ATTACHMENT AND THE THERAPEUTIC RELATIONSHIP: AN ELUCIDATION OF THERAPEUTIC PROCESS IN A SINGLE CHILD PSYCHOTHERAPY CASE

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ABSTRACT

The overall objective of this study was to delve into the intricacies of the therapeutic process and the therapeutic relationship from an attachment perspective. A single retrospective child case study was conducted, which entailed the construction of a narrative synopsis of the process. The hermeneutic approach of a Reading Guide Method was applied, and through a repeated re-reading of the narrative, pertinent themes emerged that shed light on therapy as a process in motion. Specifically, the motion of the therapeutic process manifested through a scrutiny of the therapeutic relationship in view of the participant's attachment style. The results of this study revealed the capacity of the participant to move away from an avoidant and somewhat ambivalent organisation of defences by virtue of establishing a secure base and exercising her faculty for emotional and self-expression. Accordingly, it can be established that in view of psychotherapy from an attachment perspective, the seemingly imperceptible vicissitudes of change are indeed appreciable.

To paraphrase John Bowlby:

The young child's hunger for her mother's love and presence is as great as her hunger for food.

The undertaking of this dissertation has led me far beyond that which I initially envisioned, and opened many doors that I may never have wished to enter: I did not choose the topic for this dissertation; it chose me. It is for this reason that what I have accomplished during this process cannot be articulated with due accuracy through mere words. What can be said is that it is truly through our closest and dearest relationships that we come to know ourselves. Among the few yet treasured significant others in my life, there are two individuals in particular to whom I wish to dedicate this dissertation:

To my mother: – for loving me unconditionally in spite of my imperfections and for believing in me, believing that I am doing what I am *meant* to be doing; for allowing me to challenge her with a willingness to reflect upon her own imperfections, and loving me all the more for it.

* * *

To Sarah: – for walking into my life and challenging me; for granting me access into her world and affording me with an invaluable experience that I will carry with me forever.

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CHAPTER ONE
INTRODUCTION

As an ever-progressing discipline as well as one that promotes a wide array of theoretical and practical stances, the practice of psychotherapy merits a measure of enduring research to fuel its development. For the aspiring psychotherapist, this presents an obligation and moreover, a constructive opportunity for illuminating a preferential interest in the field. Such a task can indeed be regarded as somewhat daunting considering that the end-product will constitute a mere drop in the ocean while at the same time, entail a painstaking undertaking for the researcher. Bearing this in mind, I opted to explore an area of research that would yield valuable and meaningful insight from a personal perspective with the further anticipation that for the discipline, it would at the very least be regarded as indeed, a drop in the ocean.

Of all the resources available to the aspirant psychotherapist, it is indisputable that there is no better guide than hands-on experience. This viewpoint is of course far more appreciated in hindsight, which generously allows for retrospection and the mind-set that what is to be gained will serve as tools for further practice. Correspondingly, I considered an encounter of my limited experience as a psychotherapist as an apt starting point in view of my steadfast ambition to one day, 'master' the practice of psychotherapy. Furthermore, my limited experience required me to rely upon a 'gut feeling' in determining an encounter upon which to focus that would engender beneficial and meaningful understanding. Unsurprisingly, an experience of psychotherapy with a child came to mind. To a certain extent, this was influenced by the fact that I have always been drawn to children, just as they tend to take to me with ease. More importantly however, my proclivity for working with children therapeutically stems from the degree of authenticity in their demeanour, not yet having solidified their defences that we as adults cling to in our interactions with others.

Being an adult inevitably renders working with children quite challenging to say the least. The paradox lies in the fact that in psychotherapy, children openly lay bare their spirits and sources of distress with such simplicity that they can so easily be concealed by virtue of our tendency as adults to be immersed by complexity. In this way, the task of conducting psychotherapy is often perceived as exigent. The beauty of this perception

(or misperception) lies in the rewards to be gained from the perspective of the psychotherapist: the greater the challenge, the lower the expectation and accordingly, the more heightened the appreciation for any degree of progress. Above all however, is the heightened level of appreciation and respect that is afforded to the child who, despite her immaturity, commits herself to the therapeutic process knowingly and with remarkable acuity. This point of view has naturally been cultivated by my experience of working therapeutically with several children yet more particularly, by that of my encounter with the child who constitutes the focal point of this study.

Perhaps the most striking feature in working with this particular child is the degree to which she exhibited remarkable insight towards the therapeutic process throughout my encounter with her. Although not at the focal point of this study, this child's astuteness endured throughout and it was this that impacted significantly on my decision to focus my research on my encounter with her. Of further inspiration was the extent to which I struggled to connect with her. This disconcerted me at the time thus rendering it a significant point of consideration.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The current status of psychotherapy research lends itself to a well-established grasp of the nature, benefits and prevalence of a practice that extends across the domain of the human condition. This has indisputably been impelled by the denunciation of Eysenck in the 1950's who attested to the credit of 'spontaneous remission' in favour of affording merit to the practice psychotherapy as worthwhile (Kazdin, 1993). Consequently, psychotherapy treatment research emanated in an endeavour to establish a status of effectiveness with a focus on treatment outcome as a means of endorsement. With the practice of child psychotherapy merely pioneering at the time, such reconsideration thus constituted a predominant focus on the treatment of adults. Correspondingly, reviews of child psychotherapy relied upon a dearth of literature, rendering the effectiveness of treatment tentative (Kazdin, 1993). Naturally, with the support of Levitt this gave weight to Eysenck's contention. Due to the lack of empirical endeavour as observed in the challenge to the effectiveness of psychotherapy with adults, the success of treatment of children failed to be revealed.

In spite of Eysenck's criticism, research on child psychotherapy has proceeded significantly over the past two decades and continues to persevere. Accordingly, the effectiveness of treatment has been ascertained to the extent that, such status is closely comparable to that of outcome research with adults (Kazdin, 1993). Regardless of such progression however, the literature on psychotherapy with children has yet to attain the level of intricacy afforded to that of research with adults. More specifically, Kazdin (2002) highlights significant limitations of current research, with a focus on two areas in particular. Firstly, he maintains that "the ways in which psychotherapy research is studied depart considerably from how treatment is implemented in clinical practice" (p. 54). This discrepancy is evident through a number of crucial factors, such as the recruitment of children for therapy studies. Kazdin (2002) argues that such practice fails to provide an accurate representation of those children typically referred for therapy with regard to severity and comorbidity of their impairment. Furthermore, existing evidence that supports the effectiveness of therapy is applicable to only a small portion of the

diverse range of interventions available. In addition, Kazdin draws attention to the administration of treatment, which for research purposes, is typically restricted to a fixed and minimal duration of eight to ten sessions.

Secondly, Kazdin (2002) draws attention to the restricted focus of psychotherapy research. In doing so, he bears mention of a limited focus upon questions concerning treatment technique, as well as upon the use of symptom reduction as the sole condition for the assessment of treatment outcome. Of particular concern however, is his contention that "the greatest single limitation [of psychotherapy research] is the inattention to and seeming disinterest in the question of why or how psychotherapy works" (p. 55). Kazdin (1993) emphasizes this statement in reference to the study of factors that influence treatment outcome which has been afforded to research with adults, yet is scarce in respect of child psychotherapy research. He delineates fundamental concerns pertinent to treatment research in the form of priority areas regarding the current status of child psychotherapy research. Kazdin identifies a range of research questions which have been elaborated upon by the abundance of literature on adult psychotherapy, in contrast to the narrow focus on child psychotherapy. Of particular interest, included in these questions are that of the components of the treatment that contribute to change, and the role of various treatment processes. In essence, Kazdin (1993, 2002) avers that the restricted focus on clinical practice research is indicative of the neglect of, and an ostensible disinterest in, the fundamental elements critical to therapeutic process that render psychotherapy with children effective.

In support of Kazdin (1993, 2002), Weisz and Jensen (2001), maintain a distinction between 'research therapy' and 'clinic therapy', the former of which comprises the mainstream research literature. Specifically, they contend that mainstream research focuses on the efficacy of psychotherapy via the intentional recruitment of children for this purpose and hence, has created a significant hiatus between research and practice. Further, it is 'clinic therapy' that Weisz and Jensen assert lends to the effectiveness of psychotherapy by diverging from a focus on process, outcome and symptom reduction in favour of highlighting the essence of why psychotherapy is beneficial. They moreover state that the effectiveness of psychotherapy with children however, remains

underestimated by virtue of the fact that mainstream research is essentially conducted by research-trained therapists as opposed to practicing therapists themselves.

2.2 Outcome and process research

Wallerstein (2001) bears mention of the two research questions central to psychotherapy research, namely the 'outcome' question and the 'process' question. The former refers to the changes that "take place during and as a consequence of therapy", and latter, to "how those changes come about, or how they are brought about" (p. 244). Lis, Zennaro and Mazzeschi (2001) define psychotherapy as a psychosocial treatment that is particularly "characterized by the presence of a [therapist-client] relationship" (p. 36), thus entailing an interpersonal context. The nature of such a relationship is however, further defined in terms of a demarcated period of time, ideally ending once the goals of treatment have been reached. Accordingly, outcome research can be conceptualised as that which informs upon the efficacy of treatment, whereas process research focuses on treatment with the aim of "systematically studying interpersonal, emotional and cognitive processes" (Lis et al., 2001, p. 46) that are fundamental to the practice of psychotherapy. In their review of the current status of child psychotherapy research, Lis et al. contend that the elaborate body of adult psychotherapy outcome and process research continues to expand, and is in contrast with the minority of such studies that have been conducted with regard to children. They indeed acknowledge the existence of literature that lends towards the efficacy of treatment with children which encompasses at least a sufficient number of outcome studies, yet argue that "the literature continues to be dominated by a search for the main effects of treatment without consideration of the many moderators on which treatment effects are likely to depend" (p. 48)

In reference to the existing body of process literature, Lis et al. (2001) assert that the significance of therapeutic processes for the treatment of children is merely assumed. They further maintain that in spite of the practice of process research having been established nearly fifty years ago, the insufficient quantity of existing literature is indicative of a widespread neglect of, and lack of concern for what actually transpires during child psychotherapy. Essentially, they contend that the central task of process research has been disregarded. The significance of process research in respect of

developing the effectiveness of psychotherapy with children is aptly highlighted by Llewelyn and Hardy (2001), who state that process research "aims to demonstrate how therapy works, partly to increase understanding, but primarily to increase effectiveness by pointing to crucial ingredients which effect change" (p. 1). In summary, the current status of child psychotherapy research warrants a continued effort towards establishing effectiveness of treatment. Accordingly, this can be accomplished by means of a focus on two interrelated factors: the critical need to bridge the hiatus between research and clinical practice; and the endorsement of a necessary interest in the question of why or how psychotherapy works.

2.3 Attachment theory and psychotherapy

Taking into consideration the interpersonal context inherent to and characteristic of psychotherapy it stands to reason that the nature of the relationship between therapist and client plays a significant role throughout the process of treatment. Accordingly, the nature of therapeutic relationship can be considered a critical feature that contributes to the effective outcome of treatment, as has been supported by the current literature. A more pivotal concern however, extends to the discernment of the role of the therapeutic relationship, which requires the scrutiny of the innate dynamics characteristic of human relationships in general. Fittingly, the eminence of John Bowlby's theory of attachment stems from a fundamental concern for human development within the context of close relationships and accordingly, remains "one of the prominent theoretical perspectives guiding research on interpersonal relationships and personality development" (von Sydow, 2002, p. 80).

2.3.1 Attachment theory defined

Bowlby's fundamental sphere of study, the 'making and breaking of affectional bonds' gave rise to the principle that a close, constant caregiving relationship is necessary in order for a child to thrive emotionally (Howe, Brandon, Hinings, and Schofield, 1999). Correspondingly, the child's instinctive endeavour to gain physical and psychological proximity to her primary caregiver in the face of emotional distress constitutes the concept of attachment behaviour. Beyond the sense of physical security that the child derives from the presence of her caregiver is the more critical intangible sense of safety that enables the child to explore the environment with little apprehension.

Howe et al. (1999) clarify the advantages of proximity in reference to Ainsworth's association between the systems of attachment and exploration, which asserts that the attachment figure or caregiver is used as a secure base from which to explore. Moreover, Bretherton (1997) emphasises that such exploration embodies that of the child's inner world. In essence, attachment behaviour is elevated under conditions of anxiety or distress, resulting in the suppression of exploratory behaviour. Howe et al.(1999) emphasise that "exploration promotes survival by helping children to learn about and adapt to their psychosocial environment through cognitive development" (p. 16). Accordingly, the child who is consumed by engaging in attachment behaviour is correspondingly encumbered in her discovery about self, others and relationships.

Fundamental to Bowlby's theory of attachment is the notion that "the quality of close relationships has a profound bearing on how the self, others and social interaction are viewed and understood" (Howe et al., 1999, p. 22). Bowlby (1978) delineates this notion according to the establishment of an 'internal working model' which is the central in determining the child's perception of self and others, and which governs the manner in which the social world is understood and confronted. Howe et al. (1999) explicate that "within close relationships young children acquire mental representations, or internal working models, of their own worthiness based on other people's availability and their ability and willingness to provide care and protection" (p. 21). In other words, the nature of the caregiver-child relationship together with its characteristic behaviour patterns is internalised by the child in the form of mentally represented beliefs and expectations. Howe et al. (1999) emphasise that it is on the basis of such beliefs and expectations that children then develop behavioural strategies designed to have their needs met.

The nature of the attachment system is such that it explicably involves a mutually defined organization of interaction, thus requiring a caregiver who is emotionally attuned and responsive to the signalled needs of her child. With the child's innate capacity to relate and inclination to approach, it is the caregiver's corresponding reaction that "will convey significant information about [the child's] worth, emotional state and interpersonal effectiveness" (Howe et al., 1999, p. 24). Too frequently however, the child's goal of attachment is impeded by the caregiver's failure to provide proximity, thus compelling the child to adapt her behaviour. Such behaviour is referred to as a 'defensive

strategy' or 'adaptive response' (see 2.5), and serves the purpose of assisting the child to cope with anxiety or of searching for other ways of gaining proximity. It is this organisation of defensive strategies that gives rise to an attachment pattern, which encompasses the nature of other close relationships. Moreover, it is the quality of the attachment pattern that is representative of the child's internal working model and hence, serves as a primary determinant of the self and the ultimate endurance of personality.

2.3.2 Significance of the therapeutic relationship

In light of the abovementioned overview of the basic principles of attachment theory, the significance of the therapeutic relationship as a focal point of study is apparent. The application of attachment theory to inform psychotherapy research however is innovative, and current literature appears to be restricted to a focus on adults. Farber, Lippert and Nevas (1995), as well as Parish and Eagle (2003) conducted studies examining the ways in which therapist function as attachment figures for their clients. Based on the contention that "using attachment theory to understand psychoanalytic relationships emphasises the unique importance of a therapist to a [client] and can offer new perspectives on therapeutic and attachment processes" (p. 271), their findings suggest that psychotherapy with adults is effective by virtue of the fact that it functions as an attachment relationship.

Central to Bowlby's (1978) theory of attachment is the pivotal role of the earliest relationship between infant and primary caregiver, typically the mother, as it is the very nature of this reciprocally determined relationship that serves as a blueprint for the infant's future relationships. Accordingly, the unique interpersonal context characteristic of the therapeutic relationship provides a condition conducive to the manifestation of the client's fundamental attachment organisation. Pistole (1989) supports this contention with the assertion that an effective therapeutic relationship provides conditions synonymous with the very function of attachment. Specifically, the therapist's capacity for emotional availability, as well as for emotional containment is analogous to the mother who provides an emotional milieu favourable for the development of secure attachment. Moreover, Pistole (1989) emphasises that this renders the therapist an attachment figure, hence affording her "access to the attachment system and the emotional and cognitive components of its working model" (p. 191).

