

Chapter 6

6. The Data Collection Process and Data Analysis

6.1 The Research Participants

Initially two of the three psychologists who agreed to be part of the study were concerned with how the research would affect the therapy process with the children. Consequently they requested more information of the sort of questions that would be asked and they required reassurance as to the confidential nature of the research. One of the psychologists felt it was necessary to discuss the research with her supervisor to obtain an external opinion of whether such interviews would impact negatively on the therapy process. After discussing the possible questions with the psychologist, feeling reassured of the confidential nature of the research, and after obtaining her supervisors approval, the psychologists agreed to participate in the study. The mother and child participants were obliging and enthusiastic about assisting in a study. In fact, the children's reaction indicated that they were somewhat excited and it appeared to make them feel special and important.

Before each interview, the researcher introduced the participants to the study by explaining that the aim of the research was to obtain an understanding of their experience of the therapy process. The researcher explained that the questions were around: - their understanding of the therapy process, to develop an idea of what they perceive to be important issue which they discuss in therapy and to generally develop a sense of what therapy meant to each participant. It must be noted that the questions used were merely guidelines and when the researcher required more information further questions were asked.

6.2 First Reading: Reading for Global Understanding and Employment

As noted, the researcher transcribed the audiotapes as described earlier. Initial feeling and hunches about the process of therapy were observed. These were noted and used as part of the initial process of determining the themes, which were eventually outlined. The transcripts were 'read' and 'reread' to familiarise the researcher with the material. This involved obtaining a sense of each protocol as a whole experience.

The transcripts were read First for global understanding and employment. The interviews of the participants were summarised into commonalities and differences in the main themes and plots, across participants. This was done in a table form (Appendix A). The tables enabled the researcher to gain access to each participant's understanding of the therapy, the meaning they gave to it and impact of being learning disabled. This process enabled the researcher to gain an understanding of the data as a whole. The tables were used to create a summary of the findings for the three sets of participant.

6.2.1 Description of the Data

The themes across the three different participants, namely the mother, the child and the therapist, were fairly consistent across the interviews. These themes also related to the biographical information provided in each of the children's history prior to entering the school. As a way of introducing the discussion, a very brief overview of the important aspects of each child's history will be given in order to contextualize the discussion as well as to provide meaning to the deductions. Since the researcher provided the participants with assurance of confidentiality, names and any possible identifying information will not be given.

6.2.2 Introducing the Participants: A Brief Outline of Each Child's History

Child Participant A (Cp-A)

Child participant A is a male who is ten years old. He was born six weeks prematurely and significant distress was noted at his birth. Nonetheless, postnatally, he was healthy and bonding was described as good. His early developmental milestones were within normal limits. Difficulties at school emerged in his grade 1 year and he entered the remedial school a year ago. He is currently in Grade 4. He is the youngest of three children. His parents divorced and both parents remarried. Cp-A had been in therapy for 11 months at the time of the interview.

Child Participant B (Cp-B)

Child participant B is a male who is ten years old. He was born three weeks before his due date on account of complications. His milestones were within normal limits. Difficulties at school emerged in his first year at nursery school and as a result he attended a number of therapies. He entered the remedial school three years ago. He is currently in Grade 5. His parents are married and he is the third of six siblings. One sibling passed away before his birth due to illness. Cp-B had been in therapy for 14 months at the time of the interview.

Child Participant C (Cp-C)

Child participant C is a female who is ten years old. She was born at term. However, her mothers' labour and her birth were very traumatic. Except for some slowed motor-development, her milestones were within normal limits. Difficulties at school emerged in her Grade 1 year and she entered into the remedial school the following year. She is currently in Grade 5. Her parents are divorced and her father remarried. She is the only child of her mother and her father has two older children from a previous marriage. Cp-C had been in therapy for 28 months at the time of the interview.

6.2.3 Findings of Reading One: Reading for Global Understanding and Employment

As discussed, three children were interviewed, as were their mothers and their therapists. Once all the interviews were summarised (a summary of the tables created for this purpose are in Appendix A), a brief overview of the significant themes was noted. The themes are focused on the three different groups of participants: - the three mothers, the three children and the three therapists. Each of these groups will be discussed in turn, since the three different methods of analysis provide different insights to the therapy relationships and the therapy process. Further discussion of each theme will be discussed in the second reading.

Mothers

The main theme as to the mothers' understanding as to why their children were in play therapy was around their children having a low self-esteem and a lack of confidence. Related to this were the themes of poor self-acceptance and the need to learn to develop coping

strategies to manage their world effectively. These coping strategies were seen to be needed to deal with the daily difficulties the children encounter, social problems and coping with feelings of anger and frustration.

The mothers generally felt that their children had good relationships with their therapist's which allowed them to discuss their problems, to develop an understanding of their concerns and to work out solutions. In addition, it was felt that this relationship was a safe place which provided support for their children. Only one of the mothers expressed that their child was not always happy to go to therapy and she felt this was because a focus of the therapy was to deal with anger and frustration.

The role of the mother in terms of the therapy, and her relationship with the therapist, revealed a common theme around having a co-operative relationship in order to develop understanding and a sense of the child in relation to their family, school work and their social world or peer relationships. The mothers felt guilty when they did not know how to cope or deal with difficulties with their child. The role of the therapist was seen to provide the mothers with feedback over the concerns that became evident in the therapy and where necessary advice on how to be a more effective parent.

The themes for the primary issues dealt with in therapy were around family relationships. Two of the participants came from divorced families and the third came from a very large family, both of these were seen by the mothers to create stress for the children. Social difficulties and social skills were also seen to be important aspects of the therapy. Although having a learning disability was not seen to be one of the primary reasons for the therapy or as a primary theme of the therapy, all the mothers felt it impacted on the child emotionally. The emotional impact was seen to be around being stupid, not coping, being different, learning to cope with their emotions and dealing with previous difficult experiences related to school.

Although the mothers were never directly asked, themes emerged around the psychoanalytic nature and value of the therapy. Themes that emerged in relation to this were around mother-child relationships, abandonment issues, poor attachment, insecurities, difficulty in containing the children's emotions, immature defence mechanisms and struggles or conflicts

with the children's inner worlds. Interestingly, the mothers tended to use psychological terms when describing the value of the therapy.

The themes focused on how the therapy had helped develop an understanding of family relationship, an understanding of being different to other children, it helped the children to cope better socially, and provided the mothers with guidance and support, as well as general management of emotions

Therapists

There were two common themes around the understanding of the therapists of why these children were in therapy. These were around helping these children cope with family relationships and school-related issues. Two of the therapists focused on the need for emotional containment. Only one of the therapists discussed early development, poor bonding and a poor relationship with her mother as being significant.

The therapists generally felt they had some form of connection with the children. However, there were many indications that these relationships were fragile and tentative at times. The therapists understood these indications as being as a result of the children's internal dynamics, which did not always allow for trusting relationships.

The primary themes in the therapy were felt to be around mastery, social difficulties, mother-child relationships and family relationships in general. The child having a learning difficulty was only seen to be of primary importance in terms of mastery and around the child feeling different or damaged.

In terms of psychoanalytical therapy and theory assisting the therapist with the therapy process, themes around poor attachment, poor bonding, and providing a safe, containing and holding experience for the child were important in the therapy process. Therapists expressed that it was necessary to use simple and concrete interpretations when working with the children. All three therapists found it difficult to work in the transference, but were unable to explain the reason for this. Providing the children with relationships they had previously not experienced, and understanding their projections onto the therapists, were important.

Therapists felt the role of the mother was important in terms of working on the mother-child relationship, helping the mother understand their children and improving family relationships. Another theme related to this was how working with the mothers helped improve the mother-child relationships.

The therapists' psychoanalytical formulation of the children were all related to attachment, poor bonding, difficulties with the children's internalization of their objects and providing a formulation of the child personality structure in psychiatric terms. The two therapists, whose clients were male, interestingly focused on self-destructive tendencies as being important in their psychoanalytical understanding of the children. The other therapist focused on the child's anxiety as being important.

Children

One of the difficulties interviewing the children was that, although they were enthusiastic to participate, their responses were generally limited which resulted in the researcher having to ask them numerous questions. This was particularly evident with Cp-B's responses as he tended to provide one-word answers and even with a great deal of questioning, he provided minimal responses. It is important to note that the researcher was not unfamiliar to the children, they all knew who she was and had informally spoken to her at some point during their time at the school.

The main themes concerning the children's understanding of why they were in play therapy was around helping them deal with problems and difficulties that they encountered in their world. These difficulties ranged from coping with divorce, sibling rivalry, fears, family relationships either with their mother, stepparent or father, school-related problems and friendships.

The children used descriptive words to express their feelings towards their therapists. All of the children felt that they had "nice" relationships with their therapists and that their therapists liked them. Trust and understanding were also important aspects to the therapy relationship. In addition, it was felt that these relationships enabled them to feel understood which they felt helped them.

The children felt the role of their mothers in terms of the therapy was to provide the therapist with information about the childrens' families and possible difficulties they were experiencing in the families. These included poor step-parent relationships, sibling rivalry, concern over the father-child relationship and difficulties with the mother-child relationship. Themes of telling the therapist what the child was like and helping mothers to cope with them also emerged.

The themes of the primary issues dealt with in therapy were around family relationships. Social difficulties were also seen to be an important aspect of the therapy. All of the children had a clear understanding of what a learning disability was and that it is something that causes difficulties for them. However, none of them felt it was an important aspect of the therapy process.

The children felt that the therapy helps them understand family relationships, overcome their problems in general, help with relationship difficulties such as friendships and to cope with their feelings.

6.2.4 Reading Two: Content Analysis

The Second reading was for content analysis- coding categories where lined to meaning units in the text. The researcher entered the various "text" searching for meaningful units and segments. Natural meaning units can be described as statements or actions expressing single, delimited aspects of a subject's expression (Bauer, 2002). In this Second reading coding categories were developed. The coding was defined thematically (Bauer, 2002). It also involved reading for various categories, which were refined and revised. These categories or themes evolved through this reading as well as using the tables and the notes made in the initial observation. One of the difficulties encountered with outlying the various themes was that many of the themes seemed to be related and impacted on each other. Thus, the researcher had to be careful when outlining the themes that they were not just different ways to describe the same thing. From this process it became evident that the themes' impacted on each other in an almost reciprocal manner.

The themes enabled the researcher to enter the hermeneutic circle (i.e. the dialectical relationship between understanding and interpretation) (Packer & Addison, 1989). The

themes enabled the researcher to have a starting place for interpretation. Thus, a legitimate access to the entity being investigated was chosen through the various themes being selected (Packer & Addison, 1989). The transcripts were read many times as the researcher initially could not be certain that the best access to the circle of understanding and interpretation had been found. Through the process of being informed researcher and the course of interpretation the researcher was able to enter the hermeneutic circle (Packer & Addison, 1989). The themes have been outlined below and are coded next to the text to indicate when the theme is present. The following themes emerged:

1- Family boundaries and relationships

The family boundaries and relationship theme focused on aspects where the participant made reference to their family. That is any part of the interview where participants mentioned feelings, actions or situations, which involved members of their family.

2- Self-concept and self-confidence

The self-concept and self-confidence centered on those areas where expression was made in terms of how the self was perceived. This referred specifically to the child's sense of self.

3- Understanding, clarification, guilt and pity

The theme of understanding, clarification, guilt and pity focused on what the participant understood about the therapy process and whether it gave them clarification. Since guilt and pity tended to occur with understanding and clarification they were included as part of this theme. Guilt referred to feelings that the participant was not comfortable with thoughts, actions or feelings and indications of feeling sorry or sympathizing with a person, the feelings of pity. Guilt and pity did not always occur.

4- Containment and a holding relationship;

This theme focused on aspects where participants made reference to the therapy relationship, when the relationship was seen to provide support, guidance and empathy when needed.

5- Having a learning disability is not being "stupid"

This theme focused on where subject made reference to having a learning disability and the impact it had on the world around them.

6- Social difficulties

The social difficulties theme focused on where the participants made reference to social difficulties, behaving socially appropriately and friendship.

7- Anxiety and defences

The themes of anxiety and defences focused on aspects where participants made reference to unpleasant feelings or a sense of not coping and any comment, action or situation that indicated a need to protect against anxiety or unpleasant feelings.

8- Cognitive versus affective aspects of having a learning disability

This theme centered on those areas where expression was made in terms of how having a learning disability affected the therapy process.

9- Dependency, Insecurity and the Ability to Think

The dependency, insecurity and the ability to think theme focused on any reference to a dependent therapy relationship, the feeling of insecurity and the participant's ability to think about the relationship.

10- The relationship and the knowledge to help.

The theme of the relationship and the knowledge to help focused on the therapy relationship, that is any references to their feelings towards the therapist that they were assisting, guiding and helping either the child or the mother or the therapist understanding.

The Second reading was when the data was coded. The data transcripts were broken into parts or unit segments. The purpose of this phase was to organise the raw data into a more manageable form before analyzing it from a chosen interpretative perspective. The coding process helps to condense unwieldy discourse into manageable chunks (Bauer, 2000). The following section contains an example of a set of transcripts (i.e. a mother, a child and a therapist), since these transcripts also include the themes from the third reading it will be included after the discussion of the third reading.

It was in the Second reading these meaningful units were compared across all participants' interviews. The most frequent coding categories, i.e. similarities across participants and sessions, were identified. Patterns were recorded. The interpreter explored the categories and the patterns that connected them. The researcher looked for similarities across the participants as well as taking note of differences. This would involve constructing the phenomenon. By analysing across cases, one is at risk of making generalisations that do not consider the many individual factors influencing action. However, cross-case analyses are necessary if we wish to explore commonalities in experience across multiple instances of the same phenomena. Conceptualising data is necessary in order to 'talk' about one's research. This process of comparing the meaningful units was done by taking note of the similarities of all nine

participants as well as outlying the differences not only between the mothers, children and therapists, but between all of the mothers, children and therapists.

An example of how the data was coded from one set of transcripts (mother A, child A and therapist A) has been included. It also contains the third reading's codes, consequently the third reading will be discussed before the coding procedure is illustrated. The six other transcripts can be found in appendix B.

6.2.5 Reading Three: Reading for the Meaning of Psychotherapy with Learning Disabled Children

Finally the Third reading, reading for the meaning of psychotherapy, was done. The transcripts were read for aspects of the meaning the participants would give to psychotherapy. Up until this stage, the data analysis was primarily descriptive. At this stage the essential identified themes were interpreted according to a theoretical framework. Themes and symbolic interpretations were compared with existing literature. This required "theoretical sensitivity" - ways of being able to stand back from our initial assumptions and seeing certain significance's in the data. It was necessary for the researcher to ignore the findings in the second reading and read the transcripts from the process of understanding the meaning of psychotherapy. A continual dialogue is maintained between proposing relationships and checking with the data. These interpretations were then checked against the data collected to check their "fit". The themes have been coded next to the text. The following themes emerged:

11- Making sense of their worlds

This theme focused on any reference made to understanding or making sense of their world and their emotional experience.

12- Interpretation and containment

The interpretation and containment theme focused on areas where participants made reference to the therapy making them feel that it was a space where they felt understood and secure.

