

**The Process of Relational Play Therapy between a Trainee Therapist and a
Maltreated Child: A Case Study**

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Dedication

This treatise is dedicated to the therapists and clients who risk engaging in relational therapy, and who are undoubtedly changed because of it.

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Abstract

Research in the field of attachment theory and object relations theory has indicated that early attachments between a child and his or her primary caregiver have significant implications for the development of that child. Early relationships begin to shape the child's sense of self and other and healthy relationships lead to secure attachments. However, children who encounter early maltreatment or a disruption in caregivers are particularly vulnerable to developing insecure attachments and a disrupted sense of self and other, which has consequences for their subsequent psychological development.

In the South African context, increasing numbers of children are being orphaned or placed in formal foster care with many children at risk for insecure attachments. This has implications for therapeutic work with an increased need to promote secure attachment relationships and a stable sense of self and other. The current case study aimed to describe the relational experience of play therapy that took place between a maltreated five year old female child and a female trainee therapist with this purpose in mind. The therapeutic process was embedded within a relational therapy framework which included object relations and attachment theory. The researcher made use of a qualitative descriptive dialogic research approach to conduct the research. The data were analysed using content analysis, where the play therapy sessions were analysed according to concepts relating to Fairbairn's (1963) object relations theory as well as Winnicott's (1965) object relations theory. Prominent themes that emerged included the role of the holding environment, splitting of good and bad objects and the presence of a false self versus a true self. In addition, the conflicting presence of two repressed ego structures, namely the libidinal and antilibidinal ego structure were noted throughout the therapeutic process.

Keywords: antilibidinal ego; attachment theory; case study research; descriptive dialogic; libidinal ego; research design; object relations theory; play therapy; relational therapy

Declaration

I, Sheralyn Ann Watkiss, student number 202316769, hereby declare that this treatise for the degree Magister Artium in Counselling Psychology is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another university or for another qualification.

Sheralyn Ann Watkiss

Date

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CHAPTER ONE

INTRODUCTION AND MOTIVATION FOR THE STUDY

“There is no greater agony than bearing an untold story inside you.”

— Maya Angelou

Introduction

There is a story that as yet is untold. It is the story of a five year old girl child and her female therapist, and their relational process through therapy. It is also the story of the relationship between a therapist and the child and the risks and rewards of relational connecting. It is the story about a trainee therapist and the development of a therapeutic self. Finally, it is a story of exploring and integrating the above into a mode of research that creates a space for the untold story to be told, and for a sense of meaning to be created.

Why does this particular case or story warrant telling? One could argue that every person has a story and a journey that is meaningful and to which there should be witnesses, however, it is also the researcher’s belief that this story has relevance in terms of therapeutic training and work with children in South Africa. At this point it is relevant to provide a context for the proposed study.

Motivation for the Current Study

It has long been established in literature and clinical practice that parents and caregivers play a fundamental role in children’s development. According to Seligman (2012), experiences during infancy affect how adults feel and interact with others and themselves. Similarly, Howe, Brandon, Hinings and Schofield (1999, p. 9) indicate that “the quality and character of children’s close relationships is proving to be the central concept linking the countless factors that have a bearing on development.”

It is within the context of relationships that children are born and it is the quality and character of these close relationships that matter in a child's psychosocial development.

However, the macro-environment within which this case is framed is related to increasing numbers of children within the foster care system in South Africa. According to the United Nations Children's Fund (UNICEF, 2012), there are approximately 3.7 million orphans in South Africa, many of whom have lost parents to the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). In addition to children orphaned by HIV/AIDS, many children are victims of crime, abuse, and neglect. Accordingly, foster care has expanded in recent years. Data from the South African Security Agency in 2008 indicate that as many as half a million children in South Africa were in formal, court-ordered foster care as a result of maltreatment.

The World Health Organisation (WHO) defines child maltreatment as follows:

Child maltreatment includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished, namely, a) physical abuse; b) sexual abuse; c) neglect and negligent treatment; d) emotional abuse; and e) exploitation. (2013, para. 1)

Child maltreatment brings a new dimension to the view that children in foster care have of themselves and others. In addition, it influences the relationships that the children establish with caregivers in foster homes, since many of these children have histories of trauma, neglect and loss.

It is important to note that within maltreating families, children are not safe and do not trust their primary attachment figures to meet their needs for physical and emotional safety (Ryan, 2004). As a result, they develop internal and external strategies for feeling safe, often

by trying to organise their behaviour to increase parental attention coercively or alternatively to appear detached and self-sufficient. These strategies are then brought into children's new attachment relationships in foster care settings (Ryan, 2004). Benson and Haith (2009) mention that children in surrogate care have experienced a change in caregiver at least once, which has implications for a child's representation of 'self' as effective and 'others' as reliable. As a consequence O'Connor (2005) states that children who have been adopted, or who are in the foster care system, are at particular risk for neglect and for developing attachment disorders.

In response to the above, therapeutic work with maltreated children and their substitute families is increasingly recognised as a priority in clinical practice, since new environments alone can be insufficient in changing a child's internal working model (Ryan, 2004). By seeking to strengthen and promote more positive social environments for children, the intention is to disconfirm their insecure working models of both the 'self' and 'others'. If successful, this will increase children's resilience, thus enabling them to cope better with stress and adversity (Howe, et al., 1999). Play therapy is one route through which this can be achieved.

The current study describes the process of relational play therapy that was conducted with a girl child who was considered to have a history of maltreatment. The case study is a retrospective analysis of the therapeutic process. The researcher in this case was also the trainee therapist and is therefore referred to in the first person where relevant. Pseudonyms were used throughout the study when referring to the child participant and her foster family.

A relevant consideration to the current research is that it was influenced in a number of ways by time frames. Firstly, the therapy process itself was influenced by time constraints. Whereas, traditional psychodynamic therapy is considered long term (Seligman, 2012), the practicality of this arrangement was not possible given the context that the child participant

and her foster family find themselves. Seligman (2012) indicates that we [practitioners and researchers] need to think about linkages between conceptual levels and between processes occurring in different time frames. Seligman (p. 502) states that

I am referring simultaneously to the time frames of each psychotherapy session, ranging from the second-to-second and minute-to-minute flow of each hour to the processes that occur across sessions over days, weeks and months, and even years, as well as the decades and eras involved in a development of the individual's life.

The current study considers the process of relational play therapy that was experienced in the manner that Seligman describes above. Each moment of time in play therapy was considered to be important to the child's development of 'self' and 'self-other' interactions. It is this process that I wish to describe in this study.

Additional time frames that were relevant to this study include my own therapeutic training. There was a period of time assigned to my learning and growth within this Masters programme. This study is therefore influenced by the learning and therapeutic growth that has taken place. As a therapist in training, there are constraints in terms of what I can know in this moment of time, and as such I acknowledge that this study is framed within my current knowledge of both therapy and research. Finally, the research itself was influenced by time frames set by myself and various stakeholders.

Overview of Chapters

The current research is comprised of seven chapters including the current chapter. Chapter two provides an overview of object relations and attachment theory as these theories form the theoretical foundation of the current research. In particular, relevant works of Ronald Fairbairn, Donald Winnicott and the collective works of John Bowlby and Mary Ainsworth are discussed.

Chapter three considers the role of play in a child's development as it links to play therapy. Important historical influences of play therapy are discussed after which the concept of relational play therapy is described. Specific attention is paid to Benedict's (2006) object relations play therapy approach, which is considered to be an assimilative integration founded in object relations and drawing from concepts related to child centred play therapy and attachment theory.

Chapter four considers the specific methodology that was selected in meeting the aim of the current research. The methodology includes the design of the study as it provides a framework for meeting the aim and objectives. The primary aim of the current study was to describe the process of integrative relational play therapy that took place between a trainee therapist and a maltreated girl child. Specific objectives related firstly to describing the child's and trainee therapist's relationship through the lens of object relations and attachment theory. Secondly, the process of integrative relational therapy is described.

Chapter five provides a breakdown of the therapy sessions that took place between me and the child participant. In addition, my training and belief system concerning therapy is briefly described as this forms an important and relevant influence upon how the case was approached both in therapy as well as in terms of the research.

Chapter six highlights the findings of the therapeutic process when analysed according to relevant object relations theory. In addition, the findings are reported within Benedict's (2006) framework of object relations play therapy phases.

Chapter seven provides the final concluding remarks on the current study and its limitations and considers recommendations for future research.

CHAPTER TWO
THEORETICAL OVERVIEW OF CONCEPTS RELATING TO OBJECT
RELATIONS AND ATTACHMENT THEORY

“Indifference and neglect often do much more damage than outright dislike.”

J.K. Rowling, *Harry Potter and the Order of the Phoenix*

Introduction

The current chapter provides an overview of the theoretical concepts that informed the relational approach to play therapy employed in the current study as well as the theory that informed the analysis of the case. It is pertinent to provide an overview of these concepts and theories so as to create a foundation that describes the kind of play therapy that was conducted in the current research. The current research was informed and analysed specifically with four psychodynamic theorists in mind, namely Ronald Fairbairn, Donald Winnicott and the collective works of John Bowlby and Mary Ainsworth. All four theorists consider the mother or primary caregiver as an important figure in an infant’s development (Ainsworth, 1978; Bowlby, 1988; Fairbairn, 1963; Winnicott, 1965). Each of these theorists is discussed in the subsequent section with particular emphasis on the development of ‘self’ and ‘self-other’ relationships. Benedict’s (2006) object relations play therapy informed the therapeutic approach used in the current study. However, this approach is discussed in Chapter three under play therapy approaches.

While the current research does not use the specific work of Melanie Klein, she has had a prominent influence on object relations theory. Where relevant Klein’s concepts have been included and juxtaposed against the selected theories so as to provide further historical background and insight into selected theories.

General Assumptions of Object Relations Theory

The core of object relations theory is the human relationships that make up the psyche and the external ones in the real world. No other approach to human experience or therapy so focuses on the human need for relationship and its role in therapeutic change. (Stadter, 1996, p. 30)

Theorists in this field are concerned with how early parental relationships are internalised and how these representations provide a structure for the developing 'self', as well as for 'self-other' relational units (Nolan & Nolan, 2002). In essence, object relations theorists are concerned with how individuals relate to themselves and those around them.

Object relations theory is one of four theoretical models of psychodynamic psychotherapy. The other three include Self Psychology, Ego Psychology, and Attachment theory (Stadter, 1996). Melanie Klein is most often cited as the first object relations writer, although object relations concepts go back to Freud (Stadter). Where Freud is often considered to be the father of psychoanalysis and psychology in general, Klein is often referred to as the mother of object relation (Cashdan, 1988).

The original use of the term 'object' came about through the work of Freud in 1905.

The term is used to convey that sometimes people do not perceive others as they really are, but rather as they imagine them to be. It is as if they are having a relationship with a two dimensional fantasy object/person in their minds, rather than with a real multidimensional person. (Frankland, 2010, p. 6)

A real person is experienced as having both desirable and less desirable qualities, while a fantasy object may be inaccurately perceived as all good or all bad (Frankland, 2010).

Kernberg (1976, p.58) states that "the term 'object' in object relations theory should more properly be 'human object' since it reflects the traditional use of this term for relations with others." Cashdan (1988) indicates that these relations may be internal, external, fantasised or

real, but that they essentially focus on interactions with other human beings. Whereas Freud saw the libido as pleasure-seeking, object relations theorists see the libido as primarily object-seeking (Person, Cooper & Gabbard, 2005), that is, the focus is on the desire for relatedness.

An infant's first object relation is the internal representation of the mother or caregiver, which is understood by the infant as being part of him or herself (Teyber, 1992). It is only later in development that the infant acknowledges the separateness of the other person or other object. It is these early object relations that are thought to influence one's interpersonal and intrapersonal relationships throughout life (Teyber, 1992).

If one considers some of the basic premises on which object relations relies, theorists have typically held three fundamental assumptions (Benedict, 2006). Firstly, they believe that interpersonal relationships are the driving force of human development, that is, human development is socially constructed. Secondly, through these experiences and interactions with others, humans develop cognitive-affective structures about the self, others, and the relationship between the two, known as object relations (Benedict, 2006). These cognitive-affective structures are known to attachment theorists as internal working models and their development is reliant on the infant's interactions with others and more importantly, the infant's perception of those interactions, to form a sense of self (Benedict, 2006; Kaslow, 2002). The third assumption according to Benedict (2006) is that object relations develop during the first three years of life through the relationship between infant and primary caregiver or attachment figure, usually the mother.

Considering Fairbairn and Winnicott

Ronald Fairbairn and Donald Winnicott are often grouped together with Melanie Klein as part of the British School of Object Relations (Frankland, 2010). All three theorists focus on the importance of the early infant relationship with the mother or primary caregiver, and the influence of this relationship on later development of the self (Cashdan, 1988). However,

there are certain differences as well as similarities between their works. Similarities between the work of Klein (1952), Fairbairn (1963) and Winnicott (1965) include a belief in the importance of the early mother-child relationship which provides the setting for normal child development. In addition, similarities are noted with concepts such as *splitting* as well as *transference* and *countertransference*. Differences relate to the infants' *dependency* needs. These concepts are discussed in greater detail below.

The Role of Dependency

Fairbairn (1963) and Winnicott (1965) differ from Klein in that they focused on the operation of *dependency* in the relationship rather than on destructive *phantasies* proposed by Klein (Cashdan, 1988). The destructive phantasies that Klein (1952) speaks of refer to the psychic representation of an infant's biological instincts. A "newborn infant's world at the outset is a bodily world, and phantasy represents the infant's attempt to transform somatic events into a mental form" (Ogden, 2004, p. 11). That is, according to Klein (1952), the infant experiences a bodily conflict between love and hate, satisfaction and frustration. In this early stage, he or she phantasises about destroying the object that causes frustration (Phillips, 1998).

The use of 'ph' in phantasy refers to more of the unconscious dimension [where these processes are taking place out of conscious awareness], whereas fantasy with an 'f' is be used to refer to the more conscious, daydream level of this group of mental activities (Ogden, 2004, p.10).

Fairbairn (1963) and Winnicott (1965) assert that rather than focusing on destructive phantasies of destroying the maternal object, the infant wants to connect with the maternal object so as to preserve his or her own existence. The authors indicate that the infant exists only because of the maternal care he or she receives from the mother figure. In this way the

infant is dependent on the mother's provision for his or her existence (Fairbairn, 1963; Winnicott, 1965).

The role of dependency in normal child development is considered according to three broad stages outlined by Fairbairn (1963). Fairbairn believed that each of these stages was a stepping stone towards autonomous functioning and the development of self. Each developmental stage is described briefly below. Concepts that relate to Winnicott (1965) are integrated where relevant as this adds further to the foundation for later description and analysis of the current research.

Early infantile dependence. During this phase the child is psychologically and physically merged with the primary caregiver. There is very little differentiation from the mother or caregiver and a poorly developed sense of self (Fairbairn, 1963). Winnicott (1965) expands on this notion by stating that it is more appropriate to refer to a nursing couple at this stage, where the infant is bound to the mother in a very primitive way. Winnicott indicates that the beginning of ego emergence requires absolute dependence upon the ego of the mother [or primary caregiver], that is *good enough mothering*. Good enough mothering refers to the attentiveness that a mother may show the infant when meeting his or her needs. Winnicott states that good enough mothering refers to the good enough provision as the average expectable environment that parents and caregivers have over centuries provided in meeting infants' needs.

He states further that the environment is an essential feature of dependence. In this sense Winnicott (1965) is referring to the role of an *adequate holding environment*. The holding environment refers to a certain kind of environmental provision. Winnicott states that characteristics of this early environment relate firstly to provision of physiological needs, as physiology and psychology are not yet distinct. Secondly the environment is reliable, which in this sense refers to the mother's level of empathic response to the infant's needs and

includes the concept of *attunement* whereby the caregiver is particularly sensitive to the infant's needs and meets those needs accurately (Winnicott).

The term *holding* according to Winnicott (1965, p. 48) "takes account of the infant's skin sensitivity, such as touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity) and of the infant's lack of knowledge of the existence of anything other than the self". Holding includes especially physical holding of the infant, which Winnicott considered to be a form of loving. In this way the fulfilling or gratifying caregiver or mother is experienced as good enough (Winnicott), and the environment is considered optimal for normal development to occur (Fairbairn, 1963). The mother figure's response to the infant's dependency needs is therefore crucial to early development.

