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The Potential of the Therapeutic Relationship in Dealing with Learning Disabled Children.

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ABSTRACT

This study is an exploratory investigation into the intrapsychic experiences of three learning disabled children whom have been in psychoanalytic therapy. The research used open-ended interviews to focus on the child, the therapist and the parent's experience of the therapeutic relationship. As there has been limited research in this area, the research searched for tentative, common experiences. A qualitative methodology was used as a means to elicit the essential meanings held by the participants, without initially presuming what they might be. The aim of the research was description and conceptualisation, rather than hypothesis testing. The methodology that was applied was an interpretative method that followed hermeneutic phenomenology principles.

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. Results indicate a positive working relationship with the mother. This relationship was seen to work in a reciprocal manner and enhanced the effectiveness of the therapy. The working alliance with the mother appeared to be an intervention in its own right. The research indicated that the learning disabled children's relationship with their mothers impacted on their emotional well being. The lack of containment and lack of confidence from the mothers resulted in an insecure relationship with their child. Consequently, the mothers needed guidance, assistance and reassurance.

The research confirms that learning disabled children are not emotionally limited, however it often takes time to explore their emotional experiences. In examining the participant's experience, it is of interest to note that family dynamics and family relationships were consistently the most important theme in the therapy. Family circumstances appeared to shape the child's and the mother's concerns. Themes of guilt, pity and contempt were evident in both the mother's and the therapist experience of the therapy process in relation to the child. The findings are largely confirmatory of other research studies that have outlined the impact of a learning disability on self-esteem. The use of the enmeshed and preoccupied defence styles emerged as a way of coping for the learning disabled child.

Finally, the therapy was found to assist the learning disabled child with making sense of their environments and emotional experiences. The therapy by providing a containing and holding space for the mother and child, not only improved relationships but also enabled the child to develop a stronger sense of self. Possible directions for future research of the psychoanalytical therapeutic work with learning disabled children are discussed.

Key Terms:

Psychotherapy
Learning disability
Remedial school
Mother-child relationship
Family
Attachment
Defence style
Self-concept
Interpretation
Social difficulties

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Chapter 1

1. Introduction

Research into the effectiveness of psychotherapy has made enormous strides in the last thirty-to-forty years. However, therapy with children in terms of process and outcome research has not been as well documented or traced over time as it has for adults (Kazdin, 2000; 1997; Kernberg & Clarkin, 1994; Weiss, Catron, Harris & Phung, 1999). Furthermore, the literature suggests that there is tension and separation between clinicians and researchers. Practising clinicians are seen to contribute very little to the research base of clinical psychology (Kernberg & Clarkin, 1994; Weiss et al., 1999).

Psychotherapy is seen to be a highly complex and multifaceted process. Even after many years of scientific research, few assertions can be made about psychotherapy on which there would be general agreement. One assertion that can be made pertains to the relationship that develops between therapist and client or patient. Despite the ambiguousness of the relationship, nearly all psychotherapy practitioners, theoreticians, and researchers agree that the relationship that develops between therapist and client is fundamental to the process and outcome of the treatment. Although there is general agreement that the relationship importantly influences treatment, there are numerous debates as to what elements and aspects of this relation are important to the outcome and process of therapy (Kazdin, 2000a).

The area of child psychotherapy is entering a critical period. Traditional child treatments, especially psychodynamic play therapy which has been practised widely by child clinicians for decades, are being challenged from one side by the development of promising behavioural and family interventions, and from another by the need for empirically validated and cost-effective treatments (Kazdin, 2000a; Orlinsky, 1994; Richardson, 2001). Research into psychotherapy has traditionally been committed to methods favoured by experimental psychology that attribute a strong preference for measures that are operationally defined, such as behavioural measures and symptom checklists over less operational used measures that explore and investigate what the psychoanalyst wants to know (Kazdin, 2000a).

Not only is psychodynamic therapy is challenged by external sources, but also from within the practice itself. The absence of systematic dialogue between child practitioners and clinical

researchers is seen to be the most prominent weakness (Shirk & Russell, 1996). Despite the existence of vast literature on interpersonal, emotional and cognitive processes, insights from basic research have not been imported into the conceptualisation or investigation of the child treatment processes. Thus, it is vital for child psychotherapy research to integrate research, that is the examination between psychodynamic theory and the procedures or interaction that occur in the therapy process (Kazdin, 1997, 2000b; Shirk & Russell, 1996; Target & Fonagy, 1996).

Children and adolescents, their parents and teachers, and mental health professionals in many specialities invest massive amounts of time and energy in the psychotherapy process. However, there is limited information, that outlines the relationship dimensions of these efforts, as well as the possible outcome of psychodynamic therapy with children. Furthermore, there is even less material written about the learning disabled children who are seen in psychotherapy. This study aims to examine and describe aspects of psychoanalytic theory and practice in relation to the therapist's understanding of his/her work with learning disabled children. In addition, the assessment of whether there is a connection between the therapist's perspectives and the patient (child), as well as their mother's understanding of the relationship. This research provides insights into the learning disabled child's experience of psychodynamic therapy and as such provides support for more research in this field.

In terms of how this research dissertation is ordered in the following manner: chapter two provides an outline of the causes, definitions, prevalence, aetiology, the possible manifestations of learning disabilities, prognosis and finally the types of interventions required when working with learning disabled children. Chapter three provides a theoretical review of object relations theory and development, which includes the psychotherapy relationship and its components. The theoretical inquiry in this chapter evolves around attachment theory and therapy, the development of the self and the impact of significant relationships on the self. This is followed by a discussion of the impact of a disability on the individual's sense of self. Once the theoretical aspect of object relations therapy have been outlined chapter four will discuss psychotherapy with the learning disabled child and the role of the parent in the therapy. The focus of this chapter is to outline the debate as whether learning disabled children are suitable for psychotherapy, to explain the use of interpretation in psychotherapy with learning disabled children and to discuss the common themes that may arise when working with these children in terms of an object relations framework. This is

followed by a discussion on the role of the parents in child analysis and the possible themes that may arise when working with parents of a learning disabled child. A discussion of the research methodology follows in chapter five, it not only provides an outline of the research process but considers the methodological perspective of phenomenological hermeneutics and the interpretative approach. Chapter six is a description of the findings and a conceptualisation of the data. The participants of the research are introduced in this chapter and an outline of the process of analysis is followed by a discussion of the themes that emerged in the research. The final chapter involves a discussion of the meaning the participants gave to the psychotherapy relationship. The conclusion in this chapter provides a summary and integration of the findings and concludes with an evaluation of the research.

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Chapter 2

2. Children with Learning Disabilities

2.1 Introduction

It is generally accepted today that there is a group of children whose learning does not progress as desired, in spite of a seemingly adequate mental potential and a stable pedagogical and didactical environment (Adelman & Taylor, 1993; American Psychological Association [APA], 1994; Lerner, 1993; Whitemore & Bax, 1999). The name given to this group of children, who experience difficulties with learning are learning disabled children. Although learning disabilities were referred to as far back as 1800, learning disabilities, as a comprehensive field of study only really made its debut in 1947 with the publication of Strauss and Lehtinene's work the "brain-injured child" (Derbyshire, 1991; Whitemore & Bax, 1999). However, the term learning disability was only introduced in 1963 (Lerner, 1993). Thus, the field of study is a relatively new discipline. In spite of on-going research as to the definition, cause and treatment of learning problems, all of these remain controversial issues. As Sleeter (1987,p.68) puts it " creating definitions of learning disabilities has been a popular past-time in the US over the years…"

Perhaps the difficulty when trying to understand learning disabilities is that they are a heterogeneous group of symptoms with diverse aetiology (Silver & Hagnin, 2002). While many different characteristics are associated with learning disabilities, each individual is unique and will present only some of these characteristics (Lerner, 1993; Gupta, 1999; Silver, 1996; Silver & Hagnin, 2002). In addition, certain difficulties are more prevalent than others at particular ages (Lerner, 1993). Learning disabilities, therefore, are a complex disorder, which some researchers argue, affects up to 30 percent of the school population. What researchers do agree upon is that it is seen to detrimentally influence the total course of the learning disabled individual's life, from birth to adulthood (O' Connor & Pianta, 1999; Derbyshire, 1991; Lerner, 1993; Gupta, 1999; Silver & Hagnin, 2002).

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2.2 Causes of Learning Disabilities

2.2.1 Prevalence and Epidemiology

The estimated prevalence of learning disabled children varies widely- ranging from 15 percent to 30 percent of the school population (Torgesen, 2000; Brown & Minnus, 1999; Gupta, 1999; American Psychological Association [APA], 1994; Silver & Hagnin, 2002). The number of children and youth identified as having learning disabilities depends largely on the criteria or the definition applied (Brown & Minns, 1999; Gupta, 1999; American Psychological Association [APA], 1994; Silver & Hagnin, 2002). The more stringent the identification criteria, the lower the prevalence rate (Brown & Minns, 1999). The World Health Organisation has calculated that between 2,2 % and 2,6% of learners in any school system could be identified as disabled or impaired (South Africa White Paper, 2001). An application of these percentages to the South African School population would project an upper limit of about 400,000 disabled or impaired learners (South Africa White Paper, 2001).

Learning disabilities are more common among boys than girls. In studies that compare sex ratios, boys do outnumber girls, ranging from twice to eight times as many boys as girls (Lerner, 1993; Silver & Hagnin, 2002). The reason for the gender difference remains speculative (Lerner, 1993, American Psychological Association [APA], 1994).

2.2.2 Aetiology

Although biological, environmental and social factors are all considered to be involved in causing learning disabilities (Emerson, Hatton, Felce & Murphy, 2001), in most cases of learning disability the cause is unknown (Gupta, 1999). Though difficulties in learning are assumed to be due to neurological dysfunction, it is rare to find specific abnormalities in neurological investigations (Brown & Minns, 1999; Gupta, 1999). There are a number of antenatal, perinatal and postnatal factors that may place the child at risk for learning disabilities (Gupta, 1999; Hadders-Algra & Lindahl, 1999; Silver & Hagnin, 2002). These include antenatal factors such as infections. For example, should the mother contract rubella, become intoxicated, be physically damaged or have an endocrine disorder such as hypothyroidism the child is placed at risk (Gupta, 1999; Silver & Hagnin, 2002). Perinatal factors such as low birth weight, birth asphyxia, congenital infections and intraventicular damage are all risk factors (Gupta, 1999; Silver & Hagnin, 2002; Tait & Genders, 2002).

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However, it is important to note that a single pre or perinatal risk factor rarely results in a developmental disorder, such as a learning problem. The disorder is normally the result of a multitude of risk factors (Hadders-Algra & Lindahl, 1999). Postnatal infections such as meningitis, which may result in some minimal brain damage, or injury, for example from an accident, or child abuse may place the child at risk (Gupta, 1999; Silver & Hagnin, 2002; Tait & Genders, 2002).

Furthermore, learning disabilities can arise from a variety of generalized conditions such as lead poisoning, neurofibromatosis, or from localized conditions in the central nervous system which may result in minimal brain injury (Born & Lou, 1999; Gupta, 1999). Genetic factors are also known to contribute to the prevalence of learning disabilities (Gupta, 1999; Stevenson, 1999; Tait & Genders, 2002). This will be discussed further in the next section.

Finally, since some learners neither show any signs of brain damage nor does their history reveal a family history of learning disabilities, researchers presume that biochemical abnormalities or irregularities could be the causative factors (Rasmussen & Gillberg, 1999). Some researchers argue that an imbalance in the neurotransmitters such as seratonin, dopamine and other neurotransmitters might cause problems with the transfer of neural impulses, which, in-turn give rise to learning and behavioural problems (Rasmussen & Gillberg, 1999).

2.2.3 Family Factors

The genetics of specific learning disorder has a chequered history. Research indicates that for some disorders such as reading disability there are numerous studies documenting familial occurrence (Stevenson, 1999; Silver & Hagnin, 2002), while for others there is no established body of genetic investigation (Stevenson, 1999). Nonetheless research generally suggests that among clinically referred children and adolescents, learning disabilities is a highly familial disorder and that the childhood cases of learning disabilities that continue through adolescence and adulthood have especially strong familial components (Stevenson, 1999; Stocker, 1994; Silver & Hagnin, 2002). Research has shown that families of children with learning disabilities have increased incidences of parental and family dysfunction (Michaels & Lewandowski, 1990).

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Families of children with learning disabilities tend to be less structured, more disorganised and more conflicting than other families (Michaels & Lewandowski, 1990). Children of parents with learning disabilities are at greater risk for abuse and neglect and are probably over-represented in childcare services (McGaw & Sturney, 1994; Silver & Hagnin, 2002). The family environment can therefore be identified as a key factor that can place the learning disabled child at risk.

Compared to parents of normal achieving children, parents of children with learning disabilities have higher levels of anxiety, perceive their families as more chaotic and report higher levels of conflict among family members (Culbertson & Silovosky, 1996). The research indicates that the personal characteristics of the child and parents, the structural characteristics of the family and the extent of support available to the family determine how the family functions with the learning disabled child (Morrison & Cosden, 1997). Investigators have hypothesized that certain structural family characteristics place children with learning disabilities and their families at greater risk (Morrison & Cosden, 1997).

Difficulties such as transactional patterns of enmeshment, overprotection and rigidity make it difficult for families to resolve problems in general, and result in dysfunction when the family is faced with additional stress and a child with a learning disability (Miller, 1996; Morrison & Cosden, 1997). Thus, the learning disabled child may place the family at risk for greater stress and dysfunction or maladjustment, which would impact on the child's development. However, it must be noted that parents of learning disabled children are a heterogeneous group of individuals with some parents presenting with significant needs and who are at-risk parents and others who have simple or relatively transient difficulties (McGaw & Sturney, 1994).

2.3 Defining Learning Disabilities

In order to understand the term learning disability, it is necessary to briefly look at the development of this concept, particularly in the United States of America. Prior to the 1940's, in the USA if children had trouble learning, they were put into one of three major categories: (1) those children who were mentally retarded; (2) those children who had emotional problems; or (3) those children who were socially and culturally disadvantaged (Spencer, 1997; Silver, 1996). By the early 1940s, a fourth group of children who were having trouble

learning was recognised because of the way their nervous systems were functioning (Silver, 1996; Silver & Hagnin, 2002). The initial reason for their difficulties was thought to be a result of brain damage (Spencer, 1997). The term that was applied to this group of children was Minimal Brain Damage as, except for this difficulty with learning, these children appeared normal (Derbyshire, 1991; Silver & Hagnin, 2002).

Towards the end of the 1940s and early 1950s, more and more evidence was presented that demonstrated no damage to the brains of these children (Derbyshire, 1991). Rather, there existed a faulty neural functioning so the name was then changed to Minimal Brain Dysfunction. By the early 1960s, as a result of confusion around this term, the National Institute of Health convened a "Consensus Conference" to summarise all of the research and clearly define the meaning of the term (Silver, 1996). The conclusion of this panel was that Minimal Brain Dysfunction referred to a group of problems often found together, where the child had trouble learning because of the way his or her nervous system operated. Many of these children were hyperactive and/or distractible and many of them had emotional, social or family problems.

The American National Advisory Committee on Handicapped Children in 1969 formulated a definition for specific learning disabilities, which was incorporated in the legislation as part of the Children with Specific Learning Disabilities Act in the same year (Derbyshire, 1991; Silver & Hagnin, 2002). However the definition was not very specific and was argued to be limited. In 1981 the American Joint Committee for Learning Disabilities proposed a better definition:

Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous systems dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g. sensory impairment, mental retardation, social and emotional disturbances) or environmental influences (e.g. cultural differences, insufficient/inappropriate instructions, psychogenetic factors) it is not the direct result of these conditions or influences (Cited in Derbyshire, 1991, p.379).

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Although this definition is considered to be more inclusive, it has been criticised for not taking into account the actual potential of the child and their level of functioning. There is a lack of emphasis on the abilities of the children and on the fact that learning disabilities can never be caused by certain other disabilities and environmental factors. (Derbyshire, 1991; Silver & Hagnin, 2002).

According to Adelman and Taylor (1993, p.9) the insertion of "presumed to be due to a central nervous system dysfunction" is significant because the term learning disability is being over used for every type of learning difficulty. This has led to the fact that more learners than those who actually experience learning difficulties as a result of a neurological dysfunction, are being classified as learning disabled. Such problems are also seen to occur in South Africa. Learners who experience learning difficulties as a result of other factors such as poor teaching are sometimes classified as learning disabled and then sent to special schools.

As a result of the controversial history of learning disabilities, many writers, researchers and educational departments in South Africa approach it in dissimilar ways. Although before 1963 a small number of children had already been identified as learning disabled, the learning disabled child only came under the spotlight of investigation in 1968 under the term of minimal brain dysfunction (Derbyshire, 1991). The debate followed similar lines to the international forums, with the international term of learning disability finally being used.

In South Africa, the Murray report (South Africa, 1969) used the term "minimal brain dysfunction" rather than "learning disability". However, in 1980 Murray also recommended the term "learning disability" be used in South Africa. Authors in South Africa such as Gerber (1985) have attempted to explain the rationale behind the term "learning disability" further. However, for this context it is important to note that South African authors use the American definitions.

The definition that is used most in the USA is the one that incorporated in the Federal Public Law 101-475, the "Individuals with Disabilities Act or IDEA (1990) and reads as follows:

The term *children with specific learning disabilities means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may*

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> *manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and development aphasia. Such a term does not include children who have learning problems, which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.* (Cited in Derbyshire, 1991,p. 380).

Lerner (1993) points out that although many different definitions have emerged they all have the following in common:

- neurological dysfunction
- uneven growth pattern of the two hemispheres of the brain
- difficulties in academic and learning tasks
- discrepancy between potential and performance
- exclusion of other causes

According to the DSM IV (APA 1994, p.46)

> *Learning disorders are diagnosed when the individual's achievement on individually administered standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills.*

From this discussion one is able to note that in the last two decades there has been a movement away from the tendency to associate learning impairment only with neurological dysfunction. Disparity over the definition of the concept has led to many researchers questioning the existence of learning impairment as such (Coles 1989; Sleeter, 1987; Westman, 1990). According to these researchers the definition is too strict and excludes many learners who experience learning difficulties as a result of emotional problems, which means that they are then excluded from assistance.

It is clearly evident from this discussion that the definition of the term learning disability has been and continues to be debated. However, for the purpose of this research the definition cited under the Federal Public Law 101-475 will be used. Although, the inclusion or

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exclusion of emotional difficulties in the criteria has not been conclusively decided upon, it appears to be seen generally as a comorbid aspect of the learning disabled child. This will be clearly outlined in the following section.

2.4 Manifestation of Learning Disabilities

2.4.1 Cognitive, Motor, Perceptual and Language Manifestation

Learning disabilities are seen to be a heterogeneous group and each person has his or her[1] own combination of symptoms, manifestations and characteristics (Derbyshire, 1991; Gupta, 1999; Silver, 1996). As Lerner (1993,p.20) states it includes a "...cluster of disorders... and no one individual will display all of them." Although the implications of each of the manifestations are complex, the following groups are seen to have common characteristics:

Motor Manifestations -There are two types of motor output problems: gross motor difficulties which refer to co-ordinating groups of large muscles, the arms, legs and trunk; fine-motor difficulties which refer to co-ordinating teams of small muscles for example for written tasks (Silver, 1996; Silver & Hagnin, 2002).

Perceptual Manifestations - Perception is seen as the interpretation of and giving meaning to information received by the brain from various senses (Derbyshire, 1991; Silver & Hagnin, 2002). There are two types of perceptual difficulties: visual perceptual difficulties and auditory perceptual difficulties (Silver, 1996; Silver & Hagnin, 2002).

Cognitive Manifestations - "Cognitive ability is characterised by various distinguishable but inseparable acts of knowing such as perception, conceptualisation, representation, intelligence, learning, thinking and memory" (Derbyshire, 1991,p.389). Cognitive ability is seen to be bound to all other aspects of a person's being such as their motor ability, language and socialisation. Thus, cognitive deficiencies occurring in the learning disabled child would affect many aspects of the child's development, from not being able to move from the concrete to the abstract,

[1] He and his will from this point refer to both he and she or his and her.

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having problems with integration to having planning difficulties (Derbyshire, 1991; Tait & Genders, 2002).

Language Manifestations - Language difficulties manifest in a variety of forms but tend to concern one or more of the following aspects of language: auditory-receptive, auditory-expressive, visual-receptive and visual-expressive language (Derbyshire, 1991; Silver & Hagnin, 2002).

Attention disturbances - These include hyperactivity, distractibility, poor concentration and short attention span (Lerner, 1993; Silver & Hagnin, 2002).

Inappropriate social behaviour - Problems with social perceptions, emotional behaviour, establishing social relations and personality problems (Derbyshire, 1991; Leondari, 1993, Spencer, 1997; Silver, 1996, Rawson & Cassady, 1995; Tait & Genders, 2002). Since this is pertinent to the present study it will be discussed in detail in the next section.

2.4.2 The Emotional Manifestation of Learning Disabilities for the Child and the Family

Research in the past has emphasised that cognition and feelings about oneself appear to be one of the key factors in the well-being and successful functioning of the individual (Leondari, 1993; Rawson & Cassady, 1995). A positive self-concept is considered not only a valued state for its own sake, but evidence suggests that it is significantly related to how individuals will approach and react to achievement demands (Leondari, 1993). In addition, the development of children's self-esteem and social development skills are considered important for successful integration and adjustment in school (Kistner, Haskett, White & Robbins, 1987).

Most researchers involved with learning disabled children report that the children have a poor self-concept (Derbyshire, 1991; Leondari, 1993; Spencer, 1997; Silver, 1996; Silver & Hagnin, 2002; Rawson & Cassady, 1995). Theories seem to agree that self-concept or self-esteem is formed mainly through the interaction with significant others (Strain, Guralnick & Walker, 1986). The initial role of the parent is considered fundamental to the formation of a

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positive self-concept. However, many learning disabled children fail to stimulate the parent's normal responses of pride (Silver, 1996). Parents become anxious and often disheartened, which results in either rejection or overprotectiveness (Bungener & McCormack, 1994). Thus, even before the learning disabled child enters the school environment, their self-esteem may already be lower.

As children enter school, the major roles played by parents are complemented and possibly even superseded by teachers and classmates (Leonardi, 1993). It is argued that the school environment plays a central role in the formation of self-concept and self-worth (Ramsey, 1991; Rawson & Cassady, 1995). Furthermore, it is contended that during middle childhood the most instrumental and enduring self-perceptions are shaped and that these perceptions are dependent on one's experience during this time (Leonardi, 1993). Children enter school expecting to be successful and feeling good about themselves and are not very concerned about achievement outcomes (Silver & Hagnin, 2002). However, over time, they learn to care about their academic achievement and may come to have negative beliefs about their experience of success.

Research has shown that self-concept is a problem for learners with learning disabilities as it relates to their perception of their school-related functioning (Sarbornie, 1994). The assumption is that children with learning disabilities (versus non-learning disabled peers) experience underachievement in school situations and hence their academic self-concept is lower than their general self-esteem (Sarbornie, 1994). Research clearly indicated the presence of a learning disability is, in itself, a risk factor; however, there are wide variations in the emotional and social adaptation of individuals with learning disabilities (Morrison & Cosden, 1997). What is evident is that there is often a comorbidity of emotional problems and learning disabilities (Morrison & Cosden, 1997).

In order to understand this risk, one must consider the impact of the personal and environmental risk on the exacerbation of difficulties for those with learning disabilities. There are two areas that risk factors may impact. Firstly, risk factors may be internal to the individual, as a function of specific neurological characteristics that affect behaviour (Kazdin, 2000b; Morrison & Cosden, 1997). Secondly, they may be external, when the structure of the family, peer relationships and the social environment result in frustration ((Kazdin, 2000b; Morrison & Cosden, 1997).

On the emotional level, these children present with higher levels of anxiety and depression than do their counterparts who do not have a disability (Greg, Hoy, King, Moreland & Jagota, 1992; Huntington & Bender, 1993; Morrison & Cosden, 1997). There are a number of factors hypothesised to contribute to this. It is argued that certain types of learning difficulties such non-verbal learning disabilities are at higher levels of risk for depression and emotional problems (Morrison & Cosden, 1997). Another hypothesis is that depression and anxiety are the results of high levels of frustration and perceived lack of control and predictability, which results from having a learning disability (Morrison & Cosden, 1997). In sum, the majority of individuals with learning disabilities do not have significant emotional problems; nevertheless, the presence of a learning disability places one at greater risk for depression and anxiety.

Learning disabled children are socially at risk since their self-esteem and overall emotional well being is adversely affected (Vaughn & Elbaum, 1999). According to Vaughn and Elbaum (1999) social competence comprises four factors: social skills, relationships with others which includes friendships and peer acceptance, age-appropriate social cognition (including the child's self-concept) and behaviours that suggest adjustment or the absence of behaviours associated with maladjustment such as acting out.

Children's relationships with their peers have long been considered to play an important role in development. Research indicates that learners with disabilities are less popular, less well accepted, and more often rejected by peers than classmates without disabilities (Vaughn, Elbaum & Schumm, 1996; Vaughn, McIntosh, Schumm, Haager & Callwood, 1993). These findings suggest that a disproportionately high number of learners with disabilities are therefore likely to face significant challenges in the social domain in addition to facing the challenges related to their primary disability.

In addition, self-perception of social acceptance for learners with learning disabilities is significantly related to depression (Vaughn & Elbaum, 1999). Children who are rejected by peers report high levels of depression, loneliness and social anxiety (Heath & Wiener, 1996, La Greca & Vaughn, 1992, Morrison & Cosden, 1997). They also report high levels of social avoidance and peer related distress (La Greca & Vaughn, 1992). Finally, children and

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adolescents who experience interpersonal difficulties are at risk for later psychological maladjustment (Parker and Asher, 1987; Morrison & Cosden, 1997).

While the majority of learning disabled children function well in society, from the above discussion it is evident that children with learning disabilities are at greater risk for emotional, family and social difficulties. Although it is not necessarily a comorbid condition, there is an increased likelihood of the learning disabled child developing an emotional disorder. The comorbidity of this has led many researchers to argue that the emotional aspect should be taken into consideration when diagnosing these children (Silver & Hagnin, 2002).

2.5 Diagnosis of Learning Disabilities

A child is learning disabled if his/her academic achievement is a few grades lower than that predicted by his/her academic potential (Gupta, 1999; Silver & Hagnin, 2002). In other words, a child may be considered learning disabled if his/her achievement is two or more grades behind the grade level expected for his/her IQ (Gupta, 1999). According to the DSM IV (APA, 1994,p.46),

> *Learning disorders are diagnosed when the individual's achievement on individually administered standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills.*

2.6 Prognosis

Research into the functioning of children with learning disabilities in later adolescence and adulthood tends to be inconsistent. However there is consensus that learning disabilities persist into adulthood (Gupta, 1999, Shessel & Reiff, 1999). The research on adults with learning disabilities has increased considerably in recent years (Shessel & Reiff, 1999). The scenario for some adults with learning disabilities is characterised by unemployment and/or underemployment, low pay, part-time work, frequent job changes, no engagement with the community, limitations in independent functioning, emotional problems, dissatisfaction with their life and limited social lives (Greenbaum, Graham & Scales, 1995; Shessel & Reiff, 1999).

Other research such as Gerber, Schneiders, Paradise, Reiff, Ginsberg and Poops (1990) noted 37 percent of adults with learning disabilities were classified as highly successful on the basis of their job, eminence within their occupation, earned income, job satisfaction and education. Shessel and Reiff (1999) also noted how many adults with learning disabilities have productive careers and satisfying lives, and many even credit their success to the positive impact of learning disabilities. In that for example, self-awareness serves as a protective factor in part as it allows the individual to develop compensatory strategies for achieving, not only in school but in their career (Morrison & Cosden, 1997). By having self-awareness these individuals are more likely to seek assistance and obtain support, which increase their chances for successful adaptation to the demands of adulthood (Morrison & Cosden, 1997). Evidence of the continuation of learning disabilities into adulthood is clearly evident. The research clearly indicates that learning disabilities continue and affect the individual's functioning into adulthood both positively and negatively.

2.7 Intervention with Learning Disabled Children

The word treatment implies a possible cure, or at least for the majority, positive effects on the causative mechanisms underlying impairment. In the great majority of specific learning disorders, however, no treatment can be expected to produce such effects, either on the learning deficit as such, or on the associated behaviour problem (Gillberg, 1999). Consequently it is more appropriate to discuss learning disabilities in terms of 'intervention' as opposed to treatment. Since in most cases cure is generally not possible, intervention should be seen to help the individual and the family improve their situation rather than to treat the underlying condition (Gillberg, 1999; Silver & Hagnin, 2002).

Once the diagnosis is made and the child and the parents have been given a comprehensive understanding of the disorder, educational measures are normally set in place (Gillberg, 1999). The aim of this research is not to debate the type of educational intervention (segregated versus inclusive education). Nonetheless, some form of educational intervention program is required. Whatever the form of schooling, the research clearly indicates that the vast majority of children with learning disorders require a great deal of extra, individualised, one-on-one training to enable the child to overcome at least some aspect of the academic

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difficulties that are otherwise likely to ensue (Derbyshire, 1991; Lerner, 1993; Gillberg, 1999; Sharp, 1999; Silver & Hagnin, 2002).