13- Psychotherapy as a way of coping

The theme of psychotherapy as a way of coping focuses on aspects where participants made reference to the therapy enabling them to cope or to be more effective in their world.

14- Psychotherapy working towards reparation of relationships

The psychotherapy working towards reparation of relationships theme focuses on areas where participants made reference to the therapy helping them to make sense of their emotional experiences and/or to overcome relationship difficulties.

These findings from the Third reading are outlined in section 6.4. Findings of Reading Three: Reading for the Meaning of Psychotherapy with Learning Disabled Children.

6.2.6 Illustration of the Second Reading and Third Reading Codes in a Set of Transcripts: Mother A, Child A and Therapist A

Narrative/ interview data: Interview with Mother Participant A	Code
<p>Nicky: The first thing I want to know sort of from you, is what is your understanding as to why your child is in play therapy. How do you understand it?</p>	<p>(1)Family boundaries and relationship (2) Social difficulties</p>
<p>Mother#A: (1) I think to firstly build his self-esteem, he has very little confidence so I guess to help that. Play therapy why else? (2) I think it's basically to teach him to interact with other children and also to read the signs, whether he's sort of irritating people, whether he's comfortable, that sort of thing.</p>	
<p>Nicky: Do you think there were any other reasons why you wanted him in play therapy other than that,</p>	

	initially?	
Mother#A:	When you say play therapy, what do you mean?	
Nicky:	The therapy that he's in, when he goes to his therapist and he spends time with her.	
Mother#A:	I think basically they just deal with his day-to-day problems (3)and issues where he's feeling insecure. Just to give him more confidence and help him to learn to cope with things. (4)	(3) Making sense of their worlds (4)Family boundaries and relationships;
Nicky:	And what are some of your thoughts about him being in play therapy, some of your thoughts and feelings around it?	Insecurity and the ability to think
Mother#A:	I think it's a positive thing. There are a lot of things they can't speak to their parents about and I think its nice that they've got somebody else who they can confide in (5) and it also helps me as well because I will then come and see you and you will let me know if there's a problem or where I need to look at or I can say to you there's a problem with this, just check he's okay or whatever it is or (6) what ever I may have done	(5) Understanding, clarification, guilt and pity; Making sense of their worlds (6) Containment and a holding relationship (7) Understanding, clarification, guilt and pity; Making sense of their



	which I should not have. (7)	worlds; Interpretation and containment
Nicky:	If you were to tell another parent what it's about, a parent who didn't know anything about therapy, what would you tell them it was about?	
Mother#A:	Basically therapy is just an opportunity for your child to express him or herself. If they've got problems, something they're worrying about, something they're not sure of, they can speak to that person, because children don't want to upset their parents, so a lot of times things will happen and then they don't have anyone to speak to because they can't speak directly to you (8). So it's nice that they do have an adult to speak to who can also give them advice. (9)	(8) Understanding, clarification, guilt and pity; Making sense of their world; Interpretation and containment (9) Containment and a holding relationship; Making sense of their world; Interpretation and containment
Nicky:	And in terms of that, what do you think your child's specific issues are?	Interpretation and containment
Mother#A:	I think he's battling with abandonment because of the divorce, which makes him very insecure (10). Also I think being in a remedial school he might feel that he's different,(11) and also he doesn't really identify well with other children,(12) he	(10) Family boundaries and relationships; understanding, clarification, guilt and pity (11)Insecurity and the ability to think (12)Social difficulties



	<p>does, he really has the need to be liked, he wants everyone to think he's cool and like him and think he's funny and smart. (13)</p>	<p>(13) Understanding, clarification, guilt and pity</p>
<p>Nicky:</p>	<p>How would you describe, what you know about the therapy, how would you describe your child's relationship with his therapist?</p>	<p>(14) Making sense of their worlds</p>
<p>Mother#A:</p>	<p>He's very comfortable with her,(14) he says that she doesn't have much of a sense of humour when he jokes with her, but he doesn't always speak to me about it. In the beginning he used to come and say to me today he saw her and this is what they spoke about or whatever but now it's sort of become routine, he doesn't really speak to me about it, but he's very comfortable with it. (15)</p>	<p>(15) Containment and a holding relationship; Making sense of their worlds</p>
<p>Nicky:</p>	<p>So if you had to give it describing words, what would you place on it ? How would you say it is, his relationship?</p>	<p>(16) Containment and a holding relationship; Making sense of their worlds;</p>
<p>Mother#A:</p>	<p>I'd say it's comfortable, he trusts her, I think it's very beneficial for him as well, and I've seen a big difference in him. (16)</p>	<p>Psychotherapy as a way of coping</p>



Nicky:	Can you tell me about the differences you've seen in him?	(17) Self-concept and self-confidence; Making sense of their worlds; Interpretation and containment
Mother#A:	He always used to be very sort of jumpy, in your face, loud, always wanting to be noticed, it was very important that he was always noticed all the time, always needed to be entertained, battling to get him to do homework, very sensitive, took everything personally, over-reacted, now I find that he's able to keep himself amused, you can say to him look I'm busy can you please give me ten minutes and he doesn't take it personally or as a rejection, he's more confident within himself, (17) he's settled down a lot, there's no more fighting for him to do homework.(18) He seems to have a better perception of what life is like around him. (19)	(18) Family boundaries and relationships; Psychotherapy working towards reparation of relationships (19) Understanding, clarification, guilt and pity; Containment and a holding relationship (20) Containment and a holding relationship; Psychotherapy working towards reparations of relationships
Nicky:	How do you think the therapy has done that ? What do you think in the therapy has made all these changes possible?	(21) The Relationship and the knowledge to help
Mother#A:	I think the fact that he's been able to be honest with somebody and say to them exactly how he feels (20) and that person didn't judge him, (21)	(22) Containment and a holding relationship; The



	<p>didn't go around and betray his trust,(22) and he just knows that he goes to therapy to help him, and whatever he says is confidential and for his benefit. (23)</p>	<p>Relationship and the knowledge to help (23) Containment and a holding relationship; psychotherapy working towards</p>
<p>Nicky:</p>	<p>What do you think they do in the therapy that has helped him?</p>	<p>reparation of relationships</p>
<p>Mother#A:</p>	<p>I think it's, as far as I'm aware they talk, I don't know too much about the play side, but I think it's, also if something does happen and I contact THE THERAPIST immediately he gets seen, which is important for him as well because then he can see that he is important and that people do care about him and I think that is very good as well. (24)</p>	<p>(24) Understanding, clarification, guilt, and pity; containment and a holding relationship; Interpretation and containment</p>
<p>Nicky:</p>	<p>What do you think your role is as the parent in this therapy process, if you were to try and describe it, what is your role?</p>	<p>(25) Containment and a holding relationship</p>
<p>Mother#A:</p>	<p>I think to sort of give feedback and keep up-to-date with what's happening.(25) Also if something happens on my side to inform the therapist so she can deal with it and also if the</p>	<p>(26) Understanding, clarification, guilt and pity; Making</p>

	<p>sense of their worlds</p>
<p>therapist feels that there's something that I need to deal with, to be open enough to be able to come in and say alright,(26) what is it and whether it's about me or whatever it is, to be able to deal with it as well and not sit and take it personally and feel that the child is speaking out of turn. I try to change what needs to be changed and if its me then I have to look at that.(27)</p>	<p>(27) Understanding, clarification, guilt and pity; Containment and a holding relationship;</p>
<p>Nicky: So it's a dual process, the one is to provide information, but also for you to perhaps work on yourself as a parent?</p>	<p>Cognitive versus affective aspects of having a learning disability; Psychotherapy as a way of coping; Psychotherapy towards reparation of relationships</p>
<p>Mother#A: Yes.</p>	
<p>Nicky: Do you discuss other things other than your child's difficulties when you have feedback sessions?</p>	
<p>Mother#A: I think just generally, what's happening, you know within the family, with the siblings,(28) sometimes school work, but no, I wouldn't say, not too much,(29) it's normally focused on the child and what his needs are. (30)</p>	<p>(28) Cognitive versus affective aspects of having a learning disability</p> <p>(29) Self-concept and self-confidence; Cognitive versus affective aspects of having a learning disability</p> <p>(30) Containment and a holding</p>



<p>Nicky: Do you ever directly focus on your child's learning difficulties in your feedback sessions?</p>	<p>relationship</p> <p>(31) Self-concept and self-confidence</p>
<p>Mother#A: No, it's more emotional and how he's coping and things like that? (31)</p>	
<p>Nicky: Is it ever the emotional aspect relating to a learning difficulty?</p>	<p>(32) Having a learning disability is not being "stupid"</p>
<p>Mother#A: What do you mean, that he would think he was stupid or something? (32)</p>	
<p>Nicky: Ja.</p>	
<p>Mother#A: No, not really, because I think we sort of dealt with that from the beginning. It hasn't really ever come up as far as I know.(33)</p>	<p>(33) Having a learning disability is not being "stupid"</p> <p>(34) Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability</p>
<p>Nicky: Do you feel that that's not a theme in the therapy?</p>	
<p>Mother#A: No I don't think so.(34)</p>	<p>(35) Family boundaries and relationships; Psychotherapy</p>
<p>Nicky: What aspects, when you say you speak about home-life, what aspects of home-life do you feel are important?</p>	<p>working towards reparation of relationships</p> <p>(36) Family boundaries and</p>



Mother#A:	Sort of how his siblings are interacting with him, (35)if there's problems at home, if he's being difficult, if there's a lot of pressure at home or if there's stress or something different has happened, something out of the ordinary, you know, if there's a change (36), how he's coping with his school work, you know(37), just basically general things in the home-life. (38)	relationships; Psychotherapy as a way of coping (37) Having a learning disability is not being "stupid" (38) Family boundaries and relationships
Nicky:	Do you ever discuss peer relationships when you have feedback sessions?	
Mother#A:	Ja, we do.	
Nicky:	What aspects of peer relationships are important?	
Mother#A:	I think what tends to come up is that he battles to make friends and have friends over and he gets bored with his friends very quickly and then he wants them to go home, so ja, we'll talk about that. (39)	(39) Social difficulties (40) Understanding, clarification, guilt and pity
Nicky:	And is it helpful to talk about these things in feedback sessions?	(41) Family boundaries and relationships; Understanding, clarification, guilt



Mother#A:	<p>Yes I think so because as a parent you may think your child is coping or that he's perfectly normal but you know if, I'm not a person who has friends and a lot of people around, so I wouldn't notice that he would (40)then need it I would just take it that he was that kind of child, you know, but then you find no wait a minute,(41), there is a problem he's feeling insecure or he's not confident, he needs to feel more secure and contained (42).</p>	<p>and pity; Insecurity and the ability to think; The relationship and the knowledge to help; Interpretation and containment</p> <p>(42) Family boundaries and relationships; Interpretation and containment; Psychotherapy as a way of coping</p>
Nicky:	<p>So the feedbacks are helpful?</p>	
Mother#A:	<p>Ja.</p>	
Nicky:	<p>What do you think the therapist focuses on, what do you think they discuss in their therapy sessions? What do you think he does in those therapy sessions with his therapist?</p>	<p>(43) Containment and a holding relationship; Making sense of their worlds</p>
Mother#A:	<p>I think if he needs to talk about something he will but if he doesn't then maybe they just talk about general things. I don't think it's a formal thing, you know every week he goes in and every week it's 'what problems do you have' or....(43)</p>	



<p>Nicky:</p>	<p>Okay, if you were to summarise it, what do you think he focuses on? What are the primary themes or issues that he probably takes to therapy?</p>	<p>(44) Containment and a holding relationship; Psychotherapy as a way of coping</p>
<p>Mother#A:</p>	<p>I don't know. I think it would just basically be how he's coping with things.(44)</p>	
<p>Nicky:</p>	<p>Coping with what sort of things?</p>	<p>(45) Family boundaries and relationships</p>
<p>Mother#A:</p>	<p>Maybe problems at home (45), maybe problems with his friends at school, I know that he complains a lot about some of the kids are very nasty to him and he doesn't know how to handle that. You know, I remember him saying at one stage that some of the kids were playing a game and if you miss the ball or something then everyone had a chance to punch you or something, so I think, things like that maybe, that need to be sorted out. (46)</p>	<p>(46) Self-concept and self-confidence; Anxiety and defences; Making senses of their worlds; Psychotherapy working towards reparation of relationships</p>
<p>Nicky:</p>	<p>Could you tell me a bit more about the peer relationships that he would perhaps discuss in therapy? More specifically what issues he would discuss about home-life, what do you think he</p>	



<p>would discuss?</p> <p>Mother#A: I think maybe whether having an older brother and sister, you know they do put a lot of pressure on him and you'll find that if he does do something wrong, everybody shouts at him, maybe if rules change or if there's discipline issues, you know, he's got a stepfather as well and maybe he battles sometimes with him, also maybe not seeing his own father or having different rules on that side understanding it all.</p> <p>(47)</p>	<p>(47) Family boundaries and relationships; Cognitive versus affective aspects of having a learning disability</p>
<p>Nicky: Do you think there's anything else he discusses in therapy?</p>	
<p>Mother#A: I wouldn't know, I mean he hasn't told me.</p>	
<p>Nicky: But your main focus would be that he probably focuses on home and school. Just peer relationships or any other aspect of school life do you think?</p>	<p>(48) Having a learning disability is not being "stupid"</p>
<p>Mother#A: Maybe teachers as well, if he's got a problem with a teacher or whatever, he might speak to her</p>	



	<p>about it just to find out if it's okay for him to feel that way. (48)</p>	
<p>Nicky:</p>	<p>The last question that I want to ask you is what do you think it means to have a learning disability or to have a learning difficulty, what do you think it means?</p>	
<p>Mother#A:</p>	<p>I think that everybody is different and some people are tradesman and some are academics and with the new school system its almost as if everybody has to be an academic and what they basically doing is if you can't get the marks, then you have to go for extra schooling, but I think in my sons case it's more the fact that he's in the school is because he didn't get the correct grounding because the way he does his eight's, the way he does his zeros, the way he adds, things like that, he wasn't taught how to do it and I think that's a lot to do with it, because as far as I'm concerned his marks are excellent, he's doing very well at school.(49) I felt bad for him having to struggle and that it took me a while to realize he was learning disabled, so that I felt a bit guilty about not noticing sooner (50)</p>	<p>(49) Having a learning disability is not being "stupid"</p> <p>(50) Family boundaries and relationships; Self-concept and self confidence; Insecurity and the ability to think</p>



<p>Nicky: So your understanding is that he didn't have the proper grounding, that he wasn't taught correctly?</p>	
<p>Mother#A: Yes. He wasn't taught correctly and also he was premature, so don't know.</p>	
<p>Nicky: Tell me a bit more about him being premature, how do you think that impacts on having a learning difficulty.</p>	
<p>Mother#A: Well, he was born when I was seven months pregnant and the doctor did say to me that he might have some problems with his development level, he might be very immature for his age, and I also heard that from other people as well. But I also heard other people say that their children were premature and there was no difference. So I don't really know what the answer is. You know, I think that when they found out that he didn't have the necessary grounding what they did was he went through remedial,(51) which then caused, well it was in a normal school which caused the other children to tell him he was stupid, which made him think he was stupid (52) also the remedial teacher was not properly qualified to</p>	<p>(51) Cognitive versus affective aspects of having a learning disability</p> <p>(52) Understanding, clarification, guilt and pity; Having a learning disability is not being "stupid"</p> <p>(53) Family boundaries and relationships; Having a learning</p>