The transitional period. This phase is considered to be a bridge between stage one and two. Fairbairn described it as interplay between object seeking and object relating. That is there is an increasing tendency to abandon the attitude of infantile dependence and adopt an attitude of mature dependence. Pereira and Scharf (2002) indicate that the term 'transitional' is widely recognised as a term used by Donald Winnicott to refer to transitional objects and transitional phenomenon, but that Fairbairn had used this term some ten years before Winnicott (1965). This phase therefore refers to the developmental space between seeking relation with other objects for survival needs versus relational needs as one matures.

Mature dependence. During this phase, relationships are marked by mutuality and exchange. Relationships are characterised by the acknowledgement of differences and a healthy independence or interdependence is formed (Cashdan, 1988). During this stage, the individual does not require the defense of splitting. He or she is able to reconcile both good and bad aspects of self and others. The concept of splitting is discussed below.

Splitting and its Link to Environmental Deprivation

Fairbairn (1963) believed that as long as early relationships are satisfactory, the ‘self’ remains whole (Bliss, 2010), and there is no need for splitting to occur. Fairbairn (1963) and Winnicott (1965) believed that infants developed difficult object relations when there was some sort of real deprivation in the environment (Cashdan, 1988). Deprivation in this sense might refer to a

lack of engagement or bonding with the mother figure, or caregiver neglect such as physical neglect, unwashed skin, diaper rash, skin infections, and dirty clothing. The back of the baby’s head may be flat with a bald patch over the flattened area, implying that the child is left unattended for long periods of time lying on his back in the crib (Salkind, 2002, p.146).

This differed from the work of Klein (1952) for example, who felt that it was the perception of deprivation that was of importance for the infant’s object relations (Cashdan, 1988).

“If the environment is less than optimal, such as frustrating, depriving or neglectful, a splitting of the ‘self’ occurs and frustrating objects (or others) are internalised in an effort to control them, while simultaneously preserving external attachments” (Jones & Michel, 2007, p. 56). The mother or primary caregiver will be experienced as bad if she fails to meet the infant’s needs or rejects his or her advances for attention or affirmation (Cashdan, 1988). Thus, splitting is considered to be a primitive psychic mechanism (Winnicott, 1965), “an immature *defense mechanism* that reduces anxiety by keeping notions of good and bad separate in the person’s mind” (Frankland, 2010, p. 57). It refers to a process whereby the self and others are “experienced as all or nothing, either good or bad, satisfying or unsatisfying, accepting or rejecting, but not mixtures of these states” (Stadter, 2009 p. 41).

Fairbairn (1963) uses the term splitting, to refer to the way an infant deals with an unsatisfactory and inconsistent world (or mother). When the mother fulfils the infant's needs and wishes, she is experienced as good. However, there are times when the mother would be experienced as bad, such as when she ignores the child or rejects his advances for affection or attention (Cashdan, 1988). The difficulty that the infant experiences, is that he or she cannot leave, nor can he or she control the mother. So how does the infant cope with this dilemma? The infant finds it intolerable "to have a good object which is also bad, and proceeds to alleviate this dilemma by splitting the object (the mother) into two objects, one good and one bad" (Fairbairn, 1944, p. 82). Therefore, the infant constructs an inner world that is inhabited by different parts of the mother and in this way the infant is able to remain dependent without constantly feeling threatened (Cashdan, 1988; Fairbairn, 1963).

Fairbairn's Endopsychic Situation

The concept of splitting based on the infant's unsatisfactory early relationship with the caregiver is considered further in Fairbairn's (1963) object relations theory where he states that the infant begins to experience a conflict between the aggression that is felt towards the caregiver for the lack of care and protection and the risk of further losing the caregiver if that anger or disappointment is expressed. The primitive defense of splitting allows the infant to repress the experience and feelings related to the bad object (or disappointing other) as well as the feelings linked to his or her own ego, such as the experience of being rejected or unloved (Bliss, 2010). Fairbairn discusses this internal world of the infant as the *Endopsychic Situation*, which refers to the structure of the ego or self in relation to the bad internalized object.

According to Fairbairn (1963), this inner world or Endopsychic State consists of three separate ego structures or parts of the self, namely, a) *the central ego*; b) *a repressed libidinal*

ego; and c) a *repressed antilibidinal ego (internal saboteur)*. Each of these will be discussed in more detail below.

The central ego. This ego structure is derived from the good internal object or ‘ideal object’ and is considered to be the “only part that is connected to those parts of the mother that were once gratifying” (Cashdan, 1988, p.11). As such this ego structure does not need to employ defenses of splitting. The central ego is conscious, and is therefore available to real relationships with real people, whereas the other two ego structures are repressed because they tend to create pain. The other two ego structures are present as a result of environmental deprivation (Fairbairn, 1963).

The libidinal ego. This ego structure is considered to be more infantile than the other ego structures in that it has a lesser degree of organization and a small measure of adaptation to reality. This part of the ego contains feelings of longing and neediness as well as a hope for gratification (Bliss, 2010; Jones & Michel, 2007).

The libidinal ego shows great devotion to an internalized object (Fairbairn, 1963), meaning that it maintains the split between good and bad thus preserving the view of the internal object as being good. It cannot allow the central ego to know that the internal object has bad qualities, as this would threaten the infant’s existence. Fairbairn (1952) stated that despite the best intentions, some clients will be unable to let go of their attachment to ‘bad’ objects due to their loyalty to these internal structures, and an unconscious belief that attachment to bad objects is better than no attachment at all. Related to this ego structure, an object or other that offers a potential promise of meeting the infant’s needs and hopes for connection is known as the *exciting object*.

The antilibidinal ego (internal saboteur). This ego structure is inherently hostile and aggressive towards the libidinal ego (Fairbairn, 1952). The antilibidinal ego hates the libidinal ego for retaining its hope that the mother figure may one day fulfil its needs. It tends

to be devoid of moral significance and therefore guilt is not attributed to its activity (Fairbairn, 1963). It serves a protective function in that it attacks the other needy part of the 'self' and aims to destroy the part that wants a connection (Bliss, 2010; Fairbairn, 1963). This part of the ego structure is closely linked to what Fairbairn (1963) called the rejecting object, which refers to the internalized unsatisfactory aspects of the mother's ability to frustrate (Jones & Michel, 2007). The antilibidinal ego therefore rejects all attempts made by the libidinal ego for connection, and attacks its alliance with the exciting object (Jones & Michel, 2007).

Splitting of these ego structures results in an inner world that is fragmented, leaving parts of the 'self' cut off from consciousness. The splitting results in painful parts of the 'self' being repressed which are then felt as feelings of frustration, persecution, and self-denigration (Cashdan, 1988). Winnicott (1965) indicates that when parts of the self are cut off from consciousness, a *false self* develops. The false self is a part of the self that is compliant with the needs of others in order to gain approval. However, in the process the infant later loses his or her true self (Kaslow, 2002). Winnicott states that at the extreme of abnormality the false self can easily get itself mistaken for real, so that the real or true self is under threat of annihilation. Through this false self, the infant develops a false set of relationships and the personality structure of the individual may be built upon this false foundation (Winnicott). The infant's needs become secondary to the needs of the caregiver. Fairbairn (1952) explained that this often results in the paradox where abused children remain attached to an abusive or non-attuned caregiver. He referred to the protection that the child gives to the ungratifying caregiver as *obstinate attachment*. The child needs to preserve the attachment to the caregiver so as to prevent annihilation (Pereira & Scharf, 2002). According to Burlingham and Freud (1942, p.47), "children will cling even to mothers who are continually cross and sometimes cruel to them. The attachment of the small child to his [or her] mother seems to a large degree

independent of her personal qualities". Bowlby (1969, p. 366) states that the "potential for attachment is ever-present in a child and ready, when starved of an object, to fix on almost anyone" to elicit caregiving from a parental figure. Although there is some overlap in ideas with object relations theorists, Bowlby's attachment theory with contributions from Ainsworth is discussed separately in the subsequent section.

Attachment Theory

Bowlby's attachment theory stemmed from a convergence of several trends in biological and social sciences (Ainsworth, Blehar, Walters & Wall, 1978) and includes psychodynamic influences. Ainsworth et al. (1978) indicate that an initial psychoanalytic orientation was integrated with the biological discipline of ethology, which considered the behaviour of animals in their natural habitat and usually proposed evolutionary explanations. In terms of the psychoanalytic influences, attachment theory is considered to have developed from the thinking of object relations theorists (Slater, 2007), where the early relationship with the mother is considered to be of great importance to the child's development. Disruptions in the emotional tie or mother-child relationship could lead to later psychopathology (Slater).

According to Bowlby (1988) human beings are instinctively programmed to seek and form attachment with others. More than just 'nice to have', this predisposition is thought to have evolutionary significance in that it serves a critical survival function by activating a response from an infant's caregiver (Bowlby, 1969).

Historical developments of attachment theory began with the work of John Bowlby in the 1940s. Bowlby (1944) worked with war orphans and evacuees exploring the long-term developmental impact on these children after being separated from their parents for long periods of time. He indicated that many of these children went on to experience a range of behavioural, emotional and mental health problems which he believed were related to the early loss of parental caregiving (Bowlby, 1944; Bowlby, 1958).

A further development in attachment theory relates to Robertson and Bowlby's (1952) observations of infants who had been separated from their mothers. These infants appeared to experience a recognisable sequence of highly distressed behaviours. The first reaction was *protest*, where the infant would cry inconsolably and at times attempt to follow the mother. This was then followed by a period of *despair*, listlessness and apathy. If the separation continued for several days, the infant would withdraw, and enter a period of *detachment* and display apparent lack of interest in the lost caregiver. If reunion with the caregiver did occur, it was met with a mixture of anger, crying, clinging and rejection (Bowlby, 1969; Howe, Brandon, Hinings & Schofield, 1999).

Bowlby distinguished between the concepts *attachment* and *attachment behaviour*. Attachment is defined as an "emotional tie that an infant constructs and elaborates with his principal caregiver(s) in the context of everyday interactions" for the main goal of survival (Bowlby, 1958). Attachment behaviour on the other hand refers to a system whereby the action of the infant serves the adaptive function of keeping the caregiver in close proximity (Bowlby). Attachment behaviour is discussed in greater detail below.

Attachment behaviour

In exploring attachment behaviour, Bowlby (1969) paid particular attention to the animal world. Bowlby (p. 181) asked the questions "What causes animals to remain in each other's company? What function is fulfilled by doing so?" Should the young animal stray, the mother may then herself behave in a way so as to restore proximity. Bowlby noted that human infants show the same tendency to keep within the vicinity of the mother once they become mobile. This kind of behaviour is characterised by two main features, namely proximity to another animal, and specificity of the other animal. That is,

both parent and young behave towards each other in ways that are different from the ways in which they behave towards other animals. Thus, individual recognition and

highly differentiated behaviour are the rule in parent-young relations of birds and mammals. (Bowlby, 1969, p. 181)

According to Bowlby (1969) young animals show certain kinds of behaviour that encourages the mother to stay close. He considered any behaviour on the part of the young animal that results in proximity to the caregiver could be regarded under the general term *attachment behaviour*. The reciprocal behaviour of the parent in response to the young is termed *caretaker behaviour*.

Like object relations theory, Bowlby (1969) indicates that the attachment behavioural system involves a cognitive-affective component, that is, a mental and emotional representation of the attachment figure, the self, and the environment. These mental representations are known as internal working models and serve the function of allowing an individual to anticipate the future, as well as to select attachment behaviour that will work best with different people. According to Bowlby, when young children feel distressed or insecure they need to get into close proximity to their primary caregiver. It is a protective strategy that the child employs. However, prolonged or repeated exposure to physical or psychological absence results in prolonged distress for the child (Howe, Brandon, Hinings & Schofield, 1999). Bowlby emphasised that the accumulation of early experiences becomes internally represented for the infant as a system of enduring, emotionally toned beliefs and expectations about relationships. It is the child's early experiences that provide the platform for the development of either *secure* or *insecure attachments*.

Secure and Insecure Attachments

When an infant feels afraid, his [or her] attachment behaviour is likely to be activated, likewise when he [or she] feels secure, the attachment behaviour will be at a low level of activation. This process accounts for the phrase, *using the mother as a secure base from which to explore*. (Ainsworth, Blehar, Walters & Wall, 1978, p. 22)

Bowlby (1988) introduced the concept of the *secure base* where the caregiver is perceived by the infant as safe, stable, and caring, enabling the infant to feel free to move away from the caregiver and explore the environment (Kaslow, 2002). A colleague of Bowlby, Mary Ainsworth (Ainsworth, Blehar, Walters & Wall 1978) expanded upon this phenomenon and introduced the concepts of *secure* versus *insecure attachments*.

According to Ainsworth (1978), securely attached children are characterised as using their caregivers as a base for exploring their environments, and are then able to return to their caregivers should they be upset. The secure infant is more harmonious and cooperative in his or her interaction with the mother, and more willing to comply with the mother's request. When attachment behaviour is activated, such as when a stranger approaches, the child seeks close proximity to the other, the mother in this instance, is reassured, and then continues with explorative play (Ainsworth, Blehar, Waters & Wall, 1978; Prior & Glaser, 2006).

On the other hand, children who are unable to use their caregivers as a secure base for exploring their world and who do not maintain proximity to caregivers when upset will typically show a type of attachment that is insecure (Ainsworth et al., 1978; Prior & Glaser, 2006).

Types of insecure attachments. There are varying types of insecure attachments that can develop, based on the nature of the early experiences and perceptions of the child. Howe, Brandon, Hinings and Schofield (1999) emphasise that mildly insecure patterns do not equate to psychopathology but that extremes of these patterns are noted in children whose developmental trajectory has been negative. Ainsworth and Bell (1970) indicate that strong attachment behaviour limits a child's exploration of his or her world which is important for play and overall development. Howe et al., note that there are increased developmental risks for those in insecure attachment relationships. The insecure attachment types are discussed below in relation to the parenting styles that promote them.

Insecure-avoidant attachment style. Children with an insecure avoidant attachment style tend to look or turn away from the caregiver, showing a kind of detachment to the caregiver (Ainsworth & Bell, 1970). They usually maintain a relatively high level of exploration across separation and reunion with their caregivers (Prior & Glaser, 2006). That is, they tend to show little response to separation (which is a clue to danger) and show conspicuous avoidance of proximity-seeking or interaction with the mother in reunion episodes (Prior & Glaser).

According to Howe, Brandon, Hinings and Schofield (1999), children with an insecure-avoidant attachment style have experienced parenting styles that are comprised of a combination of distress, rejection, and hostility, which is then mixed with control, intrusion, and overstimulation. The authors indicate for example, that a child may be told that there is nothing to cry about, that he or she is not really distressed, even if the child is hungry, hurt or requires changing. The result is that the child's confidence in his or her own perceptions is undermined. It is the caregiver's discomfort towards strong feelings that cause him or her to intrude upon the feelings of the child. As a result, when attachment behaviour is activated, and the child shows signs of distress and is needy of reassurance, the parent figure becomes emotionally less available and psychologically distant (Howe et al.). As a consequence, the child's attachment behaviour and expression of negative affect are inhibited. If the child is to remain in proximity to the caregiver, it is best that he or she downplays any need or upset or to psychologically disconnect from feelings (Prior & Glaser, 2006).

Insecure-ambivalent attachment style. Infants with this insecure attachment style show a mixture of contact-seeking and contact-avoiding behaviour (Ainsworth & Bell, 1970). Infants with this attachment style tend to cry more than avoidant infants (Prior & Glaser, 2006). In a situation where the mother leaves they respond immediately with intense distress. As much as they show strong contact-seeking behaviour when the caregiver returns, it is mixed with some

contact-resisting behaviour, making them seem ambivalent (Ainsworth & Bell). These infants are less easily soothed than the previous group, and when picked up they may mix angry resistance with clinging behaviour (Prior & Glaser).

Children who show an insecure-ambivalent attachment style have had caregivers who are inconsistently sensitive to these children's needs (Howe, Brandon, Hinings & Schofield, 1999). These infants experience their caregivers as unpredictably unresponsive (Prior & Glaser, 2006). Psychologically, these caregivers are underinvolved with their infants and as a result miss many of the distress signals the infant gives. Children who have an ambivalent attachment style feel anxious as a result of the caregiver's inconsistency (Prior & Glaser). They tend to feel distressed when separated from their caregivers but are then angry and reluctant to engage with their caregivers upon return. According to Howe et al., the caregiver's own psychological needs determine the level of involvement with the infant, and while there is love for the child, according to the infant it is in scarce supply and hard to win.