Although, as noted previously not all children with learning disabilities have emotional difficulties, but there are those who do. If a social, emotional, or family problem is recognised, it is important to differentiate between primary problems and secondary problems (Lerner, 1993; Gillberg, 1999). If the problems are secondary to the frustrations and failures experienced because of unrecognised or incompletely treated learning disabilities, the psychological intervention may be less effective if the underlying cause of the frustration and failure is not directly addressed (Lerner, 1993; Gillberg, 1999).

As noted, a child with learning disabilities generally requires an appropriate educational program. Thus, the first aspect to any intervention program is to address the educational aspect of the learning disability and then should the emotional problem still persist, this is addressed through the most appropriate therapy for the presenting problem (Silver & Hagnin, 2002). That is, individual psychotherapy, behavioural therapy, family therapy, group psychotherapy and so forth may be indicated (Kazdin, 2000a).

2.8 Conclusion

From the literature overview it seems clear that learning disabilities are a very widely defined disorder, based upon a variety of assumptions, without a clear-cut aetiology, definition or even manifestation. The focus of diagnosis is mainly based upon presented academic performance and behaviour. Research in the past has primarily focused on the motor, perceptual, cognitive, language and attention manifestation of a learning disorder. More recently, research has focused on the emotional aspects of learning disabilities. Research clearly shows that having a learning disability puts a person at risk for developing both emotional and social difficulties. An object relations perspective that provides an understanding of the emotional and relationship factors of a learning disability will be explored in the following two chapters.

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Chapter 3

3 Object Relations Theory

3.1 Overview

Chapter two's main focus was that of learning disabilities, its definition, clinical features and the possible different treatments in containing this disorder. It provided an overview of the current state of affairs with regard to the children and their parents/family who are affected by this disability.

As noted in the previous discussion, learning disabled children are at risk for emotional, familial and social difficulties. Traditionally, the treatment of psychological (i.e., emotional and behavioural) difficulties within learning disabled children has been at the level of behavioural management combined with skills teaching and medical approaches (Hernandez-Halton, Hodges, Miller & Simpson, 2000). However in the last two decades, there has been a move to use a psychoanalytical approach with learning disabled children (Hernandez-Halton et al., 2000; Sinason, 1992). It is evident from the research that psychotherapy with learning disabled people is possible.

In spite of this surge in research, there is very little published literature on the outcome of psychotherapy with learning disabled people, and there is even less on children (Hernandez-Halton et al., 2000, Kazdin, 2000, 2000a, Sinason, 1999, Smith-Acuna, Durlak & Kasper, 1991). Thus, the way in which these children perceive the therapy relationship, their sense of self and their difficulties, as well as the therapist and parental view is important in our understanding of the therapy process with learning disabled children. Before this is discussed a brief overview of the object relations theory used in this research will be given.

The theoretical inquiry of chapter three will evolve around attachment theory and therapy, the development of the self and the impact of the relationship with the 'other' on the self. Understanding the impact and how a 'handicap' could possibly influence the individual will consequently be explored. This will specifically be linked to a developmental view from an object relations perspective.

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3.2 Object Relations Theory and Attachment

In the broadest terms, psychoanalytic object-relations theory represents the psychoanalytic study of the nature and origin of interpersonal relations, and of the nature and origin of intrapsychic structures deriving from, fixating, modifying, and reactivating past internalised relations with others in the context of present interpersonal relations (Hamilton, 1988; Likierman & Urban, 1999). Thus, "Objects" in this theory refer to people, and "object relations" to relations with people. The object could be internal or external, fantasised or real, or memory invested with emotional energy (Cashdan, 1988; Hamilton, 1988, Likierman & Urban, 1999). The primary premise of object relations theory, the sense of who we are in relation to others, begins in infancy. The infant is motivated to make contact with the object rather than discharge tension (Hamilton, 1988, Likierman & Urban, 1999). Thus, the common principle of object relations theory is that human motivation is fundamentally towards object contact, rather than drive discharge (Summers, 1994). In short, object relations is towards an understanding of the interactions and relationships with the object and through the way in which they are internalised, towards the development of the self (Cashdan, 1988; Hamilton, 1988).

Like object relations theory, the central claim of attachment theory is that the infant-mother attachment is based on a primary and autonomous instinctual system rather than representing a secondary derivative of the hunger drive or oral gratification, as was outlined by Freudian theory (Eagle, 1997). Attachment theory arose from the encounter between the new science of ethnology and that phase in the history of psychoanalysis, which was moving from drive towards the relational perspective (Greenberg & Mitchell, 1983). In both psychoanalytical and attachment theories the repetition of behaviour is accounted for by early 'structures'- infantile wishes, conflicts and defences, on the one hand, and internal working models on the other- that develop in childhood and influence later relationships and behaviour.

The purpose of this section is to move away from a behavioural description of the inner world of parent and child to an object-relations perspective, that of Melanie Klein, Wilfred Bion, Margret Mahler and Donald Winnicott. A brief review of the current research on the significance of attachment and a definition of attachment will be followed by an outline of Klein and Bion's theories with reference to attachment and development. These two theories have made it possible to think about the nature and meaning of human behaviour as it is

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affected by the changing predominance of different mental states and by the impact of those states on the development shifts appropriate to specific ages (Waddell, 1998). Bion's theory focuses on the mother-infant relationship and the ability to think. In order for one to gain an understanding of how normal development can be hindered one has to have a sense of what normal development tasks are and the processes that lead to 'good enough' emotional health and functioning. The theory of Mahler is then outlined as it provides a developmental approach to understanding 'normal' development and the consequences of possible developmental arrests. Finally, Winnicott's theory of a 'good enough holding and containing' environment is briefly discussed as these are two important components to a therapeutic relationship. This chapter concludes with a discussion of the impact the mother-infant relationship has on the ability to learn.

3.3 Attachment Theory and Therapy

Attachment theory should not so much be seen as a single theory, but rather as an overall framework for thinking about relationships; that is, those aspects of relationships that are shaped by threat and the need for security (Holmes, 1997). The history of attachment theory reveals that it arose from the encounter between the new science of ethnology and that phase in the history of psychoanalysis in which the theory moved from drive towards the relational perspective, seen in the work of Balint, Winnicott, Fairbairn and Melanie Klein (Greenberg & Mitchell, 1983). Attachment theory and research have increasingly focused upon the dyadic psychobiological events that occur within the primordial social relationship; the one between mother and infant.

This same period of advance in theory has been paralleled by an expansion in neuroscience technology. Current neurophysiological, neurobiological, psychological and psychiatric developments are now detailing the brain system that mediates the infant's coping capacities (Siegal, 2001). This research may allow for a more precise characterization of the links between secure attachment and adaptive infant mental health as it is evident that "maternal care during infancy serves to 'program' behavioural responses to stress in the offspring" (Caldji, Tannenbaum, Sharma, Francis, Plotsky, & Meaney, 1998,p.5335).

The first few years of life are when the basic circuits of the brain are developing. These will be primarily responsible for a number of critical mental processes involving emotions,

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memory, behaviour and interpersonal relationships (Schore, 2001). These processes include the development and regulation of emotion, the capacity for flexibility or mindful reflective behaviour, the ability to understand and care about the minds of others and the ability to engage in interpersonal communication (Siegal, 2001). Thus, the interaction and type of relationship clearly have an important impact on the development of mental processes.

Longitudinal studies reveal that securely attached children appear to have more positive outcomes in their development then insecurely attached children (Cassidy & Shavier, 1999). However, insecure attachment can often be associated with "emotional rigidity, difficulty in social relationships, impairment in attention, difficulty in understanding the minds of others, and risk (in) the face of stressful situations" (Siegal, 2001, p.77). Panskepp (2001) in his review of the literature reveals that severe early separation has life-long consequences for emotional health of children. Excessive separation sets the young child up for future depression and panic attacks, feelings of sadness and devastation, a tendency towards submissive behaviour and feelings of defeat in adulthood and shyness and introverted tendencies in children.

The findings on the neurobiological development of the brain and attachment research suggest that the mind seems to continue to develop in response to emotional relationships throughout the lifespan (Lichstein-Phelps, Belsky & Crnic, 1988). Changes in attachment may enable the individual to acquire a more integrated way of life, a more compassionate world of human connections and the development of flexible self-regulation (Siegal, 2001).

Secure attachment is seen to refer to such things as confident expectation that one's attachment figure will be available, the internalization of a secure base, and the capacity to explore the world from that secure base (Eagle, 1997; Holmes, 1997; Siegal, 2001). Insecure attachment refers to such things as a lack of confident expectation in the availability of one's attachment figure, the relative failure to internalize a secure base, and the inability to develop versatile strategies to deal with the feelings that are evoked by the failure of the attachment figure (Eagle, 1997). Secure attachment is therefore positively related to the exploration of the external world, as well as the meta-cognitive functioning and exploration of one's inner world (Main, 1991; Eagle, 1997). Eagle states that this relatively simple idea provides a valuable framework for understanding and conceptualising the respective roles in the therapy relationship. Put very succinctly, the therapeutic relationship provides a secure base from

which the patient may feel more self-assured to explore, confront and understand their inner world. Attachment and exploration thus operate in a reciprocal manner; that is the availability of a secure base is the facilitation of the individual range of exploration.

The type or level of attachment would then determine the individual relationships and defence mechanisms they use to cope (Eagle, 1997). Understanding attachment therefore becomes critical in the therapeutic relationship, as it will determine or impact on how the patient will present in therapy as well as what defence mechanisms they will use. For example, according to Bowlby (1980), there are those individuals who are insecurely attached who characteristically employ "defensive exclusion" of attachment cues, signals and feelings. These individuals have a pseudo self-sufficiency, which is a defence to earlier unavailability of their attachment figure hence they yearn for the support and affection. Their "defensive exclusion" then determines how they possibly would interact in therapy, that is they would be cut-off from feelings of loss, sadness and anger in response to severe disappointment of their attachment figure (Eagle, 1997).

On the other end of the spectrum, West and Keller (1994) describe the defensive style of the enmeshed or preoccupied individual. Unlike the defensive exclusion characteristic of the avoidant or dismissive individual, as the terms imply enmeshed and preoccupied individuals do not defensively exclude attachment cues, information and feelings. These individuals are intensely preoccupied with attachment concerns. Clinically they are those clients who have intense separation anxiety and overreaction to anticipated and actual separation from their attachment figures (West & Keller, 1994). For West and Keller (1994) the primary therapeutic work with these clients is to help them give up the fantasy of recovering a lost relationship.

The current literature and Eagle's (1997) view provide a valuable framework for understanding the therapeutic relationship: - the therapist and the therapeutic relationship have the potential to provide a safe and secure base from which the child/patient can gain confidence and feel capable to explore, confront and understand the anxiety laden aspects of their inner world. The therapeutic relationship, by providing a safe space where the attachment figure (the therapist) is consistently available, will allow for a change in the patient towards a more integrated self. This will be discussed further in the following section.

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3.4 Theoretical Considerations- From Klein to Bion

In trying to understand and to help children traumatised in infancy, it is important to know what factors foster the development of resilience in order to help them face the adversity in their lives. Fonagy, Steele, Steele, Hedged and Target's (1994) study on resilience isolated one factor above all else that serves as a protective function against adversity, which they called "reflective self function". The reflective self function essentially means the capacity to make sense of emotional experience, one's own and by extension, that of others. This function arises out of the child's relationship with his/her caregiver, whose capacity to reflect upon the child's psychological experience provides him with that aspect of the mental equipment fundamental to establish his own reflective self. This then refers to the caregiver's capacity to provide a 'good enough holding' environment (Winnicott) or capability of 'reverie' in thinking about the child's or baby's communication (Bion) or to provide a good internal object to help the infant contain his anxieties (Klein). Klein and Bion's theories address the child's psychological experience in terms of object relations. Both these theories will be discussed briefly in terms of how a secure or insecure foundation affects a child's emotional well-being.

3.4.1 Melanie Klein

Klein differentiated between two basic groupings of anxieties and defences; the paranoid-schizoid and the depressive positions. Klein asserts that the ego is in existence, in a primitive form at least, at the moment of birth, with the background for its earliest view of the world shaped by the intra-uterine environment (Weininger, 1992). Initially, the breast is the first object the infant encounters. The frustrations and satisfaction the infant experiences in relation to the breast bring the earliest defence mechanism into play (Coply & Forryan, 1987). The ego splits itself. This primitive mechanism of defence is an effort to maintain the little integrity the ego has and the desire to survive (Weininger, 1992). Phantasy is present at birth and is used by the infant to begin to define external reality. The spelling phantasy is used to represent mental representations in the unconscious, whereas fantasy is used to represent conscious mental images (Weininger, 1992). The ego introjects aspects of reality, which, in turn reshape the original internal phantasy, and consequently the perception of reality (Klein, 1997c). Through a process of interaction with the phantasised mother and the real mother, the infant moves through a series of mental representations that are positions of

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ego development (Waddell, 1998). These positions are seen to be dynamic and in continuous movement and represent specific groupings of anxieties and defences which appear and re-appear during the first years of childhood and then throughout life (Waddell, 1998; Weininger, 1992). Each position can be compared with almost any aspect of mental life in terms of characteristic anxieties, defences, mental structures and kinds of object relations (Waddell, 1998; Steiner, 1992).

3.4.1.1 The Paranoid-schizoid Position and the Early Mother-child Interaction

Klein (1997a) in her paper "Notes on some Schizoid Mechanisms" uses the term 'paranoid-schizoid position' to describe a cluster of phenomena that exist from the beginning of life: a relationship to *part objects*, destructive impulses and persecutory anxieties, the splitting of one's own feelings into idealised love and unmitigated hatred. The term paranoid-schizoid includes both the nature of the predominant anxiety, which is the fear of persecution, and the defence against such fears (Waddell, 1988). In early infancy these psychotic anxieties, mechanisms and ego-defences influence the development of the ego, superego and object-relations (Klein, 1997d). The 'schizoid' or splitting function occurs when the first object, the mother's breast, is split into the good and bad breast (Waddell, 1988). During this position the state of mind tends to be solely concerned with one's own interests and the primary focus is on self preservation (Waddell, 1998).

In Klein's view all reality is introjected and plays the part of an internal, psychic reality, which is as compelling as the external one (Weininger, 1992). The establishment of the object-relations, external or internal, is conditioned by the interplay of the infant's phantasies (Smirnoff, 1971). As a *part object* the breast may be hallucinated or phantasized and introjected. From then on the *part object* (the breast) is experienced by the infant as part of his inner world (Weininger, 1992). Introjection is easier at this stage because the external quality of objects is not yet clearly perceived (Smirnoff, 1971). Since the representation of needs is expressed through phantasies, the introjected phantasy object is experienced by the child as 'good' or 'bad': a good or bad breast according to whether the need is satisfied or frustrated (Klein, 1997a) . These experiences of gratification or frustration are not yet felt as external events; they are part of the undifferentiated experience of the child (Smirnoff, 1971). Consequently, in this phase, the oral gratification and frustrations, whether real or imaginary, create the phantasy-images of a 'good' and a 'bad' breast (Weininger, 1992).

The primitive anxiety in this position is a fear of annihilation from within the personality. As a result, as a defensive measure, the infant projects the bad feelings that cannot be contained onto the object (Waddell, 1998). The persecutory fears arising from the infant are seen to be strongest during the paranoid-schizoid position. "It is clear that Klein thought that normal splitting and projective identification associated with it were necessary parts of development, and that without them the basic differentiation between good and bad and between self and other would not get firmly established so that the ground work for the later depressive position would be impaired" (Spillius, 1992, p.60).

3.4.1.2 The Ego Defends Itself: Some Basic Patterns of Phantasy on the Paranoid-schizoid Position

Klein (1997a) proposed the term "projective identification" to describe normal early developmental processes that are bound up with the paranoid-schizoid position and are characterised by splitting and persecutory anxiety. She delineated an intrapsychic phenomenon by which certain parts of the ego were put into parts of the object for defensive and protective reasons. Bion (1959) elaborated upon these ideas and described the deterioration in emotional and cognitive development when there is failure of maternal containment. The baby then strives desperately to rid itself of unwanted parts of the self, resorting to excessive use of splitting and projective identification. "When the projections are not contained and transformed by maternal reverie, the process of projective identification fails in its aim of communication and becomes a forceful evacuation, giving rise to fragmentation of self and confusion between self and object" (Miller, 1992, p.123-124).

Through the mechanisms of introjection and projection, the child's relation with part objects is established (Smirnoff, 1971). The infant is seen by Klein to possess an immature ego in the earliest months of infancy. This immature ego allows the infant to experience anxiety, to protect himself against it, to deflect the death instinct and to establish primitive object-relations (Weininger, 1992). The early ego is exposed to anxiety stirred up by the inborn polarity of instincts as well as by the impact of external reality. The ego establishes a relation with two objects, which result from splitting the primary object: the ideal breast and the persecutory breast (Waddell, 1998). The phantasy of the ideal breast merges with gratifying experiences of love, whereas the persecutory phantasies merge with real experience of

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deprivation and unpleasure attributed by the child to the bad object (Segal, 1979). In situations of anxiety the split is widened and projection and introjection are used to keep the ideal and persecutory objects separate (Segal, 1979).

3.4.1.3 Good-enough Experience

Klein stressed the importance of normal splitting for healthy development (Segal, 1964). In healthy development the ego is strengthened to the point where it can tolerate ambivalence (Weininger, 1992). The split is seen to be reduced and a shift towards the depressive position is ensued. However, should the anxiety become excessive and not mastered, defences are used which may be extreme and damaging in their effects. Should the separation process be inhibited or interrupted, then defensive splitting may continue to be activated during times of emotional or interpersonal stress in an attempt to protect good self-object experiences from contamination by bad self-object experiences (Weininger, 1992). This splitting is used as a defence mechanism to protect the individual who has experienced overwhelming deprivation and insufficient warmth and mirroring from an early significant caretaker (Weininger, 1992). The lack of an available object results in these children having a great need for a good internal object; an object they can rely on that will help them contain their anxieties and enable them to encounter new difficulties and challenges (Segal, 1979). Klein (1997b) observed that when the infant's experience of anxiety is too intense, whether for constitutional reasons or because of inadequate parental containment, the internal resources, which foster the transition from part-object to whole-object relationships and the capacity to work through the tasks of the depressive position, are impaired.

The importance of the mother's function as a receptacle for the infant's earliest experiences is clearly outlined by Klein. Klein (1997a) stressed the infant requires a mother who can consider and respond appropriately to the infant's needs and distress, as well as to his love. The infant needs to receive back his experiences from his mother in a way that assures him of his feelings, that he has been tolerated and accepted. A mother who, for whatever reason is unavailable may result in the infant's bad object being stronger than the good object (Weininger, 1992). The lack of availability of the mother would not enable the infant to contain the anxiety aroused by phantasies of persecution and, as noted, excessive splitting is used as a defence. The infant's lack of confidence in the availability of the object would result in excessive anxiety (Klein, 1997a) and an insecure attachment (Eagle, 1997).

3.4.1.4 The Depressive Position: Ego Development and Object Relations

In normal development when favourable conditions predominate over bad ones, the persecutory position will progressively be abandoned and replaced by a process of integration, which is described by Klein (1997a) as the "depressive position". The concept of the infantile depressive position was introduced by Klein in her paper "A Contribution to the Psychogenesis of Manic Depressive States" (1935), and further developed by her in "Mourning and Its Relation to Manic-Depressive States" (1940) in which she described how the infant experiences depressive feelings which reach a climax just before and after weaning.

During the depressive position the recognition of whole objects begins; the infant is able to recognise that the breast that frustrated him is the same one that gratifies him. This results in integration over time; the object that is loved and the object that is hated are the same. Feelings of concern for the object upon which the individual depends and the beginning of the capacity to experience remorse for the harm, which is felt to be done to the object, are evident (Waddell, 1998). Thus, the 'other' is experienced as separate from the 'self'. Once the individual becomes aware that these are the same object, guilt is seen to be inevitable (Joseph, 1989). Pain and anxiety are caused by such guilt and by the attacks towards the object (Joseph, 1989).

This altered perception of the object suggest that the child's ego has undergone a fundamental change; it no longer split but is whole, like the object itself (Stein, 1996). This ego-integration runs parallel with a physiological and psychological maturation and the development of thought and memory processes, a development, which brings with it the knowledge that he both loves and hates one and the same person, namely his mother. During this phase relations with the object are characterized by ambivalence (Segal, 1979). The persecution anxiety existing at the time of the paranoid position is replaced in the depressive situation by an anxiety based on the fear that his destructive impulses might have destroyed the object he loves and the one he depends on so completely (Segal, 1979; Weininger, 1992). The need to ensure possession of this object, which he feels might escape him intensifies the processes of introjection. By incorporating the object he protects it against his own destructive impulses. The depressive position sets in at the oral-sadistic phase where need and love are linked with the aggressive drive of biting and devouring (Weininger, 1992). Introjection enables him to

protect the good object against the destructive instincts represented by both the external and internalised bad object (Joseph, 1989).

At the peak of his ambivalence the child feels the depressive despair, the mourning for the lost or destroyed object and guilt of having himself destroyed the internal object (Steiner, 1996; Weininger, 1992). The child's despair and his guilt of having destroyed his mother arouses the wish to restore and to recreate her in order to regain her as an object, alive and whole. The depressive conflict is a constant struggle between the destructive phantasies and the reparative wishes, both of which are part of the child's feelings of omnipotence (Schneider, 1988). In favorable circumstances when the child is confronted with the reality of his mother, he gradually modifies his belief in the omnipotence of his destructive impulses and his magical reparation and learns to estimate more reasonably the limits of both his love and hate (Weininger, 1992).

Whilst both the paranoid-schizoid and the depressive positions develop in keeping with normal and 'psychotic' development in the first year of life, they remain as part of our personality throughout life (Waddell, 1998). In Klein's work, there is a life long fluctuation between the two positions (Steiner, 1992). For meaningful progress to be seen in therapy, a shift towards the depressive position is observed. However if there is a deterioration or regression, for whatever reason, a move towards the paranoid-schizoid position may occur.

3.4.2 Wilfred Bion.

3.4.2.1 Containment and Reverie.

Wilfred Bion (1962b) discusses early infant-mother interaction in terms of the importance of the mother's capacity to take in the infant's projections of unbearably distressing emotions, to contain and work them over in her "reverie" and pass them back to the infant in modified and more manageable form. The infant who has repeated experiences of this kind of mental containment introjecting the experience of a containing mother is then able to progressively learn to contain himself. Such feeding back is an unconscious activity. It is accompanied by the transmission of her caring feelings to the infant, not her conscious intentions and thoughts but the "psychical quality" of them (Bion, 1962). This kind of primitive communication is seen to pre-date conceptual and verbal communication, and is the only one available to the

infant (Likierman, 1988). The infant "picks up" from the mother the psychical quality of feelings, which she transmits in her interactions, and it is this quality, which is containing, and together with 'reverie', is the mother's means of reaching her infant (Likierman, 1988).

The infant suffers a 'primary disappointment' when there is a failure of the parental object to meet his innate needs (Emanuel, 1996). This would include Bion's view of the infant's expectation of a containing object that can 'think' about him which would then involve the parent (container) being in a state where it can receive the infant's primitive communications, which would consist of mainly unmetabolised data called *beta* elements. To give them meaning the parent (container) has to think about them, a process called *alpha* function by Bion (Emanuel, 1996). Through this repeated experience of having a parent/container tuning into the infant's experience and then having the capacity to reflect upon it enables the infant to slowly start to identify with this function of its caregiver and able to begin to reflect upon his own experience more fully (Emanuel, 1996; Waddell, 1996). The infant is then able to begin to think about his own emotional experience. This enables a space to exist in the baby's mind and their inner reality can then be differentiated from their outer reality. "Thus the container acts upon the contained through the process of reverie or alpha function, which gives rise to a mental apparatus for thinking" (Emanuel, 1996,p.219).

3.4.2.2. Attachment and the Ability to Think.

The forerunner of thinking is seen in the primitive method of communication between mother and infant (Britton, 1992). The most basic way of thinking these thoughts would be something like having a dream. The process by which *beta* elements are transformed into *alpha* elements is regarded by Bion as essential in the production of thoughts. If the *beta* elements are unprocessed "they cannot be treated like ordinary thought but neither can they be treated as ordinary perceptions of the material world. They are on the boundary of somatic and psychic experience, of mental and physical" (Britton, 1992,p.105).

When there is not the availability for the infant to make sense of emotional experience, as referred to by Fonagy et al. (1994) as "reflective self function", trauma is likely to result. The resultant effect is a failure in the development of the protective shield that mediates between the infant and the environment, and that, which interprets it for him. These raw experiences

or *beta* elements are then unable to be processed by the baby. When the caregiver is inconsistent or unavailable to perform these functions for the infant, or when they are performed in aberrant ways, a trauma is likely to ensue. Consequently, 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 would be the result of unmetabolised *beta* elements.

Bion's earlier form of thinking was the basis of his later form. This early form "strives to know psychic qualities, and is the outcome of early emotional events between a mother and her infant which are decisive for the establishment-or-not of the capacity to think in the infant" (O'Shaughnessy, 1981,p.181). This would imply that, for the infant, knowledge of a psychological world exists before knowledge of the physical one. O'Shaughnessy (1981) postulates that Bion sees thinking as a human link, that is, the attempt to experience oneself and others in an emotional way. If the mother-infant relationship does not develop normally, the superego is no longer helpful, rather a 'ego-destructive superego' develops (Bion, 1962; Britton, 1992). The mother who was unable to absorb the infant's projections is then perceived by the child as hostile to any attempt at projective identification (Britton, 1992). Consequently, the child experiences the world as a place where every thought or idea he has is not wanted.

3.5 Klein, Bion and Attachment.

Klein and Bion's theories indicate how the primary function of the psychotherapist working with children is to help them make sense of their emotional experience. It would involve initially receiving and containing their emotions by being conscious and aware of the fragments presented, as well as being aware of the emotions evoked by the child (Emanuel, 1996). This is referred to as getting 'alpha function around the experience' (Emanuel, 1996). Emanuel (1996) argues that before thought about the relationship between the elements is possible, the child has to learn to label their emotional experience. The naming process is an essential part of getting into the *alpha* function around the experience, but it cannot be seen to stop there. The meaning of the experience needs to be worked through in a mourning process. Linking this to a lack of or poor attachment, the object being unavailable would not allow for the consistent interaction to enable this process of naming to develop effectively.

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Both Klein and Bion viewed an oscillation and an interplay between the states of mind, characterised by each phase of development which is influenced by the type of interaction with the object (Waddell, 1998). Thus attachment, even though it requires an object to whom to bond, is composed of a variety of developmental processes. Such as object introjection, splitting and projection, that all have the potential under, a secure mother-infant relationship to lead to traits of independence, closeness, warmth and security. However, insecure mother-infant relationships have the potential to lead to traits of anxiety, insecurity, introversion and depression.

3.6 Margret Mahler: Separation and Individuation

Mahler and her colleagues' ten year observation study of infants resulted in a series of detailed observations to delineate what they called the psychological birth of the human infant (Hamilton, 1988). Mahler's theory provides an outline of the understanding the psychic development of a child or the developmental arrest that could occur and their consequences. The phases and subphases of this growth include: Autism (0-2 months), symbiosis (2-6 months), separation-individuation (6-12 months), hatching subphase (6-10 months), practising subphase (10-16 months), rapprochment subphase (16-24 months) and developing object constancy (24-36+ months).

Mahler refers to a state of "normal autism" as existing at birth (Horner, 1991). This phase is seen to cover the first month of life. A failure or fixation of development at this stage would be reflected in the lack of development of the undifferentiated self-object image and the consequent incapacity to establish a normal "symbiotic" relationship with the mother. Mahler proposed that this autistic phase precedes the capacity for relationships (Hamilton, 1988). Perhaps the best way to understand this phase is as an intermediate zone between infantile and extrauterine life. The infant's psychological withdrawal appears to provide protection or insulation like that of the intrauterine life.

The next stage is normal "symbiosis" or the stage of the primary, undifferentiated self object representation which occurs between two and six months. This is seen to be the basic good self-object constellation, which becomes the nucleus of the self-system ego and the basic organiser of the integrative functions of the early ego (Kernberg, 1968). During this period, the child develops a faint awareness of the need-satisfying object (Mahler et al., 1975). This

awareness of a two-person relationship provides an initial sense of self in relation to the object. This relationship allows for the unfolding ego functions. A relationship with a loving parent enhances the unfolding ego function (Hamilton, 1988).

Should the child not adequately receive cues about his needs and responses to them, the ego function fails to develop (Hamilton, 1988). Pathological fixation or regression of development in this stage is clinically characterised by the failure or loss of the differentiation of ego boundaries (Kernberg, 1976). In extreme cases, the child may return to an unrelated or autistic phase (Hamilton, 1988). The development of internalized object relations comes to an end when the self-image and the object-image have been differentiated in a stable way within the core "good" self-object representation- this is built up under the influence of the pleasurable gratifying experiences of the mother-infant relationship (Horner, 1991).