	<p>handle the children, I felt bad and of course there were no results and then it was decided to put him in a remedial school and (53) here he has an opportunity to excel and to do better than other children and to be top of his class and I think that's given him a lot of confidence as well. (54)</p>	<p>disability is not being "stupid" (54) Self-concept and self-confidence</p>
<p>Nicky:</p>	<p>So do you think your child's learning disability will be an important part of the therapy process ?</p>	<p>(55) Having a learning disability is not being "stupid"</p>
<p>Mother#A:</p>	<p>I would imagine so. (55)</p>	
<p>Nicky:</p>	<p>What do you think they would focus on if it was part of the therapy?</p>	
<p>Mother#A:</p>	<p>That he's like any other child, that there's nothing different with him, there's nothing wrong with him, this is something that we going to have to deal with and it's a short-term thing and it's not an issue. (56).</p>	<p>(56) Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability</p>
<p>Nicky:</p>	<p>I would like to firstly thank you. And another thing I'd like to ask you, is there anything that you would like to add on the therapy process that perhaps I haven't covered in the questions I've</p>	



	<p>asked you, that you think would be important to know about the therapy process from a parent's perspective?</p>	
<p>Mother#A:</p>	<p>I think that it's necessary, I really do, I think that it should be a standard in schools, that children should receive therapy, maybe not on a regular basis but I think they should have sessions because there's so much pressure on kids in general these days(57). Both parents are working, sometimes they don't know what's going on and children just get lost along the way,(58) they really do, and I think it's very important that they can have somebody that they can speak to that they can trust, just to monitor them just to see that they coping.(59)</p>	<p>(57) Understanding, clarification, guilt and pity; Making sense of their worlds (58) Family boundaries and relationships; Psychotherapy working towards reparation of relationships (59) Containment and a holding relationship; Psychotherapy as a way of coping; interpretations and containment</p>
<p>Nicky:</p>	<p>So what do you think that would do? What would that do if most children have that? How would it change things?</p>	
<p>Mother#A:</p>	<p>I think that you'd have a lot less pregnant teenagers and I think you'd have a lot less promiscuity between teenagers, a lot less drug use. What's happening is, our children are getting</p>	<p>(60) Social difficulties</p>



<p>lost, they not coping with the peer pressure, especially with all these games that are being played by teenagers, (60) you know, these sexual games and things and I think that if a child was able to turn around to someone and say look, I'm being pressurised to do this, I'm not comfortable doing it,(61) that person, it's not a parent, so they don't have to worry about being chastised, that person can turn around and say, you know what, stand your ground, don't do it. Say to them it's okay to feel that way.(62)</p> <p>Nicky : Great, thank-you.</p>	<p>(61) Anxiety and defences</p> <p>(62) Self-concept and self-confidence</p>
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<p>Narrative/ interview data: <i>Interview with Child Participant A</i></p>	<p>Codes</p>
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<p>Nicky: Adults often ask what therapy is like for children, if you were to tell another child in your class, like your best friend, what would you say therapy was about?</p> <p>Child#A: It's just helps me so much because she sorts out my problems so I don't have anything that's going wrong or anything (1)</p> <p>Nicky: okay, that's great, why do you think you're in therapy?</p> <p>Child#A: um, I normally have problems with my family, like fighting (2) and I think my mom put me in therapy because I'm having a bit of a hard time (3) so that's why...she helps me when I can't deal with stuff, like when things make me</p>	<p>(1)Containment and a holding relationship; Making sense of their worlds; Interpretation and containment</p> <p>(2)Family boundaries and relationships; Psychotherapy as a way of coping</p> <p>(3)Anxiety and defences</p>



	sad or I guess stuff like that. (4)	
Nicky:	what are you having a hard time with?	(4)Containment and a holding relationship; Psychotherapy as a way of coping
Child#A:	with my dad, because they divorced and we split weekends, and my brothers and sisters, there's just problems with everyone, (5)	(5)Family boundaries and relationships
Nicky:	what do you do in therapy?	
Child#A:	if she takes me for like, say my normal time is on 3 on a Thursday and if she takes me on Wednesday or whatever, she wants to talk to me then if she takes me on Thursday, then we play Uno and we play chess and talk (6)	(6)Psychotherapy as a way of coping
Nicky:	what do you discuss with her while you play?	
Child#A:	I discuss the way that my dad has been treating me badly or if I'm having problems with my mom if we fighting and slamming doors (7)	(7)Family boundaries and relationships; Making sense of their worlds
Nicky:	do you discuss school with her?	
Child#A:	not really (8)	(8)Cognitive versus affective aspects of a having a learning

Nicky:	do you discuss friends with her?	disability.
Child#A:	yes, like I am having a fight with a friend and I don't know how to deal with it at school. (9)	(9)Cognitive versus affective aspects of a having a learning disability, Social difficulties
Nicky:	do you discuss anything else?	
Child#A:	we discuss the way that my friends get on with me, like (name of friend),(10) and because I'm going to his house this Thursday and I'm just wondering if my dad is going to be alright with it because it's his weekend and I'm getting worried, and that's why I'm waiting for Thursday so I can talk with her (11)	(10)Social difficulties (11)Family boundaries and relationships
Nicky:	what do you feel about THERAPIST A?	
Child#A:	I feel that she's a very nice person, she's gentle and soft (12)	(12)Containment and a holding relationship
Nicky:	tell me what you think your therapist may have thought or felt about you, what she would think about you?	
Child#A:	she thinks that maybe I'm a troubled child, that	(13)Self-concept and self-confidence



	<p>he needs therapy,(13) that he can't handle his family,(14) so he comes to me to sort out his problems and, you know (15)</p>	<p>(14)Family boundaries and relationships</p> <p>(15)Containment and a holding relationship, Making sense of their worlds; Interpretation and containment; Psychotherapy as a way of coping.</p>
<p>Nicky:</p>	<p>if THERAPIST A were to tell someone about you, like if she were to tell me about you, what do you think she'd say about you?</p>	
<p>Child#A:</p>	<p>she would say I'm having problems with my dad and um, I think that she doesn't talk to you about our whole, just that maybe a little bit of stuff, and I think she tells you about my dad, as well as my brother and sister, you know (16)</p>	<p>(16) Family boundaries and relationships; Psychotherapy working towards reparation of relationships</p>
<p>Nicky:</p>	<p>why do children come to this school</p>	
<p>Child#A:</p>	<p>because children that come to this school have got a problem with either reading, spelling or anything, I'm here because I have a problem with spelling and I'm main-streaming this year. (17)</p>	<p>(17) Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability</p>



Nicky:	is this school different to other schools?	<p>(18)Having a learning disability is not being “stupid”; Cognitive versus affective aspects of having a learning disability</p>
Child#A:	yes (18)	
Nicky:	how’s it different?	
Child#A:	<p>kids over here get special stuff, like the school I was at in 2000 they didn’t have they didn’t have reading, they didn’t have Afrikaans, it’s just that this school has so much subjects that it actually helps (19)</p>	<p>(19)Having a learning disability is not being “stupid”; Cognitive versus affective aspects of having a learning disability</p>
Nicky:	<p>alright, how would you describe it if you had to tell a friend about what’s different about this school?</p>	
Child#A:	that the tuck-shop list is better	
Nicky:	<p>what would you tell a friend about having a learning difficulty?</p>	<p>(20) Having a learning disability is not being “stupid”;</p>



Child#A:	a learning difficulty, I'd say you should just do your best so you can go back to mainstream coz(20) when I go to my other friends school they make fun of me because I'm in a problem school, so I can't have this in mainstream (21)	Cognitive versus affective aspects of having a learning disability
Nicky:	what does it mean to have a learning difficulty, what do you understand about learning difficulty	(21) Having a learning disability is not being "stupid"; Social difficulties
Child#A:	either you not learning right or your teacher is just not teaching you the right stuff. (22)	(22)As above
Nicky:	do you ever discuss having a learning difficulty with THERAPIST A	(23)As above
Child#A:	no (23)	
Nicky:	does THERAPIST A always understand what you trying to tell her?	
Child#A:	yes	(24)Understanding, clarification, guilt and pity
Nicky:	does she ever not understand you ?	
Child#A:	sometimes she doesn't understand me and	(25) Understanding,

	sometimes she does (24)	clarification, guilt and pity
Nicky:	what do you do when she doesn't understand what you trying to say?	
Child#A:	I've got to say it in easier better ways (25)	(26) Understanding, clarification, guilt and pity
Nicky:	and then does she understand?	
Child#A:	yes (26)	
Nicky:	have you ever told or been able to tell THERAPIST A when you unhappy or angry with her?	
Child#A:	no	
Nicky:	have you ever been unhappy or angry with her?	
Child#A:	no	
Nicky:	sometimes your mom meets with another therapist, okay, what do you think they talk about with this other therapist	(27) Containment and a holding relationship;
Child#A:	this other therapist probably asks my mom	Making sense of

	<p>questions and my mom tells them and she asks questions about what you like, do you want (27)...brother or sister or BROTHER'S NAME to come to therapy, and then she chooses which one comes to discuss problems. She needs to know what is happening at home. (28)</p>	<p>their worlds; Psychotherapy as a way of coping (28) Family boundaries and relationships; Understanding, clarification, guilt and pity.</p>
<p>Nicky:</p>	<p>how do you feel about your mom talking about your therapy</p>	<p>(29) Self-concept and self-confidence</p>
<p>Child#A:</p>	<p>I feel a little bit like why she's doing this, there's nothing wrong with me (29) but like that, and also I guess she does this because she loves me and she probably knows the best, (30) it helps me if I forget to tell her something and then she knows why I am not feeling so good. (31)</p>	<p>(30) Understanding, clarification, guilt and pity, Making sense of their worlds; interpretation and containment (31) Containment and a holding relationship (32) Family boundaries and relationships; Making sense of</p>

Nicky:	what do you think they talk about?	their worlds; interpretation and containment;
Child#A:	they talk about at home what's happening, is everything alright, if anyone's in a car accident, or if anyone's in trouble, or something, and stuff. (32) Also for my mom to get stuff she may need to help me, to help her understand me better (33).	Psychotherapy as a way of coping (33)Family boundaries and relationships; anxiety and defences;
Nicky:	one last question for you	Containment and a holding relationship
Child#A:	okay	
Nicky:	if you were to tell a therapist, like me or like THERAPIST A, what is the best way to help kids, what would you say	(34)Understanding, clarification, guilt and pity; Making sense of their worlds;
Child#A:	I'd say the best way to help kids is to just sort out their problems and to just make their life straight, if you dealing with teenagers, like make sure they don't commit suicide or anything (34) To like I guess make sense of their family stuff and to help them with it , to understand it.(35)	interpretation and containment (35)Family boundaries and relationships
Nicky:	how should they sort their problems out, what do you think would be a good thing for them?	(36) Containment and a holding relationship; making sense of

<p>Child#A: Um, just to tell them that don't worry you know, if they having problems with their mom you should just say, ja well she's just probably having a hard time or she's just not feeling right, you see, you can sort things out, you just have to find a way to do it (36)</p> <p>Nicky: and that's what therapists need to know, that you can sort things out ?</p> <p>Child#A: ja</p> <p>Nicky: okay, thank you very much</p>	<p>their worlds; interpretation and containment; Psychotherapy as a way of coping; Psychotherapy working towards reparation of relationships.</p>
<p>Narrative/interview data: Interview with Therapist Participant A</p>	<p>Code</p>
<p>Nicky: The first question that I want to ask you is, what is your understanding as to why this child is in play therapy?</p> <p>Therapist#A: Well he came into therapy because he's a (1) very anxious little boy and was very weepy in his class (2) and battling to come to terms with his parents' divorce. So those were really the presenting</p>	<p>(1)Family boundaries and relationships</p> <p>(2)Anxiety and defences</p>

	problems. (3)	
Nicky:	If you were to discuss this child with another therapist, how would you describe your feelings about this child?	(3) Family boundaries and relationships
Therapist#A:	He's quite a difficult little boy in some ways, he's difficult to work with because he doesn't form relationships easily, and he's got a very inauthentic presentation so it's always difficult to feel like I'm connecting directly with him, but I do feel that even with that, over time we've built some sort of relationship and he does come willingly to therapy and he does seem needy of the space but I do feel that our relationship (4) is fairly fragile and he does split quite a lot which means while at times he does idolise me in a sense, (5) at other times I can imagine that he would de-value me, but I do see it in terms of a long-term therapeutic intervention. (6)	(4) Understanding, clarification, guilt and pity (5) Anxiety and defences (6) Understanding clarification, guilt and pity
Nicky:	How do you psychoanalytic play therapy assisting your work with this particular child?	
Therapist#A:	I do think taking that kind of framework helps one	

<p>understand where the child has come from, that he's a very unbonded little boy with very poor attachment, so his objects really haven't been adequate, so in terms of understanding the framework I think it has been useful, (7) but in terms of pure psychoanalytic terms, (8) I wouldn't say that I've even worked to that way because it's been difficult to develop a transference relationship with him because of his difficulty with relationships and relating to people. But you know, try and reform his internal representations, I mean his internal objects by providing him with a safe containing experience has been different to the experience that he's had at home. Ja, so in both ways I found it useful. (9)</p>	<p>(7) Family boundaries and relationships</p> <p>(8) Interpretation and containment; Psychotherapy as a way of coping</p> <p>(9) Containment and a holding relationship; interpretation and containment</p>
<p>Nicky: Do you feel using psychoanalytic techniques such as interpretation, you mentioned transference, projective identification, confrontation, work with this child?</p>	<p>(10) Having a learning disability is not being "stupid"; Cognitive and affective aspects of having a learning disability</p>
<p>Therapist#A: I've got to use very simple language and use very concrete examples, ja, but sometimes making transference interpretations has been helpful and he has been able to take them. (10)</p>	

<p>Nicky: Do you feel he responds to interpretations that involve his internal world?</p>	
<p>Therapist#A: If I put them very simply and if I give him examples that maybe are related to external objects, ja, he has been able to take them, but they really have to simple interpretations. (11)</p>	<p>(11) As above</p>
<p>Nicky: The object relations literature contains many analogies between good enough mother, good enough therapist, between the holding environment, the holding function of therapy, do you see this as being part of the therapy with him?</p>	
<p>Therapist#A: Ja, I do think that trying to give him a different experience and trying to re-mother him in a sense and provide a holding space and help him feel that I can hold him in mind is important because a lot of his therapy has been about not being remembered and being forgotten and not feeling like either of parents can hold him in their minds or think about him. (12)</p>	<p>(12) Self-concept and self-confidence; Understanding, clarification, guilt and pity; Making sense of their worlds; interpretation and containment</p>
<p>Nicky: Do you feel your work or understanding in this area is different because you working with a</p>	