Disorganised-insecure attachment style. A fourth category of insecure attachment style was introduced by Main and Solomon (1986, 1990). These authors found that some infants did not share a new pattern of behaviour but instead exhibited odd behaviour which lacked a coherent, organised strategy for dealing with the stress of separation (Prior & Glaser, 2006). According to Main and Solomon (1990), infants should be considered to meet the criteria for this category if they show the following behaviour:

- a) Sequential display of contradictory behavioural patterns, such as very strong attachment behaviour suddenly followed by avoidance, freezing or dazed behaviour.
- b) Simultaneous display of contradictory behaviours, such as strong avoidance with strong contact seeking, distress or anger.

c) Undirected, misdirected, incomplete and interrupted movements and expressions – for example, extensive expressions of distress accompanied by movement away from, rather than towards the mother.

d) Stereotypical, asymmetrical movements, mistimed movements and anomalous postures such as stumbling for no apparent reason and only when the caregiver or parental figure is present.

Essentially, the attachment behaviour of this style tends to be incoherent showing a mixture of avoidance, angry responses and behavioural disorientation (Booth & Koller, 1998). Children with a disorganized attachment style develop no organized behavioural strategy for regulating their affect and gaining proximity, care, and protection from their caregivers. Disorganized behaviour results when the child has been alarmed by the caregiver or parental figure rather than an external situation. According to Howe et al., (1999), unpredictable, scary, violent or deeply puzzling behaviour by the caregiver leads the child to be either afraid of or afraid for the caregiver. The unresolvable paradox is that in the state of distress, the child's attachment behaviour increases, and he or she seeks out protection and comfort. However, in this case the caregiver is the source of fear. Children with a disorganised attachment style have a heightened sense of arousal and develop defensive strategies for gaining proximity to the caregiver. However, Erskine (2011) indicates that if the very person on whom the child depends for need satisfaction is the same one who is predictably punishing, then the child's experience of body sensations, affects, needs, and relationship will be profoundly confusing. The child may encounter an implicit fear of violation during later adulthood.

Of importance to the therapeutic intervention, Howe et al., (1999, p. 230) state the following.

Attachment is a lifespan concept. With the prospect of new relationships at any stage in the lifespan, a re-organisation of existing internal working models is always possible. Relationships provide opportunities not only to acquire new strengths and understandings, but also to develop new vulnerabilities. Practice interventions aim to disconfirm insecure working models and promote the protective effects of secure attachments and positive relationships.

Conclusion

The foundation of the current study is based in object relations and attachment theory and therefore this chapter provided an overview of important aspects of an infant's development as it relates generally to these two theories. Specifically the works of Ronald Fairbairn, Donald Winnicott, John Bowlby, and Mary Ainsworth highlighted the role of the primary caregiver or maternal object and the adequate environment she provides in order for an infant to develop a mature sense of self and other. An infant's dependency upon the maternal figure was considered particularly important by Fairbairn (1963) and Winnicott (1965) in developing this sense of self.

In addition, it was noted that when there is environmental deprivation or abuse, the infant employs a number of defenses in order to ensure survival. These defenses include splitting of the self and other into good and bad parts. Fairbairn (1963) introduced the concept of the Endopsychic Structure to refer to parts of the self that are split off from conscious awareness and that serve a protective function that prevents the infant and later, young child, from relationally connecting with other objects which may threaten his or her existence. The analysis of the current study was informed by the work of Fairbairn (1963) and Winnicott (1965) and the relevant concepts outlined in this chapter are therefore referred to again in Chapter six. The method of play therapy that was implemented in the current study was relationally based and has an object relations foundation. This form of play therapy is

discussed in the subsequent chapter. In addition, general concepts relating to play therapy are discussed.

CHAPTER THREE

PLAY AND PLAY THERAPY

“You can discover more about a person in an hour of play than in a year of conversation.”

Plato

Introduction

The current chapter focuses on an integrative relational approach to play therapy. Play therapy has developed from the knowledge that practitioners have about children’s play. For this reason consideration has been given, firstly to the concept of play and how this relates to development, and secondly a discussion on approaches to play therapy follows. Particular focus is placed on relational types of play therapy as it links to the aim of the current research.

Play

Play starts in the very first week of life, and typically begins with the relationship between caregiver and infant (McMahon, 1992). In the early waking hours the infant experiences the pain and distress of hunger and physical discomfort inside or outside its body. The infant also experiences the excitement and pleasure of feeding, and the relaxed comfort and pleasure of warmth and physical contact when urgent needs have been satisfied. According to McMahon, it is in this tranquil state as mothers playfully talk to and touch their infants, that the infants start to explore and play with their own and their mothers’ body. In this way, the infant begins to find its physical boundaries, for example, “Where do I stop and where does mom begin?”

A child’s introduction to the world takes place through the experience of play, and as such, play is recognized as holding a significant place in the lives of children. Nothing expresses a child’s sense of being more than play (Van Fleet Sywulak & Sniscak, 2010).

Van Fleet et al. (2010) indicate that there is no universal acceptance of what play entails, although Else (2009) indicates that play is a process that is chosen and directed freely by its participants, is itself its own reward, and is normally pleasurable. However, Vygotsky (1933) suggested that a definition of play based on the pleasure it gives a child is incorrect. His reasoning lay in the notion that we deal in a number of activities that give a child a greater sense of pleasure, such as when a child uses a pacifier. He further stated that it is impossible to ignore the fact that a child satisfies certain needs and incentives in play, and that understanding the uniqueness of play lies in understanding the nature of a child's needs and incentives.

'Play', according to Frank (1982) as cited in Landreth, (2012 p.8), is defined broadly as:

The way people learn what no one can teach them. It is the way they explore and orient themselves to the actual world of space and time, of things and animals, structure and people. To move and function freely within prescribed limits. Play is children's work.

According to Winnicott (1971), play is a sequence of relationships with the object world in which the mother figure has special roles. She is there to be available to the child, yet not to intrude. It is these types of play activities that are necessary for individuation and the growth of 'self' (Cattanach, 2008, p 48).

Stages of play

There are typically five types of play that children progress through at various ages (McMahon, 1992). Each age results in varying levels of development that is evident in the types of play. The various types of play include a) sensory/creative play; b) physical play; c) exploratory play; d) social play and e) symbolic play.

According to Schaeffer (2009, p. 22), there are substantial changes in the nature of play during the preschool years in particular. Children are known to progress from parallel or

exploratory play at about age three years towards cooperative and social play around four years. At this stage, play themes begin to emerge that move between reality and fantasy and also include others' perspectives into their play. By age five years, children continue to develop more co-operative play and engage in make-believe and pretend or symbolic play. Through pretend play children learn to understand, identify and regulate their emotions (Schaefer, 2009). Appendix 1 provides a more detailed summary of the types of play listed above. "Play allows children to use their creativity while developing their imagination, dexterity, and physical, cognitive, and emotional strength. Play is important to healthy brain development" (Gingsburg, 2007, p. 183).

Essentially, play forms part of a child's expressive capacity and play therapy therefore becomes a tool towards that end. According to van Fleet, Sywulak and Sniscak (2010, p. 12), play therapy refers to the "use of systematic play interactions in the context of a therapeutic relationship in order to help children psychosocially, for the purposes of both healthier development and problem resolution". Similarly, the Association for Play Therapy (2001, p.20) defines play therapy as "the systematic 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". Commonalities to each of these definitions relate to play therapy being a systematic process that takes place between a trained therapist and a child in the context of a therapeutic relationship with the aim of psychosocial growth and problem resolution.

Russ (2004) indicates that in the child therapy literature, four broad functions of play emerge as important specifically in therapy. Firstly, that play is the natural form of expressing feelings and thoughts in children. Therefore, through play children express their internalised world. This expression of emotion is sometimes termed catharsis and is known to be therapeutic (Russ). Secondly, Russ indicates that the child uses the language of play to

communicate with the therapist. In turn, the therapist empathises and interprets the play which makes the child feel understood. “For many children, this feeling of empathy from the therapist facilitates change in their interpersonal representations and interpersonal functioning” (2004, p. 34). The third function of play according to Russ is a psychodynamic one. “Psychodynamic theory views the emotional resolution of conflict or trauma as a major mechanism of change in child therapy... where the play process itself has been thought of as a form of conflict resolution” (Russ, p.35). The fourth major function of play relates to the safety of the play environment. In the safe therapeutic space, the child is able to practice a variety of ideas, behaviours, interpersonal behaviours, and verbal expressions without fear of judgment or real-life consequences (Russ, 2004).

Since the early 1990s, play in some form was used in child therapy by the majority of clinicians (Russ, 2004). These interventions range from psychoanalytic and non-directive to more directive approaches; however, no single approach emerged as a preferred treatment (Kaslow, 2002). Regardless of the form that the play therapy takes, Van Fleet, Sywulak and Sniscak (2010) indicate that play is the therapy. The therapist does not use play or toys as a means for the child to discuss cognitively the meaning of his or her play. The expression is in the play itself.

The subsequent section provides a brief overview of the historical influences of play therapy. Specific focus is placed on an integrative object relations or relational approach to play therapy as is relevant for the current case.

Play Therapy Approaches

The most cited beginnings of play therapy are widely attributed to Anna Freud and Melanie Klein during the 1930s (Russ, 2004). Both women developed psychoanalytically based play therapy approaches, although they were somewhat different from each other. Both Klein and Freud believed that children under the age of five years could be successfully

analysed (Melanie Klein Trust, 2013), however their philosophy and approach to play therapy differed (McMahon, 1992).

Melanie Klein's Psychoanalytic Approach to Play Therapy

Klein (1932) indicated that play therapy provided direct access to a child's unconscious (Cattanach, 2008) and emphasised the immediate use of interpretation to the child. She considered the spontaneous play of the child to be synonymous with free association of the adult (Klein). In this way, she used the medium of play to reveal the source of problems that are in the unconscious, rather than seeing play therapy as a curative factor in itself (Cattanach).

Anna Freud's Psychoanalytic Approach to Play Therapy

Anna Freud (1928) was considered to be more cautious than Klein and aimed to help children become more conscious of the reasons they behaved and felt the way they did (Bromfield, 1992). Before beginning work with children, she aimed to create a loving and caring relationship with the child so that he or she would like her and feel dependent on her (McMahon, 1992). This process is important if one considers the role of dependency in early infant development mentioned in the previous chapter, which provides the infant with the security to develop a mature sense of self. Play was the means through which Freud fostered this process of dependency (McMahon). Once the relationship had been established, Freud (1965) indicated that the positive tie created earlier helped the child face often very painful revelations of repressed material.

She considered children's play in a similar way to the use of dreams in psychoanalysis (Cattanach, 2008). Freud (1928) looked at the unconscious motivation behind imaginative play and drawings. However, she did not interpret the latent content of the child's play until the therapeutic relationship had been established (Cattanach). According to McMahon (2002, p. 32) Anna Freud "always kept sight of the child's real world and worked only slowly down

from reality and conscious feelings towards deeper levels of the child's unconscious. She did not think a quick, deep interpretation could be lastingly therapeutic". Of key importance was the relationship between herself as the therapist and her child client.

Relational Approaches to Play Therapy

A relational approach to therapy has humanistic as well as psychodynamic influences. Faris and van Ooijen (2012) noted that contemporary psychodynamics has moved away from intra-psychic explanations towards inter-relational and inter-subjective ways of viewing human experience and development. A relationship-based approach to play therapy is particularly suited to treating attachment difficulties in preschool children (Benedict, 2006; Benedict & Hastings, 2002). Relational psychodynamic therapists offer a therapeutic stance that is closer to a humanistic way of working (Faris & van Ooijen).

A humanistic orientation towards play therapy is seen in child-centered play therapy which developed from the work of Carl Rogers (1959) and Virginia Axline (1969). This approach is discussed below.

Child-centred play therapy approaches. Originating from Person Centred Therapy (PCT), Child-centred Play Therapy allows the child to direct the process and the therapist is supportive but nonintrusive (Van Fleet, Sywulak and Sniscak, 2010). There is an overarching belief in the clients' own abilities to understand themselves and to strive towards self-actualisation (Van Fleet, et al.). In this approach to play therapy, the therapist gives permission to the child to be him or herself, providing unconditional acceptance, without judgement or evaluation. Axline (1969) indicated that in an optimal environment such as the playroom, the exposure to empathy, implementation of structured limits, and acceptance by the therapist allows the child to self-actualize, grow, develop and release blocked emotions.

Axline (1969, p.73) provided eight guidelines towards conducting child-centred play therapy.

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he or she is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his or her feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him or her in such a manner that he or she gains insight into behaviour.
5. The therapist maintains a deep respect for the child's ability to solve his or her own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

(Van Fleet, Sywulak & Sniscak, 2010).

Certain of these guidelines are relevant to the current case in that they also speak to aspects of object relations play therapy, such as how to establish a secure base relationship. In this sense the warmth of the therapist, acceptance of the child as is and the belief in the child's ability to lead the process is important. The secure base is discussed in greater detail under object relations play therapy.

Russ (2004) indicates that the importance of expression through play and communication with the therapist is thought to be important to both Child Centred and Psychodynamic therapeutic approaches, such as object relations. Thus overlap between the two approaches relates to the use of play as a means towards building relationship and highlights the importance of the relationship between therapist and child for change to occur.

Object relations play therapy. “Object-relations play therapy uses the therapeutic relationship to reshape pathological internal working models of self and others in ways that promote more faith in caregivers, encourage respect for limits, and develop more adaptive strategies for relating interpersonally” (Kaslow, 2002, p. 69). Benedict (2006) states that the core feature of object relations play therapy is the relationship between the therapist and the child with the aim of helping the child with difficulties experienced in interpersonal relationships. Alternatively named attachment-based play therapy or object relations play therapy, this approach focuses on building a secure-base relationship with the child and then changing the child’s internal working model (Schaefer, 2009). As stated earlier, relational approaches to play therapy are particularly suited when working with preschool children with attachment difficulties (Benedict, 2006).

According to Kaslow (2002) object relations play therapy draws its theoretical base from object relations therapy with adults but has also incorporated many techniques from different play therapy approaches including the work of Axline’s Child Centred Play Therapy. As such, object relations play therapy is considered to be an integrative form of play therapy. The concept of integration is discussed briefly below before moving into object relations play therapy.

Object Relations as an Integrative Play Therapy Approach

Schaeffer (2003) indicates that because psychological disorders, especially for children, are multi-layered, complex, and multi-determined, a multifaceted treatment approach is

needed. Integrative play therapy can serve this need. An integrative therapy approach attempts to combine the theories or techniques of two or more therapeutic approaches and may take various forms. Object relations play therapy is considered to be an assimilative form of integration (Benedict & Hastings, 2002). According to Drewes, Bratton and Schaeffer (2011) there are three forms of integration, namely, ‘common factors integration’ which identifies clinical strategies and change processes shared by the models being integrated, that is, the mechanisms of change. In ‘assimilative integration therapists work from a specific model, adopt elements from other models, and integrate this into their primary working model. ‘Theoretical integration’ on the other hand, would take the best elements of two or more approaches and blend them with the expectation that the results will be more than the sum of its parts.

Therapeutic integration has relevance where one considers the uniqueness of each therapeutic encounter. For example, Nolan and Nolan (2002, p.8) mention that “each moment of therapy involves a distinct human encounter between the particular client and therapist so its nature and direction cannot be fully predicted”. It is in this unique relationship that the therapist must strive to look creatively and openly at his or her client. Maintaining a fixed ideological position can limit the creativity of practitioners (Nolan et al.).

Acknowledging that the therapeutic relationship is a unique encounter of human relating, an integrative relational play therapy approach was considered for the treatment of the child in the current study. Specifically, the case was informed by Benedict’s (2006) object relations play therapy, which is considered to be a form of assimilative integration based in object relations theory but informed by various theories including child centred play therapy and attachment theory. These theories highlight the importance of relational connecting and the importance of early relational attachments in forming a stable sense of self and other.

Benedict's (2006) object relations play therapy approach encompasses two phases of play therapy. Each of these phases is discussed in the subsequent section.

Key Aspects of Object Relations and Attachment Based Play Therapy

Phase one. Building a secure base relationship is an important focus for therapy of this kind which has many similarities to Axline's (1969) guidelines for play therapy described earlier.

According to Bowlby (1988), a secure base relationship is one where the child experiences attachment to the therapist and feels safe to explore his or her psychological world. Benedict (2006) indicates that this is challenging for the therapist, as the children most likely to benefit from relational play therapy are those who have encountered relational trauma during the first three years of their life and have emerged with attachment difficulties.