Symbiosis blends into the beginning of the separation-individuation phase when the child is about five or six months old (Kernberg, 1976). It is during this stage that the infant the integrates the "good" and "bad" self-representations into an integrated self-concept, and the integration of "good" and "bad" object representations into "total" object representations, that is the achievement of object constancy. The differentiation of self and object components determines jointly, with the general development of cognitive processes, the establishment of stable ego boundaries (Horner, 1991). However, there is not yet an integrated self, so this is a stage of part-object relations (Kernberg, 1976). During this stage pathological fixation of the internalised object relations determines the borderline personality organization (Kernberg, 1976).

At around eighteen months, the toddler becomes increasingly aware of his or her separateness from the mother (Horner, 1991). During the rapprochement phase there is an alternating movement away from the mother towards separateness (Cashdan, 1988). Feelings of self-assertion and separateness come to the fore as the child develops a new sense of independence (Cashdan, 1988). While the child is making increasing strides in separating himself from the mother and establishing himself as an individual, there remains a strong need for help and reassurance (Cashdan, 1988, Horner 1991). If there is a deficit in the structural organization of the self-representation, either as the result of unfavourable circumstances or as the result of some deficit in the child's organically based synthesising capabilities, these deficits become evident at this time (Horner, 1991). Echoes of the

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rapprochement phase can be heard in later development, in that the sense of self and other is still being determined by the nature of the self and object representations that were in existence at that early time of development (Horner, 1991).

The final subphase of the separation-individuation process is perhaps the most critical because it plays such an important role in the creation and ultimate nature of the self (Cashdan, 1988). Referred to as the libidinal object constancy, this subphase has its onset at about two and a half years and lasts until about three years. The principal task of this period is the development of the stable inner representation of the mother (Horner, 1991). Unless this is accomplished, the child continues to depend on the mother's physical presence for security and can never develop an autonomous sense of self (Horner, 1991).

There is considerable evidence of the ability to develop individual and object constancy in the midst of rapprochement (Horner, 1991). Object constancy "means the ability to hold a steady image of the object, especially the mother whether she is present or absent, gratifying or depriving" (Hamilton, 1988, p.53). The signs of object constancy and the developing individuality appearing as the back and forth separating and returning of rapprochement wanes (Hamilton, 1988). This final phase of object constancy and individuality continues throughout life,

The ability to hold an image of the 'good enough mother' constantly in mind is determined by the child's experience and neurophysiological development (Hamilton, 1988). The child's experience determines the ability to remain secure and influences the development of the sense of self. Separation, identity and an integrated sense of self do not end at this stage of development, rather they continue throughout life. These observations of Mahler's infantile phases and subphases are paralleled by a set of intrapsychic and interpersonal mechanisms.

Mahler's theory has contributed to an understanding of the development of personality and the complex process of mother-infant symbiosis and ensuing processes of desymbiozation and separation-individuation. Her theory provides an understanding as to how developmental arrests at various stages of development may manifest.

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3.7 Klein, Bion and Mahler - The Common Goals of Therapy

One is able to note that the common aspect of all three theories is the role that internal object relations play in the creation and maintenance of relationships and relating to others. The nature of a child's or adult's difficulties are therefore traced to arrests in the development of the self and anomalies in splitting. The critical considerations therefore have to do with how early arrest occurs, the precise character of the splitting, and the degree to which it permeates the patient's various identities. The most important component that the object relations therapist must adopt when working in a therapeutic setting is that the therapist-client relationship forms the basis of therapeutic change (Cashdan, 1988). The ultimate goal of therapy is to use the therapist-patient relationship as a stepping stone to healthier object relationships and to promote positive changes in the patient's sense of self.

Klein, Bion and Mahler's theories indicate how the primary function of the psychotherapist working with children is to help them make sense of their emotional experience. It would initially involve receiving and containing their emotions by being conscious and aware of the fragments presented, as well as the emotions evoked by the patient in the therapist (Emanuel, 1996). Thus, a theoretical understanding as to what is "normal" development is crucial in understanding how deviations from this affect the emotional development of a child, especially when working with learning disabled children. As Henry (1983, p.82) states, a link "can be made between very early deprivation and its impact on the equipment that is necessary for a child to acquire and retain knowledge, but most of all, to think". This arrest in thinking is seen to be affected by emotional experience. How this comes to the fore in therapy is the aim of this study. In other words, what affects the development of these children, how does the therapist, the child and the adult understand this?

3.8 Donald Winnicott: The Holding and Containing Mother

In keeping with the three theories discussed above, Winnicott further contributes to our understanding of psychological development in terms of the mother-infant relationship. Winnicott views the mother-infant relationship as a fundamental growth-facilitating relationship upon which all other relationships mutually depend (Seinfeld, 1993; Summers, 1994). The mother, in Winnicott's view, is deeply preoccupied with the infant, even before its

arrival and devotes herself completely as an attentive medium facilitating her baby's growth (Weisberg, 1994). Winnicott coined a number of terms to describe and understand the mother-infant relationship. The term *psychosomatic partnership* is used to describe the quality of the mother-infant relationship in which there is an initial overlap between the physical and psychological relationship (Scharff, 1992). Through physical holding and the almost physical quality of the gaze between the mother and infant, the first psychological growth relationship whereby the baby is psychologically organised is established (Scharff, 1992). It is only when the infant starts contributing to this partnership or relationship that the mother can become a mother (Phillips, 1989; Scharff, 1992).

When Winnicott coined the term *holding environment*, he put into words the importance of the physical holding during the symbiotic phase of development (Hamilton, 1988). However the holding required develops gradually. The child very quickly needs not only to be held in the mother's arms, but also to be held in their mother's attention (Hamilton, 1988). The holding parent could also be described as the "arms round" parent (Scharff, 1992, p.41). This holding according to Winnicott allows the infant to feel safe and, through this process, the baby's sense of self begins to develop (Scharff, 1992).

The degree and kind of holding according to Winnicott did not have to be perfect, but only "good enough" (Winnicott, 1981,p.190). There is an understanding that perfection does not exist. Rather the mother provides a facilitating space with comfort and consistency to the dependent baby. Failures by the mother are not only inevitable, but important and necessary for the infant's health (Weisberg, 1994). However, this inevitable failure may be harmful when the mother does not empathise with the 'injured child' (Weisberg, 1994). The mother who provides the space and opportunity for repair, that is, regression is permitted by the 'good-enough' mother to a state of dependence in such situations, is seen to be essential for Winnicott (Weisberg, 1994).

Should the child be left in despair, the immature sense of self is overwhelmed and a range of earlier defence mechanisms are used to deal with the primitive anxieties of annihilation, disintegration and abandonment (Horner, 1999). If these continue into childhood, good peer relationships and the capacity for independent functioning may be affected (Horner, 1999).

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Winnicott focused on the movement towards individuation and autonomy. Holding, according to Winnicott, occurs within the *transitional space*, the external space that exists between the mother and child that marks the child's separation from the mother (Seinfeld, 1993). At a certain stage of the child's development, objects other than the mother are used to facilitate the developmental process. Described by Winnicott as transitional objects or transitional phenomena, there mark the child's first 'not-me' possession (Seinfeld, 1993, St Clair, 1986). The phenomena are transitional because they occur at a transitional stage in which the child is moving from symbiosis to independence (Eagle, 1997). This object creates an illusion of symbiosis with the mother at a time during which self and object representation are only partly separated and individuated (Weisberg, 1994).

The transitional object is not actually taken to be the mother, and yet, is also not fully an abstract symbolic representation of her (Eagle, 1997). The child is aware that the transitional object is not the mother. However, the child reacts affectionately to these objects and obtains comfort from them. The external objects allow the child to be soothed which results in a freer and safer exploration of the external world (Eagle, 1997). Within the transitional space the child searches for the mother and sometimes finds something that feels like her. The transitional object provides a presence of the mother even in her absence, and thereby eases separation anxiety. This separation is tolerable should the mother return within a reasonable period. However, should the period not be reasonable, traumatic loss of basic trust ensues (Wright, 1991).

The "good enough" mother provides the space for the infant and later the toddler, to explore and to grow. Within this holding space transitional phenomena such as transitional objects are at work. These, according to Winnicott (1971), are the toddler's way of using this space in his movement towards separation. If the space is experienced as actual space, signified by a gap or break in the relationship with the mother, the child will be left with feelings of abandonment, filled with anxiety. If this space is experienced as a potential space, where the child is left on his own but not alone, it provides an opportunity for the child to flourish, explore and is the foundation of the capacity to be alone and of creativity (Hamilton, 1988).

Winnicott's 'good enough mother' in object relations literature is often used as a parallel to the good enough therapist (Clarkson, 1994; Hamilton, 1988; Sharff, 1992). References are also continually made to the holding function of therapy. Thus, the therapy relationship is

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seen to be an extension of the mother-infant relationship. Therapists use their understanding of development to provide a therapeutic environment conducive to the child utilising the insight aspect of therapy towards a growth process.

3.9 Attachments, Mother-Infant Relationship, Containment, Curiosity and The Failure to Think and Learn

The importance of relationships, particularly the mother-child relationship for adjustment can clearly be noted from the theoretical discussion alone. How it affects the child's ability to learn will be discussed in terms of attachment, neurodevelopment and from a psychoanalytical perspective.

3.9.1 Attachment and the Failure to Learn.

Attachment theory suggests that experience in early intimate relationships and representations are tied to mental health (Bowlby, 1969). Bowlby (1969, p.180) hypothesised that developmental processes are the product of the interaction of a unique genetic endowment with a particular "environment of adaptiveness, and especially of his interactions with the principal figure in that environment, namely his mother." Thus, the infant's social, psychological and biological capacities can be best understood from the mother-infant/child relationship.

From a neuro-developmental perspective it is clear that mother-infant attachment affects the development of the child's ability to process information. Research shows how the impact of secure or insecure attachment relationships influence the emotional well being of a child to the point of affecting the neuro-development of the mind (Siegal, 2001). Longitudinal studies on attachment have found that securely attached children seem to have a number of positive outcomes in their development (Cassidy & Shaver, 1999). These include enhanced flexibility, social functioning and cognitive abilities. Some studies suggest that secure attachment conveys a form of resilience in the face of adversity (Siegal, 2001). Insecure attachment is seen to be associated with emotional rigidity, difficulty in social relationships, impairment in attention and difficulty in understanding the minds of others in the face of stressful situations (Siegal, 2001). Thus, there is no doubt that in the literature the mother-

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child relationship is of great significance and has a powerful and lasting impact on the individual, even to the point of affecting the neuro-development of the mind (Siegal, 2001).

3.9.2 The Mother-Infant Relationship and the Failure to Learn

As outlined above, object relations theory is based on the premise that adjustment difficulties in adulthood stem from problems in early mother-child relationships. As Mahler's theory points out, developmental arrest in terms of the mother-infant relationship are seen to manifest in different ways. The emerging self and object-images are defined by the infant's emotional experience. Should there be a disruption, a fixation or regression, development may not proceed correctly along the chronological phase sequences. According to Sinason (1999) such a disruption in the mother-child relationship may affect the child's ability to learn.

There are a variety of views from various psychoanalytical perspectives as to why the child fails to learn or has learning difficulties. However there is no single personality pattern of psychopathology, or single theory of psychoanalysis to explain the origins of learning or inability to learn (Simpson, 2002). According to Freud's view as outlined by Simpson (2002) the development of the ego, including the capacity to learn, depends on there being a shift in mental life from the dominance of the pleasure principle to the dominance of the reality principle. Freud's view is that "thought develops as a response to the need to bridge the gap between the experience of a desire and its satisfaction, which is necessary for this transition to take place" (Simpson, 2002,p.217). This transition from the need for immediate gratification, the pleasure principle, to an acceptance of the necessary struggle to meet our conflicting needs and the reality principle is seen to be a difficult transition (Simpson, 2002). As Bion (1962b) explains, the capacity to make this transition and to learn from experience depends upon the individual's capacity to tolerate frustration. This transition for the learning disabled is difficult. Firstly, the learning disabled person may not have the cognitive capacity to accomplish this transition due to organic deficits (Simpson, 2002). Secondly, the ability for learning disabled people to tolerate frustration is often limited (Simpson, 2002). Thirdly, the reality that learning disabled individuals have to face is often very difficult to acknowledge and confront (Simpson, 2002). .

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. An object which is unavailable for whatever reason does not allow for the mother to take in his projections resulting in the object being experienced as an additional external source of destruction, of communication and awareness (O'Shaughnessy, 1992). Bion has suggested that the maternal object who fails to introject, in effect a mother who has failed to absorb the infant's projections, is then perceived by the child as hostile to any attempt at projective identification (Britton, 1992).

An 'ego-destructive superego' develops and the normal integrative processes of the depressive position does not occur (Britton, 1992). The resultant effect is a child whose experience is that the world did not want to know their thoughts (Britton, 1992). An object of this nature would result in an 'ego-destructive superego' and an internal object that does not allow for a thinking and perceiving mind (Britton, 1992). Bion (1962a, p.112) sums it up clearly with the following:

> *The model I propose for this development is a psyche that operates on the principle that evacuation of a bad breast is synonymous with obtaining sustenance from a good breast. The end result is that all thoughts are treated as if they were indistinguishable from bad internal objects; the appropriate machinery is felt to be, not an apparatus for thinking the thoughts but an apparatus for ridding the psyche of accumulations of bad internal objects.*

3.9.3 Maternal Containment and the Failure to Think

What Bion (1959) seems to be describing is a deterioration in emotional and cognitive development when there is a failure of maternal containment. The infant strives desperately to rid itself of unwanted parts, resorting to excessive use of splitting and projective identification. When the projections are not contained and transformed by maternal reverie, the process of projective identification fails in its aim of communication and becomes a forceful evacuation, giving rise to fragmentation of self and confusion between self and object.

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Bion (1962a) described how the development of normal thinking may be disturbed to such an extent that, in the place of normal thinking, projective identification occurs as an 'evacuating' process. This interferes with the ability to learn from experience. O'Shaughnessy's (1981) description of Bion's view seems to fit well with the inability to develop the thinking process. He states that the first form of thinking is a struggle to know psychic qualities and is the outcome of the early emotional events between a baby and its mother. Thus, thinking is seen not to be an abstract mental process but rather an emotional experience dependent upon human relationships with the aim of understanding oneself and others. Accordingly, the only way to know and understand ourselves is through our relationships and the experience of being known by others. This then becomes very difficult for a learning disabled child and they may then actively move away from reality, as they expect the object is one that cannot bear to know them (Simpson, 2002).

Alvarez's (1992) view is somewhat different to Bion and Freud's view in that she does not agree that it is primarily through frustration, absence and separation that thoughts are born. Her view is more in line with Simpson's idea of the effect of the object relationships on learning. Alvarez's (1992, p.216) view is:

> *that the present object possesses several features important for the promotion of learning about reality: its willingness to enliven, seek, and when the child is depressed, reclaim him; its eagerness to return to the child after absence, its ability to receive pleasure and delight from the child, to permit reparation, to forgive.*

In other words, how the parent understands the child's needs and reacts to them affects the child's functioning and ability to think.

3.9.4 Curiosity and the Ability to Learn

The importance of the mother's function as a receptacle for the infant's earliest experiences is clearly outlined by Klein. Klein (1997a) stressed that the infant requires a mother who can consider and respond appropriately to the infant's needs and distress, as well as to his love. A mother who, for whatever reason, is unavailable may result in the infant's bad object being stronger than the good object (Weininger, 1992). The lack of availability of the mother would not enable the infant to contain the anxiety aroused by phantasies of persecution and, as noted, excessive splitting is used as a defence. The infant's lack of confidence in the

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availability of the object would result in excessive anxiety (Klein, 1997a) and an insecure relationship (Eagle, 1997).

Klein (1975) stated that 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, often subtle, emotional attitude is of greater importance than Klein emphasised.

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 show pleasure and interest in the child's curiosity, or they may show embarrassment, hurt, guilt or simply unresponsiveness. "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). Secondly, 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 it to thrive.

3.10 Conclusion

The four theoretical perspectives discussed in this chapter provide different developmental perspectives of understanding the psychological development of the child. As outlined in the discussion, the individual sense of the world depends upon early object relations, the mother-infant relationship. Though these early struggles, internalizations and differentiation, the individual forms the self and object-images (Hamilton, 1988). The nature of a child's difficulties can be traced to arrests in the development of the self and anomalies in splitting. The primary function of the psychotherapist working with children is to assist them to make sense of their emotional experiences. The goal of psychotherapy is to improve adjustment and

functioning in both intrapersonal and interpersonal spheres as well as to reduce maladaptive behaviour and to reduce various psychological difficulties.

The child's ability to think and process information is the primary focus of this study. As noted, the mother-infant relationship becomes crucial when trying to understand the child's ability to process information and the neuro-development of the mind (Siegal, 2001). As noted by Sinason (2002), there are various psychological views as to why the child fails to learn or has learning difficulties. However, there is no single pattern or theory, which can explain the origins of learning disabilities. What is evident, in terms of analytical theory, is the arrest in development as a result of early relationships that may impact on the ability to think or result in an inability to learn. Thus, what constitutes normal development is important when considering what deviations impact on the ability to think and learn.

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Chapter 4

4. Psychotherapy with Children who have a Learning Disability

4.1 Introduction

A child whose motor, perceptual or cognitive development is impaired or delayed is invariably a frustrated child. In addition, learning disabled children are often angry, insecure, and have a lowered self-esteem (Leonardi, 1993; Silver, 1996; Rawson & Cassady, 1996). As a result, learning disabled children often experience emotional difficulties and require some form of psychotherapy. The focus of the previous chapter was to provide an understanding of four principal object relations theorists. The present chapter aims to discuss psychotherapy with learning disabled children and the role of the parent in the therapy process. The focus of this chapter will, therefore, be in two parts. The first section will outline the debate on whether learning disabled patients are suitable for psychotherapy, it will explain the use of interpretation in psychotherapy with children with specific reference to the learning disabled child and a discussion on the common themes which may arise when working with these children in terms of an object relations framework will be addressed. The child does not exist in an isolated context; consequently the second part of this chapter will briefly discuss the therapeutic work with parents of a child in psychoanalytic therapy. Since the focus of this research is on learning disabled children, a discussion of the possible themes that may arise when working with parents of a learning disabled child will be included.

4.2 Emotional Intelligence and Suitability

Current psychoanalytic development theories tend not to take into account the effects of neurocognitive differences and consequently do not explain their impact on children's personality development (Palombo, 1995). They tend to emphasize trauma and environmental over constitutional and neurocognitive factors. Theorists such as Weil (1985) and Greenspan (1989) have attempted to integrate the concept of differences in endowment into their theories. However they do not speak directly of learning disabilities. Rouke (1989) reviewed and summarised the literature, from 1980 to the time of publication of his work. He focused on the relationship of socio/emotional problems of learning disabilities. Rouke states that no single personality pattern of psychopathology could be found in common for all children with

learning disabilities. In spite of there being no specific personality pattern, psychoanalysis is seen to be useful in providing theories for understanding the origin of learning (Hernadez-Halton, Hodges, Miller, & Simpson, 2000, Simpson, 2002, Sinason, 1992).

Learning disabled people have rarely been considered for psychotherapy treatment and though this is changing as a result of research, some concerns still arise about the undertaking of such work. One of the primary concerns is around being understood particularly when there is a recognisable difference in IQ and there are significant difficulties with the person's verbal abilities. However, as Sinason (1992) notes, a person can be emotionally aware and knowledgeable despite major deficits in cognitive intelligence. In addition, a common finding regarding language is that expressive abilities often increase and become more coherent in psychotherapy as the patient has ongoing experience of the psychotherapist trying to make sense of their communications, whether they are verbal or non-verbal (Bungener & McCormack, 1994).

The concept of emotional intelligence, which involves the experience and expression of emotions has now gained wide spread acceptance (Goleman, 1998). The ability to know one's own emotions and the ability to understand the emotions of the other constitutes a core aspect of emotional intelligence (Goleman, 1998). Sinason (1992) and Stokes (1987, cited in Hernadez-Halton, Hodges, Miller & Simpson, 2000) distinguish between emotional and cognitive intelligence. Stokes (1987) acknowledges there is a relationship between the two. However he does not perceive it as a one-to-one correlation. He rather highlights the depth of the emotional capacity of the learning disabled person. In other words, the learning disabled person's capacity to feel emotions is not limited. Sinason states that

> *However crippled someone's external functional intelligence might be, there still can be intact a complex emotional structure and capacity. To reach and explore this emotional intelligence a great deal of guilt must be dealt with, guilt of the patient for his handicap and guilt of the worker for being normal* (Sinason, 1992, p.74).

The learning disabled person is not necessarily limited emotionally. However, emotion often takes time to explore as many defences may be in place.

As noted in the above discussion, it is increasingly accepted that the emotional lives of learning disabled people are indeed worthy of exploration (Hernadez-Halton et al., 2000; Sinason, 1992). However, due to the limited number of psychotherapists specialising in this

field there is a lack of research as to the criteria for suitability (Aleksandrowcz & Aleksandrowcz, 1989; Bungener & McCormack, 1994; Hernadez-Halton et al., 2000). The primary focus of suitability should not be focused on the client but rather on the therapist. It is important for the therapist to be aware of what they can bear as the client can be very demanding and difficult in therapy (Bungener & McCormack, 1994).

The first step of assessing the suitability of psychotherapy for a child with emotional and/or behavioural difficulties is a comprehensive assessment of the presenting problem (Kazdin, 2000a). This assessment typically includes a history of the child's development, the presenting problem, the interpersonal and intrapersonal stresses and conflicts which underlie the disturbance, the degree and nature of the child's dependency needs and the child's internalization of social norms (Bernstein & Sax, 1992). The therapist's aim is to consider the most appropriate form of intervention, for example individual psychotherapy versus family therapy versus parent counseling and so forth (Kazdin, 2000a). Consideration needs to be given to the parents' commitment to therapy to maintain the analysis (Bernstein & Sax, 1992). The child's state of mind needs to be evaluated to assess whether the child is not for example psychotic where a more appropriate form of intervention would be required (Burgener & McCormack, 1994). Some of the literature outlines insufficient intellectual endowment as a contraindication for psychotherapy (Bernstein & Sax, 1992). However, as discussed, Sinason (1992) argues there is the capacity for a learning disabled person to use therapy. Nonetheless, an assessment of the child's ability to use the therapy needs to be obtained (Hernadez-Halton et al., 2000). This includes the clients ability to use interpretations and comprehension of the therapy process (Hernadez-Halton et al., 2000) To sum up, the criteria for suitability of child psychotherapy seems to concern the most appropriate form of intervention, the child's state of mind, the commitment from the parents to maintain the therapy and, finally, the client's ability to use the therapy process.

From the above discussion it is clear that psychotherapy with people who have learning disabilities is possible. However it is important to be aware of the limitation that may exist as a result of their disabilities. Psychic development with learning disabled clients is possible, provided a realistic assessment is obtained, and the therapist is aware of the difficulties or limitations of the client.

4.3 The Techniques of Clarification, Confrontation and Interpretation

While adults use words to express and communicate their feelings and thoughts, children often need to do this through play (Lanyado & Horne, 1999; Passey, 1994). The child talks and plays out their emotional world but may also, for example, be silent and resistant, communicating non-verbally (Lanyado & Horne, 1999). It is the therapist's task to be receptive to the child, to allow for the impact of the child's communications, both verbal, and non-verbal and respond to the various forms of communication (Lanyado & Horne, 1999; Passey, 1994). For insight and growth to be achieved clarification, confrontation and interpretation are required (Hamilton, 1988).

Clarification, stated simply, is asking a question to obtain more information (Hamilton, 1988). In psychotherapy clarification is not only aimed at conscious material but at the deeper preconscious material, and wider, to the full range of thinking, feeling and acting (Ducey, 1995). In terms of play therapy, the therapist may make a simple comment, which clarifies the meaning of the child's play (Lanyado & Horne, 1999). Confrontation in psychotherapy means to forcefully direct the client's attention to something previously overlooked (Ducey, 1995). In other words, the aim of confrontation is to point something out about the patient, to draw their attention to it whether it is done gently or forcefully by the therapist (Ducey, 1995; Hamilton, 1988). The difference between confrontation and interpretation is that confrontation calls attention to something whereas interpretation explains it (Ducey, 1995; Hamilton, 1988). The therapist interprets the client's thoughts and feelings, as well as their behaviour (Ducey, 1995). The aim being to provide meaning, insight and purpose where previously none was thought to exist (Ducey, 1995). Interpretation is seen to have a number of functions. In its most simple form it may be merely describing the way in which the child seems to be experiencing the psychotherapist or their world (Passey, 1994). It may also involve sorting out powerful, frightening or confusing feelings that the child has depicted by naming the confusion and making it available for thought (Passey, 1994). Finally, it may involve linking significant experiences in the past to the here-and-now (Passey, 1994).

The therapist's task with the child is to respond to their various forms of communication whether they act it out through play or they put it in words (Lanyado & Horne, 1999). The therapist tends to respond to the child's various forms of communication in a number of different ways. At times the therapist may simply comment on the child's play in order to

clarify the meaning of the play, this may be as simple as naming the possible feeling (Lanyado & Horne, 1999). At other times the therapist may be able to interpret or identify common or recurring themes in the child's feelings or thoughts (Lanyado & Horne, 1999). The therapist will respond according to how the child reacts, this reaction may be in words, play or action (Lanyado & Horne, 1999). An important part of the therapy process is to enable the child to develop a sense of curiosity and a capacity for reflection (Lanyado & Horne, 1999).

As noted by Lanyado and Horne (1999) it is important for the therapist to keep in mind how the child is able to listen to or understand what is being said. In other words the therapist's language must be in tune with that of the child. This is important when working with learning disabled children whose verbal capacities are limited or non-existent. As Sinason (1992) explains it is important to carefully monitor the learning disabled patient's responses to interpretations or comments to assess whether the client has understood what has been said and is also aware that their reaction may not have the meaning or understanding the therapist gives it. She warns, "sometimes, a patient can provide a nod which might be compliant rather than a sign of real agreement " (Sinason, 1992,p.251). Thus it becomes important to assess that the learning disabled child has understood the interpretation through obtaining clarity of their responses. In practice, this would mean working more intensely with counter-transference feelings as well as consistently obtaining clarity when working with a learning disabled child (Sinason, 1992). This will be discussed further in the next section.

4.4 Common Therapy Themes

There are four area's where common themes in therapy with a learning disabled client are seen to emerge. Firstly, a "secondary handicap" may develop in the form of anxieties and defences (Sinason, 1992). Secondly, in the transference, issues around dependency, the inability to think, envy and abandonment may surface (Sinason, 1992). Thirdly, themes in the counter-transference around the therapist's ability to think, and the trio of feelings, namely, contempt, guilt and pity are common (Bungener & Mc Cormack, 1994). Finally, there are common aspects of how the learning disabled child perceives their internal and external world. Each of these will be discussed in turn.

4.4.1 Anxieties, Defences and the Concept of Secondary Handicap

Anxieties are seen to be an important part of everyday life, giving the individual warnings when there is possible danger whether it is emotional or physical (Lanyado & Horne, 1999). How the child's anxieties have been contained or exacerbated in the past by parents or caretakers, determines how anxious the child is in life and how they cope with these anxieties (Lanyado & Horne, 1999). Defences are developed and utilised by the ego to protect itself at times of anxiety. Without defences, the individual becomes vulnerable in their interaction and is likely to respond inappropriately or be easily hurt (Lanyado & Horne, 1999). One of the most important concepts of psychotherapeutic work with the learning disabled is that of secondary handicap. The secondary handicap is the particular use 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). It is also used as a defence against the reaction of others towards them (Hernandez-Halton et al., 2000).

A secondary handicap is seen to come after the original handicap as an exaggeration and extension of it (Bungener & McCormack, 1994; Sinason, 1992). It could be a newly created handicap as a result of a defence, for example against abuse and trauma (Bungener & McCormack, 1994; Sinason, 1992). Initially in therapy the secondary handicap may pervade the personality to such an extent that it is often difficult to identity the client's real potential or the primary handicap (Bungener & McCormack, 1994; Sinason, 1992). One of the key issues in therapy is differentiating the primary disability, from the secondary handicap (Sinason, 1992).

Sinason's (1992) distinction between the three types of secondary handicaps is useful in understanding the learning disabled client. The first type is called "mild secondary handicap". This is where a person who already has an existing handicap exaggerates the handicap. The person is seen to do this in order to make himself or herself as innocuous, inoffensive and as easy going as possible. Sinason states that it's most distinctive feature is the handicapped smile: "some handicapped people behave like smiling pets for fear of offending those they are dependent on" (1992,p.21). For example, outwardly the client appears to be friendly, happy and confident although underneath this exterior they are sad, insecure and lack self-confidence. Their outward demeanour is seen as an unconscious attempt to guard or defend against the feelings that the disability may arouse in themselves and others.

The second type is called an "opportunist handicap" (Sinason, 1992). This is when the handicapped person uses the handicap as an outlet and a home. This is often the result of severe psychological disturbance in the personality. The handicap is then used for every emotional difficulty and disturbance the individual has (Bungener & McCormack, 1994). In other words, the handicap is used as a defence against the difficulties the individual encounters as opposed to their own contribution to their unmet needs or psychological immobility (Bungener & McCormack, 1994).

