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INTERACTIONAL PATTERNS OF CHILDREN ADMITTED TO A PSYCHIATRIC HOSPITAL USING THE MARSCHAK INTERACTION METHOD

by

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Abstract

The aim of this study was to explore the interactional patterns of children who have been admitted to a psychiatric hospital in South Africa and their primary caregivers by means of the Marschak Interaction Method (MIM). This study set out to describe the interactional patterns observed as well as the similarities and differences between the dyads. Attachment theory views the way in which the children interact with their primary caregivers as a crucial influence in their development and functioning. A qualitative research design was implemented to gather information regarding the interactional patterns of the dyads. Three primary caregiver-child dyads participated in this study. The primary caregivers showed similarities in that they were unable to react sensitively to their children's aggression and at times were not attuned to their children's emotional states. The children in the dyads showed similarities in that they took to the lead in the interactions. One child showed a marked difference as he appeared to be more attuned to his primary caregiver's needs and seemed to want to meet these needs. The two remaining children seemed to want to take control in the interactions. This supports the current theory that states that children who are seen to have disorganised interactions attempt to take control in two different forms: controlling punitive or controlling care-giving.

Keywords: Marschak Interaction Method, primary caregiver-child interactions, in-patient, psychiatric hospital

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction

Children are not immune to mental health conditions. In South Africa, children may under serious circumstances be admitted to a psychiatric hospital. The focus of the present study was on these children and their primary caregivers, and in particular, on their relationships with their primary caregivers. The Marschak Interaction Method (MIM) is an instrument that sheds light on the nature of the interaction between such relationships. Given the context, the focus of this study was: *"What does the MIM reveal about the interactional patterns of primary caregiver-child dyads of children admitted to a psychiatric hospital?"*

In this chapter, the background and context of the research, as well as the motivation and purpose of the study are outlined. In section 1.5, the specific terminology that was used throughout this research study is defined. Finally, in section 1.6 an outline of the remaining chapters of the dissertation is presented.

1.2 Background of the study

Existing literature provides the background to this study, as it elucidates the research that has been conducted as well as the context in which this study was located. Literature on existing research also provides insight into what research possibilities still exist.

Children are vulnerable by virtue of their age and at times prone to developing serious mental disorders that require hospitalisation. Recent research indicates that there is an increase in the number of children admitted as in-patients to psychiatric wards in the USA. The reasons for admission include depression, bipolar disorder and psychosis (Bardach et al., 2014). The World Health Organisation (WHO) last collected data reporting the prevalence of child and adolescent mental health disorders in 2005. The data indicated that 20% of children worldwide had been diagnosed with a mental disorder and furthermore, 4 to 6% of these children were in need of clinical interventions such as in-patient treatment (World Health Organisation, 2005).

The family environment is one context that may contribute towards the children's mental health. Attachment theory describes the infant's need to develop a relationship with at least one primary caregiver. This relationship is essential for the infant's successful emotional

development, in particular for learning how to effectively regulate one's affective feelings state. In addition to mothers and fathers, other individuals in the infant's life are seen as equally important to become attachment figures as long as they provide most of the primary child care and related social interaction (Bowlby, 1997; Music, 2011; Santrock, 2009). Attachment research has shown that a child's early relational patterns can have an influence on the developing brain and can lead to a variety of symptoms which affect interactions with others, self-esteem, self-control and learning difficulties as well as other aspects of mental and physical health (Fishbane, 2007; Parritz & Troy, 2014).

The present study addressed the domains of primary caregiver-child interaction and hospitalised children. A great deal of research on the family environment and its impact on a child's functioning was conducted in the 1990s and further studies after 2000 (e.g., Cassidy, Woodhouse, Sherman, Stupica, & Lejuez, 2011; Hoffman, Marvin, Cooper, & Powell, 2006; Kashani, Suarez, Allan, & Reid, 1997; Repetti, Taylor, & Seeman, 2002; Shiner & Marmorstein, 1998; Strauss & Knight, 1999; Warren, Huston, Egeland, & Sroufe, 1997).

When one considers the second domain, that of research on hospitalised children, there is a substantial body of literature. In comparison to studies conducted on children in psychiatric hospitals, there are more studies on children in general hospitals. It appears that there has been a preference to conduct research in general hospitals and not psychiatric hospitals (e.g., Board, 2004; Diaz-Caneja, Gledhill, Weaver, Nadel, & Garralda, 2005; Latour et al., van, 2011). Other studies have focused on a more general experience of children who are hospitalised in general hospitals (Coyne, 2006; Lindeke, Nakai, & Johnson, 2006; Prelander & Leino-Kilpi, 2010).

A decade ago, De la Rey (2006), found that there were only a few studies that had focused on children as in-patients at psychiatric hospitals. Those that have been conducted have focused mostly on available programmes and treatment approaches (e.g., Bates, English, & Kouidou-Giles, 1997; Curtis, Alexander, & Lunghofer, 2001; Leichtman, 2006; Pfeiffer and Strzelecki, 1990). At the beginning of 2016, it appears that the research that has focused on children in in-patient settings is limited. The researcher found that not only is there a lack of research investigating children who are treated as in-patients and their primary caregivers in a psychiatric hospital, but more importantly, there seems to be an absence of this type of research conducted in the South African context.

There has, however, been more recent studies that have focused on the interaction styles between primary caregivers and their children who have not been hospitalised (Martin, Snow, & Sullivan, 2008; Marvin, Cooper, Hoffman, & Powell, 2002). Therapeutic interventions carried out by institutes such as The Circle of Security® and Theraplay® have based their interventions on research that has focused on the primary caregiver and child interactions (Martin et al.; Marvin et al.; Page & Cain, 2009; Powell, Cooper, Hoffman, & Marvin, 2013; Zanetti, Powell, Cooper, & Hoffman, 2011). Considering the review of literature, one can then conclude that there is a lack of research on children and their interactional patterns with their primary caregivers within the psychiatric setting in South Africa[1].

1.3 Context of the study

The present study focused on very specific circumstances and contexts: the psychiatric in-patient facility and the primary caregiver-child dyad. Firstly, a psychiatric hospital and in particular, in-patient treatment of the child that is admitted, and secondly, the psychiatric hospital that was involved in this study is a government run academic hospital in Gauteng province, South Africa. According to De la Rey (2006), it is assumed that the individuals using the services are individuals without medical insurance leaving them unable to make use of private facilities. Therefore, one needs to acknowledge that it is often families from a lower socio-economic status that may make use of the hospital.

However, in the researcher's opinion one must be careful when making such assumptions, as the hospital in question is one of the few hospitals in the Gauteng region that offers in-patient treatment for children younger than 12 years of age. Therefore, some of the hospital users do in fact have medical insurance, but use the hospital as it is their only option.

This investigation was not solely directed towards the child for it was about the child and the child's primary caregiver, and their interactional patterns. Thus, the specific context of this dyad's relational processes was taken into consideration. [1]

1.4 Motivation for the study

This appears to be a paucity of information regarding the interactional patterns of child-caregiver dyads admitted to psychiatric hospitals in both South African literature and that throughout the world. The value of this study is that it could contribute to the

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[1] A literature review was conducted by the researcher, her supervisor as well as the Information Specialist for Social work & Criminology, Psychology at the University of Pretoria in 2015.

understanding of the interactional patterns of children who have been admitted into the children's ward of a psychiatric institution. As such it will extend knowledge and literature in this area. Limited research with regard to children admitted to a psychiatric hospital has been established. This was the primary motivation for this study as there appeared to be a gap in research of this nature.

