Therapy drop-out: A descriptive case study of an imperfect sand-play therapy process with an aggressive 12 year old boy.

By

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Dedication

This research is dedicated to all psychologists and counsellors with failed therapy processes.

Acknowledgements

First and foremost, I would like to acknowledge my God who has been the guiding and comforting presence throughout this journey. Then, to Qolani my client, for his bravery in allowing me into his world. It was an honour.

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Abstract

This case study sought to document an imperfect sandplay therapy process with an aggressive 12 year old male. Premature abscondment is a recognised issue in child and adolescent therapy. Extra-therapeutic factors like social support from family and friends have been found to be determinants of child psychotherapy outcomes. There is a significant gap in case study research documenting a failed child therapy process. This research aims to address the omission by using qualitative methods to elicit a nuanced account of such a process. The results of thematic analysis found that parents played a crucial role in the failure of the process. Not only were they instrumental in stopping therapy attendance but their disengaged attitudes infiltrated into the child's process. Implications for clinical practice were discussed and recommendations were made for more documentation of failed therapy processes. This case study hopes to form part of the ground work for future investigations.

Keywords: imperfect therapy process; therapy drop-out; sandplay; aggression; 12 year old male

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1. Introduction

The proposal for this thesis had very different aims and objectives. The initial goal of the thesis was to investigate whether sand play therapy was effective in alleviating symptoms of aggression in a 12 year old male. However, as many child psychologists have experienced, the therapy process was fraught with obstacles obscuring both the goals of research and therapy (Dallos & Stedmon, 2009). The main obstacle throughout the course of treatment was the significant lack of engagement of the child's parents. Research has confirmed that in this particular case, parent/guardian engagement is crucial for the success of child psychotherapy. Their full commitment is needed to endure lengthy and challenging treatment (Urwin, 2007). Furthermore, research illustrates the significant effect of the family on a child's psychotherapeutic process by reporting that child therapy often centres on the family, irrespective of the primary treatment approach or modality (Haine-Schlagel & Walsh, 2015). This is due to the family having a significant impact on the child's behaviour and development. Given the lack of parental engagement and the research-confirmed crucial role parents play in child psychotherapy, a premature and abrupt end to this particular case study felt inevitable.

The sandplay case study reported on in this thesis therefore epitomises a process where the full engagement from parents was lacking. It was therefore decided to change the focus of the case study and document the effect the parents lack of engagement/commitment had on the child's process. It was deemed a valuable topic to investigate as research affirms the importance of understanding the contributing factors to high therapy drop-out rates in child psychotherapy (Kazdin, Holland and Crowley, 1997). One of the major themes in this case as evidenced in the client's therapeutic process and in the practical elements of therapy (i.e., arriving to session on time), was the lack of structure and routine in the client's life. This theme will be woven into the literature review, data analysis and discussion sections of this thesis, along with other pertinent themes that contributed to the imperfectness of the case.

This thesis will provide a detailed account of a child psychotherapy process without parent engagement which resulted in premature termination, and how this was reflected in the child's sandplay. It will also describe what parental disengagement looks like. The layout of the thesis is as follows, a literature review, research

methodology, ethical considerations, clinical methodology, case contextualisation, case formulation, treatment plan, results and discussion and conclusion. The results and discussion sections were merged to ensure flow and continuity. Due to the scope of the case study the thesis is divided into sections rather than chapters.

2. Literature review

Research has found that in child and adolescent therapy, 40-60% of families who start treatment abscond prematurely and against the recommendation of the clinician (Kazdin, 2000). Therapy dropout is defined as the autonomous decision of the client to terminate treatment, either overtly, through expressing their desire to terminate and not attending any more appointments, or implicitly, by neglecting to attend sessions even when followed up. Completion of treatment is described as mutually agreed termination of treatment (Johnson, Mellor & Brann, 2008). High treatment drop-out rates have significant repercussions for research, clinical practice, and service delivery. In terms of clinical practice, clients who begin treatment but abscond are less likely to reap the benefits of treatment when compared to clients who stay in treatment (Kazdin, Holland, & Crowley, 1997). Regarding service delivery; continual cancellations and non-attendance among those who ultimately drop out raise the costs of services (i.e. in staff time) and occupy appointments that might be given to others (Kazdin, Holland & Crowley, 1997).

The contributing factors of such high drop rates include parent psychopathology, familial dysfunction and stress, poor parenting practices (inconsistency/no routine, corporal punishment, neglect etc.), and severity of child externalising behaviours (Kazdin, Holland and Crowley, 1997). Interestingly, research has found a correlation between parental personality disorders and child conduct problems (Dutton, Denny-Keys & Sells, 2011). Additionally, low social-economic status was noted as a contributing factor. These factors lead to low treatment motivation (van der Stouwe, Asscher, Hoeve, van der Laan, & Stams, 2016). Third party referral were also positively correlated with therapy drop-out rates (Snyder & Anderson, 2009). A study found that self-referred clients were more likely to complete therapy whereas those referred by court or school were more likely to drop out (Frankel & Simmons, 1992).

Similarly, research confirms the influence of ‘extra-therapeutic factors’ like social support from family and friends as determinants of the outcome of psychotherapy.

In support of this, Wampold (2001) conducted a quantitative review of twelve meta-analyses and found that extra-therapeutic factors affected psychotherapeutic outcomes by 87%. Furthermore, Lambert (2002) conducted a review of 100 psychotherapy studies and found that extra-therapeutic factors affected therapy outcomes by 40%. It is interesting to note that although the impact of extra-therapeutic factors is clearly significant, Carr (2009) found that 38% of the effects of psychotherapy are owed to the therapeutic alliance. Harwood and Eyberg (2004) reported that in family therapy, the relationship between the therapist and parent has been described as critical to families’ attendance and participation in treatment. Furthermore, Kazdin, Whitely and Marciano (2006) found that the parent's alliance with the therapist may influence compliance with and support of treatment outside of the sessions and therefore also may be associated with therapeutic change.

Given that child and family mental health treatment engagement has significant consequences for clinical implementation and policy when enhancing quality and effectiveness of care, research has shifted focus from outcome to treatment processes (Haine-Schlagel & Walsh, 2015). Without consideration of the process of child and family engagement, efforts to increase effectiveness and efficacy of treatment are largely unsuccessful.

Treatment engagement processes comprise of attitudinal and behavioural factors (Haine-Schlagel & Walsh, 2015). The attitudinal component of engagement is to believe that the gains of treatment offset the costs. The behavioural component, otherwise known at participant engagement, consists of three distinguishable elements that build on each other. Firstly, help must be sought and initiated, secondly attendance of the service is critical, and thirdly, active and meaningful participation in the service must be evident, both in interaction with the clinician and by applying treatment recommendations (Haine-Schlagel & Walsh, 2015). Parent participation engagement (PPE) is notably important for child and family therapy given the crucial part that parents (or any primary caregiver) play in acquiring and facilitating treatment attendance (Haine-Schlagel & Walsh, 2015).

It is a given that parents/caregivers must uphold an element of structure and routine in their homes in order to facilitate consistent treatment attendance. The effect of a lack of structure and routine essentially means that a child is constantly exposed to sudden and 'unbuffered' change making them feel insecure and unsafe (Standstrom, & Huerta, 2013). The crucial buffer is the presence of a supportive and engaged parent/guardian helping children regulate emotions and negotiate negative life events. Furthermore, there is mounting research emphasising the independent positive impact an engaged father has on a child's behaviour (Ward, Makusha & Bray, 2015). Some change is normal and anticipated; however, sudden and dramatic disruptions are exceptionally stressful and affect the child's experience of security (Standstrom, & Huerta, 2013). Research has also found that poor parental monitoring or supervision is the most significant parenting predictor of adolescent delinquent behaviours. However, low socio-economic status (SES) fathers are often confronted by several obstacles to being involved with their children, including high rates of unemployment, early childbearing outside of marriage, a constant succession of negative life events, and the absence of positive male role models (Fagan & Iglesias, 1999). Family routine has also been linked to lower levels of externalising behaviours (Lanza & Taylor, 2010).

Research has highlighted two forms of instability that children could be exposed to; chronic instability that is intrinsic in low-income settings and episodic instability that occurs with external shocks, such as job loss or parents separating (Standstrom, & Huerta, 2013). Research has found that the over-activation of the stress response to sudden changes can result in poor academic performance, lack of social competence and an inability to regulate emotions (Standstrom, & Huerta, 2013).

2.1 Why aggression in a 12 year old male, and why sandplay?

This section will describe what sandplay is and why aggression in a 12 year old male was investigated using sandplay as a therapeutic medium.

Worldwide solutions are sorely needed for aggression. Children have been made vulnerable to adversities, particularly in South Africa where violent crime statistics are notably high (Moen, 2019). In the Eastern Cape specifically, the site of this research, there is a murder rate of 60.9 per 100 000 people (Africa Check, 2018). Research has reported that children living in violent environments show increased levels of aggressiveness (Cooley-Strickland et al., 2009). Aggression is defined as intentional physical and psychological harm caused to others because one cannot regulate their emotions and therefore expresses emotion in undesirable ways (Han, Lee & Suh, 2016). Late childhood (ages 9-11) aggression was found to be a strong predictor of violent misconduct in early adulthood (Kalvin & Bierman, 2017). Consequently, aggressive behaviour is imperative for the healthcare sector to study because of its cost to public health (Lui, Lewis, & Evans, 2013).

Hudak (2000) argued that by engaging in play, the therapist joins the world of the child rather than imposing the adult's world onto the child, thereby building a strong therapeutic alliance. Dora Kalff, a Jungian psychologist, was the first to use the term 'sandplay' (Bradway, 2006). Kalff regarded the development of a healthy ego as a crucial task for children. The purpose of the ego is to mediate between inner drives and the outer world. To Kalff, the ego is made stronger by a deep, internal feeling of mother-child unity that builds gradually from birth and climaxes in the second and third years of life (Allan & Berry, 1987). Distress is experienced in children when there is a break in attachment bonding. This break damages the inner feeling of wholeness and weakens ego functioning. In sandplay, the child has the opportunity to resolve the damage by externalizing the fantasies and developing a sense of mastery over inner impulses (Allan & Berry, 1987).

The objective of sandplay is to stimulate healing energies at the inner-most level of the subconscious using toy miniatures and sand to mirror the client's internal world. The symbolic activity helped by unrestricted and imaginative play with the miniatures, enables unconscious processes to be revealed in three-dimensional arrangements. The main assumption of sandplay therapy is that the subconscious

has a natural inclination to heal itself given the correct conditions (Lubbe-De Beer & Thom, 2013).

Dora Kalff originally formed sandplay as an explicitly Jungian tool (Knoetze, 2013) deriving from Jung's belief that the psyche can be stimulated to move instinctively towards wholeness and healing (Boik & Goodwin, 2000). Believing that sandplay permitted children to express both archetypal and intrapersonal worlds (with a tangible, physical link to an outer reality), Kalff hypothesised that this symbolic play formed an exchange between the conscious and the unconscious mind of the child resulting in reconciliation and wholeness (Boik & Goodwin, 2000). The process starts when the therapist invites the child to play with the sand and to choose from the range of toy miniatures. Each miniature has its own physical structure and symbolic meaning, and each tends to prompts a fantasy reaction (Allan & Berry, 1987). Kalff (1981) stated that "the symbols speak for inner, energy laden pictures of the innate potentials of the human being" (p. 29), which, when expressed, enable psychological development. While other methods of sandplay therapy have emerged in therapeutic settings, Jungian-Kalffian sandplay remains the most widely practiced version (Davids, 2005; van der Merwe, 2016).

The sand-tray[1] (recognized as the vehicle of expression) is where the client creates a world that recounts his or her personal and social experience. The client places toys and figurines in a tray (50cm by 70cm with a depth of 8cm), which is half filled with light sand (Rogers-Mitchell, Friedman, & Green, 2014) and with the sides and bottom of the inside of the tray painted blue to represent the sky or water (Smit, 2015). The toys and figurines are placed near the tray and are meant to rouse the client's imagination and act as representations of various facets of their reality – the selection and use of which guides the therapist in symbolically interpreting the client's experiences (Rogers-Mitchell, Friedman, & Green, 2014). These figures may include animals, buildings, fantastical figures, fighting figures, food, furniture, human-like figures, monsters, mountains, other natural scenery, pebbles, people, rocks, shells, and vegetation (Boik & Goodwin, 2000; Turner & Unnsteinsdottir, 2011).

[1] It is important to note the difference between "sand-tray" and "sandplay". Bradway (2006) describes "sand-tray" as a generic term (in that it can be incorporated into several different theoretical orientations) and "sandplay" as a specific method. The word 'sandpicture' will be used to describe the object of the sandplay process.

In Sandplay, the therapist is predominantly separate from the process while still providing an empathic and containing presence. This permits self-healing to take place with the client's psyche as the guide.

Research has found that sandplay is effective in reducing externalizing behaviour like aggression (Han, Lee & Suh, 2016). In order to address the central problem causing childhood aggression, the therapeutic approach adopted needs to release a child's mind and support them in expressing themselves. One might argue that sandplay meets this need. Sandplay creates a safe and protected space which allows for the client's imagination to be activated. The safe space is reinforced by the therapist's acknowledgement of the client's boundaries (Lubbe-De Beer & Thom, 2013). This allows for negative and harmful predispositions, like those found in aggressive children, to be transformed rather than repressed. It also helps the child internalize a respect for the boundaries of others by having their own boundaries acknowledged. For example, at the beginning of sand play therapy with an aggressive child, the child can feel free to express intense negative emotions in an unstructured/unlimited way and still feel accepted and contained within those boundaries. Through this they learn how to reduce problematic behaviour by expressing and regulating their negative emotions (Han, Lee & Suh, 2016).

The benefits of sandplay include; enhanced social skills (Zhang, Zhang, Haslam, & Jiang, 2011), its appropriateness for children, adolescents and adults (Homeyer & Sweeney, 2005), its non-threatening traits which allows for the expression of 'undesirable' feelings and instincts (Oaklander, 2003), the betterment of client's emotional state (Allan & Berry, 1987) and its soothing aspect, as sand can be a calming medium to work with (Homeyer & Sweeney, 1998). This helps decrease the anxiety associated with working through personal challenges (Homeyer & Sweeney, 1998). These benefits could be seen as especially applicable for aggression treatment.

