.

The sixth session involved Lizo informing the therapist that he was scared of a dark doll in the playroom. The therapist had previously seen Lizo avoid confronting his emotion of fear, but in this session, he began sharing with her that he was scared. The therapist had allowed Lizo to confront his emotions at his own pace and did not hurry him and consequently when he felt safe in the relationship he willingly stated that he was scared and trusted his relationship with her.

In Session 8,Lizo spent time talking about a certain character that was silly and took people's food and a theme of criticism emerged but his conversation was somewhat incoherent. No attempt to make Lizo tell a more coherent story, thereby attempting to hurry the process of play was made, and Lizo gradually relayed his story in a clearer manner. The therapist recognised that it was a story of a comedy he saw on television. Lizo's criticism was indicative of his own feelings of shame.

In session 11, the therapist enquire of Lizo's safety concerns, specifically if he still had contact with the child who had perpetrated the trauma. This was not an attempt to hurry the process of therapy but this directive component of the session was implemented only intended to ensure Lizo's safety.

In session 13 Lizo decided to break a limit regarding the number of times he could be excused to the toilet during a session and faced the consequence that was ending the play session. The therapist accepted that Lizo made the decision to end the session and did not attempt to impinge on his choice in an attempt to hurry the play process.

The penultimate and the last session meant for Lizo that therapy had to conclude. The therapist accepted the work that had been done, and that not done and made no attempt to quickly resolve any remaining conflicts that Lizo experienced.

6.2.8 Establish only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility

In Session 1, the limit regarding the duration of play was stated when it was about to be broken by Lizo. This occurred as Lizo wished to go to the toilet and return to the playroom when there was only five minutes of the session that remained. The therapist informed him that he would not be able to return to the session on that day. This limit ensured maintenance of structure in therapy and encouraged Lizo to feel secure and knowing what to expect (VanFleet et al (2010).

Limits regarding the starting and ending time of play therapy sessions were re-stated when Lizo and his grandmother were late for the second session and that the consequence was a shorter play therapy session. The limit of starting and ending was re-enforced to maintain consistency. In Session 1, the therapist had to re-state a limit of allowing only one trip to the toilet during a play session as Lizo requested a second trip to the toilet. The consequence of breaking the limit was stated and Lizo decided to excuse himself and visit the toilet for the second time and consequently the session ended.

During session 13 Lizo requested to take the toy bus out of the playroom to show his grandmother. The general limit in CCPT is usually that toys are not to leave the playroom (VanFleet et al, 2010). In this instance, the therapist in her judgement decided to allow Lizo to

show his grandmother the toy for a minute. This was done because the therapist viewed the provision of permissiveness with Lizo on that day as more beneficial than adhering to the limit. This in turn assisted Lizo to feel a sense of agency as he had on that day, felt shame and helplessness due to experiencing encopresis.

Session 14 included a preparation for terminating the therapy process with Lizo. The limit regarding the finite nature of play therapy to prepare Lizo for ending therapywas mentioned. In the last session the limit of ending therapy was addressed and Lizo's reaction of sadness at this limit was also acknowledged and he was further encouraged to take responsibility for his play outside of therapy and with his friends.

6.2 Conclusion

The findings of the research study indicated how each of the principles of Axline's CCPT was implemented and unfolded with Lizo in the relevant therapy sessions. The themes that emanated from therapy with Lizo and their resolution were discussed. The principles and how they facilitated the resolution of each theme from Lizo were also discussed. Certain principles had immediate effect on Lizo while others had a cumulative effect.

Chapter 7
Conclusions, Limitations and Recommendations

7.1 Introduction

In this chapter,the researcher concludes the research study and providesa summary of the research findings, the limitations and the recommendations that emanated from the study. In this chapter,all relevant aspect of the current research study is co-ordinated to provide concluding comments to the study.

7.2 Summary of the Findings

The research findings indicated themes that were expressed by Lizo's play which were related to dealing with the trauma and they are: shame, mistrust, needing control, and perfectionism. On resolution of the above-mentioned issues or themes by Lizo, themes emerged of autonomy, nurturing, protection and safety.

The research findings indicated that the implementation of the principles of CCPTby the therapist revealed that some of the principles had an immediate effect on Lizo resolution of trauma related issues, where others appeared to have a cumulative effect in resolving trauma.

The first principle concerned with establishing rapport with Lizo required time and consistency in ensuring empathy from the therapist. Each relational interaction with Lizo served to foster trust and trust eventually to consistently ensuring accurate empathy, and congruence towards Lizo. The establishment of a trusting relationship was signified by Lizo's spontaneous expressions of excitement at seeing the therapist at the beginning of therapy.

The implementation of the principles relating to permissiveness and acceptance indicated an immediate positive impact on Lizo by facilitating resolution of mistrust and shame. This was signalled by him, working through his aggressive play at his own direction, until he was satisfied and moved on to non-aggressive play.

Further implementation of the principle regarding accurately reflecting his behaviour had an immediate impact of facilitating insight into his verbal and non-verbal behaviour and intentions such as fear.

A significant research finding related to discovering that once the therapeutic relationship between Lizo and the therapist was established it did not seem to be affected when he was away from therapy for months as evident from how he approached the therapist with excitement despite not seeing herfor a month.

There was also divergence from the CCPT practice guidelines with regards tothe therapist usingherclinical judgement in implementing play regarding a certain limit; when allowed Lizo to take a(toy) bus out from the playroom for minute to show his grandmother. The therapist considered it beneficial for him to feel a sense of agency on the day particularly as he had experienced encopresis. The therapist intuitively enquired of the ages of the dolls. Lizo was playing with and that was discouraged by CCPT, as questions are not advised. In this case it assisted the facilitation of insight in Lizo with regards to the identity of the dolls which was essential for processing his trauma.

CCPT was able to be implemented in the case of Lizo for treating PTSD although the play therapy process had to be prematurely ended some symptoms were resolved such as the dissociation and sucking his thumb. Encopresis in Lizo was not fully resolved, as it would still infrequently occur by the time his mother requested therapy termination. Themes evident during play demonstrated a working through themes related to trauma.