<p>learning disabled child?</p> <p>Therapist#A: Ja, I do think it's different, I think it really means I have to be careful with my interpretations and that it's not just purely about a relationship between him and me but there are external factors in terms of how(13) you relate socially (14) which I do think have to do with his learning disability, ja, we've had to bring in those kind of things. (15)</p>	<p>(13) Cognitive and affective aspects of having a learning disability</p> <p>(14)) Cognitive and affective aspects of having a learning disability, Social difficulties</p> <p>(15) Having a learning disability is not being "stupid";</p>
<p>Nicky: Work directly with him in terms of his learning disability?</p>	<p>Cognitive and affective aspects of having a learning disability</p>
<p>Therapist#A: Not directly in terms of labelling him as a learning disabled child, other than what it means to be here and he does feel like he's a damaged little boy, he feels damaged and that being here sometimes confirms that for him because he's different (16) and different to his siblings (17).</p> <p>But his learning disability for me comes out because he relates so poorly socially (18).</p> <p>He's missed social queues and he's insensitive to</p>	<p>(16) Having a learning disability is not being "stupid"; Making sense of their world</p> <p>(17) Family boundaries and relationships; anxiety and defences</p> <p>(18) Having a learning disability is not being "stupid"</p>

<p>others and some of his reactions are inappropriate but ja, he's also a very inattentive little boy, so we've sometimes dealt with that.</p>	
<p>(19) Ja, and looked at what could help his focusing and concentration and looked at medication, but it really hasn't been a primary focus of therapy. (20)</p>	<p>(19) Social difficulties; The relationship and the knowledge to help</p>
<p>Nicky:letting on what their true feelings actually are ?</p>	<p>(20) Cognitive and affective aspects of having a learning disability; The relationship and the knowledge to help; Psychotherapy as a way of coping</p>
<p>Therapist#A: I don't think in terms of the latter but I think being here in some way his needs are met, I think just being at SCHOOL that he gets therapy (21) and there's more one-on-one attention, not that he uses his learning disability in that way, but I do think inadvertently it's getting more of his needs met than he would have if he was just in an ordinary school. (22)</p>	<p>(21)Containment and a holding relationship; The relationship and the knowledge to help; Psychotherapy as a way of coping</p> <p>(22)Cognitive versus affective aspects of having a learning disability</p>
<p>Nicky: What other things are focussed on in therapy?</p>	
<p>Therapist#A: Well a lot about how to have his needs met and that in order to get his needs met he really needs to please others. Please his parents, please his</p>	



teachers, and also looking that in order to have his needs met (23)he presents as being quite histrionic and with many many schematic symptoms and so it's looking at that, but often, well I think always, if he's more autonomous or more independent, (24) his mother doesn't meet his needs or she becomes quite rejecting and quite persecutory and then he needs to be come placatory and self-sacrificing, so that's really what we've been focussing on the most(25) and then because he's such a pleaser, he then tries to stop his anger and so it is hard to address his anger because he is so placatory because his needs have never been meet, so it is difficult to work with (26).

We've looked at an analogy of him being a chameleon, that he needs to be a different person with all the different people in his life, including me, and there we've used the transference quite a

(23)Understanding, clarification, guilt and pity; Making sense of their world

(24)Anxiety and defences; Making sense of their world; The relationship and the knowledge to help

(25) Family boundaries and relationships; Understanding, clarification, guilt and pity; Psychotherapy working towards reparation of relationships

(26)Understanding, clarification, guilt and pity; Containment and a holding relationship; Interoperation and containment; Psychotherapy as a way of coping



	<p>lot about, that in order for me to like him, he's got to do various things and go along with me and help me win games and all those kind of things. (27)</p>	<p>(27)The relationship and the knowledge to help; Interpretation and containment; Psychotherapy as a way of coping</p>
<p>Nicky:</p>	<p>How do you see the role of working with the mother in terms of this child in therapy?</p>	<p>(28) Family boundaries and relationships, Self-concept and self-confidence, Understanding, clarification, guilt and pity; anxiety and defences; Making sense of their world; interpretation and containment; Psychotherapy as a way of coping</p>
<p>Therapist#A:</p>	<p>Well I think it's really essential because primarily his difficulties have arisen from his poor relationship with her which continue, so I do think working with the mother is absolutely essential and I think without that, the child is really quite a serious risk. She needs to develop the necessary skills to meet his needs, to be there for him. (28).</p>	<p>(29)Family boundaries and relationships; Making sense of their world; interpretation and containment</p>
<p>Nicky:</p>	<p>You say family relationships impact on him emotionally and is this part of the process with the child and the parent?</p>	<p>(30)Family boundaries and relationships</p>
<p>Therapist#A:</p>	<p>Ja, they continue to impact on him because he always feels, well he's an anxiously attached child and always feels, (29)well his trust in his mother is always so questioned, (30) so he feels that she often lets him down and she probably does and often misreads him, so her relationship with him is</p>	



<p>continually an important theme, as with his father, and his father and mother have an acrimonious relationship which obviously also impacts on him. And just a continued nature of both families, of his father's new family and his mother's new family, ja, they have continual effects on him.(31)</p>	<p>(31) Family boundaries and relationships; Understanding, clarification, guilt and pity; Anxiety and defences; Psychotherapy working towards reparation of relationships</p>
<p>Nicky: How do you see it having an effect on him?</p>	<p>(32) Family boundaries and relationships; Psychotherapy working towards reparation of relationships</p>
<p>Therapist#A: On his level of distress most obviously, by the fact that he's so often distressed by what's going on at home or by how his parents interact with him. That he continuously feels anxious and untrusting of them, and he just has a permanent anxiety about being abandoned, and when his parents are not communicating, as they don't, it somehow leaves him feeling (32) less contained and, as I say, more anxious.(33)</p>	<p>(33) Family boundaries and relationships;; Containment and a holding relationship; Anxiety and defences</p>
<p>Nicky: I wonder if you can just give me your psychoanalytic formulation of him?</p>	
<p>Therapist#A: Well, first of all, clinically if not an anxiously</p>	



<p>attached child, a reactive attachment disorder, and his attachment is poor and because of that he has such difficulty trusting the objects that he's internalised are persecutory and abandoning (34) which leaves him feeling very unsafe in the world and feeling as if his needs aren't going to be met (35) and as a result he presents with quite histrionic symptoms and quite self-destructive symptoms. (36)</p>	<p>(34)Family boundaries and relationships; anxiety and defences; Making sense of their worlds</p> <p>(35)Containment and a holding relationship</p>
<p>Nicky: The last question for you, if there's anything that you can think of about the process of therapy that I haven't covered with this child, is there anything you would like to add to it?</p>	<p>(36)Understanding, clarification, guilt and pity</p>
<p>Therapist#A: I just think that the process has been so difficult because it's basically been about forming a trusting relationship which he has such difficulty with, and also because he's untrusting of me, as he is with all adults in his life, ja, but it's just a very slow process.(37)</p>	<p>(37)Containment and a holding relationship; The relationship and the knowledge to help; interpretation and containment; Psychotherapy as a way of coping; Psychotherapy working towards reparation of relationships</p>
<p>Nicky: Thanks.</p>	
<p>Therapist#A: I suppose one more thing with this little boy is that</p>	

socially things are so unsuccessful for him that he can't make friends and he battles with friends, he battles even on the sports field, he battles in every area of his life,(38) and some way a long-term aim of therapy should be to help him feel more in control of his world and more in control of (39) what happens at home and what happens at school (40)so that he can gain some sort of sense of mastery because he doesn't have any sense of that at the moment.(41)

(38)Social difficulties; Making sense of their worlds

(39) Containment and a holding relationship

(40) Family boundaries and relationships; Insecurity and the ability to think; containment and a holding relationship

(41) Self-concept and self-confidence; Insecurity and the ability to think; The relationship and the knowledge to help; Making sense of their world; Psychotherapy as a way of coping

Nicky: Anything else ?

Therapist#A: And I suppose that the aim with his mom is just to help her get her child more, just to see his need more and for his need for nurturing and

<p>consistency and predictability and just even though it's a very basic parental counselling, to just help him have his needs met in some way, even if it's with packed school lunches or whatever, but just to start at that level.(42)</p>	<p>(42) Family boundaries and relationships;</p> <p>Psychotherapy as a way of coping;</p> <p>Psychotherapy working towards reparation of relationships.</p>
<p>Nicky: Thanks.</p>	

6.3 The Findings of Reading One: Reading for Global Understanding and Employment

One of the primary difficulties encountered with outlining the various themes was that many of the themes are related and impact on each other in an almost reciprocal manner. This will be discussed as each of the themes is individually outlined.

As noted, the following themes emerged:

Family boundaries and relationships; self-concept and self-confidence; understanding clarification, guilt and pity; containment and a holding relationship; having a learning disability is not being “stupid”; social difficulties; anxiety and defences; cognitive versus affective aspects of having a learning disability; dependency, insecurity and the ability to think; and the relationship and the knowledge to help.

6.3.1 Family Boundaries and Relationships

Family relationships across all three groups of participants were the most important theme in terms of the children's play therapy. Although the perspective, understandably, from the three different viewpoints was slightly different, the theme was consistently around the need to understand family structures and how family relationships may affect the child.

Mothers felt families were an important issue in terms of understanding the complex nature of family relationships. Mother participant A (Mp-A) felt the difficulties where “ **having an older brother and sister, you know they put a lot of pressure on him and you’ll find that if he does something wrong, everybody shouts at him, maybe if rules change or if there’s discipline issues, you know, he’s got a stepfather as well and maybe he battles sometimes, also maybe not seeing his own father or having different rules on that side.**” Mother participant B (Mp-B) felt the therapy helped to “**discuss specifically his relationship with his siblings and go through each one individually, what he finds difficult with certain relationships and which ones are positive for him and different aspects of those relationships...**” Mp-C (Mp-C) was slightly different as here child is an only child and the issues were around her relationship with her child, as well as her relationship and her child’s relationship with her ex-husband and his wife. She felt her child needed to talk about her mother in therapy as well as “**about her dad and her dad’s wife. The dad’s wife was a big issue on our lives and at one stage I didn’t know how to deal with it so I used to say to (name of child) speak to (name of therapist) about it...**”

One can clearly note the family circumstances shaped the child’s difficulties; two of the three participants came from divorced families while the third’s family was a very big family. Thus, the main themes of the therapy were the family structure, divorce related issues and sibling rivalry.

The mothers felt their children needed to have a space outside of the family to address possible anxieties and concerns about family relationships. They felt that issues of abandonment, lack of containment, and insecurity might have occurred with their children as a result of the difficult family relationships, which influenced how they related to their children. It would seem that the mothers’ experience of their children was that they did not feel contained or securely attached, consequently they could not learn to contain themselves. Thus, these children could not make sense of their emotional experiences. The mothers were able to acknowledge the importance of the child’s context and how family relationships and mother-child relationships impinged on their child’s life. The mothers were not seen to blame the child as the reason for them needing therapy rather they could acknowledge their role in not always providing a containing or secure environment. As the Mp-B stated: “**Because as a parent I am too involved and I get too emotionally drained and too frustrated with him. Something that comes to mind is the day I was taught how to help my child when he was**

so completely out of control. Just to turn him around and hold him, just that little bit of advice has helped enormously to manage.”

The therapists felt the family relationship difficulties were around parents not meeting the child's needs emotionally. Therapist participant A (Tp-A) stated **“his mother doesn't meet his needs or she becomes quiet rejecting and quite persecutory and then he needs to become placatory and self-sacrificing, so that's really what we've been focussing on the most...”** Therapist participant B (Tp-B) expressed **“family relations, I think part of his struggle is being one child out in a family of quite a large family of lots of children, feeling lost, that would be one of the very strong themes, you know, struggling for space in his mom's mind, having an important place and his parents knowing that there are quite a lot of siblings in his family...”** She went on to say **“I think a lot of his frustration at not being able to have his mom all to himself..”** Therapist participant C (Tp-C) felt her relationship with her parents played a significant role in the therapy and was a predominate theme. She stated **“ her home life, definitely, and her relationship with her parents and the difficulties in her background, the fact that she came from a home where she didn't feel like she had enough emotionally and materially...”**

The therapists' felt the impact of the family relationships resulted in the children feeling uncontained. The therapists seemed to feel that in order to assist the children with this they not only needed to work with the children but it was imperative to assist the mothers in a providing more containing relationship for them. Tp-A expressed that working with the mother was essential, as the child's primary difficulties were a result of the poor-mother child relationship. Tp-B expressed that working with the mother was necessary for feedback to help her understand him better. Tp-C felt working with the mother was important to help the mother to understand her child and provide her with the necessary skills to meet her child's needs.

Tp-C was the only therapist who raised concerns regarding the therapist's relationship with the mother impacting on the therapy. This therapist felt that, ideally, it would have been more beneficial if the mother had her feedbacks with another psychologist as not only was the child protective of her therapy space but the feedbacks seem to have moved into the mother's own needs and her need for therapy.

The primary themes of the three children's therapy were around family relationships. An analysis of their responses in the interviews revealed that they felt the therapy enabled them to understand and come to terms with different family relationships whether it was divorce, sibling relationships or parent-child relationships. The children felt that by being given the space to think, talk and understand family relationships they were able to begin a process of overcoming some of their difficulties.

The children in this study seemed to be aware of the importance of the therapist working with their mothers and felt the contact with the mother enabled the therapist to gain a deeper understanding of the family context. Specifically, they felt it was important for their mothers to inform the therapists of anything that they may have forgotten to tell the therapist.

6.3.2 Self Concept and Self Confidence

The mothers in this study seemed to feel having a lowered self-esteem and a lack of confidence was the primary reasons for their children being in therapy. The mother participants explained it as follows:

Mp-A explained that her child was in therapy **“to firstly build his self-esteem, he has very little confidence and I guess to help with that...”**. Mp-B felt her child was in therapy **“because he needs to come to a level of acceptance of who he is and the difficulties that he faces. He does not have a lot of confidence about who he is. The things that he's been given and his lack of self acceptance, a lot of it has to do with anger about that, his reactions to it are angry, frustrated and I think the therapy has helped him to first of all vent that anger in an appropriate setting and second of all to come to an acceptance of who he is and to accept the difficulties that he faces which in turn enable him to go forward.”** It is interesting to note that this was the reason given, however, it would seem from the interview he was originally in therapy as a result of a hi-jacking. Mp-C very clearly stated her child was in therapy **“originally I think it was more of a psychological thing to get over her, because she came into the school with low self-esteem, low confidence, everything was low, and that was my understanding that she went in there to build up her self-esteem and her confidence and help her deal with, well, to be confident.”**

In spite of the mothers' feeling that the main reason for their children being in therapy was around self-esteem issue, it was interesting to note that they felt the main issues or themes

discussed in therapy were not around self-esteem. The mothers felt the main themes of the therapy were around family relationships and social difficulties. Only in the analysis did the researcher realise this and it would have been interesting to explore this further in the interviews.