Research shows that sandplay is an appropriate method to use in resource-limited and vulnerable communities like those found in South Africa (Lubbe-De Beer & Thom, 2013). There has been significant development in South African sandplay research in the last few years.

Lubbe-De Beer and Thom, (2013) explored whether expressive sandwork could be used as a form of psychological support for a youth with psychosocial vulnerability. They found that expressive sandwork enabled the participant to become more aware of his emotional well-being and fostered a sense of hope. Similarly, a case study conducted by Snelgar, (2018) found that sandplay increased resilience in an isiXhosa speaking child who had experienced parental abandonment and chronic trauma stemming from by bullying and poverty. Sandplay was also found to be effective in creating a space for an eight year old Zulu boy to encounter masculine development (van der Merwe, 2016). A study conducted by Chibizhe (2016), found that the symbolic expression of a 16 year old girl in rural South Africa, was congruent with trauma symptoms highlighted in sandplay literature.

There have been some limitations of sandplay noted in the South African context. Oosthuizen, (2017) noted the practical implications of conducting sandplay therapy in high-need and under-resourced areas like rural communities. She found that physical comfort and confidentiality was compromised. Presumably due to limited classroom space, sandplay had to take place on the ground, outside in the sun and with little privacy. Other children could walk past and make comments on the client's sandpicture. There was also a language barrier between the researcher and the client which made it difficult for the researcher to understand the client and for the client to express themselves. Another limitation posited by Snelgar (2018) pointed to the limited cross-cultural research on sandplay therapy. He made reference to the culture-boundedness of sandplay theory as it originated from a western 'nuclear family' context. Therefore, more investigations need be made into the relevance of sandplay therapy in cultural contexts where collective and 'non-traditional' family structures are present.

[2]Aims and Objectives

This thesis falls part of the shift from outcomes-focused to process-focused therapy research (Haine-Schlagel & Walsh, 2015). Therefore, it will give a detailed account of a child therapy process without parent engagement, and how this was reflected in the child's sandplay. Kalffian sandplay could have been only part of the approach to treat Qolani's presenting problem but, with the premature termination, the focus of the thesis opted to highlight the contribution of sandplay therapy as an area of focus. Furthermore, since the potential for confirmation bias in the scientist-practitioner's understanding of the premature termination of the therapy process is high, it needs to be made explicit that this study focused on parental collaboration and commitment as a central determinant of therapeutic success. It will also aim to contribute to discussions on the importance of the therapeutic alliance, specifically its ability to circumvent this lack of parental engagement. To accomplish this, the following questions will be answered starting with broader and leading to more specific aims:

1.) What role does parental disengagement play in facilitating an imperfect child sandplay therapy process?
2.) Are these factors reflected in the client's sandplay?
3.) What are the signs of parental disengagement from child therapy?
4.) Even without parental engagement, was there progress in the client's presenting problem (healing)? If yes, what helped this progress and what are the implications for clinical practice?

[2] Discussions were had to include the impact of the Covid-19 pandemic. However, it was deemed too large a topic to include in this mini thesis. Furthermore, the precautions accompanying the pandemic (face-masks, face shields, screening etc.) did not significantly impede/restrict the course of therapy.

3. Research methodology

3.1 Theoretical orientation

3.2 Jungian/Kalffian sandplay theory

In this thesis Jungian/Kalffian sandplay theory was used as the basis for data analysis and qualitative understanding. Dora Kalff originally formed sandplay as an explicitly Jungian tool (Knoetze, 2013) deriving from Jung's belief that the psyche can be stimulated to move instinctively towards wholeness and healing (Boik & Goodwin, 2000). Kalff hypothesised that through symbolic play (e. g. via miniature toys and other materials) an exchange is formed between the conscious and the unconscious mind of the child resulting in reconciliation and wholeness (Boik & Goodwin, 2000). Kalff (1991), inspired by Jung, believed that symbols speak for internal, energy-bearing images of characteristics of human-ness which, if they become visible, exert an ongoing impact on the human being's development.

Through the creation of the visual constructs known as 'sandpictures', symbolization and archetypal work is incorporated, which, in turn, is believed to be "the main means of the therapeutic process… impacting both individual and collective levels of the individual's psyche" (Lipadatova, 2014, p. 130). Facilitating this process is the client's intention "to engage with specific issues or, as happens more often, by a subtle projective process that relies on spontaneity, or play" (Pearson & Wilson, 2014, p. 4). Over its course, sandplay therapy aims to "facilitate clients' healing and strengthen internal resources" (Taylor, 2009, p. 56).

The end goal of the process of sandplay is the transformative healing intrinsic in 'individuation' and the 'transcendent function' (van der Merwe, 2016). Jung described individuation as the differentiation process by which individuals mature and create distinct personalities and the transcendent function as the aspect of growth that occurs through the integration of opposing forces within the psyche (Frysh, 2012). In essence it is the process of the client becoming aware of their wholeness through an integration of opposing forces within themselves (Lubbe-De Beer & Thom, 2013; Boik & Goodwin, 2000**;** Pearson & Wilson, 2008) that Jung believed to be a central drive within the psyche towards wholeness and healing (van der Merwe, 2016). Following the Jungian tradition, Kalff's analysis of the sandplay process involves the tracking of the process of individuation (Bradway, 2006).

This is made possible by sandplay providing “a free and sheltered space” for psychic exploration, catharsis, and healing (Kalff, 1981, p. 29). As the client’s symbolic expressions in sandplay are done over a succession of scenes and a period of time, Kalff believed that they led to individuation (van der Merwe, 2016).
Kalff (2003) identified three stages of ego development necessary for individuation: the animal-vegetative stage (up to approximately 6 or 7 years of age); the fighting stage (up to approximately 11 or 12 years of age); and the adaptation to the collective stage (12 or so onwards) (Boik & Goodman, 2000). In the first stage, the ego expresses itself primarily in pictures where animals and vegetation dominate – the conscious ego symbolically masters nature (such as instinctual energy) through scenes where animals are either hunted or tamed (Lipadatova, 2014).

The next stage brings battles that appear recurrently, especially during puberty, where the client’s ego begins to overcome its dependence on the mother archetype and develops instead a strong identification with the father archetype (Lipadatova, 2014). Following this second stage, the ego has become established as a separate conscious entity (from the mother and father), and is now directed towards mastery instead of the exterior world (Lipadatova, 2014). Finally, therefore, the individual is admitted to the environment as a person and becomes a member of the collective expressed in the sandpicture in a marketplace-type form (Kalff, 1981).

While these patterns do at times occur in the clients’ sandpictures, it is not a given. Boik and Goodwin (2000) state that the patterns observed help to enhance understanding of a client’s process and that the scenes more commonly observed are the ones which shift from chaos (in earlier stages of development) to order (as children mature and develop a greater sense of identity). This claim seems to imitate with more clarity the order inherent in Jung’s concept of transformative healing in individuation and the transcendent function.

Another way that this research aligned itself with Kalffian/Jungian theory was by utilizing Grubbs’ (2005) Sandplay Categorical Checklist (SCC). Grubbs’ SCC was adopted to order observations of the ‘sandpictures’. The guidelines for the Grubbs’ (SCC) are based on the theories formulated by Carl Jung and Dora Kalff.

The 19 categories comprised the following features of sandpicture creation: “the thematic content of the tray and the process involved in creating it,” “the creator’s personal report or story of what the tray signifies to them,” and “the progressive or regressive changes that occur from one tray to the next” (Grubb, 2005, p. 2). To summarise, Kalffian/Jungian theory was the lens through which the data was understood, and Grubbs (SCC) is the application of the theory to the data.

4.3 Pragmatic paradigm

Following from the last research aim regarding clinical implications, this research project therefore aligns itself with the pragmatic paradigm. Pragmatism is a philosophy of knowledge that stresses practical answers to applied research questions and the consequences of inquiry. The paradigm is known to advocate for a mixed methods approach (Giacobbi, Poczwardowski & Hager, 2005). However, Morgan (2014) argues against the idea that pragmatism is somehow uniquely related to mixed-methods research (MMR). He states that this link is reminiscent of some paradigmatic claims that qualitative methods must be connected to constructivism and quantitative methods must be connected to post-positivism (Morgan, 2014). There may be an affinity between paradigms and methods, but there is no deterministic connection that forces the use of a particular paradigm with a particular set of methods. Although the recent resurgence of interest in pragmatism was indeed sparked by efforts to resolve issues within MMR, this says more about the historical context involved rather than inferring an intimate connection between mixed methods as an approach to research and pragmatism as a paradigm. The argument here is that pragmatism can serve as a philosophical platform for social research, regardless of whether that research uses qualitative, quantitative, or mixed methods (Morgan, 2014). In light of the emancipation of the pragmatic paradigm from a mixed methods approach, this thesis is exclusively qualitative in design.

4.4 The Scientist-practitioner model

This research was executed using the scientist-practitioner model. The model posits that clinicians should rely on both empirical evidence to steer their treatments while also contributing to research (Jones & Mehr, 2007). It is the main training model used in graduate clinical psychology programs (Jones & Mehr, 2007). The model views the development of research skills and clinical competencies as equally important.

Therefore, the overarching aim of the scientist-practitioner model is to keep clinicians liable for their quality of work and not only to stick to their preferences (Jones & Mehr, 2007). However, the model has not been realized as many practitioners rely on their personal experiences to guide their professional practice (Orlinsky & Rønnestad, 2005). This represents a shift away from the scientist-practitioner model. This research project will therefore strive to integrate the roles of scientist and practitioner embodied by the model. To operationalize this, from now on the researcher will refer to herself as the scientist-practitioner.

4.5 Case studies

The clinical case study is an example of research birthed from the scientist-practitioner model. The case study falls within the pragmatic paradigm which focuses on investigating utility within a specific environment (Fishman & Westerman, 2011). The case study is a research methodology that is able to elicit clinically significant data straight from the interaction between client and therapist in a therapeutic environment (Widdowson, 2011). In line with the pragmatic paradigm, case studies can provide insight into the utility of a therapeutic approach by concentrating on a small quantity of clinical data in order to enrich the meaning of theoretical concepts by concretizing them (Fishman & Westerman, 2011). The result of this process contributes to the foundation of evidence-based practice in psychology (Edwards & Dattilio, 2014). Therefore, by using a single case study, this thesis will attempt to contribute to evidence-based practice.

Case studies can be exploratory, descriptive, or explanatory. The case study covered in this project will be descriptive in nature. Since ‘imperfect/incomplete’ therapy processes are not well researched, specifically in case study research, a descriptive approach was deemed most appropriate for this project. Edwards (1998) advocated that description is essential when investigating new or little researched phenomena. This calls for a detailed observation of the phenomenon and the documentation of simple concepts and characteristics which enables what has been observed to be described accurately (Edwards, 1998).

While a large-scale, quantitative study would best respond to Warr-Williams’ (2012) call for research that supports the depiction of sandplay as evidence-based, the scope of this mini-thesis is better suited to purposive sampling.

The participant for this case study was chosen because they had requested services from the Rhodes University Psychology clinic. The coordinator of Rhodes Psychology Clinic was notified of the inclusion criteria namely: the participant needed to be a 12 year old male child, able to interact with the scientist-practitioner in English and present with aggression.

Furthermore, Edwards, Dattilio, and Bromley (2004) suggest that large-scale, randomised controlled trials (like those suggested by Warr-Williams) have resulted in the marginalisation of practitioner-oriented research, which instead provides findings more appropriate for work with clients for whom group comparison designs are unsuitable (Whitefield-Alexander & Edwards, 2009).

4.6 Quality Control

As a case study, the current research risks lapses in quality control due to concerns surrounding theory building, validity, case selection, and objectivity (Widdowson, 2011). To address these issues – they will be discussed individually in relation to the current study. Regarding theory building, due to the novel nature of the study, this research aims to pioneer a theoretical proposition of the impact of extra-therapeutic factors on a sandplay therapy process (MacLeod, 2010). Second, while the current methodology is of low internal validity (due to the absence of experimental controls), it is of high external validity (as the results are relevant to everyday clinical practice) (Widdowson, 2011). It is therefore intended to provide findings helpful to real-world psychologists/counsellors who could extrapolate and assimilate the findings into their practice. Third, this research adopted purposive sampling. Thus, instead of carefully choosing a participant likely to confirm the research hypothesis, one was chosen due to a) having applied for services at the Rhodes University Psychology Clinic, b) being an aggressive 12 year old male, and c) being able to interact with the scientist-practitioner in English. Lastly, to resolve critiques of bias, the client and his guardian's views are incorporated in the form of oral feedback and a standard outcome measure (the SDQ – the YP-CORE was included but due to the sudden end of therapy a post YP-CORE could not be administered) for the reasons of triangulation. Due to these pre-cautions, this research project sought to maintain rigor and thereby provide valuable insights to the profession.

4.7 Sources of data

4.7.1 Measures

Case studies of individuals in healthcare research frequently require in-depth data collection from participants and key informants (Zucker, 2009). Therefore, the cornerstone of a case study pivots on the meticulousness with which the case is documented and, as a result, adherence to systematic assessment. This may include combining, where appropriate, qualitative information and quantitative data from psychometric tests or self-report scales (Whitefield-Alexander & Edwards, 2009). All assessment should be oriented towards examining problems, answering questions, and uncovering the factors encompassing the development and maintenance of problems – instead of merely diagnosing (Fishman, 2005). Subsequently, during the course of therapy, the following items were utilized as sources of data:

1. Pre-sandplay Strengths and Difficulties Questionnaire (SDQ) to be completed by the client's guardian.
2. Pre-sandplay YP-CORE administered to the client.
3. Sandplay therapy session records systematically chronicled as process notes and arranged according to Grubbs' (2005) Sandplay Categorical Checklist (SCC).
4. Voice recordings of all sessions, including interviews and feedback sessions with the guardian. (See appendix F for permission and release forms.)
5. Photographs of the client's sandpictures.
6. Two month follow up SDQ completed by the client's guardian.[3]
7. Journal documenting the scientist-practitioners' counter-transference experiences with both the client and his guardian during the course of treatment.

[3] A follow-up YP-CORE could not be administered because the client's guardian could not bring him to sessions, abruptly ending the process. However, the pre sandplay YP-CORE is used as a source of data in itself to make meaning of the qualitative findings (and vice versa).