According to Benedict (2006, p.5) "the establishment of a secure base relies firstly on the process of attunement, which is best described as interactive synchrony", whereby the therapist deliberately tunes his or her activities to the child's cues during interaction. In this way, the therapist engages when the child signals readiness and disengages when it is necessary (Schoore, 2003). Adopting a child-responsive approach to therapy can facilitate attunement. In this way, object relations play therapy is neither directive nor non-directive but rather responsive to the child's cues. Another important part of attunement is ensuring the therapist's responses and behaviours are developmentally appropriate to the child.

According to Benedict (2006) additional therapist characteristics that are considered important for building the relationship include being warm and accepting of the child as well as being emotionally constant. This entails being predictable in reactions and behaviours as well as providing a constant therapeutic environment. It is important to limit changes in the play materials, preserve traces of the child's play, and have a box or locker where the child can leave personal things and know that other children will not disturb them.

Maintaining a physically and psychologically safe environment is another key aspect of object relations play therapy that was informed by the work of Donald Winnicott (Benedict, 2006; Winnicott, 1965). Allowing the child to control the activities and interaction (apart from when physical safety is threatened) is one way to accomplish this. In addition, making use of an invitational approach when responding in an attuned manner can provide some direction where the therapist can alter the course of therapy or provide interpretations (Gil, 1991). Benedict (p. 6) indicates that this process is invitational in nature in that “it is offered by the therapist in a tentative manner, that is, there are no negative consequences should the child choose to decline or ignore the invitation.”

Phase two. The second phase in the process of object relations play therapy is to modify the child’s object relations or internal working model. According to Benedict (2006), there are several ways in which to achieve this, all of which involve challenging the existing maladaptive object relations. The author mentions that many of these challenges occur within the relationship between child and therapist. According to Kaslow (2002) it is generally accepted that the child’s interpersonal relationships in the outside world become active in the context of the therapeutic relationship. This is done through the process of *transference*.

According to Frankland (2010, p.65), “transference is the process by which a patient unconsciously and inaccurately perceives the therapist as possessing qualities that characterized important figures from her past (often a parent)”. Kaslow states further that modern psychodynamic theorists tend to make extensive use of their subjective reactions in order to better understand the roles that the child is implicitly asking them to play. The therapist’s subjective experience or *countertransference* provides a clue to the child’s unconscious phantasies. The therapist’s capacity to tolerate these phantasies becomes a key component in successful treatment (Kaslow). Similarly, Batcheler (2003) states that “traditional psychodynamic treatments emphasise a restorative holding and nurturing

therapeutic relationship, allowing regression and transference within a relationship where the therapist's adult faculties are intact". According to McMahon (1992, p. 53),

knowing about transference helps us to recognize that the feelings we are experiencing are usually also those of the child towards its parent. The task is to hold onto these feelings and to think about them, eventually passing them back to the child in a more manageable form.

Each time the therapist fails to confirm a child's expectation of a negative interaction, the negative internal working model is challenged. This challenge can relate both to the child's view of self and view of other. For example, a negative internal working model of the other may result in a child expecting that others will hurt him or her however, when the child experiences the therapist as warm and attuned the child's internal working model may be altered where the child becomes open to the idea that not everyone is going to hurt him or her (Benedict, 2006). The same occurs regarding the way the children feel about themselves. A self that is seen as bad and unlovable may begin to shift towards a belief that they are lovable. It is a child's internal working model and object relations that are considered when utilising this approach to therapy.

Conclusion

This chapter outlined the importance of play in a child's development, where children are known to display various types of play across different ages. A natural means of self expression, play became the tool through which therapeutic work with children was conducted. Originating with the work of Melanie Klein and Anna Freud, play therapy has expanded dramatically in the last century, with relationally based play therapy approaches being the treatment of choice for children who have experienced relational trauma.

Object relations play therapy as outlined by Benedict (2006) is considered to be a form of assimilative integration that has a foundation in object relations theory and draws on

attachment theory as well as some aspects of Child Centred Therapy, such as guidelines of how the therapist should be in order to create a secure base relationship. This model of play therapy consists of two phases, firstly, to establish a secure base relationship and secondly, to challenge the child's internal working model. This approach to play therapy was utilised in the current study. The findings of each phase as well as the process followed are elaborated upon in Chapter six according to the aim and objectives of the current study. The subsequent chapter covers the methodology of the current study and considers the aim and objectives in greater detail

CHAPTER FOUR

METHODOLOGY

Introduction

The following chapter highlights the specific aim and objectives of the current study as well as the process followed in realising them. This includes sampling methods, data collection and analysis, as well as ethical considerations that were pertinent to the current research. The methodology is influenced by the researcher's philosophy or epistemology, which is discussed below.

Epistemological Base

Willig (2001) states that the interpretations and findings in research are noted to be influenced by the particular epistemological base of the researcher. My own epistemological base influenced the approach to the current research in a number of ways. Firstly, my involvement as both therapist and researcher meant that it was not possible to be an objective and neutral observer, which Willig (2001) states is important for case studies. Rather than taking on a realist worldview which Willig indicates is common for case study research, consideration was given to the dialogical nature of this case study. Dialogical research relies on ideas about communication in dialogue forms, and examines the role of reflexivity at each step of the dialogue (Russell & Kelly, 2002). Reflexivity refers to being aware of the researcher's contribution to the construction of meaning throughout the research process, and the impossibility of remaining outside of the subject matter. Connelly and Clandinin (1990, p.4) indicate that "when both researchers and practitioners tell stories of the research relationship, they have the possibility of being stories of empowerment". To allow for meaning and empowerment, a state of collaboration between researcher and practitioner, where the practitioner's voice is heard is important. In the current case, the researcher was also the practitioner. In this way I was reflecting upon myself in relation to conducting

relational play therapy. This process was influenced by my own training and background as well as my personal belief system. The current research case is therefore taken from my own perspective and linked to the perspectives of relevant theorists as a means of creating greater understanding of the process that took place between me as the trainee therapist and the child participant. My particular training and relevant background experiences are elaborated upon in Chapter five.

Aim and Objectives

Primary Aim

The primary aim of the current study was to describe the process of integrative relational play therapy that took place between a female trainee therapist and a maltreated girl child.

Objectives

To describe the following:

1. The child and trainee therapist relationship through the lens of object relations and attachment theory.
2. The process of integrative relational play therapy that took place.

Design

A research design refers to the structure of research that is designed to answer the research question and includes the planning of the research procedure as well as the procedure for data analysis and collection (Allison, 2000). The current study employed a qualitative descriptive-dialogic case study in the pursuance of the primary aim of describing the process of integrative relational play therapy between a female trainee therapist and a maltreated girl child. Each of these concepts is expanded upon below.

Qualitative Research

Qualitative research involves an interpretive and naturalistic approach to research, “meaning that researchers study things in their natural settings attempting to make sense of or

interpret phenomena in terms of the meaning that people ascribe to them” (Denzin & Lincoln, 2000, p.3). Advantages of qualitative research include uncovering more about people’s experiences and meaning and in this way facilitate the generation of novel insights and new understandings. Qualitative research allows for gaining a more complete picture of data by paying attention to outliers or idiosyncrasies, rather than discarding such data (Willig, 2001). However, qualitative research does not provide the researcher with certainty, in that alternative interpretations of the data are always possible (Willig, 2001). It is therefore important in this regard, to allow for space for the practice of reflexivity. This concept is expanded upon later in this chapter.

A particular advantage of qualitative research is that it may be less expensive to conduct in that it relies on smaller sample sizes, although on the other hand, the small sample size does not allow for generalisation of findings (Willig, 2001). The purpose of this study, however, is less to generalise than it is to inform about a therapeutic process and gain greater understanding of relational play therapy as well as to make provision for future research in this area.

The research was seen as descriptive in nature firstly because the process of relational play therapy was described within a framework of object relations and attachment theory and secondly because a description of the unique process of relational connecting between the trainee therapist and child was emphasized. In this way, the researcher aimed to better understand the intrapersonal and interpersonal experiences that both the child and the therapist experienced.

The case study as a form of qualitative research. A case study can be defined as “an empirical enquiry that investigates a contemporary phenomenon in its real life context when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used” (Yin, 2009, p. 18). According McGloin (2008) case

study research is gaining increasing credibility as a suitable methodology for healthcare research studies. This methodology provides an intensive, in-depth method of enquiry focusing on a real-life single case, and on a variety of resources. According to McLeod (2010) many case study approaches are motivated by professional goals and interests, such as developing theory, evaluating outcome or documenting professional knowledge. In the current case my particular interest concerned gaining greater insight and understanding into the process of relational play therapy as well as greater insight into myself as a trainee therapist.

Participant and Sampling

Non-probability purposive sampling was employed in the current study. According to Frost (2011) purposive sampling refers to a method of selecting participants because they have particular features or characteristics that will enable detailed exploration of the phenomenon being studied.

The current research relied on retrospective therapeutic work with a child who had been in therapy for behavioural and relational difficulties. The particular child who was selected for the current research was a five year old African girl who is fluent in both English and Afrikaans. This child was given up at birth and housed in a place of safety for the first eight months of her life and the biological mother has had no contact with her since. When she was nine months old, she was adopted by a family who allegedly maltreated her. The child remained with this family for four years, after which time they abandoned her to a place of safety. Childline was brought in to manage the placement of the child at this point. She is currently placed with a new foster family who foster other young children. The current foster family brought her in for play therapy following behavioural difficulties in the home. It was envisaged that the child would remain with this family until the age of eighteen years. At the

start of therapy, she had been with her current foster family for nine months. More specific details of the selected case are discussed in Chapter five of the current study.

An advantage of non-probability purposive sampling is that once suitable participants have been identified, the research becomes less time consuming. However, disadvantages of this sampling method are that the inclusion criteria are often subjective, and it cannot be representative of the whole population (Coolican, 1999). In addition, Coolican indicates that non-probability sampling cannot establish a cause and effect relationship. However, the aim of this study was not to establish a cause and effect relationship, but rather hoped to increase understanding of a process that took place in therapy.

Procedure

Prior to the commencement of the study, several processes were required. Firstly, permission to conduct the study was obtained from the Nelson Mandela Metropolitan University's research bodies at faculty level and institutional level, namely the Faculty Research, Technology and Innovation Committee (FRTI) as well as the Research Ethics Committee (Human)(Rec-H) respectively. Specific ethical considerations that are pertinent to this case are considered and highlighted below.

Ethical Considerations

Informed consent. Standard therapeutic practice relies on obtaining written informed consent to the process of therapy before said therapy commences. This is outlined by the Professional Board of Psychology (Ethical Code of Professional Conduct, section 6.1). This process was undertaken with the client's legal guardians who are the current foster parents. Consent for therapy from the biological parents was not possible as they have not had contact with the child since birth (five years ago) and efforts to find them were unsuccessful.

Informed consent to conduct research includes a full description of the nature of the study, potential risks and benefits, the knowledge that the family can withdraw at any stage and

knowing who will have access to the case information once the study is completed (Ethical Code of Professional Conduct, section 10.4, 2002, p. 19). There were a number of people that were considered relevant in this regard. Because the participant in the proposed study was a minor, written informed consent was obtained from the child's legal guardians as recommended by the Professional Board of Psychology (Ethical Code of Professional Conduct, section 10.4, 2002, p. 19). A letter was sent to the child's legal guardians explaining the purpose and procedures of the current research study and questions were welcomed at any stage during the research process.

As stated earlier, there was no way to contact the biological mother, who has not been present since birth and as such, obtaining informed consent to conduct the research was not possible. Similarly, the client's previous foster parents had abandoned her more than a year prior to commencement of therapy and have had no contact since as they have given up all parental rights. As such, informed consent was not obtained from the previous foster parents. The therapist did not in any event meet or speak to the previous family, nor has any way of identifying them. Childline, who is managing the client's foster care, also considered limiting input and contact with the previous foster family to be ideal, and the decision was strongly supported by the current foster parents.

The NMMU Psychology Clinic manager was also consulted regarding the use of the client's records, and the relevant consent was obtained.

Non-maleficence and beneficence. The notion of doing no harm as well as promoting human welfare is paramount within the field of psychotherapy as well as research (Ethical Code of Professional Conduct, section 2.6, p. 4, 2002). Although no foreseeable risks were evident, every attempt was made to ensure that no harm came to the participant and her family during the course of this research study.

The NMMU Psychology Clinic agreed to act as a gatekeeper specifically concerning the access and storage of the clinic file. The Clinic will keep record of the client's file, which included therapy process notes and informed consent to therapy. This file will be safely stored within a locked and access controlled storage space for a period of five years, after which time it will be shredded. No duplicates of this file were made in order to limit the amount of information available in multiple forms and therefore ensure greater control of access to the information.

Anonymity and confidentiality. Every attempt was made to protect the client and her previous and current foster family's identity. This was done by disguising all identifiable details of all relevant parties through the use of pseudonyms. Should it have happened for any reason that anonymity was not preserved, therapy was offered as an option to relevant affected parties.

The client's identifying details are available in the clinic file however access to the file is strictly prohibited in order to protect the client's anonymity and confidentiality. Requests to access the file need to be made through the NMMU Psychology Clinic Manager, who acts as the gatekeeper in this regard. In addition, written informed consent to access the file needs to be obtained from the legal guardians before access to third parties is granted.

Confidentiality was maintained by the researcher and her supervisor as part of professional conduct and as a means of adhering to ethical guidelines established by the Professional Board of Psychology (Ethical Code of Professional Conduct, section 3.10, p.8, 2002).

Data Collection Method

Yin (2003) describes three principles of data collection that need to be adhered to in qualitative research in order to ensure high quality and credible research. Firstly, multiple sources of information need to be consulted; secondly, a case study data base should be created and thirdly, a chain of evidence needs to be maintained. In order to meet these data

collection principles, the current researcher made use of detailed process notes in the case file that were based on therapeutic sessions as well as telephone conversations with the current caregivers in order to maximise data validity.

Rule and John (2011) indicate that if one is an active participant in the case that is being studied, recordings about feelings and additional self-reflection becomes invaluable data. Qualitative research makes allowance for this process and is considered under the concept of reflexivity. Reflexivity provides a space for the potential influence of the researcher (Thompson, 2004), particularly in case study research which acknowledges the place of the researcher in the process, rather than trying to hide her (McGloin, 2008). Reflexivity as a research process means the examination of research decisions, such as one's theoretical assumptions, selection of participants, the analysis of the data, as well as the relationship between the researcher and participant. In this way, the process of reflexivity aims to make the process of qualitative research more transparent and accountable to one's colleagues and the public (Frost, 2011). Shenton (2004) mentions that reflective commentary may record the researcher's initial impressions of each data collection session or any patterns that may be emerging. The data collected after each therapy session also made space for my own comments and reflections which were included in the overall data collection. The concept of reflexivity is particularly relevant for the current study as the researcher had formed part of the therapeutic process. In this way, the researcher was both a participant and an observer. The researcher's theoretical assumptions and personal experiences were considered in the research as influencing variables since the researcher cannot be an objective observer, but influences and is influenced by the research process taking place. My beliefs and assumptions as both researcher and therapist have been informed largely by my training and personal philosophy which is expanded upon in Chapter five.

Additional quality control considerations in qualitative research are important, since “the trustworthiness of qualitative research is often questioned by positivists, perhaps because concepts of reliability and validity cannot be addressed in the same way in naturalistic research” (Shenton, 2004, p. 63). According to the Shenton (2004), a qualitative researcher should implement a model to assess the trustworthiness of data when considering the case study approach. The current research will use these recommendations as the basis for ensuring the quality of the current study, and will consider Guba’s (1981) model of trustworthiness, as described below.

a) Credibility or truth value: refers to the level of confidence that the researcher has with the truth of the study’s findings, that is, does it measure what was intended? Shenton (2004) highlights several provisions that qualitative researchers make in order to maintain the level of credibility. In this sense, supervision and peer scrutiny should be welcomed and encouraged in order to refine methods and consider fresh perspectives. The current researcher made use of peers within the field of psychology to assist in this regard. McGloin (2008) indicates that the use of methods that include direct observation maintains the overall credibility of the research. The therapeutic process relied upon observation of the child in therapy as well as her responses to the therapist, which were noted as process notes in the clinic file. Credibility was further enhanced through the process of reflexivity.

b) Applicability: refers to the criterion of transferability. It is acknowledged that case study research cannot be applied to a wider population due to the limited setting and sample size; however, the principle of transferability is applicable with the purpose of contributing to a wider evidence base. The current study aimed to describe the process of play therapy within the theoretical framework of relational play therapy with the aim of contributing to current practice in this area. The aim was less to generalise than it was to describe a process that occurred in play therapy

c) Consistency: refers to the degree of consistency in a study that might allow for replication of the study at a later stage; however Guba (1981) argues that variability is to be expected due to the naturalistic nature of qualitative research. In this regard it is necessary to be meticulous when describing the setting and conditions within which the qualitative research will take place (Coolican, 1999). The methodological processes in the current study have been described in as much detail as possible so as to allow for greater understanding of the processes followed. This is important should there be a need to replicate the process, given the understanding that we are living in a changing society with changing conditions and that each person interacts and impacts another differently.

d) Neutrality: refers to the notion of remaining objective in the research process, where findings are the result of participants and conditions of the research, and not the result of other influences such as biases or perspectives (Kreftling, 1991, cited in McGloin, 2008). Two independent coders were used in order to recheck the thematic analysis and to prevent potential research bias.