7.3 Value of the Study

The study provided an opportunity for an in-depth understanding of the therapeutic process of CCPT with a child with PTSD. The knowledge generated from the study adds to the knowledge base of therapeutic approaches that can be utilised for treating PTSD in children. As CCPT has not always been preferred for treatment of PTSD, it is useful to demonstrate how

it has been applied in this case. It offered the researcher an opportunity to review the therapeutic process that she had undergone with Lizo, learn and develop her own therapeutic skills by examining them from a researcher's perspective.

7.4 Limitations of the Study

The limits of the current study are; the research participant family needing to end therapy prematurely and pursue an alternative cultural method and the therapeutic process could not achieve complete success. Financial difficulties regarding bringing the research participant to therapy consistently, delayed the progression of therapy, consequently, the research conducted was not based on a smooth treatment process. The data depended largely on the process notes taken by the therapist but these were limited by the therapist's observational skills at the time of recording as the data was not originally generated for research purposes.

Another possible research limitation is those associated with the qualitative case study research method. The major critique of case study research is that of its credibility and the possibility of researcher bias. The researcher took measures to reduce possible bias and these include exercising reflexivity, utilising researcher triangulation, receiving supervision from the research supervisor.

7.5 Recommendations

If the study were to be repeated, incorporation of a specific developmental framework would be useful in fully conceptualising the child's development undergoing therapy. It would also be useful to include appropriate family members in the treatment process through filial therapy to facilitate a collaborative support from both the therapist and the family for the child in play therapy. Video recording the process of therapy sessions is advised as it would capture data that may be missed by the therapist. A careful consideration of the family' cultural beliefs during the therapy process would also be valuable especially with regards to adherence to therapy.

7.6 Conclusion

The research study has value in adding to the knowledge base of therapeutic approaches used in treating PTSD in children. The insight gained by the researcher from the experience also aided her development as a novice therapist and a qualitative researcher.

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Appendices

Appendix 1

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event (s).

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event (s), beginning after the traumatic event (s) occurred:

1. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event (s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Such trauma-specific re-enactment may occur in play.

2.Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event (s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event (s) or negative alterations in cognitions and mood associated with the traumatic event (s), must be present, beginning after the event (s) or worsening after the event (s):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event (s).

Negative Alterations in Cognitions

1. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).

2. Markedly diminished interest or participation in significant activities, including constriction of play.

3. Socially withdrawn behaviour.

4. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event (s), beginning or worsening after the traumatic event (s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).

2. Exaggerated startle response.

3. Problems with concentration.

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behaviour.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealisation: Persistent or recurrent experiences of unreality of surroundings

(e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Appendix 2

Guidelines for psychological evaluations in child protection matters

Guideline 1. The primary purpose of the evaluation is to provide relevant,professionally sound results or opinions in matters where a child's health and welfare may have been and/or may be harmed.

Guideline 2. When psychologists conduct evaluations in child protection matters to address specific referral questions, they are aware that the interests of the parties in the case may differ from one another.

Guideline 3. When the referral question in the evaluation addresses concerns about the parent/caretaker and child relationship, psychologists are mindful of: the parent/caretaker's parenting capacities, including circumstances or factors relevant to maltreatment of the child; the child's wellbeing and psychological needs; and the resulting fit.

Guideline 4. The role of psychologists who conduct child protection evaluations is that ofa professional expert who strives to maintain an unbiased, impartial approach to the evaluation.

Guideline 5. Psychologists strive to gain competence sufficient to provide effective and ethical forensic services when conducting child protection evaluations and when addressing case-specific issues that may require specialised professional knowledge, training, or skills.

Guideline 6. Psychologists strive to be aware of personal biases and societal prejudices and seek to engage in non-discriminatory practice.

Guideline 7. Psychologists providing child protection evaluations strive to avoid role conflicts and multiple relationships that may compromise their objectivity, competence, or effectiveness, or that may otherwise risk harm or exploitation to the person or identified client (e.g., court, state child protection agency) with whom the professional relationship exists.

Guideline 8. Based on referral issues or questions that define the focus and scope of the evaluation, psychologists determine the methods that are appropriate to address the referral issues or questions.

Guideline 9. In accordance with the APA Ethics Code, psychologists performing psychological evaluations in child protection matters obtain appropriate informed consent or assent from all adult participants, and as appropriate, inform the child participant.

Guideline 10. Psychologists use multiple methods of data gathering.

Guideline 11. Psychologists seek to properly interpret clinical or assessment data that inform or support their conclusions.

Guideline 12. Psychologists conducting a psychological evaluation in child protection matters strive to provide opinions only when they have obtained sufficient data to support those opinions.

Guideline 13. Recommendations, if offered,address the evaluation's specific referral questions, which may encompass various concerns related to the child's welfare and health in a child protection matter.

Guideline 14. Psychologists create and maintain records in accordance with ethical and legal standards.

Appendix3
Grid for Data Collection and Analysis

Axline's CCPT Principles	Play Therapy Session no…
1. Establish a warm and friendly relationship with the child.	
2. Accept the child unconditionally for who he or she is	
3. Create an atmosphere of permissiveness in the relationship to encourage the child's expression of feelings.	
4. Recognise the feelings which the child is expressing in speech and play and reflect these back so that the child can get some insight into his or her behaviour.	
5. Deep respect for the child's ability to solve his or her own problems when given the opportunity and that the responsibility to make changes belong to the child.	
6. Not attempt to direct the child's actions or conversation during play and allow the child to lead.	
7. Make no attempts to hurry the therapy process but recognise that the process is gradual	
8. Establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility.	

Appendix 4

Play Therapy Sessions

The sessions will be presented in a chronological order, form first to fifteenth. A discussion of the sessions includes what occurs outside of the therapy session, prior to therapy or after the session. The information will be included as it elucidates details on the presenting problem, the process, and the progress of therapy.

Session One

Each session presents behaviour? occurring prior to and after play therapy sessions, which is referred to as non-play therapy behaviour ; and behaviour that took place during the actual play therapy sessions. .

Non-play activities

The first session commenced a week after Lizo's grandmother and mother had presented for an intake interview. His grandmother brought Lizo to therapy and while they waited in the waiting area, the therapist observed him sitting next to his grandmother in the couch and sucking his thumb. Later, he moved to the small table in the waiting area and began to play with the puzzles. When the therapist went to fetch Lizo from the waiting area, he was sitting on the small table with puzzles. the therapist introduced her-self to him and asked if he wanted to go and play with me. She observed that he appeared to be 'blanking out' as if he was not present; she continued to talk to him about the toys in the playroom and he eventually agreed to come to the playroom with me. The therapst considered that his dissociation could be triggered by the anxiety of visiting a psychologist, knowing he would probably have to talk about the traumatic event he had experienced.