4.7.2 Sandplay

Details of the client's sandplay process were recorded as process notes and arranged according to Grubbs' (2005) Sandplay Categorical Checklist (SCC). Furthermore, photographs of the sandpictures were taken.

4.7.3 Materials

Two measures were administered in this research. Strengths and Difficulties Questionnaire (SDQ) and the Young Person's Clinical Outcome in Routine Evaluation (YP-CORE). It was planned to readminister the assessments after every four sessions in order to gauge the effectiveness of the treatment. The SDQ is a 26-item behavioural screening questionnaire which measures emotional and behavioural issues in children and adolescents. The SDQ has four subscales to measure major difficulties frequently experienced by children and adolescents, these include conduct problems, hyperactivity-inattention, emotional symptoms, and peer problems (Essau et al., 2012). There are two versions of the SDQ; the informant-rated version of the SDQ completed by either the parents or teachers of the child/adolescent and the self-report version which can be completed by the child or adolescent if between the ages of 11 and 16 years old. The SDQ is used both in clinical and community settings worldwide (Essau et al., 2012). The popularity of the SDQ is attributed to its succinctness, simplicity and good reliability and validity. Only the informant version of the SDQ was used in this research. The client's biological mother completed the questionnaire.

The client was given the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE), a 10-item generic measure that evolved from the CORE-OM – itself a pan-theoretical and pan-diagnostic measure of psychological distress (Mellor-Clark & Jenkins, n.d.). The YP-CORE has been validated by the developers for young people aged 11–16 years. The YP-CORE has 10 items that measure subjective well-being, commonly experienced problems or symptoms, risk, and life/social functioning (Twigg et al., 2009). These items were chosen for inclusion in the YP-CORE by a researcher and mental health professionals, and the questionnaire was piloted with samples of young people in clinical and non-clinical settings (Twigg et al., 2009).

4.7.4 Data collection and data processing

All therapy sessions with the client and interviews with parents were tape recorded and transcribed. The seven (representing the seven contact sessions), twenty-eight-page long transcriptions were analyzed. The general qualitative data analysis approach was adopted when analyzing the transcripts. The approach entails five steps; 1) *compiling* the data into a usable form, 2) *disassembling* the data to create meaningful groups i.e. codes, concepts etc. 3) *reassembling* the codes to be put into context with one another to generate themes - a theme depicts something vital about the data in relation to the research question (Castleberry & Nolen, 2018). 4) the scientist-practitioner makes analytic conclusions about the data embodied as themes; this is known as *interpretation*. 5) the researcher makes meaningful conclusions about the data set in relation to the research aims and objectives (Castleberry & Nolen, 2018). Doing this helped to streamline information produced in each session for research purposes.

4.7.5 Analysis

The impact of extra-therapeutic factors on the effectiveness of a child sandplay was analysed as it reflected in both qualitative and quantitative measures. The scientist-practitioner's observations and interpretations (through Kalffian analysis of the sandpictures with the aid of Grubbs SCC (2005) and thematic analysis of transcribed recordings) was used. The client's perspective was analysed through the YP-CORE (see appendix E), and from guardian's perspective was analysed through the SDQ (see appendix D), intake interviews, feedback sessions, process notes and informal conversations.

4.7.6 Qualitative Analysis

Following from the discussion on case studies at the start of section 2 about a detailed documentation of the phenomenon, the scientist-practitioner was interested in all sandplay and broader therapy related work and interviews with parents. To describe and analyse the client's therapeutic process, the scientist-practitioner explored the major themes arising over the course of the sandplay process (based on Jungian symbolism).

By taking a Jungian stance, the research aligned itself with standard Kalffian sandplay practices. Additionally, a vital contribution to the interpretation was also the client's descriptions of these elements. Another way that this research aligned itself with Kalffian theory was by utilizing Grubbs' (2005) Sandplay Categorical Checklist (SCC). Grubbs' SCC was adopted to order observations of the sandplay. The guidelines for the Grubbs' (2005) Sandplay categorical checklist are based on the theories formulated by Carl Jung and Dora Kalff. The 19 categories comprised the following features of sandpicture creation: "the thematic content of the tray and the process involved in creating it," "the creator's personal report or story of what the tray signifies to them," and "the progressive or regressive changes that occur from one tray to the next" (Grubb, 2005, p. 2).

4.7.7 Synthesis of Results

Both the SDQ and YP-CORE were scored. Changes from before and after therapy in the SDQ were reported and described and qualitatively discussed. Only the pre-therapy YP-CORE could be reported on and qualitatively discussed. No follow-up YP-CORE was administered due to premature end of therapy facilitated by the client's mother. This is a qualitative study; however quantitative measures were used but these are described and discussed qualitatively.

4.8 Confidentiality and ethical factors

4.8.1 Informed consent

Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undertake the intervention (Shah, Thornton, Turrin, & Hipskind, 2020). At the start of therapy, the client and his mother were furnished with informed consent (consent from client's mother and assent from client) surrounding the scientist-practitioner's status as a trainee, and researcher and that comprehensive notes were to be taken and securely stored in the Rhodes University Psychology Clinic (see appendix B for "letter of explanation to parents", and appendix C for "parents informed consent form" and "client assent form").

It was emphasized that their participation was completely voluntary and that they could stop the research process at any time without repercussions. Stopping the research process would not impact the therapy process in any way.

4.8.2 Clinical and research supervision

As part of informed consent, the client and his mother were made aware that case details would be discussed with a clinical supervisor - who also acted as research supervisor. The twofold supervision was intended to safeguard that the case upheld an efficient and effective organisational structure so as to not interfere with the clients' therapeutic process.

4.8.3 Conflict of interest

Conflict of interest occurs when a psychologist has interests or relationships that may affect their capacity to perform professional duties. The scientist-practitioner therefore considered the risk of following a course of treatment that better suited the research agenda than the client's best interests. To prevent this from happening, all decisions about courses of treatment were discussed with the clinical/research supervisor. The scientist-practitioner also reported back to the research/clinical supervisor following implementation of the discussed treatment option. The supervisor is also a registered psychologist and an experienced practitioner in child psychology. The scientist-practitioner therefore followed his judgement if there was a difference in opinion. In the same vein, the scientist-practitioner remained aware of the difference between the research and clinical methodology. This was difficult to do for the present study as the clinical and research methodology overlap (the focus of both being the sandplay itself).

4.8.4 Gatekeeper Permission

Gatekeeper permission refers to access into an institution/organisation. This access can either be physical or informational. All Institutions/ organisations have the right to be aware of and be accorded the right to grant or decline permission to a researcher to conduct research in their domains (General Guidelines for the Ethics Review Process, 2014).

The Rhodes University Psychology Clinic manager and Clinical Psychology course coordinator were both contacted, and permission was requested for one of the clients on the clinic's waiting list to be chosen by the scientist-practitioner for research purposes (see Addendum for "Gatekeeper Permission"). Ethical clearance was also granted from both the university (RUESC) and Psychology department's (RPERC) ethics committees (see section Addendum for "Ethical Clearance").

4.8.5 Risk Aversion

No harm was expected during the course of this research as it was made clear to all parties involved that participation, non-participation, or withdrawal would not reflect in the quality of the supervised therapeutic service delivered to the client. Additionally, given that previous research implies that the client would benefit from sandplay therapy, the principles of beneficence and non-maleficence were confidently adhered to.

4.8.6 Confidentiality and Anonymity

Confidentiality and anonymity are ethical practices designed to protect the privacy of human subjects while collecting, analysing, and reporting data. Confidentiality refers to separating or modifying any personal, identifying information provided by participants from the data. By contrast, anonymity refers to collecting data without obtaining any personal, identifying information (Allen, 2017). Therefore, in this research project client identity and that of their family was protected by pseudonyms. Other identifying information was disguising or left out (e. g. name of school, teacher etc). Furthermore, all original administrative documents were securely stored in the Rhodes University Psychology Clinic.

4.8.7 Trustworthiness Criteria

Trustworthiness in research simply poses the question 'can the findings be trusted?' Numerous definitions and criteria of trustworthiness exist, but the most recognized criteria are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility

Credibility refers to the confidence that can be placed in the truth of the research findings. Credibility determines whether the findings represent plausible information derived from the participants' original data and is an accurate interpretation of the participants original views (Lincoln & Guba, 1985). Via the inclusion of detailed process notes, photographs of sand-expressions, and quantitative data from one instrument, this research sought to instil confidence in the credibility of its findings.

Transferability

Transferability refers to the extent to which the results can be transferred to other contexts or settings with other participants. The researcher aids the transferability judgment by a prospective user via thick description (Lincoln & Guba, 1985). While a single participant does not allow for confident transferability, the dense descriptions found in this research provides the reader with the opportunity to choose how extensively inferences can be drawn to their own context.

Dependability

Dependability refers to the consistency and reliability of the research findings and the extent to which research procedures are documented, allowing someone outside the research to follow, review, and evaluate the research process (Moon, Brewer, Januchowski-Hartley, Adams & Blackman, 2016). In order to control the research's dependability, the scientist-practitioner safeguarded that the data was collected in as short a space of time as possible and included in the discussion of the results any interim phenomenon that may have influenced the findings.

Confirmability

Lastly, confirmability refers to the degree to which the findings of the research study could be confirmed by other researchers. Confirmability is concerned with verifying that data and interpretations of the findings are not figments of the researcher's imagination, but clearly obtained from the data.

In an effort to maintain a relationship with the material of study and improve the reliability of the qualitative aspect of the research (Willig, 2008), the scientist-practitioner engaged themselves with and strived for prolonged immersion in the process data.

4. Clinical methodology

Clinically, this research studied sand-play therapy with a single participant. The process of sandplay therapy is epitomized by the creation of conditions for healing which allows for client self-expression without the use of words (Moon, 2006). Client self-expression is carried out by making a three-dimensional image in a sand tray utilizing toy miniatures (Moon, 2006).

A case conceptualization and treatment plan were executed. There were seven contact sessions. Five of which were with the client alone, the other two for intake and parental guidance. In the initial interview, informed consent and assent were sought from the parent and client. The first two sessions with the client aimed to establish rapport and collect information through projective tests, namely the kinetic family drawing and the kinetic classroom drawing. Attention was given to building strong rapport, therefore the last 20 minutes of each session with the client were dedicated to activities that the client enjoyed, i. e. playing soccer. The third contact session was the first sand play session.

In the first sand play session, non-directive techniques were used. The client was asked to ‘build his world in the sand’. This instruction was taken from Margaret Lowenfeld’s (teacher to Dora Kalff) pioneering work in sandplay therapy (1935). It became clear that the instruction was too board and that client was resistant to non-directive approaches. Instructions during sandplay became more specific and narrative in nature, i.e. ‘tell me a story of your family in the sand’. Child-centred directive techniques were predominantly used during sessions. It became evident during the course of therapy that the client’s issues were linked to parental instability. Attempts were made to include guardians in the process, however only one parent was able to make the session dedicated to parental psychoeducation. The process was subsequently cut short by the mother of the client before further attempts could be made to introduce family therapy.

5. Contextualising the case

The Rhodes Psychology Clinic coordinator selected 'Qolani[4]' from the Rhodes Psychology Clinic waiting list to received psychotherapy from the scientist-practitioner.

6.1 Identifying information

At the time of our first contact on the 7th of October 2020, Qolani was a 12:11 year old boy in Grade 5. At the time of therapy, he was repeating Grade 5. He was isiXhosa speaking and went to school close to his home in one of the local government schools in the location in Makhanda, Eastern Cape.

6.2 Referral information

Qolani was referred to the Rhodes Psychology Clinic by his teacher early 2020. He was therefore a secondary referral by another professional. His teacher described Qolani's behaviour as disruptive in class. Qolani was aggressive with learners, often in fights and blaming other children for starting them. His teacher specifically notes that Qolani teases quiet girls and "beats them". Qolani also used sexual language/profanity when talking about girls. Girls had reported that Qolani touched them inappropriately and looked under their skirts. Qolani did not show remorse when disciplined and repeated the problematic behaviour. His teacher also stated that no resolution regarding Qolani's behaviour had been made by Qolani's mother and father. Between the time of the referral and the intake interview, Qolani's mother reported that there were no further complaints from the school about inappropriate behaviour towards girls', but the fighting and aggression wad continued. Qolani's mother did agree with the school's assessment of his behaviour and acknowledged that it was problematic, both at school and at home.

6.3 Presenting Problem

Qolani's mother relayed that his behaviour was 'strange', and that he was often in dangerous situations. For example, he went hunting with a group of boys and their dogs and on their return one of the dogs bit a goat. The shepherd chased Qolani and hit him on his head, he was sent to hospital but no charges were made against the shepherd.

[4] Pseudonym used for confidentiality

He was also known to only return home at 00:30am, staying out with other children his age and older. He also sneaked out the house when his grandmother is asleep. He came home one night smelling of cannabis and the owner of the local café told Qolani's mother that Qolani has bought cigarettes. His mother used the word 'terrified' to describe how she felt about Qolani. She was scared he would get hurt. She also mentioned she felt drained by him. She had noticed that she was very critical of him because she was used to Qolani being in trouble.