The researcher found it striking that all of the therapists, when speaking about the children's difficulties, did not feel self-esteem were one of the primary issues in the therapy. Poor self-esteem was only discussed in relation to the children's learning disabilities and social concerns. For example Tp-B only discussed his self-esteem when she was asked about his learning disability, **"Well it may contribute to, he's quite defensive and I think he does have quiet, he has issues of self-esteem, I do feel that may be contributing, but from his therapy what he offered in the sessions was more personal family matters, but I do think it probably contributes to his low self-esteem and his defence system that he has developed for himself."** Tp-C discussed her client's self-esteem in terms of how it affected her socially, **"socially she sometimes battles to understand why people do things or behave in a particular way, she sometimes lacks confidence in herself which affects her socially and she needs reassurance of her social abilities."**

The therapist felt that part of developing an understanding of the children's low self-esteem was being aware that the children felt, or had an awareness of, being damaged or feeling they were different. Tp-A when discussing working with the child's learning disability stated **" he does feel like he's a damaged little boy, he feels damaged and that being here (referring to the remedial school) sometimes confirms that for him because he's different and different to his siblings."**

It would be difficult for a child to articulate that they were in therapy for self-esteem problems or a poor self-concept. Self-esteem difficulties were alluded to indirectly in terms of not feeling successful in their functioning at school, having social difficulties and a general sense of feeling they were not coping at school or at home with the difficulties they encountered.

6.3.3 Understanding, Clarification, Guilt and Pity

In examining the mothers understanding of the impact the therapy and the therapy relationship, it is of interest to note that the mothers used many terms used in psychotherapy theory. It would seem that the mother, to some extent, had taken on the language of “therapy” to obtain or make sense of their child’s world. Mp-A said **“I think he’s battling with abandonment because of the divorce, which makes him very insecure.”** When discussing her role in the therapy she went on to say **“there is a problem he’s feeling insecure or he’s not confident, he needs to feel more secure and contained.”** Mp-B when expressing her thoughts on the therapy ended with **“with (name of therapist) it seems to have worked, it is a safe space for him, I think it is a safe place and it seems to be containing him.”** Mp-C said the following when discussing her child’s relationship with her therapist, **“Loving, in fact she’s almost like a second, not a second mom but a second person that she can really trust. She understand her difficult relationship with me and that I have not always been able to be good-enough.”**

The therapists noted that contact with the mother enabled them to obtain an understanding of the child’s state of mind and to discover how the interaction with the significant object had supported or discouraged the child’s development. This, in turn, enabled the therapist to develop a working alliance with the mother and appeared from the mother’s response to provide an intervention in its own right. The relationship with the mother provided a dual role: - that of a supportive role by providing a space for them to be understood and providing insight as to their child’s dynamics. This relationship with the therapist seemed an important space to allow for the mother to discuss and address their guilt about having a learning disabled child.

The work with the mothers seemed to have contextualized their child and provided a very deep understanding as to their inner world. Both the therapists and the mothers described a helpful working relationship between them, and this therapeutic relationship would appear to have been enhanced by the child’s awareness of them working together to help him/her.

It would seem that the therapists were aware of their feelings of compassion and empathy for these children. In addition, when analysing the transcripts it became apparent that an element of pity was also present in the therapists’ feelings and thoughts towards the children. The

therapists described each child in a positive way and then would describe the child as difficult to work with. They would then almost make allowances for them being such a difficult child by explaining their behaviour as a result of their family relationships or their situation. As Tp-A articulated when focusing on what is discussed in therapy, **“ his mother doesn’t meet his needs or she becomes quiet rejecting and quite persecutory and then he needs to become placatory and self-sacrificing, so that’s really what we’ve been focussing on the most and then because he’s such a pleaser. He then tries to stop his anger and so it is hard to address his anger because he is so placatory because his needs have never been meet so it is difficult to work with him.”**

The feelings of guilt, pity and contempt appear to be important feelings in understanding the mothers’ role in the therapy relationship. These feelings appear to be important themes in the mothers’ thoughts towards their children. All of the mothers felt a level of guilt about having a child with learning difficulties. Mp-A acknowledged this when she said **“I felt bad for him having to struggle and that it took me a long time to realise he was learning disabled, so I felt a bit guilty about not noticing sooner.”** When discussing her child’s learning disability Mp-B said **“As far as the family is concerned, I mean it hasn’t been easy, it has not been easy having my child go through these things, sometimes I felt to blame for his difficulties, especially when he is raging...”** The mothers felt pity and compassion for their child’s difficulties, however there was also a level of contempt. The mothers made numerous concessions for their child’s behaviour because they had “difficulties”. It would seem the mothers were apt to letting their children off being accountable or responsible for their behaviour. For example, mother participant B justified her child’s anger as a result of the child being different to others. Mp-C accepted her child’s behaviour being the result of her difficulties, **“ You know because of her difficulties I had to understand may be she needed to steal at that time or why she says the things she does to me.”**

6.3.4 Containment and a Holding Relationship

All of the participant’s described positive working relationships with each other and the relationships seemed to work in a reciprocal manner: - the child acknowledged the benefit of the therapist seeing their mother, the mother expressed the view that the therapist was assisting them with parenting and helping their child understand their world, and the therapist felt they could not assist the child without working with the mother. This was evident even

with Tp-C who was aware that in an ideal setting the mother would be seen by another therapist, however, she still felt the work with the mother was important as it helped the mother to be a more consistent parent who was more able to meet her child's needs.

The therapeutic relationship in terms of the mother-therapist relationship appeared to provide the mother with a holding environment to assist her towards becoming a more effective mother. Tp-A explained the importance of working with the mother as **“Well I think it's essential because primarily his difficulties have arisen from his poor relationship with her which continue, so I do think working with the mother is absolutely essential and I think without that, the child is really quite a serious risk. She needs help to develop the necessary parenting skills to meet his needs, to be there for him.”** Mp-A when discussing working with the therapist said **“I think to sort of give feedback and to keep up-to-date with what's happening. Also if something is happening on my side to inform the therapist so she can deal with it and also if the therapist feels that there's something that I need to deal with to be open enough to be able to come in and say alright, what is it and whether it's about me or whatever it is, to be able to deal with it...”**

All the mothers valued their relationship with the therapists in that they felt it not only provided them with support but, when needed, some guidance. The therapists expressed that a crucial part of the therapy was working with the mothers towards understanding their children and improving the mother-child relationship. As Tp-B expressed when discussing the type of work she does with the mother **“in terms of actual work that I do with (mother's name) is important, an important part of the process because (name of child) needs a lot from her, she needs more consistency, she needs more boundaries from her mom, she needs more understanding, so all of those things I've tried to convey in my work with the mom. Basically she needs to understand her child's needs better so they can have a better relationship.”**

The therapists, without a doubt, felt they used their understanding of the mother or family history to provide a therapeutic environment conducive to the child having a relationship that enabled them to obtain insight into their difficulties and towards growth. Tp-B used the child's history to understand his difficulties. This was expressed by comments like **“I sense that there may not be strong enough attachment as he would've liked, I think the mother may have, I mean I'm not sure what happened losing a son before him, and**

obviously it hasn't been, we haven't looked into it in deep analysis, it hasn't come up with him at all, but I do sense that there has been, I don't feel that mom is that available, I think having lots of children firstly, lots of other children doesn't offer the availability as much as he needs her to be..." Tp-C felt the child's difficulties were a result of her early developmental history, "Well, I think because her problems are so deep one has to look at the early years, more dynamic than analytic I suppose, so understanding how things went wrong with her and her mom in terms of attachment."

The therapy relationship from the therapist's descriptions was seen to be an extension of the mother-infant relationship as well as providing the child with a holding environment where previously they had not experienced a good-enough mother. As therapist participant A pointed out "I do think that I try to give him a different experience and trying to re-mother him in a sense and provide a holding space and help him feel that I can hold him in mind is important.... Not feeling like either of parents can hold him in their minds or think about him."

6.3.5 Having a Learning Disability is Not Being "Stupid"

The common theme of learning disabled people is that of their internal world of feeling "stupid" and their perceptions and understanding of how others see them, how society places great value on intelligence (Bungener & McCormack, 1994). However, neither the children nor the mothers indicated that they felt "stupid". The focus of stupidity was more on society not understanding their difficulties. The concern for the mothers was on the child being labeled and the impact that would have on their self-esteem.

The children all had a very clear understanding of what it meant to have a learning disability. Cp-A explained that children went to this remedial school "because children that come to this school have got a problem with either reading, spelling or anything. I'm here because I have a problem with spelling." Cp-B said the school was different because "teachers are nice and they care about you and they there to help you, there's much less children in a class so they can help you." He went onto explain a learning difficulty meant that its "just that you not stupid, you can't understand things." Cp-C explained that children came to the remedial school because "They've got a problem, like reading or math's, because some people, their minds just go different. Like my sister and my

brother, they used to come to this school, they had problems with math's and reading, I've got a problem with reading, because I can't read words, I get difficult, I normally add words into it." It would seem that these children's understanding of what a learning disability was did not make them feel different or stupid. This could be the result of the school environment not allowing them to feel different because all of the children have learning difficulties or the therapy had enabled the child to explore their defences and they had overcome such feelings. It would be impossible to sift out which it is, but it is likely a combination of these.

All of the mothers acknowledged that their children's learning disabilities impacted emotionally on their children and indicted that learning was a struggle for them. Of note was Mp-A, who was aware that her child struggled to learn but then gave a conflicting statement **"there is nothing different with him, there's nothing wrong with him, this is something that we are going to deal with and it's short-term thing and it's not an issue."** Mp-B gave a very positive account of her child having a learning disability. She was aware of the struggle her child went through but felt that because he struggled to such an extent, he learnt perseverance and was also given the opportunity to understand himself, which she felt was a **"tremendous"** thing. Mp-C clearly blamed herself for not initially taking note of her child's struggle and she felt a great deal of guilt as a result. She also indicated that as a result the mother-child relationship was difficult.

The focus from the therapists' perspective was on whether they felt their understanding and their work was possibly different when working with this learning disabled child. The therapists felt they had to use more simple and concrete interpretations in their therapy. This will be discussed further in a later section.

6.3.6 Social Difficulties

From the therapist's perspective the social difficulties seemed to be related to having a learning disability in that the children had to learn to master social skills and develop a social understanding. As Tp-C explained when referring to the therapy with Cp-C and her learning disability **"I think there are areas where she feels competent but I think her learning disability has given us material to work on in terms of her feeling like learning is a battle for her and learning to interact socially and what is ok socially."**

In examining the mothers' perspective their descriptions of their children's social difficulties appeared to relate to the child's inability to always think about reacting in a socially appropriate manner and a level of acting impulsively in social situations. Mp-A in her discussion as to why her child was in therapy said **"I think it's basically to teach him to interact with other children and also to read the signs, whether he's sort of irritating people, whether he's comfortable and that sort of thing."** It would seem from both perspectives that the social difficulties are related to the child's failure to learn.

The children felt the therapy was a place to discuss possible friendship problems. Cp-A said he discussed friendships with his therapist, **"like if I am having a fight with a friend and I don't know how to deal with it at school."** Cp-B, when asked about whether he discusses school, he responded with **"about my friends being horrible to me and all that...(when) they call me names and tease me."** When asked whether she discussed anything else other than her family in therapy, Cp-C responded by saying **"Maybe some of my friends hurt me, but nothing's happened to me with my friends so far, just my family."**

6.3.7 Anxiety and Defences

From the interviews there was no indication that the children, the mothers nor the therapists felt they used their learning disability as a defence. Rather, the child's anxieties and defences appear to be more in relation to their early mother-infant relationship and related to poor attachment. The failure of these children to internalise a secure base appeared to have resulted in difficulty with developing versatile strategies to cope with their worlds.

For all three groups, the importance of the child's relationship with the mother was seen to be critical. To illustrate this point I will provide quotes from one of the three sets of participants. Tp-A expresses that working with the mother was **"Well I think it's really essential because primarily his difficulties have arisen from his poor relationship with her which continue..."** Mp-A in discussing her role in the therapy started off by saying it was to provide information as to the child's world and she went on to say **"also if the therapist feels that there's something that I need to deal with, to be open enough to be able to come in and say all right, what is it and whether it's about me or whatever it is, to be able to deal with it as well and not sit and take it personally... I try to change what needs to be**

changed and if its me then I need to look at that.” Cp-A felt that his mother’s role in the therapy was **“they talk about at home what’s happening, is everything alright, if anyone’s in a car accident, or if anyone’s in trouble, or something, and stuff. Also for my mom to get the stuff she may need to help me, to help her understand me better.”**

The three groups commented that anxieties were the result of not having effective coping strategies to manage their worlds effectively. The therapists’ all agreed that the primary therapeutic work with these learning disabled children was around containment and the recovery of a lost early object relationship. This was further reinforced by the children’s view that their mothers’ needed help to improve the child’s relationship with their mother. It is interesting to note that two out of the three therapists expressed concern around their client’s self-destructive impulses and the third therapist repeatedly expressed concern over the child’s anxiety. The concern appeared to be around how these defences could influence the child’s ability to function in the world.

Thus, the learning disabled defence styles seem to have been a preoccupation with attachment concerns. The lack of an available object appeared to result in these children having a greater need for a good internal object, hence the therapists’ feeling the need to provide these children with containment. All of the therapists had a sense that these children could be helped by the therapy to contain their anxieties and enable them to encounter new difficulties and challenges. Hence they stressed the importance of the therapy relationship as well as working with the mother.

6.3.8 Cognitive versus Affective Aspects of having a Learning Disability

All of the therapists discussed how, when making interpretations with these children, they had to be in a simple and concrete manner. As noted by Tp-A **“I’ve got to use very simple language and use very concrete examples, ja, but sometimes making transference interpretations has been helpful and he had been able to take them.”** Tp-B felt that **“if I’d been completely psychoanalytic in my whole approach with him, I think I would’ve lost him, to be honest with you, after session two. I had to change my interpretations to a more simple framework, more accessible.”** Tp-C noted that she had **“to learn to be very gentle and sometime strategic in the way that I make interpretations and sometimes I**

The therapy relationship with the mother seemed to enable the mother to think about the child. This resulted in a mother that became more available to the child resulting in the mother being experienced as more containing.

6.3.10 The Relationship and the Knowledge to Help

The therapy relationship with the child and the mother was described as being a good relationship, in spite of one of the children not wanting to be in therapy, according to the mother and the therapist. The therapist's all felt that they had some form of connection with the child but they had to be careful with interpretations and felt the relationship was fragile. From all three parties the relationship, in terms of their attitudes and feelings towards one another, was very positive. It is interesting to note that all three children described their therapist as "nice", even the child who did not want to be in therapy and acted out his anger and frustration physically towards his therapist.

6.4 Findings of Reading Three: Reading for the Meaning of Psychotherapy with Learning Disabled Children

6.4.1 Making Sense of their Worlds

The primary process of the therapy with these learning disabled children was to provide a forum that enabled both the mother and the child to be in an environment conducive to this. The most important function of the therapy was to help them make sense of their emotional experience.

Obtaining an understanding of their emotional world for the children involved addressing their difficulties in two distinctly separate areas: - the family world and the school world. In understanding the family world, the children felt the role of their mother was important in terms of providing the therapist with an understanding of the family relationships, the family structure in terms of siblings or step-parents and any changes in the family. The children felt they could not communicate the complex nature of their families without the assistance of their mother. The therapists supported this, as they required clarification of the child's external reality.