Data Analysis

Case study research typically does not lend itself to statistical inference, rather Yin (2003) states that validity is established through a logical process, that is, analytic generalisation, analytic induction or content analysis. The data of the current study was analysed according to Irving Alexander's (1988) content analysis technique which enables the extraction of core identifying units or themes in order to understand and classify the phenomenon under study. Alexander (1988) suggests approaching the data by firstly letting it reveal itself by using nine principles of data salience. Alexander's (1988) nine principles of data salience are outlined below. Each of the examples related to the findings are elaborated upon in Chapter six.

Primacy refers to the association that is made between the first concept and its importance. The information presented first is often perceived as being most important or on one's mind.

For instance, the first theme that Ella, the child participant, expressed was conflict in relationships, both between ‘self’ and ‘self-other’ interactions.

Frequency is the certainty and importance that can be ascribed to information that is presented frequently. An example of this was seen in the frequency with which Ella struggled to form connection with self and other.

Uniqueness refers to events or information which is singular or odd and should be further explored. It includes looking for unique verbal and non-verbal cues. In this case, Ella’s play of gorging and vomiting up food was unique in that it did not fit completely with the other findings.

Negation concerns statements which are denied or turned into opposites, which may be indicative of repressed or unconscious material. An example of this was seen when Ella denied that we made a good team, and emphasised that she can do things on her own.

Emphasis refers to that which is overemphasized, underemphasized or mistakenly emphasized and which should be noted by the researcher. Over-emphasis is seen when something considered ordinary receives attention, while under-emphasis refers to events of information that is important receiving little attention. Ella tended to under-emphasise her need for relational connection throughout our sessions.

Omission is what is missing. Alexander (1988) stated that a therapist should pay particular attention to that affect, which is commonly omitted while description of actions and events are prominent. I thought an example of this, was incongruence between her hyper-vigilance and her forged smile.

Error or distortion concerns mistakes or errors related to the data. For example, mistakes related to general facts about the case or to facts about the individual (Alexander, 1988). I did not find an example of this in the data.

Isolation refers to what is alone or does not fit. This may leave one asking questions such as, does this make sense; where did this come from and is it thought to contain important information (Alexander, 1988). This was seen in Ella's sand tray play, where she symbolically gorged on food and vomited it out. This did not fit completely with previous theories. This finding is elaborated on in Chapter six.

Incompletion relates to that which is not finished (Alexander, 1988) and is seen when an event is described or explained but ended without closure. An example of this was seen when Ella started a conversation about the rain being too much, and then changed the topic.

Recurring themes in the current research were analysed by using the nine principles of data salience described above in conjunction with a theoretical matrix that was constructed specifically for the study (See Appendix B).

In addition to the nine principles of data salience, Alexander (1988) suggested asking the data questions based on the research aim and objectives. Bauer and Gaskell (2000) indicates that codes need to flow from the principles that underpin the research, as follows.

- i. What sections of the data will allow for the description of the relational play therapy process between child and trainee therapist?
- ii. What sections of the data will allow for the description of object relations theory and attachment theory concepts?

Once the data had been analysed and themes had been extracted, the researcher placed the themes into a qualitative framework through which the findings are discussed. The findings of the current case are observed through the lens of object relations and attachment theory and discussed in Chapter six.

Conclusion

The current chapter provided an outline of the research methodology that was used in meeting the aim and objectives of the current research. The study was qualitative in nature

and took the form of a therapeutic dyad consisting of a therapist and her girl client. The data was collected in the form of therapeutic process notes which were analysed using Alexander's (1988) approach to content analysis. The themes that emerged were based upon concepts relating to Winnicott and Fairbairn's object relations theory.

The following chapter discusses the backgrounds of the child and therapist and highlights each therapy session that took place between the child and trainee therapist.

CHAPTER FIVE

CLINICAL PICTURE AND PRESENTATION OF THE THERAPEUTIC CASE

“Supposing a tree fell down while we were underneath it?” said Piglet. “Supposing it didn’t,” said Pooh after careful thought.

A.A. Milne, Winnie the Pooh

Introduction

This chapter describes the process of relational play therapy that took place between a female African child and a female trainee therapist. My own training as a therapist will be described followed by a description of the child in the current case, which includes her history and reason for referral. Finally a session by session account of the therapy process including transference and countertransference emotions is described. Commentary related to the transference and countertransference experiences is in italics under therapist reflections, because although it relates to the play therapy sessions, it is specific to me, and I feel also forms part the reflexivity of the current research. All session data, including personal reflections were recorded in the process notes in the clinic file. The layout of the sessions in the current chapter was considered for ease of reading.

I have chosen to use the word ‘space’ in subsequent chapters in line with Axline’s (1969) description of an optimal environment being an actual physical place, such as the playroom, as well as the exposure to empathy, implementation of structured limits, and acceptance by the therapist. In this way, ‘space’ refers to therapeutic conditions that promote corrective emotional experiences.

It is important to reiterate that pseudonyms have been used when referring to the child participant and her current foster family. The chosen pseudonyms are Ella, and Mr and Mrs Hill respectively.

The Therapist's Foundation of Theory and Practice

My own journey into the therapeutic domain began with a class on humanistic, Person Centred Therapy (PCT). During that process I found myself resonating with the philosophy espoused by this approach, particularly, that each individual is unique in his or her own right and that reality is subjective and based on one's perceptions, beliefs and biases. The basis of this belief fosters openness to others' subjective experiences of reality and to all that an experience may contain, allowing meaning and significance to be shaped by that new experience alone, and not to be clouded by prior experiences (Tudor, Keemar, Tudor, Valentine & Worrall, 2004).

I also believed that clients are trustworthy, and that this "trust resides in the belief that every organism (including the human being) has an underlying and instinctive movement towards the constructive accomplishment of its inherent potential", that is, every organism wants to grow and develop (Thorne, 2007, p.3). I believed that given the right space or conditions, an individual will instinctively move towards a place of healing.

As I moved into the practice of therapy, and child therapy in particular, I began to approach each therapy session as openly as I could, honouring each client's uniqueness and waiting for what the he or she brought to that session. However, there was something about the actual practice of Person Centred Therapy or Child Centred Therapy that did not come completely naturally to me at the time (Child Centred Therapy is discussed in greater detail in chapter two). I was advised by a supervisor to wait for other therapy modules, which she felt may be a more natural fit to the way I preferred to work. In those early days of training to be a therapist I was not certain what this meant.

Several months later I was introduced to object relations theory and therapy started to make more sense to me. This module focused predominantly on the work of Melanie Klein, but also made reference to theorists such as Donald Winnicott and Otto Kernberg. My

interest peaked as we began to discuss the idea that early relationships and one's environment have a profound impact on an infant's development of self and on his or her development and subsequent relationships. The development of self, how it is constructed and how it finds space in this world had been an interest of mine since early undergraduate training and object relations theory started to provide an outlet for some of my own thinking and questions that I had about who we are as human beings, that is, what is it that drives us?

The object relations theorists indicated that as human beings we are driven by the need for connection and relationship to others, and this notion appealed to me. At this time, my approach to therapy and play therapy in particular, began to feel more natural. I found that I could acknowledge clients' unique states of being, trust that they instinctively knew what they needed from therapy while simultaneously working on the relational issues that I believed framed one's existence.

Following on from this module, I began to explore various psychodynamic theorists and how their approaches were similar or different to one another, specifically their ideas regarding early relationships, defenses that are employed to protect the self, and the actual development of self. In addition, I and several peers formed an informal psychodynamic group where we began to explore psychodynamic literature in greater depth and used this forum to gain additional peer supervision as it linked to cases and to our own reactions to certain cases.

Throughout all the training and influences experienced through the course of my training programme to become a psychologist, I found myself returning to the belief that the therapeutic relationship is central to correcting negative relational experiences. On a personal note, I find inspiration in the writings of object relations theorists, playful creativity, and in the wise words of a children's storybook character, Winnie-the-pooh. That said, I believe that therapeutic work with children in particular allows for creativity, care, and possibility. It is

with these beliefs and my own background influences that I entered into the therapeutic process that is the focus of the current study.

Reason for Ella's Referral

Ella was first brought into the University Psychology Clinic by her new foster parents Mr. and Mrs. Hill following incidents of behavioural difficulties in her new home. Ella was staying in a place of safety which housed nine other children under the age of seven. Circumstances leading up to this placement are discussed under Ella's relational history later in this chapter.

The behaviour that was considered problematic by Mr. and Mrs. Hill was related to attention-seeking when people visited the home; aggressive and jealous behaviour towards other children in the household, where she would bully the other children; encopresis and self-harming were also concerns. Ella would self-harm where she would repeatedly scratch at wounds to open them up, pull out her hair, and create new wounds by pinching or hitting herself. Of concern to Mr. and Mrs. Hill was that when Ella did hurt herself accidentally she did not report this to her caregivers, or appear to notice that she had been injured.

Ella's Biographical Information

Ella is a five year old African girl who loves the colour pink. She is of average height and build, with short hair and big brown, watchful eyes. Ella is an intelligent child who is fluent in both English and Afrikaans and does well in the school environment.

Ella had been with her current foster parents for nine months at the start of play therapy. Prior to this she had lived with another foster family for four years. Her biological parents had given Ella up for adoption from birth and have had no contact with her since.

Ella was initially well-groomed and wore dresses that tended to highlight her delightfulness. However, as time went on, various marks and sores were visible on her body and her appearance became disheveled and unkempt.

Ella's Relational Background

Ella was born of an unplanned pregnancy and was given up for adoption at birth. She came to be in the care of a local safe-house for infants where Mr. and Mrs. Hill were employed. Her early development in terms of feeding and sleeping patterns was considered by Mrs. Hill to be appropriate. However, as time went on it was reported that Ella would cry often and it was difficult to settle her. Mrs. Hill reported that one day she had found Ella in a linen closet where she was left to “cry it out” by the caregivers at the safe-house. This had allegedly been common practice for some time.

Ella was adopted at approximately eight months of age by an Afrikaans Caucasian family. The adoptive parents came to know Ella when they were volunteers at the safe-house where she had been placed. They had two older biological daughters and Ella's relationships within this family system appeared to be inconsistent and abusive. Ella was reported to have a special relationship with her foster father that caused conflict within the family system, although the reason for this could not be established. There was also suspicion of sexual abuse which could not be verified.

The relationship between the adoptive-mother and Ella was reported to be strained. The adoptive mother forbade her to wear dresses or anything feminine, while her two blonde sisters were allowed to wear feminine outfits. Ella was reportedly badly bullied by her two adoptive sisters. In addition, Ella did not have her own bed but slept on a mattress on the floor which was shared with the family dog. She was excluded from going on holiday with the family and was dropped back at managers of the safe-house that Mr. and Mrs. Hill managed over the weekends that the family was away.

In 2011, Ella's adoptive-mother gave her husband an ultimatum that he either choose his biological family or Ella. Ella was then dropped at the safe-house with Mr. and Mrs. Hill where she has since remained. Ella was told by her adoptive father that “Daddy had to go to

work” and would see her next week. However, Mr. and Mrs. Hill were told that he would not be returning. At this point, Childline became involved and the adoptive father was called to explain to Ella that he would not be returning to fetch her. Mrs. Hill was with Ella through this process and reported that Ella did not show any emotional reaction to her adoptive father’s explanation at that time, but appeared to be blank, leaning slightly against Mrs. Hill’s leg, which she considered to be a form of comfort seeking.

Early Considerations

Ella required a relational experience that would challenge her internal working model or object relations, and give her a different experience of her ‘self’ and others. In addition, she required a great deal of “environmental holding” as proposed by Winnicott (1960) to allow her to feel safe. Practically, I thought that Ella could benefit from Booth and Jernberg’s (2010) Theraplay techniques, originating from object relations and attachment theory, which would help to foster a holding environment for our work together.

In addition, I needed to consider that Ella was part of a broader system and context, and in this sense it was initially thought to be of primary importance that Ella be better able to relate to and express herself with her current foster family. Part of Theraplay (Booth et al., 2010) is to include the parents in specific activities to promote relational connecting. However, Ella was adamant early on that “mommy” and “daddy” were not allowed to join the sessions. This I saw as a sign that I needed to respect Ella’s internal processes and to build family relations as time went on. I also felt a responsibility to honour Ella’s wishes and for this reason I remained in regular contact with Mr. and Mrs. Hill (Ella’s current foster parents) telephonically as their presence in therapy was restricted until Ella felt ready to bring them in. However, Theraplay as a specific intervention was not utilised.

Therapeutic Aim

The aim of therapy was to create a space for corrective emotional experience and in doing so, challenge Ella's internal working model self and self-other, and provide a space where she might express her need for connection.

Course of Psychotherapy

The therapeutic process was conducted over a period of eleven therapy sessions spread over four months, including the intake interview with Ella's foster parents. All sessions took place in the Clinic's playroom and lasted an hour at a time. The therapeutic approach that was selected for Ella's case was based on Ella's relational difficulties and early relational trauma. That is, given Ella's history of disrupted and inconsistent attachment figures, Benedict's (2006) relational integrative approach to play therapy was adopted. In addition, Fairbairn's theory of object relations was considered important for Ella's case.

Of importance to me as the therapist, was that contemporary psychodynamics has moved away from intra-psychic explanations towards inter-relational and inter-subjective ways of viewing human experience and development (Faris & van Ooijen, 2012). In this way, relational psychodynamic therapists offer a therapeutic stance that is closer to a humanistic way of working. I believed that given the right space, Ella would intuitively move towards a place of healing, uncovering the unconscious processes that were occurring within her relationship with self and other. It was therefore important to foster a relational connection with Ella and to allow her to work at her own pace when required. In this way, the process would be led by her but in relation to me. The child-led nature of our interactions would mean that Ella would lead the sessions, with some input from me that would be invitation in nature (Benedict, 2006). With Ella leading, I would focus on becoming attuned to Ella's needs and respond in ways that would challenge her internal working model.

The Therapeutic Journey

The therapeutic journey that Ella and I followed relied a great deal on what was occurring between us in the therapeutic relationship, that is, the transference and countertransference. An important part of object relations therapy is the transference and countertransference experienced during the therapy process.

Fairbairn's object relations theory describes the sensing and felt nature of transference and countertransference, which according to Sills (2009) could be described as an energy exchange where a person feels the projected energy or internal world of the other. It is exactly this description which I felt in my interaction with Ella, where her projected feelings became introjected within me. I will expand on this where relevant below.

Session 1 - Hello Ella. Hello Sherry. I met Ella for the first time in the waiting room. She was dressed in a lovely little pink dress that looked new. Ella accompanied me to the playroom willingly, smiling, and holding my hand. However, there was a watchful ambivalence in her interaction with me as her eye contact was limited and it was important for her to be busy. There was a forged smile on her face as well. Her jovial and self-confident way felt inauthentic and I wondered how I might try to connect with this very guarded little being.