6.4 History of presenting problem

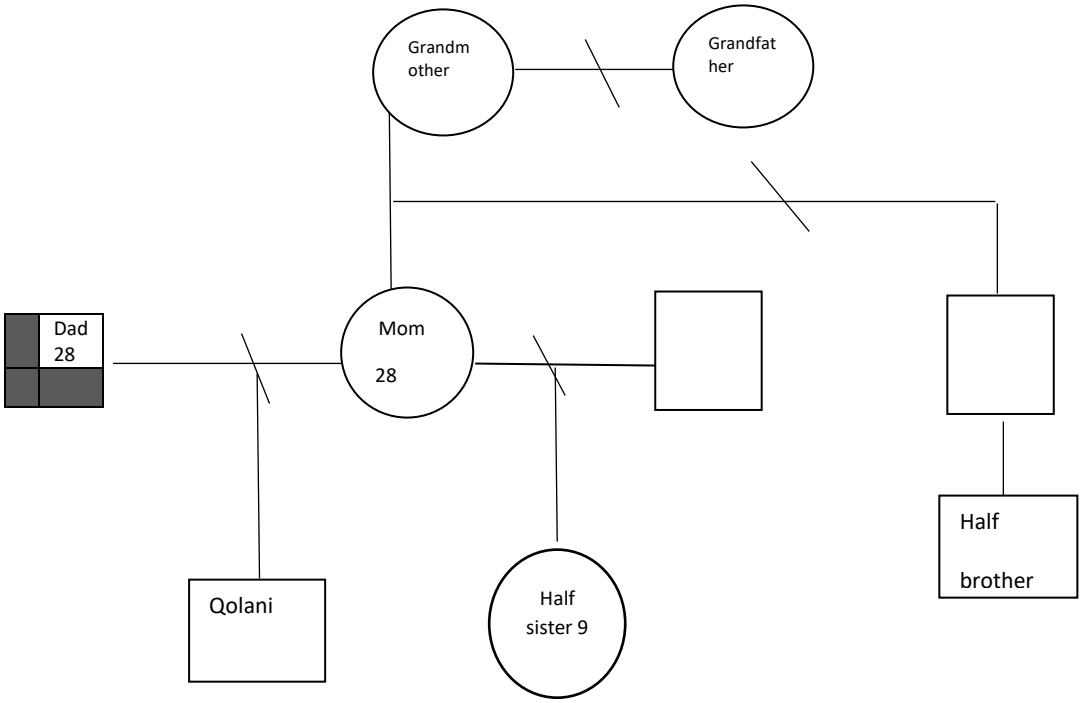
Qolani began fighting at school from the beginning of Grade 4. His mother and grandmother noted no significant precipitating factor. He would always get in fights at school and would defend his actions by saying the other children started the fight and that the teachers 'always blamed him'. His mother reported that Qolani had been involved in dangerous activities (staying out late, hunting etc.) for a year and a half. His mother felt so helpless that she thought of sending him to a juvenile centre in Port Elizabeth. She went to the department of social development where they said he needed to be assessed at Fort England. They did not go for the assessment due to the Covid-19 pandemic.

6.5 Developmental history

Qolani's mother was given a child background questionnaire to complete as part of Rhodes Psychology clinic protocol but did not the return the document, despite numerous reminders from the scientist-practitioner. However, during the intake interviews no developmental issues were indicated.

6.6 Family history

Qolani's immediate family genogram:



Qolani lived with his grandmother, and two younger siblings – all three children were from different fathers. His mother is no longer in a relationship with any of her children's fathers. His mother helped raise him and his siblings but did not live in the house with them. She stayed in a bachelor flat close by. He saw his father intermittently. His father was described by his mother and grandmother as unstable, never having a proper job and involved in crime and drugs. He often promised things that he could not provide. The promises were predominantly around material goods. Qolani's mother did not like Qolani spending time with him because she thought he exposed Qolani to dangerous circumstances. Qolani had a good relationship with his grandmother who he confided in. Qolani's mother was the disciplinarian out of the two women and often resorted to "using the stick" (mother reported) when she could not control Qolani's behaviour.

6.7 Educational history

Qolani repeated Grade 4 and Grade 5. During therapy he was repeating Grade 5. His mother reported that he was repeating due to not completing homework and not paying attention in class. He managed with schoolwork from grade 1 to grade 3 but as of Grade 4 he stopped doing homework and would forget his books and "always came with stories" (mother reported) as to why he did not have his books.

6.8 Summary and diagnosis

It is evident that Qolani's behaviour was keeping him from flourishing in his everyday life. Qolani met the criteria for conduct disorder as he met three of the 15 symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The three symptoms are: initiating fights with others, often stays out late despite parents prohibitions (before the age of 13), and has stolen non trivial items without confronting the victim (only reports of theft had been from his mother who would give him money to buy bread but not bring home the change) (American Psychiatric Association, 2013). The clinical cut off for a diagnosis of conduct disorder is the presence of three symptoms (American Psychiatric Association, 2013). It could be argued that Qolani's presenting problem in terms of conduct disorder was mild as he just met the clinical cut off.

6. Case formulation: Dynamic Interpersonal Therapy

A dynamic interpersonal therapeutic (DIT) perspective was used to conceptualize Qolani's case. Dynamic interpersonal therapy is based on the belief that a client's symptoms emerge because of unhelpful patterns of relating to others. When the therapist understands the client's view of themselves and their view of others in relationships, the therapist can treat the symptoms (Lemma, Target, & Fonagy, 2011). It is important for a case formulation to include the following; the problem from the client's perspective, contextualization of the problem, cost of the problem, defenses, the dominant and recurring self-other representation and the associated affect. The last two aspects of the formulation are collectively known as the interpersonal affective focus (IPAF) (Lemma, Target, & Fonagy, 2011).

Presenting problem:

Qolani struggled with aggression, his mother reported that he was often in fights. His teacher reported that he did not listen when disciplined and distracted other children in class. Qolani felt that he is often to blame and that other children start a fight with him. Qolani did not speak much in the intake sessions therefore a more detailed appraisal of his perspective of the problem is lacking. However, from his drawings and some little engagements around the drawings it seemed that Qolani did not feel the presence of adults in his life and may have had a poor role model in his father. There is also the question of what impact repeating a grade twice had on his self-esteem.

Cost of the problem:

Due to Qolani's aggression and resultant fighting, Qolani kept himself in a position of receiving negative feedback from his environment, in all spheres of his life. This maintained his low self-esteem which kept him from achieving and thus escaping the negative cycle. Additionally, the lack of structure Qolani experienced from the adults in his life caused him to engage in high-risk behaviours, e. g. staying out late, smoking (cigarettes and cannabis), hunting with dogs, and socializing with much older people.

Contextualizing the problem:

Predisposing factors:

Qolani had a loving but unstable early childhood. His mother and father had him when they were both teenagers which meant that Qolani's grandmother played a big role in raising him. His parents broke up when he was very young. His mother has admitted that she did not grow up with structure which could explain why Qolani's upbringing has been so unstructured. This might also explain Qolani's inability to regulate his emotions and behaviour. Another factor could be the negative example set by Qolani's father who engaged in theft and drug use and who seemed to have interpersonal problems of his own.

Precipitating factors:

The precipitant of Qolani's behaviour was unknown. Both his mother and grandmother reported that he started misbehaving at the beginning of grade 4. Erikson's stages of development could help explain this (Erikson, 1956). Qolani starting misbehaving during the industry vs. inferiority phase when children start learning complex tasks and experimenting with their capabilities. It could be that due to the lack of guidance and structure, Qolani experimented with unhealthy behaviours which triggered negative feedback.

Maintaining factors:

The maintaining factors in Qolani's life could have been: 1) the lack of structure set by the adults in his life which meant that Qolani did not feel safe or regulated in his environment which maintained his aggression and his destructive behaviour. 2) The lack of structure also did not motivate him to do his schoolwork which influenced his performance and subsequently his self-esteem. 3) The unstable father figure and male role model in his life and 4) the replacement of primary mother relationship by the surrogate mother in grandmother.

Protective factors:

Although Qolani's parents were not behaving in a way that was beneficial for him, there was a sense that he is loved and cared for. He had a good relationship with his grandmother who he confided in. Even though Qolani's father was inconsistent, he did make the effort to see and spend time with his son. Furthermore, the concern the school shows indicates a caring and protective interest from at least one adult in this important environment.

Recurring self-other representation

Conscious self-other representation: IPAF

Self	**Other**
1) Wrongly accused	1) The real perpetrator
2) Innocent	2) Is to be blamed
Associated affect: Anger and aggression	

Less Conscious self-other representation: IPAF

Self	**Other**
Not important	Not dependent/present
Neglected	Flighty
Unloved	Inconsistent
Associated affect: helpless, empty, sad	

Defensive function of the self-other representation

It is likely that Qolani's saw himself as an after-thought in relationships. He may have seen the other as relevant but generally not present and not dependable. This may leave him feeling unregulated and neglected, which could have explained his aggression or/and risk-taking behaviour. The defensive function of the conscious self-other representation over the less conscious self-other representation could be that at least his aggression and risk taking behaviour is garnering him some attention, even if negative. This keeps him from feeling alone, unloved, unprotected, and perhaps gave him the structure that he craved.

Treatment plan

The primary goal of Qolani's treatment was to address the underlying, less-conscious difficulties that were contributing to Qolani's emotional and social difficulties (such as his anger/aggression, his high-risk behaviours and subsequently his low self-esteem). Sandplay was used to elicit and bring to consciousness Qolani's less conscious self-other representation of the self as not important/neglected/unloved and the other as not dependable/flighty/inconsistent. DIT posits that once the less-conscious representation is exposed and undergoes a corrective experience via therapy, the problematic defences (in Qolani's case, his aggression) would fall away. A secondary goal of treatment was to address Qolani's parents inconsistent parenting style which seemed to perpetuate his problematic way of relating to the world. A parent psychoeducation session on implementing structure and consistency was provided. Family sessions were planned to be executed to evaluate dynamics and further implement structure with practical guidelines.

Sandplay therapy is effectively a nonverbal form of psychotherapy (Lipadatova, 2014). A therapist provides "a client with objects, a container, and the natural material of sand – in a context of creative freedom – and they will usually set about constructing scenes that reflect relevant intrapsychic forces" (Pearson & Wilson, 2014, p. 4). This play is typically a projection of the child's life, interactions, relationships, and significant experiences (Ben-Amitay, Lahav, & Toren, 2009; Boik & Goodwin, 2000). The Kalffian sandplay approach was used to treat Qolani's presenting problem. As previously discussed, Kalff posited that distress is experienced in children when there is a break in mother-child attachment bonding. This break damages the inner feeling of wholeness and weakens ego functioning. In sandplay, the child has the opportunity to resolve the damage by externalizing the fantasies and developing a sense of mastery over inner impulses (Allan & Berry, 1987). The objective of Sandplay is to stimulate healing energies at the inner-most level of the subconscious using toy miniatures and sand to mirror the client's internal world. The symbolic activity helped by unrestricted and imaginative play with the miniatures, enables unconscious processes to be revealed in three-dimensional arrangements. As the client engages in sandplay, the therapist records what figures are used and what the client may say or do.

The therapist may also sketch or ‘map’ a diagram of the sandpicture for future reference and take photographs of the completed sandpicture to allow them to study and enhance their understanding of the client’s symbolic work (van Wyk, 2013). The primary goal of the therapist, however, is always to be engaged as an empathic and emotionally-present observer – in both the process and the therapeutic relationship (Bradway, Chambers, & Chiaia, 2005). The presence of the therapist, who is trained to understand the literal and symbolic meaning of the figures used, supports positive development in the client through either the aforementioned silent witnessing or, if invited, actively playing with the client (Rogers-Mitchell, Friedman & Green, 2014).

7. Results and discussion

This section provides a detailed account of the application of the previous section’s treatment plan. Qolani completed three sandplay sessions during the course of therapy. Each of his trays is categorised and presented using Grubbs’ (2005) Sandplay Categorical Checklist. It will then include vignettes taken from transcribed interviews with Qolani’s parents and vignettes from sessions with Qolani. These vignettes were organised into themes and situated in available literature. Themes in the sandplay will also be discussed in terms of how they might problematise or support the themes found in the vignettes and corresponding literature. Selection of these vignettes was guided by the questions posed in the aims and objectives of this paper. The following section forms part of phase three and four of qualitative data analysis as outlined by Castleberry and Nolen (2018). Phase three encompasses *reassembling* the codes to be put into context with one another to generate themes - a theme depicts something vital about the data in relation to the research question (Castleberry & Nolen, 2018). This section also represents the fourth phase of qualitative research as outlined by Nolen and Castleberry (2018). The scientist-practitioner makes analytic conclusions about the data embodied as themes; known as *interpretation*.

Course of therapy

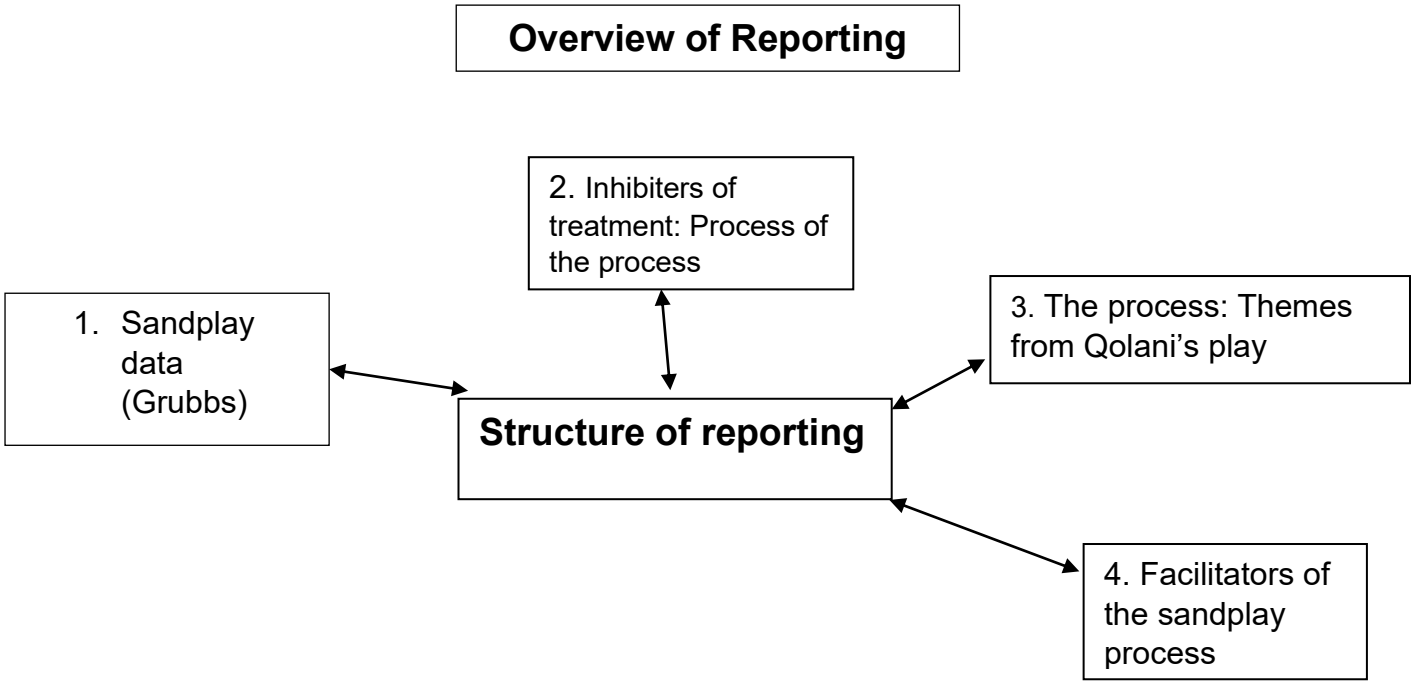
Qolani was referred to the scientist-practitioner by the Rhodes Psychology Clinic coordinator because he was on the waiting list and because he met the inclusion criteria for this research project. Qolani's therapy took place from the 7th of October 2020 to the 26th November 2020. Qolani's mother was the main point of contact for arranging sessions. Contact was made and within two days the first session took place. The scientist-practitioner asked that both parents and Qolani attend the intake session however Qolani's father was unable to attend. The first two sessions were dedicated to intake and rapport building. The first session was the only session out of the 7 contact sessions that Qolani arrived on time and on the initially agreed upon day. Session two was rescheduled last minute by one day. For session three Qolani's father was supposed to bring him but failed to attend – Qolani's mother speculated that Qolani's father had used the taxi money she gave him to bring Qolani to therapy for something else. Qolani's father did bring him to therapy the next day after the scientist-practitioner arranged it with Qolani's mother. Session four was cancelled and rescheduled because Qolani's mother "could not find Qolani". Session five was a feedback and psychoeducation session with Qolani's parents. Qolani's father did not attend. Qolani's father, although he did attend one session, was a non-role player in Qolani's process. When Qolani's mother was asked if Qolani's father could attend the feedback/psychoeducation session the answer was "I don't know where he is/can't get hold of him". Nevertheless, the feedback/psychoeducation session was cancelled and rescheduled – this was only after the scientist-practitioner verified if Qolani's mother was coming for the session. Throughout therapy Qolani's mother did not notify the scientist-practitioner that Qolani was not going to be able to make his session. There was a three-week lull between the fifth and sixth session, the excuses varied from illness to transport issues[5]. Qolani's last session for the year was also rescheduled – Qolani's mother said that "something came up and she needed to go to Pedi". Engagements with Qolani's mother throughout therapy had a laborious flavour to them. There was a sense that her son being in therapy felt like a burden which was confirmed by the consistent rescheduling – and not notifying the scientist-practitioner that Qolani would not make his session.