Literature has shown (De la Ray, 2006; Eloff & Moen, 2003; Martin et al.,2008; Mckay, Pickens, & Stewart, 1996) that the way in which the caregiver and child interact has an effect on the child's psychological functioning. Therefore, using the MIM and observing these interactions, the researcher would be able to describe the type of interactions that the dyads display as well as describe similarities displayed by the patients and their caregivers in the hospital.

The therapeutic value of this research lies in the contribution it may add to the understanding of the interpersonal patterns of these children. Understanding these patterns may aid in the promotion of therapists taking a more holistic view when dealing with children in these circumstances. This could lead to interventions focusing not only on the child, but on their environment, which include the type of relationships they have with their primary caregivers.

It is hoped that the present study will promote attachment-based interventions for children and their primary caregivers which have proved to have positive outcomes in programmes that have been implemented in other parts of the world (Martin et al., 2008; Marvin et al., 2002; Page & Cain, 2009; Powell et al., 2013; Zanetti et al., 2011) The researcher hoped that exploring this topic would also add to the development and enhancement of new forms of therapy, with a greater understanding of how these children interact with their primary caregivers and how the caregiver responds to the child. This would, in turn, add to the professional's understanding of how the interactional patterns impact on the child's psychological dysfunction.

With this new understanding of the primary caregiver-child dyad, professionals in South Africa may be able to facilitate change in interactional patterns. From a theoretical perspective, this research study would also add to understanding the interactional patterns displayed by children diagnosed with psychiatric disorders and their primary caregivers**.**

1.5 Purpose of the study

The focus of the research project was to investigate interactional patterns by directly observing the caregiver and child. The MIM observation method was employed to investigate these interactional patterns. The MIM is a play-based, structured technique for observing and assessing the relationship between a primary caregiver and child. Myrow (2000) stated that with the use of the MIM, the researcher/therapist is able to observe the actual interaction of caregiver and child and therefore, identify patterns that reflect the quality of the relationship. He also stated that these interactions can offer clues about the quality of the attachment. The principles of the MIM are based on attachment theory, inter-subjectivity and brain research (Booth & Jemberg, 2010; Lindaman, Booth, & Chambers, 2000).

Attachment theory sees attachment and the way in which children interact with their caregivers as a crucial influence in the child's development and functioning. Research (e.g., Lyons-Ruth, Dutra, Schuder & Bianchi, 2006; Tronick, 1989) has confirmed this link and the literature review, particular in the South African context, has shown that research in this area is limited. This link is, therefore, important to note when exploring the relational patterns of the dyads. If the child presents with any problems regarding self-esteem, self-control, learning difficulties as well as other aspects of mental and physical health, one may be able to identify repetitions in the relational patterns that may have contributed to the child's difficulties.

In the present study, the following question was asked: What does the MIM reveal about the interactional patterns of primary caregiver-child dyads of children admitted to a psychiatric hospital?
The aim of this study was to explore the interactional patterns of children who have been admitted to a psychiatric institution and their primary caregivers by means of the MIM.
The first objective of this study was to provide a description of the interactional patterns observed between primary caregiver-child dyads. The second objective was to explore and describe the similarities and differences in the interactions of the participating primary caregiver and child dyads. Finally, the third objective was to attempt to understand these observations by means of attachment theory.

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1.6 Specific terminology

Several concepts specific to this study are defined as follows:

- A *dyad* may be described as "…pair; specifically two individuals (as husband and wife) maintaining a sociologically significant relationship…" (In Merriam Webster Online, n.d.).

- *Child* as defined by the Children's Act 38 of 2005 "…means a person under the age of 18…". 'Child' in this study referred to the children admitted to a children's ward in a psychiatric hospital; this population referred to children between the ages of three and 12 (Children's Act 28, 2005, p. 12).

- *Primary caregiver* may be defined as "…A person who cares for, nurtures, loves and looks after one or more children; his/her role is similar to that of a parent…" (Department of Social Development, 2008, p. 5).

- An *interactional pattern* refers to the behaviour of the child in response to their caregiver and the caregiver's response to the child (Moen, 2003).

- *Psychiatric hospital* made use of the definition provided by the Mental Health Care Act 17 of 2002, namely, "…a health establishment that provides care, treatment and rehabilitation services only for users with mental illness…" (Mental Health Care Act, 2002, p. 6).

- *The Marschak Interaction Method (MIM)* is a structured technique employed to observe and assess different features of a relationship between a child and the primary caregiver. It consists of a set of simple tasks that are intended to elicit behaviours in four dimensions: structure, challenge, engagement and nurture (Booth & Jernberg, 2010; Lindaman et al.,2000) The aim of the MIM is not therapeutic, but it is a method of assessment to inform a particular therapeutic intervention, namely, Theraplay®.

1.7 Outline of dissertation

This study consists of six chapters. In Chapter Two, the specific theoretical approach that was used in this study as well as other relevant literature that relates to interactional patterns and its influence on the child's functioning is discussed. The manner in which these interactions may be explored and the children in the psychiatric context are also examined. In Chapter Three, there is an overview of the research process and in Chapter Four, the results

of the analysis of the data are presented. An interpretation of the results follows in Chapter Five and the study is concluded in Chapter Six.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter commences with a discussion of the theoretical orientation of the study. Most of the emphasis is placed on the pioneers of attachment theory, namely, John Bowlby (1997, 1998) and Mary Ainsworth (1967). Furthermore, additional developments of attachment theory and primary caregiver interactions by Harlow, (1958), Tronick, (1989) and Marschak (1960) are considered. Attachment theory has its focus on the interactional patterns as it plays out between a primary caregiver-child dyad. Bowlby (1997, 1998) described how early attachment establishes the dynamics of long-term relations between humans.

One way in which clinicians and researchers observe and assess interactional patterns between primary caregivers and children is by means of the Marschak Interaction Method (MIM). In the next section, close attention is given to the origins, assumptions and uses of the MIM. The last section of this chapter addresses literature specific to the child in a psychiatric context, focusing on the mental health of South Africa's children.

2.2 Theoretical point of departure

Several factors can influence a child's psychological development and functioning; however, many may argue that the most important factor is the child's relationship with the primary caregiver and more specifically, the nature of the interactional patterns between this dyad. The importance of this relationship has its roots in the work of Marschak (1960). Attachment theory has had a great impact on both clinical practice and research within the psychological field and it is currently the leading framework for understanding a child's social and emotional development (Powell et al.,2013).

2.2.1. Attachment and relational patterns

Attachment theory attempts to explain how humans respond to specific relational patterns. It describes, for instance, how the individuals will respond within the relationship when separation occurs, when they are hurt or when they are challenged (Bowlby, 1997; Kerig, Ludlow, & Wenar, 2012). For infants, the attachment is understood to be a motivational and behavioural system that directs the infant to seek proximity with his or her primary caregiver. The need for attachment and development thereof seems to be innate (Bowlby, 1998).

John Bowlby transformed the way in which individuals thought about children and their attachment to their primary caregiver; he expanded on the way in which a child is disrupted through separation, deprivation and bereavement. Bowlby formulated the basic tenets of his theory by drawing on concepts from ethology, cybernetics, information processing, developmental psychology and psychoanalysis (Bretherton, 1992).

Bowlby (1997) explained that the infant develops attachments to a primary caregiver as well as familiar caregivers and this can be seen as the result of evolutionary pressures. Attachment behaviour is considered necessary for the infant's survival in the face of danger from external elements. In support of the concept of attachment as evolutionary, research has shown that attachment is not a western norm, but rather a biological and evolutionary process, which occurs for all human beings (Fishbane, 2007; Parritz & Troy, 2014). Attachment, thus, has an evolutionary basis, but the primary caregiver is not the only object with whom such a bond can be established.