Because Ella initiated contact through hand-holding I opted for two play activities to begin our relational play therapy process, firstly, a "greeting game" that would place emphasis on her physical 'self'. We greeted each other's hands, toes, noses, and eyes which Ella played along with although a part of her seemed to want to connect and another part of her appeared very hesitant –but smiling all the while. We then moved onto the 'baking game', a therapeutic activity designed to increase nurturing contact. I explained the game to Ella and asked if she would like to try it. The game consists of the child being a metaphorical biscuit (in this case, Ella was the 'biscuit') where various ingredients are chosen to put into the

‘biscuit’. We pretended to put pink sprinkles, tomatoes, sugar, and other ingredients into this special biscuit as suggested by Ella. We then kneaded it, where I placed my hands gently on Ella’s hands and arms and ankles being very careful not to be invasive but also monitoring Ella’s response, checking in with her, and verbally explaining what I was doing at each point in this process. For instance, when adding the sprinkles, I softly finger-tapped on Ella’s stomach asking her if it was ok, and then asking her to add her own sprinkles to her stomach. This process was repeated when we kneaded the ‘dough’. I explained that I was going to put my hands on Ella’s arm and gently apply pressure or gently “squish the dough” and asked if that was okay. Each time I moved to a different arm or leg I repeated this explanation. The explanations were done slowly, allowing Ella to respond to what I was about to do and I watched Ella for any signs of uncertainty and discomfort throughout. It was also important for the explanations to be playful. Finding the balance meant that I had to be invitational, warm and attuned in my approach to Ella.

I focused a great deal on how lovely this biscuit looked and how very special and different it was with all its special ingredients. It was then time to bake, where my lap became the oven in which she would bake. Ella happily jumped into my lap without any hesitation, I put my hands around her shoulders and we “baked”. When I suggested that we had finished baking she indicated that we still needed to bake some more and so I asked Ella to tell me when she felt fully baked and ready. I used Ella as my guide in this interaction as I was very aware of the possibility of past abuse and overstepping physical boundaries. Ella played out the game and found her voice to the extent that she was able to ask for more nurturing.

***Therapist reflections.** I found myself feeling more anxious than usual at the start of therapy but did not pay too much attention to the possibility of transference. I was aware of Ella’s background and I wanted to provide a connecting space right from the start, and I just assumed that the anxiety was part of that. It was only on reflection that I began to consider*

transference. By the end of the session I felt excited and happy. The session had been good, in the sense that Ella had asked for more nurturing and I felt that this was a good start for our relationship.

Session 2- Will you love me if I'm pretty? During our next session together, Ella chose to play with the 'girl toys', asking several times if these toys were meant for girls. This included the dolls, dressing table and pretend makeup. Normally I would have responded that the toys could be whatever she wanted them to be. However, it seemed important for Ella to be feminine and that I acknowledge this need. I understood this in the context of having been forbidden from wearing dresses or being feminine at her previous adoptive home. She began to cook for me, appearing to nurture me, and although she was willing to let me cook for her, she changed the activity before the food could be eaten. That is, she was uneasy in having me 'nurture' her with pretend food in this session.

Ella then moved onto the puppets where she played out a scene with a prince and a princess. In this scene the two puppets looked the same and were in love. It was important that they had the same kind of hair and skin colour. She then chose a goat (which she named Skunk) and a bear (which she named Hungry Bear). The bear chased the goat away because he was angry that the goat was not listening. At this point Ella's face changed and her anger was visible, however it quickly became masked again with a smile.

***Therapist reflections.** In this session there was much emotional transference, where I could feel Ella's sense of loss and sadness at being different to and rejected by the ones she had loved. I wondered to myself if Ella felt that she did not belong in her white family, possibly because she looked different. The anger she felt seemed to be related to her hunger for nurturing (expressed by her use of the character 'Hungry bear') and yet the disregard for this need, where her caregivers seemed not to listen or hear this need.*

Session 3- Bad therapist. This session started as usual in the playroom, where Ella could choose what she would like to play with. We played with the cars in the playroom and then moved onto the doll's house. Ella picked a blonde fairy that she chose to play with, and I was to be her friend, the pony. The play seemed to start off quite unnaturally, as if it was forced. As the session progressed, Ella became more involved in her own fantasy story and it was difficult for me to follow. In addition, her body language seemed to suggest that she did not want me to be involved in the play. She would turn to face the opposite direction while she played, with her back facing towards me.

I decided to take a step back and watched Ella create a story of friendships and fights, where she reenacted the pony and fairy's relationship (which she had then taken control of). The pony had done something to upset the fairy, although I was not sure what this was. Ella played out the scene until our time was up.

Therapist reflections. The transference I felt was quite intense and had a theme of rejection attached to it. I felt rejected by Ella's body language and her initial invitation for me to join, which she took back when she felt I was not playing the role the way that she needed. What was this about? What made me feel so rejected, confused and bad? Ella seemed to be giving me the message that she will reject me first. I also thought that Ella was trying to tell me that she expected me (the pony) to mess up our relationship.

Session 4- I need protection. This session is recorded slightly differently from above, as it highlights three different themes that were important to Ella's therapeutic process. As such, personal reflections are recorded after each theme is discussed.

This session was particularly noteworthy in gaining greater insight into Ella's internal world. Ella was more withdrawn than previously and there was a noticeable difference in terms of the confidence she portrayed in terms of coming with me to the play room. There was a lack of eye-contact and she declined any suggestions I made about therapeutic

activities (the baking game). Her mood seemed low and she was very quiet. Ella asked if I would read her a story, however she did not seem interested in the story as such but appeared to be looking for a safe way to connect. I focused more on the pictures and together we sat in close proximity in the reading corner. From here I suggested play dough or finger paint to her as I wanted to engage her senses with the feeling of different textures. Ella opted for play dough. She repeatedly stated that “I can’t” in this activity, when trying to roll a ball of dough and so I decided to use this as a nurturing activity. She placed the dough in her hand and I used my hand on top to roll the dough into a ball.

***Therapist reflections.** I felt such a deep longing to connect with Ella, almost desperation. I was aware of my own transference and the need I felt to rescue her and it became difficult to know how to navigate the session. In a sense there was a fear in reacting from my needs versus being therapeutic. However, I also feel that this was Ella’s transference and fear around connecting with me. I had become the exciting object, tempting Ella with the hope that I might gratify her emotional needs for connection and that scared both of us. I have found that when I begin to over think things I lose focus, however I can trust my intuition to be a good guide in my therapy work, and this is what I did. There seemed to be a disconnection between Ella’s internal and external worlds and intuition told me that sensory work would be help.*

Ella proceeded from us rolling balls together to making purple grapes with the dough and shells for protection, stating that it was to keep other people from taking them away. I reinforced the message of protection being important to keep the grapes safe. I asked if the grapes might be taken away like she had been taken away, but she commented that she had only ever had one family, that is, her current foster home.

***Therapist reflections.** This was the first hint Ella had given about her feelings of being removed from her home. I wasn’t sure if she meant her previous or her current foster home. I*

had felt ashamed of mentioning her previous home – why? Was Ella feeling shame towards her previous home?

Can mommy play too? Session four had been planned with the idea that Mr and Mrs Hill might join the second half of the session so as to observe and encourage familial connection. However, Ella was quite firm that “mommy” was not allowed to come and join the session. However, she proceeded to make a dough version of herself, which she took to her foster mother (Mrs. Hill) as a surprise and asked her to come and join the session. She took the exercise we had done together (rolling the dough) and did it with Mrs. Hill, placing her hand on top of Mrs. Hill’s hands the same way she and I had done and rolled balls. She made a mother and father figure from the dough and indicated that Mrs. Hill should make a protection figure. Of interest was that initially none of the figures apart from her own had legs, but she added this when Mrs. Hill made a remark to me that none of them had legs.

***Therapist reflections.** It was clear that initially Ella did not want Mrs. Hill to join the session as planned, so I was surprised when Ella took the initiative to invite her in. Was she trying to please me? I was not sure. The fact that she asked Mrs. Hill to make a protection figure I felt was important. Ella fluctuated between being independent and then needing someone to show her how and offer protection, and I became aware of the repressed bad objects coming up. Because the hope for connection had been raised in therapy, the internal saboteur was trying to step in to destroy the need she had to connect with me and her foster mother.*

Session 5 - Music and magic. Session five saw Ella even more withdrawn than previous sessions. She appeared disheveled and was wearing clothes that were old and too big. She had no expression on her face and avoided all eye-contact. I became alerted to Ella’s non-verbal behaviour and her physical state as she had looked physically uncomfortable, scratching at her vagina. Later she had asked to go to the bathroom.

Both Ella's hands were peeling (as if being submerged in bleach for some time) and there were various marks and scabs on her body. It seemed that even more than previous sessions, Ella did not know how to connect to her 'self' and other. I had wondered what could have happened in the space of a week for her appearance to have changed so dramatically.

Ella explored the playroom and found the musical instruments. At this point I felt that I needed to show her that I was with her and although she was experiencing something that was difficult, together we could "be". As she played the instruments somewhat aimlessly I began to clap along with her. Together we used rhythm to create a shared space. That is, we created an environment that was attuned to the other person. I would clap along mimicking her beat and eventually it became possible to anticipate her movements so that we could be in rhythm simultaneously. Ella smiled, and I felt for the first time that this was an authentic smile. The result of our attunement was that Ella went on to discover the soap bubbles and a fairy costume in the playroom. As I blew the bubbles, Ella danced and sang through them wearing a pink fairy costume and magical wings.

Before Ella left I asked her what we could do next time to try to help her sore hands to feel better. Ella had not identified them as sore, but I felt it important to let her know that I noticed them and that I was concerned. She did not know what we could do, so I suggested we put some cream (lotion) on next time.

***Therapist reflections.** I felt that this was my first experience of real attunement. I discovered in this moment that a state of 'being' together can be far more powerful than verbal expression and is more than just being sensitive to the child's needs. In fact there was hardly any speaking for this session, just a space of drumming and clapping that led to the experience of play. Donald Winnicott states that in therapy if the patient cannot play, something needs to be done to enable the play process to take place, after which psychotherapy can begin (Nolan & Nolan, 2002. p.17). I believe that through attunement,*

Ella broke away from the internal saboteur for a short while, allowing her defenses to be let down long enough to be a beautiful pink fairy dancing through bubbles.

Session 6 - I exist. As discussed at the end of our previous session, Ella was given the option of us (her and I) nurturing her sore hands with lotion, to which she responded enthusiastically. Again this was aimed at nurturing, using her senses, creating a new experience of touch, as well as ensuring that I was seen as a consistent nurturing adult in her life. As I put the lotion onto her hand I slowly traced each little line towards each fingerprint remarking how perfect and unique each line was. This was deliberately a slow process where Ella was asked what the lotion felt like (was it cold, ticklish etc.) and whether she could smell it. In that moment of togetherness Ella looked at her hand as if for the very first time. It was like she had just received permission to exist and the experience was unbelievably intense.

Once the lotion soaked in, she asked for more and I took this as an indication that she was open to receiving nurturing. She asked if I would put some onto a little sore on her ankle and I used this opportunity to teach her to connect cuts with physical pain - that sometimes when we cut or hurt ourselves it feels hot and burny. Ella was unable to relate what it felt like to her, and I became aware of how detached this child was from her 'self', both verbally and physically.

***Therapist reflections.** To put the transference and countertransference of this experience into words just cannot do it justice. It was overwhelmingly intense and honestly felt as if time had stopped. Ella was in absolute awe of herself and I felt so very humbled and privileged to share this moment with her. I experienced feelings of joy and disbelief, the latter which I ascribe to Ella's transference.*

But it's safer for me in a cage... Our hands were slippery from the lotion when we moved onto the Lego-type blocks. After the intensity of our earlier connection we worked together to try to pull the Lego apart. I remarked that we made a good team, and after some silence she

told me that “we don’t make a good team, I can do it on my own”. I felt that Ella had been required to be independent for some time and she was letting me know that she was capable of continuing on her own. At this point she began to make a cage from the blocks where she was going to put the lion, because the lion was bad. She roared louder than the lion and was then able to catch him. Ella indicated that my Lego structure was of a man who had let the lion out, and as punishment he then needed to be put inside the cage.

She then told me of a scary dream she had the previous night about a snake and a dinosaur (there was no content to the dream itself), and progressed to putting the Lego cage around my face and then hers. She remarked that she wanted to be in the cage. At the time I felt that she was inviting me into the cage with her, and was also asking for protection. This was the end of the session and in response to inviting me into the cage with her, Ella smiled authentically and skipped away from the session. I felt that we had shared an experience that was important, although I was not sure what it meant.

***Therapist reflections.** As I pondered on our session afterwards I wondered, who the lion was and who was the man that needed to be punished? Again the splitting was evident where I had just shown her that her need for connection could be met through the lotion exercise, but the fear of that connection (me highlighting that we make a good team) alerted the internal saboteur. I was the bad man who let the bad “needy” lion out, and so, I needed to be punished. But she also did not want me to be alone in my cage, hinting that she was fighting this saboteur. She wanted to join me in the cage where it felt safe, and she was asking me to protect her as she ventured out of the cage.*

Session 7 - There’s too much rain. After the connection that we had shared in the previous session with the lotion and the lion in the cage, Ella was again withdrawn, not talkative and avoidant of the playroom. She was able to acknowledge when we spoke that she did not want to be there that day. She was ambivalent about connecting, and I honoured this

resistance by following her lead in the session. She began painting her mother, father and step-brother, all who had no arms, legs eyes or faces. She then started painting herself with long blonde hair, no arms and no face. Ella had originally painted herself with feet, but had then painted over them to put herself in trousers. She painted another faceless person, a car, and rain. I reflected on how much rain there was and she replied quietly by stating that “there’s too much...it’s not sad or angry, it’s just a lot.” I felt that Ella was indicating that she possibly felt submerged by the all the pain she was experiencing. She was unable to name a feeling, but was able to say that it was just too much.

***Therapist reflections.** Ella’s repressed bad objects seemed to be moving into conscious awareness and the pain and disappointment she felt was overwhelming. Faceless people who provided no secure base (feet) or nurturing (hands). I did not feel much in this session. I could sense her resistance, but there was no sadness or anger, but more of a numb, matter of fact logic.*

Session 8 - I don’t want to go to the playroom. An alternative to straight play therapy was offered to Ella after a great deal of protest and fear around entering the playroom again. This alternative was sand tray. I felt that Ella was trying desperately to keep me and the playroom at bay and it occurred to me that the connection that had occurred between us in the space of the playroom before was possibly overwhelming and was also something that she had to leave behind each week. By not engaging, she did not run the risk of the pain of connecting and separating. This was consistent with her attachment difficulties. I wanted to show Ella that we did not have to go to the playroom, but that I did want to share some time with her. I felt that it was important to offer an alternative version of connection and structure that was not forced upon her as well as initiate Ella’s curiosity –what was this sand tray thing?

Protection first. Ella began constructing her sand tray with cages, umbrellas, a house, and a dog. Then she added additional structures such as towers and trees. She spent the session reorganizing the structures until she felt that they were in the correct place.

Oops, there are no people in my world. Once everything was in place, Ella remarked with surprise “There are no people there!” She responded to this dilemma by adding a girl, a dog, and a pony. The pony vigorously gorged itself on sand until it felt so sick that it wanted to vomit. Still it ate more sand. At the end of the session, Ella asked if I would keep the tray the same for next time.

Therapist reflections. *There were a number of things that stood out for me in this session. Firstly, only once there was enough protection in her world could she add people indicating that she wants people in her world, but she also needs to be guaranteed that they cannot hurt her. Once she did add people, she was desperate to take in more and more nurturing, and I understood her need to throw up and have more as indicating that she had been starved of nurturance for so long, that she could not get it in quick enough.*

Session 9 - Things need to be the same. Ella had asked for the sand tray to be the same in the previous session. I had photographed the sand tray in order to reconstruct it the way that she needed. I had mistakenly left out a tiny barrel that she had used in the first tray to feed the pony. She requested the barrel and we went to find it. Ella spent a good deal of time desperately filling a volcano with sand and then having it explode when it was too full. There was very limited verbal contact made. Again Ella fed the pony once her protective structures, namely the house, towers and umbrellas were firmly in place. She proceeded to have the pony vomit up the food and then take in more.

Therapist reflections. *I was surprised that Ella had remembered the little barrel that I had forgotten. This alerted me to just how hypervigilant she was, in that she had remembered exactly what was in her sand tray world and where each figure was positioned. I became*

aware that the same theme of feeding the pony was important. I had feelings of uncertainty at this point, and a certain sense of helplessness. Ella was resolving some kind of conflict, I wasn't sure what she needed from me.