The third handicapping process is where the handicap is used as a defence against the memory and knowledge of trauma and abuse. Sinason (1992) clarifies the original meaning of the word "stupid" as meaning numb with grief. She is suggesting that stupidity can be a kind of defence against the trauma of knowing too much of a painful kind. Sinason is referring in this regard to the existence of trauma, sexual abuse and severe deprivation. She suggests that the original meaning of the word stupid comes through, as a lot of the pain and secondary effects of handicap are to do with the grief of internal and external trauma (Sinason, 1992).

Since a learning disability is not necessarily a fixed handicap and there is the potential for the person to progress, there is then the scope in therapy for therapeutic change (Bungener & McCormack, 1994). In order for therapy to progress it is important during the psychoanalytical therapy process for these anxieties and defences to be evoked and experienced in the therapy relationship (Lanyado & Horne, 1999). Thus, it is imperative to identify whether there is a secondary handicap and the type of secondary handicap in order to work through these anxieties and defences.

According to Lanyando and Horne (1999) there are two aims when working with defences in therapy. Firstly to explore the defences that are not age-appropriate and not helpful. Secondly, to increase the range of defences available to the child in order to assist them to cope with the unbearable anxiety or emotional pain. Working with the learning disabled client would therefore involve exploring the traumatic effects of the handicap, the use of the handicap as a defence, mourning the handicap and then providing more appropriate defences or coping mechanisms.

4.4.2 Transference

Psychotherapy may be thought of as consisting of a technical part and a relationship part. The technical aspect includes the techniques used by the therapist in an effort to modify client behaviour, and the theoretically prescribed roles taken by the participant (Hamilton, 1988). The relationship aspect consists of the feelings and attitudes the therapist and client hold towards one another, and the psychological connection between the two, based on these feelings and attitudes. It is this relationship that is difficult to grasp theoretically and clinically. Consequently, it is also difficult to study empirically (Gelso & Hayes, 1998). Thus, even after many years of research, few assertions can be made about psychotherapy on which there is general agreement (Gelso & Hayes, 1998).

Despite the ambiguousness of the relationship, nearly all psychotherapy practitioners, theoreticians and researchers agree that the relationship that develops between therapist and client is important and has a significant effect on the process and outcome of treatment (Gelso & Hayes, 1998). As noted in the previous chapter, the child's sense of who he is and how others will react is very much affected by expectations based on his past and present family relationships, particularly the relationship with his mother. It is the 'transferring' of these expectations onto the new relationship with the therapist, which constitutes the transference-countertransference relationship (Sandler, Dare, & Holder, 1992). This aspect of the therapy relationship is the most extensively written about, for it is extremely well developed, articulated and effectively used in the psychoanalytical tradition as well as other approaches (Clarkson, 1994).

Transference may thus be defined as "as a specific illusion which develops in regard to the other person, one which, unbeknown to the subject, represents, in some of its features, a repetition of a relationship towards an important figure in the person's past or an externalisation of an internal object relationship" (Sandler, Dare, & Holder, 1992,p.58). There are four common transference themes when working with learning disabled clients outlined in the literature: dependency, the use of dependency not to think, envy and finally abandonment. Each of these will be discussed briefly.

Mannoni (1973) outlines a particular type of relationship that is easily set into motion with the learning disabled person. The client perceives the therapist as somebody they must fit in

with. As a result of their sense of not being able or capable, the learning disabled person very rarely opposes others. They try to mould themselves to the desires of others. The resultant effect of this is a dependant relationship, as the client is determined to keep everything nice. Thus, it becomes safer for the client to fit in with the perceived representation that others have, that of being damaged and different. As Bion states, "the interpretation is accepted, but the premises have been rejected" (1963,p.54). The client outwardly accepts the therapist's interpretation, however it is not internalised and is meaningless for the client.

Another aspect of dependency on transference onto the therapist, is dependency in terms of not thinking (Bungener & McCormack, 1994). In therapy, the re-activating of the thought process can be extremely painful, and, as a result it is easier for the client to remain dependent on others for their thinking (Bungener & McCormack, 1994). This dependency in terms of the therapy relationship can be seen to be a major dynamic in the maintenance of 'stupidity' for the learning disabled person (Bungener & McCormack, 1994). It therefore becomes easier for the learning disabled person to cut off their thinking.

Envy also commonly appears in the transference with the learning disabled client (Bungener & McCormack, 1994). Bion describes projective identification as the first link between baby and mother (Spillius, 1992). As noted in chapter three the infant projects into his mother and the mother then responds with what Bion referred to as "reverie" (Emanuel, 1996). The initial projective identification can be done in love or hate, and these early emotions can determine the infants way of exploring and perceptions of the world which can be seen as the beginning of learning (Britton, 1992; Malcolm, 1992). Bion called this learning, "K" activity, which he referred to as "coming to know" (Malcolm, 1992).

Bion's 'K' activity or learning brings together emotion and cognition and, according to him, this occurs in a meaningful relationship between people (Malcolm, 1992). This relationship could be between mother and infant, or therapist and client. 'K' activity results in the acquisition of pieces of knowledge. Bion used the term 'minus K' to refers to reversals of learning (Malcolm, 1992). He described the phenomena of 'minus K' as not understanding or misunderstanding, and he links this to primary envy (Malcolm, 1992).

In terms of primary envy, as a result of the infant's excessive envy of the breast, he is unable to experience the mother's reverie as relief. Without going into detail, this inability to

experience reverie is connected to the maternal pathology, which results in the child being unable to experience relief. Consequently, where it would have been relieving the anxiety, by projecting this envy into the mother, it is experienced as the mother taking his own value away (Malcolm, 1992). How this manifests in therapy is the client being unable to tolerate the therapist's interpretations, which are also not perceived as relieving or as conducive to growth. Although the client will appear to be together with the therapist, the interpretations are experienced as empty of meaning, useless and repetitious (Malcolm, 1992). One can therefore note that envy appears in the therapy in a rather disguised form.

The patient is unable to use the input from the therapist and is therefore unable to learn from the analysis (Malcolm, 1992). Malcolm sees the repetitive use of "minus-K" in the analysis as a repetition of earlier difficulties of the patient and a way of preventing the exploration of their internal situation (1992). Again, one can note how the theme of the client not using or internalising interpretations is evident.

Another common theme occurring with learning disabled clients is the expectation of being abandoned or being unwanted by the therapist (Bungener & McCormack, 1994). Although fears about abandonment occur with many clients, with the learning disabled client it is around feeling a burden or that they are defective and consequently unwanted (Bungener & McCormack, 1994). The expectation from the client is that the therapist is tired of them and is unable to stand them any longer. Issues of this nature may manifest themselves in the transference through feelings of boredom and displeasure (Bungener & McCormack, 1994).

4.4.3 Counter-transference

Simply stated, counter-transference is the therapist being affected by the client; the therapist's emotional response to the client (Bungener & McCormack, 1994; Hamilton, 1988; Lanyado & Horne, 1999). As a concept this has changed considerably since Freud, who considered it as something to be eliminated (Hamilton, 1988). Subsequently, counter-transference is considered to be an important indicator of the client's state of mind and a valuable clue as to how the client typically interacts with others (Hamilton, 1988). It involves a process of self-analysis by the therapist and working through their own feelings and thoughts, which are evoked by the work with the client (Hamilton, 1988).

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Counter-transference becomes particularly valuable and important when working with patients whose verbal capacities are limited or where they fluctuate (Bungener & McCormack, 1994). It is one of the primary tools which make psychotherapy possible with a profoundly verbally handicapped child (Bungener & McCormack, 1994). Sinason (1992) states that there is a need to work more intensively with counter-transference feelings with non-verbal patients. She writes that there is a need to monitor carefully the patient's response to interpretation or comments based upon counter-transference impressions. However, she does warn, "sometimes, a patient can provide a nod which might be compliant rather than a sign of real agreement" (Sinason, 1992,p.251). When unsure of one's impressions, she emphasises the need to check it out again with the client. In addition, she stresses that in order to use one's emotional responses towards the patients with increasing effectiveness, one requires supervision.

Bungener and McCormack (1994) write that one of the most common counter-transference feelings is the experience of feeling of drowsiness, or an inability to remain alert and thinking. When this occurs it is helpful for the therapist to register that these feelings are a consequence of counter-transference, which is in the form of not being able to think. By registering these feelings, the therapist starts digesting and processing the feelings in order to understand what aspects have occurred from the state of mind of the patient and why. When the therapist registers and processes the 'mind-numbing' counter-transference, the therapist retrieves their capacity to think and enables the patient to do likewise (Bungener and McCormack, 1994).

According to Bungener and McCormack (1994) another common occurring counter-transference is most often found in a trio of feelings. Contempt, guilt and pity all come together to create a key set of feelings, which can be difficult to detect. These feelings may initially arise out of a situation of difference, the patient feels different from the therapist. The difference is that the therapist appears to have more than the patient, which can result in feelings of guilt. Contempt is often felt towards learning disabled clients by the therapist; often the therapist is unaware of this. This can often manifest in the therapist making allowances for the learning disabled client that they would not normally do for 'normal' clients, such as letting them off being accountable or responsible for their behaviour. It may also become evident in the therapist's behaviour for example, not arriving on time for sessions as the learning disabled client will not mind. Guilt may arise as a result of no change

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or no development in the therapy. The learning disabled client may himself or herself try to induce this cycle of contempt and guilt in the therapist which may be aided by the therapist's intolerance of their own areas of disability. Such a cycle may be the result of the client already believing they are unwanted and then setting out to prove this. Omnipotently, the therapist believes that the client is the only one with the handicap in the room. Thus, what is being defended against by both parties is developmental change as both seek to maintain the status quo. Developmental change would involve considerable psychic pain for the client and the integration of the disabled aspect in the therapist. In order to move out of this cycle it is imperative in the counter-transference to recognise these three feelings, contempt, guilt and pity.

4.4.4 The Interaction of the Internal and External World

The internal world is made up of a number of components and can be seen to be the place where individuals will live the most intensely (Lanyado & Horne, 1999). The internal world is a private world of thoughts, fantasies and feelings. It is a world that is often difficult to articulate (Lanyado & Horne, 1999). The external world is the world that can be observed by others (Lanyado & Horne, 1999). The way in which the internal world and external world interact with and affect each other is the subject of much debate, since our external world is perceived through the eyes of our internal world, which has also been affected by what has actually occurred in our external world experience (Lanyado & Horne, 1999). The earlier in life that these experiences take place, the more intense, powerful and strong the hold they have on the internal world (Lanyado & Horne, 1999). It is the therapist's task to access the child's internal world, which is done through the medium of play (Lanyado & Horne, 1999).

The internal views of the therapist and client are seen to be the gains made in therapy. Bungener and McCormack (1994) use the example of when the patient comes to the realization that they are more capable than people outside realise and it may be difficult for them to sustain this in the outside world as they may be pushed back by others into their familiar ways of being. In addition to the learning disabled client having their own internal concerns, there are the concerns from the external world. That is, the fears of others about stupidity and failure are often projected into the learning disabled client (Bungener & McCormack, 1994). The common theme would therefore seem to be the client's internal world of feeling "stupid" and their perceptions and understanding of how others perceive

them. The external world would be focusing on how others perceive them and whether they have internalised these perceptions.

Society places a great deal of value on intelligence. Thus, a learning disabled person becomes a repository for the unwanted aspects of themselves (Bungener & McCormack, 1994). When the projections onto the individual are on-going throughout life, the experience of being labelled and marked as damaged can take a strong hold over the client. The re-activating of thought processes related to this becomes very painful for the client in the therapy process (Bungener & McCormack, 1994).

One of the major goals of the interpretative process is to help the patient recognise that his emotional problems are often the result of and have been sustained by his own mental activity (Levy, 1984). Interpretation enables the hidden mental actions of the patient to be recognised and for their passive view of their problem to move into an active one (Levy, 1984). The resultant effect is the possibility of change (Levy, 1984). The intention of interpretation is for the patient to become conscious of the motives for his actions (Levy, 1984). The goal is to develop an understanding of the patient's internal, interpersonal environment that is conducive to change (Lanyado & Horne, 1999; Levy, 1984). Fluctuations of understanding in this change are likely to occur (Bungener & McCormack, 1994). The therapist may be required to repeatedly explore defences particularly in relation to intelligence and the external beliefs in the client's world (Bungener & McCormack, 1994). This back and forth movement in terms of the client being in touch with their intelligence may at times result in the patient reverting to feeling 'stupid' and, likewise, the therapist can experience in their counter-transference a belief that the patient is not intelligent or has an inability to think (Bungener & McCormack, 1994).

4.5 The Role of the Parent in Child Analysis

Since our inner world develops from our experiences, and, since for most children this will mean experiences located within the family, it is clear that, when working with children understanding the family environment becomes important. The child who is brought to therapy does not exist in a vacuum but in a family and social context which are seen to impinge onto each other's lives (Kazdin, 2000a). Children generally see analysts for therapy because their parents bring them (Kazdin, 2000). The parent observes the manifestation of the

child's difficulties and fears that they will persist and take more serious forms; as a result they seek help for their child (Glenn, Sabot & Bernstein, 1992). In addition, the school may encourage parents to take the child for therapy as a result of social difficulties, self-esteem issues and behavioural problems (Glenn, Sabot & Bernstein, 1992; Kazdin, 2000). It stands to reason then the treatment of children incorporates the parents and, at times, the family and the teacher in some way (Kazdin, 2000a). Since the context and their influence are bound to change over the course of development, it becomes important to involve the parents extensively to understand these changes for therapy to be effective (Aleksandrowicz & Aleksandrowicz, 1989; Kazdin, 2000a; Wilson & Ryan, 2001)

4.5.1 The Initial Consultation

Since children are generally not considered to be reliable reporters, parents are usually the primary source of information about the child's functioning (Kazdin, 2000a). The initial consultations with the parent/s are generally used to obtain and evaluate the history of the child's development and the presenting difficulties (Aleksandrowicz & Aleksandrowicz, 1989; Bernstein & Sax, 1992; Passey, 1994). It is also essential that the child's therapist develops an understanding not only of the child's circumstances but to ensure that there is an adequate support for the therapy (Wilson & Ryan, 2001).

Rustin (2000) provides an outline of the broad aims of the initial consultation/s or initial assessment at the Tavistock Clinic, London. In summary, she uses this assessment to not only gain an understanding of the child's development but also to obtain a preliminary formulation of the child's state of internal object relations, internal conflicts and defence systems. She uses this assessment to prioritise the type of work needed, for example, work with the school or work with the parents as opposed to with the child. Rustin aims to describe the child's likely capacity to make use of psychoanalytic psychotherapy and to make a judgement about the appropriateness of such an intervention. The process is used to establish a base line of clinical description, which may then change over time. Rustin (2000) emphasises the importance of allowing for enough time to work through what is being proposed for the child, parents and any other significant figures.

For the therapist to understand the child's state of mind it is important to discover how the parents have reacted to the child and if their behaviour will support or discourage their child's

progressions in development (Bernstein & Sax, 1992; Fitzpatrick, 1995). Part of this process is to try to establish whether the parents will be able to sustain the analysis (Glenn, Sabot, & Bernstein, 1992).

In this meeting the therapist will also be able to explain the boundaries of treatment, and address the concerns, anxieties and doubts the parents may have (Aleksandrowicz & Aleksandrowicz, 1989; Bernstein & Sax, 1992; Passey, 1994). It is also during this time that the psychotherapist explains that the content of their child's session are generally confidential (Passey, 1994; Harper, 1994). This will enable the child to feel secure and safe enough to explore possible painful and angry feelings without the fear that these will be disclosed to their parents (Passey, 1994; Harper, 1994). Consent to treatment and the way in which psychoanalytic therapeutic content is communicated to parents and others, such as teachers should be clarified in the initial sessions with the parents (Harper, 1994). The initial consultation will also assist parents to prepare their child for his initial visits (Glenn, Sabot, & Bernstein, 1992).

Besides obtaining an in-depth understanding of the child, the purpose is also to sustain a co-operative relationship between therapist and parents (Rustin, 1999). The relationship the therapist has with the parents is important as a working alliance between them is required if the treatment is to succeed (Bernstein & Sax, 1992; Wilson & Ryan, 2001). The interaction between the parents and analyst during the initial consultation constitutes the start of the alliance (Bernstein & Sax, 1992). Although Melanie Klein wrote very little specifically about the therapist relationship with the parents and sometimes advocated minimal contact with parents, she did, however, write:

> *If we can succeed in establishing a good relationship with the child's parents and in being sure of their unconscious co-operation, we are in a position to obtain useful knowledge about the child's behaviour outside analysis...but if information...is only to be gotton from parents at the price of raising difficulties of another kind, then I prefer to do without it, since, although valuable, it is not absolutely essential* (Klein, 1932,p.48).

This statement is in overall agreement with general psychoanalytic therapy practice, however it tilts to some extent towards avoidance of parental contact. In modern day practice a lack of parental contact would result in the analysis no longer being able to continue, as this would

result in no parental consent. Stated very simply, it is important for the therapist to obtain a working relationship with the parents if therapy is to continue with the child.

4.5.2 Continuing Consultations with Parents

The purpose of the consultation with parents is to sustain a co-operative relationship between therapist and parents in order to assist the therapist in obtaining an ongoing understanding and sense of the child with respect to their family, their school life and their social world (Rustin, 2000). Such meetings are used to review the child's progress in the therapy, to provide the parents with an opportunity to enquire about the therapy and to test out their confidence in the therapist's capacity to help their child (Harper, 1994; Passey, 1994; Rustin, 2000). Where possible, many institutions such as the Tavistock Clinic, London, will use another therapist to work with the parents as a way of providing the space for the parents to work through their own difficulties without compromising the child's therapy (Passey, 1994; Rustin, 1999). Working with parents alongside a child's therapy can sometimes be seen as an intervention in its own right, as without it, changing parental functioning is deemed almost impossible (Rustin, 1999; Fitzpatrick, 1995). The scope of work with parents is wide and varied. For example, supporting parents whose own mental state may impinge in a damaging way on their children, or helping vulnerable parents such as single-parents, or working in a way which attempts to explore the ways in which parental functioning is influenced by unconscious aspects of the parents' own way of perceiving things (Rustin, 1999; Glenn, Sabot, & Bernstein, 1992). Work with parents is seen to be dependent on the parents' presenting difficulties, thus it may be a supportive role by proving a space for the parents to feel understood on the one hand, whilst possibly providing an insight-orientated approach on the other (Rustin, 1999).

The therapist is there to provide a model of how to respond to emotional distress (Rustin, 2000; Wilson & Ryan, 2001). This is done by providing the parents with a safe and reliable setting to enable the parent to feel secure enough to talk through their difficulties (Rustin, 1999). It is the therapist's role to help the parents understand their own children. As a result, it is important to use some form of shared language to describe the emotional state of the child (Rustin, 2000; Wilson & Ryan, 2001). Often by helping the parent feel understood and helping them to think about their own feelings, they are, in turn, able to understand their own child (Rustin, 2000; Glenn, Sabot, & Bernstein, 1992). In order to deeply understand the

complexities of the child, at times, the therapist may be required to work with the parents' internal world and with the constraints of the external reality (Rustin, 2000). The work with parents may also involve focusing on the meaning of behaviour, not only the behaviour of the child but the parents behaviour (Rustin, 2000; Glenn, Sabot, & Bernstein, 1992).

The parent occupies a complex position in terms of the child's analysis. Their role is not only to sustain and supplement the child's ego in maintaining continuity of treatment, but also to develop an information alliance with the therapist to provide information about the child's present situation and past experience (Rustin, 2000; Glenn, Sabot, & Bernstein, 1992). For this to occur generally there is continued contact between the therapist and the parent throughout treatment (Bernstein & Sax, 1992; Fitzpatrick, 1995). Should the therapy become difficult for the parents and/or the child, the therapist is available to provide the parents with support when symptoms increase, persist, or, after disappearing, return (Bernstein & Sax, 1992). The therapeutic alliance tends to be enhanced when the child is aware that his parents and his therapist are working together towards helping him (Glenn, Sabot, & Bernstein, 1992)

For interpretations in the therapy to benefit the child it is important for them to be accurate. As a result, it is necessary to obtain information regarding the child so that the child's anxieties and defences are interpreted with regard to their reality (Bernstein & Sax, 1992; Rustin, 2000). As noted, one of the purposes of seeing parents is to help maintain treatment even when the symptoms and behaviour may worsen as a result of the therapy process. This may occur when the child becomes in touch with distressing feelings, anxieties and discomforts within the therapeutic relationship (Lanyando & Horne, 1999). It is the therapist's task then to provide the parents with emotional support. This may not just be providing the parents with information, but also interpreting the parents' interactions. However, it is necessary to point out that the role of the therapist is not to treat the parents (Bernstein & Sax, 1992). Should the parent require more treatment they should then be referred to another therapist for help (Rustin, 2000).

Parents must show a willingness to engage with professionals in trying to solve parenting problems that they believe exist, which they acknowledge that they have contributed to. Parents will not benefit from treatment if they persistently deny responsibility for their part in the parent-child relationship. The general discussion on working with parents is a broad outline of the psychotherapeutic work with parents of children in therapy. These principles do

not differ when working with a learning disabled child in therapy. However the themes that may emerge may differ from that of other difficulties (Aleksandrowicz & Aleksandrowicz, 1989; Culbertson & Silvosky, 1996).

4.6 Parent-Child Problems in Relation to Learning Disabilities

The following section will discuss a variety of relational problems and difficulties that may develop between parents and children who have learning difficulties. The discussion will focus on a range of potential or possible difficulties that may develop and is not meant to suggest that all learning disabled children have relational problems. Rather the discussion serves to delineate the range of potential problems or possible themes that may emerge when working with parents.

There are four primary areas in which relational problems may develop as a consequence of having a learning disability. Problems may arise as a result of:

- cognitive (for example, understanding versus misperceptions of the disorder) and affective aspects (emotional response of the parent and/or child to having a learning disability),
- family boundaries,
- the social and emotional impact of the parent-child relationship
- and the functional impact of a learning disabled child (for example, the increased demands on the parents to care for the learning disabled child) (Culbertson & Silovosky, 1996). Each of these will be discussed in turn with specific reference to the importance of working with parents of children in psychotherapy.

4.6.1 Cognitive and Affective Aspects

At the most basic level it is important for parents to understand the child's difficulties (Culbertson & Silovosky, 1996; Case, 2001). Parental expectations may be appropriate or inappropriate based on their understanding of the information available to them about their child's difficulty (Case, 2001). Thus, the first level of working with parents is helping them to understand the child's difficulties at a cognitive level as well as the potential impact of the disability on the child's functioning as well as the influence or impact on the parents life (Case, 2001; Culbertson & Silovosky, 1996; Silver & Hagnin, 2002). This would involve

providing the parent with an understanding of the disorder, and the implications and nature of learning disabilities (Case, 2001). Although this may be seen to be more of a psycho-educational approach it may be required should the parents not understand their child's learning difficulties. As Rustin (2000) points out, it is the therapist's role to make a judgement about the type of intervention and the appropriateness of such an intervention. Consequently, when working with parents therapy may not always follow the traditional psychoanalytical model, but rather depends on the needs of the parents.

The second level of understanding is more affective than cognitive. The parents' emotional response to having a learning disabled child needs to be understood and addressed (Case, 2001). The parents' emotional response may include grieving the loss of the idealised child and may involve a variety of defences such as anger, denial or projection (Culbertson & Silovosky, 1996; Silver & Hagnin, 2002). Parents' adaptation to having a learning disabled child is seen to be an ongoing process, changing as a function of the child's developmental stages and life experience (Culbertson & Silovosky, 1996).

As the child's difficulties continue, parents' denial or non-acceptance of the child's disorder are often replaced by depression and guilt (Silver & Hagnin, 2002). Depression may be the result of the future of the child being uncertain and that the child will not fulfil parental wishes (Silver & Hagnin, 2002). Guilt in terms of blaming themselves which often leads to projecting blame on others in search of a possible cause for the learning disorder (Silver & Hagnin, 2002). Consequently, anger is often directed at all those who are involved with the child such, as the paediatrician, the school, a spouse and even at the child (Silver & Hagnin, 2002).

Bicknell's (1983) classic paper 'The psychopathology of handicap' has emphasised the impact the arrival of a handicapped child has on the family and the possible problems, that may arise as a result of a failure to resolve this crisis. She focuses on the importance of loss in disability and the impact, that it can potentially have on the individual and the family, not only at the time of birth but at subsequent developmental stages. She argues that the failure to resolve the grief surrounding these losses can result in a variety of difficulties, such as rejection, seeking alternative diagnoses and chronic grief. Although learning disabilities tend not to be diagnosed at birth, her paper highlights the importance of dealing with loss when there is a disability.

In addition to assisting the parents with managing the child's response to being learning disabled, helping them understand the possible reactions from the child upon discovering their disorder is important (Culbertson & Silovosky, 1996). Children's affective response to learning about their learning disability may take various forms. The child may obtain some relief in finally understanding the reason for their academic struggle (Culbertson & Silovosky, 1996). The child may feel embarrassed at being different or feel anger related to their difficulties as a result of the disorder (Silver & Hagnin, 2002). Such children may use a variety of defence mechanisms to try to protect themselves from the painful aspects of their disability (Culbertson & Silovosky, 1996). It is important for the parent to understand the child's reaction to their difficulties as parental misinterpretation may lead to relational problems (Culbertson & Silovosky, 1996).

It is important when working with parents that their adaptation to their child's disability is not a one-time occurrence. Rather, adaptation is on-going over the child's life span and may change as a function of the child's developmental stages (Silver & Hagnin, 2002). The process of parental grieving over the loss of the "idealised" child is therefore not pathological. However, it may become pathological if the parent is unable to move forwards. Work with the parents in this regard may be required.

4.6.2 Family Boundaries

Inappropriate parental expectation, characteristics inherent within the child (e.g., immaturity, poor social skills), or the interaction of these factors may lead to separation/individuation and boundary issues (Culbertson & Silovosky, 1996). The parental role in relation to the child or the child's behaviour in relation to the parent may be adversely affected by the impact of the child's learning disability (Culbertson & Silovosky, 1996). For example, the child may be delayed developmentally and require support for dependent behaviour that is not necessarily age-appropriate. A parent in this situation may overcompensate by becoming overprotective which in turn could result in an enmeshed relationship (Culbertson & Silovosky, 1996). At the other end of the spectrum, is the parent who as a result of shame or disappointment, disengages with the child emotionally (Culbertson & Silovosky, 1996). These feelings directly affect the parent-child relationship and may then contribute to relationship problems.

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Family issues may also develop depending on how the learning disabled child is treated in the family. For example, the child's status within the family, having little status in the family or, the other extreme, obtaining higher status as a result of being 'different', will affect family relationships particularly if there are siblings (Culbertson & Silovosky, 1996). Since the learning disabled child may have difficulties with expressing himself, communication difficulties between members may develop (Culbertson & Silovosky, 1996).

4.6.3 The Social and Emotional Impact of the Parent-child Relationship

There may be problems within the child that make social relationships and/or interaction difficult (Derbyshire, 1991; Leondari, 1993, Spencer, 1997; Silver, 1996, Rawson & Cassady, 1996; Tait & Genders, 2002). These communication problems may result in misunderstandings between parent and child. Social perception and social interaction problems are often severe enough to lead to social rejection and isolation among peers, but may also interfere significantly with interactions within the family (Burgener & McCorsmack, 1994; Culbertson & Silovosky, 1996; Silver, 1989). Learning disabled children are often extremely difficult to live with in the family as they often have poor understanding and perception of other's feelings (Culbertson & Silovosky, 1996). These children may also have problems with interpreting non-verbal cues and therefore often misinterpret other peoples behaviour (Culbertson & Silovosky, 1996; Silver & Hagnin, 2002). Related to this is a poor ability to benefit from parental teaching of appropriate social behaviour (Culbertson & Silovosky, 1996). Such difficulties within the family environment may result in frustration and anger, which in turn may have a negative impact on the parent-child relationship.

4.6.4 The Impact of a Learning Disabled Child on Day-To-Day Functioning

On an ongoing, day-to-day basis increased demands are common in families that have a child with a learning disorder. These can range from problems related to homework, working for tests, general organisation, needing more practical assistance and an increased need to monitor the child in general (Culbertson & Silovosky, 1996). In addition to this, as a result of the child not coping in the school environment, parents often become involved with school related issues when the child becomes overly frustrated (Culbertson & Silovosky, 1996). These increased stressors may result in parents feeling frustrated or angry which may impact negatively on their relationship with the child (Culbertson & Silovosky, 1996). In sum, a

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number of aspects of the parent-child relationship may be severely strained due to stressors associated with the learning disabled child. However, assessing the clinical significance of these aspects is critical to helping not only the child in therapy but the parent relationship with the child.