The school world, surprisingly, did not involve making sense of being learning disabled. Rather it was around social difficulties. The therapy relationship for the child gave them the opportunity to explore their concerns. The learning disability primarily impacted on their ability to understand and interpret social situations, either in the family or at school.

6.4.2 Interpretation and Containment

The ability of the therapist to contain not only the child but also the mother's anxieties and frustrations seemed vital for all the participants in this research. This containment referred to being understood, supported and given the necessary help or guidance. The holding environment was a space where the child and the mother felt empathised with, understood and it was a place free of judgements. By providing a holding environment for the child and the mother, it enabled the child to feel safe and to develop a stronger sense of self. This occurred by giving the mother the space and opportunity to repair the past as well as empathise with her child about issues she previously misunderstood. For the child experiencing a trusting and understanding relationship enabled them to not only have the space to address their difficulties but to feel that their therapist could help them deal with their anxieties.

The mothers' experience was that the therapist enabled them to understand their child's world, which enabled them to feel their child's experiences. With this process the mothers were able to develop empathy for their child, which improved their relationships. In addition, by giving the mother the opportunity to discuss the ordinary detail of their own life and feelings, the therapist became the container of their anxieties and enabled them to endure and understand their child.

For the children, they were first able to experience the therapist as a container which resulted in them feeling understood. The therapist was able to respond to the child's emotional needs, take them in and work them over and pass them back in a modified and more manageable form. This was noted by the child feeling understood and that their therapist was able to help them overcome their concerns and anxieties. For this containment to be effective it was, however, necessary for the therapist to modify their interpretations by making them more simple and concrete.

6.4.3 Psychotherapy as a way of Coping

The main vehicle that seemed to enable these children to feel they were able to cope with their worlds was through their therapy relationship and their mother obtaining some assistance and guidance. The children and mothers felt that their therapist were emotionally available and attentive to their needs. This enabled them to feel someone was there to help them discover and manage their difficulties, which enabled them to feel that they, themselves, were able to cope.

6.4.4 Psychotherapy Working towards Reparation of Relationships

The primary function of the psychotherapist working with children is to help them make sense of their emotional experience and overcome relationship difficulties. The space created for these children enabled them to explore and to grow. The primary difficulties outlined by all participants were around family relationships and the need to understand them in order to develop better relationships. By providing the child and the therapist with a safe and secure base from which they could gain confidence the children felt capable of discussing their concerns and confronting their anxieties. This safe space, where the therapist was available, enabled the child and the mother to move toward not only having a better relationship but also to enhance the separation process. The mothers and the children all expressed that therapy helped improve relationships.

6.5 Evaluating the Data Analysis

As noted from the hermeneutic perspective, the researcher actively participates in the construction of the interpretation. However, there are criteria for evaluating and mediating between contesting interpretations. Denzin's (2002) set of eight questions to evaluate the interpretation of the method, and Packer and Addison (1989) criteria for mediating between contesting interpretations were referred to by the researcher throughout the analysis of the transcripts. At the end of the analysis, the researcher went back to the questions to assess whether these criteria had been met, as well as to enable her to distance herself from the

material and provide a clear evaluation that all these criteria had been met. Each of the criteria will be discussed.

Coherence

The research was seen to provide a sense of consistency in that the themes were consistently and clearly linked. The interpretative account was seen to connect to the object relations frame of reference and was plausible.

Uncovering

The logical process of analysing and interpreting the data resulted in the data being comprehensible and understandable. This in turn resulted in a formulation of a framework for conceptualising the data.

Validation of interpretation by another researcher

By proving the step-by-step process of the research, the reader is able to follow the logical process of interpretation as laid out by the researcher. Although the researcher supervisor was not used to assist in the interpretation, as he would have different fore structures and, therefore different interpretations, his reading of the data collection process and analysis ensured that the research followed a logical process.

As noted Denzin (2002,p.362) uses a set of eight questions to evaluate the interpretation of the materials. Each of these questions will be briefly discussed to assess how the research is seen to fulfil these criteria.

Illumination

The research is seen to examine the learning disabled child's experience of being in therapy from the three participant experiences which provided a clear understanding of each participant's experience. The material provides clarity on each of the participants lived experience of the therapy process.

Thickly Contextualised Materials

The interpretations that have been developed are as a result of the experiences of the participants as they outlined them in the interviews. For the research to be meaningful the context of the social situation has been described, that of learning disabled children in a

remedial school. The interpretations have documented and explained the meanings, thoughts, emotions and actions of the participants.

Historical and Relational Grounding

The literature review and reference to research has allowed the data to be historically and relationally grounded by providing a literature review and outlining where and how the research proceeded. The experiences of the participants have also been located in the lived world.

Process and Interaction

The interpretative account is seen to provide a clear outline of the process, how the research was formulated and what steps were taken in the analysis of the data has been given. The analysis provided an outline of how the various connections were formulated. The relations or interactions between the findings is provided. In other words, the data is outlined and the analysis process enables the reader to follow the various links made by the researcher.

Engulfment of What is Known

The researcher or interpreter was an informed reader even before the research as she works in the field. In addition the process of developing a literature review ensured she was an informed reader about the topic and this further expanded her knowledge on the topic.

Prior Understanding

The researcher's prior understanding of the topic and her further understanding, which was enhanced by the literature review, were used to assist her in developing the interpretations and to ensure they were meaningful. The researcher also constantly made notes as to her thoughts about the data and her understanding of the data, which were used to assist her in her interpretations.

Coherence and Understanding

This was seen to be achieved in that the interpretations produced an understanding of the experience that comes together into a meaningful whole. This included all the relevant information and prior understanding. This results in the reader being led through in a meaningful way. This was further assessed by the researcher's supervisor being able to understand how the interpretations were related and how they formulated a meaningful

whole, thus providing an understanding of the therapy relationship with learning disabled children.

Unfinished Interpretations.

The researcher was aware that all interpretations like understanding, are considered to be unfinished, provisional and incomplete. Thus, this does not mean that the interpretations are inconclusive, it only means interpretations are never finished.

Chapter 7

7. Conceptualising the Data

The findings will be discussed under three different sections, which are seen to correspond with the literature review. Since the focus of the research is on learning disabilities this will be the initial focus of the discussion. This will include a debate on emotional intelligence and suitability of the learning disabled child for psychotherapy; discussions around self-concept and self-confidence; social difficulties, anxieties and defences; the therapy relationship, the knowledge to help and transference; the internal and external world of the learning disabled child and, finally guilt, pity and contempt. This will lead into reviewing the results from an object relations perspective which will include debates on object relations theory in terms of attachment and the learning disabled child's ability to think; the need for a containing and a holding relationship; interpretation and containment; the mother-infant relationship and the failure to learn; and lastly, curiosity and the failure to learn. Finally, the role of the mother in relation to the child's therapy will be discussed in relation to the cognitive and affective aspects of having a learning disabled child and in terms of family boundaries and relationships.

7.1 Psychotherapy with Children who have Learning Disabilities

7.1.1 Emotional Intelligence and Suitability

As noted in the literature, learning disabled people have rarely been considered for psychotherapy and though this is changing as a result of research, some concerns still arise about the undertaking of such work. The primary concern is around being understood, particularly when there is a difference in IQ and there are significant difficulties with the person's verbal abilities. The interviews with the children in this research indicate some difficulty with expressing themselves; as a result it was necessary for the researcher to ask numerous questions. Consequently, the children were led and the thoughts or feelings around the therapy process lacked spontaneity. Nonetheless, the research confirms Sinason's (1992) view that learning disabled people are not limited emotionally. However, it often takes time to explore them emotionally. The therapists noted that it was necessary in the therapy to reframe interpretations into simple language. As noted in the literature, cognitive deficiencies

occurring in the learning disabled child would affect many aspects of the child's development, the research illustrates how these difficulties emerged in the child's inability to translate abstract interpretation. Nonetheless, the research indicates the children seemed emotionally aware and knowledgeable despite major deficits in their cognitive intelligence.

Lanyado and Horne (1999) noted how it is important for the therapist to keep in mind how the child is able to understand what is being said. In other words, the therapist's language needs to be in tune with the child. The therapist not only needed to make their interpretation simple and concrete but they had to be explicit when trying to explore these children emotionally. This was also evident in the interviews with the children; the questions had to be very explicit and precise. In spite of this, the interviews from the children yielded fairly limited information.

As the literature notes, children may communicate their feelings in different ways such as through words, play or action (Lanyando & Horne, 1999). This is seen to be important when working with learning disabled children whose language capacities may be limited or the child may experience difficulty expressing themselves (Sinason, 1992). One is able then to note the drawback of doing interviews is that all the non-verbal information, which occurs through play and action, as well as the transference relationship, could not be examined. What is clearly evident is that learning disabled children are emotionally intelligent and benefit from the therapy relationship. They showed the ability to know their own emotions and the ability to understand the emotions of others, which are seen to be core aspects of emotional intelligence (Goleman, 1998).

7.1.2 Not Being "Stupid"

The common theme of learning disabled people is that of their internal world of feeling "stupid" and their perceptions and understanding of how others see them is how society places great value on intelligence (Bungner & McCormack, 1994). However, neither the children nor the mothers indicated that they felt "stupid". The focus of stupidity was more on society not understanding the child's difficulties. The concern for the mothers was on the child being labelled and the impact that would have on their self-esteem. The children all had a very clear understanding as to what it meant to have a learning disability. Thus, the hypothesis could be that it is this understanding that did not allow them to feel stupid, or it

could be that the remedial school environment does not allow them to feel different because all of the children have learning difficulties, or the therapy has enabled the child to explore their defences and they had overcome such feelings. It would be impossible to sift out which it is but it is likely a combination of all three.

7.1.3 Self Concept and Self Confidence

As already discussed, most researchers involved with learning disabled children report that these children have a poor self-concept (Derbyshire, 1991; Leondari, 1993; Spencer, 1997; Silver, 1996; Silver & Hagnin, 2002; Rawson & Cassady, 1996). It stands to reason then that this would be one of the themes in this research. It was evident from the mothers that they felt having a lowered self-esteem and a lack of confidence was the primary reasons for their children being in therapy. In spite of this, the mothers felt the main themes of the therapy were around family relationships and social difficulties and nothing was discussed on self-esteem. Although no apparent reason for this emerged in the research it is hypothesised that the children's poor self-concept would have resulted in behaviour such as anxiety, anger and depression. This behaviour would have alerted the mothers or the school to possible emotional problems. The children's difficulties with family relationships and social concerns would then have emerged through the therapy relationship. It is also hypothesised that these concerns resulted in lowered self-esteem and a poor self-concept. In addition, the children had all been in therapy for more than six months and self-esteem issues may have emerged initially in the therapy.

The theories seem to agree that self-concept or self-esteem is significantly related to how individuals will approach and react to achievement demands (Leondari, 1993). Research has emphasised the fact that cognition and feelings about oneself appear to be important factors in the well being and successful functioning of the individual (Leonardi, 1993; Rawson & Cassady, 1995). In addition, the initial role of the parent is considered fundamental to the formation of a positive self-concept (Strain, Gulralnick & Walker, 1986). It is therefore striking that all of the therapists when speaking about the children's difficulties, did not feel this was a primary issue in their therapy.

Poor self-esteem was only discussed in relation to the children's learning disabilities. The therapists focused on how these children all had some difficulties with social relationships.

Vaughn and Elbaum (1999) state that learning disabled children are socially at risk since their self-esteem and overall emotional well-being is adversely affected. The therapists felt that part of developing an understanding of the children was being aware in the therapy relationship that the children felt or had an awareness of being damaged or feeling they were different. One of the therapists stated that because the child felt that they were damaged, being learning disabled confirmed this feeling of being damaged. This self-perception of being different would place the child at risk for depression and a lowered self-esteem (Kazdin, 2000; Morrison & Cosden, 1997). Perhaps the impact of having a learning disability was not in terms of a sense of self as being “stupid” rather the impact was on the child’s poor self-concept, that they were in some way different or, as one of the therapist stated, damaged.

As already noted, it would be difficult for a child to articulate that they were in therapy for self-esteem problems or a poor self-concept. Self-esteem difficulties were alluded to indirectly in terms of not feeling successful in their functioning at school, having social difficulties and general sense of feeling that they were not coping with the difficulties at school or at home. These difficulties would lead to a great deal of frustration and a lack of control and predictability over their environment. The combination of their sense of poor social competence, lowered self-esteem and a self-perception of being different would place these children at risk for depression and anxiety (Kazdin, 2000; Morrison & Cosden, 1997). Considering the literature and the research confirming that self-esteem is a concern for all three parties, it is interesting then that, other than being aware of the children’s lowered self-esteem, very little emphasis has been placed on it in the actual therapy process.

7.1.4 Social Difficulties

Learning disabled children are at risk socially since their self-esteem and overall emotional well being is potentially adversely affected (Vaughn & Elbaum, 1999). It stands to reason that all of the participants cited social difficulties as being an important component of the therapy, as problems with social perceptions and establishing social relations are often seen to be characteristic of having a learning disability (Derbyshire, 1991; Leondari, 1993, Spencer, 1997; Silver, 1996, Rawson & Cassady, 1996; Tait & Genders, 2002). From the therapist’s perspective the social difficulties seemed to be related to having a learning disability in that the children had to learn to master social skills and develop a social understanding. Thus, the learning disability did not merely affect the cognitive realm but also resulted in the children

having to learn social skills. The researcher is in agreement with the on-going debate around the need to include social difficulties in the definition of what constitutes a learning disability, as it seems to be an important deficit for these children

In examining the mother's perspective, their descriptions of their children's social difficulties appeared to relate to the child's inability to always think about reacting in a socially appropriate manner and a level of acting impulsively in social situations. It would seem from the therapist and the mothers' perspectives that the social difficulties are related to the child's failure to learn. This would then link to Bion's 'K' activity, which he referred to as coming to know (Malcolm, 1992). The mother-infant relationship with the children would result in 'minus-K' or a reversal of learning. Bion described the phenomena of 'minus-K' as not understanding or misunderstanding, and he links this to primary envy, which is influenced by the mother-infant relationship (Malcolm, 1992). Thus, the children being unable to understand social situations or having social difficulties relates to the child's failure to learn.

According to Horner (1999), the child who is left in despair has their immature sense of self overwhelmed and uses a range of earlier defence mechanisms to deal with the primitive anxieties of annihilation, disintegration and abandonment. When these continue into childhood the resultant effect is poor peer relationships and an inadequate capacity for independent functioning (Horner, 1999). It is evident that this occurred with these children. For a movement towards autonomy and individuation the therapists felt that the mothers had to assist with the process.

7.1.5 Anxieties and Defences

As noted in the literature review, the anxieties are seen to be important themes when working with learning disabled children (Hernandez-Halton et al., 2000; Sinason, 1992). Sinason (1992) focused on the use of a "secondary handicap" as a defence mechanism against anxiety. As already stated, the "secondary handicap" is the particular use, which the person makes of the original organic or traumatic damage as a defence against the feelings associated with the original handicap (Hernandez-Halton et al., 2000; Sinason, 1992). From the interviews neither the children, the mothers nor the therapists felt that they used their learning disability as a defence. Rather, the child's anxieties and defences appear to be more in relation to their early mother-infant relationship and related to poor attachment. Sinason's

(1992) “secondary handicap” may not have emerged as these children are placed in a remedial environment, which is accepting of their difficulties. Consequently, it stands to reason that neither the mothers nor the children would feel the need to use their learning disability as a defence against the reaction of others towards them.