Play-activities

The therapist introduced Lizo to the playroom and invited his participation by informing him that he could play in any way he wishes. In the playroom, he played with

various toys and the therapist observed that he moved from one toy to the next very quickly and did not seem absorbed in his play. He displayed some perfectionistic tendency by carefully packing away every toy he moves away from. He began playing with the miniature toy cars, then moved to the trucks, and then moved to the box of puzzles. Lizo had moments where he stood still and appeared to be unaware of his surrounding and dissociating. He continued his play, which was predominantly dominated by small cars and trains. He chose a car that has miniature people inside it and decided to remove the people from the car. When the therapist reflected that he didn't want the people in the car, he was taking the people out, he further stated, he took the people out because they could not drive anyway. He then continued driving the car without the people. As he was driving he began talking about his friend who had inserted plastic into him. Stating his name and they were play buddies. While telling the therapist about his friend, he appeared to be anxious. He suddenly started telling the therapist that he had ten friends. She reflected that he had many friends to which he responded he could count to twenty and demonstrated. He put the train away in a box and after being reminded that he had five minutes, he took a plastic sword and exclaimed "I wish this was a real blade I would stab some-one with it" The therapist reflected that there was someone he wishes to stab and he responded "no, no-one" and he said he wanted to go to the toilet. At which point the therapist informed him he could not come back to the playroom as the time had run out. He went to the toilet with the therapist's company and afterwards he ran to his grandmother in the waiting area and snuggled to her and asked for his lunchbox.

Session Two

This session also consisted of a play anda non-play section, described in the so named sections below.

Non-play activities

The second session was shorter in duration due to Lizo's grandmother having transport problems and subsequently arriving 45 minutes late. After addressing the time concern with his mother, the therapist explained to him that the session would be shorter. Lizo willingly went to the playroom with the therapist.

Play activities

Lizo played with a puzzle and was forcing pieces to fit then he became frustrated and put it away. The therapist reflected Lizo's feeling of frustration with the puzzle not fitting. He began playing with the doctor's kit, taking the medical instruments out one by one, looking at them and playing with the stethoscope by demonstrating where it should be placed, then putting them back inside the kit and struggling to close the kit but eventually closing it. He suddenly moved to the miniature toy cars and drove them around. When he was done he put them in the box. His play ended with him packing every toy back to where he found them. Before the session ended, he packed the medical kit into the cupboard and put the puzzle back to its box. He appeared pre-occupied with putting everything. The session ended and he ran to his grandmother to have his sandwich.

Session Three

Session three consisted of activities in both non play and play and they are both described.

Non play activities

In the waiting area, Lizo sat in the wooden horse and was sucking his thumb. He appeared to be 'blanking out'. His grandmother was sitting in the couch not too far from him. The therapist approached him and attempted engaging him, by asking if he had ever seen a red horse before. He responded he had seen it on television. He said goodbye to his grandmother at the therapist's request as they walked to the playroom.

Play activities

In the playroom Lizo played with the coloured counting board and rapidly moved on to play with the beach ball. He packed each toy away when moving to the next toy. He took the paint tubs and placed them in the small table, and started painting, while naming the colours that he was painting, which were red, yellow and blue. He said nothing about the nature of the picture but only mentioned the colours; the picture itself had no definite form and appeared to be a mixture of the paints. The therapist sensed he was showing her that he knew colours; The therapist reflected "you are naming all the colours as you paint, you know the colours" he seemed to be in a good mood after this activity, and made up a song for the therapist and danced, then looked at her and laughed. The therapist sensed that he might feel that his song was silly; the therapist engaged with him and danced along with him. He asked the therapist to go to the toilet and asked her to go inside with him, as he was scared. On return to the playroom he took the beach ball and kicked it around then towards the therapist and they kicked it back and forth between them. The therapist informed him to get ready for ending as there were five minutes left in the session. The session ended and he returned to his grandmother in the waiting area and asked for eats.

Session Four

Session four consisted of non-play activities and play activity. The non-play activity consisted of observations of Lizo prior to play.

Non-play activities

Lizo was sitting in the small table in the waiting area and sucking his thumb. His grandmother had brought him in. He was not playing with the toys in the waiting area. The therapist greeted him and he responded. the therapist noticed that his hand was placed in his pants, specifically in his genital area.

Play activities

In this session Lizo moved from toy to toy fast and ensured that each toy was placed back to where it was taken as he moved from one to the next. Firstly, he played with the small car toys, driving them around and making car engine noises and he then moved to paintings. He opened the paint tubs and began painting colours, ensuring he named each of the colours as he painted them blue, red, yellow. The therapist realised that this was a demonstration for her. She engaged with him regarding the colours stating that he knew the names of the colours. His painting again appeared to be just a mixture of colours and had no identifiable form. Lizo moved on to the reading corner and picked out a book. He gave the therapist the book and she read it for him. The book was entitled when "I'm feeling loved" and was about identifying the emotion of love as it occurs. After reading the book he took it and made up his own story for the therapist. His narration although it consisted of inconsistent stories was of a violent theme. He explained how the one of the main characters in the book would beat someone up. The same character told someone and the children to take their pants off and this character who he calls uncle would hit someone who did not play along. The therapist engaged him by empathically experiencing and reflecting his feeling of fear and stated that "the children are scared and hurt by this character who hits them". He looked at the therapist and then moved to play with a box of cards and puzzles. He did not seem absorbed or present in the play and moved between the cards and the puzzles. He piled the cards and the puzzle pieces on top of each other. The session ended and he went to his grandmother and took his juice bottle.

Session Five

The events that precipitated during the non-play and during play activity for this session are illustrated below.

Non-play activities

Lizo arrived with his mother early and they waited in the waiting area. Lizo sat on the wooden horse with his thumb in his mouth. The therapistapproached him and greeted as he screamed out “Kanyisa” The therapist asked him if he came to the clinic by horse or by bus or taxi and he laughingly responded that he came by taxi and he then followed the therapist to the playroom.