4.7 Conclusion

Psychotherapy with learning disabled children is possible, in spite of the differences in ability and the possibility of poor verbal expressive skills. It is evident that although there is no single personality pattern with learning disabled individuals there are common themes, which may arise in the therapy. From the above discussion it is clear that the common themes or issues that arise appear to be interlinked and will not necessarily emerge in isolation to each other. The uses of defences will emerge in the transference and counter-transference as well as in the external and internal world of the client.

As outlined in the discussion, the external world is important in understanding the client. Also, therapy with children does not occur in isolation and an understanding of their world is important when trying to understand the child. It is for this reason that consultations with the parents are necessary when working with children to obtain an understanding of not only their external world but to further one's understanding of the relationships the child has. This would also enable the therapist to further understand the common themes that emerge in the therapy, as well as to assess how others perceive them or how they originated.

Most parents of children bring their child to therapy because they feel concern and compassion for their child's distress. However, at the same time, they often come to the therapist burdened with guilt, fear, denial and anger. When working with parents of a learning disabled child these feelings appear to often revolve around specific themes. It is the role of the therapist when working with these parents to provide support, a working alliance, to obtain the required information for continuing to work with the child and at times help parents confront difficult issues with regards to themselves in order to help the child. Sustaining a co-operative relationship between therapist and parent in order to give the therapist a sense of the child's world is often difficult, particularly when dealing with a fragile parent or a parent who is damaged in some way. It is the capacity to empathise with both the parent and the child's perspective that results in therapeutic progress (Rustin, 2002).

Family support may be the most important buffer to the child with a learning disability in dealing with the stresses inherent in the disorder (Culbertson & Silvosky, 1996). The discussion clear outlines that providing that the therapy with the child is conducted so that parents are fully involved in the therapy process, and that they are given, where necessary appropriate guidance and help, it can be highly effective in helping both children and their parents with their difficulties.

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Chapter 5

5. Research Methodology

5.1 Introduction to the Study

This study was an exploratory investigation into the intrapsychic experiences of three learning disabled children whom have been in psychoanalytic therapy. The research used semi-structured open-ended interviews to focus on the child, the therapist and the mother's experience of the therapeutic relationship. As there has been limited research in this area, the research searched for tentative, common experiences. A qualitative methodology was used as a means to elicit the essential meanings held by the participants, without initially presuming what they might be. A quantitative approach involves preselecting categories, whereas a qualitative approach constructs or discovers categories. Thus the aim of the research was description and conceptualization, rather than hypothesis testing.

As Huberman and Miles (1994) point out, choices that a researcher makes all through the process, contribute to data reduction and influence the outcome of the research. Qualitative designs are not predetermined. In their nature, they have to be constantly revised to suit the particular research. In qualitative research, the research design is a flexible set of guidelines to guide inquiry and provide methods for analysing data and linking it to theory (a framework for interpretation) (Denzin & Lincoln, 1994). Qualitative researchers can draw upon and utilise numerous methods, techniques and approaches (Denzin & Lincoln, 1994). It is therefore seen to be multipragmatic and transdisciplinary in focus, as well as often multimethod in its approach (Denzin & Lincoln, 1994). The important aspect of qualitative research is to make one's choices concerning method explicit, so that a reader may follow the process.

The choices made in this research are discussed in this chapter, including the methodology for interpreting the data gathered, the participants, the interview process, recording the data, and the researcher's position in constructing the data. This chapter is divided into two distinct sections; the first part will provide a discussion and outline of the methodology. This includes a broad overview of qualitative methodology, which is followed by a discussion of the specific methodology used in this research, namely, phenomenological hermeneutics, and

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includes an outline of the philosophy and the methodological process. The second section outlines the actual research process in the form of the steps taken in the interpretative process. This includes an outline of the participants used for the research, the development of the research questions, the interview process and finally a discussion of the actual data collection.

5.2 The Research Methodology

5.2.1 A Broad Outline of Qualitative Methodology

Although sharing a basic set of beliefs or paradigms, qualitative researchers have different perspectives, based on their world –views, of what scientific truth entails (Shurink, 2001). The term qualitative research therefore means different things to different people and, consequently, it is difficult to describe it in a way that will satisfy everybody. For the purpose of this research, qualitative research will be defined as

A multiperspectve approach (utilising different qualitative techniques and data collection methods) to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings that the subjects attach to it (Denzin & Lincoln, 1994,p.2).

Qualitative methodologies in research have developed as a way of understanding the subjective meaning of human experience and interaction. The aim of qualitative research is not to explain human behaviour in terms of universally valid laws, but rather to understand and interpret the meanings and intentions that underlie human action and behaviour (Shurink, 2001). Qualitative research emphasises the importance of meaning and interpretation as an essential human process, seeking answers to questions that serve to highlighting how social experience is created and given meaning (Denzin & Lincoln, 1994; Patton, 1990; Shurink, 2001).

Only through direct contact and interaction with people in open-minded, naturalistic inquiry, followed by exploration, elaboration, interpretation and systematisation in inductive analysis can one come to understand the world of the people being studied (Denzin & Lincoln, 1994; Patton, 1990). Qualitative research stresses that interpretations are influenced and shaped by the researcher's preconceptions, cultural norms for understanding, and previous knowledge and experience of meaning (Denzin, 1994; Denzin & Lincoln, 1994; Patton, 1990; Shurink,

2001). As Dilthey notes (cited in Denzin, 2002,p.364) "interpretative researchers hope to understand their subjects better than the subjects understand themselves, to see effects and power where subjects see only emotion and personal meaning." Qualitative research seeks to have access to perspectives on the participant's lives that they are often unaware of and to see things the participants cannot (Denzin, 2002).

A qualitative research methodology from a phenomenological hermeneutic method has been adopted in this research, as the aim of the study is to gain insight into the participants' construction of their intrapsychic experience of psychoanalytical therapy from three different perspectives, from the child, the mother and the therapist's point of view, and to obtain understanding of how having a learning disability impacts on the therapy.

5.2.2 Phenomenological Hermeneutic Philosophy

Before the methodological process can be outlined a brief overview of the phenomenological hermeneutics philosophy using an interview method is briefly discussed to provide the reader with a background of the philosophy and the process. This is followed by an outline of the interpretation and analysis.

The methodology that was applied in the present research was an interpretative method that followed Heidegger's lead in the hermeneutic phenomenology of *Being and Time* (Denzin, 2002). The primary reason for using this method as opposed to any other is because there is not a strong case law for this specific area, therefore an exploratory method was ideal. This method like traditional methods seeks procedures and steps to help in the task of understanding the phenomenon being researched. However, unlike traditional methods, the phenomenon is also focused on in terms of meaning and its relation to the lived world (Holstein & Gubrium, 1994; Parker & Addisson, 1989).

By acknowledging man's relation to reality or the lived world hermeneutics takes into account the context that the phenomenon occurs in; for a holistic understanding to be gained the original setting must be considered (Schwant, 1994). The inclusion of the context acknowledges the fact that action does not occur in isolation or independent of context but is influenced by its setting (Holstein & Gubrium, 1994). Thus, all aspects that could form valuable parts in the research are accounted for or investigated. This method therefore avoids

fragmentation and allows for a holistic understanding to be achieved (Holstein & Gubrium, 1994; Parker & Addisson, 1987).

The hermeneutic approach argues that there is no such thing as objectivity, that is to say a method or investigation can never be interpretative-free (Packer & Addison, 1989). Objectivity is not possible for two main reasons: firstly, we are human and therefore influence our investigation (Holstein & Gubrium, 1994) and secondly, all natural scientific truth flows out of a method based upon an adopted perspective therefore it cannot be objective. The interpretive method argues that if the focus is on human activity it is important to recognise our own fore-structures or pre-understanding so that a better perspective of the phenomenon can be obtained, which is achieved by the acknowledgement of how our understanding influences the account (Holstein & Gubrium, 1994; Packer & Addison, 1989).

This approach argues that meaning is built on prior meaning, thus it allows the understanding to be continuously revised and developed so that a better, deeper and richer understanding can be achieved (Denzin, 2002). For an understanding to be gained there must be a continuous dialogue between understanding and interpretation of the phenomenon, thus the interpretation and our understanding is continuously revised and changed (Denzin, 2002; Packer & Addison, 1989).

Thus, one can clearly note that the phenomenological hermeneutic method was an appropriate method for the present study as the research is aimed towards understanding and describing the process of therapy with learning disabled children, and the method is directed towards understanding.

5.2.3 An Outline of the Methodological Perspective of Phenomenological Hermeneutics

A hermeneutic approach is not a set of prescribed techniques, but rather an approach to research, which focuses on the process of interpretation and is based on certain assumptions. It recognises that participants of research are meaning giving beings, they give meaning to their actions and so the meaning they ascribe to their actions are important for understanding the research. However, the researcher will only know the subject's meaning through his own

interpretation, but can also see meaning that the participant cannot yet see (Ricoeur, 1981). Heidigger (1927, cited in Ricoeur, 1981) argues that a person can only know himself in an approximate and tentative way, through externalisation of himself (speech and action) and interpretation of others reactions to those externalisations. As Ricoeur (1991,p.548) states "discourse is the necessary condition for the meaningfulness of the experience and behaviour."

A world, which is shared with others, and to that extent is objective, can only be known through different observers referring to the same reality through a shared language. We always have some prior understanding; a horizon through which we appropriate what is new. As we enter into communication with what is unknown, our standpoint changes and our horizon is broadened. The interpreter's horizon merges with that of the work. The interpreter arrives at a deeper understanding of what he began by presupposing (Delius, Gatzemeier, Sertcan & Wunscher, 2000). Hermeneutists are aware that they are constructing a reality based on a reciprocal relationship of their interpretation and the meaning giving of the participants (Eichelberger, 1989, in Patton, 1990).

Schleirmacher (in Bleicher, 1980) introduced the concept of the hermeneutic circle, for the interpretation of texts. Interpretation operates in a circular fashion in which the constituent parts are interpreted within an understanding of the whole, and an understanding of the whole is made up of an understanding of the constituent parts (Denzin, 2002; Bleicher, 1980). There is a dialogue between specific details and global structure (Patton, 1990).

Phenomenology aims to provide the conceptual tools that help us understand and articulate the movement from experience to theoretical formulation (Brooke, 1993; Holstein & Gubrium, 1994). Initially all our experience comes from our sensory experience of phenomena. However, to explicate that experience it must be interpreted and described. Interpretation is essential to an understanding of experience and the experience includes an interpretation of what is happening (Holstein & Gubrium, 1994). Ricoeur (1991) introduces the concept of discourse as dialectic of event and meaning. Discourse is self-referential and is always about something. What is communicated in speech is the speaker's interpretation or meaning made of an event and not the experience as experienced. The discourse relates some sense of the lived experience, but is already an interpretation of it. At the same time discourse also refers to experience in the world. Because we experience being in the world first, we

then have something to say. Discourse therefore tells us something about the speaker, as well as telling us something about the outside world (Valdes, 1991).

Phenomenology, therefore, focuses on how we put together or express the phenomena we experience (Fischer & Wertz, 2002). Although phenomenology argues there is no objective reality for people, it also assumes that there is an essence or essences to shared experience (Fischer & Wertz, 2002; Holstein & Gubrium, 1994). These essences are meanings that are commonly understood by people who have had similar experiences. Phenomenological psychology has sought to understand the essences of particular human experiences via description in written and verbal form. The subjective experiences of people are therefore analysed and compared to identify commonalties in experiences of a phenomenon.

The problem with data collected with phenomenological methods is that the written text becomes fixed and is atemporalised and decontextualised. Ricoeur (1981) therefore proposed a phenomenological hermeneutic in which psychological data be treated as a text analogue in need of interpretation. Ricoeur (1981) considers the use of text-interpretation methodology as a paradigm for interpretation in the human sciences. He considers the extent to which meaningfully oriented behaviour can be interpreted in the same way as text. Can action possess readability characteristics that open it up to interpretation by unintended readers who are not co-present to the action?

Ricoeur (1981) applies the four criteria of a text, to the concept of meaningful action and therefore to phenomenological hermeneutic data:

1. The fixation of meaning
2. Its dissociation from the mental intention of the author
3. The display of non-ostensive references
4. The universal range of its addressees.

<u>The fixation of meaning:</u>

For meaningful action to be an object of science, it has to be subject to a kind of objectification, equivalent to the fixation of discourse through writing. Phenomenological data consists of written or tape-recorded protocols that make subjective experience available for scrutiny. Descriptive protocols therefore become texts or linguistically fixed documents. They are objectified and made available for scientific inquiry (Ricoeur, 1981). In this

research the interviews fix the action like a text, which is preserved by using tape recordings and transcribing the action and dialogue.

The dissociation of meaning from the mental intention of the author:

In writing, there is a dissociation of the verbal meaning of the text and the mental intention of the author, giving the text autonomy from the finite meaning of the initial intention of the author. The author's intention is not lost but is not the only criterion for interpreting the text. Rather, the text is opened up to a plurality of meanings. The reader re-figures the textual meaning by appropriating the text in some personal way.

The dialectic between the reader (the research psychologist) and the writer (the subject) is not reducible to immediate reciprocity of a shared world of discourse. Other influences need to be made explicit. The text needs to be interpreted and contextualised with various frames of intelligibility (Ricoeur, 1981).

The display of non-ostensive references:

The importance of an action can go beyond its relevance to a particular situation. Texts are not just an arbitrary arrangement of sentences, but rather specific words or actions are chosen and organised. Why particular words are used and not others may give us clues to meaning. Texts therefore project a world other than their original meaning and open up other possible meanings. We are given clues to unconscious aspects of a person's discourse as well as to cultural influences (Ricoeur, 1981).

The universal range of addressees:

Because a text is fixed it awaits different interpretations from different interpreters from different perspectives. Human action is also addressed to an indefinite range of possible readers. Actions can be interpreted according to new references. Others can often perceive deeper or further significance to our actions which we cannot initially see (Ricoeur, 1981; Ricoeur, In Bleicher, 1980).

The reader re-figures the textual meaning by appropriating the text in some personal way. Appropriation is incorporating an understanding of another's words into one's own schema. The reader is enlarged in his capacity of self-projection by receiving a new mode of being from the text itself. For explanation and understanding in phenomenological hermeneutic

research the data is in some way appropriated and interpreted by the researcher. A theoretical framework is proposed to explain the actions.

To understand a text is not to rejoin with the author. Rather the text has multiple possible meanings, from which one attempts to choose the meaning with the best possible fit. A text as a whole is open to several readings and several constructions. We guess the meanings or interpretation and then attempt to validate (rather than verify) which interpretation is the most probable. The text or action is a limited field of possible constructions, which we attempt to defeat or refute in order to arrive at interpretations that we feel, have the best fit.

Interpretation is a process, a movement back and forth between text and interpreter. The task of hermeneutic inquiry is therefore at the intersection of two directions of language, neither solely with the text, nor solely with the reader but in the interaction between the two.

There can be no completion of the interpretative process, but only a temporary pause necessary to allow another player to enter the court. "This does not mean that there is no sense of truth or knowledge in the interpretative process, for the very goal of interpretation must be to share one's insights with others" (Valdes, 1991, p.11). The theory of phenomenological hermeneutics is the theory of the productive engagement between text and reader as a process of re-describing the world.

The final stage of research is the movement from description to explanation and providing a theoretical framework within which to understand the phenomenon explored. As suggested in the description of phenomenology, common experiences often elicit similar meanings for participants. It is the reservoir of shared meaning and consensus that makes explanation possible (Ricoeur, 1981). Therefore, the final step is to provide a theoretical framework to the data. This is not the absolute or final meaning of the phenomenon, but a point at which to stop for the researcher, and may be contested by other interpretations. Thus, the researcher shows how the participants experience the phenomenon, in this case the experience of psychotherapy from three different perspectives.

5.2.4 Multiple Readings of the Narratives

Using the philosophical basis of the phenomenological hermeneutics to develop an understanding and Ricoeur's (1981) four criteria of text analysis, the text was read with this in place. Since interpretation is a process, a movement back and forth between the text, multiple readings of the narrative, is seen to the most appropriate method. Mathner and Doucet (1998) developed a method for multiple readings of narratives. Each reading focused on a different voice in the narrative. The research focused on this for multiple readings of the data, with various foci, so that data may be grasped as an understanding of the whole as well as the constituent parts. The method offers one way of operationalizing, in a systematic and deliberate manner, the paradoxical hermeneutic circle. This involves building an interpretation of a whole interview narrative out of its constituent parts. Thus the interpretative procedure is a fundamentally circular one, because while the whole can only be understood in terms of its parts, by the same token, the parts only acquire their proper meaning within the context of the whole. (Packer & Addison, 1989, p.144).

Mathner and Doucet (1998) outlined the following method:

> First reading: reading for global understanding and employment.
> Part one of this reading involves reading for the manifest content of the narratives. Part two of this reading involves making the researcher's understanding and thoughts about the interview/assessment explicit (Mathner & Doucet, 1998)
>
> Second reading: Content analysis.
> In content analysis the data/text is broken down into thematic meaning units and coded according to predetermined coding categories. The advantage of content analysis is that it is a systematic and public way of conceptualising the data (Bauer & Arts, 2000). However, in separating the units of analysis, one can loose the global understanding of the data, as well as the sequentiality of the text, and by focussing on frequencies one can miss the rare and absent in data, which is often considered a strength in qualitative research (Bauer, 2000). For this reason, the other readings are done to compensate for this.

Third reading: reading for the meaning of psychotherapy

This reading would be based on the research question, which is concerned with the meaning of therapy for leaning disabled children.

5.2.5 Evaluating Interpretative Materials

From the hermeneutic perspective, because researchers actively participate in the construction of an interpretation, it is difficult to distance oneself and contemplate the findings of a process in which one is a part. This does not imply that all interpretations are equal however. Using Ricoeur's (1981) example of a court case, one adjudicates between opposing interpretations and evidence. There are criteria for meditating between contesting interpretations (Packer and Addison, 1989).

Coherence

Coherence refers to a sense of consistency in how the themes are linked and if they are consistent with the data gathered. Is the interpretive account plausible and intelligible in terms of the frame of reference used?

Uncovering

Does the interpretation make sense of data that was previously incomprehensible? Does it provide a viable framework for conceptualising the data?

Validation of interpretation by another researcher

Reliability can be ascertained if another researcher comes to the same interpretive conclusions. However, hermeneutics assumes that a different researcher will have different fore structures and therefore come to different interpretations. What is important is that other researchers can follow the interpretive logic of the argument. A reader can examine the logic process of interpretation as laid out by the interpreter and according to the interpreters said perspective, thereby establishing a degree of validity.

Denzin (2002,p.362) uses a set of eight questions to evaluate the interpretation of the materials. Each of these evaluation methods will be discussed briefly. They were used in combination with Coherence and Uncovering to enable the researcher to distance herself from the material and to provide an understanding of the phenomenon being studied.

1) Illumination

An interpretation must illuminate and clarify what is being studied. Thus, does the material illuminate the phenomenon as lived experience?

2) Thickly Contextualised Materials

Interpretations develop out of events and experiences that are described in detail and are located in social situations. They document meanings, thoughts, emotions and actions.

3) Historical and Relational Grounding

Interpretative material must be historically and relational, it must be located in the lived world.

4) Process and Interaction

An interpretative account must be both processual and interactional.

5) Engulfment of What is Known

The researcher or interpreter must be an informed reader about the topic. That is finding out about the phenomenon by expanding the framework for interpretation. It must be noted that understanding and interpretation are always incomplete and unfinished.

6) Prior Understanding

Engulfing merges with incorporating prior understanding into the interpretations of experience. Prior understanding includes background information and knowledge about the area of research, which are contained in the research literature. In addition, nothing can be excluded, including how the researcher understood the phenomenon at the start of the research process.

7) Coherence and Understanding

Coherence and understanding are concerned with whether the interpretations produce an understanding of the experience that comes together into a meaningful whole. This includes all the relevant information and prior understanding. This results in the reader being led through in a meaningful way.

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8) Unfinished Interpretations.

Finally, all interpretations, like understanding, are considered to be unfinished, provisional and incomplete. The interpretation is always conducted in the hermeneutic circle. It must be pointed out that this does not mean that interpretations are inconclusive it only means interpretations are never finished.

The question of validity asks if the research measures what it set out to measure. Wolcott (1994) argues that qualitative research does not seek validity. However, he does follow certain steps to ensure that he is not getting it all wrong. These steps include:

- Talk little, listen a lot
- Record accurately
- Begin writing early
- Let readers see for themselves
- Report fully and write accurately
- Seek feedback
- Try to achieve balance between presenting the data and fitting into a theoretical framework.

Finally, the validity and reliability would be enhanced with the aid of triangulation. Data triangulation was used in the present study, that is three data sources were combined that of the therapist, the child and the mother.

5.3 The Steps to Interpretation

The philosophical basis of phenomenology hermeneutics, Ricouer's (1981) four criteria of text analysis and Mathner and Doucet's (1998) method for multiple readings of narratives, were used to analysis and construct the research. The various stages and processed of the research are discussed using the aforementioned as the methodological basis. This includes a discussion of the choice of participants, how the research questions were formulated and framed, and finally the data collection and analysis process are addressed.

5.3.1 Choice of Participants

The choice of participants was initially based on the specific criteria set out by Stones (in Kruger, 1988). The participants were required to (a) experience of the phenomenon (b) be verbally articulate and fluent (c) have the same home language as the researcher, and (d) have a willingness to be open to the researcher.

Three sets of participants were used for the research. The parent (mother) of the child in therapy, the psychologist working with the child and the child in the therapy. Thus, three children, three therapist's and three mothers participated in the research. The focus of the research was to develop an understanding of the therapy process from three perspectives. As noted, object relations is towards an understanding of the interactions and relationship with the object, since the primary object is generally the mother, the mother was the focus in the interviews

5.3.2 The Mothers, the Children and the Therapists

The following was required from the participants: -

The Mothers

1) Written consent from the mother was obtained to do all three interviews (see appendix C). This also involved explaining the research as well as the confidential nature of the research. It also included a letter to each mother, which explained the research, which they could then read thoroughly at their leisure.

2) The mothers were not to be in the field of psychology as this may have influenced their responses.

The Children

1) The children were diagnosed as having a leaning disability and were in a remedial school. The diagnosis of the children's learning disability was done through a multi-

disciplinary team assessment; thus they were assessed by an Occupational Therapist, a Speech and Language Therapist, a Remedial Therapist and a Psychologist.

2) The children were all assessed on the Wechsler Intelligence Scale for Children-Third Edition (WISC-III) and were required to have at least an Average Full Scale Overall IQ score.

3) The children all had the experience of being in therapy with a psychoanalytic therapist for at least 6 months.

4) The children were to be between the age of seven and eleven. The reason for this would be so that they could verbally articulate their experience of the therapy and secondly the focus of the study is on children. The selection of the age is also based on the beliefs of development theory. Piaget (1952, in Sorenson, 1993) says that children between the ages of seven and eleven are in the stage of concrete operations and have evolved logical thought processes and have developed more social communication. Children at this age are able to understand the causes of events, to express themselves, and to understand that different people react in different ways (Madorin, 1999).

5) Before the interview, the process of the interview was explained to the child to ensure that they were firstly, willing candidates, and secondly, to explain to them the confidential nature of the interview and to reduce their anxiety as to the process of the interview.

The Therapists

1) The therapists were all trained in a psychoanalytical approach to therapy and had practiced this approach with the participants. The therapist's had been in practice for a minimum of two years.

2) The therapist's consent to be interviewed was obtained.

3) The process of the interview and the confidentiality of the research were explained to the therapist, in particular that the mother or the child did not have access to the interviews.

The reason for using three sets of participants is that it resulted in triangulation. Triangulation is broadly defined by Denzin (1978,p.291) as "the combination of methodologies in the study of the same phenomenon". It involves using multiple independent measures and sources of the same phenomena (Huberman & Miles, 1994). The type of triangulation used in this study is the "within-method" kind (Denzin, 1978,p.301), which uses multiple techniques within a given method to collect and interpret data. This refers to using "multiple comparison groups (Glaser & Strauss, 1965,p. 7 cited in Jick, 1983) to develop more confidence in the emergent theory. By measuring something in more than one way, researchers are more likely to see all aspects of it (Eisenhardt, 2002; Huberman & Miles, 1994).

The "within-method" essentially involves cross-checking for internal consistency or reliability. Triangulation is seen to capture a more complete, holistic, and contextual portrayal of the units under study (Eisenhardt, 2002; Huberman & Miles, 1994). That is, beyond the analysis of overlapping variance, the use of this results in the uncovering of unique variance which otherwise may have been neglected by a single method. Thus, triangulation may be used not only to examine the same phenomenon from multiple perspectives but also to enrich our understanding by allowing for new or deeper dimensions to emerge (Eisenhardt, 2002; Huberman & Miles, 1994).

5.3.3 Procedure

The means of locating the participants was through a well know remedial school in Gauteng. The reason for using the school was due to convenience as the researcher has access to the school, as a member of staff. This was seen to be an advantage as the researcher was immersed in the setting and the participants were then more likely to be willing, open participants, as they were familiar with the researcher.

5.3.4 Data Collection

The interviews were taped to allow for as little interruption of dialogue as possible. The spoken interview was used above note taking or questionnaires as it facilitates spontaneity of expression and "respondents are encouraged to relate their experiences, to describe whatever

events seem significant to them, to provide their own definitions of their situations, and to reveal their opinions and attitudes as they see fit" (Nachmias & Nachmias, 1990,p.190).

Before entering into the interview setting the researcher was familiar with the proposed research questions and the process of asking subsequent questions. The outline of these questions will be discussed under the research question. Nonetheless, the interview used the process of question-and-answer sequences, which allowed for the researcher to reach a point where the interviewer regards the research question as having being answered.

The interviews where carried out with all nine participants by making formal appointments with each participant. The children were interviewed during school time which seemed to make them feel special as they where missing a lesson of class. It must be noted that taking children out of class for a lesson was not an unusual occurrence as throughout the day children attended therapy. Many of these children left the classroom during their week to attend Occupational Therapy, Speech and Language Therapy, Remedial Therapy and in all three children for their Psychotherapy session.

5.3.5 Transcribing the interview from audiotape

Each interview was transcribed in order to obtain the protocols that form the basis of analysis, "transcription, as boring as it is, is useful for getting a good grasp of the material, and as monotonous as the process of transcribing may be, it opens up a flow of ideas for interpreting the text" (Jovchelovitch & Bauer, 2000,p.69). In addition, the advantage of having transcripts, is that it allowed for a more detailed review as one is able to return to the transcript for clarification with further knowledge of the process (Loizos, 2000). This is linked to the hermeneutic process of looking at the constituent parts as well as the whole (Bleicher, 1980).

5.3.6 Preparatory Stages

5.3.6.1 Preparatory Theoretical Phase as A Way of Framing the Research Question

Packer and Addisson (1989) and Denzin (2002) describe the nature of the procedure through which a researcher reaches a preliminary understanding of text or text-analogue. The

research requires a point of access to the phenomenon and the first task of the research is to develop preparatory ways of thinking about a phenomenon to be investigated (Eisenhardt, 2002). The preliminary question and the projected understanding implicit in the questions provide an essential, but corrigible, access to the phenomenon under study; i.e. they provide a starting place for understanding (Denzin, 2002; Eisenhardt, 2002; Neuman, 2000). Research is, from this point of view, conceived as a means of asking more meaningful and useful questions. The research is intended to come up not with results, but better ways of thinking about the phenomena under investigation (Neuman, 2000). Conceived like this the end result of a research study would not be answers, but better questions through which to understand the phenomenon and through which to further explore it. (Packer & Addison, 1989). Thus, the starting point would be to obtain an understanding of the therapeutic relationship with learning disabled children, from the therapist, the child and the mother's perspective.

Denzin (2002) states the research question is framed by two sources, the researcher and the subject. In addition, the researcher uses his own life experience as a background for inquiry. This research was framed by the researcher's own experience as a psychotherapist working with learning disabled children. The research question evolved firstly, through the researcher's own inquiry into how learning disabled children understand the process of therapy and how their therapist and mothers perceive the process and secondly, through immersing herself in the literature.

This phase involved a review of the literature on learning disabilities (chapter 2), theoretical underpinnings of psychotherapy (chapter 3), psychotherapy with learning disabled children and understanding the mothers' role in their child's psychotherapy (chapter 4). This was done in order to gain an understanding of previous models of understanding and observations and to examine preconceptions. As Denzin (2002) notes, framing the research question involves examining how a phenomenon has been previously studied as well as the theoretical literature.

Out of this process, the initial question was developed which was to ask the participants to "tell me the story of your experience of (your) the (child's) therapy process, how it evolved and what it means to you." Since an aspect of the research data was going to be obtained from children, it was felt such a broad and open-ended question with children was likely to obtain limited information from them. Consequently, more specific questions were outlined

that would elicit more information from them. Smith-Acuna et al. (1991) used an adaptation of the self-report instrument developed by Orlinsky and Howard (1975) cited in Smith-Acuna et al. (1991) to assess dimensions of the therapy process. The researcher focused on this self-report instrument as a possibility, however, the assessment instrument is limited and does not focus on meaning rather it focuses on effect and interpersonal behaviour between child and therapist. For this reason, the researcher constructed more specific questions around process rather than a self-report instrument. The following was used for the initial basis of the questions:

Tell me about your therapy with (therapist's name). If this leads into a discussion, the researcher will be led by what the child says. Should it lead to a short, closed answer other questions will follow. The following questions provide a broad outline for the researcher to follow.