Session 10 - Relationships confuse me. This session took place very much the same way as the previous sand tray sessions. Similar characters in the form of a purple pony named Lily, a blonde plastic figure, structures for houses, a volcano, bucket, and a “Fiona” figurine from the Shrek movie. This session was different in that initially she invited me to play her ‘sister’ through the Fiona character. As the session progressed, Ella continued a dialogue indicating that she was angry with me (her sister). Although she did not express the reason for her anger, her actions and non-verbal’s towards me were very angry. Eventually the play continued without me. Ella had decided to cut me out. She then proceeded to fill the buckets and volcano with sand while the pony gorged on the ‘food’, again unable to get enough.

***Therapist reflections.** I felt a lot of pressure in this session. I was unsure how Ella had wanted me to behave within this role. Did she want to replay her past experience with her sisters? Did she want to create a new experience with a ‘new’ sister? I really struggled to gauge what Ella’s needs were. I felt her saying in the end that she would meet her own needs by feeding herself. I also felt her transference of “this relationship and others are confusing. What do you want from me?”*

Although additional sessions were negotiated, this was to be our last session of therapy. The reality and demands of the South African context made it difficult for Mr and Mrs Hill to bring Ella into therapy. Both Mr and Mrs Hill manage a non-profit organisation which is reliant on funding. Transport to therapy became too expensive for them to maintain weekly or even bi-weekly sessions. Eventually, six successive sessions had been missed following the last session, that Mr and Mrs Hill thought it better to terminate sessions after our last contact. They felt that bringing Ella back to therapy would essentially indicate that she would be

beginning a process rather than ending it, which they felt may have confused Ella more. They had indicated that they wanted to end therapy for practical reasons. Ella's case was handed over to Childline, who would do regular home visits that focused on play therapy.

***Therapist reflections.** My own feelings of this unplanned termination were strong. I understood Mr and Mrs Hill's difficulties with transport, but I also understood the importance of continuing with Ella as she had been at the point of challenging her view of self and other. I was frustrated and felt helpless in getting Ella the care that I felt she needed. I felt that somehow I had promised Ella relational connection, but had unwillingly become part of a system that 'abandoned' her when she began to express her needs. On a personal level, this was difficult for me to resolve. At this point I also needed to acknowledge the boundaries of our therapeutic relationship and challenge my need to emotionally rescue Ella.*

Conclusion

The current chapter discussed aspects of my training and the development of my own therapeutic philosophy. In addition, the therapeutic sessions that took place between me and Ella were described in conjunction with my own commentary and experiences through therapist reflections. Understanding and acknowledging my own feelings and thoughts during play therapy with Ella was important in establishing a therapeutic relationship and in acknowledging that Ella instinctively knew where she needed to go. My role was to create a safe corrective relational experience for her to do this.

CHAPTER 6

FINDINGS AND DISCUSSION

Introduction

In terms of the aim and objectives of the current study, this chapter describes the process of integrative relational play therapy that took place between a trainee therapist and a maltreated child. In line with the first objective of the current study, namely to describe the child's and trainee therapist's relationship through the lens of object relations and attachment theory, the results from the play therapy sessions were analysed through the use of a matrix that was constructed according to concepts relating to Winnicott and Fairbairn (see Appendix B) as well as Benedict (2006). Conceptual themes that emerged were plotted in the matrix and then confirmed by two independent coders.

The second objective of the current study was to describe the process of integrative therapy that took place. In order to do this adequately, space for the process of reflexivity is provided. In this way, I could report on my own journey of being a trainee therapist. This includes my own insights and learning gained through both the therapy and in looking retrospectively at the journey during the write up of the case, and similar to the previous chapter, are presented in italics. Finally, realities of the South African context were important considerations. This included economic constraints which influenced transport to therapy on a weekly basis.

The findings are presented according to the conceptual themes that emerged from analysis and placed into the two phases of the therapeutic intervention described by Benedict (2006) in Chapter three.

Beginning Therapy

The therapeutic process was influenced firstly by Ella's relational background. Her presenting problem centred around relational difficulties with her 'self' and with others

(particularly her new foster family). Secondly, my belief concerning the importance of early relationships in establishing a sense of ‘self’, as well as the belief that a therapeutic relationship can provide corrective emotional experience for a client undoubtedly influenced my choice of therapeutic intervention with Ella. As such an integrative relationally based therapeutic intervention was selected.

In this regard, Benedict’s (2006) model of object relations play therapy was applied. Benedict highlights two phases of therapy. The first is to establish a secure base relationship and the second is to challenge the child’s internal working model. The findings that emerged through analysis of the current case are presented in line with these two phases along with the conceptual themes that were relevant. Many of the same concepts were evident in each phase of therapy, although in different ways and are presented as such. The phases of therapy, the link to theory, as well as my own understanding (in italics) is presented in the subsequent section.

Linking Theory to Practice: Themes That Emerged from Play Therapy Sessions

Phase One

The beginning phase of therapy lasted approximately three sessions. Benedict (2006) asserts that phase one of play therapy involves establishing a secure base. The concept of the secure base as indicated in chapters two and three stems from the work of Bowlby (1980) and Ainsworth (1978) and is important for the child to develop a means of safe exploration of his or her world. Axline (1969) also provided guidelines to therapy which encourage the establishment of a secure base relationship.

Establishing the secure base in play therapy relies on the therapist’s warmth, attunement, and an invitational approach towards activities (Benedict, 2006). In this way, the process is child-led. It also speaks to the creation of a safe physical and emotional environment as well

as the therapist's ability to respond to the child's cues by being fully present and attuned to the child's needs.

Ella's early years were characterised by alleged maltreatment, neglect and possible physical abuse and there was a likelihood of having developed an insecure attachment style (Howe, Brandon, Hinings & Schofield, 1999). Ella's initial cues that she provided (as described in Chapter five) supported this hypothesis and were indicative of a child with an insecure attachment style. Ella's insecure attachment style was evident during the beginning phase of therapy, where she was quite happy to come with me to the playroom, appeared to be 'connecting', but was also not really engaging. Ella was watchful and hyper vigilant, while simultaneously trying to appear carefree. In addition, Ella was hesitant to explore the playroom, she struggled to spontaneously approach any toys and seemed to be waiting for me to tell her it was alright, she could go and explore. Even then, she never really explored, but would aimlessly manoeuvre around the playroom appearing 'dazed' at times. At the end of certain sessions she would happily approach her current foster parents, whereas at other times she would ignore them and play in the waiting room oblivious to their presence. I found Ella's behaviour to be confusing, and difficult to respond to. There was a great deal of contradictory actions which appeared to be consistent with an insecure disorganised attachment style (Booth & Koller, 1998).

The insecurely attached disorganised child's behaviour tends to be incoherent, showing a mixture of avoidance, angry responses, and behavioural disorientation (Booth & Koller, 1998). Children with a disorganized attachment style develop no organized behavioural strategy for regulating their affect and gaining proximity, care, and protection from their caregivers. They have a heightened sense of arousal and develop defensive strategies for gaining proximity to the caregiver. However, Erskine (2011) indicates that if the very person on whom the child depends for need satisfaction is the same one who is predictably

punishing, then the child's experience of body sensations, affects, needs, and relationship will be profoundly confusing. This confusion was very evident in Ella's behaviour, where her current foster parents, Mr and Mrs Hill, reported that she was extremely attention seeking particularly when there are visitors in the home and jealous of her foster siblings. In addition, through sessions it became evident that Ella's physical sense of being had not been well established, and although she wanted to connect with others she was uncertain as to how to do this.

Identifying Ella's attachment style was important in informing how I approached our sessions. In this regard, a particular conceptual theme that was relevant for both phases one and two was Winnicott's (1965) concept of the holding environment. The subsequent section considers the conceptual themes that emerged during the two phases of play therapy.

The role of holding and a safe space during phase one. Winnicott (1965) indicates that infant care starts off very simply with actual physical holding of the infant, and gradually becomes more complex, but is essentially still related to the caregiver 'holding' the developing child. In the first session, a game called the 'baking game' was played which facilitated physical contact with Ella and was aimed at mimicking the early maternal relationship. This game can be considered to be somewhat physically invasive, and I did have reservations.

Therapist reflections. Given Ella's history of suspected physical abuse, I was uncertain how this game might be received by Ella. However, I also felt strongly about facilitating the experience of early infantile care from the beginning and although it is considered to be a directive therapeutic game, I allowed Ella to direct the interaction, and in this way removed myself from being in a "power over" to a "power with" role.

Ella's response to this game was that she wanted to 'bake' longer, or stay in my lap longer. It indicated how desperate Ella was for physical and emotional maternal care and affection.

In addition to physical holding, Winnicott (1965) speaks of environmental holding, or establishing a safe environment. Benedict (2006) indicates that there are a number of ways to do this, including being warm, empathic, attuned, and consistent. It is this mode of being that creates a secure base relationship. Benedict mentions that consistency is important for creating a secure base, which was my primary goal at this point in the therapeutic process. Ella had developed a disorganised attachment style as a result of contradictory, neglectful and alleged abusive behaviour of her previous caregivers. Consistency would provide Ella with a secure and predictable environment where she could eventually begin to resolve her internal struggles. Consistency was maintained firstly in how the playroom looked each week, that is, that furniture and toys were where they had been during our previous session. Secondly, consistency was shown in meeting and fetching Ella from the waiting room and my behaviour throughout the session, which was invitational but never prescriptive and I aimed to be at all times 'present' with Ella.

***Therapist reflections.** In addition to the normal aspects of establishing secure consistency described above, I also started to consider my appearance from week to week. I made a conscious effort to wear similar clothes and keep my hair the same way. I had wanted to be as predictable and reliable as possible. Although I have not found literature to support this view, my instinct or intuition told me this was important, not just with Ella but with children who had been exposed to a great deal of unpredictability in their young lives. I felt I needed to be a consistent object in how I responded and in how I looked.*

An important and frequent theme that emerged in phase one, was that Ella was ambivalent to making connection with me. This ambivalence is discussed under the conceptual theme of *splitting*.

Splitting during phase one. Right from the beginning of play therapy, Ella showed evidence of Fairbairn's (1963) concept of splitting, where there was a conflict between

wanting to connect and the fight against this need. Fairbairn's two repressed parts of her 'self', namely the libidinal and antilibidinal ego structures, began to emerge as early as session one. I was aware of Ella wanting to physically connect with me through the baking game, but she was also very watchful and uncertain. She would glance at me out of the corner of her eye, seemingly fighting the urge to fully engage and also wanting to appear nonchalant. Although she was willing to come with me to the playroom in the beginning phase, her non-verbal body language was conflicted. She would smile, but avoid eye-contact, hold my hand, but try to appear busy. This behaviour could be considered to be indicative of an active libidinal (repressed part of the 'self' wanting connection) and antilibidinal ego (the repressed internal saboteur aiming to destroy connection).

Additional aspects of splitting were noted where Ella saw herself as 'bad' and others as 'good', and sometimes where others were 'bad'. She was never 'good' during this first phase of play therapy which confirmed a disrupted internal working model, or negative view of her 'self'. Again a theme in relation to her view of 'self' and others was a great deal of confusion, contradiction, and uncertainty. Was she bad, were others bad? Perhaps everyone was bad? What made someone good?

The good/bad split that Ella demonstrated indicated that she was unable to integrate 'good' and 'bad' within her 'self' and others. This early defense mechanism preserved the parental or caregiver figure in Ella's internal world (Fairbairn, 1963). It could be hypothesised that if she was to acknowledge her previous caregivers' 'badness', then she would have to acknowledge her disappointment, anger, and feelings of being unloved, all of which were deeply repressed emotions. Acknowledging these emotions was too threatening for Ella's psychological existence at this stage, so in her own way she kept the bad at bay, taking it into herself. This was evident in the presenting problem, where Ella had come to therapy because she was fighting with other children and showed various behavioural difficulties, such as

soiling herself and self-harming. According to Winnicott (1965, p.24) “the good becomes protected from the bad, and a highly complex personal pattern is established as a system of defense against chaos within and without”. Ella’s behaviour may indicate that she was protecting the ‘good’ of her previous caregivers by taking on their ‘bad’. In this way she protected herself from chaos within and without so that she could survive psychologically.

The splitting was also evident in session two, where it seemed that Ella needed to look the same as others in order to be loved, that is, she needed to be white and blonde (as her previous family was). She had started to associate being black with being bad, and there was no way she could change this. Being black in her mind meant that she was permanently bad, and there could not be any good within her. In addition, Ella was unable to acknowledge her feminine identity. In her relational history, being a girl was considered to be good, but Ella had been forbidden from wearing dresses or being or appearing feminine. She was not a girl, she was not good. It was important that this internal working model be challenged, that Ella could see herself as delightful and beautiful as she was. This was addressed in phase two and is discussed later.

The false self. Winnicott (1965) indicates that the presence of a false self is built up on the basis of compliance, where it performs a defensive function protecting the true self. The more Ella split the more she rejected real connection with me and with others and as a result, it seemed that a false self, as proposed by Winnicott, was developing. I came to this finding through the countertransference that I felt towards Ella. There was something inauthentic in our interactions. Her smile was forged on her face because it seemed to be what people wanted from her. Her eyes did not mirror the smile she had or the seemingly indifferent attitude she took with me; rather, she was watchful at most times.

Phase Two

There were a number of corrective emotional experiences that took place during this phase that provided Ella with the space to change her internal working model. The second phase of therapy began from session four and was essentially characterised by Ella fighting the repressed internal saboteur, that is, she was fighting herself so that she could connect with me. She was very adept at letting me know how frightening this connection was for her, and it was vitally important that I responded to this. I used Winnicott's (1965) notion of the holding environment, discussed in Chapter two, to respond to Ella's fear around connection and relationship.

Therapist reflections. During this phase in particular, I felt it was important for me to be even more consistent and attuned to Ella through her verbal, non-verbal and transference communication, that is, to respond to Ella's needs very much the way a good enough mother might respond to her infant. In this way I hoped to provide Ella with a new nurturing experience, and an experience of 'self' as special and visible.

The role of holding and a safe space during phase two. Physical contact with Ella had become an important way for her to express her need for connection and nurturing. This was seen initially through Ella's request to me to hold her longer during the "baking game". In addition, the play dough exercise during session four provided Ella with a safe way of physically connecting and experiencing nurturing. Telling me she couldn't roll the play dough balls could have been her way of inviting me into her world, as well as inviting me in to teach her and to nurture her. By placing my hand on top of Ella's and rolling the balls together, I was showing her that I believed she could roll the balls, and that I wanted to connect with her on a relational level. This was the first challenge to her internal working model, or challenging her view of herself, others and the world as bad.

Winnicott (1965) speaks of healthy progress in an infant's development where, through adequate holding, the infant becomes aware that he or she is a person in his or her own right. Associated with this attainment is the infant's psychosomatic existence. A limiting membrane provides the infant with the position of 'me' and 'not me', where the infant comes to realise he or she has an inside and an outside. The limiting membrane that serves this purpose is the skin (Winnicott, 1965). The first contact with the limiting membrane and the notion of 'me' and 'not me' occurred during the play dough exercise. A second experience of connecting with Ella's self through her skin was evident in the lotion exercise in session six. During this session, I made use of lotion to nurture Ella's sore hands. At the same time I was consciously making Ella aware of each special and unique line on her hands and fingers. My aim was to provide a very concrete corrective emotional experience of acknowledging Ella's physical self. During this exercise, there was a shift in Ella's mannerisms where she looked to be in awe of herself, as if she had been given permission to exist.

***Therapist reflections.** The intensity of this moment cannot be fully expressed in writing. I found myself feeling quite choked up and aware that I had just witnessed something quite amazing. Suffice it to say that this experience confirmed my own view that relational connecting is a powerful means of providing clients with a different view of themselves.*

Winnicott (1965) refers to this concept of connecting to the 'self' as *continuity of being* which is thought to be a personal psychic reality and a personal body-scheme that individuals develop as they mature.

Session five was particularly noteworthy in terms of creating a holding space through the use of rhythmic attunement with musical instruments which facilitated Ella's ability to spontaneously play and shifted the split she experienced from being bad to being good. This is discussed in greater detail in the subsequent section.

Splitting during phase two. The splitting as proposed by Fairbairn (1963) was evident throughout sessions in phase two, but in varying degrees. At the start of session four, Ella's mood was low; she avoided eye contact and was very quiet. The message I received was clearly from the internal saboteur or antilibidinal ego and seemed to convey something like 'I don't want to connect'. However, the libidinal ego seemed stronger in a sense, and she asked to be close to me through the task of reading a book together. The conflict between wanting to connect and fearing that connection was evident, but what was becoming important and more prominent was that Ella was finding 'safe' ways of connecting with me. She had begun fighting the internal saboteur. The presence of the libidinal and antilibidinal egos was again seen in session four when Ella had been ambivalent about wanting her current foster mother to join the session. Initially she had refused, but then had later invited Mrs Hill into the session, which had resulted in greater connection between Ella and Mrs Hill.