2.3.3 The therapist as an attachment figure

In view of the therapeutic relationship from an attachment perspective, it is imperative to distinguish the therapist as an attachment figure in comparison to the primary attachment figure. D'Elia (2001) delineates this distinction, stating that "as a secondary or supplementary attachment figure, the therapist differs of course from primary attachments in pervasiveness in the life of the [client]" (p. 333). She further upholds that within a comparatively restricted period of time, the therapist is generally influential. Although the working relationship usually comes to an end upon termination of therapy, "the representational model of the relationship may persist… and the therapist can then represent more than a grateful memory of a helping figure, once important for a limited time in one's life" (p. 333)

Farber et al (1995) concede that there are many apparent parallels between attachment relationships during childhood, and the relationship between therapist and client. They additionally uphold however, that "the latter relationship is necessarily mediated by unique temporal, financial, structural, and ethical boundaries that render it significantly different from childhood attachment relationships" (p. 204). Farber et al. (1995) illustrate this contention in emphasising the fundamental feature of the therapist-client relationship. Specifically, the therapist is indeed a collaborator in the dyad who is engaged in the process of the relationship, yet is distinctly less emotionally concerned in comparison to a mother's role in relation to her child, hence rendering the therapist substantially more emotionally removed. Accordingly, the client's discernment of this is likely to restrain her tendency to deem the therapist as a central attachment figure. Farber et al.'s further (1995) mention of other unique boundaries that negotiate the therapeutic relationship likewise comprises the distinctive nature of the 'psychotherapeutic situation'. In other words, it is the nature of the psychotherapeutic situation that inevitably denotes the ways in which the attachment relationship represents itself in therapy.

2.3.4 The therapist as a secure base

Bowlby's (1978) notion of a 'secure base' is central to attachment theory and hence, the development of meaningful relationships. Essentially defined, a 'secure base' denotes a measure of safety characteristic of relationships in general that affords individuals the freedom to relate with assertively and with self-confidence. With specific

reference to psychotherapy, Rappoport (1997) contends that psychological safety is the sole requirement for change. He states that "the degree of safety the [client] feels with the therapist is crucial in determining the effectiveness of psychotherapy" (p. 250).

Waters and Cummings (2000) assert that "to be attached is to use someone preferentially as a secure base from which to explore" (p. 165). Although in the case of psychotherapy the therapist is not in actuality 'chosen' by the client, Jones (1983) stresses that "as attachment theory points out, a child becomes attached to whoever is consistently present caring for him [or her]" (p. 240). In this respect, it is over time and through the establishment of the therapeutic relationship that the client (child) will come to regard the therapist as an attachment figure. More specifically D'Elia (2000) maintains that " a secure base implies occasional expressions of interest and concern as well as an enduring representational model of the therapist as accessible, trustworthy and ready to assist the [client] in exploring painful memories of the past and in reconstructing a self-representational model as worthy of being helped" (p. 333).

Expounding a more elaborate stance on the secure base phenomenon, Jones (1983) draws attention to two features characteristic of all psychotherapies. Specifically stated "the [client] has confidence in the therapist's ability and willingness to help; psychotherapy occurs in a place of healing" (p. 239). In reference to the former, he states that the client's confidence is determined by her perception of the therapist as someone who is sincerely concerned about the client's well-being. Moreover, such concern "does not necessarily imply approval, but rather a determination to persist in trying to help no matter how desperate the [client's] condition or how outrageous [her] behaviour" (p. 239). Jones's (1983) latter feature that he cites illustrates that the therapeutic setting essentially becomes a 'secure base' which by definition, is a sanctuary that shelters the patient from daily life stressors. Accordingly, this affords the client the security, autonomy and openness to articulate emotional expression of affect, and to engage in extensive self-exploration, while doing so removed from her external reality.

2.3.5 Development and attachment theory

Fundamental to the appreciation of attachment theory is the tenet that the need for intimate relationships is critical to survival, and that the manifestation of attachment styles is a continuous progression. Correspondingly, it is during the formative years of

infancy and childhood that patterns of attachment are established, becoming further entrenched with the onset of adolescence and early adulthood. Although this implies that attachment styles can be considered resolute by adulthood, the prospect for positive shifts at this stage of life is certainly possible.

In delineating the development of the 'attachment behavioural system', which Bowlby (1978) suggested commences primarily during the first year of life, four phases of attachment processes are identifiable. As cited in Howe et al. (1999) 'undiscriminating responsiveness' or 'pre-attachment' occurs from birth to two months of age. During this phase, the infant merely displays 'prosocial' behaviour, appearing to become animated by other's efforts to engage with them. At three to six months of age 'discriminating responsiveness' or 'attachment in the making' begins to emerge. Here the infant exhibits increasing curiosity in, and becomes familiar with, the primary caregiver. Accordingly, "interaction between [infant] and [caregiver] is increasingly attuned, the [infant] being able to 'read' the [caregiver's] behaviours and moods better than those of anyone else" (Howe et al., 1999, p. 20).

During a lengthier period of seven months up to three years of age, 'active initiative in proximity and contact' or 'clear-cut attachment' materialises. With a discerning attachment towards one caregiver, the infant or child becomes ever more involved in pursuing and maintaining communication with the caregiver. As the child becomes more mobile, acquires motor control and the later capacity for verbal communication, so this task becomes more accomplished. Moreover, the progressive formation of the internal working model allows for the cognitive depiction of relationships and hence, the ability to adjust behaviour. At this point, "the child becomes increasingly purposeful and deliberate in choosing behaviours designed to bring about a response in the carer" (Howe et al., 1999, p. 20).

From the age of three onwards, the course of attachment endeavours towards a 'goal-directed partnership'. Ideally, the practice of dialogue, sharing and negotiation constitute the goals to which the partnership aspires. With a more intricate awareness of self and other, the child has the benefit of managing and adjusting the caregiver's behaviour, as well as her own.

In reference to the above-mentioned formation of the internal working model, it is at the approximate age of two that the child characteristically begins to make use of her caregiver as a 'secure base'. This can be attributed to a diminished need for physical proximity on account of the child's capacity to gain a 'felt security' via a symbolic representation of her caregiver. As a result, the child's innate need for self-rule and independence begins to emerge, and is fostered by trust in the caregiver's psychological availability.

2.3.6 Theory and practice

Current research regarding attachment and psychotherapy with adults draws considerable interest in terms of challenging unyielding patterns of human relationships, patterns which are complexly intertwined with an enduring sense of self. The implications of the nature of attachment behaviour and its solidification into adulthood render the task of therapeutic intervention for therapist and client alike, arduous. The application of attachment theory to the treatment of adults has explicably emanated from the study of attachment behaviour that is established during early childhood. With childhood constituting the fundamental years during which attachment patterns are moulded, the coinciding of therapeutic intervention at this stage of development draws noteworthy interest. Such interest is further compounded by the current status of child psychotherapy research. Irrefutably, the vital role of psychotherapeutic intervention with children is accentuated by Howe et al. (1999), who state that "when attachment behaviour is activated, the child is unable to engage in other useful development experiences such as exploration, play and dealing with others for reasons other than protection" (p. 16).

2.4 The case under study

The case under study encompasses a retrospective long-term psychotherapy process involving a six-year old child, who will be referred to as Sarah for the purpose of maintaining confidentiality and ensuring anonymity.

2.4.1 Background

In essence Sarah was subjected to an enduring abandonment by her mother at the critical age of twenty-four months, who left her in the care of her maternal grandparents. This was preceded by the divorce of her parents at the age of eighteen months. Up until this age, Sarah was described as a self-assured child, who typically took the initiative in

playing with others. According to her mother, she and Sarah were ‘inseparable’, yet Sarah expressed a willingness to explore her environment while in the presence of her mother. Sarah was then assimilated into the home of her maternal grandparents over an ensuing period of six months before her mother finally relinquished her there. It was during this period that Sarah began to experience transient separations from her mother when required to spend time away from her new home for visits with her father. Apparently, she would verbally express her wish for her mother to accompany her when leaving with her father to spend time with him. These transient separations soon became enduring with the event of her mother’s departure, and despite being compensated for by the nurturance of substitute caregivers, the impact of losing her mother began to manifest. Although her mother would initially visit her on a daily basis, the frequency of these visits gradually became less consistent. As Sarah entered her early childhood years, she adjusted to the acceptance of her grandparents as her primary parental figures, and their home environment became hers.

Essentially, the loss of her mother gave rise to a marked diminishment in assertiveness and an associated emergence of dependency needs within Sarah. This regression was further exacerbated by her grandparents’ own need to compensate for Sarah’s loss. In effect, her sense of devastation was cushioned by material incentives and contained by her grandfather’s unquestionable tolerance on the one hand, and her grandmother’s constant restriction on the other. The inevitable transition to pre-school at the age of five elicited notable defiance within Sarah. For the first six months, she protested by crying incessantly and refusing to be separated from her grandmother. This tumultuous period was then further exacerbated by the return of her mother with the intent to reclaim her daughter and assimilate her into a new family, comprised of a stepfather to Sarah and an anticipated new sibling. Consequently, Sarah’s underlying anger over her mother’s primary rejection of her materialized, leaving her in the predicament of regaining her mother which was contingent upon losing her substitute primary caregivers.

2.4.2 Clinical presentation

Accordingly, Sarah displayed a clinical presentation indicative of a lack of an established and positive sense of self. This manifested through apparent anxiety over the

exploration of her environment, as evident through a notably shy and withdrawn demeanour with a tendency to cling to primary and subordinate caregivers when in the presence of strangers. Further, her presentation of oppositional and defiant behaviour, together with an inability to regulate and direct her emotions was predominant. Specifically, she displayed an obstinate temperament with a determination to dominate and control others, as well as to ignore authority with blatant defiance. The latter in particular, was exhibited through Sarah's inclination to recede into a world of her own by means of a refusal to hear the instructions of others. Alternatively, she would resort to incensed temper-tantrums with only the promise of material rewards presenting as a possible means of placating her.

2.5 Styles / patterns of attachment

Before providing a further illustration of the case under study from a comprehensive attachment perspective, it is necessary to expand upon our definition of attachment styles or patterns. As previously mentioned, it is the quality of an attachment pattern that represents the child's working model and hence, her sense of self and mode of relating to the world and significant others in her life. Substantiating this assertion Meyer and Pilkonis (2001), state that "attachment styles are formed in response to real-life experiences with caregivers and other people, and they reflect mental representations of others, of oneself in relation to others, and of relationships in general" (p. 466).

In support of Bowlby, Ainsworth contributed to the clarification and illumination of individual differences in the attachment of infants to caregivers. Rather than focusing on the degree to which individual attachments differ, Ainsworth adopted a viewpoint pertaining to categorical differences (Barnett and Vondra, 1999). More specifically Ainsworth classified three distinctive styles or patterns understood to "reflect infants' coping responses to their caregivers' interactive styles" (Barnet and Vondra, 1999, p.2). This classification resulted from Ainsworth's implementation of the 'strange situation' experiment designed to assess the quality of mother-infant relationships. Categorised into Types A, B and C, Ainsworth identified 'insecure avoidant', 'secure' and 'insecure resistant/ambivalent' attachments respectively. It is important however to regard Ainsworth's categories in terms of a continuum, as opposed to demarcated categories, upon which to determine patterns of attachment.

According to Howe et al. (1999) all types of attachment patterns including those that are secure, "represent efforts by children to organise their behaviour to achieve some kind of proximity and with it, a felt security" (p.26). In light of the notion that the attachment system involves a mutually defined organization of interaction, it stands to reason that the degree to which a child is compelled to adapt her behaviour through the use of defensive strategies reflects the extent to which the caregiver is out of synchrony with her.

2.5.1 Secure attachment (type B)

In reference to the notion of secure attachment, Bowlby avowed "that to grow up mentally healthy the infant and young child should experience a warm, intimate and continuous relationship with [her caregiver]… in which both find satisfaction and enjoyment" (Bretherton, 1997, p. 34). The significant focus of attachment theory on mental health is further mentioned in Bretherton (1990), who supports the notion of complementary working models ensuing from a loving caregiver-child relationship. Specifically, Bretherton (1990) states that in this case "the working model of the loving [caregiver] is likely to be complemented by a working model of self as worthy of support and love" (p. 240).

Howe et al. (1999) confirm that the individual who holds a perception of self as loved, valued, self-sufficient and competent, and who perceives others as available, accommodating and reliable, benefits from a secure attachment style. Essentially, this denotes the representational model of an attachment figure that is consistently available and responsive to the individual's needs. More to the point, loving and supportive relationships engender experiences that promote healthy development, affording the individual with a perception of self "as secure and autonomous, but willing to accept help" (Howe et al., 1999, p. 10).

An alternative term for the idea of a supportive relationship as mentioned above is Bowlby's concept of 'maternal sensitivity'. An avid supporter of this concept, Ainsworth regarded such concern as the caregiver's unmitigated "ability and willingness to try to understand behaviours and emotions from [the infant's] point of view" (Howe et al., (1999, p. 19). Consequently, both caregiver and infant become increasingly in tune with

one another and the synchronization of the relationship allows for discovery of needs and affect regulation.

Explicably, it is the pivotal pursuit of exploration that further facilitates self-discovery. With the psychological and physical presence of a secure base, the infant or child is furnished with the freedom to explore her surroundings with confidence. This denotes a compatibility of attachment and exploration, which Bowlby regarded as 'co-evolved behavioural systems' (Howe et al., 1999). Accordingly, the securely attached child is not to be regarded as 'dependent' but rather, as progressing towards the optimal development of independence without having to relinquish the interminable, innate need for intimacy.

2.5.2 Insecure: avoidant attachment (type A)

According to Barnett and Vondra (1999), Ainsworth characterised this attachment style in terms of "a paucity of positive, affectively engaged interaction with and interest in … attachment figures" (p. 10). Further defined by Howe et al. (1999), such an individual typically experiences anxiety when overcome by intense emotions, as well as when such emotions are expressed by others. Consequently, the individual considers the accessibility of close relationships with apprehension and caution. Moreover, emotional and physical proximity are perceived with uncertainty in spite of an inherent need for such intimacy. Justifiably, a sense of safety "is achieved by an overreliance[sic] on the self and an underreliance[sic] on other people" (Howe et al., 1999 p. 61).

More simply stated, children instinctively articulate their emotions in order to elicit responses from their caregivers designed to meet fundamental needs. This, in turn, affords the child with a sense of control. Correspondingly, the avoidant child characteristically feels powerless under the restrain of the caregiver and therefore manages such vulnerability by inhibiting her emotions. Such adaptation represents the child's effort "to cope by 'shutting down'… [in an] attempt to regulate emotion by ignoring it or denying it" (Howe et al. 1999, p. 64). In addition to behavioural compliance, the child reinforces her display of detachment and autonomy through initiation of exploration of the environment with the presence of a secure base being irrelevant. Explicably, this defensive strategy or 'adaptive response' gives rise to

disadvantageous consequences that may impede the child's emotional, social and cognitive development.

As highlighted in Howe et al. (1999) the avoidant child is disengaged "from the world of feeling and close relationships" (p. 64) and does not benefit from the experience of emotional expression as a tool to direct behaviour and manage close relationships. Furthermore, the child who employs the defensive strategy of emotional restraint essentially fails to express access or acknowledge innate feelings. This in turn prevents her from applying the awareness contained within affect that facilitates the management of social behaviour in the context of relationships. Howe et al. (1999) uphold that "avoidant children have therefore learned (cognitively) how to avoid hostile rejection but not how to elicit warm, accepting caregiving" (p. 64). In this manner, they are governed by cognitive processes as opposed to emotional intuition as a means of making sense of social situations. As a result, it is explicable that where the child grasps a substantially limited proficiency for the assimilation of emotional and cognitive processes, a contrastingly advanced aptitude for cognitive development is apparent. As mentioned above, her penchant for initiating exploration further heightens the capacity for cognitive over emotional processes.

In the absence of warm, responsive and permissive caregiving, the child learns that relationships are unreliable and is therefore compelled to turn elsewhere for securing a positive self-perception. Respectively, the child turns to objects and concrete activities, which do not pose any threat to the availability of the caregiver. Moreover, proficiency in this domain affords her with a degree of self-worth, internal control and positive regard. Overwhelmed by anxiety with regard to relationships, she favours conversing over objects and things, hence creating a comfortable degree of distance from others.