Tell me what it was like to be in therapy?

Children feel lots of different things in therapy and lots of different things happen in therapy, what are some of the things you felt in therapy?

Tell me what you used the therapy time for.

How did you feel about your therapist?

Tell me about having a learning disability?

Tell me what do you think your parents think of your therapy?

Tell me what is your understanding as to why you are in therapy?

The researcher was concerned with how such an open-ended question would be answered by the participant's; consequently a pilot study was conducted.

5.3.6.2 The Pilot Study

As noted, the aim of the pilot study was to assess and explore whether the questions initially outlined by the researcher would be useful ways to ask about and facilitate the child and mother's expression of their understanding of as to the process of being in psychotherapy. The therapist was not interviewed in the pilot study, as the researcher was only aware of three psychologists who at the time of the research fitted the criteria needed in order to be participant's in the final study.

From the pilot study, it became clear that more questions would be required to obtain a deeper and more meaningful understanding of the process of psychotherapy with learning disabled children. Using the broad open-ended question "Tell me the story of your experience of your child's therapy process, how it evolved and what it means to you" did not elicit much from the mothers. The researcher felt the children's questions needed to become more refined and comprehensive. In addition, with specific questions being planned for the two other sets of participants, the questions to the children would have to be in a similar line, across comparable themes. Finally, both participants asked for the researcher to be more specific. As a result of the limited information obtained from these interviews they were not used in the research. For more meaningful and useful questions to be developed the researcher decided that it was important to return to the literature to develop appropriate questions for this research. By outlying the important themes across the literature, the researcher was able to develop more detailed meaningful and appropriate questions.

The researcher formulated questions in three sections, those for the child, the mother and the therapist. The questions were formulated to follow specific themes from the literature for all three sets of participants. The reasoning behind each question, from a theoretical stance was given to assist the researcher in her understanding as to the forestructure. This enabled the researcher to capture the phenomenon being studied. For each participant the questions were worded slightly differently so that each participant was able to understand what was being asked in order to allow the participant to provide meaningful responses.

The theoretical reasoning for each question will be given underneath each question. The theoretical understanding is related to the chapters on therapy with learning disabled children and working with mothers.

5.3.7 The Research Questions

Research Questions for Mother Participant

Question:

1. "What is your understanding as to why your child is in play therapy?"

Reason for the Question:

The aim of this question was to assess whether or not there is a link or a common understanding between all three participants. The focus of this would also to be to asses whether there was a link between the child's internal and external world. Since the external world is observed by others this question would allow for the possibility for this to be elicited. Does the parent perceive the child's learning disability to be the primary focus which would possibly create an internal sense for the child that their inability to learn would be the focus of their difficulties or they possibly internalise a sense of themselves as being "stupid".

Question:

2. "What are some of your thoughts and feelings about your child being in play therapy?"

Reason for the Question:

The focus was to develop an understanding of whether themes such as parental guilt, pity and contempt (Shame) are part of the parental experience. Since these are the three common occurring themes, which may occur in the counter-transference relationship (Bungener & McCormack, 1994), it was considered valuable to evaluate whether these are feelings that occur within the parent.

Question:

3. "How would you describe your child's relationship with their therapist?"

Reason for the Question:

Since the relationship is an important component of any therapy relationship in terms of process and outcome it was important to obtain an assessment of this. In addition an evaluation as to how the three participants see the relationship was important to obtaining an understanding of the possible transference dynamic or themes that may be common to working with these children

Question:

4. "What is your role as a parent in the therapy process? How would you describe your relationship with the therapist? "

Reason for the Question:

The role of the parent in play therapy is pivotal, the reasoning for this question was that it would enable the researcher to obtain a parental perspective of how they see their role as important and what their relationship is like with the therapist. The literature focuses on the need to obtain a co-operative relationship between mother and therapist, is this really the case? Is the primary focus of involving parents in the therapy process educational and fact-finding, or does it focus on more psychoanalytical issue? It is hoped that such questioning would enable a more in-depth understanding of this.

Question:

5. "What do you think the therapist focuses on or what is discussed in your child's therapy?"

Reason for the Question:

Again, this question was aimed at assessing what the mother felt the primary difficulty with the child was. Was it having a learning disability or was the focus on some other difficulty? Since Sinason (1992) focuses on the possibility of the patient developing a "secondary handicap" it was considered valuable to assess whether there was a link between this and the mothers view. Could the mother be moving their focus away from the learning disability, which would impact on the child's view. In addition, this question would indirectly assess whether the mother perceives family dynamics and/or other relationships to be an important part of the therapy process.

Question:

6. Should the parent not discuss their child's learning disability the following questions will be asked. "Do you think your child learning disability would be an important part of the therapy process?"

Reason for the Question:

As noted in the discussion there is very little written about working with learning disabled children in therapy. It would appear from the literature that the role the parent plays in understanding their child's difficulty is critical to how the parent interacts with the child. By obtaining an understanding of the mother's view and comparing it to the child and the therapist may result in an in-depth understanding on how the parental role may impact on the child's perceptions or even interactions in the therapy. In addition, this question was seen to

evaluate whether the focus of mothers would follow the literature in that the primary areas in relation to parental understanding of children's learning disabilities is in the cognitive and affective realm, family boundaries and the social and emotional impact of the parent-child relationship, as well as the functional impact (Culberston & Silovosky, 1996).

The literature emphasises the impact of the arrival of having a learning disabled child and the possible problems that may arise as a result of the failure to resolve this crisis (Bicknell, 1983). This questioning would obtain an indication of how mothers felt about having and learning disabled child and whether they felt it was a primary focus.

Research Questions for Child Participant

1. "Adults and children often ask what therapy is like with children. If you were to tell a child in your class what would you say it was about?" Should the child provide a close-ended response the following questions may be used. "Children think lots of different things about being in play therapy is, tell me what you think about being in therapy and why you think you are in therapy? "

Reason for the Question:

The aim of this question was to assess the child's understanding of their difficulties without directing them in any way. It was also a way of assessing whether the common themes outlined in the literature emerged with these children and did these differ to the responses of the other two participants (mother and therapist). Did the child perceive their primary difficulty to be their learning disability or were there other areas they felt were the reason for therapy? Part of this would be to hold in mind Sinason's (1992) idea of the "secondary handicap", did the child acknowledge their learning disability in their reasoning. This question would also allow for the possibility of the child's therapy themes to emerge.

Question:

2. "What sort of things do you discuss in therapy? "

Reason for the Question:

The aim of this question was to obtain an idea of the emotional component of being in play therapy. To assess whether learning disabled children were able to express their emotions or

to what extent they could and to what extent they were able to use psychoanalytical therapy? As noted earlier a possibility is that the child feels similar emotions to those of their mother, they may feel guilty, pity or shameful. The aim was to obtain an understanding of what the child feels their primary difficulty in therapy is. As noted in the question to the mother, the question would assess the possibility of the child developing a "secondary handicap".

In addition, the literature outlines very specific themes that are seen to arise in therapy with learning disabled children, this question enabled some sort of assessment to be obtained in this regard.

Question:

3. "How do you feel about your therapist? Tell me what you think your therapist may have thought or felt about you? "

Reason for the Question:

As noted earlier the most important component of the therapy is the relationship between the therapist and the child. By linking all three participant's views one would be able to assess whether their views overlap, it would also give some sort of indication as to the transference relationship.

Question:

4. "Why do children come to this school? Is this school different to other schools?" This will be a way of introducing some aspect of having a learning difficulty, which would then lead into the next question. "What would you tell a friend about having a learning difficulty? Do you ever discuss having a learning disability with your therapist? "

Reason for the Question:

The purpose of these questions was two-fold, firstly to establish the child's understanding of having a learning disability, which was seen to enable the researcher to assess whether it is in a similar light to how their mother understands it. In addition, if they have little understanding of having a disability it would stand to reason that they would not focus on it in the therapy. The second reason for this line of questioning was to ask this question directly, especially if it did not come up directly in the child's reasoning for being in therapy. These questions would also establish if having a learning disability according to the child impacts

on the family and whether the themes in the literature are areas the child feels to be important.

Question:

5. "Sometimes your mom meets with your therapist, what do you think they talk about? How do you feel about your mom meeting with your therapist? "

Reason for the Question:

The role of the mother in the therapy is an important part of the therapy process, how the child perceives this would be an interesting part of the research.

Research Questions for Therapist Participant

Question:

1. "What is your understanding as to why this child is in play therapy?"

Reason for the Question:

As noted earlier the aim of this question was to assess whether or not there was a link or a common understanding between all three participants. In terms of the therapist it was hoped an understanding of how they perceive the child psychoanalytically would be obtained. The aim at this point would not be to ask the therapist directly but to rather assess whether this comes out spontaneously. Should this not be the case at the end of the interview the researcher would ask the participant to give their psychoanalytical formulation.

Question:

2. "If you were to discuss this child with another therapist how would your describe your feelings towards this child and your relationship with this child? "

Reason for the Question:

As noted, the relationship is the most important component of the therapy and determines the process and outcome, thus it is an important question. Again evaluating how all three participants perceive the relationship is important, as it enables the researcher to assess how the therapist experiences the child and whether this influences their interaction, this would impact on the transference and counter-transference in the therapy.

Question:

3. "How do you see psychoanalytical play therapy assisting your work with this child? "

Reason for the Question:
Since the focus of the research is on psychoanalytical therapy and the literature on learning disabled children focuses on specific themes, this would establish whether these themes emerge in the therapy.

Question:

4. Should it not be mentioned in the previous discussion the following question would be asked. "Is part of the therapy process with this child working with them having a learning disability? "

Reason for the Question:
The importance of the therapy focusing on learning disabled children has been previously discussed

Question:

5. "What other major themes are focused on in the therapy?"

Reasons for the Question:
This question would establish what other areas are the focus of therapy with learning disabled children. Are these themes similar to the existing research or are there new themes. The aim was to assess whether the themes between all three participants overlap, or were they very different to the therapist's perceptions?

Question:

6. "How do you see the role of working with the mother in terms of this child's therapy? Do the family relationships impact on this child emotionally and is this a part of the therapy process with the child and the parent? "

Reason for the Question:

Part of the research is to obtain a further understanding of how the family dynamics and mother-child relationship impacts on the therapy.

Question:

7. Should it not have emerged in the interview, the therapist will be asked to give their psychoanalytical formulation of the child.

Reason for the Question:

As addressed the focus of the therapy is psychoanalytical; the question was aimed at assessing whether therapists are able to work in this framework with learning disabled children.

5.4 Conclusion

The methodology outlined in this chapter and the information gleaned from the pilot study in terms of the research questions was then used to collect and analyse the data. The aim was to use this information as conceptual tools to understand the process of analysis. Once the interviews were obtained the researcher using the philosophical basis of the phenomenological hermeneutics and Ricoeur (1981) four criteria of text analysis, was able to interpret the data.

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 commonalties 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, postnataly, 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.

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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 where 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 where 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 commonalties 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**
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?	
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.	**(1)Family boundaries and relationship (2) Social difficulties**
Nicky:	Do you think there were any other reasons why you wanted him in play therapy other than that,	

	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; Insecurity and the ability to think**
Nicky:	And what are some of your thoughts about him being in play therapy, some of your thoughts and feelings around it?	
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?	
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**

	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)	**(13) Understanding, clarification, guilt and pity**
Nicky:	How would you describe, what you know about the therapy, how would you describe your child's relationship with his therapist?	**(14) Making sense of their worlds**
Mother#A:	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)	**(15) Containment and a holding relationship; Making sense of their worlds**
Nicky:	So if you had to give it describing words, what would you place on it ? How would you say it is, his relationship?	**(16) Containment and a holding relationship; Making sense of their worlds; Psychotherapy as a way of coping**
Mother#A:	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)	

Nicky:	Can you tell me about the differences you've seen in him?	
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)	**(17) Self-concept and self-confidence; Making sense of their worlds; Interpretation and containment (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 (21) The Relationship and the knowledge to help (22)Containment and a holding relationship; The**
Nicky:	How do you think the therapy has done that ? What do you think in the therapy has made all these changes possible?	
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)	

	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)	**Relationship and the knowledge to help (23) Containment and a holding relationship; psychotherapy working towards reparation of relationships**
Nicky:	What do you think they do in the therapy that has helped him?	
Mother#A:	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)	**(24) Understanding, clarification, guilt, and pity; containment and a holding relationship; Interpretation and containment**
Nicky:	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?	**(25) Containment and a holding relationship**
Mother#A:	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	**(26) Understanding, clarification, guilt and pity; Making**

	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)	**sense of their worlds** **(27) Understanding, clarification, guilt and pity; Containment and a holding relationship; Cognitive versus affective aspects of having a learning disability; Psychotherapy as a way of coping; Psychotherapy towards reparation of relationships**
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?	
Mother#A:	Yes.	
Nicky:	Do you discuss other things other than your child's difficulties when you have feedback sessions?	**(28) Cognitive versus affective aspects of having a learning disability**
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)	**(29) Self-concept and self-confidence; Cognitive versus affective aspects of having a learning disability** **(30) Containment and a holding**

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

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:	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).	**and pity; Insecurity and the ability to think; The relationship and the knowledge to help; Interpretation and containment** **(42) Family boundaries and relationships; Interpretation and containment; Psychotherapy as a way of coping**
Nicky:	So the feedbacks are helpful?	
Mother#A:	Ja.	
Nicky:	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?	**(43) Containment and a holding relationship; Making sense of their worlds**
Mother#A:	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)	

Nicky:	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?	**(44) Containment and a holding relationship; Psychotherapy as a way of coping**
Mother#A:	I don't know. I think it would just basically be how he's coping with things.(44)	
Nicky:	Coping with what sort of things?	**(45) Family boundaries and relationships**
Mother#A:	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)	**(46) Self-concept and self-confidence; Anxiety and defences; Making senses of their worlds; Psychotherapy working towards reparation of relationships**
Nicky:	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	

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	would discuss?	
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. (47)	**(47) Family boundaries and relationships; Cognitive versus affective aspects of having a learning disability**
Nicky:	Do you think there's anything else he discusses in therapy?	
Mother#A:	I wouldn't know, I mean he hasn't told me.	
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?	**(48) Having a learning disability is not being "stupid"**
Mother#A:	Maybe teachers as well, if he's got a problem with a teacher or whatever, he might speak to her	

	about it just to find out if it's okay for him to feel that way. (48)	
Nicky:	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?	
Mother#A:	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)	**(49) Having a learning disability is not being "stupid"** **(50) Family boundaries and relationships; Self-concept and self confidence; Insecurity and the ability to think**

Nicky:	So your understanding is that he didn't have the proper grounding, that he wasn't taught correctly?	
Mother#A:	Yes. He wasn't taught correctly and also he was premature, so don't know.	
Nicky:	Tell me a bit more about him being premature, how do you think that impacts on having a learning difficulty.	
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	**(51) Cognitive versus affective aspects of having a learning disability** **(52) Understanding, clarification, guilt and pity; Having a learning disability is not being "stupid"** **(53) Family boundaries and relationships; Having a learning**

	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)	**disability is not being "stupid" (54) Self-concept and self-confidence**
Nicky:	So do you think your child's learning disability will be an important part of the therapy process ?	**(55) Having a learning disability is not being "stupid"**
Mother#A:	I would imagine so. (55)	
Nicky:	What do you think they would focus on if it was part of the therapy?	
Mother#A:	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).	**(56) Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability**
Nicky:	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	

	asked you, that you think would be important to know about the therapy process from a parent's perspective?	
Mother#A:	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)	**(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**
Nicky:	So what do you think that would do? What would that do if most children have that? How would it change things?	
Mother#A:	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	**(60) Social difficulties**

	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)	**(61) Anxiety and defences** **(62) Self-concept and self-confidence**
Nicky :	Great, thank-you.	

Narrative/ interview data: *Interview with Child Participant A*	**Codes**

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?	
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)	**(1)Containment and a holding relationship; Making sense of their worlds; Interpretation and containment**
Nicky:	okay, that's great, why do you think you're in therapy?	
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	**(2)Family boundaries and relationships; Psychotherapy as a way of coping** **(3)Anxiety and defences**

	sad or I guess stuff like that. (4)	**(4)Containment and a holding relationship; Psychotherapy as a way of coping**
Nicky:	what are you having a hard time with?	
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**

		disability.
Nicky:	do you discuss friends with her?	
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**

	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)	**(14)Family boundaries and relationships** **(15)Containment and a holding relationship, Making sense of their worlds; Interpretation and containment; Psychotherapy as a way of coping.**
Nicky:	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?	
Child#A:	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)	**(16) Family boundaries and relationships; Psychotherapy working towards reparation of relationships**
Nicky:	why do children come to this school	
Child#A:	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)	**(17) Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability**

Nicky:	is this school different to other schools?	**(18)Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability**
Child#A:	yes (18)	
Nicky:	how's it different?	
Child#A:	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)	**(19)Having a learning disability is not being "stupid"; Cognitive versus affective aspects of having a learning disability**
Nicky:	alright, how would you describe it if you had to tell a friend about what's different about this school?	
Child#A:	that the tuck-shop list is better	
Nicky:	what would you tell a friend about having a learning difficulty?	**(20) Having a learning disability is not being "stupid";**

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** **(21) Having a learning disability is not being "stupid"; Social difficulties**
Nicky:	what does it mean to have a learning difficulty, what do you understand about learning difficulty	**(22)As above**
Child#A:	either you not learning right or your teacher is just not teaching you the right stuff. (22)	**(23)As above**
Nicky:	do you ever discuss having a learning difficulty with THERAPIST A	
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**

	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)	**their worlds; Psychotherapy as a way of coping** **(28) Family boundaries and relationships; Understanding, clarification, guilt and pity.**
Nicky:	how do you feel about your mom talking about your therapy	
Child#A:	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)	**(29) Self-concept and self-confidence** **(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**

Nicky:	what do you think they talk about?	**their worlds; interpretation and containment; Psychotherapy as a way of coping**
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).	**(33)Family boundaries and relationships; anxiety and defences; Containment and a holding relationship**
Nicky:	one last question for you	
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; interpretation and containment**
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)	**(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**

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)	**their worlds; interpretation and containment; Psychotherapy as a way of coping; Psychotherapy working towards reparation of relationships.**
Nicky:	and that's what therapists need to know, that you can sort things out ?	
Child#A:	ja	
Nicky:	okay, thank you very much	
Narrative/interview data: Interview with Therapist Participant A		**Code**
Nicky:	The first question that I want to ask you is, what is your understanding as to why this child is in play therapy?	**(1)Family boundaries and relationships**
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	**(2)Anxiety and defences**

	problems. (3)	**(3) Family boundaries and relationships**
Nicky:	If you were to discuss this child with another therapist, how would you describe your feelings about this child?	
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	

	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)	**(7) Family boundaries and relationships** **(8)Interpretation and containment; Psychotherapy as a way of coping** **(9) Containment and a holding relationship; interpretation and containment**
Nicky:	Do you feel using psychoanalytic techniques such as interpretation, you mentioned transference, projective identification, confrontation, work with this child?	
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)	**(10) Having a learning disability is not being "stupid"; Cognitive and affective aspects of having a learning disability**

Nicky:	Do you feel he responds to interpretations that involve his internal world?	
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)	**(11) As above**
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?	
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)	**(12) Self-concept and self-confidence; Understanding, clarification, guilt and pity; Making sense of their worlds; interpretation and containment**
Nicky:	Do you feel your work or understanding in this area is different because you working with a	

	learning disabled child?	
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)	**(13) Cognitive and affective aspects of having a learning disability** **(14)) Cognitive and affective aspects of having a learning disability, Social difficulties** **(15) Having a learning disability is not being "stupid"; Cognitive and affective aspects of having a learning disability**
Nicky:	Work directly with him in terms of his learning disability?	
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). But his learning disability for me comes out because he relates so poorly socially (18). He's missed social queues and he's insensitive to	**(16) Having a learning disability is not being "stupid"; Making sense of their world** **(17) Family boundaries and relationships; anxiety and defences** **(18) Having a learning disability is not being "stupid"**

	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.	**(19) Social difficulties; The relationship and the knowledge to help**
	(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)	**(20) Cognitive and affective aspects of having a learning disability; The relationship and the knowledge to help; Psychotherapy as a way of coping**
Nicky:	……..letting on what their true feelings actually are ?	
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)	**(21)Containment and a holding relationship; The relationship and the knowledge to help; Psychotherapy as a way of coping** **(22)Cognitive versus affective aspects of having a learning disability**
Nicky:	What other things are focussed on in therapy?	
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	

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

	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)	**(27)The relationship and the knowledge to help; Interpretation and containment; Psychotherapy as a way of coping**
Nicky:	How do you see the role of working with the mother in terms of this child in therapy?	
Therapist#A:	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).	**(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**
Nicky:	You say family relationships impact on him emotionally and is this part of the process with the child and the parent?	
Therapist#A:	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	**(29)Family boundaries and relationships; Making sense of their world; interpretation and containment** **(30)Family boundaries and relationships**

	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)	**(31) Family boundaries and relationships; Understanding, clarification, guilt and pity; Anxiety and defences; Psychotherapy working towards reparation of relationships**
Nicky:	How do you see it having an effect on him?	**(32) Family boundaries and relationships; Psychotherapy working towards reparation of relationships**
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)	**(33) Family boundaries and relationships;; Containment and a holding relationship; Anxiety and defences**
Nicky:	I wonder if you can just give me your psychoanalytic formulation of him?	
Therapist#A:	Well, first of all, clinically if not an anxiously	

	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)	**(34)Family boundaries and relationships; anxiety and defences; Making sense of their worlds** **(35)Containment and a holding relationship** **(36)Understanding, clarification, guilt and pity**
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?	
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)	**(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**
Nicky:	Thanks.	
Therapist#A:	I suppose one more thing with this little boy is that	

	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	

	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)	**(42) Family boundaries and relationships; Psychotherapy as a way of coping; Psychotherapy working towards reparation of relationships.**
Nicky:	Thanks.	

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**

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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**

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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.

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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.

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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 asses whether these criteria had been meet, as well as to enable her to distance herself from the

material and provide a clear evaluation that all these criteria had been meet. 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 forful 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 participants 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 where 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.

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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 led 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 someway 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

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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.

Mannnoni (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

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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 is 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.

Siegal (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'

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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

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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.

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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 ones 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.

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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

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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

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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.

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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 suprisingly, 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

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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.

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Appendix A: Summary tables of Interviews

Therapists question	Therapist One	Therapist Two	Therapist Three
Why are they are in play therapy?	▸ anxious ▸ tearful in class ▸ could not come to terms with his parents divorce	▸ loss of a sibling may have impact on him emotionally ▸ anger management ▸ social difficulties ▸ difficulties with cultural difference ▸ school	▸ poor bonding and early relationships ▸ poor mothering ▸ unstable family life ▸ learning difficulties
The impact of Psychoanalytical play therapy with this child.	▸ helps understand where the child comes from ▸ understanding he is poorly attached and unbonded ▸ have not worked purely because cannot develop transference relationship easily ▸ provide him with a safe containing experience ▸ concrete interpretations and simple language ▸ try to re-mother him ▸ provide a holding space and hold him in mind as it feels his parents cannot	▸ used psychoanalytic therapy to a point, found it limiting with him ▸ used it to explore his issues ▸ strong transference but took time to develop ▸ worked slowly with interpretations needed to develop relationship first ▸ felt as therapist was container (Containing mother) to tolerate projections, anger and frustration ▸ displacement of people in his world onto therapist	▸ understanding where the child comes from ▸ understanding attachment and bonding ▸ understanding her personality structure ▸ transference to understand her ability to relate particularly to her mother ▸ projection onto her therapist ▸ therapy a holding place for her ▸ providing her with a relationship she has not had ▸ gentle with interpretations
Working with a learning disabled child.	▸ careful with interpretations ▸ awareness that his learning disability has impacted socially ▸ he feels he is a damaged child and being learning disabled confirms this ▸ work with being different to his siblings	▸ had to work a lot on frustration and difficulty with school work ▸ relation to being different to siblings and different school ▸ low self-esteem	▸ have to work more concretely ▸ issues around mastery have emerged as a prominent theme ▸ being different

	▸ having a learning difficulty has allowed him to get his needs meet more attention at the remedial school		
Other themes in the therapy.	▸ his need to please others ▸ need to be more independent and autonomous ▸ untrusting of the adults in his word ▸ social difficulties = battles to make friends ▸ mastery = help him feel more in control of all his worlds ▸ mother-child relationship	▸ family relations, large family ▸ struggling for space in his mothers mind ▸ feeling different from his siblings because of his anger and being in therapy ▸ hating rules and structure at school and at home	▸ home life and parent relationships ▸ her difficulty showing her vulnerabilities ▸ developing a sense of mastery
Feelings and Thoughts about Play Therapy.	▸ difficult child ▸ does not form relationships easily or connect with others ▸ fragile relationship ▸ splits therapist - idolizes and de-values her ▸ difficulty developing a trusting relationship	▸ adorable, wonderful, good sense of humour ▸ enjoy working with him but at times difficult	▸ fond of her, worry about her, a sweetie ▸ there is a good connection between therapist and child ▸ not sure if she is attached or bonded to her therapist ▸ difficult relationship
Role of mother and family.	▸ his difficulties are a result of his poor relationship with his mother therefore it is essential to work with her ▸ anxiously attached ▸ cannot trust his mother ▸ misreads his mother ▸ father and mothers poor relationship also impacts ▸ distressed by family dynamics ▸ fear of abandonment when	▸ crucial for the mother to understand their relationship ▸ difficult being in such a large family ▸ helping them understand him	▸ seeing the mother is an important part of the process ▸ difficult sometimes to work with the mother in relation to the child because of the mothers own issues ▸ working on the parents relationship ▸ helping the parents develop a better relationship with her

	parents fight ‣ working with mother to improve relationship is important		
Psychoanalytic formulation.	‣ anxiously attached ‣ reactive attachment disorder ‣ unable to trust his objects ‣ internalized objects as persecutory and abandoning = feeling unsafe and needs not going to be meet ‣ histrionic symptoms ‣ self-destructive symptoms	‣ attachment not strong enough, mother not available enough ‣ mild anti-social tendencies ‣ uses a lot of defence mechanisms to protect his vulnerability ‣ high death drive and self-destructive tendencies ‣ persecutory anxiety ‣ poor internalised object	‣ narcissistic personality structure = difficulty dealing with vulnerability and a level of falseness ‣ bonding = poor bonding initially affects her relationships ‣ poor attachment resulted in her personality structure ‣ internalised a stranger object ‣ a sense of deprivation as a result of the poor mother-child relationship

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Mother question	Mother One	Mother Two	Mother Three
Why is their child in play therapy?	▸ interact with other children whether he is happy ▸ day-to-day problems ▸ feeling insecure ▸ develop his confidence ▸ learning to cope	▸ acceptance of himself and his difficulties ▸ deal with his anger and frustration ▸ to deal with his learning difficulties ▸ to deal with being different from his family members, his siblings and other children ▸ his low self-esteem	▸ to help her with her low self-esteem, low confidence ▸ to help her become more confident ▸ to discuss her problems with someone outside of the family
Feelings and Thoughts about Play Therapy.	▸ a place other than with his parents to confide with someone ▸ to understand his problems ▸ to help deal with his problems ▸ a place to give him advice	▸ it has helped him ▸ he is not always happy to go but he has benefited ▸ it has helped him learn control of his feelings ▸ it has given him support ▸ it a safe place to get rid of his anger	▸ it is brilliant for her ▸ it has developed her confidence ▸ it has built her self-esteem ▸ helped her deal with peer relationships, particularly boys
The impact of Psychoanalytical play therapy with this child the parents understanding of this impact.	▸ to deal with his insecurity and abandonment issues ▸ he is very comfortable in this relationship ▸ he trusts her ▸ helped him to be more confident ▸ doesn't take things personally and is not as easily rejected ▸ a better perception of life around him	▸ they play as they work through his anger ▸ the therapy has enabled him to obtain a level of acceptance of who he is ▸ it helps him to discuss things at home, relationships with his siblings ▸ helps him understand friendships and peer relationships	▸ initially it was hard, felt left out and that they had secrets ▸ had to learn to trust the therapist ▸ she trusts her and they have a loving relationship

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Working with a learning disabled child.	▸ having a learning disability and feeling different ▸ how he is coping ▸ other children have called him stupid ▸ previous school experience of not coping ▸ to help him realise he is not different to other children ▸ his relationship with his teacher	▸ learning how to fit into a structure world which was hard for him ▸ lack of self worth and frustration ▸ learn to persevere and work hard ▸ positive aspect had to work hard and learn to understand themselves early on ▸ having a learning disability affects the family relationships, friendships etc	▸ not a main focus rather the social side is ▸ she does however discuss some of her academic difficulties she has at school
Other themes in the therapy.	▸ abandonment issues because of the divorce ▸ his insecurities ▸ social skills = wanting to be liked by everyone and wanting to please everyone, children being nasty to him ▸ his relationship with his teacher	▸ social difficulties ▸ anger management ▸ sibling and family relationships	▸ her relationship with her father ▸ home life ▸ building her self-esteem ▸ peer relationships ▸ her behaviour at school ▸ to be able to go into her little girl world
Role of mother and family.	▸ to give feedback ▸ to help the mother work through something if she needs to ▸ to learn that therapy is about the child ▸ keep up to date as to what is going on in the therapy ▸ to discuss siblings and family ▸ to address any difficulties at school ▸ general family stresses ▸ discipline issues at home	▸ to feedback information on school, home etc ▸ to provide guidance to help him ▸ for me to be aware of his difficulties, somethings I wasn't even aware of ▸ the sibling relationships are important ▸ to provide information as to his general well-being ▸ to feedback how he is managing his anger	▸ feedback ▸ if I have a problem at home with her to discuss it ▸ the therapist is a role model ▸ gives me advice on how to deal with difficult or embarrassing situations ▸ to discuss her relationship with her father ▸ home life in general ▸ her behaviour at home

How the therapy has helped.	▸ a secure place to talk ▸ a person who cares about him ▸ a place where someone does not judge him	▸ anger and frustration management ▸ understanding his siblings and family ▸ understanding being in a different school ▸ provide him and me with support ▸ to understand him better and to find other ways to help him	▸ building her self-esteem and confidence ▸ dealing with family issue particularly her father ▸ social issues, particularly around relationships with boys ▸ provided me with a role model ▸ given me advice and guidance ▸ to understand what is important to her better

Child question	Child One	Child Two	Child Three
Why are they in play therapy?	▸ family problems like fighting ▸ divorced family ▸ sibling rivalry	▸ fears ▸ helping you overcome things ▸ the therapists says things that help me ▸ difficulties at school	▸ helps with problems ▸ problems at home ▸ problems with my parents and their divorce ▸ helps with family relationships ▸ to discuss friendships ▸ to talk about my difficulties at school but that not that important
Feelings and thoughts about Play Therapy.	▸ she is nice, soft and gentle ▸ she thinks that I am a troubled child ▸ that I need therapy to handle my family and to sort out the problems there	▸ it helps me ▸ she is nice ▸ she likes me and thinks I need her more than I actually do ▸ understands things	▸ therapist is kind and understand my feelings ▸ trust her ▸ nice
The child's understanding of his/her learning disability.	▸ problems with either reading, spelling or other school subjects ▸ not learning right ▸ the teacher not teaching the correct information ▸ it is not important in terms of the therapy	▸ you have a problems with learning ▸ you can't understand things ▸ having a learning difficulty is not important in terms of the therapy	▸ problems with reading or math ▸ their minds are different ▸ I read differently and add words to things ▸ it is difficult ▸ other people don't always understand what it is like to have a problem ▸ having a learning disability is not important in the therapy
Other themes in the therapy.	▸ Friends related to divorce issues, like whose weekend is it.	▸ hi-jacking ▸ school difficulties ▸ sibling difficulties ▸ friends	▸ problems with my dad and step-mother ▸ friends when they hurt me

Role of mother and family.	▸ to tell the therapist what I am like ▸ discuss my siblings ▸ any problems at home	▸ my mother talks about how I am doing ▸ to discuss what is going on at home ▸ the therapist helps my mother with what she needs to do	▸ my mom is there to tell the therapist if I forget something ▸ to talk to her about my family
How the therapy has helped.	▸ with the divorce ▸ family problems like fighting ▸ friendships	▸ help me overcome my problems	▸ helped me to deal with my anger ▸ my family ▸ friendships ▸ deal with my feelings and to help me smooth them out

Appendix B: Interviews with other six participants

Themes for Content Analysis

Each of the themes have been numbered and this number is will be placed at the end of each section where that theme is seen to occur.