[5] It may be important to note that Qolani's mother was not working at the time and had access to a car.

Qolani's process had to be put on hold due to December holidays. The scientist-practitioner explained to Qolani's mother that it was important for Qolani to resume therapy in the new year as he was in the middle of a sandplay process and there were important family dynamic issues to discuss. The scientist-practitioner also wanted to further investigate his poor scholastic performance. Qolani's mother agreed to resume the process in the new year but there was a reluctance in her tone. The scientist-practitioner suspected that this was where she disengaged from the process. Qolani's mother had expected the process to finish at the end of the year. In the new year when arrangements were made for a session she did not attend. When the scientist-practitioner made attempts to reschedule she blocked her number effectively ending the process.

Grubbs Sandplay Analysis

The following section presents the sandplay data and thereafter a summary of themes from the conversations supported by transcribed exerts. This will be followed by a presentation of themes pertinent to the process. Both presentations of themes, 'the process of the process' and 'the process' highlight facilitators and inhibitors of an imperfect sandplay process. Discussions for each theme will also be included.



Sandpicture one: (non-directive) took place in week three of therapy

Sandplay Categorical Checklist (SCC)

Direct Observation and Objective Analysis

1. Story	Qolani said that “the two dinosaurs were in a fight” and the other figurines were “watching the fight”. With probing from therapist the story evolved; the triplet aliens wanted to “stop the fight” and the doctor was there to “help someone if they got hurt”. The triplets would stop the fight by addressing each dinosaur saying “they must not fight”. “The dinosaurs would not listen”.
2. Figures	See image above.
3. Setting	Organised with use of people, animals and fantasy.
4. Creation Process / Dramatic Play	Scene made intact with few changes, no evidence of dramatic play as scene is made.
5. Use of Human and Animal Figures	Animal figures used appropriately/realistically, human figures placed in dangerous situations (as spectators of fight) and fantastical creatures present taking on human characteristics (siblings) and being able to talk to dinosaurs.
6. Use of Sand	Dry

7. Use of Tray	Figures placed on top, sand untouched Sparse Area of focus: Bottom half of tray Empty spaces: On top half of sand tray Figures placed in centre: dinosaur and human figurines.
8. Creator's Response to Scene	Indifferent or no response
Subjective Impressions and Implied Meanings	
9. Main Psychological Expressions	Aggression Violence Alienation/loneliness Fantasy
10. Cognitive Development and Scene Progress	Cognitive: Age appropriate (11-12 years) Scene progress: Not applicable for first tray.
11. Coordination of Whole and Parts of the Scene	Scene coordinated as a whole.
12. Structuring of Relationships (human and animal)	Opposing groups/individuals Two interactions one was destructive/sadistic, the other was cooperative/constructive.
13. Boundaries	Entire scene runs together
14. Movement / Obstacles	Free flow of movement with no obstacles
15. Relationship of Parts and Opposites	Opposites kept separate, there was an attempt to unify opposites upon therapist probe.
16. Therapist's Impression of the Scene	Angry, fearful, sad and painful. Left alone to face the violence
17. Significant Symbolic Representations and Thematic Play	Not applicable for first tray.
18. Significant Repetitive Theme and Figures Used	Being observed: dinosaurs being watched by aliens, man with stump, neanderthal, and doctor. Violence: Dinosaurs Danger: dinosaurs engaged in fight being watched by people Fantasy: Aliens Emptiness

Sandpicture two: (non-directive) took place same session as sand tray one

Sandplay Categorical Checklist (SCC)

Direct Observation and Objective Analysis

1. Story	The two cars were racing, “the winner would get the loser’s car” and the people wanted to see “who would win”.
2. Figures	See image above.
3. Setting	Organised with use of people only.
4. Creation Process / Dramatic Play	Scene made intact with few changes, no evidence of dramatic play as scene is made.
5. Use of Human and Animal Figures	No animals present. People used appropriately/realistically.
6. Use of Sand	Dry Figures placed on top, sand untouched
7. Use of Tray	Sparse Area of focus: left side of tray Empty spaces: top and bottom bit of tray. Figures placed in centre: None
8. Creator’s Response to Scene	Satisfied, somewhat energized when talking about how race will be won.

Subjective Impressions and Implied Meanings

9. Main Psychological Expressions	Competition/challenge Organizing/structuring Emptiness
10. Cognitive Development and Scene Progress	Cognitive: Age appropriate (11-12 years) Scene progress: progressive (no violence/less danger)
11. Coordination of Whole and Parts of the Scene	Scene coordinated as a whole.
12. Structuring of Relationships (human and animal)	Opposing groups and or individuals Cooperative
13. Boundaries	Entire scene runs together with boundaries around the scene.
14. Movement / Obstacles	Movement with appropriate obstacles
15. Relationship of Parts and Opposites	Opposites kept separate

16. Therapist's Impression of the Scene	No feeling or connection. Structured emptiness.
17. Significant Symbolic Representations and Thematic Play	Human spectators Opposing entities
18. Significant Repetitive Theme and Figures Used	Being observed: race being observed by people. Two opposing entities Emptiness

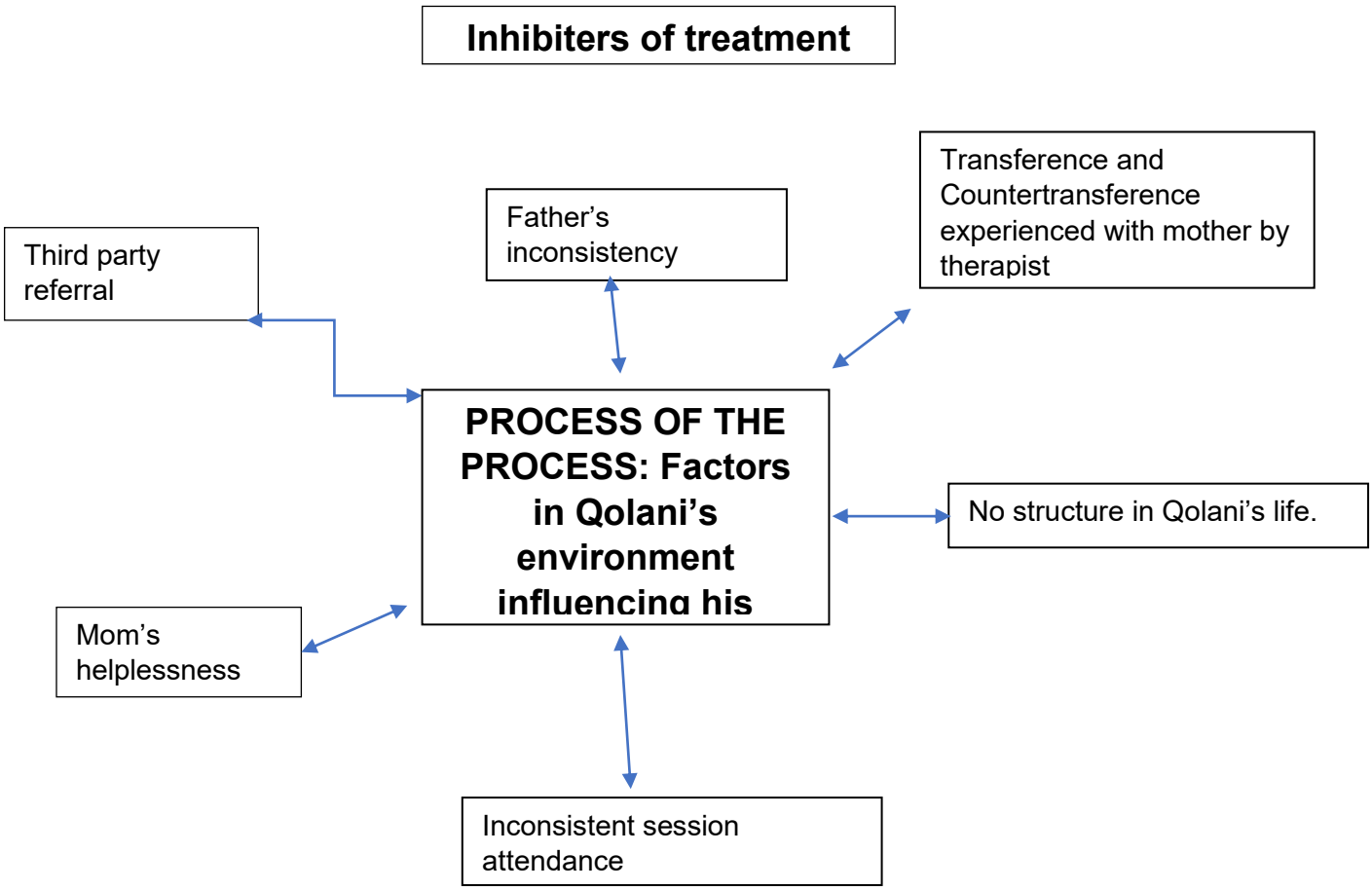
Sandpicture three: (Directive) took place during session six of therapy

I asked Qolani to tell me a story about his family in the sand.

1. Story	Qolani placed himself with his friends in a circle. His mother was talking to her neighbour (mother is blonde figurine) and his father was helping a friend fix his car. His baby brother is playing outside.
2. Figures	See image above.
3. Setting	Organised with use of people only.
4. Creation Process / Dramatic Play	Scene made intact with few changes, no evidence of dramatic play as scene is made.
5. Use of Human and Animal Figures	No animals present. People used appropriately/realistically, although two fantastical creatures present (aliens).
6. Use of Sand	Dry Figures placed on top, sand untouched.
7. Use of Tray	Sparse Area of focus: top half of tray Empty spaces: bottom of tray Figures placed in centre: seems to be mother and baby brother.

8. Creator's Response to Scene	Satisfied, slightly engrossed
Subjective Impressions and Implied Meanings	
9. Main Psychological Expressions	Self-nurturance Alienation/loneliness
10. Cognitive Development and Scene Progress	Cognitive: Age appropriate (11-12years) Scene progress: progressive (no violence and most detailed sand tray he has done since therapy started)
11. Coordination of Whole and Parts of the Scene	Scene coordinated into small groupings.
12. Structuring of Relationships (human and animal)	One or more communities/groupings Cooperative/constructive interactions
13. Boundaries	Boundaries formation through groupings.
14. Movement / Obstacles	Movement with appropriate obstacles (mom having wall between her and neighbour).
15. Relationship of Parts and Opposites	Opposites kept separate
16. Therapist's Impression of the Scene	Separation of adults from children, children creating their own sense of community without adults.
17. Significant Symbolic Representations and Thematic Play	Trying to create structure (use of fencing and organisation). Specifically putting mom in structured environment. Perhaps expressing a need for mother to be a more contained/containing presence.
18. Significant Repetitive Theme and Figures Used	Emptiness (lack of figures used)

Diagram of themes found in transcribed interviews.



Process of the process: Factors in Qolani's environment influencing his therapeutic process

Theme 1: Third party referral

Qolani was referred for treatment by his teacher. This is in direct contrast to what research states regarding the importance of the parents/caregiver's initiating and seeking therapy. This would indicate that a parent is engaged in treatment which means a higher likelihood that therapy will be a success (Haine-Schlagel & Walsh, 2015). Furthermore, Snyder and Anderson (2009) found that third party referrals positively correlated with therapy drop out rates. Another study found that self-referred clients were more likely to complete therapy whereas those referred by court or school were more likely to drop out (Frankel & Simmons, 1992).

Theme 2: Mother's helplessness about Qolani's presenting problem: There was a sense that Qolani's mother had abandoned responsibility for Qolani's issues.