Mary Ainsworth, a student of Bowlby, was able to further demonstrate this point as she conducted field studies which involved detailed observations of mothers and babies in Uganda. Ainsworth's ground-breaking methodology made it possible to test some of Bowlby's ideas empirically. Her findings helped to expand the theory itself (Ainsworth, 1967).

Fathers and other individuals in the infant's life are seen as equally important to become primary attachment figures as long as they provide most of the childcare and related social interactions (Bowlby, 1997; Music, 2011; Santrock, 2009). The development of attachment is important for the development of an individual's ability to regulate emotions and has an influence on various aspects of human development.

Attachment research has shown that a child's early relational patterns has an influence on the developing brain, which leads to a variety of signs and symptoms such as interactional styles with others, self-esteem, self-control, learning difficulties as well as other aspects of mental and physical health (Fishbane, 2007; Parritz & Troy, 2014). Steele (2003) identified four assumptions which explain the principles of Bowlby's attachment theory.

The first assumption explains that our survival as individuals and as the human race depends on the capacity to establish and maintain an emotional relationship with others. This is evident from birth and can be seen throughout the individual's life span. It is especially

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evident in times of crisis, that is, the drive to cry, reach out to others and hold on to others, and can be seen as a functional expression of our biological make-up which is evolutionary. These conclusions were made by Bowlby in a new model of human motivation which resulted from advances in neurochemical, cognitive and evolutionary theory (Parritz & Troy, 2014; Steele, 2003).

Ainsworth's research with mothers and their children in Uganda helped develop some critical elements of attachments. These findings rose from her observations which took place outside of the western world. These observations in Uganda enabled Ainsworth to see attachment as a system of species, instead of being culturally specific. In addition, she advanced the concept of the attachment figure as a secure base from which an infant can explore the world. Furthermore, she elaborated on the concept of maternal sensitivity to the infant signals and its role in the development of infant-mother attachment patterns (Ainsworth, 1967; Parritz & Troy, 2014). The assessment of a strange situation is one that was originally used by Ainsworth, which she used to observe attachment relationships between the caregiver and the child. Comparatively, the MIM is an assessment used to observe the interactional patterns between the caregiver and the child.

The second assumption stresses the idea that how a child is treated has a significant impact on an individual's development and specifically, later personality functioning (Steele, 2003). To state that the way in which a caregiver treats a child is important may be obvious to most. However, historically some analysts suggested that the focus of clinical energies of a child or an infant was based upon the caregivers or the child's fantasy; Bowlby rejected this claim and stated that clinicians need to know as far as possible what might have happened to the individual child as this would affect the intervention depending on what one knows about the child's actual experience (Music, 2011; Steele, 2003). Therefore, the present researcher supported the assumption that knowing the way in which a child is treated and understanding the way in which he/she feels is of utmost importance for psychologists to know as it will enable them to plan the individual's treatment accordingly. In this study, the way the child is treated and the way in which the child reacts was observed and therefore, the researcher attempted to understand the effect of the different interactional patterns and the different outcomes of the way in which the child is treated.

According to the third assumption, attachment behaviour is to be viewed as part of an organisational system. This system utilises the concept of an internal working model in which

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the individual holds beliefs about the self and about the other, and how to direct their behaviour (Steele, 2003). The attachment relationship provides the individual with a model to guide their behaviour. The attachment relationship influences the way they see themselves and their world, and this will affect later attachment and personal and social adaption (Fishbane, 2007; Parritz & Troy, 2014).

The fourth assumption extrapolated by Steele (2003) addresses change. On the one hand, typical attachment behaviour seems quite impervious to change. However, according to attachment theory, there is an ongoing potential for change. This acknowledgement for change means that a person is unlikely to ever be impermeable to either favourable influences or adversity. Therefore, the findings of the present study can build on literature that attempts to develop early intervention treatments that are based on the interactional patterns and attachment relationship. Thus, if one is to observe a relational pattern that is dysfunctional then it has the potential to change with intervention and therapy.

In this section, it was argued that a child's early relational pattern has an influence on the developing brain which leads to a variety of signs and symptoms such as interactional styles with others, self-esteem, self-control, learning difficulties as well as other aspects of mental and physical health. In this section, the need for attachment being innate and not a phenomenon of the west was examined. However, attachment is not just one type of relational dynamic; it differs among individuals and is open to change.

No other variables have more far-reaching effects on personality development than children's experiences within the family. Starting during their first months in their relation to both parents, they build up working models of how attachment figures are likely to behave towards them in any of a variety of situations; on all those models, all their expectations and therefore, all their plans are based, for the rest of their lives (Bowlby, 1973, p.369).

2.2.2 Individual differences in attachment

Bowlby explained that the way in which children experience their family will have a profound effect on their personality and attachment style. Within one's immediate family environment, they will experience different interactional patterns and develop different attachment styles. This was first observed when Mary Ainsworth was conducting observations studying the different ways in which infants react to their primary caregivers when separated, reunited and introduced to a stranger (Ainsworth & Bell, 1970).

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Ainsworth and Bell (1970) identified three main attachment styles, namely, secure (Type B), insecure-avoidant (Type A) and insecure ambivalent/resistant (Type C). She concluded that these attachment styles were the result of early interactions with the mother. A fourth attachment style known as disorganized was later identified (Main & Solomon, 1990).

Individual differences arise due to specific care-giving, interactional patterns and histories that become internalised early on in development. These specific interactional patterns are observed in various countries and cultures (Gross, 2003; Parritz & Troy, 2014).Several factors contribute to the development of individual differences.

The way in which the child is handled with regards to sensitivity, availability and predictability will contribute to a child's emotionally prominent beliefs and expectations. In addition, the affection, direction from the caregiver, stress tolerance of the caregiver, interruption of emotional contact (separation), identification, communication and playfulness all contribute to the individual's development of self (Parritz & Troy, 2014). Furthermore, attachment theory maintains that adult attachment styles will also have an effect on their relationships with other adults and with their children, and that secure and insecure attachment styles might be transmitted from one generation to the next (Rholes, Simpson, & Friedman, 2006).

2.2.3 Different types of attachment

Four different types of attachment have been identified. The normative states associated with attachment styles are feelings of vulnerability when separated from attachment figures and feeling a sense of security when with their primary caregiver. When infants are distressed, their internal system produces specific types of behaviours to seek physical and psychological proximity to attachment figures (Rholes et al., 2006).

Bowlby described that an individual who has formed a secure attachment "is likely to possess a representational model of attachment figure(s) as being available, responsive, and helpful and a complementary model of himself as at least a potentially lovable and valuable person"(Bowlby, 1980, p. 242).

Children that are securely attached will possess a positive sense of self and others around them and they are more likely to "approach the world with confidence and, when faced with potentially alarming situations, is likely to tackle them effectively or to seek help in doing so" (Bowlby, 1973, p. 208).

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However, children whose emotional needs have not been sufficiently met see the world "comfortless and unpredictable; and they respond either by shrinking from it or doing battle with it" (Bowlby, 1973, p. 208).

The disturbance of an interaction between a primary caregiver and the child usually results in an insecure attachment and this is seen as one of the main causes of psychopathology as the child usually feels chronic anxiety and distrust. The faulty attachment style leaves these children feeling less able to cope with difficult experiences and emotions, and they are more likely to behave in a way that leaves them in difficult circumstances and with challenging emotions (Bowlby, 1998).