2.5.3 Insecure: ambivalent attachment (type B)

Central to this style of attachment is the presence of conflict within the child over the need to maintain proximity towards the caregiver, versus the need for autonomy and independence. Such conflict can be understood to reflect a 'love-hate' relationship, whereby the child clings to her caregiver out of separation anxiety and at the same time, exhibits underlying anger over exploration being hindered. More adequately, Howe et al. (1999) portray the ambivalent child as one who "seek[s] proximity but doubt[s] and

resist[s] comfort [displaying] a mixture of approach and resistant behaviours that include distress and aggression, need and rejection, clinging and fighting" (p.91). They clarify this by stating that the child's apprehension over exploring and accentuating autonomous behaviour stems from the fear of losing the accessibility of close relationships. They further emphasise that such an attachment style emanates from an inconsistently available caregiver, hence "convey[ing] the message that the child cannot take [the caregiver's] emotional availability for granted" (p. 92).

The sense of ambivalence and uncertainty manifested within the child gives rise to "deep anxieties about the lovability and value of the self, and a troubled preoccupation with whether or not people have sufficient interest in [the child] to be emotionally available in times of need" (Howe et al., 1999, p. 87). In this way, the caregiver's inclination to disregard the child's needs at times further exacerbates anxiety and gives rise to heightened attachment behaviour. This inevitably brings her within close physical proximity of the caregiver, obviously compensating for the lack of emotional proximity, hence penetrating the caregiver's lack of concern. As opposed to the avoidant child who is overly self-reliant, the ambivalent child is drawn to enmeshed relationships as means of achieving a derivative 'felt security'. In short, anxiety vis-à-vis the caregiver's lack of availability in times of need "is reduced by the child organising a defensive strategy that increases or hyperactivates their attachment behaviour" (Howe et al. 1999).

The caregiver's failure to respond with consistency in times of distress ultimately compromises the child's capacity for emotional regulation. Consequently, the ambivalent child's behaviour is governed by emotional states that are experienced as unmanageable and therefore leave her feeling vulnerable and needy. Pertinent to an ambivalent attachment style, the caregiver's inconsistent availability renders it impossible for the child to predict their (the caregiver's) responses based on cognitive processes. Explicably, this engenders an excess of emotionally driven behaviour, with "little energy left over for constructive play, task accomplishment, curiosity and exploration of the environment, either physically, emotionally or intellectually" (Howe et al, 1999, p. 91).

Howe et al. (1999) further emphasise that the lack of differentiation between the experience of self as needy versus angry inevitably promotes an "experience of the self as not of sufficient interest or worth to command automatic love and care" (p. 90).

Accordingly, the ambivalent child requires the physical presence and attention of the caregiver for affirmation. As a result, the absence of the caregiver amplifies ever-present feelings of uncertainty, incompetence and worthlessness. In addition, the strategy of initiating attachment behaviour with no audience is rendered futile and consequently, the child is left feeling not only anxious and insecure but also with a predominant sense of emptiness.

2.6 Sarah: avoidance and ambivalence

Ainsworth, Blehar, Waters and Wall (1978) highlight Mary Ainsworth's identification of avoidant and ambivalent attachment styles as the two subtypes of insecure attachment, the former manifesting in anger and the latter, in seeking and rejecting behaviour. It is the combination of these subtypes that illustrate Sarah's clinical presentation of problematic behaviour and hence, her template for attachment relationships. Levy and Orlans (2000) further delineate insecure attachment in terms of disordered attachment that impinges on various aspects of a child's functioning. They categorize such aspects as follows: behaviour, emotions, thoughts, relationships, physical, and moral/spiritual. Correspondingly, Sarah's presentation in terms of this categorization attests to the organization of an avoidant/ambivalent attachment pattern. This is further substantiated by Howe et al. (1999), who maintain that "children who show insecure avoidant and ambivalent attachment patterns have learned that there are 'conditions' attached to their gaining proximity to their caregiver" (p. 27). Howe et al. iterate that such children therefore adopt associated strategies that serve to enhance the caregiver's emotional availability as well as to engender care and security in spite of enduring feelings of anxiety and insecurity associated with the caregiver. Correspondingly, it can be conceptualised that by virtue of Sarah's ability to adapt her behaviour to that of defiance, she was able to gain proximity and connectedness when necessary.

This perceptible illustration of a child wrought by deep-rooted insecurity was nevertheless veiled by a defensive veneer of indifference, suggesting a detached attitude towards relationships. D'Elia (2001) bears reference to the notion of an 'affectless character': correspondingly, Sarah was avoidant, controlling and demanding in her approach to the therapist. Such an attachment style according to D'Elia (2001), suggests an individual who associates intimacy with pain and rejection and thus "…strive[s] to be

emotionally self-contained and insulated against intimate contacts" (p. 334). Sarah's presentation manifested itself clearly upon her entry into psychotherapy, persisting somewhat before discernible behavioural changes transpired. Associated with this development, the surfacing of emotional articulation as well as Sarah's cognitive convictions facilitated the progression from a stance of disengagement and indifference to an apparent attachment towards the therapist.

Levy and Orlans (2000) define attachment as "the deep and long-lasting emotional connection established between the child and caregiver in the first several years of life [and which] profoundly influences every component of the human condition – mind, body, emotions, relationships and values" (p.6). Further, they maintain that beyond the basic function of secure attachment, that is, the provision of safety and protection by means of proximity, several developmental functions are pertinent. Among these, establishing a foundation for the formation of identity, the capacity for emotional self-regulation, and the ability to create and maintain emotionally reciprocal relationships are of particular significance regarding the case under study. It is within the context of the ensuing development of an attachment relationship between Sarah and the therapist that the case material serves to highlight the significance of the abovementioned functions. Over the course of therapy, the nature of Sarah's attachment style shifted to one of warmth, trust and compliance. Accordingly, it is such a shift that can be rendered indicative of therapeutic change, and which warrants further illumination in contributing towards the nature of effectiveness in psychotherapy with children.

CHAPTER THREE
CASE NARRATIVE

3.1 Introduction

This chapter presents a case narrative, the description of which is phenomenological in nature. The narrative will not be interpreted through the literature at this stage but rather, will be delineated by the three fundamental phases of the therapeutic process, namely the initial, intermediate and termination phases. From a retrospective view of the case under study and the process in its entirety, the narrative will be framed according to the research objective of illuminating the therapeutic process from an attachment theory perspective, with a particular focus upon specified characteristics pertinent to attachment theory and the formation of close relationships. Accordingly, each phase of therapy will be structured according to a focus on the three research aims successively: an existing foundation for identity formation; the capacity for emotional self-regulation; and the capacity to create and maintain emotionally reciprocal relationships.

This comprehensive illustration of the therapeutic process will be preceded and contextualised by a detailed case history of the participant. In addition, the therapeutic process will be introduced by an overview of the abovementioned research aims, as well as by my initial impressions of the participant derived from my initial encounter with her during the intake interview.

The case selected for this research study involves a six-year-old little girl named Sarah. My initial motivation for selecting this case originated from a merely intuitive incentive in reflecting upon my experience of this child on the whole. More specifically, I was struck by the degree to which I had struggled to develop an affection for Sarah. My initial impression of her being that of a rather over-indulged and ungrateful child, sustained over a lengthy period of time before I began to warm up to her. This indisputably came with increasing acumen into the nature of Sarah and moreover, revealed a propensity within her deemed worthy of further elucidation. Essentially, my overall experience of therapy with Sarah presented unanticipated challenges and by the same token, invaluable rewards. In coming to know this special individual, her impact

upon me as a therapist will endure, and it is my hope that the narrative to follow will convey this at least sufficiently.

3.2 Case History

The sources of this history are: Sarah Johnson; her mother, Kate Greyling; and Sarah's maternal grandmother, Rachel Gordon. These names are pseudonyms and have been used for the purpose of maintaining confidentiality and ensuring anonymity.

3.2.1 Personal history

Sarah was conceived legitimately and after a healthy pregnancy was born in 1997. Shortly after her birth, it was discovered that she was suffering from jaundice, which resulted in her having to be separated from her mother and hospitalised for a period of one week. Thereafter, Sarah and her mother reportedly bonded well and were 'inseparable'. Sarah was eighteen months old when her parents decided to divorce. Apparently, her parents would argue constantly, and her father is reported to have been verbally abusive. Consequently, Sarah and her mother moved in with her maternal grandparents. Six months later Sarah's mother moved out, leaving Sarah with her grandparents yet visiting her on a daily basis. Kate Greyling reported that up until this point, Sarah would typically take the initiative in playing with others in that she would approach them without hesitation and engage freely. Subsequent to leaving Sarah in the sole care of her grandparents however, she started becoming withdrawn and 'clingy' towards her mother and grandmother. While in the care of her grandparents, Sarah's mother would visit her daily, whereas Sarah seldom saw her father. Sarah was three years old when her mother met Andrew, who she subsequently became intimately involved with. She however continued to live with her grandparents while receiving visits from her mother less frequently. Further, she was habitually excluded from her mother and Andrew's social activities.

At the age of five, Sarah's grandparents decided to send her to pre-school. According to Rachel Gordon, this transition engendered notable behavioural changes within Sarah. She was highly resistant towards attending preschool and for several months, would cry out of protest against being separated from her grandmother. She would also refuse to play at other children's houses. It was also several months into Sarah's first year at preschool that her mother and Andrew married, with the revelation

that Kate was pregnant. Coinciding with this, Kate decided that the time had come for Sarah to begin spending more time with her and Andrew, as it was Andrew's wish that they start to become a cohesive family unit. Essentially, this entailed Sarah spending one night a week overnight with Kate and Andrew. Within six months, Sarah was spending six nights a week with Kate and Andrew, and one with her grandparents.

3.2.2 Reason for referral

Sarah was referred for therapy by her mother and maternal grandmother due to her recent display of behavioural problems, including crying, screaming and temper-tantrums. At the time of referral, Sarah was preparing to start Grade 1 and they were therefore concerned about her ability to cope emotionally with this transition. Further, her mother had recently remarried and was expecting her second child within the ensuing month. Accordingly, Sarah had expressed concern over having a different surname from that of her mother and expected sibling.

3.2.3 Presenting problem

According to Kate, Sarah was defiant, believed that she was not loved by her parents, and at times, expressed the wish that she were 'dead'. This occurred particularly after returning home from visiting her grandparents, who Kate believed would 'spoil' her. Kate further reported that Sarah would become angry when she was not indulged and was typically 'clingy' towards her mother when in the presence of strangers.

Rachel reported that Sarah's behaviour was 'fine' until the approximate age of five when she began to behave rebelliously. Rachel admitted that she and Sarah's grandfather had always 'spoilt' her with material rewards and by allowing her to 'have her own way'. She said however that with Sarah becoming increasingly defiant, they had had to resort to smacking her or sending her to the bathroom as a means of punishment. According to Rachel, Sarah's rebellious behaviour typically occurred upon her return from visiting her father. More specifically, she would return in a 'cross' mood and be 'cheeky' towards her grandparents. She stated however, that over the past six months, Sarah had had no contact with her father. Rachel further reported that Sarah was contrastingly well behaved with her grandparents and that this was fairly consistent. She added though that Sarah appeared somewhat withdrawn in social situations. Rachel maintained that when Sarah encountered dominating peers she would typically 'fight back'. At other times, she

played well with others and occasionally appeared to be playing with an 'imaginary' friend.

Rachel attributed Sarah's behavioural changes to the change in her familial situation. She was of the opinion that Sarah did not like Andrew, who Rachel described as 'strict' and a 'perfectionist' and further reported that Sarah had told her that she 'does not want to be a Greyling' (Andrew's surname). She added that Sarah would typically question why she could not spend more time with her grandparents and that she regarded their home as her home.

3.3 Therapeutic Process

3.3.1 Introduction

As mentioned in the previous chapter, certain developmental functions are pertinent to the development of a secure attachment style. Accordingly, it is obvious that any degree of debility in such areas of functioning denotes a contrastingly insecure style of attachment. In order to grasp a sound understanding of these functions, which essentially constitute the research goals of this study, further elaboration is necessary.

The principle of an 'existing foundation for identity formation' pertains to the child's current sense of self, which is in accordance with her attachment style or more specifically, her internal working model. Correspondingly, an insecure attachment style is indicative of a negative internal working model and hence, a diminished perception of self-worth, a lack of a sense of self-competency and a discrepancy between autonomy and dependence. With a lack of confidence, the insecure child struggles with differentiation between self and other, displaying difficulty in discerning discrete boundaries.

Insecurity explicably endorses an over-reliance on others that is, the external, as opposed to internalised self-confidence. Encompassed within such dependence, lies the lack of ability to assuage distressing emotions. This is manifested through a surge of uncontainable emotional upheaval or, a contrasting concealment of intolerable emotions by means of repression and denial. Fundamentally, the caregiver who is ineffective in alleviating her child's distress fails to provide the degree of attunement required for self-regulation of emotions. In effect, the caregiver mirrors an inability to tolerate

unmanageable feelings, thus disabling the child in the development of affective tools and skills.

Further characteristic of an insecure attachment style is the compromised capacity to create and maintain emotionally reciprocal relationships. Primarily, this constitutes a lack of empathy and altruism thus, impeding the development of prosocial behaviour. Explicably, the lack of effective mirroring prevents the child from developing the capacity to perceive reality from the perspective of others. Primarily egocentric, the child lacks the capacity to identify with others and, filled with scepticism, regards others with mistrust. In essence, the child who has not been taught to effectively identify and process her own emotions cannot justifiably be expected to understand others with due compassion and insight.

3.3.2 Intake interview: initial impressions

My first encounter with Sarah left me with the impression of a rather vulnerable child as evident through her demeanour as well as her physical appearance. She arrived at the Intern House, closely clutching the hand of her heavily pregnant mother and, rather timidly, hovered slightly behind her mother as if to shield herself from any potential threat. Reluctant to separate from her mother, Sarah continued to cling to her as they sat down together, casting her eyes towards me several times without uttering a word. She refrained from exhibiting any inclination to explore her environment, and initially declined my invitation for her to draw by means of shaking her head. In a sense, it seemed as if she had set aside my invitation in favour of sussing me out.

Sarah further presented as an apprehensive six-year-old little girl of average height and below average weight. She was a quite petite as well as an attractive child. Her face was gaunt and her physique appeared delicate and under-nourished (this observation was contrary to the fact that Sarah came from a familial background of average socio-economic status). Moreover, Sarah displayed a somewhat frosty demeanour coupled with an intimation of sullenness. She smiled at times, yet such expression was transient and superficial, with the lack of an emotive core. Even so, I was left feeling unconvinced by her detached disposition, as she seemed to betray a distinct air of sadness which indeed suggested the presence of an emotive core concealed beneath a feigned veneer of indifference.

3.3.3 Initial phase of therapy (sessions 1-13)

a) Existing foundation for identity formation

Consistent with my first encounter with Sarah during the intake interview was a degree of separation anxiety as she arrived for her first therapy session with her mother, to whom she clung tightly. Although noticeably shy and reluctant to leave her mother, Sarah promptly agreed to accompany me to the playroom, smiling. She appeared somewhat apprehensive and anxious, exploring her new environment thoroughly yet exhibiting marked anxiety over making a mess. In response to my comment that she seemed concerned about this, and that it was alright to make a mess, Sarah appeared more at ease and continued to explore more freely.

Reluctant to end our first session together Sarah exclaimed, "We're not finished yet!" and insisted upon drawing a picture on the blackboard. She drew a picture of a girl with blonde hair and without any arms. She also informed me that next time we meet she expected to see her drawing still there. Sarah was of course quite upset the following week upon discovering that her drawing had been erased. Again, she drew a picture of the same girl but this time with arms. She also referred to the drawing as "a picture of herself" and said that she was going to make it "so big that no-one can rub it off". Through this second illustration, Sarah 'introduced' herself to me and in doing so, conveyed her despondency. Once again, this activity was carried out at the end of the session and like the previous session, Sarah was reluctant to end. This time however, she blatantly ignored my reminder that our time was up, adding further detail to her drawing as if she simply had not heard me.

Sarah's need to ascertain a sense of identity materialized from the very first session through the ritual of removing our shoes once we had entered the playroom. This practice was initiated by Sarah with the firm request for me to do the same, evidently affording her the opportunity to wear my shoes, especially when assuming the role of 'teacher'. She introduced this game, instructing me to sit at the table while she took her place at the blackboard. I construed Sarah's assumption of this role as indicative of the need for her to be taught and 'shown the way'. More explicitly, as the 'teacher' she was able to compensate for a perceived lack of competence and control. The ritual of wearing my shoes continued throughout the therapeutic process and incidentally, she

arrived one day wearing new pair of shoes declaring, “look, I’ve got boots just like yours!”.