> *Q Mother: "I'm terrified that something bad could happen to him. Because within this incident, I felt like it's too much for me to handle".*
>
> *Q Mother: "Also, that's what I thought because we really needed Qolani to be away even if it's one of those schools. Because I felt like being there, having the routine and then even if they, I felt like if I could get a place for Qolani just to be out of the environment."*

Throughout therapy there was not a clear indication of an adult taking responsibility for Qolani's development. Qolani's mother's helplessness about her son's situation could be interpreted as her disengaging from her son's struggles. It could be that because Qolani's grandmother is also taking care of him, Qolani's mother has gotten used to stepping out of the parenting role. This belief is also mirrored in her desire to send him to a boarding school for delinquent children. There is a sense that she wants someone else to 'fix' her child, i. e. relinquishing responsibility for her child. Qolani's mother's passive attitude is in direct contrast to the active stance parents need to take for their child's psychotherapy to be successful (Haine-Schlagel & Walsh, 2015). Research states that parents need to meaningfully participate in their child's therapy via interaction with the clinician and by applying treatment recommendations. This implies that the parent must take responsibility for their child's healing. Another explanation for Qolani's mothers lack of parental responsibility can be found in the work done by Sadler, Anderson, and Sabatelli (2001). Sadler et al., (2001) found that grandmothers play a prominent role in parental competencies among urban African American adolescent mothers during the early stages of the adolescent's transition to parenthood. The maternal grandmother often assumes some of the more traditional supportive paternal roles and responsibilities, while she concurrently holds the role of mother for the adolescent mother[6]. Qolani's mother was adolescent mother (she was 17 years old when Qolani was born). Qolani's grandmother may have taken on most of the parental roles when he was born but the transition of parental responsibility to Qolani's mother simply did not take place.

[6] Although this research was conducted in the USA, Sooryamoorthy and Makhoba (2016) found that more and more grandparents are taking on the role of parent in South Africa.

Theme 3: Father is inconsistent/unstable. It must be emphasized from the outset that all interpretations of Qolani's father were informed by Qolani's mother and grandmother. They are therefore not viewed as facts. Qolani's father was unavailable to comment, therefore, the perspectives of the other significant adult's in Qolani's life will direct the discussion below. Qolani's father was described as an unstable presence. There was also no certainty around Qolani's father's visits and no consistent financial input. His instability was a frequent narrative throughout therapy.

> *Qolani's mother:" …his father is involved in bad things, drugs and theft. He does not have a job."*
>
> *Qolani's grandmother: "You don't know where he lives around the location."*
>
> *Qolani's father: "It's the very problems you see that I have in my past that are putting me away from him."*

There were times in therapy that similar behaviours were reported by Qolani's mother in both father and son. On two occasions Qolani's mother could not find Qolani to bring him to therapy. Qolani's mother also could not find his father to bring him for a follow up session. The lack of a consistent fatherly presence in Qolani's life and Qolani's externalizing behaviour does confirm research by Ward, Makusha and Bray (2015). They reported that the presence of an engaged father has an independent positive impact on a child's behaviour. Qolani's father was inconsistently engaged which therefore could partly explain Qolani's problematic behaviour. Research provides reasons for Qolani's father's lack of consistency and involvement. Low socio-economic status (SES) fathers are often confronted by several obstacles to being involved with their children, including high rates of unemployment, early childbearing outside of marriage, a constant succession of negative life events, and the absence of positive male role models (Fagan & Iglesias, 1999). Moreover, Qolani's father's low socio-economic status and instability in his parenting role does align with Kazdin, Holland and Crowley (1997) research on the factors contributing to therapy drop-out rates, i. e. low socio-economic status.

Theme 4: No structure instilled in Qolani's life. A distinct lack of structure was noted in Qolani's life. There were times when he would come home at 00:00am or sneak out while his grandmother was sleeping to play in the streets with his friends. There did not seem to be a set homework time or bath time.

> *Q Mother: "And then my mother said, no Qolani, you've still got maybe she thought that he already stopped this coming late thing. Now he starts again because he went out at 6:00pm and came back around past 11:00pm."*
>
> *Q Mother: "when he comes home from school, he sleeps a lot. He sleeps until 5pm, then goes out and plays."*

The lack of structure/routine could be due to the lack of responsible adult presence. There is little research that overtly links child therapy drop-out rates and lack of structure/routine in a child's life. It is likely that it is difficult to get such children into therapy for that variable to be assessed. However, this vignette further illustrates the lack of engaged parent in Qolani's life instilling structure and routine. This explains not only his presenting problem, as research has found a connection between lack of parental involvement and externalising behaviours in children (Lanza & Taylor, 2010), but also the premature end to therapy (Haine-Schlagel & Walsh, 2015).

Theme 5: Mother inconsistency in bringing Qolani to sessions.

Throughout the seven sessions that I engaged with Qolani and his parents, only one session started on time and without rescheduling for another day. All other sessions were rescheduled. One session was rescheduled because Qolani had gone playing with his friends and his mother could not find him. For the third session, his father was supposed to bring him but did not. His mother suspects that his father took the taxi money she left for him and used it for something else. For the sixth session Qolani was supposed to be brought by his grandmother, but his mother did not leave taxi money for her (this was right after I had spoken to his mother about the importance of the sessions and creating structure in Qolani's life). The session ended up being rescheduled.

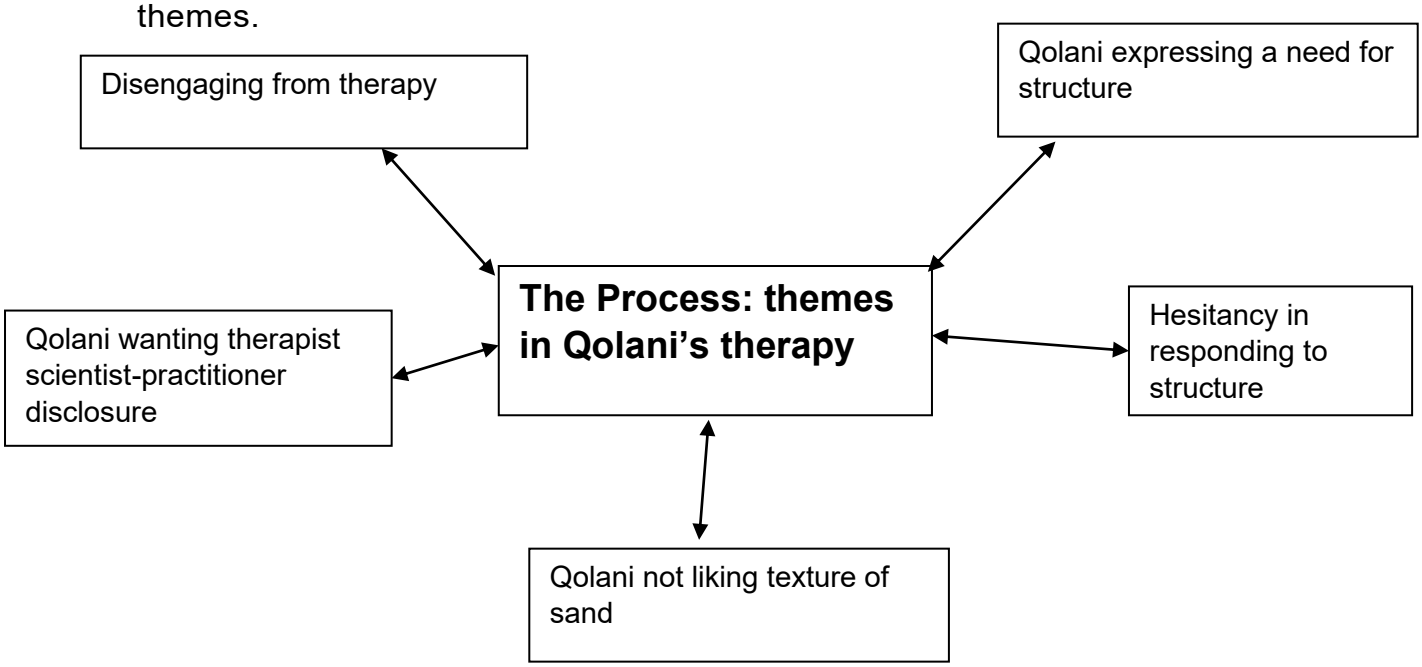
I suspect this made it challenging for Qolani to fully engage in the process as there was never a guarantee that he would come to his sessions. According to Haine-Schlagel and Walsh (2015), one of the main behavioural factors necessary for treatment engagement processes is session attendance. The vignette above encapsulates what session attendance should not look like. Kazdin, Holland and Crowley (1997) state that consistent cancellations/no-shows are a hallmark of those who eventually drop out of therapy.

Theme 6: Transference and countertransference experienced by the scientist-practitioner when engaging with Qolani's mother. Throughout the course of therapy, I tried many times to engage Qolani's mother in Qolani's process. Whether by merely encouraging her to drop him off for sessions (or get someone else to drop him off) at the agreed time or even at all, or via feedback, where I tried to explain what Qolani was feeling and what changes she needed to make to best help him. As time went on, I may have responded to her disengaged-ness with frustration that was birthed from feeling helpless. The countertransference I experienced may have stemmed from me feeling like my professional and research priorities were not aligning with Qolani's mother's priorities. She might have sensed my growing frustration which may have affected our rapport and possibly her willingness to engage in her son's process. This aligns with research by Harwood and Eyberg (2004) who reported that in family therapy, the relationship between the therapist and parent has been described as critical to families' attendance and participation in treatment. Furthermore, Kazdin, Whitely and Marciano (2006) found that the parent's alliance with the therapist may influence compliance with and support of treatment outside of the sessions and therefore also may be associated with therapeutic change.

What I was experiencing with Qolani's mother may have offered valuable intel into what Qolani experiences with his mother; a sense of helplessness and frustration in trying to get her to engage. Again, it may point to a disengaged parent which is the opposite of what research states is needed for a successful child therapy process (Haine-Schlagel and Walsh, 2015).

THE PROCESS

The following vignettes are taken from the sessions with Qolani. They serve to illustrate the impact of the factors in the lives of the adults shown above and their influence on Qolani's process. Below is a diagram summarizing the main themes.



Theme 1: Qolani expressing a need for structure.

In the first two sessions, Qolani completed a kinetic family drawing and classroom kinetic drawing. In both drawings there was a marked absence of adults and an emphasis on the structure of roofs and walls (Qolani took considerable time and care to draw both). According to my subjective clinical interpretation of the drawings, Qolani indicates a need for structure/security and the lack of felt presence of adults in his life. Qolani's expressed need does align with research stating that children need the dependability and security that comes with structure put in place by an involved care-giver/parent (Standstrom & Huerta, 2013).

Theme 2: Hesitancy in responding to sandplay work/ largely empty sandpictures

Qolani was very hesitant to engage with sandplay – an example of structure enabling free expression.

> *QOLANI: And you can start yours.*
> *AIMEE: Sorry?*
> *QOLANI: You can start yours.*
> *AIMEE: Do you want me to start mine?...What is making you want me to start? Are you scared, are you nervous or shy or...?*
> *QOLANI: I don't know how to do it.*

Qolani's hesitancy could be due to his lack of experience with structure and therefore lacked confidence in it. He spoke in muted tones in most of our sandplay sessions. This could indicate his withdrawal. Standstrom and Huerta (2013) state that children rely on their parents – an example of an engaged empathic presence - to help them regulate emotion and negotiate negative/new situations. Qolani may have not internalized an engaged empathic presence during his development therefore did not feel regulated when confronted with sandplay (a new situation) and therefore did not want to engage with it. It was also interesting that Qolani was not drawn to sandplay as research states that sandplay is effective in helping aggressive children express and release negative predispositions inherent in aggression. Another reason for Qolani's aversion to sandplay is found in the work by Grubbs (2005). According to Grubbs (2005) a very empty, lonely appearing world is an expression of withdrawal, apathy and inaccessibility. This has a similar theme to the counter-transference of helplessness that I felt with Qolani's mother (as documented in the previous section). Qolani's empty sandpictures could be an expression of what he feels most of the time as research does confirm that what children build in the sand, mirrors their internal world (Lubbe-de Beer & Thom, 2013). It is also interesting that Qolani's response to sandplay is the opposite to what Homeyer and Sweeney (1998) posited. They stated that because sand is a calming medium to work with, it lessens the anxiety inherent in being faced with one's problems. Qolani seemed reluctant to engage with the sand, perhaps even more guarded around it.

Theme 3: Qolani wanting scientist-practitioner disclosure. As evidenced in the vignette above, Qolani would ask me to "go first" each time sandplay was presented as an activity.

> *AIMEE: I can see your eyes looking that way.*
> *QOLANI: Ma'am doing yours.*
> *AIMEE: Hey?*
> *QOLANI: You can do yours (sand tray).*
> *AIMEE: Can you tell me a story of your family in the sand?*
> *QOLANI: You do yours first.*
> *AIMEE: Must I do my family first? Then we do you yours?*
> *QOLANI: Yes.*

In the first sandplay session, Qolani wanted me to demonstrate how to engage in sandplay. This could be due to his aversion to losing my approval as I was an adult giving him undivided attention. Qolani was not used to the kind of attention I was giving him. He might have been so attached to the attention that he did not want to lose it by doing something "incorrectly". This interpretation does align with research conducted with children of narcissistic parents (Dutton, Denney-Keys & Sells, 2011). These children were found to have a predominant desire to please others and focus their attention on the thoughts and actions of those around them. They are unable to penetrate their parents' self-absorption, therefore the child develops a chronic obsession to please others (Dutton, Denney-Keys & Sells, 2011).

Theme 4: Disengaging from therapy process

Qolani disappeared to play with his friends the day of our fourth session, his mother could not find him which resulted in last minute cancellation. The session was postponed to the next day. Qolani was quite resistant – evident in his muted tones (for most of the session his voice was inaudible on the recording). He also did not want to engage freely with the sand tray, even more so than in the previous session.

> *AIMEE: Okay. So, what do you feel like playing with? You can come and grab and play and do whatever.*
> *Qolani: mmm..hmm*
> *AIMEE: Hey?*
> *Qolani: mm what must I do?*
> *AIMEE: Just, you take the lead. We'll do whatever you want to do with the toys, or the sand, or do you want to do something else?*
> *Qolani: no, you can do it.*

AIMEE: Okay. What do I feel like playing with today? Let's think. I'm feeling like maybe playing with some cars. I'm just looking at the cars and I'm just taking them all out, and we can just play.
Qolani: You can play it first.

*****

AIMEE: Do want to do another sand play or do you want to just talk?
QOLANI: Talk. (muted voice)
AIMEE: Do you want to talk? Okay. I was wondering how you felt last week when, you know we were supposed to see each other? I think it was last week Wednesday, hey? And then you couldn't come or your mom couldn't take you and your dad had to come and take you, hey? On the Thursday and he took you on the Friday? What was that like for you? Am I going to Aimee, am I not going to Aimee? What …
QOLANI: [inaudible 00:00:45]
AIMEE: Sorry?
QOLANI: I thought I weren't going
AIMEE: You felt that you weren't going? Okay. Did you feel that on the Wednesday and the Thursday? Or the whole week?
QOLANI: I felt the whole week.