Interactions with primary caregivers can change the way in which the attachment style functions. If infants seek comfort and their primary caregiver regularly accepts them and helps the infants regulate and the caregiver responds to emotional states, secure attachments typically develop. However, if infants try to seek proximity with the caregiver during times of distress and they are continuously rejected or if they experience a combination of acceptance and rejection, insecure attachment patterns typically develop (Rholes et al., 2006). Each attachment style is thus discussed in more detail:

Secure *attachment*

Schore (2000) has contended that attachment theory can be understood as a regulatory theory. He explained that the interaction between a secure primary caregiver and infant is that the caregiver is able to continuously regulate the infant's shifting arousal levels and inevitably the infant's emotional states. This is done at an intuitive, non-conscious level.

Srofe (1996) defined attachment as a dyadic regulation of emotion, and as a result of the infant being exposed to the primary caregiver's own regulatory abilities, he/she is able to adapt to the stressful changes in the external environment, more importantly in the social environment. This regulation allows the child to develop appropriate responses to cope with stressors. It is important to note that this does not only include unpleasant experiences, but also normal, everyday experiences such as happiness and excitement.

A secure attachment can be described as the primary caregiver being used by the child as a secure base from which the child is able to explore. If the child is separated from the parent, the child may protest; however, upon being reunited the child will seek contact and will

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easily be soothed. Furthermore, the caregiver's behaviour is responsive and non-intrusive (Rholes et al., 2006).

A history of warm and consistent parenting is related to 'secure' (Type B) attachment, which is characterised by the child's use of the attachment figure as a secure base from which to explore, appropriate distress during separation from the caregiver, and age-appropriate affective engagement with the attachment figure (Rholes et al., 2006).

Insecure-avoidant (Type A)

When attachments are categorised as insecure-avoidant, infants are seen to be reluctant to seek comfort from caregivers and are suggested to minimise the expression of negative emotions. This type of attachment is associated with a primary caregiver whom the child has experienced to be rejecting and/or negative. Furthermore, it is characterised by limited emotional and physical engagement with, a marked avoidance of, and failure to seek comfort from the attachment figure (Dorothee, Bakermans-Kranenburg, & Van Ijzendoon, 2009).

An avoidant attachment can be described as the child being precociously independent. When the child and caregiver are separated, the child has a minimal reaction and when reunited, avoids proximity. The child appears to be comfortable with the separation; however, they do feel a sense of stress, but choose to not show this. The primary caregiver's behaviour is unresponsive and rejecting (Kerig et al., 2012).

Insecure ambivalent/resistant (Type C)

This type of attachment style is related to the inconsistency of the primary caregiver. The child has a need for the attachment figure that inhibits independence, and experiences difficulty separating from the attachment figure and difficulty in deriving comfort from the primary caregiver (Dorothee et al., 2009).

Children with insecure ambivalent/resistant attachment can be seen to maximise the expression of negative emotions and the display of attachment behaviours so that they can draw the attention of their inconsistently responsive caregiver. These children have been observed to remain passively or aggressively angry at the primary caregiver (Dorothee et al., 2009).

An insecure ambivalent/resistant attachment can be described as the child being clingy and not able to explore his/her environment without much anxiety. When separated from the

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primary caregiver, the child is highly distressed and when reunited the child is not able to be soothed easily, but will seek and reject proximity concurrently. The primary caregiver's behaviour can be described as inconsistent. When the child is anxious, the caregiver has little capacity to calm distress and create feelings of security (Kerig et al., 2012).

Disorganised attachment

Disorganised attachment is described by Main and Solomon (1990) as the irresolvable paradox that arises when the primary caregiver of the child is both the cause of the child's fear and the refuge in which the child tries to find safety. This contradiction leaves children feeling constantly afraid to the point that they feel they are able to lose emotional and behavioural control, but they are unable to source adults for help as they do not see them as a solution to their chronic stress.

According to Dorothee et al. (2009), an unbalanced interaction can develop into an unbalanced primary caregiver–child relationship, which is likely to manifest in emotional and/or physical withdrawal as well as unresponsiveness from the primary caregiver and/or in negative, hostile and intrusive behaviours. These behaviours, along with the parent's incapacity to repair their disruptions, leave the child in a state of extreme fear.

Lyons-Ruth, Bronfman and Atwood (1999) hypothesised that misattuned caregivers' responses to their children's attachment needs are frightening because of their inability to influence the behaviour of the primary caregiver when the children are anxious and stressed. When a child, for example, cries for comfort and his/her primary caregiver does not respond, his/her need for calming goes unmet and even by crying the child is not able to influence the primary caregiver's behaviour. Therefore, the disorganised child is raised in the context of fear, which can manifest in two ways:

1) Hostile intrusiveness; hostile intrusive behaviour is directly frightening to the infant, and includes physical abuse, frequent and intense physical punishment, angry outbursts from the primary caregiver and/or the primary caregiver being psychological unavailable.

2) Helpless withdrawal of maternal behaviour where non-hostile and superficially responsive behaviour is combined with subtle fearfulness; for example, the primary caregiver being anxious, nervous, disorganised or being in a dissociative detached state which will be distressing or alarming to the distressed child that is in need of comfort and security.

According to Allan, Fonagy and Bateman (2012), children develop controlling strategies of interacting with their primary caregiver. This can be seen as the child's frantic effort to reconstruct their relationship. These strategies of control can take two different forms:

1.) The children are controlling and punitive, and they become aggressive both physically and verbally towards their primary caregivers. The child will attack and humiliate the primary caregiver in order to manage the relationship.

2.) The complete opposite may develop in which the children become controlling in a care-giving manner in which they attempt to entertain, direct, organise or reassure the primary caregiver in order to maintain the relationship.

Although the majority of children will develop one of these, some children will remain behaviourally disorganised. These children remain disorganised, showing unpredictable behaviour and confusion. They have been unable to adopt any effective strategy for maintaining proximity to their primary caregiver.

A disorganised attachment can be described as the child's behaviour being inconsistent. When separated from their primary caregiver they display odd behaviours and when reunited the children display distorted attempts to seek proximity. The caregiver's behaviour is coercive, frightening at times and shows the children mixed signals. A disorganised attachment is an indicator of high risk for mental health problems of the child (Kerig et al., 2012).

Bowlby (1997, 1998) powerfully illustrated and described how a child's relationship with his/her primary caregiver provides the foundation for later social-emotional development. The way in which the early attachment relationship is formed becomes the foundation on which later representational models of self and attachment figures are constructed. Such models strongly influence the ways in which a child relates to others, approaches the environment and resolves critical issues in later stages of development; these strategies to cope with the environment, relationships and stressors are seen as the child's attachment style. In the next section of this chapter, the way in which the primary caregiver and the child interact and the influence this interaction can have on their psychological functioning is explored further.

2.3 The psychological impact of primary caregiver and child interactions.

Harry Harlow who became interested in the study of love in the late 1950s stated, "The initial love responses of the human being are those made by the infant to the mother or some mother surrogate. From this intimate attachment of the child to the mother, multiple learned and generalized affectional responses are formed (1958, p. 673).

Harlow was of the opinion that not enough research was conducted on love. Many of the theories at the time expressed the thought that the primary caregiver-child attachment was for the child to satisfy his/her primary needs of hunger, thirst and safety (Harlow, 1958).