Sarah’s precarious self-perception and her corresponding need to establish a firm identity further manifested through a lack of self-differentiation, exhibiting a virtual yearning to feed off the fruits of my output. Moreover, she exhibited marked and pervasive discontent directed towards herself with a tendency to disparage her creative efforts vocally, together with an internalised tone of criticism and austerity. Sarah accomplished this by including me in her activities to the extent that I was required to replicate her handiwork. From the outset, she displayed a keen interest in drawing in particular, which endured throughout the therapeutic process. This activity soon ensued to the point where she would ask to trace my drawings as she was dissatisfied with the quality of her own, often declaring that her drawing was “ugly” or that mine was “nicer” than hers. Sarah later adopted the routine of requiring that we exchange drawings and label them with our first names accordingly, indicative of a desire to take ownership of my capability. This routine additionally required that she take ‘her’ drawing home while giving her original drawing to me.

In criticising her drawings while using a direct comparison to mine, Sarah revealed a tendency to measure her worth according to the performance of others. She would voice repeated references to ‘others’, typically expressing her irritation towards the obvious fact that other children also used the playroom. She would walk into the playroom, immediately scan the room and complain, “look what they *did*!” (in reference to the poorly cleaned blackboard) or “*someone* re-arranged the furniture!” (in the doll’s house). On one occasion, she openly expressed her intent to even the score through an attempt to defile the playroom walls with a wet duster, stating “I have a plan… *that* will teach them!”. On another occasion, she actually asked me directly if I would disclose the names of the other children that used the playroom. This request was repeated with persistence several times before Sarah finally accepted defeat.

The first feedback meeting took place after our eighth session and included Sarah, her mother and her grandmother. Sarah responded to the idea of feedback meetings positively, opting with great enthusiasm to attend. This first meeting was highly significant and shed considerable light upon a primary concern voiced by Sarah’s mother

and grandmother with regard to: Sarah's problematic behaviour; and her inherent longing to establish a sense of self, complicated by understandable confusion at that point in her life. Specifically, it had been reported that Sarah displayed a tendency to ignore instructions, such as tidying her bedroom, to the that it appeared as though she had simply 'not heard' her mother or grandmother. Of further concern was Sarah's expressed desire to become a 'Greyling' and her associated stated experience of herself as an 'outsider'.

During the meeting, Sarah sat positioned between her mother and grandmother with both adults having opted to sit on either side of her. Shortly after we sat down, a substantial degree of animosity between the two adults began to surface. Accordingly, both adults became increasingly argumentative over the topic of Sarah spending less time with her grandparents relative to recent past practice. This gave rise to audible shouting from both parties. In the midst of this chaos, I noticed that Sarah had begun to cry softly and proceeded to cover her ears with her hands while shaking her head at the same time. At this point I called 'time out' and asked Sarah if she would prefer to leave the room. She opted to do so with apparent relief, and was left under the supervision of another therapist.

I took this opportunity to direct both adults' attention to what had just taken place, with an emphasis on what had transpired within Sarah while they argued so intensely. This was indeed an appropriate course of action as both adults awkwardly admitted that they had failed to notice Sarah's reaction in the midst of their altercation. Explicitly, I remarked that Sarah seemed to 'disappear' and was 'forgotten about', as if they had both simply thrust her aside. Ultimately, their dispute had appeared to take on a life of its own, leading them to 'lose sight' of Sarah and her best interests. I thereafter invited Sarah to join us once again and, before doing so, she led me to the other therapist's office. There, I observed a considerable mess that she had created and apparently refused to clean up. More significantly however, Sarah showed me what she had written on the black board: "Look here, Sarah Johnson Greyling". We subsequently returned to my office and having reached the conclusion of the meeting, Sarah promptly drew me a picture of a blonde girl identical to that of the one drawn previously on the blackboard, although in this drawing the girl was smiling.

The incident of the eventful feedback meeting indeed inspired a noteworthy shift as evinced during our ensuing session. This shift constituted a marked change in Sarah's attitude towards me, as well as the display of increasing autonomy in an endeavour to claim a firm sense of identity. Specifically, she was more gentle in her approach towards me and her tone of voice in conversing with me was far more pleasant than initially. Further, the usual activity of drawing (in this case using paint) became more one-sided and subjective, at first instructing me, yet soon after allowing the activity to become hers alone. While engaged in this activity, the paint began to drip down her picture (as it was not thick enough) thereby altering the nature of her drawing. Sarah responded to this with intrigue, responding "wow" in awe of what was materialising. At this point I commented that she was "allowing the paint to do what it wanted to do", to which she responded, "Just like I can do what I want when I come here". I found myself quite amazed by this statement as I perceived it to reveal an insightful awareness within Sarah pertinent to the fundamental purpose and nature of the therapeutic process. Of further value, Sarah embraced this activity with noteworthy enthusiasm, declaring with animation and delight "I am an artist!".

As Sarah became increasingly familiar with the therapeutic milieu, so her independence was reinforced and her resolve continued to surface. She arrived one day to inform me that from that session onwards she would prefer it if I receive her in the playroom. This afforded her the opportunity to 'make an entrance', which was naturally conducive to her habitual role of 'teacher'. Moreover, it required her grandmother to proceed directly to the waiting room, thus allowing Sarah to arrive independently and so precluding her grandmother's relentless inclination to intrude. Prior to this, Sarah would typically combat her grandmother's intrusive attempts to converse with me about her by gently shoving her grandmother into her chair and leading me to the playroom, hand in hand. Henceforth, it became custom for me to await (with the door slightly ajar as per her instruction) Sarah's ever-punctual arrival in the playroom, now confidently bringing herself to therapy each week. In contemplation over my sentiments, observations and experience thus far, I noted:

> This child knows why she is here and what she is doing. She has a sound intuitive grasp of the function/meaning of therapy. From the outset, she instinctively granted me access to her world by leading me, commanding

me, and directly positioning me in her shoes while, at the same time, revealing the need for me to direct her (wanting to literally walk in my shoes).

b) Capacity for emotional self-regulation

On the surface, Sarah came across as an emotionally inhibited child with subtle indications of underlying anxiety, anger and sadness. With regard to emotional expression, it was clear that according to her mother and grandmother's reports of her behavioural problems, such acting out served as ploys to gain attention and indicative of an inability to channel her emotions in a constructive manner. What was more apparent to me however, was the extent to which Sarah made use of emotional detachment as a defensive strategy. As a result, my overall impression of her was that of a child who oscillated between suppressing her feelings and impetuously venting them at times. Further, it seemed as if she would tend towards the former when in my presence, while being more inclined to act out when with her caregivers.

In further reference to Sarah's evident degree of emotional detachment, it is necessary at this point to elaborate further upon my experience of her. Sarah struck me as a rather aloof child, almost as if enclosed and shielded by an impenetrable layer of ice. This made it considerably difficult for me to establish a connection with her, rendering the prospect of her opening up to me, dubious. She impressed as quite bitter, yet her eyes portrayed a faint intimation of sadness and it was this that convinced me of her innate capacity for warmth beneath her frosty demeanour. In truth, I found it extremely difficult to develop a fondness for Sarah and when I discovered myself starting to like her more and more, I was alerted to the gradual emergence of a child who hungered for affection, unconditional love and acceptance.

The first indication of Sarah's anger was expressed during our second session in response to her discovery that her drawing on the blackboard from the previous session had been erased. Her anger escalated significantly during our third session after I informed her that due to an unforeseen commitment, I would not be able to see her the following week. Sarah was painting at the time and instinctively responded by jabbing the paintbrush with force, while at the same time inquiring as to exactly why it was that I would be away, while destroying her painting in the process. I explained to her that my impending absence was due to a work related commitment, to which she responded

angrily “but *this* is your work!”. As Sarah’s anger intensified she became more destructive, attempting to splatter paint all over the walls of the playroom. This required me to convey to her that “the walls are not for painting on”, a limitation which she then accepted without dispute.

On several occasions Sarah would further express her feelings of irritation and frustration towards “the other children who use the playroom”, such as criticising the poorly cleaned blackboard and thus attempting to sabotage the playroom with a wet duster stating “I have a plan… that will teach them!”. At other times Sarah would criticise the condition of the toys and more progressively, began to direct these feelings towards herself.

In accordance with Sarah’s inherent and legitimate need to express suppressed feelings of anger and frustration, as well as the need to be in control, she fittingly introduced the game of “teacher and child”, naturally reserving the role of “teacher” for herself. In effect, she crafted a means of channelling emotions perceived by her as unacceptable, in a socially acceptable manner. She would typically become the strict, unsympathetic and critical teacher who was demanding and controlling. In addition to facilitating the expression of underlying suppressed emotions, it is also likely that Sarah was illustrating her own experience of school by subjecting me to an analogous understanding. Overall, these repeated experiences left me feeling inferior, devalued and incompetent, feelings that were undoubtedly familiar to Sarah.

On one occasion, Sarah arrived at therapy extremely angry to the extent that she was somewhat enraged. Her mood unsurprisingly surfaced directly after having informed me that her new sibling had arrived, and that she now had a new sister as opposed to a previously anticipated brother. Respectively, she was especially harsh towards me throughout the session to a point that at one time, I felt as if she was essentially attempting to annihilate me. She further expressed extreme irritation and dissatisfaction towards the condition of the toys, and at times directed her anger inwards through articulating dissatisfaction over the quality of a self-portrait. By the end of the session, her anger had subsided marginally, with feelings of frustration and irritation still quite apparent.

Sarah's ensuing change in her attitude towards me gradually led to an indirect expression of her feelings towards me. On one occasion in particular, her mother phoned me prior to our session to inform me that Sarah would not be coming to therapy that day as there was no one to accompany her. I suggested that she ask Sarah if she would still like to attend the session without anyone to sit in the waiting room for the duration of the session. Sarah decided that she would be quite at ease with this arrangement and attended therapy independently and of her own accord that day. She arrived with a gift for me in the form of an envelope containing fifteen cents as well as a drawing of the two of us smiling. During the course of the session, Sarah offered a more explicit disclosure of her feelings via a letter. First, she constructed a basket out of paper which she stated was for me. She then proceeded to scribble furiously on the inside of the basket while at the same time saying "look, nothing, NOTHING!" in an angry tone of voice. Her anger subsided somewhat as she wrote the word "LOVE" on the bottom outer side of the basket. She then decided to write a letter to put into the basket. Having sealed the letter, she then placed it in the basket and instructed, "Read it in front of me!". On the outside of the letter she had written "Melody crap" and she giggled as I read this out aloud. Inside, the letter read "Dear Melody, I love you, 8 9 10, here I come". Sarah smiled as I read the letter out aloud and thereafter instructed me not to show it to anyone. Her explicit expression of her anger prior to giving me the letter surfaced rather abruptly, yet with a certain degree of restraint. This appeared to facilitate her in taking charge of her emotions, thereby enabling her to express herself directly and channel her anger in a constructive manner. Having vented her frustration, she appeared observably relieved, leaving her appropriately buoyant in her contrasting expression of delight.

c) Capacity to create and maintain emotionally reciprocal relationships

My initial sentiment that therapy with Sarah would prove to be somewhat challenging was substantiated by evidence of poor relational functioning within her family. More importantly, Sarah impressed as self-absorbed, lacking in empathy and emotionally detached. For some time, she treated me as inconsequential and as if I simply was not there. She was blatantly uncooperative, appeared to ignore my comments and reminders that our time was up at the end of sessions and behaved with a lack of conscience. In particular, she took the initiative in helping me tidy the playroom at the

end of our first session together. After hearing of my unanticipated absence following our fourth session, she made a point of informing me that she would not be helping me tidy up, and took apparent pleasure in stating "you will have to tidy up on your own". In addition, Sarah displayed a lack of concern for my feelings, constantly criticizing and shouting at me, and came across as quite nasty at times when reprimanding me. For the most part, I felt manipulated and used like a mere object, especially when engaged in the "teacher-child" game. This was blatantly obvious through an incident where Sarah turned to me and declared, "I am the boss of you and you have to do what I tell you!".

Subsequent to the abovementioned feedback meeting however, I began to feel more present during the sessions and although she continued to instruct me and criticise me at times, her approach towards me became increasingly amicable, and her tone of voice more temperate. She further exhibited a diminished need to control me and appeared more open towards mutual interaction. Unexpectedly, Sarah decided to join me one day at the table where I would habitually complete the tasks assigned to me, as opposed to standing at the blackboard with her back towards me. She also shifted from giving me instructions to carry out once she had illustrated the task, to requiring that I follow her lead, thus completing the task simultaneously. Moreover, she no longer ignored me, with an increasing inclination to acknowledge my comments verbally as evident through her facial expression. In effect, this marked the establishment of a distinctive connection between us, leading the way for a greater degree of intermittent and shared dialogue from this point onwards. In addition she began to help me tidy the playroom of her own accord and this became a regular practice.

One week following the incident of her mother and grandmother's hostile argument during the feedback meeting, Sarah conveyed for the very first time an indication of her need to receive love and affection from me. She arrived at therapy and immediately showed me some money (approximately thirty rand) that her grandfather had given her. It is important to note here that although her grandfather was not actively involved in the therapeutic process, it was evident that Sarah had a close and relatively stable relationship with him. She then proceeded to ask if I would give her some money too. I explained to her that doing so would not be appropriate and she seemed to accept this. I understood Sarah's actions to be indicative of her need to reach out and ask for what she needed in

the only way in which she knew how to as for her, money and material gifts were directly associated with love. Remarkably, she arrived the following week bearing a gift for me. With a smile on her face, she handed me an envelope in which there was fifteen cents as well as a small drawing of the two of us. As our sessions together continued, Sarah began to express her feelings towards me more directly and it was becoming further implicit that she was conveying a desire for me to care about her in the same way.

d) Summary

At this stage of the therapeutic process it was apparent that although Sarah experienced separation anxiety at times, this began to subside after a short time. This was consistent with a child who was apparently reserved and shy upon initial contact, thereafter becoming contrastingly controlling and uninhibited. Moreover, this was clearly indicative of an ambivalent self-perception as further evinced through her oscillation between: self-criticism in comparison to others; and, criticism of others as a means of self-elevation. As this stage of therapy progressed, Sarah's lack of self-differentiation became increasingly salient as her attitude towards me shifted from blatant disregard to that of nominal interest and sociability.

Further apparent was Sarah's oscillation between emotional inhibition and emotional outbursts. With the latter restricted to her home environment, Sarah's air of aloofness and emotional detachment (as was typical of her demeanour during therapy sessions) was gradually beginning to abate. Although not overly explicit in her expression, it was by this stage that she began to disclose an array of emotional responses, ranging from palpable anger to subtle indications of her affection for me.

My above-mentioned description of Sarah as self-absorbed and lacking in empathy had sustained by this stage, yet at the same time her diminished need to assert control over me, together with an emerging tendency to acknowledge my presence and existence, denoted the instigation of mutual interaction and a fundamental connection between the two of us.

3.3.4 Intermediate phase of therapy (sessions 14-26)

a) Existing foundation for identity formation

By this stage of therapy Sarah was displaying an inclination to explore with more confidence and a marked element of freedom to be herself. Such development was

revealed by an observable playfulness about her with a gradually diminishing focus on her need for control via the role of 'teacher'. Rather, she began to engage in more exhilarating activities, such as riding the motor bike around the room repeatedly before allowing herself to crash in the safety of the large cushions, laughing animatedly while doing so. She also became more playful towards me, where on one occasion she instructed me to "pretend to be sleeping" and then proceeded to place miniature animals on my face. Next, she instructed me to "wake up and pretend to be scared" prompting her to laugh wholeheartedly, thereafter repeating this scenario several times. With this evident progress in Sarah's sense of security and self-concept, she further appeared quite at ease in response to being informed of my impending leave of absence, indicating a diminished measure of separation anxiety.

In reflecting upon my experience of Sarah at this point, I found myself developing a genuine fondness for her. In contrast to her mother and grandmother's reports of Sarah's increasing refusal to listen as well as rebellious behaviour, my experience of her was quite to the contrary. I sensed that I was finally getting to know Sarah, a child with more depth to her than the somewhat superficial and disagreeable child who I was first confronted with.