Furthermore the children had all been in therapy for at least six months; consequently the manifestation of the “secondary handicap” may have previously been used. The research has also not established whether or not the use of the “secondary handicap” was evident before the children entered into the remedial school and being in an environment with children with similar difficulties they no longer needed to use it as a defence.

For all three groups, the importance of the child’s relationship with the mother was seen to be critical. How this has impacted on the child and is in keeping with Siegal’s (2001,p.77) view that insecure attachment has often been associated with “emotional rigidity, difficulty with understanding the minds of others, and risk in the face of stressful situations.” As noted by the therapists, the failure of these children to internalise a secure base appears to have resulted in difficulty with developing versatile strategies to cope with their worlds.

The three groups indicated that their anxieties were the result of not having effective coping strategies to manage their worlds effectively. According to the literature the type or level of attachment would seem to determine the individual’s relationship and defence mechanisms they use to cope (Eagle, 1997). The type of defensive styles appears to be in line with West and Keller’s (1994) description of the enmeshed or preoccupied individual. Unlike the defensive exclusion characteristics of the avoidant or dismissive individual, the enmeshed and preoccupied individual are preoccupied with attachment concerns. The therapists all agreed that the primary therapeutic work with these learning disabled children was around containment and the recovery of a lost early object relationship. This was further reinforced by the children’s view that their mothers needed help to cope.

The lack of an available object appeared to result in these children having a greater need for a good internal object, hence the therapists’ feeling the need to provide these children with containment. All of the therapists had a sense that these children could be helped by the therapy to contain their anxieties and enable them to encounter new difficulties and challenges. Hence, they stressed the importance of the therapy relationship, as well as



working with the mother. Klein (1997a) stressed the lack of availability of the mother would not enable the infant to contain the anxiety aroused by phantasies of persecution, and excessive splitting would be used as a defence. Although, splitting was not referred to as a defence, it was apparent that these children were inadequately contained. This would then result in an immature ego, which allows the child to experience a great deal of anxiety (Weininger, 1992).

7.1.6 The Therapy Relationship, The Knowledge to Help and Transference

A positive relationship between patient and therapist has been considered to be essential for successful treatment. Establishing a therapeutic relationship partly depends on the ability of the patient to recognise the therapist as a helping mediator (Kovacs & Lohr, 1995). For the relationship to be beneficial to the patient, the patient needs to feel his/her problems can be solved, they need to have confidence and trust in the therapist and willingness to self-disclose (Kovacs & Lohr, 1995). The research indicates that by providing the child and the mother with a safe and secure base from which they could gain confidence, they felt capable to discuss their concerns and anxieties. However, the researcher is of the opinion that this seemingly beneficial relationship for the child and the mother should be interpreted with caution.

It is often said that transference is the repetition of the patient's relationship with the object from past experience with the analyst in the present (Hamilton, 1988). Interestingly, the only aspect of transference that came-up was that the therapist often found it difficult to work in the transference but could not express why. From the child's perspective one would have thought that some form of negativity would have been discussed in terms of their mother not being available or their therapist not understanding them. For a deeper understanding of this it would be necessary to examine the actual therapy session to try to obtain a sense of the transference relationship.

Mannoni (1973) argues that often the learning disabled client tries to mould themselves to the desires of the other and the resultant effect is a dependant relationship, as the client is determined to keep everything nice. It is interesting to note that all three children described their therapist as "nice", even the child who did not want to be in therapy and acted out his

anger and frustration physically towards his therapist. It would seem that it was safer for the child to fit in with the expectation that they must “like” or fit in with their therapist.

The inability of the children to tolerate the therapist’s interpretations appears to be the repetitive use of the “minus-k” in the analysis. How this appears to have manifested in the therapy was that the children were not always able to tolerate the therapists’ interpretations, thus the therapists said they had to modified them. Malcolm (1992) described the phenomena of “minus-k” as not understanding or misunderstanding, which is linked to primary envy. Envy therefore appears in the therapy in a disguised form.

It is interesting that all of the therapists’ viewed the children in a positive way, even the therapist who had a child who did not always want to come to therapy and was described as being quiet aggressive at times. In addition, the therapists tended to feel that these children’s difficulties were a result of the mother and not a characteristic of the child or even the possible limitations of the therapist. It would seem that these children aroused a sense of impotence in the therapist. Rather than face the limitations of the child and the possible subsequent frustration that these children may evoke, the therapist focused on the mothers creating the child’s difficulties. This would appear, then, to have excused the child as the stimulus of counter-transference and permits the therapist to maintain a sense of being objective and caring. Thus, the mother or the family situation was seen as the obstacle for the child and thereby they displaced their frustrations and anger from the child. Accordingly, the safe, secure therapy relationship can be seen to be both helpful and counter effective in that all three participants experienced it as beneficial, however they may all have ignored important aspects of the therapy relationship.

7.1.7 The Interaction of the Internal and External World

The importance of obtaining an understanding of the child’s world through the input of the mother reconfirms the importance of understanding that the child does not exist in a vacuum but in a family and social context. The therapists noted that contact with the mother enabled them to obtain an understanding of the child’s state of mind and to discover how the interaction with the significant object had supported or discouraged the child’s development. This, in turn, enabled the therapist to develop a working alliance with the mother and appeared from the mother’s response to provide an intervention in its own right. The

relationship with the mother provided a dual role: - that of a supportive role by providing a space for them to be understood and providing insight into their child's dynamics. This relationship with the therapist seemed an important space to allow the mother to discuss and address their guilt about having a learning disabled child.

In examining the mothers' understanding of the impact of the therapy and the therapy relationship, it is of interest to note that they used many terms used in psychotherapy theory. The literature focuses on the need for the therapist to use some form of shared language to describe the emotional state of the child (Rustin, 2000; Wilson & Ryan, 2001). It would seem that this has occurred in the reverse, the mother has to some extent taken on the language of "therapy" to obtain or make sense of their child's world. The work with the mothers seemed to have contextualised their child and provided a very deep understanding as to their inner world. Both the therapists and the mothers described a helpful working relationship between them, and this therapeutic alliance would appear to have been enhanced by the child's awareness of them working together to help him/her.

The focus of the study was to use children in the 'latency stage' of development as children at this age can utilise a wider repertoire of cognitive, emotional and behavioural responses to emotional stressors (Madorin, 1999). In addition, they are able to understand the causes of events, to express themselves and to understand that different people react in different ways (Madorin, 1999). In light of this, it is interesting to note the importance the children placed on their mother communicating with the therapist and there was concern that this was needed as they may forget important aspects of their lives that they wanted the therapist to be aware of. This may have been the result of the children having a learning disability and not being confident or even lacking in the ability or skills to communicate the necessary information to the therapist. Although, the children were at a stage of development where their social communication should have resulted in more in-depth information, their responses were limited.

7.1.8 Guilt, Pity and Contempt

Bungener and McCormack (1994), in their discussion on counter-transference with the learning disabled patient make reference to a trio of feelings, namely, guilt, pity and contempt. The present research indicates that the therapists were aware of their feelings of

compassion and empathy. However, in analysing the transcripts it became apparent that an element of pity was present in the therapists' feelings and thoughts towards the children. The therapists described each child in a positive way and then would describe the child as difficult to work with. They would almost make allowances for them being such a difficult child by explaining their behaviour as a result of their family situation. This manoeuvre, under the guise of pity, actually allowed the therapist to blame the mothers, thereby possibly displacing the anger from the child or their feelings towards the child. Rather than understand the difficulties that these mothers possibly endured in their daily lives, the mothers are considered unavailable to meet their child's needs.

Although Bungener and McCormack (1994) did not intend their trio of feelings to be used to understand the mothers role in the therapy process, they appear to be important themes in the mothers' feelings towards their children. As noted, all of the mothers felt a level of guilt about having a child with learning difficulties. They felt pity and compassion for their difficulties, however, there was a level of contempt. The mothers made numerous concessions for their child's behaviour because they had "difficulties". It would seem the mothers were apt to let their children off being accountable or responsible for their behaviour. For example one of the mothers justified her child's anger as a result of the child being different to others.

7.2 Object Relations Theory

7.2.1 Object Relations Theory, Attachment and The Ability to Think

It would seem the mother-child relationship and attachment had the primary influence over the child's internal dynamics. Since all of the therapists come from an object relations perspective, it stands to reason that they felt this to be an important component of the child's difficulties.

Siegel (2001) outlines how research shows the impact of secure or insecure attachment relationships influences the emotional well-being of a child to the point of affecting the neuro-development of the mind. Insecure attachment is seen to be associated with emotional rigidity, difficulty in social relationships, impaired attention and difficulty in understanding the minds of others in the face of stressful situation. From the therapist and the mothers'

perspective they appeared to feel these children had difficult family relationships as a result of divorce or coming from a large family. The mothers' felt that the children may have had issues around abandonment, lack of containment and insecurity as a result of the difficult family relationships. The mothers' understanding is, therefore, that these children were not securely contained. This, in combination with their poor social skills, their poor birth histories and inability to always understand the therapist, would seem to indicate that they were insecurely attached (Schore, 2001). This insecure attachment appeared to have resulted in all of the difficulties that Segal outlines emerging in some way.

The mother-child relationship was important for all three participants and was seen to directly impact on the child's emotional well-being. According to Bion (1957), an infant faced with an adverse disposition will potentially have the following features; a preponderance of destructive impulses, a never decided conflict between the life and death instincts, and severe anxiety as well as an intolerance of frustration. Klein (1997a) stressed the conflict is created by the individual being aware that the object he loves is also the object against whom he rages and feels anger. In light of this it is interesting to note that two out of the three therapists expressed concern around their clients self-destructive impulses and the third therapist repeatedly expressed concern over the child's anxiety. It would seem that an ego-destructive superego developed with these children and the normal integrative process of the depressive position, which would have allowed the ego to function, as a conscience, was not there. Theoretically, this would result in a child whose experience is that the world did not want to know their thoughts (Britton, 1992).

The child's failure to develop a thinking and perceiving mind is seen to manifest as a learning disability. When interpreting the results it is clearly evident that the failure of maternal containment interfered with the child's ability to learn. Thinking from this perspective is influenced by attachment, a good-enough mother, the containment of the child's anxieties and destructive impulses and the availability of the mother to make sense of emotional experience.

7.2.2 Containment and a Holding Relationship

The co-operative alliance of client and therapist, referred to as the "therapeutic alliance", is seen as an important component in determining the outcome of psychotherapy (Hamilton,

1988). In the development of such an alliance the positive self-presentation of the therapist is generally considered a central component (Bachelor & Salame, 2000). All of the participants described positive working relationships with each other and the relationships seemed to work in a reciprocal manner: the child acknowledged the benefit of the therapist seeing their mother, the mother expressed the view that the therapist was assisting them with parenting and helping their child understand their world, and the therapist felt they could not assist the child without working with the mother.

It would seem from the therapists' descriptions that the therapist-child relationship provided a holding function and assisted the mothers towards becoming more effective parents. The mothers' felt that the relationship with the therapist provided them with support and understanding. This then would enable the mother to respond to the child's experiences, which would then theoretically assure the child that the mother could tolerate and accept their feelings. The therapist working with the mother would enable them to become more available to the child and this would reduce the child's anxiety and possibly alleviate feelings associated with insecure attachment (Eagle, 1997; Klein, 1997a).

Without a doubt the therapists used their understanding of the mother or family history to provide a therapeutic environment conducive to the child's utilising the insight aspect towards a growth process. The therapist's viewed the therapy relationship as providing the child with emotional containment as a result of difficulties with family relationships and school related issues. The therapist's were able to express how poor attachment and poor bonding affected the children, and provide a safe, containing and holding experience for the child which were important in the therapy relationship. The research did not reveal how the therapist created this with the children and there was no indication from any of the participants that this was a result of their needs being met either in the therapy or as a result of the mother's work with the therapist.

The researcher is aware that the concept of good-enough mother in the literature is not the same as that of Bion's 'container', however both concepts have in common the notion that the mother has to hold or contain emotions that are too painful for the infant to bear. The mother has to think about the child. Bion (1962) believes that the container must also perform what he called the 'alpha function', that is, assign meaning to the chaos that the baby projects onto the mother. The research indicates the importance of the therapist assisting the mother

to ‘think’ about their child, which involves the therapist assisting the mother to be in a state where they can reflect upon their child’s needs and experiences. There is further evidence of this thinking when one focuses on how the mother periodically used psychoanalytical language, she would have thought about the child and taken on some of the therapists thoughts. The therapists noted that contact with the mother assisted the mother in understanding her child and for her to address her difficulties with meeting the child’s needs. This was seen to improve the mother-child relationship.

As noted, the process in which *beta* elements are transformed into *alpha* elements is regarded by Bion as essential in the production of thought (Britton, 1992). By the therapist creating a consistent space not only for the child but also for the mother, it enabled the child to experience a world that wanted to know their thoughts. The ability for these children to process painful experiences was seen to be dependent on the presence of a therapist who could bear to be in touch with the full range of the child’s experiences. This was clearly illustrated by the child who was aggressive and did not want to always come to his sessions. Yet, he always did and he must have felt his therapist could cope with his rage. This in Bion’s terms would be providing a containing function necessary to facilitate the pain and distress (Bion, 1962).

7.2.3 Interpretation and Containment

Bion, expanding on Klein’s concept of projective identification, has transposed what happens to an infant to what happens in the link between mother and infant; and the mother’s (therapist’s) ability to contain the primitive anxieties which the infant (the client) experiences (Spillius, 1992). Thus, it is generally recognised that sufficient containment is necessary to support the child through therapy. The ability of the therapist to contain not only the child but also the mother’s anxieties and frustrations seemed vital for all the participants in this research. By providing a holding environment for the child and the mother, it enabled the child to feel safe and to develop a stronger sense of self. This occurred by giving the mother the space and opportunity to repair the past as well to empathise with her child about issues she previously misunderstood. For the child experiencing a trusting and understanding relationship enabled them not only to have the space to address their difficulties but to have a “good-enough” therapist and an object that then could contain their anxieties.

Bion's (1962) reverie is a specific function of the mother, which allows her to feel the infant in her, and to give shape and words to the infant's experience. The mothers experience was that the therapist interpreted their world and enabled them to understand their child's difficulties, which enabled them to feel their child's experiences. With this process the mothers were able to develop empathy for their child, which improved their relationships. In addition, by giving the mother the opportunity to discuss the ordinary detail of their own life and feelings, the therapist became the container of their anxieties and enabled them to endure and understand their child.

For the children, they were first able to experience the therapist as a container, which resulted in them feeling, understood. The therapist was able to respond to the child's emotional needs, take them in and work them over and pass them back in a modified and more manageable form. This was noted by the child feeling understood and that their therapist was able to help them overcome their concerns and anxieties. For this containment to be effective it was, however, necessary for the therapist to modify their interpretations by making them more simple and concrete.