Play activities

Lizo began play by taking out a box of Lego from the cupboard. He built structures resembling cars which he drove around making car engine sounds. The therapist noticed that he seemed absorbed in his play and did not seem pre-occupied with ordering the toys. He left the Lego box and went to play with the small toy cars that have the miniature toy people inside. There was a slight noise outside and he got startled. The therapist reassured him he had nothing to worry about it was just people outside. Surprisingly, he was able to tell the therapist about the boy who had sexually assaulted him stating that when the event happened, he cried and ran to tell the boy’s mother, who reprimanded the boy. The therapist empathised with him stating that he must have felt scared, and that this boy hurt him, also stating that he was strong enough to tell the boy’s mother. He then asked the therapist if he still had time left in the playroom. She reassured him that he had enough time. He asked to go to the toilet and asked her to go with him. On return to the playroom, he took a tub of bubbles, blew them and asked the therapist to blow the bubbles,and hechased them and bursts them. That activity continued until the session ended and he rushed to the waiting room and opened his lunchbox.

Session six

In session six there were both the play and the non-play activities that were observed and are described below.

Non-play activity

Lizo and his mother arrived twenty minutes late and mentioned that they were delayed through public transport. The therapist greeted and invited Lizo to the playroom and he was excited and followed.

Play activities

Lizo began play with the small toy cars withminiature toy people inside. While driving these cars he made a lot of critical talk towards the figures. He stated "You are stupid" 'you do not listen" "you are a bad boy". The therapist enquired how the miniature persons are bad and Lizo stated that he did not know why. Lizo's play moved to the doll after spending considerable time with the cars. His speech was still very critical. He said to the doll "you are stupid!" "You do not listen!" "You are a bad child!". Further stating the doll had soiled itself and did not listen and should be thrown in the forest, as it is a disgusting doll. Understanding the level of shame Lizo was experiencing and reflecting the involuntary nature of encopresis. The therapist empathised with the 'doll' stating the doll made a mistake, everyone makes a mistake. He took the doll and cleaned it up with tissue paper and stated that it is was fine to make a mistake. He suddenly stated that the doll had done it again, it had soiled itself again, it did this throughout the day and it is disgusting. For consistence in ensuring empathy the therapist re-iterated to Lizo that it was ok to make a mistake. Lizo cleaned the doll again, taking more and more tissue from the box. Lizo then began to tell the therapist that his mother shouted at him when he made the mistake and told the therapist that he did not mean to make the mistake. The therapist empathised with his feeling of shame and frustration and stated that perhaps his mother did not know how to deal with the mistake but that she should not shout at him because sometimes people make mistakes. Lizo noticed a black doll on the floor and told the therapist he was scared of it. The therapist valued the statement as significant as Lizo was a macho boy and did not willingly express his emotions; The therapist perceived that trust had developed in the therapeutic relationship. The session ended and he went to his mother. The

therapist made plans to have a meeting with his mother regarding parenting skills and review on Lizo's progress at home.

Session Seven

Session seven was an essential part of the therapy process as it was a review of Lizo's functioning and a psycho-education regarding parenting skills and Lizo's symptoms. This meeting facilitated collaborative alliance between Lizo's mother and the therapist. In essence, this session was only non-play in nature.

Non-play activities

The therapist had a meeting with Lizo's mother with the intention of reviewing Lizo's progress at home and to discuss alternative parenting approaches with her. Lizo's mother informed the therapist that she has seen improvement regarding specifically Lizo's encopresis; she stated that the frequency had decreased significantly as he only had 'accidents' approximately once in a week for the past two weeks. She stated that his play with friends was also becoming less aggressive. The therapist relayed that she wanted to discuss more beneficial methods of dealing with Lizo's difficulties to ensure more improvement. the therapist emphasised that Lizo's mother was not a bad parent, but that there were approaches that have been shown to be effective and some that are likely to worsen the difficulties Lizo was experiencing. The therapist provided a psycho-education to her regarding Lizo's PTSD symptoms, particularly regarding the regressive behaviours, such as the encopresis, to increase her sense of empathy for Lizo's experience. The therapist recommended that encouraging Lizo in his positive behaviours was more beneficial to punishing him for the negative behaviours. The therapist also engaged in a conversation about his progress in play therapy, mentioning specifically the nature of the therapeutic relationship; Lizo was initially very anxious in the playroom but was at that stage becoming more comfortable and able to express more of his feelings through play.

Session Eight

The eighth session commenced a month after session seven. The non-play activities section provides more detail regarding the reason for this. In this session, the non-play section consisted of prior to play and after play activities. The play section covers the activities that ensued in the playroom.

Non-play activity

Lizo waited with his grandmother in the waiting room and sat on the small table and appeared anxious. The therapist had not seen Lizo for a month since the meeting with his mother regarding reviewing and psycho-educating her on parenting skills.Lizo's grandmother informed the therapist that they could not afford transportation to bring him to the clinic. The therapist approached and greeted Lizo and he did not speak but willingly followed her to the playroom.

Play-activity

This session Lizo's play was chaotic as he moved from one of the small toy cars to the other. He played with the small toy cars driving them into the wall and into the door. He aggressively hit the small toy cars against the door, against the bigger toy cars, and against each other. He moved around the playroom and begun to tell the therapist a story of a character named Matolwana who was silly and did silly things. His story was incoherent but the only recognisable content was that he was critical of the character. He spent time talking about this character that was silly and went to people's houses and took food. Later the therapist realised he was narrating a story line of a comedy he had seen on television. Lizo took the small car toys again and aggressively pushed them against the door. The therapist accepted his behaviour and reflected that he was really having a go at the cars. The session ended and he went to his grandmother in the waiting area.

Non-play activity

After the session the therapist consulted with the grandmother as Lizo was having lunch and enquired how he was doing as she had not seen him in a month. She reported that the encopresis had returned to the initial frequency of every time he had a proper meal. She further informed the therapist that Lizo had been complaining of irritation around his anal region. She reported that he had been experiencing headaches more frequently. Lizo's grandmother stated that Lizo said his teacher would use a duster on his head to discipline him. The therapist made a referral of Lizo to a medical doctor to have a medical examination to determine if there had been any sexual contact. The therapist engaged Lizo's grandmother regarding a commitment to bring Lizo for at least three consistent sessions. The therapist also needed to focus on rebuilding trust with him. Later the therapit called Lizo's teacher to enquire about her discipline methods and she denied using a duster on Lizo.