In order to investigate this phenomenon, Harlow removed infant monkeys from their mothers after birth and replaced their biological mothers with surrogates, in the form of a soft cloth or wire surrogate. The wire surrogate provided food; however, the soft cloth surrogate did not. It was found that when the infant monkeys were presented with both surrogates, they preferred to spend most of their time with the cloth surrogate mother than the wire one; illustrating that comfort is extremely important in the development of the infant (Harlow, 1958).

In additional experiments conducted by Harlow (Harlow, 1973, 1975) he also illustrated that love, affect and interpersonal relationships were vital for the infant's development and illustrated that long-term devastation caused by the deprivation of love and interaction can lead to a high risk of serious psychological and emotional stress or even death. Harlow's experiments and work began to influence the way in which primary caregivers and care-giving facilities approached childcare.

Another ground breaking experiment surfaced in the late 1970s which also influenced the way in which researchers understood the primary caregiver-child interaction. The 'Still Face Experiment' introduced by Edward Tronick in 1975 remains one of the most replicated findings in child development psychology. In this experiment, Tronick (1989) explained the primary caregiver-infant interaction; however, he also illustrated how the infant became emotionless when the caregiver did not respond. When met with the latter, it was noted that the infant became anxious and repeatedly attempted to gain back the interaction of its primary caregiver. After many failed attempts the infant was seen withdrawing, looked away from his primary caregiver and became distressed (Adamson & Frick, 2003).

The 'Still Face Experiment' has been tested and replicated many times and has become a standard method for testing an infant's perception, communication, differences in

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attachment and culture as well as effects of maternal depression in children. What Tronick and his colleagues were able to demonstrate is that from an extremely young age, infants are in tune with emotional interaction and have the basic building blocks of social interaction. They have a sense of interactional patterns in a relationship and they are able to make sense of facial and bodily expressions (Adamson & Frick, 2003).

The infant attempting to re-engage with their primary caregiver over and over demonstrates that from a very early age a child already has the ability to plan and execute simple goal-directed behaviours, especially with regards to interaction with the primary caregiver, which seems important for the child's survival. When the infants are not engaged, they do have to some extent the capability to regulate their own emotional affect. This shows that from very early on infants adapt strategies to cope with mistuned interaction with their primary caregivers (Adamson & Frick, 2003).

Both these fundamental experiments helped theorists to understand that the interaction between a primary caregiver and a child is extremely important. This was something with which Maureen Marschak (1960), the developer of the MIM, strongly agreed.

According to Marschak (1960), the interaction between a child and the primary caregiver is a vital aspect involved in the formation of the child's psychological functioning, such as his/her personality, behaviour and coping mechanisms. A child's initial relationship with a primary caregiver influences the foundation of future relationships. This influence on the child's functioning is due to the fact that the interaction will affect what the child perceives how a situation is experienced, and which individuals and situations are sought after. This relates strongly to Bowlby's understanding of how internal representational patterns are developed. It is as if it is a template for all future relationships and this template is developed in the earliest of interactions (Bowlby, 1997, 1998).

According to Marrone (2002), the primary caregiver's behaviour and interaction with a child is of extreme importance and will have an impact on his/her future functioning and behaviour. The way in which the primary caregiver holds the child, feeds the child and responds to the child provides the child with the first organisers of psychic life. As the child grows, optimal regulation of the interaction distance promotes a sense of separateness and individuation that the growing child needs in order to explore and learn from the environment (Powell et al., 2013; Marrone). Marrone identified the following five variables as crucial to the child's optimal development: frequent physical contact; sensitive responses to child's

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signals; freedom to explore; an environment which the child derives a sense of consequence for his actions; and mutual delight of the child and mother in their interactions together.

Several studies have attempted to examine the interactional patterns between the primary caregiver and the child, by looking directly at the child and primary caregiver's behaviour. In the next section, a few of the studies which have observed the interactional patterns and described the different outcomes of the child and primary caregiver's behaviour are examined.

About five decades ago, Marschak (1967) investigated imitation and participation interactions of children and their caregivers in two different groups of young boys. One group of boys had been diagnosed with a mental disorder and the other group had not. The findings suggest that certain characteristics were displayed more by the children that had been diagnosed with a mental disorder. For instance, with regards to imitation, these children showed less ability to spontaneously imitate a previously modelled activity and this group of children also showed less sustained visual attention to their parent when compared to the control group. This study also concluded that the parent's characteristics for these two groups of boys also differed. Parents of the children who were diagnosed with a mental disorder showed less positive affect and practised strict control (Marschak, 1967).

Eyberg and Robinson (1982) looked at the effect of parent-child interaction training and its effects on family functioning. The results indicated that after the training, the parents are able to change their interactional patterns and the behaviour of their children. The parents in this study were able to learn how to interact non-directly with their children, and minimise correction and criticism. All the children in this study became less deviant and engaged less in attention-seeking behaviours. This study provides support for the indication that parental-child interaction contributes to the child's psychological functioning and behaviour. This study also suggests that it is possible to alter interactional patterns so that family members are able to better relate to one another and deal more effectively with problems (Eyberg & Robinson).

Jacob and Johnson (1997) investigated the parent-child interaction among depressed fathers and mothers, and the impact on the child's functioning. The results indicated that paternal and maternal depression was associated with the child experiencing adjustment problems and more impaired parent-child communication.

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Harlow's (1958) experiments with infant monkeys, Tronick's (1989) "Still Face Experiment" with human infant and the three studies discussed above are just a few studies that have helped to develop literature on the impact caregiver and child interactions have had on the psychological functioning and behaviour of the child, and the importance of the interaction between the dyad.

One method which was developed to assess and understand the interactions between a child and his/her primary caregiver is the MIM. In the next section, the MIM is explained.

2.4 The Marschak Interaction Method (MIM)

The MIM is a play-based observation used to evaluate primary caregiver–child relationships and interactional patterns. Attachment theory and attachment-based play are two foundational pillars upon which the MIM model is built. The MIM was developed by the Theraplay® Institute which believes that a caregiver's involvement in the child's life is an essential part of the child's development. The focus of Theraplay® treatment is the primary caregiver-child relationship with one of the main goals being that the caregiver is provided with a new positive and healthy way of interacting with his/her child (Booth & Jernberg, 2010)

2.4.1 History and background

The MIM is a structured technique which is employed to observe and assess the interaction and relationship between two people. The MIM was developed in the western world; however, it is deemed suitable for use in the South African context as attachment is a universal phenomenon. In the present study, the MIM assessed the interaction between a primary caregiver and his/her child as they perform a series of structured tasks together (Booth, Christensen & Lindaman, 2011). The original model was called Controlled Interaction Schedule (CIS) and depicted a variety of already existing techniques that were used for the observation of infants and children. For example, the task for infants in which the adult attempts to elicit imitation of facial expressions from the new-born child is drawn from work done by Meltzoff and Moore (1977) on the early imitation of an infant. These tasks were designed to examine only the child's behaviour; when they were used in the MIM both the adults and the child's behaviour were assessed (Booth et al., 2011).

In 1958, with the support of Yale Child Study Centre, Marschak developed this observational method. Marshack used this method to study and observe recently immigrated Polish and

Italian fathers and their pre-school sons. In 1967 she also used this technique to observe families in rural Japan. Furthermore, in 1970 Marshack examined the interactions of children who were kibbutz-reared and home-reared, and compared their interactions with both their on-site caregivers and their own parents (Booth et al., 2011). In addition to this, during 1962 and 1966 Marschak used the technique to study children diagnosed with schizophrenia in interaction with both of their parents.

Ann Jernberg and others at The Theraplay Institute® modified the original CIS for three different developmental levels: pre-natal, infant and pre-school/school age children. They also prepared different manuals and cards for each level (Booth et al., 2011).