1- Family boundaries and relationships
2- Self-concept and self-confidence
3- Understanding clarification, guilt and pity
4- Containment and a holding relationship
5- Having a learning disability is not being "stupid"
6- Social difficulties
7- Anxiety and defences
8- Cognitive versus affective aspects of having a learning disability
9- Insecurity and the ability to think
10- The relationship and the knowledge to help.

Themes for the third reading: reading of the meaning of psychotherapy

11- Making sense of their world
12- Interpretation and containment
13- Psychotherapy as a way of coping
14- Psychotherapy working towards reparation of relationships

The interviews with mother A, child A and therapist A as noted are in the text.

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Interview with Mother Participant B

Nicky: Okay, so they're very open-ended questions, the first thing I want to ask you is, what is your understanding as to why your child is in therapy

Mother#B: I think that my child is 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 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. 2

Nicky: Can you be more specific on what you think his issues are?

Mother#B: Well, I mean he's ADD so his frustration, he also has specific learning difficulties in being unable to do certain reading tasks easily etcetera and his frustration has been different from the rest of the family members, his siblings, and being different from what he perceives other children being able to do, he gets extremely angry and has had a very low self-esteem because of that, a feeling that he could not, there was something wrong with him because he couldn't achieve it. 1,5,8

Nicky: And what are some of your thoughts and feelings about him being in play therapy?

Mother#B: I've always been very pro-therapy, it's never been something that's ever bothered me. I've seen the benefits of it myself and play therapy for him definitely has helped him. He has never gone willingly though, he's not happy to go, he in fact, we got him into THERAPIST B because of his, because we had that incident at home, that hijacking and that was an excuse so he went with all the other kids and then he kind of just stayed, so it was an easy way to get him in because before then, any other therapist that we tried, he was very reticent and it didn't really work because of that. With THERAPIST B it seems to have worked, it is a safe space for him, I think it is a safe place and it seems to contain him.1,4,9

Nicky: So if you were to tell another parent about play therapy what would you tell them?

Mother#B: I would tell them to send their kid, in fact I have told many parents who have children with similar difficulties, I tell them that they have to be open-minded about it and they have to try whatever they can, and besides the medication, this is certainly one of the routes to go. 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 to help my child when he was completely out of control, just to turn him around and hold him, just that little bit of advice has helped enormously to manage…3,10,12,13,14

Nicky: So your feeling is it's a combination of two things, one is support and one is getting information of how to do things.

Mother#B: Ja, absolutely. And support for him, that there's a place for him to get rid of that anger in an okay way, without damaging his siblings or his friends or his parents. 1,3,4,6,13

Nicky: How would you describe your child's relationship with his therapist?

Mother#B: A love hate one!

Nicky: [*laughing]* you've got to tell me more!

Parent#B: It's interesting because he spends half the therapy every time telling THERAPIST B that he's not coming back and this is the last time and he doesn't need to come, but yet when he's having difficulties he wants to go to THERAPIST B and he wants to talk to her. So I think that he doesn't like being different and having to be there but he's aware at this stage, after a long time, of the benefits that he gets from it. 3,10,

Nicky: So on the one hand he sees the benefit, but on the other hand he feels 'different' being in therapy?

Mother#B: I don't know where that comes from, there's some kind of stigma that the children perceive of them going to therapy. I don't know where that comes from, it obviously comes from somewhere, it certainly doesn't come from us at home, so he feels that there's something wrong with him that he's got to go, but he sees the benefit of going. 2

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Nicky: Can you tell me more about his relationship with his therapist. What do you understand of it ?

Mother#B: What do you mean by that?

Nicky: If you were to try and describe it, like you said, it's a love hate relationship, if you were to describe in other ways, how would you describe it, what would he think about it, what would he say to you about it?

Mother#B: I think he likes THERAPIST B, but he won't admit it. That's my child, he likes being there, but won't admit that either to himself or to her, what I'm saying is that he sees the benefit of it but he just doesn't, maybe he doesn't feel comfortable being there, not with THERAPIST B, comfortable being in a therapy situation. 4,3,7,11

Nicky: What is your role as a parent in the therapy process?

Mother#B: I'm simply there to feed information on what's going on at school, at home etc, and I keep in contact with THERAPIST B about that and then we sort of have a feedback session every few weeks, once every six weeks or so, as to how he's doing and what's going on, and then my husband and I both go, but generally, if there's a problem, THERAPIST B will call me and if I have a problem I'll call her, and we'll sort of have a bit of a discussion, if something's happened that she needs to be aware of, but other than that I'm

not really involved.3,4,11,12,13

Nicky: How would you describe your relationship with his therapist?

Mother#B: I think a good relationship, in fact the previous therapist that he had I was very resentful because I felt very shut-out, a lot of therapists have this idea that it's private between them and MY CHILD, they forget that this is MY CHILD, this is not an adult that we're talking about and they don't give you any feedback and you don't know what's going on, and it's exceptionally frustrating as a parent because you need to be involved on that level, that you know what's going on, so THERAPIST B really has been fantastic, she's kept me informed and she's listened to me when I've needed to speak and she hasn't come along with any of this, 'this is private and confidential between me and your child'. Obviously she asks his permission to discuss things with me, but he doesn't have a problem with it and at least we have a, I know what's going on and he knows that I know what's going on, which is important, for me anyway.1,3,4,10,11,12,13

Nicky: What do you discuss with your child's therapist? Do you discuss your child's difficulties with her?

Mother#B: Ja, and things that he does.

Nicky: Give me an idea of general things that you discuss, quite specifically.

Mother#B: We would 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 and in fact THERAPIST B has pointed out to me that my child has difficulty with certain aspects with his siblings and something that I wasn't even aware of, which I then used that information to relay it to his sisters and they've had to deal with it to try and help him. We would discuss what's happened at school. If specifically he's had an incident at school where something has happened and it hasn't been positive, we discussed that in detail, how to go about helping him with that incident, we discuss his general emotional well-being, how he's functioning within the home, within school, within the community, his level of anger, his level of happiness, his reactions to his medication. 1,3,4,6,7,10,11,12,14

Nicky: Okay, it's quite broad. What do you think the therapist focuses on, what do you think is discussed in his therapy?

Mother#B: They do a lot of playing, he does a lot of drawing and things. I think a lot of my child's therapy has been to work through his anger because in the beginning he was exceptionally angry, in fact the one day I think he nearly even hit THERAPIST B – I had dragged him into the therapy session and he didn't want to go and he nearly climbed into her. So a lot of it has to do with anger, getting rid of that level of anger and I think that's what's really been achieved, getting to a level of acceptance with who he is. I don't know exactly what they talk about, I know she like tries to discuss with him issues of you know what's going on at school or at home, but obviously she's getting information out of him because she's imparting things that are obviously quite

valid you know, especially, as I said, at home with his brothers and sisters, you know the issues that he has, so he's giving her that information. I don't really enquire exactly what's going on in the therapy sessions. 2,3,4

Nicky: What do you think? You've said they focus a lot on the anger and maybe the siblings, do you think there's anything else they focus on?

Mother#B: I think on his friendships, on where he should have been at school, should he continue here, should he have gone and been mainstreamed, how he felt about that, was he ready to mainstream, which school he was interested in and focusing on when he's going to be mainstream, I think they discuss all of that, how he feels about it, his friendships in school, and out of school, those kinds of things as well. His family is possibly the main focus for him. 6,5,8,10,1

Nicky: Which really comes to my next question, because you've touched on it, what do you think it means to have a learning disability or to have a learning difficulty? What do you think it means?

Mother#B: In what context?

Nicky: For the child?

Mother#B: What does it mean for him?

Nicky: Ja, and even what it means for you as a family.

Mother#B: Let's start with him individually, I think for him it's 'I'm different and I can't do things like a lot of other kids can easily', not 'I can't do them, but it takes me an enormous amount of effort and perseverance to do it' – that is difficult for a child. For him it means that a lot of it interprets into I'm not good enough and I'm useless and we've been through all of that scenario. I think that they have to get to a stage where they understand that they have other areas in their life and things and all these children are incredibly gifted in many different areas, maybe not in specific learning areas that have to fit into the type of schooling that we have within this country, I'm not sure why they have to fit into a structure, a lot of these kids can learn in different ways and we have to find those ways that enable them to learn, but they still have to fit within a structure, so I think for them, that's difficult, that's what's hard – being able to fit the mould and not managing to do that and that leads to feelings of lack of self-worth and frustration on their part, and they have to learn to deal with that. On the other hand, there's the other side, that if you deal with it properly and you really embrace this instead of trying to avoid it, I believe that these children come out far superior in many ways who have it easy because they've had to work for everything that they've got and they learn that level of perseverance and they learn to understand themselves at a much younger age than other kids who maybe never get an opportunity to look at themselves. So on one hand it's difficult, on the other hand it can be a tremendous thing, but later on in life. 2,3,4,5,8,9

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 was raging, it was extremely trying on me and the family and the extended family, my mother found it hard to watch him in such pain, but once you find the right medication and you have them in the right therapy and working through it I think that in many ways it's been a bonding thing for the family because kids, although sometimes they drive him crazy and do things that upset him, they very much root for him the whole time and the younger ones adore him and I think that everybody is sort of behind him. 1,3,4

Nicky: Do you think that his learning disability is an important part of the therapy process?

Mother#B: I don't think it comes into the therapy process. I mean I think that the results of it come into the therapy process.

Nicky: Tell me about the results?

Mother#B: His reactions to that learning disability and what happens, as I've said, what happens as a result of him having that learning disability, the effect on him as a person, the effects on his relationships in and out of the family, with friends etc, the effects of him having to be in a different school from the rest of the family, those kind of things are the results of his learning disability, that's what has to be dealt with in therapy. I don't think his learning disability itself really comes into it, except maybe in an understanding that this is something he's been given and he has to learn to accept it as other people have other things that they have to accept. 5,8

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Nicky: That's all the questions that I've got, but what I want to ask you, is there anything that you feel I haven't asked that is important about the therapy process?

Mother#B: No, maybe just from, well for my child what's been important is the liaison between you and THERAPIST B, that feeling of there's continuity between what goes on at school and what goes on in therapy and what goes on in home. You know, there's a holistic approach, which I think he feels supported by that, I know what's going on and you know what's going on and THERAPIST B knows what's going on in all different areas, so he feels helped. 1,10,13

Nicky: Everybody's taking care of him?

Mother#B: Ja, and everybody is talking to each other so we all know what's happening.

Nicky: Right, thanks.

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Interview with Child Participant B

Nicky: Okay, 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?

Child#B: I would say it's about helping you and helping you overcome things. 10

Nicky: Can you tell me what things it helps you overcome?

Child#B: I would say fears, something, all that kind of stuff..like family stuff and friend who fight with you 1,6

Nicky: And if you were to tell them anything else, what would you say about play therapy?

Child#B: you talk, they talk to you

Nicky: And what do they say to you ?

Child#B: they say things that try and help me like ….. feel better about things 3,4

Nicky: children think lots of different things about being in play therapy. Tell me what you think about being in play therapy?

Child#B: they help me a lot, THERAPIST B helps me

Nicky: What does THERAPIST B help you specifically with?

Child#B: well we had a hijacking at our house and she helped me with that and then other stuff

Nicky: and after that?

Child#B: we just talk and stuff, like about family, my sister being horrible to me or I guess other stuff at home…THERAPIST B helps me with things that are like hard for me, things that make me anger, she makes me feel that or helps me cope with it 1,2,3,4,10,11,13

Nicky: why else do you think you're in therapy with THERAPIST B?

Child#B: .....

Nicky: if you were to just try and answer that what do you think?

Child#B: so that if in case something else happens she'll be there…to help me with stuff that it hard like my sister fights with me or like my mom gets angry with me then I get mad and she helps me with it…I don't know stuff like that 1,3,4,10,11

Nicky: what do you do in therapy?

Child#B: play games

Nicky: what sort of things do you discuss with THERAPIST B

Child#B: we talk about school and all of that

Nicky: and what about school do you talk to her about?

Child#B: about my friends being horrible to me and all that. 6

Nicky: now when you say people are horrible to you can you tell me what kind of horrible things they do?

Child#B: they call me names and tease me 6

Nicky: do you ever discuss your family with THERAPIST B?

Child#B: sometimes

Nicky: what do you discuss with her?

Child#B: sometimes if my sisters aren't being very nice then she helps me with that like to understand it 1,11,2

Nicky: what else about school do you discuss with THERAPIST B?

Child#B: nothing

Nicky: how do you feel about your therapist?

Child#B: she's nice 4,10

Nicky: tell me what you think your therapist may have thought or felt about you ?

Child#B: she likes me, she thinks I need her more

Nicky: she thinks you actually need her more than you actually do?

Child#B: yes

Nicky: tell me more about this

Child#B: she says she wants me to stay longer but I've feel I've had enough

Nicky: okay, if THERAPIST B was to tell someone about you, what do you think she'd tell someone about you, if she was to tell another therapist, what would she say about you?

Child#B: I'm a nice boy and other good stuff 4,10

Nicky: what other good stuff would she say?

Child#B: I'm friendly, and… I don't know 10

Nicky: why do children come to this school?

Child#B: because they've got learning difficulties

Nicky: okay, what does it mean to have a learning difficulty?

Child#B: you've got a problem with learning 5

Nicky: is this school different from other schools?

Child#B: yes

Nicky: How's it different?

Child#B: 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 5

Nicky: what would you tell a friend about having a learning difficulty, like someone who wasn't in your school?

Child#B: just that you not stupid, you just can't understand things 5,8

Nicky: do you ever discuss your learning difficulty with THERAPIST B?

Child#B: no

Nicky: never ever

Child#B: no

Nicky: does your therapist always understand what you trying to tell her, does THERAPIST B always understand ?

Child#B: yes

Nicky: have you ever been able to tell your therapist when you were unhappy with her or angry with her?

Child#B: I don't know

Nicky: sometimes your mom meets with THERAPIST B, what do you think they talk about

Child#B: talk about how I'm doing and things at home, she helps my mom with me, like I don't know what they talk about 1,3,4,10,11

Nicky: tell me what you think

Child#B: they talk about what is going on and if she thinks I need to go in for longer

Nicky: how do you feel about your mom meeting with THERAPIST B

Child#B: I feel okay about that

Nicky: is it helpful

Child#B: ja

Nicky: how is it helpful?

Child#B: because my mom comes and tells me what THERAPIST B wants me to do, sometimes I forget to tell her stuff and my mom tells her, like if I had a big fight with my sister, I don't know stuff like that, stuff about what goes on at home. 1,3,4,10,11

Nicky: I want to ask you, if there was something that you think would help the therapist work with you better, what do you think they need to know about working with kids in therapy?

Child#B: it's a problem that you help them…….. overcome and ….

Nicky: is that the most important thing?

Child#B: ja

Nicky: okay, anything else you can think of?

Child#B: no

Nicky: okay, thank you

Interview with Therapist Participant B

Nicky: The first question I'd like to ask you is, what is your understanding as to why this child is in play therapy?

Therapist#B: He was referred to me, first of all there's been quite a traumatic loss of a sibling in his family which we felt might be contributing to some of the emotions that he's experiencing, according to the parents, the main reason he was referred to me was for anger management, frustration, struggling to fit in at school, coming from quite a different religious sect to his fellow school mates which made it quite difficult for him to feel that he had a sense of belonging and that he fitted in. But all-in-all, I'd say anger issues and controlling his temper with his family and with his friends.12,6,11

Nicky: If you had to discuss this child with another therapist, how would you describe your feelings towards this child?

Therapist#B: I think he's absolutely adorable, first of all, I think he's hilarious, he has a wonderful sense of humour, I actually enjoy working with him but he does give me quite a hard time, we have a very witty kind of therapy, it's quite different to what I've been trained in, but we have quite a sarcastic session, we joke, we laugh, I am very fond of him, I have to say, he's one of my favourites. 4,10

Nicky: How do you see psychoanalytic play therapy assisting your work with this

child?

Therapist#B: *[laughing]* my supervisor will chop off my head! *[laughing]* I have used it to some limited point in the therapy, although, because he's kind of pre-pubescent, almost on that curb of being a teenager and quite on some levels, his issues are quite adolescent, I have found that I haven't really taken on a fully psychoanalytic approach with him, it's been more a sense of humour therapy, exploring issues, ja but I guess using an analytic approach with humour..

Nicky: Do you feel, using psychoanalytic technique such as working with transference, interpretation, things like projective identification and confrontation, work with this child?

Therapist#B: Let me just think, shall I go through each of those topics or?

Nicky: Just give me anything, that you think there's a psychoanalytic technique that may have worked with him.

Therapist#B: I do think there was quite a strong transference, although I didn't directly jump in and work in the transference with him as I felt he was quite defensive and it would have been quite destructive, so I'm aware there were transference issues but I did not work in them fully, in terms of projective identification, no I don't feel that that kind of concept was quite strong in the room, I didn't often experience the emotions he was feeling. What was the other one? 10,7,11,12

Nicky: Any of them that you can think of ? Okay, let me give you this, do you feel this child responds to interpretations that involve his internal world?

Therapist#B: *[laughing]* you reckon! Not, I would say if I had to give you maybe on a numerical scale in terms of one to ten, I'd maybe say 5. Sometimes he did respond, but sometimes I think, 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. 3,5,8,12

Nicky: Why?

Therapist#B: *[laughing]* Because he's got quite a spunky personality and he's quite challenging and I think if he had to sit back in a real serious kind of analytic way, I just feel we wouldn't have connected the way we have connected.

Nicky: the object relations literature contains many analogies between the good enough mother and the good enough therapist, between the holding environment and the holding function of therapy, do you see this as being part of your therapy?

Therapist#B: I actually do. I think that in terms of my therapy there were lots of tests in terms of would I be a container, would I be able to tolerate a lot of his projections, a lot of his anger, and his frustrations and I think that he certainly was quite well aware of them, in the beginning of the therapy he was raging and there often have been sessions where he's been raging at

me, and obviously I take that as a displacement for other people in his world. So I do feel that having to be a strong enough kind of container mother, has played an important role for him, and the consistency, the availability, ja I do feel that that has. 3,4,10,12,13,14

Nicky: Do you feel your work or understanding in this area is different because you're learning with a learning disabled child?

Therapist#B: I think that I never kind of processed that in my therapy, I wasn't kind of thinking 'shame, poor kid, he's learning disabled, oh geez, he's struggling', I suppose the only time it would come up is when we spoke about sometimes the frustration with his teachers and managing the work, but to me he didn't present, he's actually very bright and he didn't present as a child who does struggle and it didn't really, in fact NO, unless it was mentioned in the context of being in a different school from his siblings or from his friends, that was the only time it would come up, but in my mind, it really wasn't prevalent. 5,8

Nicky: So you don't think having a learning disability came up in any other way?

Therapist#B: Let me just think it through. Well it may contribute to, he's quite defensive and I think he does have quite, 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. 2,5,8,7

Nicky: Do you ever work directly with this child discussing what it means to have a learning disability?

Therapist#B: We had I think one session we spoke about why he's at this school and it's different from his siblings and different from his friends and the kids who attend his church group. And he seemed to understand what that was about and it was a very brief discussion, it didn't seem to come up in his mind. His anxieties are more, he does feel different from the rest of his family members because he's in the therapy, but not because of the learning, he sees his therapy as more being due to his aggression. 1,3,4,5,8

Nicky: Does this child use his learning disability in any way to have their needs met or to guard against letting on what their true feelings actually are?

Therapist#B: I haven't experienced that with him at all.5,8

Nicky: so he doesn't use it in any way?

Therapist#B: In the manipulative sense?

Nicky: In any sense. What I'm trying to get at is the focus of the therapy at all other than one session?

Therapist#B: no

Nicky: what are the other themes that are a major focus in the therapy?

Therapist#B: 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, 5 or 6, that would be one of the main themes. Another theme would be initially he was referred to me for a trauma de-briefing, I dunno if it was mentioned at all, and we obviously carried on because we seemed to connect and he did need more deep and long-term therapy, so I think one of the big things is that he does feel quite persecuted being in the therapy feeling different from his siblings why they didn't continue why they did continue, what makes him different, but I would say overall, just struggling with school work, hating homework, hating rules, he finds the whole structure of that quite difficult, it's about needing it quite firmly, struggling with adults telling him what to do and the rules in the adult world, very testy, I found him very, he tests limit a lot, wanting also to see the resilience of the people in his world. 1,5,8,11

Nicky: How do you see the role of working with the mother in terms of this child's therapy?

Therapist#B: Very important, I think the mother, the parents, have been to all the feedbacks, every 7 sessions they there, they on time, they hear what I say, they process, we talk together, I think it's crucial that the mother has her feedbacks, both at school and with me, the therapist, crucial. To help them understand him better and to help him at home feel more accepted.. 1,3,4,13

Nicky: And this particular mother?

Therapist#B: Um, I find her very responsive, very open to hearing what I'm saying, she does hear what I'm saying, I think, ja I found her responsive, very available, she does, she keeps me in touch with what goes on at school, what goes on at home. For her to understand him better and to be there more for him, ja I feel I've had quite a good relationship with the family. 1,3,4,10,13

Nicky: How do family relationships affect the therapy process?

Therapist#B: Hugely. I think in terms of being, he's kind of in the middle in quite a large family of a lot of children, I think that's part of his big struggle, I think a lot of his frustration at not being able to have his mom all to himself has been acted out in the therapy context with me, you know, kind of testing that out. Other family relationships, I think the hard part has been because I met a few of his other siblings in the debriefing initially and they haven't continued, I think it's been part of his struggle, why him, almost why has he been selected and not the others to continue. 1

Nicky: How does he see that ?

Therapist#B: He sees it that he's the naughty one and the bad one and he needs to continue and they all fine, why does he need to and they don't. So he's sees it as quite a persecutory experience. 7,3

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Nicky: A tough question, okay. Can you give me your psychoanalytic formulation on this child?

Therapist#B: *[laughing]* you can't give me one day's notice!

Nicky: Another way to ask it is how do you understand the child's difficulties psychoanalytically ?

Therapist#B: Okay, let me think. I would say that this boy is, he functions, he uses a lot of defence mechanisms, personality I think is quite vulnerable and he projects quite a tough challenging kid, where I actually think it is a defence mechanism, some of them he uses are omnipotence for example, not needing, being independent, not needing anyone in the world or me. He doesn't have very good coping skills, but I guess that is not really a formulation. He does have quite a high death drive which does concern me, he engages in quite high risky behaviour and thinks he's interests are more guns and more self-destructive tendencies. Sometimes I think he's prone to, well I don't know if this is psychoanalytical but, negative attention seeking. I don't think he's a depressed boy, I do think he has quite a lot of persecutory anxiety, I think that he does feel quite persecuted and not always safe in the world. Sometimes I feel that he is a damaged child because of his early development and he needs containment or re-mothering. 7,3,4

Nicky: Tell me about the early development and impact?

Therapist#B: Okay. I think, we haven't spent any time looking at what it must've been like for him growing up in a family where there was the loss of an older sibling before he was born. I have no doubt that that has to have contributed to some of the issues he struggles with. What specifically are you thinking? I think in terms of attachment, I sense that he doesn't seem to have separation issues, but I sense that there may not be a 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 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, I feel that he does defend against needing people, me, therapy, his therapist, his mom, he does defend against that by presenting as quite omnipotent and self-sufficient, which I do feel is a defence. He does have a sense of guilt, although when he's been quite angry in the therapy I haven't expressed any recreation unfortunately, have the anger and that's been it. Ja, I question the attachment, I don't think he has a bad relationship with his mother but I think that the attachment, I think it has been held back a lot, maybe from mom, after losing a son, having lots of children, I feel that. Separating is fine, individuating is fine, I think it's difficult because he's grown up in quite a rigid environment, he grows up in and he does have some different ideas and would like to explore different ways of being and his family rules don't allow for them, which I think is quite difficult, and he may rebel when he's older. He does have some mild anti-social tendencies, which hopefully

will be curbed. I mean he does worry with some of the things that interest him and the behaviours, and his guilt isn't strong enough, risk-taking wise. 1,2,3,4,7,14

Nicky: One last question. Is there anything that you think is important in the process of therapy with this child that I haven't covered with you. Anything that you can think that would be relevant?

Therapist#B: No, I think you've covered most issues. I mean I think obviously exploring the family background is very very important, very crucial, specifically in my mind, especially the loss of a child, and I think considering their religious orientation, having a huge family and it places a huge impact on the relationship with his mother specifically, on his mother's availability. But I think that you have covered. The therapy has given him understanding and a place to look at his anger and feel it is an ok or a safe place to do that.. Let me just think if there's anything else.... no. 1,3,4,7,14

Nicky: Thanks.

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Interview with Mother Participant C

Nicky: The first question I'd like to ask you is what is your understanding as to why your child is in play therapy?

Mother#C: Originally I think it was more of a psychological thing to get her 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, ja. 2

Nicky: And now why do you see her being in therapy?

Mother#C: I think she needs THERAPIST C, she needs the time out, because we, it's an interesting question, but what I think is that I like her to go to therapy because she needs that time out from everybody else, she needs to go back into a little child again. And if she's got problems she can't discuss with me she can always discuss with THERAPIST C and we work together with those problems. 11,10

Nicky: What are some of your thoughts and feelings about your child being in play therapy?

Mother#C: I think play therapy is brilliant for her. I've never really actually gone too far into why CHILD C's there, why, I can just see it's good for her, what THERAPIST C's doing is good for her. What was the question again?

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Nicky: Well, maybe another way of asking the same question is, what would you tell another parent about play therapy?