Session Nine

Session nine consisted of both non-play activities and play-activities, both described below

Non-play activities

Lizo was brought by his grand-mother for therapy and they were a few minutes late. As they arrived the therapist immediately invited Lizo to the playroom after greeting them.

Play activities

In the playroom Lizo spoke about his little sister, who it was later found out was actually his neighbour and not his sister. Lizo told of how his little sister was so small and cried often. The therapist empathically responded that small babies cry sometimes because they cannot talk and they need something. The therapist enquired about Lizo's own feeling and if he ever felt like that and he responded no. Lizo moved to tell the story of his friend who had sexually assaulted him. He stated that this boy is gay and walks funny like a gay. In attempting

empathic listening and understanding, the therapist enquired what a gay is and he responded in a critical, yet adult voice “that boy, that gay”. For safety purposes, the therapist enquired if he still plays with the boy. He told of how he was still playing with him, and eating lunch at his home and referred to the boy’s mother as aunt. Lizo suddenly enquired whether his time was up and was informedthat he still had a few minutes left and he continued to play. His play was aggressive and consisted of hitting the small toy cars on each other, and throwing balls all over the playroom. Lizo began to talk about how he was watching television and people were swearing. He told a story about a character named Matolwane who is a liar, tells lies about everything and touches people’s bums. Concerned with Lizo’s safety, the therapist stated that Matolwana should not be touching people’s bums. Lizo moved to talk about the boy who perpetrated the sexual assault stating again that he is a gay. The session ended and the therapist walked Lizo to his grandmother in the waiting area.

Session Ten

Session ten consisted of non-play activities which include a feedback report from the medical doctor and a discussion of safety regarding whether Lizo was still playing with the boy who perpetrated the act. The play activity consists of activities that occurred in the playroom.

Non-play activity

Lizo was sitting next to his grandmother and drinking juice from his juice bottle.the therapist approached them and requested that his grandmother accompany her to the office for feedback on the doctor’s report as she had earlier requested. Lizo’s grandmother stated that they had financial difficulty consulting a private doctor and that they eventually went to a public hospital. The letter from the medical examination reported that Lizo showed no signs of sexual abuse or bruising in his genital area at the time of observation. Lizo’s grandmother also stated that Lizo had not had encopresis for the two weeks he came back to therapy. She reported that Lizo sometimes plays with the boy that had perpetrated the trauma but she

ensures to watch them. The therapist fetched Lizo from the waiting area where he was sitting on the couch and went to play.

Play activities

Lizo began play with a ball he had taken from the cupboard and threw in the air; then he looked at the therapist and smiled. The therapist smiled at him and he kicked the ball to herand we kicked it back and forth a few times. Lizo then decided that it was time to take the ball and put it back in the cupboard. He took the doll from its court and put it on the table. He stated "the doll has not soiled itself". He gave it a dummy and stated "take your dummy, you cry a lot" "this baby is being hurt by the older child". He took the bigger doll and hit the smaller doll with it stating towards the small doll "you soiled yourself, you stupid child". He swiftly moved on to the big doll's bag and asked why there is nothing inside to which the therapist responded "you wanted something in the doll's bag" He went on to state that the big doll was not stupid, it had brains. Moving from the activity, he took the small doll and put it in the court stating that the child was sleeping. He threw the plastic food out of the court and stated the small doll was not eating because of the big child. The therapist attempted to understand his feeling behind this statement by reflecting the statement that the child did not eat because of the big doll. He took the small doll from the court and hit the big doll with it then took the small doll back to the court. His tone became critical and was directed at the big doll and he stated "you are doing nonsense" "why do you hit the small child" "You are stupid, a witch, and rude", while hitting the big doll himself. He moved to the small doll in the court, stating in a nurturing tone that it is 'boss'. He took the small doll and placed it in a bag then placed the bag back in the court. He went on to tell the therapist that the small doll's mother and father would hit the big doll. He suddenly asked if hewas out of time to which the therapist re-assured him he still had time. He told the therapist about the big doll being stupid and robbing the small doll of money. Lizo then moved to painting and made paint mixing sounds.

He went on to tell the therapist of a character named ‘gundu-gundu’ who goes to his school then he stated that in his school one gets hit even if he is quiet and that he would just say it was not him. Lizo folded the painting that he made stating that it was ugly then throwing it to the bin. He made a second painting which he folded and threw in the bin as well. The therapist reflected his unhappiness with his paintings and that he did not want ugly paintings. He suddenly stated that his mother was ‘boss’ and no-one would dare mess with her. The session ended and he ran to his grandmother.

Session 11

The session consists of describing non-play activities and play activities with Lizo and his mother. Importantly, a discussion with his mother is also described.

Non play activities

In the waiting area, Lizo was sitting on the red wooden horse. The therapist noticed he was not sucking his thumb. The therapist approached him and his mother and Lizo seemed excited. The therapist soon found out that Lizo had a poem that he learnt at school about Nelson Mandela which he happily recited for her in the hallway. He seemed to be enjoying the attention he received from the people in the hallway, the therapist, and his mother.

Play Activity

In the playroomthe therapist decided to take a more directive approach for the session because of the safety concern regarding him still being exposed to and playing with the boy who had perpetrated the trauma. The therapist educated him regarding his private areas and that no-one was allowed to touch him there, except for bathing by a parent. Further they discussed good and bad touches and that he had the right to say no and scream if someone touched him inappropriately. They constructed a hand of helpers, which was made from tracing his hand with a marker on paper and then discussing the names people he could tell if someone touched

him in a bad way or in his private area. He identified; his mother, his teacher, his grandmother, and his dad. The remainder of the session was spent with Lizo painting and making his paint mixing sounds. The therapy ended and the therapist had a short discussion with his mother regarding contracting for four more sessions, stating the progress she had observed,and considering the family's financial difficulties. Lizo's mother reported also seeing improvement in his mood as he did not cry as often. She agreed to commit to four more sessions.

Session Twelve

Session 12 follows the same approach of non-play and play activities. In this instance the non-play activities comprisesonly activities prior to the session.

Non play activities

Lizo sat with his mother in the waiting area and when the therapist approached he ran to her to show her his school report for the first semester saying he did well at school.the therapist read it and told him that he did very well and gave him a hug. The report indicated that he was completing his work, and was able to work co-operatively with others.