Together with a greater level of security, she impressed as less defended as well as more understood and accepted, and perhaps, as if she was being 'heard' for the first time. Subsequent to my return from a leave period of three weeks, the following dialogue transpired:

Sarah: Its sometimes scary when you're with people you don't know.
Melody: Like when you are with a stranger.
Sarah: Yes, like someone who didn't know me when I was born.
Melody: Like me.
Sarah: Yes, but only in the beginning.
Melody: Now I'm not a stranger.
Sarah: Yes, you know me now.
Melody: So it's not so scary anymore.
Sarah: No.

While engaged in the activity of drawing, requiring me to emulate her work, our dialogue resumed:

Sarah: I like yours (drawing). Do you like mine?
Melody: You want to know if I like your drawing.
Sarah: Yes, do you?
Melody: It's important to you that I like your drawing.
Sarah: Yes.
Melody: And you aren't sure if you like it.
Sarah: Yes, tell me, do you like my drawing?
Melody: I like your drawing.
Sarah: You can say so if you don't.
Melody: You're not sure if I really like it. You want me to really mean it if I say I like it.
Sarah: Yes.
Melody: I like it.
Sarah: I like yours better.
Melody: You wish yours looked like mine.
Sarah: Yes.

During a later session, Sarah again inquired whether I liked her drawing. After once again reflecting upon her question and eventually responding, "I like it", she retorted "Do you really mean it?", once again indicating her desperate need for validation and underlying scepticism towards herself and others. Of further prominence, was her instinctive anticipation that she would not be liked and accepted by others.

As mentioned above, the event of my three-week leave period was certainly received by Sarah with an established degree of confidence, yet she made it distinctly apparent that she was not partial to having had to await my return. This further suggested a persistent fear of abandonment which was now manifesting in a more subtle and acceptable mode of expression. Specifically, Sarah arrived early upon our reunion and, when it was time to begin, chose to accompany me to the playroom. She then decided to make a detour along the way, insisting that she needed to use the toilet. She thereafter insisted once again, in two further instances during the session, that she needed to use the toilet, each time requiring me to accompany her and wait outside the door until she was finished. Sarah appeared to actually make use of the toilet on the first occasion yet thereafter, it was quite obvious that such visits were fictitious and hence, construed as a scheme for compelling me to 'wait' for her just as she had been obligated to do so during my absence. As my absence had resulted in three 'cancelled' sessions, Sarah quite fittingly made me wait for her three times while in the toilet. Remarkably, this recurred

several weeks later after my one-week leave of absence due to a work-related commitment. She subsequently made me 'wait' considerably before allowing me to begin my 'school' task, leaving me very little time in which to complete it.

b) Capacity for emotional self-regulation

This intermediate phase of therapy marked a substantial shift within Sarah, thereby stirring my appreciation for the movement of the therapeutic process. Suggestive of this shift was my experience of Sarah as a consistently happy child who portrayed an air of comfort and authenticity. More precisely, her observable mood and affect was substantiated by her growing tendency to articulate her feelings through direct verbalisation, as well as indirectly, via her expressive intonation. She would typically arrive at sessions in high spirits, wearing a smile and exuding enthusiasm. In response to my comments at times that she looked 'happy', she would reply "I *am* feeling happy". Further, her play became infused with zeal and she indisputably derived great pleasure from spontaneous yet simple activities such as: crashing the motorbike into the cushions; positioning miniature animals on my face while I 'slept' before instructing me to wake up with a fright; and eating meals together that she had prepared for the two of us. In all these instances, Sarah laughed heartily in expression of her delight and joy at that particular point in time.

Sarah's emotional articulation was not however restricted to that of positive or 'acceptable' feelings but was further offset by the communication of fear, anger and frustration at times. Upon informing me that she would be absent the following week, Sarah explained that she was going into hospital to have her two front teeth removed. I asked how she felt about this and she insisted that she was "excited" and not in the least bit afraid. At the time, I understood this to be indicative of her primary need to deny the impending threat that the idea of going into hospital justifiably posed for her. Nevertheless, she proved to 'survive' this experience quite effectively, with her arrival the subsequent week immediately followed by the exposure of her new 'toothless' grin and the admission that the experience of going to hospital had indeed turned out to be "a bit scary". Furthermore, Sarah demonstrated a capacity for reflection upon her fears with the discovery that such intolerable feelings could actually be abated. This was evinced

through her expressed realisation that she was far less anxious at this stage of therapy, in comparison to her experience at the outset (as illustrated above in our dialogue).

Although less overtly fuelled by anger at this point, Sarah justifiably continued to retain entrenched and enduring feelings of anger and frustration. Her associated expression however, was less hostile and she appeared to channel her emotions more constructively and less impulsively. The above-mentioned incident where Sarah repeatedly made me 'wait' via her visits to the toilet attested to unquestionable anger towards me and when I suggested this to her, she verified my perception with a firm "Yes!". Her indignation towards me was again demonstrated at the end of our session where she insisted upon completing her drawing before leaving by looking up at me with a frown saying "Melody!" in exasperation before returning to her drawing.

Following this session a feedback meeting was held, with reports of a remarkable improvement in Sarah's behaviour at home. In particular, Sarah's mother maintained that although not yet consistent, Sarah was listening more when instructed to complete certain tasks. In addition, she was beginning to approach her mother directly and express her feelings openly when feeling angry or upset. Sarah's grandmother maintained that Sarah appeared to be more accepting of the consequences of her behaviour, receiving her discipline without protest and later apologising for her misconduct.

c) Capacity to create and maintain emotionally reciprocal relationships

With Sarah and I becoming gradually more familiar with each other it was also apparent to me that she was beginning to grasp the very essence of the therapeutic process. This was quite fittingly and astonishingly conveyed in an instance where Sarah initiated the session by informing me of the many 'school' tasks to be accomplished during our time together that day. I commented that there was "lots of work for me to do" and shortly thereafter asked Sarah what I was supposed to do next. She turned to me and with notable irritation responded, "you know what to do!". I further commented that being an adult, it must seem as if I always know what to do but that in actual fact, adults and myself included typically do not always have the answers. Sarah responded with an ecstatic laugh and, without further ado, proceeded to give me the necessary instructions.

What I perceived to be of further pertinence to Sarah's conception of therapy was an episode upon which she blatantly declared, "I am going to test you". She proceeded to

administrate a spelling test via dictation and thereafter, put my test answers aside to be marked at a later date. Sarah kept me in suspense for an entire week, only going on to mark my test during the subsequent session. Having done so, she generously praised my efforts with an "excellent work!" and a broad smile upon her face. Most strikingly, this was the first time that she had ever encouraged me with praise as opposed to habitually putting me down with criticism

An inevitable development by this stage of the therapeutic process was the establishment of a mutual connection between Sarah and I. Correspondingly, our relationship became more collaborative and characteristic of synchronicity. Moreover, the most exceptional indication of a process in motion was the gradual but certain emergence of intimacy, both physical and emotional in proximity. The initial suggestion of this took place when Sarah arrived one day carrying a book under her arm. She required that I sit on the mat while she sat on a chair beside me and read to me. She struggled at times with the words yet asked for my help without hesitation. For the first time there was no table obstructing the space between us and, Sarah's usual presence of positioning herself 'over' me now seemed far less intimidating.

Shortly into this phase of therapy, Sarah's interest shifted considerably from the habitual game of 'teacher and child' to that of the 'mother and child' game. Specifically, this shift occurred during the session subsequent to my above-mentioned three-week absence and bought with it, the emergence of concern, kindness and empathy. Her instinctive preference for adopting the role of 'mother' suggested a continued need to be in control, yet this form of authority was clearly more affectionate and nurturing in nature. She initiated this new game with an emphatic statement that she was my mother, and the instruction "come on, help me move the table!" for the purpose of establishing a demarcated eating area. I was required to sit at the table while she prepared the meal and thereafter, we would dine together. In the event of the second session of playing this new game, Sarah arrived and immediately asked if I was "feeling better". I asked her what she meant by this and she explained that she noticed that I was "sick" the previous week. I did in fact have a noticeable cold that week, yet she had given no indication of having been aware of this at the time. In fact, this was the first occasion upon which she had ever expressed any degree of concern for my well-being.

Sarah thereafter decided to divide the playroom into a sleeping and an eating area. Once we had eaten, she informed me that we were going to go to sleep and led me to the cushions that represented our beds. As we then lay down side-by-side she asked me to lie facing her, taking my jacket to use as her blanket and placing her jersey over me to use as mine. As we pretended to sleep, she would open her eyes and sensing this, I would do the same causing her to laugh softly. This activity was repeated throughout the session as well as during subsequent sessions. Sarah would typically arrive at therapy saying, "We are going to play that game… you are my child!". Specifically, the game comprised a sequence of waking up, eating breakfast and then dinner together, thereafter lying down to sleep once again.

Towards the end of the intermediate phase of therapy, Sarah arrived for her session and handed me a card that she had made for me. On the outside, my full name was written across the top, with my first name written twice underneath in the form of a mirror image. Inside, the card read, "I love you Melody Crafford" and encircled underneath were the words "inturned house" (for 'intern house'). On the back of the card was a circle containing what resembled a book with music notes on it. Not only did this card constitute a direct avowal of Sarah's care for me but more significantly, I understood it to allude to a more profound intimacy between us, that is, that level of intimacy that requires insight into the very intricacies of the therapeutic relationship.

Further indicative of the emergent intimacy as well as trust between us, Sarah began to open up to me more. This presented as a desire for her to share her 'secrets' with me, taking me into her confidence with the caution "Don't tell my mom". She began by sharing with me that a boy had tried to kiss her at school. Later she revealed, "My daddy (her step-father) sometimes wont let me sit next to my mom on the couch" and shortly thereafter added, "He's not my real dad". In reference to her step-father not allowing her to sit next to her mother, Sarah initially asked me to inform her mother of this at the next feedback meeting but quickly changed her mind saying "Rather don't tell mom I said that".

The theme of 'time' presented itself from the outset of therapy with regard to Sarah's initial reluctance to end sessions, which could be construed as a means of assuming control. This reluctance however soon subsided, only to resurface once again

during the latter stage of this phase of the process. Correspondingly, the theme of 'time' continued to indicate a need for control and, in addition, alluded to the prominence of the therapeutic relationship within the context of Sarah's everyday reality. She began to verbalise her desire for us to spend more time together, stating that she wished our sessions were "longer". On one occasion she arrived early for our session, which was not at all typical; in fact, this was one of the two occasions that this happened. I waited until it was time to start and Sarah then chose to accompany me to the playroom as opposed to meeting me there. During our time together the following exchange materialised:

> *Sarah*: Good, we have more time because I came early.
> *Melody*: That way we would get to spend more time together, which you would like very much.
> *Sarah*: Yes, so now we have more time.
> *Melody*: You came early today and then you had to wait a while before we started, remember?
> *Sarah*: Yes.
> *Melody*: So that means that we have the same amount of time we usually have. You arrived early but we started at the normal time.
> *Sarah*: Oh.
> *Melody*: Now you are feeling disappointed.
> *Sarah*: Yes.

Sarah still attempted to prolong the session by saying that she wanted to paint yet accepted my reminder that our time was up.

Several weeks later, our usual therapy time fell on a public holiday. For the purpose of maintaining continuity, I offered to see Sarah as per usual should she wish to attend. Having deemed this a 'special occasion' Sarah arrived for her session and presented me with a large slice of chocolate cake in show of her appreciation, and expressed that since it was a public holiday, she was wondering if we could extend the session. Although somewhat disappointed she accepted my explanation that for us, this was a day like any other and therefore we would be spending the usual amount of time together. She thereafter stated that she wished she could spend the entire day in the playroom and compensated for this by advising me of the urgency to complete our 'school' tasks quickly so that we would have enough time to play 'mother and child'.

d) Summary

By this stage of the therapeutic process, Sarah was displaying strength and advancement in several areas pertinent to her foundation for identity formation. She had become more inclined to explore, with a distinctive element of playfulness in particular together with a degree of freedom to be herself. I was becoming increasingly aware of my growing feelings of fondness towards her and sensed that she was in effect starting to experience herself being 'heard'. What still concerned me however was a prevalent degree of insecurity regarding self-competence, with an enduring and instinctive expectation that she would not be liked and accepted by others.

In contrast to the emotionally detached child that I had encountered at the outset of therapy, Sarah was now exhibiting a somewhat enduring cheerful affect. Moreover, she was becoming accustomed to articulating her emotions more appropriately via direct verbalisation and expression. Such articulation was not restricted to affable emotions, as Sarah was also inclined to verbalise her anger and frustration at times.

In favour of habitual criticism, Sarah was now more inclined to offer me words of encouragement with an apparent sensitivity towards my feelings. This, together with the emergence of trust, was indicative of the mutual connection that had developed between us. More noteworthy was the profound development of emotional as well as physical intimacy between us.

3.3.5 Termination phase of therapy (sessions 27-34)

The subject of termination was raised during session 27. In preparation for this, I reminded Sarah of having informed her at the outset that I would only be working at the intern house until the end of the year. At this stage, we were left with a period of several weeks before we would have to say good-bye.

a) Existing foundation for identity formation

Brought to the fore during this phase of the therapeutic process was a self-portrayal reminiscent of Sarah's earlier expressed self-perception of worthlessness and insignificance during the initial phase of therapy. Essentially, this emerged with the arrival of a "ghost", which made repeated appearances over a course of several sessions. Incidentally, this began just prior to preparation for termination and continued thereafter. While engaged in the game of 'mother and child', Sarah started making a "whoooooo"

sound and whispered, “Did you hear that? Who made that noise?”. This scenario occurred repeatedly throughout the session, and the following week, she promptly announced “’The ghost is back!”. I asked her to tell me more about the ghost and she explained that it was a male who only visited at night and added that she only ever sees him in the playroom. At times she would insist that she just seen him through the window after dramatically shrieking in fear. She described the ghost as white and grey in colour and claimed that he had neither a mouth nor any eyes. Eventually the ghost went away yet she was later adamant that he had returned, despite the fact that it was daylight within the context of our game.

Of further prominence at this stage of the process was the re-emergent theme of ‘others’. During the initial phase of therapy, this served to highlight Sarah’s apparent sense of incompetence and corresponding lack of self-worth. Now however, these feelings within her were more prominent and further likely to have been intensified with the idea of therapy coming to an end. During the session subsequent to initial preparation for termination, she pointedly inquired, “What do other children play when they come here… maybe we can play what they play. Are their games boring like mine?” It was apparent that Sarah was considering the possibility that I was abandoning her because she was not worthy of interest. The following week, she decided to merge our two habitual games stating, “We are going to play teacher today…you are also my child!”. Before proceeding, she placed my shoes on her feet as per usual yet on this occasion went directly to the mirror to view her appearance. In a direct expression of her need for affirmation she asked me how she looked and thereafter, we continued to play.

During the session prior to preparing Sarah for the impending conclusion of therapy, our time together once again became interrupted by several ‘intruders’ as opposed to the initial presence of just one. While ‘sleeping’, we were repeatedly disturbed by people knocking at the door, evoking Sarah to cry out, “Go away! Leave us alone!” Assuming the role of the ‘protector’ Sarah would then threaten to shoot them in order to get rid of them and thereafter followed through, finding the gun and firing several shots at time through a small opening in the doorway. Sometimes the knocks on the door were simply people selling fruit, which she then bought for us to eat. It was

during the following session that the knocking on the door appeared to have subsided, with the ghost becoming the apparent source of disturbance.

With only two weeks of therapy remaining, Sarah arrived for therapy with the expressed intent to make Christmas cards for her family, with the underlying implication of her awareness that I was not a part of her family. She later invited me to do the same, requiring me to create cards for my own family members. Encouragingly, I recognized that the direction of this session attested to a need on Sarah's part to separate while at the same time, attempting to locate a sense of belonging. The first card that she created was addressed to her mother and in taking ownership of this contribution, included her sister as well as her grandparents in name. Likewise, she then proceeded to make cards for her sister and grandparents, later making one for her stepfather as well after realising that she had forgotten to include him. In this way, she appeared to integrate the two families, perhaps having relinquished herself as a source of re-enforcing their divide.

b) Capacity for emotional self-regulation

Once again, I gently reminded Sarah of our remaining number of sessions together before reaching the conclusion of therapy (which were illustrated in the form of a calendar that we had created together). She then proceeded to count the number of sessions remaining and expressed her sadness and disappointment. Towards the end of the session, with only five minutes remaining, Sarah expressed an urgency to complete her drawing of a giraffe that she had started shortly before it was time to end the session. I acknowledged how important it was for her to do so and suggested that she could continue the following week. This failed to placate her and she turned to me imploring, "*please* Melody, I want to paint", to which I responded once again that our time was now up (I was expecting another child in the playroom directly after Sarah's session). This proved to create intolerable distress within Sarah as she abruptly burst into tears while pleading, "*please* Melody, I *need* to paint the sky". As I crouched down and gently placed my hand on her back, Sarah continued to sob while painting her sky. I reflected her sadness and frustration and only somewhat soothed, her tears having dried as we left the room together. Her heart-wrenching gasps were however still audible and her little body continued to tremble.