Interestingly, this would have been Qolani's second sandplay session. To explain Qolani's disappearance before the second sandplay session it may be helpful to examine what happened in the first. Qolani's first sandplay session (his third therapy session) was prefaced by his father not keeping the original time and date of the session. The session had to be rescheduled for the following day. As evidenced in the above vignette, Qolani believed that he would not be coming to therapy. He therefore entered his first sandplay session uncontained by the safety inherent in consistent session attendance, i. e. the routine of therapy attendance. His insecurity may have been expressed in the theme of on-lookers in both sandpictures. There is distance in being observed, rather than held by the safety/warmth inherent in an empathic presence which is a prerequisite for the therapist to embody in sandplay therapy (Boik & Goodman, 2000). This does not align with both the scientist-practitioner and her supervisor's clinical judgement as both felt that the two sessions prior to the first sandplay session established a strong enough rapport to venture into sandplay. Qolani was also prepared for the change by a short introduction to sandplay at the end of the previous session (he was showed where the sand was in the Rhodes Psychology clinic and the accompanying figurines). Qolani's insecurity in the first sandplay session could be explained by Standstrom and Huerta (2013).

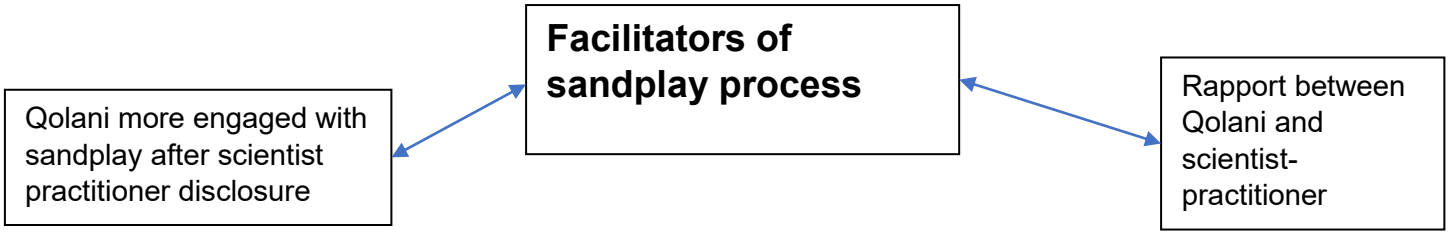
They report that children who have been exposed to episodic change such as parental job loss/parent separation (which Qolani had experienced) experience an over-activation of the stress response. One could deduce that when the change was made in therapy to sandplay, Qolani re-experienced the stress response associated with sudden change in his life. These feelings were exacerbated by the uncertainness inherent outside of his process – a lack of engaged parent – which resulted in him fleeing from the next session.

Theme 5: Qolani not liking the texture of the sand. When Qolani was asked how he felt about the sand texture, he said that he did not like it. However he was still open to engaging with the sand tray and did show engagement but not at the level expected of a child at the same stage in therapy.

> *AIMEE: Do you like sand when you touch it? Does it, do you go like this or do you not mind it?*
> *QOLANI: I go like that (makes "heeby-jeeby" motion")*
> *AIMEE: Do you? Do you not like the sand? So this you don't want?*
> *QOLANI: But its fine.*
> *AIMEE: Sorry?*
> *QOLANI: Its fine.*
> *AIMEE: Is this not fine? Okay. Is it because it feels dirty? Does it feel like, yes, can you describe the feeling? Does it just …*
> *QOLANI: Yes.*
> *AIMEE: You don't like the sand?*
> *QOLANI: But I say I like putting …*
> *AIMEE: Oh, you like putting them in the sand? Is it, do you want to put something else in the sand? Do you want to …*
> *QOLANI: No, I'm just saying it's nice but the sand is staying in my hands.*
> *AIMEE: Is it sticky on your hands?*
> *QOLANI: Yes.*
> *QOLANI: This sand it comes with my hands.*
> *AIMEE: You don't like that feeling, hey? Okay. Do you want us to not go into the sand again?*
> *QOLANI: It's fine.*
> *AIMEE: Are you sure?*
> *QOLANI: We can go in again.*

It is possible that Qolani has a sensory aversion to sand. Grubbs (2005) however, provides a psychological explanation. Qolani's unwillingness to touch the sand suggests a disconnection from the mother-element or the centre of the self.

This would align with the problematic mother themes raised in the previous section of the paper and in his third sandpicture. For children with tactile defensiveness to sand, literature advises that something coarser such as lentils or rice can be used (Tornero & Capella, 2017).



Theme 1: Qolani is more engaged with sandplay after scientist-practitioner disclosed (building her own sandpicture). The following vignette was taken from Qolani's last sandplay session. The instruction was "to tell a story of his family in the sand". This theme may seem reminiscent of a one already discussed, but what sets this one apart is Qolani's willingness to engage with his own sandplay after the scientist-practitioner was vulnerable in hers.

> *QOLANI: There's another one.*
> *AIMEE: Thank you. Okay. So that's the story of my family. I'm here in Makhanda, so let me get a donkey. There must be a donkey. Here's a horse. Makhanda.*
> *QOLANI: Here's a donkey.*
> *AIMEE: This one? Ag, jissie, thank you. Thank you, okay. So I'm here with the donkeys in Makhanda, in Grahamstown. Yes. That's my family. Do you want to try?*
> *QOLANI: Yes.*

As seen in the previous section, Qolani had asked the scientist-practitioner to "go first" whenever sandplay was introduced as an option in therapy. The scientist-practitioner had 'gone first' in a previous session but was sure to not self-disclose as the scientist-practitioner did not want to detract from his process. The result was his first sandpicture with the fighting dinosaurs – an accurate picture of his life but not much detail.

It might be possible that Qolani sensed the scientist-practitioner's reservedness in interacting with the sand and internalised it. When it came to the third sandplay session and Qolani asked the scientist-practitioner to "go first" again the scientist-practitioner decided to be vulnerable and share an accurate depiction of her family. Thereafter Qolani made his third sandpicture and it was his most detailed and revealing sandpicture out of the three sessions. Findings by Youniss' (1980) aligned with Qolani's need for the scientist-practitioner's self-disclosure and the resultant strengthening of the therapeutic alliance. They found that by middle childhood (i.e., around fourth grade), children begin to not only value, but expect mutuality of disclosure. There was found to be a dyadic effect—the process by which disclosure begets disclosure—that governs disclosure practices among 10-12 year old children. Furthermore, these findings provided preliminary empirical support for the argument that therapist disclosure with children may strengthen the alliance and facilitate greater disclosure from child clients. Conversely, a study by Capobianco and Farber (2005) found that within their sample of therapist's child clients 'almost never' request personal information and that almost all the therapists in their study found that self-disclosure was not helpful for therapeutic advancement. In this light Qolani's presentation in therapy does not align with literature.

There was also a change in theme in Qolani's third sandplay. There was no longer an element of competition or fighting signifying regression. Grubbs (2005) referred to a brief regression, working through, and return to present level of development as a sign of strength, progress, and integration.

Theme 2: Strong rapport between scientist-practitioner and Qolani

Even though therapy with Qolani was inconsistent and marred with parental instability, Qolani and the scientist-practitioner still managed to build a strong rapport[7]. The therapeutic relationship may have been solidified when soccer was introduced at the end of each session. This may have built Qolani's sense of self-worth because an adult was dedicating energy to entering and understanding his world.

[7] The strength of rapport was also confirmed by the supervisor of the case

The rapport built over a game of soccer does align with child psychotherapeutic research. Hudak (2000) argued that by engaging in play, the therapist joins the world of the child rather than imposing the adult's world onto the child. Ball play establishes a connection between the therapist and child because it shows the child that the therapist is interested in their world. This is vital to building rapport. Ball play is unique to other forms of play because it (a) is interactive and cooperative, which encourages reciprocity; (b) is simple, which reduces distractibility, and thus can be performed simultaneously with talking; and (c) encourages eye contact and can focus the attention of hyperactive children, because the child has to look at the therapist to keep the game going (Hudak, 2000).

The speed at which rapport was built could also be attributed to Qolani's need for focused adult attention. Standstrom and Huerta (2013) confirm that children have an instinctual need for consistency and stability. It is clear from the case material that Qolani's environment was not sufficiently meeting this need. The scientist-practitioner therefore acted as surrogate. Moreover, given the inconsistency of our sessions, progress was still made in Qolani's healing. This was affirmed by his teachers who said they had noticed a change in him – they reported that he was trying much harder at school. Literature affirms the impact of rapport between therapist and client. It could be that Qolani's process aligns with the research done by Carr (2009) who found that 38% of the effects of psychotherapy are owed to the therapeutic alliance alone.

8. Quantitative Measures

The Strengths and Difficulties questionnaire was given to Qolani's mother pre-sandplay and at two month follow up without any therapy engagement with Qolani. The seventh session with Qolani was in the last week of term for 2020. It was agreed that therapy would resume January 2021. This was when the follow up SDQ was to be administered. However, Qolani's mother had completely disengaged from the process. She agreed to complete an SDQ for administrative purposes but would not be bringing Qolani to sessions anymore. The follow up SDQ was administered beginning of February 2021. Qolani would have had two months without therapy engagement when his mother completed the follow up SDQ.

Week	Emotional Problems	Conduct problems	Hyperactivity	Peer Problems	Prosocial	Impact score	Total difficulties
Zero	6 High	6 High	6 High	6 High	9 Above average	6 High	24 Very High
Two month post 7th session follow up	3 Slightly raised	7 High	9 Very high	3 Slightly raised	7 Close to average	5 High	22 Very High

As is evident from the table above, there are many inconsistencies with the pre and post parent SDQ. Regarding Week 0, it is unlikely that Qolani would have "peer problems" with such a high "prosocial" score. Additionally, one would expect that Qolani's mother would have scored his "emotional problems" as severe given that Qolani's self-report for problems and symptoms was very high. This may allude to 1) an emotional disconnect between mother and son, 2) a rushed completion of the questionnaire without reading the questions properly, (which supports the scientist-practitioners' experience of Qolani's mother as not being motivated) 3) a language barrier. I suspect that it was a combination of all three. In terms of the 'post' sandplay SDQ, Qolani's mother insisted that he was doing a lot better, however, his "conduct problems", and "hyperactivity" had increased. His "prosocial" score had decreased but his "peer problems" had decreased significantly too. These inconsistencies in answers point to the three possible factors stated above.

YP-CORE: Pre-therapy

As noted in previous sections, a post-therapy YP-CORE could not be completed due to the abrupt end of therapy. However, the pre-therapy YP-CORE will be analysed qualitatively to shed further light on the qualitative analysis.

Week	Subjective-wellbeing	Symptoms	General functioning	Relational functioning	Risk to self/others	Total
0	3	9	4	5	0	21
	Severe	Severe	Severe	Severe	Healthy	Moderate-severe

According to Qolani's YP-CORE pre-sandplay, he was experiencing moderate to severe levels of distress. Qolani had elevated scores across all domains of the YP-CORE, which signified that Qolani was experiencing distress in many aspects of his life. With regards to the individual dimensions of the measure, his *subjective well-being* scored 3 (severe), *symptoms* scored 9 (severe), *general functioning* scored 4 (severe), *relationship functioning* scored 5 (severe), and *risk/harm to self* scored 0 (healthy). Overall, he scored 21, placing him within a 'moderate-severe' range of distress. It should be noted that Qolani's scores were normed according to those of British children between the ages of 11-13 (Twigg et al., 2009). It is interesting that Qolani scored the highest for symptoms, namely in depression, anxiety, trauma and physical. His results confirm again the disengaged nature of his parents. The fact that he was clearly distressed but his teacher was the one to refer for him for therapy, not his parents. The validity of child self-report questionnaires is well researched. A child has unique awareness of their own experiences, whereas parents, teachers, and clinicians observe the child only in specific settings (Riley, 2004). The face validity of reports of health and quality of life is much better when individuals report their own perceptions. If the research question focuses on well-being, symptoms, and perceived strengths and needs, the person's own voice is needed. Furthermore, for longitudinal assessments, children are likely to be the most consistent reporters over time, and their reports of health in first grade have predictive validity into adolescence (Riley, 2004). Measures like the YP-CORE are crucial for assessing clients needs and measuring client outcomes. This helps the clinician identify treatment pathways and aids in adjusting their approach if progress is not evident (Bentley, Hartley & Bucci, 2019).

9. The Scientist and the Practitioner

Throughout treatment and research, holding the roles of scientist and practitioner was contentious on two levels. On one level, as noted by Snelgar (2018) there exists a tension between the scientist and practitioner. The scientist wishes to collect sandplay data in order to meet the prerequisites of their research, while the practitioner is ethically and therapeutically bound to allow the client to freely engage in the self-expressive play they prefer. This tension arose in myself when Qolani did not want to engage freely with sandplay. I was eager to collect data as the scientist, however I needed to allow for his contempt for sandplay.

On another level, due to the inconsistent and disengaged attitudes of his parents; I also carried tension in the role of scientist and practitioner as separate entities. A premature end to the process meant a premature end to data collection, but more importantly – as this was chiefly a therapeutic process, therapy did therefore not serve the goals of the scientific endeavour – there was concern regarding how the premature end to therapy would affect the client. The end to therapy may have only further confirmed his view of the world as unstable and inconsistent.

10. Limitations and recommendations for future research

The main limitation of the study lay in the lack of further clinical assessment and assistance of parental mental health as this would have furthered insight. Another limitation was the lack of completed quantitative measures for every fourth session. This would have aided in presenting a more robust understanding of the processes that lead to the premature end to therapy. Retrospectively, the scientist-practitioner may have disengaged from the process when parental disengagement was noted in anticipation of therapy drop-out and therefore did not timeously execute the required scientist-practitioner duties. In terms of recommendation for future research, there is a noticeable dearth in clinical imperfect case studies. This case study has highlighted the crucial role parents play in producing imperfect child therapeutic processes, yet there are no case studies that document it. Therefore, this case study hopes to form part of the ground-work for future investigations. Moreover, there is also a clear dearth in specific research around the effectiveness of therapy and especially sand-play therapy with children in the South African context. Further research, building on this thesis, is desperately needed.