Play activity

In the playroom Lizo started off play by driving the small toy cars around the playroom. Then he moved to the dolls in the play house. He placed the big and the small doll on the table. He took the small doll and hit the big doll with it while talking in a critical voice stating the big doll was bad. The therapist enquired about the dolls ages, to have empathic understanding because he had consistently played with them. He told her the small doll was four years old while the big doll was seven years old. The therapist reflected the fighting activity which often happened between the dolls to him. Lizo moved to take a large ball and a small ball and placed them next to each other. He took the plastic giraffes toys, both large and small, and placed them next to each other. He took a large and a small plastic toy dog and placed them next to each other on the floor. He asked the therapist to help him place the balls, and the giraffes on

the floor. The therapist wondered if this theme was of perpetrator versus victim or of mother and child. He then moved to the plastic box which kept toys and climbed on top of it. The therapist engaged with him in a permissive manner and allowed him the behaviour. He asked to go to the toilet and he was allowed. He returned, then he asked to go again for number two; he wasthen informed that he could go but the session would have to end as he had already gone once before. He decided to go to the toilet and the session ended.

Session 13

This session consists of an unfortunate but significant event in the non-activity section, whereby Lizo had an experience of encopresis on his way to the clinic. Play activity involved aspects of his attempt to deal with the event.

Non-play activity

Lizo had again missed play therapy for a three weeks and his grandmother reported that they could not afford transportation money. Lizo was sitting next to his grandmother and the therapist realised that there was an odour in the vicinity. People passing through the hallway were also commenting on it. The therapist was subsequently informed that Lizo had experienced encopresis on his way to the clinic. His grandmother attempted cleaning him up in the clinic toilets but the odour remained. When the therapist fetched Lizo to go to the playroom he was feeling ashamed but still gave her a hug.

Play activity

Lizo began play by taking out small toy planes and throwing them in the air, and then he suddenly took them and placed them on the floor in an orderly manner. He moved from this activity to a tub of bubbles, filled it up with water until it overflew and did not turn the tap off but continued pouring water into the tub. The therapist allowed him this and did not interject in his activity. He then moved to the paint tubs on the table and named the colour of each tub. He asked the therapist if he still had time to play a lot. The therapist re-assured him that there was

still enough time. He took a toy bus and wanted to show it to his grandmother as they also came by bus. The therapist told him he could show granny for a minute when the session ends. He then told the therapist about how his friend was proud of his dancing skills and that every time he danced; his friend proclaimed that he is 'boss'. He then moved on to tell the therapist about his teacher and how she was proud of him because he finished the fastest of all the other children in class. The therapist sensed that he was communicating a need for acceptance and she reflected from his content that many people are proud of him. He made a painting and folded it, then asked if he could take it home and the therapist informed him it was up to him. He then stated "it smells good here-like food". The therapist considered that it was his way of checking if she could smell the remnant odour from the encopresis earlier and the shame he could be feeling. The therapist empathically reflected "you are distracted by the smell and wondering what it is". He looked at her and then moved to take a train and aggressively drove it against the door. He then loaded small car toys, blocks and other small trucks into a large truck and stated that he was busy. The therapist sensed he was feeling overwhelmed and reflected that he was very busy. He took the wheels of the large truck off then put them back again, then out and then back on again. Then he said with an exhausted voice "now that is better". He asked to go to the toilet and this time he asked the therapist to wait for him outside instead of going in with him. He came back and engaged in play with the two dolls again. The small doll hit the large doll until he stated it was dead. As shown in appendix , he nurtured the small doll by placing it in the court and covering it with pillows, clothes, plastic covers and box of crayons and stated "I like this child". The therapist empathically responded to him stating she sees that he likes this child. He asked to go to the toilet again and was reminded of the limit of only going once. He decided to go to the toilet and his grandmother assisted him.

Session Fourteen

Session 14 included both non play and play activities. This session had suddenly become the pre-ending therapy session and this is discussed in the non-play section.

Non-play activity

Lizo's mother and the therapist had a telephonic review meeting in which Lizo's mother stated that both her and her grandmother have difficulty bringing Lizo and would like to pursue a traditional approach of dealing with Lizo's difficulty. The traditional approach entailed an ancestral ceremony according to Lizo's father's clan. The therapist informed her that she respected their wish and that she had to prepare Lizo for ending therapy and agreed that the session following the week's session would be the last. Lizo's mother brought Lizo for therapy and in the waiting area Lizo was sitting in the wooden horse and as the therapist approached him he ran towards her.

Play activity

Lizo's play was predominantly with the dolls. He took the small doll and nurtured it by placing it in the bag and placing the bag in the court then stating that the doll was smart, and beautiful. He moved to paint a figure that looked like it could be a heart. He took coloured pens and wrote his name and the therapist sensed that he wanted approval and respond that she could see he was able to write his name. The therapist took a more directive approach as she prepared him for the next session being the last one. She shared with him how she had enjoyed playing with him for the past few months and that she thought he was better able to show his friends his playing skills. The therapist informed him that the next week would be their last play together but that he could have more time to play with his friends the same as he did with her. He did not respond and the session soon ends.

Session Fifteen

This was the ending session which unfortunately happened approximately three weeks after the 14th session. Both the play and non-play activities which ensued are described.

Non-play activity

Three weeks had passed since Lizo's mother had promised to bring him for the therapy ending session. This concerned the therapist as she had told Lizo she would play with him in one last session and he may have felt betrayed and abandoned, and could affect or exacerbating his symptoms. Attempts to have the final session with Lizo, were for the duration of three weeks unsuccessful. Lizo's mother reported that Lizo had relapsed back to his encopresis although the severity was approximately once a week. Lizo's mother brought him in for the last play session on the third week. Lizo was excited to see the therapist and she told him how happy she was to see him.