With little time to compose myself before my next appointment, I clung to what I had just experienced and reflected upon it later that day. I discovered that I felt immensely guilty for not simply granting Sarah's request through a harmless infringement of the therapeutic boundaries. This was a child who had indisputably acquired effective manipulation techniques, yet on this occasion her distress was authentic. I knew this because in that moment when Sarah began to cry I perceived a side to her that I had never experienced before. Moreover, I felt the intensity of her emotion and was left overcome by feelings of grief and loss. She arrived the following week and halfway into the session, exclaimed that she had forgotten to bring our drawings from the previous week (the giraffes) and insisted there and then that we do them over again, this time ensuring that there was enough time in which to complete them.

The reality of imminent termination beginning to sink in, so Sarah began to make her feelings known. With five sessions remaining, Sarah informed me that she had been invited to a birthday party, which coincided with our next session. She assured me however, that she had decided in favour of attending therapy, saying she would see me the following week. In anticipation of her arrival, I received a last-minute phone call from Sarah's grandmother, apologising with the news of Sarah's change of heart. That left us with only four sessions instead of five, and Sarah began our next session with a 'phonics' exercise. She embraced this opportunity to criticise my performance, and appeared to take pleasure in correcting me. This set the tone for then informing me that "last time" I had failed to colour in my pictures correctly. In reflecting how she felt about this she admitted: "I was angry with you… but only a little angry. I was this happy (indicating this measure by using her hands and smiling) and only a little angry" (indicating a comparatively small measure using her fingers). Amazed and somewhat touched by this, I noted Sarah's ability to open up to me about her discontent towards me. Even though she attempted to buffer and downplay her anger, I deemed her ability to acknowledge feeling "happy and "angry" at the same time as an indication of an increased tolerance for conflicting feelings.

c) Capacity to create and maintain emotionally reciprocal relationships

As the therapeutic process progressed, so Sarah's desire for intimacy endured, with the highlight of such expression transpiring with only three sessions remaining. While engaged in the 'teacher and child' game, we had reached the point where I was to carry out the task just illustrated. While hard at work, Sarah began to circle the table for the purpose of supervision and quite astonishingly, softly stroked my head. I looked up at her and smiled in recognition, prompting her to return my smile before reminding me to carry on with my work. She then instructed me to lay my head on the table and close my eyes once I had finished. As I complied with her request, she continued to circle the table slowly. With gentle deliberation, she then took a strand of my hair in her hand and stroked it adding, "Miss X (her teacher) does this to me". Sarah repeated her ritual once more before ending the game in favour of painting.

Sarah's consequent way of being during our next session together indeed indicated a marked degree of awkwardness, clearly self-conscious about her former display of affection. Essentially she was aloof, self-absorbed and exhibited a blatant lack of attentiveness towards me, rendering me a virtual nonentity. She offhandedly declared, "we are going to make Christmas cards" yet conveyed without question I that I was not in fact invited to join her by promptly proceeding with her activity. This was qualified by Sarah's unequivocal focus upon "my family", a categorisation by its very nature precluded me. I was instantly reminded of her initial handling of me at the outset of therapy, whereby I was likewise thrust aside without further consideration. It was only after some time, during which I merely sat like an uninvited and useless onlooker, that Sarah offered 'you can copy me but only if you want to'.

In spite of the apparently promising implications of her focus, I was left feeling rejected, insignificant and disregarded. In truth, I felt hurt and quite angry, with a strong sense that the entire therapeutic process and ultimately, the significance of our relationship, had been undermined. With some relief on my part, Sarah had reverted back to 'herself' the following week with the immediate statement, "we are not going to make Christmas cards today" in her typically amicable tone. In hindsight, I perceived this penultimate session together as the concluding one for Sarah, specifically in comparison to our final encounter, which will become apparent as I continue.

In essence, Sarah presented with an evident endeavour to collaborate in deriving meaning from our overall experience together, as well as a degree of closure. She initiated this with the statement, "I was thinking in the car (on her way to therapy)… we're going to make a book. You're going to write the story and I'll draw the pictures." She then proceeded to ask me what our book should include and, with my encouragement, determined that it would entail the following contents: "Christmas; Flowers; Butterflies; Therapy; Playing in the park"; and "When I get up in the morning". While engaged in this activity, she repeatedly declared "we're getting along well", eventually questioning herself, "why do I keep on saying that?". I commented that she though we were working well together, which she confirmed and contentedly continued with the task at hand. Shortly after this, she imparted with enthusiasm "I know, we could make books and I could go and sell them in town and we could make lots of money. Then the newspaper would take our picture and we'd be in the newspaper together".

Having recently moved house, Sarah continued with the information, "I live at… (her new address), do you know where that is?". Responding that she wanted me to know where she lived so that I would be able to find her, she asked, "When are you going to come and visit me? Are you going away forever? Are you ever going to come back?" I acknowledged her fear that I might forget about her, together with the idea that we may never see each other again. Sarah appeared to accept the element of finality that ending therapy implied and continued to express her thoughts and feelings.

Upon reaching the section of the book entitled "Therapy", Sarah dictated the following to me: "I love going to therapy. It is my favourite place and I play lots of games. Melody is my therapy lady and I will miss her when therapy is finished." To complement this, she drew a picture of the two of us seated at the table together, and the following exchange transpired in reference to her dictation:

> *Melody*: I will miss you too.
> *Sarah*: We're getting along well.
> *Melody*: It's a pity that therapy has to end. We care about each other.
> *Sarah*: I care about you a lot. I will miss you.
> Melody: It makes you sad that I am leaving.
> *Sarah*: Yes.

Sarah left that day taking the book away with her.

In anticipation of ending therapy, Sarah had requested that we have a party during our last session together, further requesting that I supply a generous variety of refreshments. I carefully explained to her that I was not there for the purpose of supplying refreshments and, after her benevolent offer to take on the responsibility alone, I compromised (thereby admittedly bending the rules slightly) by agreeing to supply the beverages. All things considered, I regarded the idea of a party as at least a means of celebrating our time together.

With an ample supply of refreshments, Sarah cleared the table and was certain to share out them out equally. The much-anticipated party however failed to materialise. Within five minutes of having made the necessary preparations, Sarah abandoned her efforts in favour of exploring the playroom. Specifically, she made a point of examining each and every item that she had never played with. Inspecting one item, she made a brief comment and then moved on to the next one. With an overall lack of enthusiasm, it seemed as if she was merely finding a means of a passing the time. Perhaps her intent lay in the need to commit to memory every aspect of the playroom, yet more apparent than anything else was her marked display of detachment towards me. This was reiterated upon our farewell. Sarah seemed slightly reluctant to end through an attempt to continue inspecting the toys, yet compliantly accompanied me out of the playroom without uttering a word, and without looking back.

We approached her grandmother, who proceeded to thank me and suggested to Sarah that she do the same. Sarah complied yet unsatisfied, her grandmother further instructed her to give me a hug. As Sarah approached me I bent down to receive her and doing so, I experienced 'nothing'. With a feeble and short-lived embrace, Sarah's corresponding facial expression portrayed a lack of emotion and saying good-bye, she departed with her grandmother with a virtually undetectable hint of sadness reminiscent of my very first encounter with her.

d) Summary

It was only during this termination phase of therapy that Sarah's core sense of self fully unveiled, with all of the initial indications noted in the first stage of therapy now manifesting in full force. I attributed this to the passage of time in the development of our relationship, as well as to the onset of termination.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

As highlighted in chapter two the core of psychotherapy, therapeutic change, constitutes a phenomenon that has apparently been overlooked in the already extensive degree of process research conducted in the field. Correspondingly, this thesis presents at the very least an endeavour to contribute to the ongoing effort towards eliminating the hiatus between theory and practice. Accordingly, such an undertaking required a methodological foundation that would allow for an attentive focus on the therapeutic process as a means of reaching a comprehensive appreciation of the phenomenon of therapeutic change.

4.2 Aim of the study

The overall objective of this thesis sought to explore the fundamental nature of the therapeutic process in child psychotherapy with regard to the manifestation of therapeutic change. More specifically, the aim of the study involved the scrutiny of the therapist-child interaction from an attachment perspective, thereby examining the establishment of an attachment relationship. This necessarily embraced an in-depth understanding of:

- the role of the child's existing foundation for identity formation
- the development of the child's capacity for emotional self-regulation
- the child's ability to create and maintain emotionally reciprocal relationships.

4.3 Research approach

4.3.1 Interpretative phenomenology and hermeneutics

Packer and Addison (1989) highlight the exigent task of investigating the process of psychotherapy research in respect of elucidating favourable outcomes, as presented by the mainstream of existing psychotherapy research. As argued in chapter two, such investigation is pertinent to an in-depth scrutiny of the intricacies of therapeutic change, as opposed to a trend towards the evaluation of treatment outcomes that appears to disregard the fundamental elements that bring about change. The central task of this thesis and hence, of illuminating the crucial constituents of the therapeutic process pertinent to change, necessarily required an endeavour that is interpretative in nature.

In reference to phenomenological research, Willis (2001) aptly contends that "all knowing is at one level subjective since it is always related to, and constructed by, the person engaged in knowing" (p.2). This is in accordance with Packer's (1997) viewpoint that "knowledge is always interpretation, arising from, an articulation of, the practical understanding gained through participation in a social practice'" (p. 4). An interpretative approach instinctively alludes to a qualitative mode of inquiry, as is pertinently validated in De Vos (1998) who upholds that "the qualitative paradigm stems from an antipositivistic, interpretative approach, is idiographic, thus holistic in nature, and the main aim is to understand social life and the meaning that people attach to everyday life" (p. 241). Moreover, qualitative research entails a wide-ranging array of techniques that afford the researcher with the luxury of adapting a methodology most suitable for the research question. Labuschnage (2003) emphasises an important gist of the term 'qualitative', stating that it "implies an emphasis on processes and meanings that are rigorously examined" (p. 100). In contrast with quantitative research, which seeks to control phenomena, qualitative research aims to understand phenomena (De Vos, 1998). More pointedly, "qualitative research explores human behaviour and the search for understanding through people's actions" (Maggs-Rapport, 2000, p.375).

As maintained by Packer and Addison (1989), an interpretative methodology endeavours to articulate our "everyday understanding of people and events" (p. 3). More importantly, this gives rise to a greater understanding of phenomena that are typically regarded as natural, allowing for an appreciation of their fundamental structure. The practice of hermeneutics, most simply put, can be defined as "the art and science of interpretation" (Chessick, 1990, p. 256). Specifically, hermeneutics furnishes the researcher with a theoretical framework for interpretation, thereby allowing for consideration of context in deriving understanding and extended meaning.

4.3.2 Hermeneutics and psychotherapy: parallel interpretative disciplines

Barclay (1993) defines hermeneutics as "a body of literature whose primary focus is upon meaning and linguisticality" (p.81). More significantly, he draws attention to the notion of Gadamer's philosophical focal stance on 'language as horizon of hermeneutic ontology', thus rendering the understanding of human experiences of the world a manifestation of intersubjectivity. Distinctively, the endeavour to establish an association

of meanings is dialogical in nature and it is in arriving at such meaning that a 'fusion of horizons' materialises (Barclay, 1993). Conceptualising this endeavour, Lang (1995) elaborates that the life story/narrative of a person "depends essentially on the 'horizon', the sense in which each event is perceived and understood" (p. 219). This naturally reinforces the notion that all meaning or truth is equivocal and should thus be sought tentatively. Further implicit, is Sass's (1998) avowal: "to recognise that human existence is intrinsically ambiguous, that all knowledge brings, as its inevitable component, a vaster penumbra of ignorance, makes it impossible to think of ourselves as simply seeking *the* correct explanation or the entirety of correct accounts" (pp. 294-5).

The essence of intersubjectivity and ambiguity inherent the practice of hermeneutics draws a distinctive analogy towards the practice of psychotherapy. Mook (1991) offers a concise and apt definition of psychotherapy, contending that it "can be described as a practical discipline which aims to understand and interpret the meanings of the lived experiences of clients by means of specific interventions in the context of a therapeutic relationship" (p. 183). Essentially, it is the expression of such experiences that hermeneutics likewise seeks to understand and interpret, specifically from an ontological perspective of human experience. Where hermeneutics directs its primary task towards the examination of texts, psychotherapy is concerned with human articulation via words and images as they are verbalised through the spoken language and via non-verbal behaviour. Accordingly, such articulations that emerge during the therapeutic process too, can be regarded as texts or narratives that warrant deciphering (Mook, 1991). In support of this Lang (1995) iterates that "psychotherapy is a genuine hermeneutic experience for [in Gadamer's words] 'the fundamental model of all understanding is dialogue or discourse'. Hermeneutics has the universal task of understanding what is, in one's human orientation to the world, encountered as incomprehensible" (p. 223).

4.3.3 Child psychotherapy: the relevance of hermeneutics to therapeutic play

The central concepts of experience, understanding and interpretation are integral to hermeneutics and likewise, primary to the practice of psychotherapy. The articulation of experience within a therapeutic context can manifest in various forms, and where the practice of child psychotherapy is concerned, such articulation is predominantly

manifested through play, which according to Mook (1991) is "widely viewed as [the child's] natural mode of self-expression" (p. 184). As a universal and fundamental mode of human expression, the art of play yields great significance in light of Gadamer's philosophical influence on the nature of human existence (Mook, 1991). Akin to the 'subject matter' of texts to be understood and interpreted by the hermeneuticist, so the child's expression of her lived experiences can be regarded as the 'subject matter' which the therapist aims to understand and interpret (Mook, 1991).

As the child engages in the therapeutic process by means of play she essentially presents to the therapist, her narrative: she articulates her life story as she currently perceives it. For the child who has been referred to therapy, it is through telling her story that she reveals her sense of being misunderstood by significant others (Mook, 1991). Characteristically, it is through such misunderstanding that symptomatic behavioural problems have emerged. Consequently, the child endures a predominant "loss of security, an [experience of] isolation and a defensive withdrawal from an increasingly threatening world" (Mook, 1991, p. 186). From a hermeneutic perspective, the therapeutic process entails the task of therapist and child entering into "a hermeneutic circle of question and answer in search of an understanding of the child's problematic world" (Mook, 1991, p. 186). It is through a 'fusion of horizons', a concurrence of meanings between the child and therapist, that understanding is delivered which in turn, engenders a degree of stability and security within the child in terms of the therapeutic relationship. In this regard, Mook (1991) states that "understanding serves the principle of stability" and further, that the therapist "serves the principle of change" (p. 187). In reference to the latter, Mook (1991) maintains that when the child accepts the therapist's interpretations a widening of the child's horizon transpires, thereby leading the child towards new possibilities for self-development.

4.4 Method

The research of this study was case-based, where a single case has been examined in considerable depth (Edwards, 1998). The use of a single case is motivated by the my objective towards an analytic focus on "the overall pattern of variables within [the] case, looking at the parts in relationship to the whole" (Kohn, 1997, p.5). Furthermore, I opted for a retrospective case study approach in light of the accordant objective to reflect upon

an already-experienced therapeutic process. More specifically, the research comprised hermeneutic work, where I have appropriated a body of theory to be "…conceived of as a lens through which the material [will] be viewed and which [will] provide access to the deeper dimensions of the case" (Edwards, 1998, p. 52). Of particular appeal in employing the case-based method, I was required to contextualise data, allowing for an adequate amount of data to be collected for the purpose of examining meaningful associations in a single case (Edwards, 1998).