Conclusion

Multiple factors play a role in child psychotherapy engagement. This thesis focused on the importance of parents. Therefore, it aimed to answer the following questions: 1) what role does parental (dis)engagement play in facilitating an imperfect child sandplay therapy process? 2) Are these factors reflected in the client's sandplay? 3) What are the signs of parental disengagement from child therapy? And 4) even without parental engagement, was there progress in the client's presenting problem (healing)? If yes, what helped this progress and what are the implications for clinical practice?

The existing research and the data in this thesis indicate that parents play a major role in the success or failure of a child sand play therapy process. Parents seem to be crucial in facilitating attendance and engagement – perhaps even the bedrock of child psychotherapeutic success. The data also seems to reveal that parent engagement in child psychotherapy may mean parent engagement in the child's life. The results of the study also found that parental disengagement may be reflected in the child's sandplay. Parental disengagement might be linked to a lack of structure and felt sense of insecurity in the child's life. Sandplay evokes the deepest subconscious desires and needs of the child. It is therefore expected that the child's potential lack of stability would be reflected in his sandplay – or in this case his resistance to sandplay. The results of this thesis suggest the following signs of parental disengagement from child psychotherapy; third party referral, consistent cancellations, "no-shows" and appointment reshuffling, a suspected lack of a responsible/present parental figure in the child's life, and advice given by the scientist-practitioner does not seem to be applied. In terms of the last question, one could say that the therapy process was healing regardless of parent engagement which may point to the crucial role of rapport/relationship between client and therapist. However, it does not seem to be enough for the child client to gain the full range of benefits from the therapeutic process. It therefore suggests that, in order for the process to unfold optimally, parent engagement is sorely needed.

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APPENDIX A

Gatekeeper permission

Request for Permission to Conduct Research

27/04/2020

Dear Psychology Clinic Coordinator

I am a masters student in Clinical Psychology. The research I wish to conduct for my Masters dissertation involves a case study looking at the effectiveness of sandplay therapy for symptom amelioration of aggression in a boy child.

I am hereby seeking your consent to access a case on your waiting list for my research.

I have provided you with a copy of my proposal which includes details of the data collection methods and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Research Proposal and Ethics Review Committee (RPERC).

If you require any further information, please do not hesitate to contact me [0765220413/aimeecounselling@gmail.com]. Thank you for your time and consideration in this matter.

Yours sincerely,

Aimee Fouche
Rhodes University
G20f8915

APPENDIX B

Information about study

Dear (parent's name),

I am currently a Clinical Psychology Master's student at Rhodes University. For my thesis, I am interested in using examples of (child's name) therapy sessions to understand how Sandplay Therapy can help local children with aggression. I would like to use your child's therapy experiences, via case notes, pictures of sand trays, voice recordings of each therapy session and short questionnaires to write a description of your child's play experience.

Taking part in this process would involve:

- An interview with you, the child's other parent/guardian if applicable, and the child regarding his/her background and early life
- Up to 50-minute Sandplay sessions with your child
- A 2-page questionnaire completed by you
- A 1-page questionnaire completed by your child
- A feedback meeting where we can discuss, with the child's assent, his/her process.

All family names will be changed and any identifying information will be changed. I will make every effort to ensure the confidentiality of you and your family. There is no fee charged for these Sandplay sessions. One benefit of participating in this project is that you would be helping other families by adding to our understanding of child therapy in South Africa. There are no foreseen risks of participating in this research and there is no financial compensation for participating. If you wish to withdraw from this project, you may do so at any time. Participating or withdrawing from the study will not interfere with the therapy being provided to your child. You will also be allowed to review any work once it is complete and decide whether it may be published publicly.

Thank you very much for considering participation in this study. If you have any questions or concerns, please feel free to contact me at 0765220413, the research supervisor (Jan Knoetze) at 046 603 8344 or the course co-ordinator (Prof. Lisa Saville Young) at 046 603 8047.

Sincerely,

Aimee Fouche

APPENDIX C

Parent consent form

I give Aimee Fouche permission to use my child's,

_____,

- YP-CORE questionnaire
- Sandplay pictures
- Case file
- Detailed process notes from session
- Voice recordings of each session
- Family background information

My own

- SDQ questionnaire for the purposes of education, research, and professional publications and presentations.

I understand that all clinical material will remain securely locked in the Rhodes University Psychology Clinic and that all identifying information of family members will be changed to ensure confidentiality. I do not expect any financial compensation in exchange for this permission. I also understand that I may withdraw from this study at any time without any penalty (such as to ongoing therapy). If I have any questions regarding this consent, I can call

- The research supervisor: Jan Knoetze at 046 603 8344
- The course co-ordinator: Prof. Lisa Saville Young at 046 603 8047

Parent's Printed Name _____

Parent's Signature _____

Date_____

CLIENT ASSENT FORM

I am doing a study to learn about how some South African people feel about counselling using Sandplay. I am asking you to help because I don't know very much about if children like you will enjoy it. If you agree to be in my study, we are going to work with sand and toys. You'll be using them when we do counselling and I'll ask you questions about what you're doing.

For example, I'll ask you explain the story when you create with the sand and toys. I will also ask you to answer a form and I will make notes about our time together. I'll also take photographs of any pictures you make and voice record our times together. You can ask questions about this study at any time.

If you decide at any time not to finish, you can ask me to stop. The questions I will ask are only about what you think. There are no right or wrong answers because this is not a test. If you sign this paper, it means that you have read this and that you want to be in the study. If you don't want to be in the study, don't sign this paper. Being in the study is up to you, and no one will be upset if you don't sign this paper or if you change your mind later.

Your signature: _____
Date_____

Your printed name: _____
Date_____

Signature of person obtaining consent: _____
Date_____

Printed name of person obtaining consent: _____
Date_____

APPENDIX D

Pre-Sandplay SDQ for parents

Strengths and Difficulties Questionnaire P 4-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Post-Sandplay SDQ (Follow-up)

Strengths and Difficulties Questionnaire

P 4-17
FOLLOW-UP

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour **over the last month**.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
☐	☐	☐	☐	☐

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

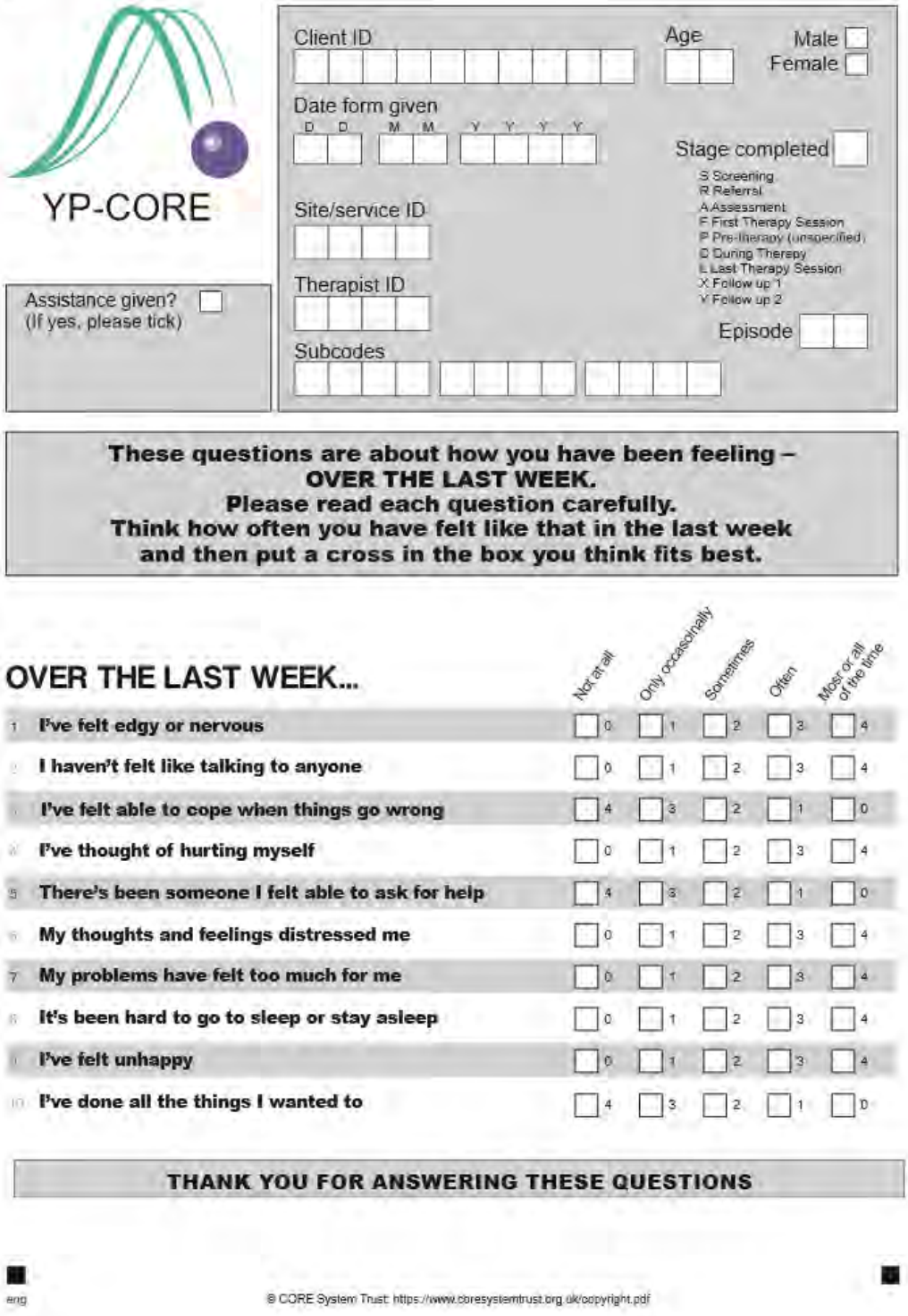
Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

APPENDIX E

YP-CORE: Young Person's Clinical Outcome in Routine Evaluation



YP-CORE

Client ID

Age

Male ☐
Female ☐

Date form given
D D M M Y Y Y Y

Stage completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Site/service ID

Therapist ID

Episode

Subcodes

Assistance given? ☐
(If yes, please tick)

These questions are about how you have been feeling – OVER THE LAST WEEK.
Please read each question carefully.
Think how often you have felt like that in the last week and then put a cross in the box you think fits best.

OVER THE LAST WEEK...	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I've felt edgy or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I haven't felt like talking to anyone	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3 I've felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 I've thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 There's been someone I felt able to ask for help	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6 My thoughts and feelings distressed me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 My problems have felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 It's been hard to go to sleep or stay asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I've felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 I've done all the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

THANK YOU FOR ANSWERING THESE QUESTIONS

eng

APPENDIX F

Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

Name of Participant			
Name of Guardian/Parent			
Email address			
Phone number			
Name of researcher			
Level of research	Honours	Masters	PHD
Brief title of project			
Name of supervisor			

DECLARATION

(Please initial/tick blocks next to the relevant statements)

1.	The nature of the research and the nature of my and my child's participation has been explained to me.	Verbally	
		In writing	
2.	I agree to my child's sandplay therapy sessions to be recorded.	Audiotape	
3.	I agree to _____ and to allow recordings to be made.	Audiotape	
4.	The tape recordings may be transcribed	Without condition	
		Only by researcher	
		By one or more nominated third	

		parties	
5.	I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written. **OR** I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions		

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

Appendix G

Ethics approval

RHODES UNIVERSITY

29/06/2020

Mr Jan Knoetze

Email: jknoetze@ru.ac.za

Review Reference: 2020-1439-3534

Dear Mr. Jan Knoetze

Re: The effectiveness of Sandplay therapy for symptom amelioration of aggression in a boy child.

Principal Investigator: Mr. Jan Knoetze

Collaborators: Ms. Aimee Roache

This letter confirms that the above research proposal has been reviewed by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee and **PROVISIONALLY APPROVED PENDING GATEKEEPER PERMISSION.**

Gatekeeper permission is required from:

a) Rhodes University Psychology Clinic

Once the Gatekeeper permission letter/s have been received please forward it to the Ethics Coordinator, (s.mangole@ru.ac.za) in order to finalize your ethics approval.

Sincerely,

Prof Arthur Webb

Chair, Human Ethics Sub-Committee, RUESC-HE

Page 1 of 1

APPENDIX H

Gatekeeper permission

Nqobile Msomi <n.msomi@ru.ac.za> Wed, Sep 30, 2020, 10:59 AM

to me

Dear Aimee

Permission to access a case on the Psychology Clinic's file is hereby granted. Please note that all protocols for working with clients at the Psychology Clinic must be followed. Importantly, the Updated Guidelines for Accessing the Psychology Clinic during COVID-19 Lockdown must be strictly adhered to and the COVID-19 Indemnity Form must be signed.

Best wishes for the process ahead!

Kind regards, Nqobile

RHODES UNIVERSITY
Where leaders learn

Nqobile Msomi

Counselling Psychologist
Lecturer & Psychology Clinic Co-ordinator: Department of Psychology
t: +27 (0) 46 603 7417
Department of Psychology, 1 University Road, Makhanda, 6139
PO Box 94, Makhanda, 6140, South Africa
www.ru.ac.za | www.nqobilemsomi.com

APPENDIX I

Plagiarism declaration

PLAGIARISM DECLARATION

1. **I know that plagiarism means taking and using the ideas, writings, works or inventions of another as if they were one's own. I know that plagiarism not only includes verbatim copying, but also the extensive use of another person's ideas without proper acknowledgement (which includes the proper use of quotation marks). I know that plagiarism covers this sort of use of material found in textual sources and from the Internet.**

2. **I acknowledge and understand that plagiarism is wrong.**

3. **I understand that my research must be accurately referenced. I have followed the rules and conventions concerning referencing, citation and the use of quotations as set out in the Departmental Guide.**

4. **This assignment is my own work, or my group's own unique group assignment. I acknowledge that copying someone else's assignment, or part of it, is wrong, and that submitting identical work to others constitutes a form of plagiarism.**

5. **I have not allowed, nor will I in the future allow, anyone to copy my work with the intention of passing it off as their own work.**

Name Aimee Foucha Student # 20f8915

Signed Aimee Date 18/06/21