The MIM is used in a variety of different settings, such as clinical evaluation of birth parent-child relationships, assessing the appropriateness of placement with foster or adoptive parents, and evaluating the relationship between the child and its step parent (Booth et al., 2011). The MIM has been proved useful in answering questions about the primary caregiver's integration when relating to his/her child and how siblings can stimulate different responses from the same set of caregivers (Booth et al.) Currently, there is a Marschak Interaction Method Rating system being developed so as to be able to use the MIM in a quantitative manner.

2.4.2 Dimensions of behaviour elicited through the MIM

Both the child and the caregiver in the dyad are observed for each dimension. The primary caregiver's involvement is evaluated to see how well he/she can (Booth et al.):

- *Structure the environment, provide safety, set clear appropriate limits and co-regulate the child's experience*
- *Engage the child in interaction that leads to optimal arousal and joyful connection*
- *Respond in an empathic, nurturing manner that calms and soothes the child when needed and conveys a sense of self worth*
- *Provide appropriate challenges that create a sense of competence and pleasure in mastery*

The child's involvement is evaluated to see how well he or she can:

- *Accept structure from the adult, as opposed to insisting on being in charge*
- *Engage with the adult, as opposed to being avoidant or super-independent*

- *Accept nurturing care from the adult, as opposed to looking only to him/herself for comfort*
- *Respond to appropriate challenges, as opposed to being helpless and clinging, or being competitive and making demands on him/herself that are too high*

2.4.3 The MIM and the assessment of attachment

The MIM is often used as a clinical tool to observe and assess the nature and the quality of the relationship of the primary caregiver and his/her child, in order to plan for intervention to improve the relationship between the dyad. At the primary care hospital where the present study took place, the MIM is often used to determine the primary caregivers' capacity to care for the child, including the dyad's capacity to form a relationship and the quality of the current relationship. The MIM is also used to assess the relationship between the child and two or more of the primary caregivers such as mothers, fathers and grandparents (Booth et al., 2011).

Interactional Patterns and the Marschak Interaction Method

In order to understand the interactional patterns, there are a wide range of assessments that are available such as The Strange Situation (Ainsworth & Bell, 1970) which looks closely at the child-caregiver attachments; The Attachment Q-sort (Posada, et al., 1995 as cited in Martin et al. 2008) which looks at the value of the child's secure base in their home environment; The Parental Bonding Instrument, (Parker et al., 1979 as cited in Martin et al.) this looks at the parent's contribution to the parent-child interactions; and the Still Face Experiment which was discussed previously, but focuses solely on infants and toddlers (Tronick, 1989).

Interactional patterns between caregivers and children of any age, that is, 0-18 years and above can be assessed using the MIM. The focus of this research project was the investigation of interactional patterns evaluated through directly observing the caregiver and child using the MIM observation method. Myrow (2000) stated that with the use of the MIM, the researcher is able to observe the actual interaction of caregiver and child, and therefore, can identify patterns that reflect the quality of the relationship. He also stated that these interactions can offer clues about the quality of the attachment between caregiver and child.

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This study employed the MIM. When reviewing research that has assessed temporal characteristics by using the MIM, it appears that there has been a consistent albeit not abundant amount of research published. McKay et al. (1996) investigated the effect of parental stress on primary caregiver-child interactions using the MIM. They found that parents reporting more stress displayed significantly lower quality parent-child interactions.

Eloff and Moen (2003) analysed the interactional patterns of mother-child dyads in a South African prison. The study found that the interactional patterns in prison were affected by the mothers' experiences of the restrictiveness of the prison environment and the lack of exclusivity of the mother-child attachment process. The study found that the mothers were inattentive to their children in situations that their children might have perceived as stressful. The study also revealed that there was an absence of imaginative play.

Martin et al. (2008) investigated the patterns of relating between mothers and preschool-aged children by using the Marschak Interaction Method Rating system. They found that the mother's capacity to structure, challenge, engage, nurture and facilitate her child's regulatory processes had a positive influence on the child's ability to explore, on reciprocity with the parent and increased the regulatory behaviour demonstrated. This study found that a parent who was not able to structure, challenge, engage, nurture and facilitate her child's regulatory processes had a negative impact on the child, who was not able to explore the environment and self-regulate. The child also seemed to be uncomfortable and unable to communicate with his/her parent (Martin et al.)

Studies such as the latter are employed to describe the relationship observed between the primary caregiver and the child. The MIM enables the researcher to observe and systematically record the behaviour and the interaction of the primary caregiver-child dyad based on the four dimensions of structure, nurture, engagement and challenge.

One area of research that seems to be limited, especially in the South African context, is looking at the interactional patterns of children admitted to a psychiatric hospital. In the next section, the circumstances under which children are admitted, studies that focused on in-patient treatment and the current situation of child psychiatry in South Africa are explored.

2.5 Children admitted to a psychiatric hospital

In-patient treatment for children in a psychiatric ward usually offers assessment and intensive care for children who are suffering from some of the most serious mental health problems in the community (Green & Jacobs, 1998).

2.5.1 In-patient psychiatric treatment for children

Deciding to admit a child to a psychiatric hospital is usually not taken very lightly and many aspects of the situation are taken into consideration before a multi-disciplinary team makes this decision. Mental health professionals are mindful that they are removing the child from their family environment and community while exposing him/her to an organised treatment programme. The decision is also based on the foundation of the Children's Act 38 of 2005 and the Mental Health Care Act 17 of 2002 in acting in the best interest of the child. The team takes into consideration the vigorous preparation for admission as well as the visiting policies of the ward while attempting to involve the family and the community agencies such as social workers in the child's treatment plan (Green & Jacobs, 1998).

However, attention to the individual child is sometimes essential to uncover distinct developmental or biological difficulties that have a very strong impact on the child's development and functioning. In addition to this, temporary removal of a child from his/her immediate environment proves to be positive as it enables the team to identify and uncover origins of disturbance such as covert abuse. According to Green and Jacobs (1998), the child has just as much right to this kind of individual assessment and care as it has a right to grow within a family context.

However, in-patient treatment for the child is short-term and often the child is relieved of symptoms and makes developmental growth during the treatment at the hospital, but is put at further risk when returning to the same developmental context following discharge (Green & Jacobs, 1998). This is why research studies such as these are important so as to focus on the primary caregiver-child interactions and interventions by focusing on the dyad instead of just the child. However, there is good evidence that out-patient care which is provided at the hospital in question is a critical part of the long-term outcome of in-patient treatment (Green & Jacobs).

In recent years, studies of children who are admitted to psychiatric institutions have lessened. Schulman and Irwin, (1992) explained that the institutionalisation of children seems to be more focused on crisis-intervention. They further stated that various models indicate that

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entire families are admitted as part of an intervention. The hospital intended for the present study admits children to the hospital on their own; thus, keeping them separate from adolescent and adult patients.

2.5.2 Child Psychiatry in South Africa

According to Flisher et al. (2012), children and adolescents are vulnerable to mental disorders in South Africa due to HIV infection, the high use of substance abuse by individuals under the age of 20 and exposure to violence at a young age. Psychiatric services play an important role in preventing and rehabilitating children exposed to these disorders in order to reduce the likelihood of the disorder carrying over into adulthood (Flisher et al., 2012).

According to Bardach et al. (2014), in-patient care for children has rapidly grown in the USA, but in South Africa representative data on the actual patients admitted and their diagnoses is lacking. It appears that most studies have focused on adolescent in-patients; for example, those conducted by Gabel and Schindledecker (1993) and King, Segal, Naylor and Evans (1992). Only a few studies, especially in the South African context, have been conducted on children who are admitted into a psychiatric hospital (De la Rey, 2006).