From a perspective of therapeutic change as the fundamental objective of the case under study, the researcher engaged in an extensive overview of theoretical literature regarding current psychotherapy research. Accordingly, the application of attachment theory was deemed pertinent, particularly in view of the subsidiary aim of bridging the hiatus between theory and practice. Moreover, the theoretical principles fundamental to this stance bring to the foreground the critical nature of psychotherapy. Correspondingly, attachment theory constitutes the theoretical lens, with a predominant focus on the establishment of an attachment relationship between therapist and child within the context of an existing avoidant/ambivalent attachment pattern.

4.4.1 Case description and selection

A single participant was involved in the study. Specifically, the participant was a six-year-old child, selected according to the following criteria for the case under study: long-term therapeutic process (a duration of 35 sessions); and, intricacy of therapeutic material with regard to the therapeutic relationship and attachment pattern.

4.4.2 Data collection

Data was gathered from play therapy sessions with the participant, as well as from regular therapy feedback sessions conducted with the participant and parent(s) and /or guardian. The participant's legal guardian was requested to provide written consent for the researcher to utilize the participant's therapeutic material. Play therapy and feedback sessions were carefully documented from memory directly after each session. Such documentation entailed detailed case records of the therapeutic process as well as the researcher's own therapeutic notes on relevant reflections on subjective experiences relative to the process. These case notes formed the basis of analysis and comprised the data for this study.

4.4.3 Data processing

The initial phase of the data processing entailed the creation of a narrative synopsis based on the wealth of raw data provided by the case material. Accordingly, Edwards (1996) refers to "[The] descriptive case synopsis [as] an accessible working summary of material stripped of redundancy and coherently organized" (p. 15). Specifically, this entailed a thorough and repeated examination of the process notes for the purpose of selecting subject matter to be regarded as pertinent to the phenomenon under study. Further, this selection took place within a broader context of the initial, intermediate and termination phases of the therapeutic process as a means of tracking the development of the therapeutic relationship. With the majority of the thirty-five sessions included, this material was then organised and compiled according to the specified aims of the study. Additionally included for adequate contextualisation of the case synopsis was that of the participant's full case history.

This laid the foundation for the next step, which constituted the creation of a 'Reading Guide', a method developed to direct the interpretation of the case narrative. This method, according to Brown, Tapper, Gilligan, Miller and Argyris (1989), involves several readings of the narrative, which enable the researcher to generate questions that are informed by the theoretical underpinnings of the research. The hermeneutic nature of the 'Reading Guide' method corresponds with the conception of the 'hermeneutic circle', which highlights the assertion that "complex human phenomena can only be understood in a somewhat paradoxical fashion that involves a circular consideration of both the whole and its parts" (Brown et al., 1989, p.144).

4.4.4 Data interpretation

The data was interpreted by means of a hermeneutic theory of interpretation, where interpretation of the meaning of the text is related to a theoretical frame as well as to the empirical context of the case (Wiklund, Lindholm and Lindstrom, 2002). Specifically, attachment theory constituted the theoretical frame, providing me with a degree of fore-understanding in approaching the phenomenon under study as a whole. This provided a context for interpretation of the constituent parts of the phenomenon and, on the basis of such interpretation, I could then endeavour towards the construal of a deepened understanding of the whole (Reeder, 1998). Engaged in this endeavour, I was required to

re-read the narrative repeatedly via the direction of the 'Reading Guide'. Pre-conceptions and initial impressions of the case were thereby refined in order to arrive at a comprehensive interpretation from an attachment perspective. In essence, this afforded me with an enlightened view of the therapeutic process and the accordant intricacies of therapeutic change.

4.5 Criteria for evaluating research findings

For the purpose of endorsing reliability of the study, my supervisor for the study acted as an independent evaluator in order to ensure an accurate interpretation of my observations. Further, Edwards' (1998) contention that "case studies…usually have better external validity than controlled experiments" (p. 62) on account of the authenticity of research conditions is in sound accord with the nature of this study. More importantly however, Kohn maintains that "external validity is a concern only for the analysis of multiple case studies" (p. 6). In reference to coherence, continuity, and credibility upon which a case narrative derives its value, De Wit (2003) maintains that the occurrences that materialise within the psychotherapeutic process "are contextualized in relation to each other rather than in relation to external points of reference [and] it is this meaningful linking… which gives hermeneutic interpretation its proper value" (p.75).

CHAPTER FIVE
RESULTS AND DISCUSSION

5.1 Introduction

In view of this study being retrospective in nature, it is inevitable that the applied method of re-reading the case narrative would yield a wealth of findings and insight that illuminate the case under study on theoretical and practical, as well as personal levels. Of prominence is the degree to which my overall perspective of the structure of the process itself has shifted. More specifically, what I initially conceived of as the closing phase of therapy I now deem as the mere 'opening'. This is of course relative to the therapeutic relationship as opposed to the time frame of the process. Having been aware at the time of having to end therapy prematurely due to situational constraints, it is only now that I am able to fully appreciate just how untimely termination arrived. Nevertheless, one must not lose sight of the significance of what transpired throughout the process, of the change that *was* brought about. After all, a relationship was born out of this process; a phenomenon that once created, will endure in some form within the individuals involved.

As highlighted in chapter two, the phenomenon of a secure base, whether indicative of secure or insecure attachment relationships, is internalised within the child as a mental representation of security. Otherwise referred to as an 'internal working model', this constitutes the child's mentally represented beliefs and expectations about her worth, emotional state, and interpersonal effectiveness. Further, it is upon the basis of these beliefs and expectations that the child develops behavioural strategies that are designed for the purpose of having her needs met; that is, in order to gain a 'felt security'. In correspondence with the above-mentioned beliefs and expectations are the aims that are central to this study, namely: existing capacity for identity formation; capacity for emotional self-regulation; and capacity to create and maintain emotionally reciprocal relationships. It is thus through an in-depth inquiry into these domains as facilitated by the case narrative that Sarah's associated behavioural strategies highlight a particular style of attachment. Moreover, it is through a parallel tracking of such behavioural strategies throughout the therapeutic process that distinctive indications of therapeutic change have been brought to the fore.

5.2 Therapeutic process

5.2.1 Existing capacity for identity formation

My initial observation of a degree of separation anxiety within Sarah when required to leave her mother in the waiting room indeed evinced an insecure attachment style and could be construed as a possible indication of an ambivalent pattern. This conjecture was shortly refuted as this reaction did not subsequently recur. Rather, Sarah was thereafter apparently unperturbed by having to separate from her mother, and later her grandmother upon her arrival for our sessions together. More significantly, Sarah appeared to display a notable degree of autonomy and independence through her exploration. Even so, her reluctance to ask for my help when needed, together with her need for stringent control over me is more indicative of a compensatory need to defend against inherent dependency needs, ineptitude and a lack of control over her world. This is further substantiated by the drawings through which she evidently conveyed a precarious self-concept and hence, and urgency to establish a solid sense of self. Of further significance is the lack of symmetry between exploration and interpersonal communication, suggesting a 'flight' from attachment towards the refuge of exploration.

From the outset of therapy, Sarah expressed notable enthusiasm towards the idea of regular feedback meetings, which included her mother and grandmother. My construal of this is quite simply indicative that she was in fact bringing her caregivers to therapy. As confirmed by the very first of these meetings, Sarah's decision to leave the room in the midst of the explicit conflict between her caregivers was her way of leaving them 'in my hands' while she went off to play. In doing so, she inadvertently directed me to the core of her distress. Specifically, Sarah's apparent tendency to 'ignore' her caregivers, even to the extent of covering her ears with her hands, can be construed as a function of: a strategic means of blocking out intolerable feelings of distress and fear as engendered by their enduring hostility towards each other; and, a symbolic gesture of their evident negligence of, and disregard for Sarah. In essence, Sarah found herself perpetually caught between their ongoing conflict, whereby she would 'disappear' with an overwhelming experience of herself as insignificant and 'invisible'.

As Sarah became increasingly visible within the context of therapy, so her embellished autonomy and independence moderated, and her feigned invulnerability

began to dissipate. Increasingly apparent was the degree to which she was lacking in self-esteem and a sense of mastery over her world. Her persistent tendency to measure her worth in comparison to others evidently brings to light the lack of a validated and internalised sense of worth, which denotes feelings of incompetence when self-critical and a need to inflate her self-esteem and appear in a positive light when directing her criticism towards others. With a marginally diminished need to fully maintain her defensive strategies when with me, Sarah further began to display a degree of freedom to be herself and endeavour to ascertain a definitive identity. Her request to meet each week by 'making an entrance' highlights her urgent need for attention yet moreover, can be conceived of as Sarah's desire to take ownership of the therapeutic process.

As Sarah became more secure within the therapeutic relationship, she exhibited a diminished need to control me yet at the same time, her self-perceived lack of self-competence continued. My experience of her was that of a child with great depth, as opposed to the superficial child I initially encountered; her play became more spontaneous and her demeanour quite good-natured, even teasing me at times. Nevertheless, despite appearing more secure in respect of our relationship, Sarah still exhibited significant insecurity within herself as denoted by: a need for affirmation; a fear of rejection with a corresponding need to be liked and accepted; and a continual tendency towards self-criticism in comparison to others. As Sarah's need to reign the sessions diminished, so the discrepancy between autonomy and dependence began to lessen. Specifically, she began to request my assistance with certain tasks and in time, this intensified to the extent that she came to rely upon my validation. Such over-reliance on others for self-validation evidently indicates an acute degree of lack of confidence and anxiety with regard to her sense of identity.

As mentioned in the case narrative, it was only at the onset of the termination phase of therapy that the extent of Sarah's experience of herself as worthless and insignificant became accentuated. In particular, it is through the fabrication of a 'ghost' together with such a detailed description which imparted a wealth of insight, that guides me further towards the heart of Sarah's inner world. In depth, the 'ghost' can be conceived of as representing an image of how Sarah believed she was perceived by others, that is, as lacking inner substance and ineffective. Her further description intimates the lack of a

distinctive self-definition, evidence of emotional distress and an associated sense of threat. More encouraging however, was Sarah's awareness of having been presented with an opportunity to be seen and understood with a related willingness to be open with me. Her embellished fear towards the 'ghost' can be interpreted as seemingly regressive and accordingly, indicative of Sarah taking ownership of her vulnerability.

5.2.2 Capacity for emotional self-regulation

To reiterate my initial impression of Sarah, I encountered a child who although apparently emotionally detached, offered me a glimpse of well-concealed feelings of sadness, anger and bitterness. In reflection upon the difficulty I experienced in regarding her as an appealing child, it is now evident that Sarah's demeanour at the time was notably indicative of her feelings towards herself as well as her perception of how others felt towards her. Sarah was undeniably aloof and reticent yet I found this an encouraging indication of her capacity to experience emotions, even if negative and distressing.

Sarah's evidently concealed capacity for authentic emotional articulation was confirmed during the abovementioned feedback meeting, as it was through her reaction to this hostile situation that she revealed powerful feelings of anguish, sadness and fear. Moreover, the fact that she was subsequently able to experience emotional containment, as well as express her accordant relief and contentment both in her facial expression and symbolically (in her drawing) provided a positive indication for therapeutic progress.

With the development of the therapeutic relationship, Sarah was gradually becoming less emotionally inhibited, particularly in respect of expressing her feelings towards me indirectly through letters and gifts. Despite evidence of enduring anger and frustration, she began to vent such emotions more constructively. It is conceivable that with the consistent experience of emotional containment within the therapeutic sessions, Sarah's ultimate fear of forming an attachment towards me began to diminish. Accordingly, her capacity to articulate her feelings for me became more direct, that is, expressing herself via a letter and thereafter requiring me to read the letter out aloud in her presence (see 3.3.3 b). One way in which Sarah's emphatic repetition of "nothing" can be understood is as a denotation of overwhelming feelings of emptiness. The basket was clearly a container, holding the "nothing" inside, while strengthened by "LOVE" (underneath it's base). Accordingly, Sarah was either expressing a recognised need for

such containment or alternatively, conveying her current experience of it. This perception is reinforced by her subsequent act of placing the letter inside the basket. Further, this incident together with others where she wrote me letters declaring her feelings for me can be interpreted as her desire to openly acknowledge her care for me.

The enduring change in Sarah's affect was quite remarkable, and came with a growing tendency to openly acknowledge distressing emotions. Moreover, it was if her 'frosty' façade had melted away, now allowing for the experience of joy and gratification. The authenticity of this affect can be substantiated by her growing capacity to express negative feelings towards me both timely and appropriately, such as allowing me to 're-live' her experience of irritation during my leave of absence by directly making me wait for her (see 3.3.4 b). This suggests that Sarah was becoming more secure, articulating her fear of abandonment with the anticipation that such fear would be acknowledged, understood and accepted.

With a primary focus on ending therapy with the initiation of the termination phase, Sarah was quite open about her feelings of sadness and disappointment, yet as directly as she expressed this she was evidently not prepared to discuss the issue further, probably for the purpose of finding refuge in denial. Her anguish over termination nevertheless manifested, giving rise to a profound revelation of Sarah's essence (see 3.3.5 b). She no longer needed to manipulate me in order to have her way, and she knew that. This brings me to the appreciation of just how urgent her underlying need was; that by allowing her to paint her sky, it would not constitute the fulfilment of her need but more imperatively, the longed for recognition of it. Clearly Sarah's need was far more profound than merely wanting to complete her drawing: rather, I perceive her expression as indicative of her beseeching hunger to be seen as an individual deserving and worthy of unconditional love. Furthermore, it is credible that the emotions of grief and loss that I experienced at the time are reminiscent of Sarah's experience of her mother leaving her in the care of her grandparents. Accordingly, it is likely that Sarah was experiencing anticipatory feelings of abandonment by me with termination of therapy.

In particular reference to Sarah's drawing it was interesting to note her selection of a giraffe with a substantially long neck and legs, thus suggesting an amplification of her needs. Significantly, her persistent urgency to complete her drawing through painting the

sky could be construed as need for her to counteract her distress through clinging to hope and an experience of contentment. It is possible that this constituted Sarah's desire to recreate her previously unsettling experience, thus defusing it through ascertaining a predictably bearable one. Furthermore, she likewise displayed a wish to repair the 'damage' that she had inflicted by virtue of her emotional exposure.

5.2.3 Capacity to create and maintain emotionally reciprocal relationships

The establishment of a therapeutic alliance is obviously critical to the therapeutic relationship for any degree of growth and change to occur. Accordingly, the establishment of a connection with Sarah proved to be the greatest challenge for me. Utterly self-consumed and without even a trace of empathy for others, it was apparent that for Sarah, others were merely objects for her to use and discard of at her convenience. It was with unwavering patience and optimism that I endured such treatment by her and only when I began to 'see' Sarah, did she begin to acknowledge my existence. It is quite astonishing to reflect upon the transformation within Sarah, to discover that she indeed held the capacity to develop feelings of empathy, as well as to display characteristics indicative of prosocial behaviour.

As we began to 'see' each other, Sarah's willingness to co-operate and engage in collaborative interaction emerged and hence, an authentic and meaningful connection was born. Less admonishing and more light-hearted towards me, even to the extent of praising me for my efforts, the synchronicity that had developed between us at this stage of the process is unambiguous. In essence, the therapeutic space was now 'ours', thus providing the conditions for promoting the emergence of the measure of intimacy characteristic of close relationships. Sarah's introduction of the 'mother and child' game directly underscores this assessment, with the theme of nurturance now a predominant feature of our relationship.

The concept of 'intimacy' within the context of a therapeutic relationship characteristically denotes proximity that is emotional and psychological in nature, with the cognisance of figurative boundaries that preclude physical proximity. With such cognisance, Sarah's need for a physical measure of proximity manifested and with astute acumen, she found a means of accordant gratification without quite having to transgress the boundaries (see 3.3.5 c). It is quite apparent that Sarah's action of circling the table

placed her within close enough proximity for her to assert her affection appropriately, unobtrusively, and with a reduced degree of awkwardness. This was additionally ensured by mention of her teacher in qualifying her actions. Evidently, Sarah exhibited on overt display of her affection for me and additionally, I construe her actions as an articulation of her desire for confirmation of my affection for her.

Such an extensive display of intimacy and vulnerability was offset the following week by Sarah's decision to make Christmas cards for her family. The fact that this occurred two weeks prior to termination leads me to consider that Sarah was likely to be experiencing a substantial measure of anxiety towards the idea of ending therapy. More significantly however, it is construable that at the time of displaying her affection, Sarah did so quite instinctively and authentically. After a week to reflect upon her actions, it is likely that the reality of imminent termination cued her to revert to her sanctuary of detachment just as instinctively. This retreat is likely to have been both fuelled and exacerbated by justifiable feelings of anger towards me on account of deeming me 'responsible' for 'severing' our relationship.