7.2.4 The Mother-Infant Relationship and the Failure to Learn

The primary function of the psychotherapist working with these children was to help them make sense of their emotional experience and overcome relationship difficulties. The space created for these children enabled them to explore and to grow. By providing the child and the mother with a safe and secure base from which they could gain confidence they felt able to discuss their concerns and confront their anxieties. This safe space where the therapist was available enabled the child and the mother to move toward having a better relationship and enhancing the separation process. This growth could be seen as part of the separation-individuation process as the child experienced the mother as more confident, consistent and secure, and the child was able to develop more confidence and a more integrated sense of self.

7.2.5 Curiosity and the Ability to Learn

As previously noted in the literature, Klein (1975) stated the early connection between the epistemophilic impulse or the desire for knowledge and sadism is very important for mental

development. The desire to know is secondarily reinforced by the need of the child to master the considerable anxiety that is provoked (Klein, 1975). However, this anxiety can also inhibit the desire to know if the damage to the mother/parent is believed to be too great (Simpson, 2002). Simpson (2002) argues that the way the mother responds to the child's curiosity in terms of their overall and often subtle emotional attitude is of greater importance than Klein emphasised.

As previously discussed, Simpson (2002) outlines two significant areas that affect the child's curiosity to learn. Firstly, he believed that children are very sensitive to the way parents may show pleasure and interest in their curiosity, or they may be embarrassed, hurt, guilty or simply unresponsive. "The extent to which a parent can tolerate curiosity in the child if it is coloured with destructive or sadistic fantasies depends upon the individual parent's capacity to tolerate her/his own fantasies in this respect, which is a function of the extent to which they have been able to work through their own oedipal conflict" (Simpson, 2002,p.218). The ability of the therapist to contain not only the child but also the mother's anxieties and frustrations seemed vital for all the participants. This involved working through the mother's guilt and providing an opportunity to repair the past as well as to empathise with her child about issues she previously misunderstood. By enabling the mothers to understand their guilt and by developing a better understanding of their child the mothers seemed more able to tolerate their child, especially their anxiety. This would create confidence in the availability of the mother and create a more secure relationship.

Secondly, according to Simpson (2002) a primary concern for children at this stage is the nature of their parent's relationship and the parent's attitude to each other. Thus, how the parents respond to the child's curiosity and how the child experiences the oedipal situation inside his parent's mind can be seen to either impede the growth of knowledge or allow for it to thrive. Although the parent's relationship was not addressed in the research, by helping the mother understand their child they seemed to feel more confident in their parenting ability which would enable them to feel confident to allow their child to explore, which would create curiosity.

Finally, the researcher would add a third significant area that would affect the child's curiosity to learn. It is felt the type of attachment comes before Simpson's (2002) view on how the parent interacts with the child in terms of their ability to tolerate curiosity or the

nature of the parent's relationship. The type or level of attachment clearly determines the child's relationships and the defence mechanisms they use cope. The early mother-infant interaction and the type of relationship has an important impact on the development of the mental processes. Without secure attachment and an inability to contain themselves, these children could not make sense of their emotional experiences and consequently, they could not engage in mindful reflective behaviour. This would then impinge on their curiosity to learn, as in order to explore one's world there needs to be a secure base from which this exploration can occur.

7.3 The Role of the Mother in Child Analysis

7.3.1 Cognitive and Affective Aspects

Case (2001) argues that the parent's emotional response to having a learning disabled child needs to be understood and addressed. This emotional response may include grieving the loss of the idealised child and may also involve a variety of defences such as anger, denial or projection (Silver & Hagnin, 2002). However, only one defence emerged in this research and even then it was not a prominent theme. This was the defence of guilt from the parents for having a child with learning difficulties. The literature reveals that when working with parents it is important to focus on the loss of having a child with a disability (Silver & Hagnin, 2002). Grief or loss as a theme did not emerge for either the parents or the therapists.

The researcher feels that there are two possible premises for this. Firstly, the predominant positive flavour of the research in itself may be a defence against focusing on the possible pain, anger and frustration of having a learning disabled child. This then would mean that the therapists were colluding with this seemingly positive view. The parents' approach to having a learning disabled child was that it was difficult, however there was no indication of parental grieving over the loss of the idealised child. The mothers and the therapists could therefore be seen to be in denial since the adaptation to having a learning disabled child is on going over the child's life span and may change as a function of the child's developmental stages (Silver & Hagnin, 2002). Secondly, by placing these children in a remedial school with children who have similar difficulties and the families socialising with families in the same position, has perhaps resulted in greater acceptance than if the child was in a mainstream environment.

7.3.2 Family Boundaries and Relationships

As noted family relationships across all three groups of participants was the most important theme in terms of the children's play therapy. Since the child does not exist in isolation one would expect this to be one of the most important themes. According to the literature the cultural values of each family determines the type of childhood and determines whether intervention is welcomed (Hopkins, 1999, Kazdin, 2000a). This was clearly evident with the participants, since the mother had an understanding and acceptance of the therapy, this enabled the child to have an acceptance of their therapy. The family circumstances appeared to shape the child's difficulties; two of the three participants came from divorced families while the third's family was a very big family. The main themes of the therapy were the family structure, divorce related issues and sibling rivalry.

Mothers felt families were an important issue in terms of understanding the complex nature of family relationships. Family members may have different interpretations and perceptions of the family system. For this reason the mother's understanding of the family dynamics and construct becomes important (Kerig, 1995).

The mothers felt their children needed to have a space outside of the family to address possible anxieties and concerns about family relationships. They felt that issues of abandonment, lack of containment, and insecurity may have occurred with their children as a result of the difficult family relationships and influenced how they related to their children. The parents' understanding of family relationships suggest that the relationship with the object and the way in which objects are internalised determines the development of the self (Cashdan, 1988; Hamilton, 1988).

It would seem that the mothers' experience of their children was that they did not feel contained or securely attached; consequently they could not learn to contain themselves. Thus, these children could not make sense of their emotional experiences. As a result, this insecure attachment due to the failure of the parental object results in an inability to develop versatile strategies to deal with feelings evoked by the failure of the attachment figure (Eagle, 1997). This then would refer to Bion's unmetabolised beta elements, which resulted in a difficulty for the child to interpret their world (Eagle, 1997). It is interesting to note that

mothers were able to acknowledge the importance of the child's context and how family relationships and mother-child relationships impinged on their child's life. The mothers were not seen to blame the child as the reason for them needing therapy rather they could acknowledge their role in not always providing a containing or secure environment.

It is generally acknowledged that parental health should be seriously considered as one of child psychotherapy components (Kovacs & Lohr, 1995). Nonetheless, one of the interesting aspects of the literature is the inconsistent and vague role of parents in the studies that do not involve family therapy (Kovacs & Lohr, 1995). The present study indicates the importance of parental involvement to such an extent that it could almost be seen as an intervention in its own right. The inclusion of the parents in the therapy process served to help the mothers become more effective in their care for their children, and also served to strengthen emotional ties.

The therapists seemed to feel that in order to assist the children they not only needed to work with the children but it was imperative to assist the mothers to become a more available and effective parents. This would tie in with Winnicott's view of the mother-infant (child) relationship as the fundamental growth-facilitating relationship and the relationship upon which all other relationships mutually depend (Seinfeld, 1993; Summers, 1994).

Grych and Fincham (1990) proposed a model of the links between marital relationships and child development that emphasises the importance of studying family relationships, as experienced from the child's perspective. In addition, it is important to assess the family environment from the perspective of the individual family members since family members may have different perceptions of the family system (Kerig, 1995). The children in this study seemed to be aware of the importance of this and felt the contact with the mother enabled the therapist to obtain a richer and deeper understanding of the family dynamics. Since the nature of a child's difficulties, from an object relations perspective, is traced to the arrested development of the self and anomalies in splitting, one can note the importance of this. All of the children were aware of the importance of the therapist meeting with their mother to obtain an understanding of their family context.

The primary themes of the three children's therapy were around family structure and family relationships. An analysis of their responses in the interviews revealed that they felt the

therapy enabled them to sort out and come to terms with different family relationships whether it was divorce, sibling relationships or parent-child relationships. The children felt by being given the space to think, talk and understand family relationships they were able to overcome their difficulties.

The focus of the research was on the mother as the parent; consequently the role or the impact of the father on the therapy process was not addressed. Since the primary focus for all the participants of the therapy was on family relationships, it would stand to reason then that the role of the father would be important. However, the father was only seen to be important in terms of divorce related concerns such as weekend visits to the father. Even with the intact family, the role of the father did not emerge. In order to obtain a clear understanding as to the reason for this further research which focused on the role of the father would be required.

7.4 Summary and Integration of the Findings

The results of this study add to the growing literature on the importance of the relationship factors in the child, mother and the therapist experience of the psychotherapy process. The positive view of the therapy was consistent with the research, which indicates better treatment outcome results from therapy in which the quality of the relationship between therapist and client is better (Wheston & Sexton, 1993; Kazdin, 2000a). In addition, this study is consistent with Kazdin's (1999; 2000) research which indicates that parents who have a better relationship and alliance with the therapist tend to do better in treatment than those who do not. Results indicate a positive working relationship with the mother and the relationship that works in a reciprocal manner enhances the effectiveness of the therapy. The working alliance with the mother appeared to be an intervention in its own right. Not only to provide a supportive role where they felt understood but to give them insight into their child's dynamics. The basis of the working alliance was for the therapist to provide a holding environment that assisted the mother towards becoming more effective parent.

The research clearly indicated that to a greater or lesser degree the attachment that these learning disabled children experienced with their mothers impacted on their emotional well-being. In addition, the failure of the maternal containment would seem to have interfered with the child's ability to learn and difficulty with developing versatile strategies to cope with their world. The lack of containment and lack of confidence from the mother resulted in an

insecure relationship with their child. Consequently these children felt the mother's needed guidance, assistance and reassurance to help develop better relationships with their children. However, this also resulted in a dependant relationship with the therapist for both the child and the mother to provide them with assistance. Yet, this dependency created commitment to the therapy relationship, which enabled the mother to become more available and containing.

This research confirms Sinason's (1992) view that learning disabled people are not necessarily limited emotionally, however it often takes time to explore them emotionally. This required the therapist to provide simple and often concrete interpretations that the children could understand. There was an indication that part of this was an inability to tolerate or understand the therapist's interpretations, thus the therapist had to modify them. In addition there was an underlying need for the child to create a dependent relationship with their therapist, as it was safer for the child to fit in with the therapist's expectations.

The results of the study revealed common or similar themes as to the therapy relationship from all three perspectives. In examining the participant's experiences, it is of interest to note family dynamics and family relationships were consistently the most important theme in the therapy. The family circumstances appeared to shape the child and the mothers' concerns as well as the mother-child relationship. The participants felt the therapy relationship provided a space to understand and improve family relationships. A significant theme related to the therapist working with the mother, was the discussion and addressing of their guilt about having a learning disabled child. Bungener and McCormack (1994) in their discussion on counter-transference with learning disabled patients referred to the trio of feelings, namely, guilt, contempt and pity. Interestingly these feelings were evident not only with the therapist but were feelings the mothers experienced in relation to their child.

It would appear that the findings of this study are largely confirmatory of other research studies that have outlined the impact of having a learning disability on self-esteem. Interestingly it was seen as a reason for the therapy from the mother's perspective but not important in the actual therapy process. Although the therapist did not feel it was an important issue in the therapy, there was an awareness of the child being damaged or different in some way.

Unlike Sinason's (1992) focus on the use of the "secondary handicap" as a defence mechanism against anxiety, the defence styles of these children were rather in line with West and Keller's (1994) description of the enmeshed and preoccupied defence styles. Specifically, the children were preoccupied with attachment concerns. The primary therapeutic work with these learning disabled children was around containment and the recovery of a lost early object relationship.

In examining the results from the present study from the perspective of the meaning of the psychotherapy with learning disabled children, four primary meanings are given to the therapy relationship:

Firstly, the primary process of the therapy with the children was to provide a forum that enabled both the mother and the child to be in an environment that allowed them to make sense of their emotional experiences. This involved making sense of their family dynamics through working with the child and the mother. Making sense of their school worlds, this surprisingly, did not involve understanding of being learning disabled, rather it was needed to make sense of their social difficulties at school.

Secondly, containment and interpretation. The holding environment for the child and the mother created by the therapy enabled the child to feel safe and to develop a stronger sense of self. Providing the mother with the space and the opportunity to repair the past and to enable her to empathise with her child improved the mother-child relationship. The therapist was able to respond to the emotional needs of the child, take them in and work them over and pass them back in a modified and more manageable form.

Thirdly, the children's therapy relationship and their mother's obtaining some guidance and assistance, resulted in them feeling more able to manage their difficulties. This in turn created a sense for the child that they were "good-enough" to cope.

Fourthly, the primary meaning the therapists gave to the therapy relationship was to help these children make sense of their emotional experience and overcome relationship difficulties. The safe space that the therapist created enabled the child and

the mother to move not only towards having a better mother-child relationship but it seemed to enhance the separation process.

The research findings of this exploratory study have revealed that there is a need to understand the relationship between all three participants in the therapy relationship with learning disabled children. It is apparent from the findings and the literature that the relationship with the therapist is of utmost importance and there is a need for the therapist to create a holding and containing space for the child and the mother. It would seem that the child's family dynamics must be addressed as a priority as opposed to other issues that are expected to be important in the therapy process, such as the child's learning difficulties.

7.5 An Evaluation of the Method and a Need for Further Research as a Conclusion

The analytic literature is replete with references to the extraordinary difficulty and complexity when designing satisfactory research methods (Kazdin, 2000a; 2000b): how to obtain data in a complete and reliable form; how to decide what is of significance and likely to be both manageable and productive. Those difficulties are seen to have occurred in this study and can be considered to provide understanding for further research. The researcher believes a more constructive view would then be to ask the question as to what might be proposed as more adequate designs for future research as opposed to what are the limitations of this study. Two lines of approach may be required.

The first has to do with further development of methods for obtaining data. This study used an interview or indirect measure rather than a direct measure, that is the therapy process was not observed over time. Observation and analysis of therapy over time would allow for inter-observer verification. In addition, it was evident that the children found it difficult to respond in the interview, and observations would then add to the depth of the research.

The second approach would be through a prospective study of the entire course of the therapy, with some part of the data from the "outside", for example supervisor's reports, therapy case notes and follow-up. This would provide not only a different perspective, but would add to the understanding of the process of the therapy. A prospective study of the entire treatment of learning disabled children in therapy would permit the systematic

observable items as opposed to self-reports and interview items.

As Kazdin (2000a) notes there is a need for research that focuses more on understanding and explaining treatment. That is, research that addresses generality of treatment and the facets of treatment that may influence them are needed. Specifically, more research on the nature of childhood dysfunction is required (Kazdin, 2000a). Thus, not only is the research on the process of child psychotherapy very limited, as Sinason (1999) notes there is insufficient research on learning disabled children and the psychotherapy process itself. To conclude, this area of research could offer a way forward to further understanding these children and their mothers as well as to develop a larger theoretical basis to work from.