Flisher et al. (2012) found that there are only a few studies that have focused on the epidemiology of the prevalence of psychiatric disorders among children in South Africa; furthermore, these studies have used assessment tools that are not validated for the South African context. However, Flisher and colleagues showed that an estimate of one in five children and adolescents in South Africa suffer from a psychiatric disorder.

The researcher found that the number of children admitted to a psychiatric ward at primary health care facilities is increasing. However, there is relatively little research that has focused on exploring or describing the primary caregiver-child interaction.

One study completed in South Africa focused on the attachment styles of children in an in-patient ward of a psychiatric hospital (De la Rey, 2006). This study found that these children tend to show more insecure attachment styles. However, the children were looked at in isolation and not in relation to their parents and/or primary caregiver.

This chapter has examined the theoretical origins of the present study. This study examined the dyad, analysing both child and mother interaction by using the MIM. Furthermore, the researcher arrived at an understanding of these interactions with the use of attachment theory

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and child development theory. In this chapter, the researcher has illustrated that the child's experience is shaped not only by the primary caregiver's patterns of behaviour, but also by his/her own response. In this chapter, the circumstances determining the admission of the child to a psychiatric hospital have been placed in context as well as a picture of child mental health in South Africa. The need for further research to be conducted in child psychiatry has also been indicated.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, the design adopted in this study to achieve the aims and the objectives stated in 1.3 of Chapter One is described. The aim was to explore the interactional patterns of children who have been admitted to a psychiatric institution and their primary caregivers by means of the MIM. The study had three objectives. The first objective was to provide a description of the interactional patterns observed between primary caregiver-child dyads. The second objective was to explore and describe the similarities and differences in the interactions of the participating primary caregiver and child dyads. Finally, the third objective was to attempt to understand these observations by means of attachment theory.

In section 3.1, the research process and assumptions used in the study, the stages the methodology that was implemented, and the research design are discussed. In section 3.2, the participants in the study are described; all the instruments that were used in the study and justification for their use are examined in section 3.3; in section 3.4 how the data were analysed is discussed; and finally, in section 3.5 the ethical considerations of the research and its limitations are examined.

3.2 Research process and assumptions

In order to answer the research question, a qualitative approach was followed. According to Vaismoradi, Turunen and Bondas (2013), the qualitative approach seeks to arrive at an understanding of a particular phenomenon. Qualitative researchers are interested in the social interactions of the participants; this concerns the complexity that underlies these interactions and how individuals attribute meaning to their interactions. Qualitative research is mostly about the study of human experience (Marshall & Rossman, 1999).

According to Adler and Adler (1994), qualitative research accepts that the individual's experience is his/her own subjective experience and it is real to the individual and should be taken seriously. The experiences can be understood by the researcher by interaction, observation and listening and therefore, interpreting the interactions and language expressed as a means to come to an understanding of the individual's experiences. The researcher in qualitative research is a vital instrument in the process and also attempts to understand the phenomena within the context being studied. The present study followed an exploratory design as the researcher sought to explore aspects that would be highlighted by the MIM. The

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study subscribed to a relativist ontology which means that there is no singular truth, but rather multiple realities and truths. The epistemology was subjectivist and thus, acknowledged that reality cannot be known objectively, and that understanding and interpretation is influenced by the researcher (McLeod, 2011; Willig, 2013). The logic of inquiry was abductive because both inductive and deductive reasoning were used in a cyclical manner (Morrow, 2007). An inductive approach was used to understand the literature, whereas deductive thematic analysis was employed to analyse the MIMs. Thereafter, the extant literature as well as attachment theory was used to come to a greater understanding of the findings of the study.

More specifically, this study employed a range of dyads that was selected by a clinician and moreover, a specific theory was used in order to understand these dyads cases (McLeod, 2011). The way in which qualitative research is conducted can be done in a variety of different ways; this research study was executed by examining MIM videos that were administered to primary caregiver and child dyads. Thematic analysis was carried out. This is explained in more detail later in this chapter.

3.3 Participants

This section deals with the process that was followed in order to identify and invite people to participate in the study. Factors that influenced decisions during this process are also addressed.

3.3.1 Sampling

The selection process began by the researcher gaining permission to conduct this research project from the psychiatric hospital in question as well as the Humanities Faculty and the Health Science Faculty at the University of Pretoria. Once permission was granted from the both these faculties the psychologist of the children's ward was asked to identify potential participants. Participants were identified by the psychologist based on the necessity of an MIM as part of planning for their treatment. Potential participants meeting the research criteria (discussed in 3.2.2) were then informed about the study by the clinical psychologists. Those that expressed an interest in participating were given an information leaflet that they could keep and were then asked to complete a consent form (Please see Appendix A) which fully explained the research objectives. The participants were able to ask questions about the study before they signed the informed consent. The participants were asked to sign the informed consent after they had completed the recording; therefore, they knew exactly what

was on the recording before signing consent for the data to be used. Each MIM was conducted by the attending psychologist at the hospital in question or by the intern clinical psychologist (under the supervision of the attending psychologist). Once the MIM was completed, the researcher was then contacted by the attending psychologist. The researcher then collected the recordings from the hospital and observed the data.

An application form was submitted to the Department of Health for Ministerial Consent for 'non-therapeutic research' that involves the participation of minors. *Non-therapeutic research is defined in the regulations relating to research on human participants as "research that does not hold out the prospect of direct benefit but holds out the prospect of generalizable knowledge". Minors are defined as persons under the age of 18 in section17 of the Children's Act (No. 38 of 2005).*The participants of this study were primary caregiver-child dyads. The children had been admitted as in-patients to a psychiatric ward in South Africa within the Tshwane District in Gauteng Province. Because this study wanted to understand a particular phenomenon, namely, interactional patterns within a specific population, namely, children in a psychiatric setting and their primary caregivers, a non-probability, purposive sampling strategy was employed. A purposive sample is selected based on the subjective judgement of the researcher. According to McLeod (2011), a small sample size of three to five is sufficient; consequently, for this study three dyads were observed. This collection of cases comprised the data set (Braun & Clarke, 2006).

3.3.2. Selection criteria

The participants in this study included children between the ages of three and 12. These age parameters correspond with both the age ranges as defined by the Children's Act 38 of 2005 and the age restrictions of Ward-1, the child and family unit at the psychiatric hospital. The children's primary caregivers had to be available to participate in the MIM. They could be of any age, cultural group and gender, and speak English or Afrikaans. These languages were used at the hospital at the time of this study.

3.4 Instruments

3.4.1Data collection strategies/procedures.

The focus of this research project was on investigating the interactional patterns of the primary caregiver and child dyads. Myrow (2000) stated that with the use of the MIM, the researcher is able to observe the actual interaction of caregiver and child, and therefore,

identify patterns that reflect the quality of the relationship. Myrow (2000) also stated that these interactions can offer clues about the quality of the attachment between caregiver and child. The researcher of the present study argued that the most non-intrusive and non-threatening way to collect the data was to make use of MIMs that would be conducted by their attending psychologist and therefore, not interfere with the treatment process.

It is noteworthy that the attending psychologist who was not the researcher conducted the MIM herself, as this is a usual practice with children who are admitted to the in-patient ward. The researcher observed the video recording of the MIM interaction after the attending psychologist had conducted the MIM.