Admittedly to my relief, Sarah's command of our penultimate session together suggests a degree of acceptance of the reality of termination, as well as a desire for closure. Quite remarkably, Sarah revealed considerable forethought in determining the direction and substance of our session together that day (see 3.3.5 c); that we would actively collaborate in an endeavour to derive meaning from the therapeutic process and our accordant relationship. Quite openly, she expressed her fantasy that our relationship would continue and in doing so, we would maintain our attachment through the generation of love and care. This construal in particular is supported by Sarah's reference to written expression ('books') and 'money', which can be regarded as her vehicles of expression for love and care. Further, her wish to publicise our relationship augments her fantasy that I might become a permanent attachment figure in her life; that in spite of therapy having to come to end, our relationship would not necessarily have to.

5.2.4 Termination and a lack of resolution

In spite of a relative degree of closure derived from our second-last session together, our last session together was of course my final encounter with her. It is indeed reassuring to reflect upon the therapeutic process and appreciate the shift that

materialised within Sarah; to recognize that the experience of therapy undoubtedly provided her with a crucial experience of a secure attachment. Still, perpetually reminiscent is the side of Sarah that I said good-bye to, having returned to her defensive strategy of aloofness and detached manner of being in the world. Aside from my own apparent feelings of disappointment and frustrations regarding the conditions of termination, it is my primary hope that Sarah has managed to take away with her and retain an experience of herself that she can benefit from within her existing and future close attachments.

5.3 Sarah: primarily avoidant with ambivalence at times

In constructing the case narrative, my initial estimation was that Sarah displayed an insecure attachment style that was a combination of an avoidant and ambivalent pattern. In hindsight, it is now apparent that although she indeed presented with this combination, more predominant is that of an avoidant pattern with only a tendency towards ambivalence at times. Correspondingly, the most prevalent impression afforded to Sarah was her detachment and aloofness that attested to her level of caution and anxiety regarding close relationships, together with a lack of empathy and blatant disregard for others. I did not however regard her as constrained to an avoidant attachment style as a strategic means of defending against this, as she displayed a tendency to act out her feelings at times. It was at these times that she unwittingly belied her seeming invulnerability and disclosed her inherent emotional needs. In short, Sarah impressed as a child who primarily utilised avoidance as a means of 'cutting off' attachment-focused signalling and related emotional reactions; and who on occasion, would revert to resistance through a contrasting heightening of signalling and emotional responses.

As maintained by Howe et al. (1999), the child's internal working model "tells us how the child mentally represents her carer's emotional availability and her own self-worth" (p. 48). Accordingly, Sarah's presentation was indicative of an internal working model of a secure base that denoted insecurity. Further, this suggested low self-worth, a detached emotional state, and a compromised degree of interpersonal effectiveness. Correspondingly, Sarah displayed particular behavioural strategies that stemmed from: an inherent belief that she was not worthy of unconditional love and interest, with the

expectation that others would reject her; the conviction that expression of her emotional needs would jeopardise the availability of her attachment figures; and intense scepticism regarding relationships, leading her to fear intimacy and approach others with caution. This was noted through the progression of therapy yet with the gradual establishment of a secure base reminiscent of security, notable shifts in her defensive system began to emerge.

5.4 Summary: a perspective of change

Characteristic of secure attachment is the capacity to conceive of and survive separation while retaining a secure base. Holmes (2001) aptly maintains that "therapy is characterised by a rhythm of separations and reunions, and within sessions by misunderstandings, minor acting out, followed by resolution, with a consequent deepening of empathy" (p. 43). He refers to this in terms of a therapeutic tool namely, of 'alliance rupture and repair' and avows that such capacity is "crucial to self-esteem and effective interpersonal functioning" (p. 43). It is apparent that Sarah's therapeutic experience afforded her with a secure base by virtue of the degree of containment provided. Further, her instinctive insightfulness was apparently cultivated by means of the process, thereby enhancing her capacity to function reflectively. The conditions of containment and insight are critical to effecting therapeutic change as they engender new experiences for the child (Holmes, 2001). Correspondingly, it is through gaining a newfound experience repeatedly in the form of emotional rupture and repair that the effect of therapeutic change is fully realised. The diminishment of Sarah's persistent attempts to prolong sessions, her increasing capacity to tolerate breaks during the process, and her overall positive shift in attitude and behaviour towards me is indeed a testament to this.

CHAPTER SIX
CONCLUSIONS

6.1 An overview

The nature of attachment styles is such that regardless of how ingrained and assimilated they become in the development of personality, they are not ultimately unalterable. Howe et al. (1999) uphold that "internal working models form within relationships and can be modified and 'disconfirmed' at any stage of the lifespan if the individual experiences new influential attachment relationships" (p. 41). In this respect, the experience of practising child psychotherapy from an attachment perspective should be embraced with optimism. Although the first three years of life are critical in determining the fundamental blueprint for future relationships, it is only once an individual approaches early adulthood that patterns of relating become more enduring. Accordingly, in the case of child psychotherapy, it is critical for the therapist to form an impression of the child's attachment style tentatively. Further, it is prudent to regard the psychotherapeutic process as an agent (as opposed to a condition) of change in the modification of an attachment pattern. Rather, it is the notion of security that is fundamental; the search for which attachment theory posits above all driving forces, emphasising the attachment bond as the foundation for survival – "a precondition for all human interactions" (Holmes, 2001, p. xii).

6.2 Case formulation

Sarah's initial separation from her mother shortly after birth, albeit for one week, can be conceptualized in terms of an abandonment experience. Unlikely to have had a fully detrimental impact on Sarah's sense of self, this transient experience however recurred when she was two years old in the form of an enduring separation. Together with the loss of her father through her parent's divorce, Sarah was deprived of consistent maternal love, affection and containment. This loss gave rise to an overwhelming fear of abandonment, which was placated by a secure environment provided by her grandparents, and their continual efforts to compensate for her loss.

Sarah's inherent sense of resilience enabled her to adapt to her surrogate familial environment, yet her pervasive feelings of insecurity and fear of abandonment compelled her to learn how to manipulate this environment in order to gain compensation by means

of material rewards. The lack of substance and sufficiency of such compensation can be underscored by the conceivable impingement upon Sarah's sense of identity and self-worth. Moreover, the event of her mother's remarriage and subsequent pregnancy is likely to have exacerbated Sarah's experience of loss and fear of abandonment with the ultimate dread that she could be replaced by her mother's new family. In essence, this would serve as the ultimate source of annihilation. Kate's abrupt inclination and intention to reaccept Sarah into her life is also likely to have left Sarah conflicted by ambiguous feelings. The notion of being uprooted from her surrogate family would give rise to feelings of insecurity, leaving her faced with a further loss contingent upon the return of the mother she lost.

Sarah's evident defensive strategy of emotional detachment that she presented with at the outset of therapy can be construed as her means of defending against perceived consequences of rejection and abandonment. Characteristically skeptical and apprehensive with regard to close relationships, it is explicable that Sarah would view intimacy with incomprehension and fear. Accordingly, an over-reliance on self would encompass minimization of attachment behaviour and affect and thereby require Sarah to present herself as emotionally self-contained. This defensive strategy is fundamentally motivated by the intent to minimize any possibility of rejection and in effect, to maximize the maintenance of proximity towards her caregiver. Sarah's particular defensive strategy is indicative of an internal working model that is founded upon negative evaluations of self and others. More specifically, her experience of inadequate love and attention has been internalized as self blame, and others are viewed with skepticism regarding the rendering of such love and attention.

This is justifiable in light of the formative stage of her development when her mother first relinquished Sarah to the care of her grandparents. The experience of therapy however served to provide Sarah with an alternative experience of the world; an experience through which she was able to discover the notion of unconditional regard, acceptance and care. In essence, the therapeutic process opened Sarah to a sense of freedom, unburdened by her reality at the time and enabling her to come to know herself better – to be herself. As her therapist, it was my role to model a measure of caring and trust, acceptance, competence and self-worth. Ideally, it is through such modeling that

these characteristics are internalized as perceptions of and expectations for self as well as others within the context of close relationships. The extent to which this is actualized essentially determines the measure of change within an attachment pattern. (Pistole, 1989).

As is in accordance with the nature of phenomenological research, an assessment of change within Sarah's attachment pattern cannot be ascertained with precision and according to a quantitative measure. Rather, the appraisal of growth and change is naturally subjective and to be found where it resides: that is, in the very material of the therapeutic process and the substance of the relationship established therein.

6.3 Limitations

Although a relatively lengthy process, it is apparent that termination of therapy was premature. Unfortunately this was unavoidable due to the circumstantial situation of my internship and, although Sarah was aware of our restricted period of time together from the outset, it is evident that she was not yet 'finished' and highly disappointed. She was presented with the option of continuing therapy with another intern the following year, yet openly declined this offer. From a psychotherapeutic perspective, I have already mentioned that termination was untimely, with integral phase of the process only just beginning to unfold.

A further shortcoming was my oversight regarding the degree to which I required Sarah's family to participate in the process. Specifically, both Sarah and I would undoubtedly have benefited from the attendance of other significant family members, such as her grandfather, step-father (her father was minimally if at all involved in her life at the time). Moreover, it is critical to note that in effect, a child is not 'brought to' therapy; rather, she brings her family to therapy as her healing is fundamentally contingent upon theirs and her 'dysfunction' a mere reflection of theirs being the very source.

Finally, it is only with hindsight that I can fully appreciate the therapeutic process from an attachment perspective. An 'ideal' study would be that of exploring therapeutic change having directly practised therapy from an attachment perspective in a child psychotherapy case. However, it is through my encounter with Sarah and my instinctive decision to further explore my experience of her that I encountered attachment theory.

As a result, my eyes have been opened in so many ways, and I have been left with invaluable therapeutic tools to be implemented and further cultivated in my future encounters as a psychotherapist.

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Appendix A

RHODES UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

RESEARCH INFORMATION

Introduction

A research study will be conducted by Melody Crafford, student researcher at the Rhodes University Department of Psychology.

Aim

The aim of this study is to explore the therapeutic process of a single child psychotherapy case, by means of describing the essence of the therapeutic relationship in respect of engendering therapeutic change. More specifically, this will involve the scrutiny of the therapist-child interaction from an attachment perspective.

Procedures

Data for the research will be gathered by means of the researcher's documented records of the therapeutic process, as well as of feedback meetings with family members.

Risks

There is no risk of harm, embarrassment or offence, either slight or temporary, to the participant or her legal guardian.

Confidentiality

In order to ensure anonymity of the participant, personal details and identifying information will be deliberately altered in the report. Such information will remain known only to the researcher and her supervisor. The participant's legal guardian has the right to withdraw participation at any stage of the research.

Appendix B

RHODES UNIVERSITY

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CONSENT FORM

I, _____, parent and legal guardian of the participant, _____, hereby grant consent for _____to participate in the research project of Melody Crafford, supervised by Jan Knoetze, on the essence of the therapeutic relationship in respect of engendering therapeutic change.

I have read and understood the contents of the research information sheet.

I understand that:

1. The researcher, Melody Crafford is a student conducting research as part of the requirements for a Master's degree in Clinical Psychology at Rhodes University.

2. The researcher is interested in describing the essence of the therapeutic relationship in respect of engendering therapeutic change.

3. The data will be written as a case narrative.

4. _____'s participation will require my authorization of detailed written records of her involvement in the play therapy process to be utilized for the purpose of conducting the research.

5. I am invited, on behalf, to voice to the researcher, any concerns I have about her participation in the study and to have these addressed to my satisfaction.

6. I am free to withdraw _____'s participation from the study at any time however, I fully commit her to full participation unless some unusual

circumstances occur, or I have concerns about her participation, which I did not originally participate.

7. The report on the research project may contain information of a personal nature however, that information will be designed in such a manner that _____will not be able to be identified by the reader.

Signed on (date) _____

by (legal guardian of participant) _____

Researcher _____

Witness _____

Appendix C: Reading Guide

Existing Foundation for Identity Formation

- Does she exhibit signs of missing her caregiver during separation (i.e. separation anxiety)?
- Does she focus primarily on toys and her environment, in comparison to others/interpersonal communication?
- Does she explore with relative confidence or rather, anxiety – what does this suggest about her level of self esteem, feelings of mastery, and differentiation of self?
- To what extent is there a balance between autonomy and dependence?
  - over-reliance on self versus over-reliance on others?
  - self-government / rule versus authoritative control / dominance?
- If apparently autonomous, to what extent is her independence restricted / inhibited?:
  - determine level of freedom / self-determination, as well as authenticity of tenacity for expressing her choices/preferences with confidence?
- Does she appear to give up autonomy for the sake of a dependent form of intimacy (ambivalent); or does she sacrifice intimacy for an exaggerated form of autonomy (avoidant)?
- Is her self-esteem short-circuited with the self ?:

- Does external validation have little impact, with the child doing her best to be in control and keep intimacy at bay? (i.e. intimacy would threaten her self-contained system of managing her self-esteem)

- Is she open to external validation, and apparently completely dependent on it?

- Defensive strategy – what does the nature of this suggest about her internal working model (i.e. her view of self and others, and how this perception guides her behaviour)?

Capacity for emotional self-regulation

- What is my initial, overall impression of her affective demeanour?
  - primarily negative (sad, angry) affect versus primarily positive (happy, smiling), or combination of both?

- Does therapy require enabling her to distance herself and see her feelings in perspective (ambivalent); or to help her get closer emotionally and to be more open to her feelings (avoidant)?
- Does she display the capacity to experience and express a wide array of emotions/emotional responses?
  - through both verbal articulation and via non-verbal expressive intonation?
- Does she typically experience/display intense negative emotions, such as, depression, moodiness, irritability and anxiety?
- Does she exhibit a basic capacity to regulate her emotions?
  - impulsive venting versus appropriate and constructive release?
- Does she respond well if at all to emotional containment as provided by the therapeutic situation; if so, does this develop over time towards the capacity for self-containment?
- Does she display the capacity to recognise and thereafter, take ownership of her feelings?
- Does she hold the capacity to tolerate and discern between conflicting emotions (integration of feelings)?

Capacity to create and maintain emotionally reciprocal relationships

- Has she ever been subjected to the experience of a warm, loving , trusting and emotionally reciprocal relationship?
- Is there any evidence that she has internalised prosocial standards of behaviour, such as:
  - co-operation and self-control?
  - altruism?
  - empathy, compassion and kindness towards others?
  - conscience and morality (versus apparent lack of conscience whatsoever)?
- Does she appear to trust too easily, or contrastingly, struggle to do so?
- Does she display an element of reciprocity in relating to others?
  - is there a tendency for her give and receive genuine affection and love?
  - does she tend to be controlling and manipulative in relationships?

- If evidence of empathy, to what extent is there an awareness of the mental state of others (this can be determined according to level of synchronicity between the child and her caregiver/s, as well as between she and I)?

Avoidant attachment style

- Is entry into close relationships viewed with anxiety and caution?
- Does there appear to be the use of an internal working model in which others are not available but the self is strong, in control and not easily upset and affected?
- Is behaviour modified as a means of defending against social rejection and withdrawal?
- Is there apparent concern over 'doing things right', or over wanting to please others and to overachieve?
- Does the child anticipate rejection when having expressed negative feelings?
- Is there a constant reluctance to express, access or acknowledge emotion?
- Is there evidence of underlying feelings of anxiety and tension, as well as isolation and sadness that tend to lead to aggressive outbursts?

Ambivalent attachment style

- Does there appear to be deep anxiety concerning lovability and value of the self, together with a troubled preoccupation with whether or not others have sufficient interest in the child to be emotionally available in times of need?
- Does there the child appear to have low self-esteem, together with a tendency to become emotionally entangled in close relationships?
- Is there considerable evidence of separation anxiety, such that separation (anticipated or actual) gives rise to increased levels of anxiety and stress?
- Does the child appear clingy while in the presence of the caregiver, while at the same time displaying unresolved anger?
- Does the child struggle to engage the caregiver's attention and interest to the extent that attachment behaviours are elevated to the extreme?