Play activity

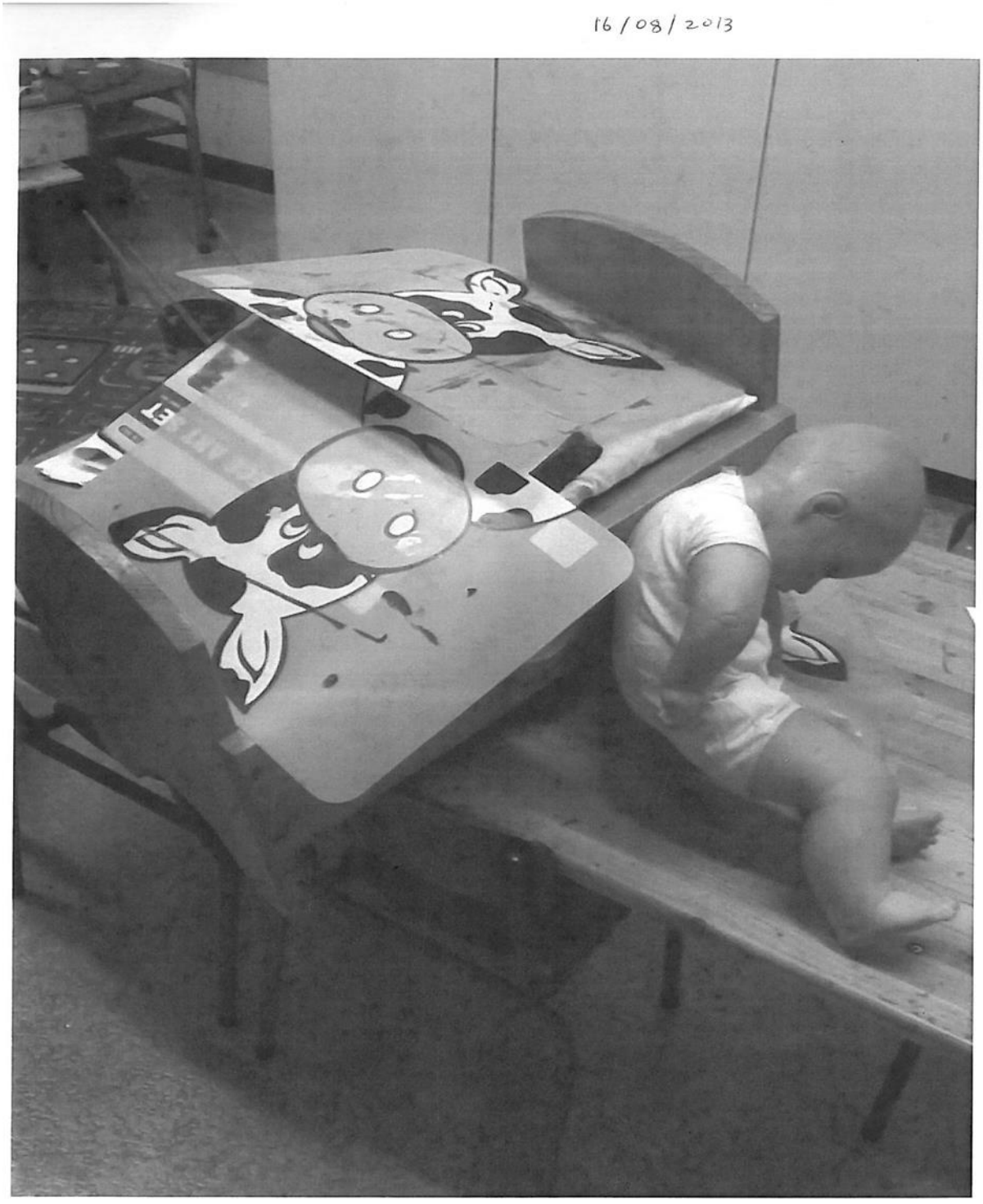
In the playroom Lizo played with the big toy truck and loaded the smaller toy cars into the truck looked at the therapist and giggled. The therapist sensed his need for connecting with the therapist and she smiled at him. He moved rapidly to a box of colour sticks and a box of cards. He took out the colour sticks and puts them back in the box again. Then he asked the therapist to play the card game with him. The cards had pictures of objects in them and he asks her what objects she has in her cards. He shows her his cards and they have; a car, a rake, a gun, a mouse, and the sun. After this card game ends he returns the cards into the box.

The therapist took a more directive approach to confront the issues relating to ending of therapy; by reminding him of the last time he was at the playroom, and that she had told him we would have one last play to say goodbye. She informed him that this would be that session and that she had enjoyed playing with him. The mood changed and he appeared to be sad, the therapist reflected this feeling of sadness by stating that he was not happy about ending play

and that she understood that. She further stated that he would have more time to play with his friends at school and at home and he would show them his play skills. The session ended as he went to his mother in the waiting area, and goodbyes were said.

Appendix5: Painting without Form

Appendix6: Protected Doll



Appendix 7

Confidential Report

8/9/2014

Miss S. J

Port Elizabeth

6000

Dear Miss J

Re: Summary of the Research Study Conducted with your Son's Therapy Material

Thank you for allowing me the opportunity to, firstly work with your son in therapy, and secondly, utilise his therapeutic process for research study. During the therapy process your son was a pleasure to work with, and further, the research project was an insightful and enjoyable experience for me. Below is a summary of the research the therapistconducted on your son's therapy process and includes the research aim, the research method and findings, and the conclusions, for your perusal

Reason for Referral

Your son was referred by a clinical psychologist from the public hospital for play therapy as she could not assist him with play therapy due to lack of resources at the hospital. She stated that he had experienced sexual abuse and was experiencing encopresis. Upon intake, you reported that the sexual assault had occurred two months prior to the consultation and the trauma was inflicted by a seven year old boy from the neighbourhood who had inserted a plastic into his anus. You reported that he had since the event been aggressive towards other children and that he recently had a poor appetite, whenever he had eaten, he would soil him-self, an experience which is referred to as encopresis. He was further reported to be moody and would cry easily and become clingy particularly to his grandmother. Also, he was reported to

be experiencing headaches since the event occurred and he would frequently complain of this pain. Clinical observations and information gathered from both you and his grandmother confirmed that he met the criteria for Posttraumatic Stress Disorder (PTSD).

Biographical Information

Name : J

Age : 4 years 8 months to 5 years 3 months

Grade : R

Language : Xhosa

Siblings : older maternal sister deceased, unknown number of half-siblings from father

Father's age :43

Mother's age: 41

Developmental History

You reported that he was born full term in a normal birth with no complications. Further you reported that you were on anti-depressants while pregnant with him due to experiencing Major Depressive Disorder from the death of your first born child who passed away two years prior to falling pregnant with your son. No other illnesses were reported from the first trimester of the pregnancy to delivery and no use of alcohol, smoking and illicit drugs during pregnancy was reported. Developmental milestones were reported to have been reached age appropriately by your son.