Session five saw the internal saboteur being particularly dominant. I had a sense that she saw herself as a bad object. Her clothes were too big and were old, her physical appearance was dishevelled, she had little sores all over her body and she avoided all eye contact. Her face was blank of all emotion. It seemed that Ella did not want to connect with me, or anybody else for that matter. As the session progressed, I felt I needed to be particularly present with Ella, which ended up with me following her lead while she played instruments. There was no talking involved, I was not going to convince her that she could safely connect to me, I was just going to share the space with her, and hopefully by doing so invite her back into relationship with me. As she aimlessly played the instruments I carefully followed her lead by clapping along to her drums or various beats. When I was able to anticipate her rhythm, instead of following after her, I clapped along with her. We were back in the same space together, connecting in spite of the internal saboteur. This was the first authentic smile that Ella had shown in therapy.

Ella then explored the playroom and found the pink fairy costume which she put on. This move was notably significant in that she had allowed herself to be a little girl in this fairy dress which was an important corrective experience from her past of not being allowed to be feminine. In this way, Ella had acknowledged more of her 'self' as a good object, and challenged the negative internal working model that she had of herself.

The splitting was again evident in session six after we had shared an experience of connection through the lotion exercise. As Ella moved onto the Lego blocks and our hands were slippery from the lotion and we had needed to work hard together to separate the blocks. When I remarked that we had made a good team, she had replied that we did not, and that she could do it on her own. The internal saboteur appeared to be such a strong defense system, that Ella had quickly responded by reminding me that she did not need anyone. She proceeded to construct a cage for the "bad lion" which I felt represented her 'self' as a bad object. I had also become a bad object who had let the lion out. This process could be seen to represent her punishing me for bringing her unconscious need for connection into conscious awareness. Rather than cut me off however Ella invited me into the cage with her, by placing the cage around both our faces. This seemed to indicate that the libidinal ego was still fighting for connection and showed that although she wanted connection, she was terrified of that very connection. It had been safe in her 'cage', however therapy had shown her a different way of connecting, and although she wanted to stay in her cage, she no longer wanted to be alone.

Conscious awareness. Session seven saw some movement from Ella's unconscious world to the conscious. She had clearly stated to me that she did not want to be there that day, and I was reminded how difficult therapy can be sometimes. Ella began painting her family and herself and then proceeded to add rain over the picture. When I remarked that it was a lot of rain, she responded by saying, "It's not sad or angry, it's just a lot". I took this statement as

indicating that Ella had moved into a state of conscious awareness, where she could acknowledge that she had many emotions that needed expression and processing. I believe Ella had begun to acknowledge the bad in her previous caregivers. What I found interesting was how Ella herself linked the rain to overwhelming emotions, and was able to express that to me. In Ella's painting, the people had no faces, no feet, and no hands. This could be interpreted as faceless people who provided no secure base (feet) or nurturing (hands). I also had a glimpse of Ella's feelings of powerlessness, no face to express herself, no feet to run away or towards, and no hands to defend herself or to make contact. After this session, Ella refused to return to the playroom, which may indicate that the movement towards conscious awareness of how her previous caregivers had let her down, was overwhelming. Similarly, the movement in our own relational connecting was also frightening. In retrospect, what Ella may have needed, was for me to slow the process down and to provide more structure and security at that point.

***Therapist reflections.** We had reached an impasse, and I felt caught. I wanted to remain consistent and provide a consistent environment however I also wanted to honour Ella's resistance. At this point I introduced sand tray. In this way I was showing Ella that I still wanted to connect with her, but that we could do something different and move at her own pace. Sand tray ended up being the perfect place where Ella could start to reconstruct her inner world the way she needed.*

Themes that emerged from sand tray. Protective elements were vital in Ella's world, and are discussed under the theme of protection, since this was an important theme to report on separately.

Particularly important aspects of the sand tray sessions emerged when Ella realised that there were no people in her sand tray world. This realisation seemed to indicate that Ella had silenced the internal saboteur and had acknowledged to herself that she had a need for

relational connecting. This provided evidence to me that Ella's internal working model was shifting, that is, her view of self and others was changing. Ella's expression of her need for nurturing became more prominent during the four sand tray sessions. Ella would symbolically gorge herself on sand, and then vomit it up and then repeat the process several times. This theme was an anomaly to me, and fits with Alexander's (1988) concept of isolation discussed in Chapter four. I could not find anything in Winnicott, Fairbairn or Ainsworth to explain what was occurring. However Melanie Klein provides some insight into what may have been occurring at this point. Klein, Heimann, Isaacs and Riviera (1952, p. 238) state that "the infant's relations to his first object, the mother, and towards food are bound up with each other". According to Klein et al. (1952), the oral component in an infant's development is important, where one sees an infant striving after the mother's breast, unconsciously feeling that there is an object of unique goodness that exists which must be introjected within the infant. Ella needed to take in this goodness or nurturing, much the same way as an infant takes in milk from the mother. It could be hypothesised that she had been so starved of nurturing or goodness that she could not fill up fast enough. It could also be hypothesised that the internal saboteur was attempting to exert dominance, by having her reject or vomit up the nurturing that she acknowledged she needed. She would need to then empty herself and start again. She needed to get more of the good introjected within her, and the saboteur needed to get rid of it.

Another possible explanation is that Ella did not know what to do with the nurturing or goodness once she had received it. She had been unable to take in the good previously because she had experienced herself as so bad, but now that she had seen some of her good in previous sessions, she was not all bad. All three explanations seem plausible and come down to Ella wanting and needing to take in more of the good and have her relational needs met by others, but she was still struggling to reconcile whether she herself was good or bad and

whether others were good or bad. In this way, the splitting was still evident, but she seemed to be moving towards trying to resolve it.

Particular emphasis (Alexander, 1988) was placed upon the theme of Ella's need for protection. While I still consider this to be part of establishing a holding environment, it was such a prominent theme that it is discussed separately.

Protection. From session four onwards, Ella began expressing her need for protection in her environment. Firstly, in session four she created protective structures for the play dough grapes we made. She followed this by asking her foster mother to make a protective structure from the play dough that would protect the family. This was a vital moment in Ella's therapy, where she was able to ask her caregivers for the protection she needed.

In session six, Ella kept herself in the cage and 'asked' me to join her there indicating that she needed protection around her. Finally, her sand tray world was the most telling of this need Ella had for protection. Her sand tray began with protective structures, such as cages, umbrellas, houses, and a dog. Only once the protective structures were in place, could Ella acknowledge the need for people in her world.

Therapist reflections of phase one. It was noteworthy at the start of our process how much pressure I felt not to disappoint Ella. It's difficult to say what part of that was transference/countertransference and what part of it was my own need to perform as a trainee therapist. I was aware of Ella's guardedness and cleverness at making people think she was connecting. I was also quite in awe of her fighting spirit and ability at defending herself. I think in these early stages we were both figuring out what our relationship would be like.

Therapist reflections of phase two. I often felt Ella's fear at connecting with me. I felt this in a countertransference where I would feel scared to connect with her and this took me by surprise. I cannot say that I did not feel the responsibility that went with opening up this little

girl's defenses that were so well built up, but the fear was something else, and it was not mine. It was at this stage that I started to use more intuitive responses to our play interactions, relying on the concept of attunement to guide me. In this way Ella was guiding me through our interactions. My role was to respond to her transferred fears by creating an environment that was safe, and myself being consistently attuned.

I feel as I write this, that my willingness to connect with Ella needed to be bigger than her internal saboteur's need to reject connection in order for her to trust this relationship.

External Constraints

Unfortunately we were never able to properly terminate the therapeutic process together. After many weeks of missed sessions due to financially related transport difficulties, Ella's current foster parents felt that it would be best to terminate sessions at this point, as they felt that bringing Ella back to therapy would begin a process again, and they had wanted to begin the process of termination. I had a number of feelings about the unplanned termination, as outlined in Chapter five, but I also needed to acknowledge the realities that we faced.

Conclusion

Sessions with Ella were informed firstly by her attachment style and relational history and were essentially divided into two phases as proposed by Benedict's (2006) model of play therapy. Phase one focused on building a secure base and was informed theoretically by the works of John Bowlby (1980), Mary Ainsworth (1978), Virginia Axline (1969), Donald Winnicott (1960) and Ronald Fairbairn (1963). Phase two focused on changing Ella's internal working model or her view of self and others, which was informed by relational therapy (Benedict, 2006; Fairbairn, 1963; Winnicott, 1965).

Ella displayed signs of a disorganised attachment style where she would show contradictory behaviour towards wanting to connect with a caregiver whilst simultaneously avoiding that caregiver. She had not developed a consistent way of getting her needs met. At

times she approached her caregivers for attention directly, other times she behaved in seemingly negative ways in order to gain attention. Still at other times, she avoided connection with others completely. The concept of a disorganised attachment style aligns well with what Fairbairn (1963) considered to be a form of splitting, particularly where the child shows contradictory behaviour of wanting connection and avoiding connection. The play therapy sessions were analysed according to concepts relating to Fairbairn's (1963) object relations theory as well as Winnicott's (1965) object relations theory. Prominent themes related to Winnicott (1965) involved the role of the holding environment, splitting and the presence of a false self versus a true self. Fairbairn's themes related to the presence of two repressed ego structures, namely the libidinal and antilibidinal ego structure which he referred to as splitting.

CHAPTER SEVEN

CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

Introduction

The previous chapter described Ella's process of therapy within Benedict's (2006) object relations play therapy framework which was described in Chapter three. The findings of the study were presented with Benedict's (2006) framework in mind and then described according to themes that related to Fairbairn (1963) and Winnicott (1965) as was determined by the conceptual matrix (Appendix B). This approach was taken in line with the aim and objectives of the current study, which was to describe the process of relational play therapy that took place between me and Ella, and more specifically to describe the relationship through the lens of object relations and attachment theory. While attachment theory informed the approach I took with Ella, object relations theory as outlined by Fairbairn (1963) and Winnicott (1965) provided deeper understanding of the interpersonal and intrapersonal processes that Ella and myself experienced.

Conclusion of the Study

The study provided a detailed account of Ella's therapeutic journey with me as a trainee therapist. This journey was contextualised within an object relations and attachment theory framework and allowed space for the therapist's commentary and reflexivity through therapist reflections. Although a single subject case study cannot be generalised to the broader population, the value of the study as a trainee therapist was in obtaining greater understanding of the process of relational play therapy with a maltreated child.

It was my hope that by reporting on this therapeutic co-journey, it would provide a sense of meaning of the therapeutic processes that took place, and in some way provide future trainee therapists with a sense of empowerment as they begin their own therapeutic journeys with clients. I considered it to be important to allow for both the voice of the researcher and

that of the therapist to be heard in the narration of this case study. In this way dialogical elements were noted, specifically where the researcher examined the relational interaction between the different parties involved in these processes.

The therapeutic process saw Ella progress from repressing her need for connection with others to acknowledging that she had a need for connection as long as she was provided safety or protection. As sessions progressed she slowly started to invite various people into her world, which indicated that she was challenging her bad objects and her view of others as all bad and in this way addressing the defensive splitting that was present. In addition, Ella had started to acknowledge her own existence and continuity of being in this world (Winnicott, 1965). She had started to see herself as good and could acknowledge a feminine part of her 'self' that had been forbidden in her previous adoptive home.

In speaking with Mrs Hill in recent months regarding permission to conduct this research what became evident was that Ella is now more able to ask for connection from her current foster family. A particularly noteworthy example is that Ella asked to play the 'baking game' with Mrs Hill's breasts. She will approach Mrs Hill and ask to play the 'baking game'. She then proceeds to put ingredients 'into' Mrs Hill's breasts, which I took as Ella finding a safe way to connect to the objects of maternal nurturing. Once the ingredients are added, Mrs Hill folds Ella into her bosom where Ella 'bakes'.

This behaviour indicates that Ella is providing herself with a corrective nurturing experience. She is taking herself back into a state of infancy to get the physical nurturing she did not get as an infant and the baking game allows her the opening to ask for this nurturing. Mrs Hill understands what Ella needs and allows her the time and nurturing conditions to play this game. My hypothesis is that once Ella feels she has taken in enough maternal nurturing she will shift to other ways of asking for infancy needs of connection to be met. Another noteworthy movement in Ella's functioning at the time of writing up this case was

that Mrs Hill reported that Ella has not self-harmed in several months and that she soils herself less frequently. I interpret this as Ella is in the process of rectifying her view of herself as bad. It may also be that she now knows that she does not need to retain the bad of her previous caregivers any longer because she has and continues to experience a safer and more loving environment than that of her past.

My own journey with Ella has led me to believe that in a therapeutic relationship between people, it is impossible not to be influenced or influence one another. With each session I felt a connection or disconnection that was different from our previous time together which had an influence upon both Ella and myself. This reinforced my belief that relationships cannot be pre-empted or activities planned to 'create' connection. I believe rather, that the most effective therapeutic work is done with an overall goal in mind, but where the focus is in the moment, from session to session, focusing on where the client is at that time and allowing oneself to become attuned to the client's process.

Limitations

Researcher bias is an important consideration particularly because the researcher was also the therapist in this case. This limitation was addressed partially through the use of two independent coders who confirmed the themes that emerged from the analysis of sessions. However, this case is relational in nature and as such relies on subjective experience. I therefore acknowledge that the findings may be affected by my own bias and therapeutic views. I have tried where possible to reflect on my thoughts and feelings throughout this study so as to remain as transparent as possible.

In terms of the methodological considerations, it is the researcher's opinion that the research was trustworthy. Although the findings are not generalizable to the broader population, they could be generalised to theory through analytical generalization by other researchers.

An additional limitation was considered as the therapy was not terminated in a traditional manner, which does leave the process somewhat open ended. However, it has also occurred to me that the experiences gained through relational therapy can continue to be active even after therapy has terminated, as Ella has demonstrated in her interactions with her foster mother.

Recommendations

This case really challenged my view of what play therapy in the South African context is and could be like. The reality is that as practitioners we are faced with many traumatised children who require therapeutic intervention, but where access to such therapy is limited or not possible. Particularly with regard to relational forms of therapy I have wondered whether we as practitioners might enter the family system or community, and work therapeutically there, instead of always having caregivers bring children to us. It is a question that has merit but also poses some difficulties. A recommendation for future research might be to explore the role of relational play therapy within the child's own context, if this context provides safe and secure conditions for therapy to occur.

Should additional research on relational play therapy be conducted, it may be useful to explore this in relation to different object relations theorists in order to gain deeper understanding of the interpersonal and intrapersonal processes that children and their care systems experience.

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APPENDIX A
Summary of different types of play and the related ages for each

Approximate age	Sensory/creative play	Physical play	Exploratory play	Social play	Symbolic play
12 months	Using the whole body and all senses (smelling, feeling, hearing, seeing, tasting)	Sensory-motor play; practice play, manipulative, repetitive and ritual play	Own and mother's body; pleasure at being a 'cause' what is this object? What can I do with this object?	Baby and mother turn taking games (peek-a-boo;pat-a-cake); imitation of mothers actions and sounds	First words; transitional object
1-2 years	Play with food and own waste products. Play with sounds and words. Using all senses	Large muscle play – walking & climbing; small muscle skills –building	Exploring the physical world; in/out; push/pull; hide/seek; up/down	Solitary play	Imitative play; self-pretend; doll-pretend; role-play; situation or sequence pretend
3-4 years	Sand, water, playdough, painting, words, stories, music	Running, jumping, riding, dancing; ball skills; drawing and cutting	Problem-solving; building; puzzles	Baby and parent (hide & seek; rough & tumble; watching parallel play with peers	Solitary elaborated symbolic play; complex and sustained themes; increasing symbolism in use of objects in pretend play; imaginary companions; dress-up;
5-12 years	Creative art, music, stories, books	Games with rules; gym, bike-riding, sewing and building, writing	Making things using domestic, scientific and technical skills	Co-operative play; domestic themes and chase games; co-operation; competition & social organisation	Co-operative socio-dramatic play; elaborate solitary small world play, books, stories
Over 12 years and adults	Creative arts, music, writing, books, sex, loving, cooking and eating children and pets	Sports and games; hobbies and skills	Science & technology	Formal games with rules	Playing with ideas; thinking; writing & role-playing; day-dreaming