Mother#C: That it's helped CHILD C and I would recommend it to any parent.

Nicky: If you can be specific, how do you see it as having helped her?

Mother#C: Confidence is up, she knows how to deal with certain situations I would not have given her the right advice about, my advice to her would've been totally the wrong advice, like with CHILD C, she had a problem with the boys at one stage, and I just was so anti her doing the boy thing, and really at the end of the day it was just her building her self-esteem and that's when THERAPIST C came in and helped her through that situation. 2,3,4

Nicky: How would you describe your relationship with THERAPIST C?

Mother#C: Good. In the beginning it wasn't, and I think it was also a jealousy thing because now she's taken a bit of CHILD C from me and CHILD C is, because my belief, and I tried to go right, from when CHILD C started the school, well since she was small, we don't keep secrets, because secrets can turn into nasty little things, so I, well with THERAPIST C, CHILD C was revealing secrets to her that she wasn't revealing to me, and I felt left out by this and I had to re-assess myself and my role in SCHOOL, but once I had got over that hurdle, it was fine, I absolutely have a 100% trust in THERAPIST C and if CHILD C has a problem that I know I can't sort out, I go directly to THERAPIST C and then she can give advice. 3,4,10,12,13

Nicky: And how would you describe your child's relationship with THERAPIST C?

Mother#C: Very good. Absolutely. Loving, in fact she's almost like a second, not a second mom but a second person that she can really trust. She understands her difficult relationship with me and that I have not always been able to be good enough. Even before her dad, THERAPIST C comes, in the sort of circle, it would be me, THERAPIST C, her dad and then whoever else is underneath. 4

Nicky: What is your role as a parent in the therapy process? How do you see your role?

Mother#C: My role in the therapy process, it's very, how do I see the role, my role, um, as long as I, put it in another way, I don't understand.

Nicky: Well, what do you see as your purpose when you go and see THERAPIST C?

Mother#C: Feedback, and if I've got problems at home that I don't know how to deal with. It could be homework it could be helping, I'm just trying to think of things, I mean anything I don't know how to deal with, or I think I'm

dealing with it wrong, then it's very important that I see THERAPIST C so that we can discuss it and she can give me advice as to how to deal with it. Because you know what, I don't have a role model, I've never, I don't have a mother, my father I don't ever ever see, and I don't have any brothers or sisters, well I do have a brother but he's down in Cape Town, but I never learnt from anybody, so I always need to get reassured that I'm doing it okay. That I'm doing well, you know I'm divorced, so there's no dad for any family support, so I actually rely on THERAPIST C to say to me yes you doing it right or maybe you should it this way, because my friends are, you know you can learn from your friends but every situation is different and in some situations you don't want to speak to your friends about and the one situation was CHILD C at SCHOOL had a problem with taking money, she did it once, but then money went missing, and I don't know how to handle the situation, and THERAPIST C gave me some good advice with that, and I mean you don't want to go and tell your friends, you know your child steals. And then she said to me there was obviously something there you know because of her difficulties I had to understand maybe why she needed to steal at that time or why she does the things she does.1,2,3,4,10,11,12,13,14

Nicky: Okay. Do you discuss other things other than your child's difficulties with THERAPIST C?

Mother#C: Ja, my ex-husband, ja.1

Nicky: And anything other than that? Do you discuss relationships?

Mother#C: Yes, I do, definitely.

Nicky: Does your child's therapist ever directly focus on your child's learning difficulty?

Mother#C: No, I think THERAPIST C, I stand under correction, but I think THERAPIST C is more on the social side and with an, she does but not directly, you don't say okay maths is bad and you must concentrate on your maths, it's a very sort of, whole lot of things that she concentrates on. 6

Nicky: What sort of things are discussed say about home life?

Mother#C: Going to bed at the right time, I do divulge quite a lot of personal stuff, but whatever happens to me directly affects CHILD C, so we discuss home life in general, when she's cheeky to me, how she dresses, that's another thing that we brought up. THERAPIST C helps me understand her and what I should do as I don't always know what to do. 3,4,10,11,14

Nicky: And then relationships other than we discussed?

Mother#C: CHILD C and myself?

Nicky: Ja

Mother#C: Yes, well I was involved at one stage and yes we did discuss that because it had a direct affect on CHILD C and also the dad. 1

Nicky: What aspects of her father do you discuss.

Mother#C: You know I just get very frustrated with her father because I, I know that I'm the mom but it's not my sole responsibility but picking CHILD C up and at one stage he wouldn't allow her to wear certain types of clothes so she's a different person in his house as opposed to my house. She's not as relaxed. And you know what THERAPIST C also told me you know, as much as that irritates me, he is still her father and the last, I haven't got a very good memory, but in the last interview I had with THERAPIST C, we discussed grades, and CHILD C's relationship with her dad is getting stronger and stronger and stronger, and that is so important because later on in life when she marries, I don't want her not to trust a man because she didn't have that trust in her father, so I backed off and he's also backed off in a way, and it's now coming right. I mean there are a few issues, but.1,3

Nicky: Do you ever discuss peer relationships with THERAPIST C?

Mother#C: About CHILD C, not that I can remember, the way she is around the kids at school, the boys has always been a big problem.5

Nicky: And is there anything else that comes to mind that you've perhaps discussed with her.

Mother#C: No.

Nicky: I know you said to me earlier that you don't discuss with CHILD C what

happens in therapy, but what do you think they focus on, what do you think they discuss in therapy?

Mother#C: Okay, in the beginning I used to because I know I was jealous of THERAPIST C and I used to almost pull out the questions, I'd ask her and get cross when she didn't want to answer me, but what I can gather is that they do a lot of playing, they pick-up-stix, she goes into a fantasy world, and that's fine with me, and I look at her as an adult, I would prefer THERAPIST C to ask the questions but then you know what, to sit her down and say right now CHILD C, this this and this, but it doesn't work like that, sometimes I want to get answers out or I want to get problems solved that I can't solve myself.

Nicky: So while they playing, what do you think they talk about?

Mother#C: I dunno. Not now, a year ago it would be about school, about me, about her dad and her dad's wife. The dad's wife was a big big issue in our lives at one stage, a very big issue and I didn't know how to deal with it so I used to say to CHILD C speak to THERAPIST C about it and she did on some occasions, I dunno how she approached THERAPIST C or what came out, but STEP-MOTHER was a big problem. 1

Nicky: And now what do you think they focus on?

Mother#C: Um, just building up her self-esteem. Because she's from a divorced family, I treat her older than what she really is, so what I can picture is she goes

into THERAPIST C's office, she goes into her fantasy world, she wishes she was a little girl and you know, baby, and then goes into that world, and that's really really fine, I think that's perfect , THERAPIST C helps her to deal with things and helps her to cope better with things, she does always know how to cope with things– so that's what I think happens. 2,7

Nicky: What do you think it means to be learning disabled, or have a learning difficulty, how do you understand it?

Mother#C: Just that she battles academically. That's really what I can see, she can't grasp the concepts like somebody who is able to do it quickly.5,8

Nicky: do you think having a learning difficulty should be an important part of the therapy process?

Mother#C: No.

Nicky: can you tell me why not?

Mother#C: Because I think a lot of children go to psychologists and they okay at school but every aspect of their lives must be A-okay, so if they okay at school but home life is not good, then they should go and see a psychologist or a play therapist.5,8

Nicky: So you don't see her as being a predominant focus?

Mother#C: No.

Nicky: And in terms of the self-esteem? How do you feel that impacting?

Mother#C: Like with CHILD C her self-esteem was very very low when she joined SCHOOL and with play therapy it got better but it was around our relationship and her relationship with her dad.2,1

Nicky: do you think it was low for any other reason?

Mother#C: Past school, her teacher really just, I think it was over a couple of years, it was me, it was her past school, and I actually wasn't seeing this little girl for who she was, I made the biggest mistake of my life, I didn't see she was hurting inside and it took one teacher at her old school to say listen, there's a problem, and if I'd seen it, and our relationship since we've been at SCHOOL has got stronger and stronger, before she was a little girl 5,1,

Nicky: So was her struggle at school, academically?

Mother#C: Struggle at school and the fact that she was at a new school, she didn't know anybody, and she had to make new friends and where she was at pre-school she was the queen, people copied what she wore, now all of a sudden she came into this new school and nobody knew her and nobody wanted to be her friend and then her teacher was, she pushed this girl down and pushed this girl down, and she was this crumbling little, I don't want those years back, I really don't. 6

Nicky: MOTHER C, one last question. I've asked you a lot of different questions. If there's something that you feel I haven't covered in terms of the therapy process, or what happens in therapy, is there anything you'd want to add?

Mother#C: No, because you see I don't really know what happens in the room. I mean THERAPIST C does, she'll pick up a problem, the last time it was with the boys, last year, but I don't ask her at all what goes on.4

Nicky: But even in terms of you and your role, anything you'd like to add that maybe I haven't covered in my questions?

Mother#C: Just not to be jealous or envious of a play therapist because they are really really there at the end of the day for the child.

Nicky: That was quite an important issue.

Mother#C: Ja.

Nicky: And you think that would be important for other parents to understand?

Mother#C: Ja, because sometimes also, you don't, you know that personality thing when you walk into a place and you don't, immediately you feel threatened by someone, you don't like that person, but really, that person might not, and I found that with quite a few teachers here, originally I didn't like the teachers, just on face value, but they not here to teach me and they not here to worry about me, they there for the child, and as long s the child gets on

with the teacher, that's the most important thing and with THERAPIST C it was the same thing, I immediately didn't like it because of the threatening, it was because of me, not because of THERAPIST C. And once I saw what the result of what she was doing, you know what, and I didn't loose my child, and really CHILD C's just grown and grown. 3,4

Nicky: A lot of fears ?

Mother#C: Ja, but from my side, because I wasn't adult enough to speak to THERAPIST C about it.

Nicky: Anything else you'd like to add?

Mother#C: No.

Nicky: Thank you.

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Interview with Child Participant C

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?

Child#C: It helps you like say if you've got a problem it helps you remember things and if you've got a problem at home and you don't want anyone else to know they will till you, you will tell the therapist your problem and you can ask the therapist to not tell anyone else, secrets between them, and your parents, you don't want them to know, so that's what I think it's about. It's fun because I like to play, but the play therapy is you, like with THERAPIST C I play with her and I tell her my problems because sometimes there's problems I just like to play and it's something that I play with the toys she can see the feelings like if I'm playing army then that means I'm angry and if I'm playing like something nice it means I'm not angry, I don't have any problems or anything, and my mom asked THERAPIST C if I could go because I get confused with other things and I like to tell somebody my secrets. 1,3,11

Nicky: (Tape stopped so restarted tape) Okay, so lets try that again, you were saying to me what sort of things you discuss in therapy?

Child#C: Like all my problems and my mom and my dad especially like my mom's ex-fiancé, well she had a problem with him because he kept on drinking and

that, so that's why I had a problem with that and like my problems with when my step-mom was being horrible to me and that, she'd like say horrible things to me, that's what I normally discuss. I worried a lot about things with my dad things at his house. **1**

Nicky: You said to me you discuss a lot about family, did you ever discuss anything else other than family?

Child#C: Maybe some of my friends if they hurt me, but nothing's happened to me with my friends so far, just with my family. 5,1

Nicky: Do you ever discuss school?

Child#C: Sometimes, well it's only when I've got to struggle and don't understand things like maths sums I'm not perfect with but sometimes I struggle a little bit but that's not really important, it's just normally my family and not school. 1

Nicky: Okay, how do you feel about your therapist?

Child#C: She's kind, she understands me, she understands my feelings and I trust her.3,4

Nicky: If your therapist were to tell someone about you, what do you think she'd say about you?

Child#C: My secrets, because if my therapist wasn't kind or trusting, she'd tell my secrets yes. 3,4

Nicky: She wouldn't tell your secrets to anyone?

Child#C: If I could trust her and she was an honest person she wouldn't tell anybody about my secrets but if she wasn't she'd tell everybody my secrets. 4

Nicky: How would she describe you?

Child#C: Maybe as a difficult person because I struggle, I normally complain, ja, she would explain me as a person who is cross and that sometimes and if I was just happy she would just smooth me out, she wouldn't do anything else.4,11

Nicky: That's great. Why do you think children come to this school?

Child#C: They've got a problem, like say reading or maths, 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 maths and reading, I've got a problem with reading, because I can't read words, I get difficult, I normally add words into it. 5,8

Nicky: Is this school different to other schools?

Child#C: much

Nicky: How is it different?

Child#C: The way the teachers teach the children, the way the therapists, they kind and the way the food is brought up in the tuck shop is no sugary sweets and that. 5,8

Nicky: What would you tell a friend about having a learning difficulty? Someone who didn't have one, what would you say to them.

Child#C: It's difficult, it's difficult to try and do everything right because the other person, if they don't have a problem, then you like feel jealous because they got a problem, I've got a problem and they don't. So it's a little bit difficult to describe to the person. 5,8

Nicky: Okay, do you ever discuss having a learning difficulty with THERAPIST C?

Child#C: No not really, actually no.5,8

Nicky: You don't discuss anything about having a difficulty at school?

Child#C: No, I'm improving my reading, no not really. 5

Nicky: Does your therapist always understand what you trying to tell them?

Child#C: I think so, because when I have a problem, I don't know if THERAPIST C

understands but I'm sure she does.

Nicky: If she doesn't understand, what do you do?

Child#C: I would tell her, I'd go from the beginning to the end and tell her the whole story.

Nicky: Have you ever told or been able to tell THERAPIST C when you unhappy with her or angry with her, have you ever been able to do that?

Child#C: Well, I'm never unhappy or angry with her, but if I was, I would, it would be easy to tell her.

Nicky: Sometimes your mom meets with your therapist, what do you think they talk about?

Child#C: Me and my mom likes to tell THERAPIST C, like say when I go to THERAPIST C I forget to tell her some things that my mom asks me to tell her so when my mom comes to see THERAPIST C she talks about private stuff I don't know anything about but things my mom wants to speak THERAPIST C about, like my step-mom, my dad, something like that. She is there to help my mom with her private stuff . 1,4,13,10

Nicky: How do you feel about your mom meeting with THERAPIST C?

Child#C: It's fine because I've got my secrets and she's got her secrets so I'm happy

with it, I don't mind.

Nicky: Do you think it's helpful?

Child#C: Ja, for my mom, if she has a problem she can tell THERAPIST C. 4

Nicky: So it's helpful for your mom?

Child#C: Ja

Nicky: Is it helpful for you

Child#C: Ja, *[laughing]*, it's helpful for me! It helps my mom then help me like she understand my worries better. 10,3,4

Nicky: One more question.

Child#C: Ok.

Nicky: Do you think there's anything that I haven't covered that's important about being in therapy, that you think I should know about.

Child#C: No, not really, I don't have anymore secrets no.

Nicky: Thank you very much.

Child#C: Pleasure

Interview with Therapist Participant C

Nicky: The first question I'd like to ask you is, what is your understanding as to why this particular child is in play therapy.

Therapist#C: I think she's got a lot of problems. She's got a very difficult background to deal with. I know you focussing specifically on learning stuff but I think a learning problem is part of the problem but I don't think it's the main problem for her actually. I think her main problem is her background. Her mom really battled with her when she was a little girl, so did her dad, but her mom's the primary caretaker now and I suppose the bond with the mom is more important in some ways for her emotional growth. They never bonded properly, and her mom had her own stuff to deal with, she never had good mothering, her own mother died when she was three I think, and so I don't think she could really be a good mom to CHILD C. That was the early time of CHILD C's life which was very difficult for her, and because her mom battled so much herself, she's had an unstable life, the mom got divorced, she's had different partners, things have been very unstable in their home in terms of actual material things available to her and then she's had the learning problem as well, so she's just had a helluva lot to deal with and I think that's affected things, like a sense of herself and her self-esteem and I think it was clear to the parent that she needed some sort of help, and I think play therapy is the right sort of help. 1,2,,11

Nicky: And if you were to discuss this child with another therapist, how would you

describe your feelings towards this child?

Therapist#C: I'm very fond of her, but I worry about her, my main thing is worry, because I know that therapy is helping and there's something of a connection between us, but I feel that the odds in a way are so loaded against her that I wish I could do more in a way, but ja, I suppose I'm doing what I can. I was thinking today, maybe if she was private child I'd have her in therapy twice a week. But she's a sweetie, she is a sweet girl, she engages, I don't know that she's a bonded child so I don't know if she's bonded to me or attached to me, but she certainly likes coming and certainly the therapy seems to mean something to her, so there's definitely a connection between us. 3,4,10

Nicky: So if you were to describe the relationship, how would you describe it ?

Therapist#C: That's quite difficult, to just kind of tone it down to one phrase. I care about her and I'm very concerned about her.

Nicky: How do you see psychoalytic play therapy assisting your work with this child?

Therapist#C: 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 and bonding. Although I know strict psycho analytic people don't talk about attachment, but I think they can tie in. I won't get all theoretical! And then to look at her

sort of actual dynamics in terms of how she functions personality-wise and in the way she relates to the world. So I suppose enough depth, it helps me to understand her. 1

Nicky: Could you elaborate further on techniques that you use, maybe it will be helpful to give you some examples like transference, interpretation, projective identification, do you use any of those techniques with her ?

Therapist#C: Ja, I think I do, certainly transfer, because certainly the way she relates to me I'm sure is very similar to the way she relates to her mom. I'll give you one example of that, I've found in the therapy that when she is more open her mom is more okay, when her mom is in a very bad place she has been quite shut down and quite conciliatory and there were months at a point in the therapy where she wouldn't beat me in a game and it was as if she felt I couldn't handle either kind of her neediness or her aggression and so I interpreted that it was like she couldn't burden mom with herself and she needed to kind of make things right for me just like she made it right with mom and that went on for a long time but then when mom got better she started being more open and I think she could see that there was some similarity, so transference definitely, I can't immediately think of examples of projection but I'm sure I do use it. 1,3,4,14

Nicky: Just in terms of what you said, the object relations literature uses a lot of reference to the good enough mother and the good enough therapist. Do you feel that's part of your process with her, is providing a holding functioning in the therapy?

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Therapist#C: I do, because I'm consistent and I think her home has been inconsistent and I think her mom is quite volatile in terms of moods and CHILD C so sensitive to how her mom is and it has such an effect on how she can be, so I would say that it's a holding place, definitely, because it's consistent and it's once a week and all that sort of thing, ja, so I do think that I'm providing her with things that haven't been provided in her life and in her primary relationship.1,3,4,12,13

Nicky: Do you feel this child responds to interpretations that involve her internal world?

Therapist#C: Ja, definitely, not easily all the time, and she sometimes resists them, so I've had to learn to be very gentle and sometimes strategic in the way that I make the interpretation and sometimes I can't and I just speak about the process like she doesn't like it when I say that, or that's hard to hear about, but she does respond. 5,8,4

Nicky: Do you think different things or issues emerge when working with learning disabled children as opposed to other children?

Therapist#C: I think they can, I mean I've wondered if it relates to learning disability or actual IQ because CHILD C is of average intelligence, if I think of some of the kids that I've had, she's been quite low average maybe, and very concrete, you certainly have to work differently and more concretely and they can't, they wouldn't be able to listen to the kind of interpretations that CHILD C can. So I suppose I think it depends on the kind of learning

problem and the actual intelligence level. I don't think I've approached the therapy differently with her than I would approach it with any other child, I don't know if the learning thing's been a big part of it except in one way which I tell you, you can tell me if I should say it now or later? Okay, there has been a big theme and quite a few of the sessions in the later part of the therapy where she's been a bit better have been about feeling like she doesn't have mastery especially over learning and in the classroom, so there's been lots of teacher teacher games, and her feeling nice to be the clever teacher and feeling like she can boss me around, which she'd like to be able to do, and I've never used the actual word learning problem with her but I've certainly spoken about she wishes the work were easier or that she knew the answer or she didn't have to battle so much or that sort of thing. 5,8

Nicky: Does the child use their learning disability in any way to have their needs met or to guard against letting on what their true feelings actually are?

Therapist#C: I don't think she uses her learning disability to do that, I think that's part of her defence, I think her defence structure is that she can't let on how vulnerable she is. 5,8

Nicky: Is that because she's learning disabled, is that your understanding?

Therapist#C: No, that's not my understanding. My understanding is that that's the kind of

personality structure that she's developed because of her life circumstances. But I wouldn't relate it to her learning problem.

Nicky: If you were to put it in a nutshell, how would you say her learning disability has impacted on the therapy?

Therapist#C: I think it's given us some issues to work on, mastery of particularly the scholastic realm and I don't think it's broader than that. Actually, I don't think it's broadened out to mastery over her life in general because there are things she's very good at, like she's a good dancer and I think there are areas where she feels very 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. 2,5,8

Nicky: What other major things can you think offhand have you focussed on in therapy?

Therapist#C: 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, her relationship with her mom who she finds quite impatient at times, although they definitely have a close, very loving but quite fraught relationship. Her dad, her relationship with her step-mother quite a lot and difficulties with her step-mom, so all the family relationships have taken up a lot of the time. And then I suppose a theme of herself and how it's hard for her to show vulnerability because she's had to manage so much in her life and in a way

when she's shown the vulnerability, it hasn't been met, or it's been met with adults equally vulnerable or who kind of take up an equal amount of space.Ja and 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.1,2,6,7,4

Nicky: And how to do you see the role of working with this mother in terms of this child's therapy?

Therapist#C: It's been quite a tricky one, maybe in an ideal world this is the sort of case where the mother shouldn't see me, but see someone else, but I started off with this case in private practice so I saw both parents and CHILD C and I say maybe I shouldn't because CHILD C is quite protective of her space with me and she gets quite threatened when I see her parents, particularly her mom. There was one point in the therapy where MOTHER C was very down and actually suicidal where I had to see her more often, and I'm sure on some level CHILD C understands that that ultimately helps her but I think that has been quite difficult for her, the fact that I see her mother. But then in terms of actual work that I do with MOTHER C is important, an important part of the process because CHILD C needs a lot from her, she needs more consistency, she needs more boundaries from her mom, she needs more understanding, so all 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. 1,3,4,11,12,13

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Nicky: So how do the family relationships affect the therapy process for this little girl?

Therapist#C: Well I haven't spoken about the dad, but one of the big things has been that the mom and the dad spend a lot of their sessions, which are individual sessions, because in the joint session they just fought and it didn't work and we decided it would be more fruitful for them to meet separately, they spent a lot of time moaning about the other parent and blaming the other parent, so we've had to get beyond all that. And then, I mean the other side of the coin is that because I know the parents so well I know what CHILD C lives with, so I suppose that's had a positive effect on my working with her because I can see how the parents are and can then speculate how they relate to her. I suppose it cuts both ways that in some way it's been difficult for CHILD C and there's been a lot of stuff that I've had to work out in my mind about which parent was giving the accurate view or where they were coming from when they were speaking so badly of each other and blaming stuff on each other about CHILD C and so on, but on the other hand, I suppose it's given me a rich picture of the family life. 1

Nicky: And the last question, what is your psycho-analytic formulation of this child, if you were to formulate it?

Therapist#C: I suppose the whole idea of formulating isn't, I mean it's fairly new for me so when I say the formulation, it's stuff that I've come up with but it does come out of supervision as well, and I suppose that I think that the formulation that my supervisor has given does fit, I took this case to

supervision for the first time at a time that I spoke about earlier when CHILD C was not bringing any difficulties or any vulnerability, she was just playing, there was no real stuff in the therapy, so it was first of all no vulnerability, then that it felt quite false to me, and those are two important aspects of her I think, and the suggestion was that she's got a narcissistic personality structure, which means that she finds vulnerability very difficult to deal with because of shame, and also that there's falseness involved, she can't feel real, she can't be real in and of herself because she's never been allowed to be real. And then what I said earlier about her bonding is an important part of the formulation, her mother was depressed when she was little and I think MOTHER C herself said that she didn't cope and she didn't feel that she bonded, and CHILD C's step-sister was very central in bringing her up in those early years, so I think that her bonding didn't go nicely, so her attachment is quite shaky, which allows that sort of personality structure to emerge I suppose. And then the other thing that I just don't know much about, this Kerberg stuff that my supervisor said that what she's internalise is a stranger object so it's someone that she never really got to know, I mean that makes sense to me but that's not a way that I've ever really thought about her, but I can certainly see that MOTHER C does have quite anti-social traits in the way she's conducted her affairs, he has not paid people back money and whatever and CHILD C, certainly in the years, has done things that are mildly conduct disordered, she has lied, and before she came to SCHOOL there was patch of stealing, which I've related all to the early not bonding and the deprivation but I suppose if one wants to attach a label to that, it is psychopathic in the making, which I

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don't like saying, I don't like using those terms, but I suppose it's true, and as you know I'm not mentioning her name, I don't know if it matters, but my supervisor is very straight but she'll always say if the absolute worst case scenario and I suppose CHILD C fits into that and has the potential for that and I hope she won't but I think realistically there's the potential. 1,4,7

Nicky: Just to ask you, would there be anything that you feel is important in terms of the therapy process with this particular child that you haven't covered?

Therapist#C: I don't, I think we've pretty much covered it.

Appendix C: Letters of Consent

University of Pretoria
Department of Psychology
Pretoria
0002
Tel (012) 420-4111

Nicola Powell
P.O.Box 69022
Bryanston
2021
Tel (011) 782-5378 or 082-899-6108

Dear Mrs

I am doing research in play therapy for my doctoral thesis in psychotherapy at the University of Pretoria. When a child enters into therapy the process involves at least three individuals, the child, the parent and the therapist. In order to obtain a more in-depth understanding of the process of therapy with children who are learning disabled I would like to interview your child, your child's therapist and yourself to obtain an understanding of the process of your child's therapy. It is felt research on the process of child psychotherapy can increase the already existing knowledge on the course of treatment and how process affects the outcome or benefit of the therapy, as well as improving the therapist's understanding of the therapist-client relationship. Such information can be seen to aid the development of maximally effective interventions. The title of the research is" Understanding the Process of Psychotherapy with Learning Disabled Children."

The questions I would like to ask are around the experience of therapy and tend to focus on ones thoughts about the therapy. The approach of the research is to use broad open-ended questions to obtain an understanding as to what the child, parent and therapist perceive to be important issues. As a result the research is designed to focus on the meaning given to the therapy as opposed to imposing ideas onto the subjects.

I would therefore like to interview your child, the therapist that is working with your child and you as the mother of the child. I would also like to obtain permission to use the confidential material held in your child's file of assessments and reports at SCHOOLs Remedial School. The interviews will be taped so that the information obtained can be analysed. No identifying information will be used in the research such as the name of the child or the parent.

I hope that the interviews will also be beneficial to yourself, the therapist and your child in that it will allow expression of feelings about being in therapy and a time to reflect on the process.

If you are willing to participate and allow your child to participate in the research, could you please sign this consent form. The participation in this research is voluntary and should you at any point not feel comfortable with your involvement in the study you may withdraw. I thank you for your time and co-operation.

Yours sincerely,

Nicola Powell
Educational Psychologist

CONSENT FORM FOR PSYCHOLOGY DOCTORATE RESEARCH

I _____

(Name of parent) give consent for my child _____

(Name of child) to participate in this research project examining the process of psychotherapy with learning disabled children. I am aware that my child and my child's therapist will be interviewed as to the process of my child's therapy and I, the mother of my child will also be interviewed. I am also aware that identifying details will not be used in the research. I hereby also give permission to use my child's assessment records and school records.

Signed : _____

Date: _____

Researchers Name: Nicola Powell

Researchers signature: _____

Signed on (date) _____

Of (month) _____

At SCHOOLs Remedial School

Nicola Powell
P.O.Box 69022
Bryanston
2021
Tel (011) 782-5378 or 082-899-6108

University of Pretoria
Department of Psychology
Pretoria
0002
Tel (012) 420-4111

Dear PRINCIPALS NAME

I am doing research in play therapy for my doctoral thesis in psychotherapy at the University of Pretoria. I would like to obtain permission to use some of the children who are currently in therapy at NAME school and interview those children, their parents and the psychologist with whom they are in therapy with.

When a child enters into therapy the process involves at least three individuals, the child, the parent and the therapist. In order to obtain a more in-depth understanding of the process of therapy with children who are learning disabled I would like to interview all the participants involved with the process of the therapy. It is felt research on the process of child psychotherapy can increase the already existing knowledge on the course of treatment and how process affects the outcome or benefit of the therapy, as well as improving the therapist's understanding of the therapist-client relationship. Such information can be seen to aid the development of maximally effective interventions. The title of the proposed research is" Understanding the Process of Psychotherapy with Learning Disabled Children."

The question I would like to ask is "Tell me the story of your experience of the therapy process, how it evolved and what it means to you?" The approach of the research is to use a

broad question to obtain an understanding as to what is important to the subjects as opposed to imposing ideas onto the subjects.

I would also like to obtain permission to use the confidential material held in the children's files of assessments and reports at NAME Remedial School. I will obtain consent from the parent to be allowed to use the information in these files for the research. The interviews will be taped so that the information obtained can be analysed. No identifying information will be used in the research such as the name of the child or the parent.

Yours sincerely,
Nicola Powell
Educational Psychologist