Scholastic History

It was reported that your son started attending preschool at age three years and was at the time of therapy, four years eight months old and in grade R. He was reported to have fought with other children in class. Academically, he was reported to be a bright child who was able to write his name.

Family History

It was reported that your son was born as the second child to you and it is not known how many children his father has with other women. It was reported that you were single, while his father was undergoing a process of divorce from his marriage of approximately four years, and that you were never married to each other. It was reported that your son lived with you at her two bedroom house and sometimes lived with his grandmother at her two bedroom house. At his grandmother's house he lived with; his uncle-who was sick, and struggled with drug abuse and unemployment, and his grandmother who receives old age pension.

The Research Study

This section describes the elements of the research study that was undertaken with the information gathered from the therapeutic process with your son.

Aim of the Research Study

The aim of the research was to explore and describe the process that unfolded during child centred play therapy, which was conducted with your son to treat his experience of PTSD.

Methodology of the Study

This section summarises the research methodology followed in conducting the research study. The research was qualitative in nature and that means the information that was gathered was in a form of a narrative and not involving numerical information. As the aim has stated it was intended for describing the process applied in the play therapy.

Participant

The research participant was selected based on the criteria that he had undergone child-centred play therapy for treating PTSD.

Procedure

Permission to conduct the current research study was obtained from the Faculty Research, Technology and Innovation Committee, and the Research Ethics Committee-Human at the

Nelson Mandela Metropolitan University. As the therapy process had been completed, written informed consent was obtained from yourself, the research participant's mother, to conduct the current case study as the participant is a minor. This ensured that the subject's mother had a comprehensive understanding about the research study and her rights and those of her child concerning the study, and confidentiality and anonymity were ensured. The main data source for the study consisted of relevant data extracted from the case file, including process notes, reports from his medical doctor, and his school teacher, which have been and will continue to be stored at the University Psychology Clinic situated in the Department of Psychology at the Nelson Mandela Metropolitan University until the researcher's degree has been awarded.

Data analysis

The information that was collected from your son's case file was then analysed using the child-centred play therapy frame work as the basis. The framework consists of eight principles which describe how child centred play therapy is conducted with children. These principles are; 1. Establish a warm and friendly relationship with the child; 2. Accept the child unconditionally for who he or she is; 3. Create an atmosphere of permissiveness in the relationship to encourage the child's expression of feelings; 4. Recognise the feelings which the child is expressing in speech and play and reflect these back so that the child can get some insight into his or her behaviour; 5. Show deep respect for the child's ability to solve his or her own problems when given the opportunity, and that the responsibility to make changes belongs to the child; 6. Make no attempt to direct the child's actions or conversation during play and allow the child to lead; 7. Make no attempts to hurry the therapy process but recognise that the process is gradual; 8. Establish only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility. The analysis was then checked by another psychologist with competency in this therapeutic approach to

ensure that the research was of good quality and did not comprises bias. A summary of the findings is provided below.

Findings of the study

The research findings were looked at from the framework of child centred play therapy which was briefly described above. How each principle was applied and unfolded with your son during the therapy sessions conducted with him was observed and documented. The findings suggested that there were patterns which emanated from the sessions during child centred play therapy, and they are; control or perfectionism, nurturing and protecting, re-assurance and need for approval, and establishment of a trusting relationship.

Establishing a trusting therapeutic relationship with your son was very important, once established it was not affected by external factors such as not seeing each other in instances when it became difficult to bring him to therapy. The first time he missed a month of therapy, he returned with a chaotic manner in play that signalled mistrust in the relationship. By the therapy ending session, after missing a month of therapy, the relationship was not affected. When he saw the therapist, he was excited and in the playroom he invited her to play with him.

The theme of needing to have control or attempting to maintain perfection was common in his play and it indicated a feeling of shame. In the earlier sessions he took the toy people out of the car, and he also carefully packed each toys back after playing with it. Further along in the therapy process he started talking to the toy people and he also stopped packing the toys after playing with them. This was indicative of him becoming more independent and overcoming his shame. Although there were still some instances when he needed to achieve perfectionism, for example, he made paintings and threw them away because they were not perfect.

He used critical talk during play when he spoke to the miniature toy people, and fantasy characters, and two dolls in the playroom. He criticised them regarding having encopresis,

being abusive, and being stupid. This was clearly indicative of a theme of shame which was also associated with elements of his traumatic experience.

A theme of nurturing emerged as therapy progressed where he began speaking to the dolls in the playroom in an approving tone, telling the small doll it was smart and that he loved it. Further he cleaned the doll up when it had experienced encopresis and stated that it had made a mistake and it was fine to make a mistake. He also protected the small doll by stating that the doll's mother and the doll's father would hit the big doll. Also, he protected the small doll by covering it up with plastic covers, clothes and a box of crayons while it lay in the court. This is recognised as a resolution of the shame and developing a sense of independence.

At times he needed re-assurance and sought approval from the therapist which was demonstrated through his frequent need to know if he still had time left in the session. He also needed approval for his abilities such as counting to ten and writing his name and naming colours.

He experienced of dissociation and thumb sucking was present in the earlier stages of therapy. Dissociation is a disturbance in the integration of identity, memory, and consciousness and may be found in association with PTSD. With progress in therapy, thumb sucking was eradicated and the experience of dissociation as it did not occur from session eleven onwards.

Limits of the study

The limits of the current study involve the research participant family needing to end therapy prematurely and pursue an alternative cultural method; and the therapeutic process could not achieve complete success. Further, financial difficulties regarding bringing the research participant to therapy consistently, delayed the progression of therapy, consequently, the research was not of a smooth treatment process.

Possible bias regarding the researcher's objectivity was addressed by utilising approved methods of ensuring trustworthiness; and the research was expected to be trustworthy.

Conclusions

The research study was conducted successfully and resulted in a treatise which will be available at the NMMU library. It offered insight and learning to the researcher and will add to a body of knowledge regarding therapeutic approaches for treatment of PTSD in children for the public.

I hope this summary provides you with clarity regarding the research on your son's therapy process. Should you have any queries regarding the research please feel free to contact, 041 504 2330.

Sincerely,

Miss K. Nyanga Professor C.N. Hoelson

Intern Clinical Psychologist Research Supervisor and Clinical Psychologist