The data for this study were recorded MIMs that were administered by each child's attending psychologist. On average a typical session takes approximately 30 to 40 minutes to complete and covers nine items. Then the recordings were transcribed on to a recording sheet by the researcher. This is an observational log; verbal and non-verbal exchanges were recorded by the researcher as well as any inferences or interpretations (Please see Appendix B for a sample observation recording form).

3.4.2 Observation of the MIM

As part of the standard administration process, primary caregivers were instructed to tell their children that they would be playing some games together and that a recording would be made. The following instructions are given in the actual MIM session after the child and caregiver are seated at the table with activity cards and materials (Booth & Jernberg, 2010; Lindaman et al., 2000; Marschak, 1980). The caregiver and child dyad are asked to perform a series of tasks; for example, "Tell your child a story about when they were a baby". These tasks are designed to reveal important aspects of their interaction, which include nurturance, engagement, structuring and challenge. The dyad sits alone in a room and the attending psychologist records the interaction and observes from behind a one-way mirror. The dyad is encouraged to perform the tasks at their own pace. The insights into the various aspects of the dyad's relationship are reached through observations.

The Theraplay Institute ® has set out a recommended basic list of tasks with alternatives in case two primary caregivers participate in the MIM or if the dyad has participated in the MIM in the past. The tasks are set out as below and the attending psychologist needs to adhere to the order of tasks wherever possible so as to keep the procedures standardised. Each task also

addresses one or more of the five dimensions of interaction that the MIM is designed to assess (Booth & Jernberg, 2010; Lindaman et al., 2000). These are indicated in brackets and discussed in the section on data analysis.

1. Adult and child each take one squeaky animal. Have the two animals play together (Engagement)

2. a - Adult takes one set of 5 blocks. Hands other set of 5 to the child. Adult asks child to "build one just like mine with your blocks". (Structure and Challenge)

   b - Adult takes one set of 8 blocks. Hands other set of 8 to the child. Adult asks child to "build one just like mine with your blocks". (This is for older children) (Structure and Challenge)

   c - Adult and child each take paper and pencil. Adult draws a quick picture, encourages child to "draw a picture like mine." (Structure and Challenge)

3. a - Adult and child put lotion on each other. (Nurture)

   b - Adult combs child's hair and asks child to comb adult's hair. (Nurture)

   c – Adult puts powder on the child. (Nurture)

4. a - Adult tells child about when child was a baby. (Nurture)

   b - Adult tells child "when you came to live with us". (Nurture)

5. Adult teaches child something child doesn't know. (Challenge)

6. Adult leaves room for one minute without child. (Stress task; this task is especially useful in revealing the child's pattern of coping with stress as well as the parent's awareness of the fact that being in a strange room without his parents might be stressful for the child)

7. Play a game that is familiar to both of you. (Engagement)

8. Adult and child put hats on each other. (Engagement and Nurture)

9. Adult and child feed each other. (Nurture)

The MIM session is conducted with the adult and child seated side by side at a table. Instructions for each task are printed on numbered cards and these are given to the adult. The instructions and materials for each activity are placed in numbered envelopes on the table. Although the adult in the initial briefing was given instructions to read, it allowed the researcher to see who assumed the parental role of providing structure.

When the dyad has completed the tasks, the psychologist returns to the room and asks the following questions:

- Was this a good picture of how things happen at home?

- If not, what did we miss?

- Were there any surprises?

- What was your favourite activity? Why?

- What was your least favourite activity? Why?

- What do you think your child liked best? Why?

- What do you think your child liked least? Why?

If the child is old enough, she or she may be asked to guess her parents' likes and dislikes, and then check with her parent to see if her guess corresponds with her parent's preferences. Responses to these questions provide insight into the meaning of the activities to the parent and child (Booth & Jernberg, 2010; Lindaman et al., 2000).

The recording was done in an overt manner using a small digital camera, after permission had been obtained from the participants. Recording the MIM is invaluable to the process of assessment as it allows for repeated reviewing to help in observing, analysing and understanding the parent-child interactional patterns (Booth & Jernberg, 2010; Lindaman et al., 2000; Marschak, 1980).

3.4.3 Patient's file

Information from the participating child's hospital file was included. However, this only included demographic information as well as the reason for admission to the hospital. This was done to ensure that the researcher did not become overly influenced by additional information outside of the relational dynamics of the dyad. This was, however, done in accordance with the ontological and epistemological positions of this study, which acknowledged that bias-free research is not possible.

3.5 Data Analysis

The researcher attended the Theraplay Institute® level one introductory training for Theraplay® and Marschak Interactional Method Training in October 2015 (Please see Appendix C). In addition to this, she was trained at the University of Pretoria in the MIM analysis. The official MIM manual was also used throughout the analysis process. Both verbal and non-verbal behaviours of the interaction such as eye contact, facial expression, movement toward and away from each other, and body contact were noted on the record sheet. Analysis is based on five different elements (Booth & Jernberg, 2010; Lindaman et al., 2000; Marschak, 1967):

1. Structure: Tasks in this dimension are designed to assess the caregiver's ability to take charge, to set limits, provide a safe, orderly, understandable environment for the child, and assess the child's willingness to accept that structure.

2. Nurturance: Tasks in this dimension are designed to assess the parent's ability to respond appropriately to the child's developmentally and situationally appropriate needs, as well as to assess the caregiver's ability to recognise tension and stress in the child and to help him/her to deal with it. It also allows an assessment of the child's ability to accept the caregiver's nurturing care and to turn to the caregiver for comfort. In addition, one can observe the child's capacity for appropriate self-soothing or self-regulation.

3. Specific stress reduction tasks: This activity deliberately sets up a stressful situation; this provides an opportunity to observe how the adult helps the child deal with this stress and attempts to reduce the stress in a variety of different ways. This also allows assessment of the parent's ability to recognise tension and stress in the child and help the child to deal with it, thus, allowing for observation of the child's ability to accept the caregiver's care and to turn to the adult for comport. In addition, one can observe the child's capacity for self-soothing or self-regulation.

4. Engagement tasks in this dimension are designed to assess the parent's ability to encourage interactive engagement appropriate to the child's developmental level and emotional state. The child's ability to respond to the engagement is also evaluated.

5. Challenge: Tasks in this dimension are designed to assess the adult's ability to stimulate the child's development, to set developmentally appropriate expectations, and to take pleasure in the child's achievement. The child's ability to respond to challenge is also assessed (Booth & Jernberg, 2010; Lindaman et al., 2000).

Data was analysed using thematic analysis. This method was found to be flexible and valuable, and accounted for the experiences and the meanings of the participants. It also provided a rich and detailed account of the data collected (Fereday & Muir-Cochrane, 2006). The motive for choosing this approach was that the main goal when using thematic analysis is to provide a description and understanding of the phenomenon being investigated. It also enables researchers to conduct an analysis from a broad reading of the data towards discovering patterns and developing themes (Braun & Clarke, 2006).

According to Braun and Clarke (2006), the first consideration a researcher needs to make is how the themes will be identified. This can be done deductively or inductively. For this study, a deductive thematic analysis approach was decided on because a predetermined framework was used to analyse data which was the MIM's four categories.

The standard analysis of the MIM is based on the four predetermined categories of structure, nurturance, engagement and challenge (Booth & Jernberg, 2010; Lindaman et al., 2000; Marschak, 1980). The deductive approach is particularly useful when the researcher has specific research questions that already identify the main categories used to group the data, and then looks for similarities and differences (Braun & Clarke, 2006). The recorded MIM was watched initially with sound in order to describe and observe verbal behaviours. The recording was then observed without any sound in order to observe any non-verbal behaviours of the interaction. All the observations and descriptions were recorded on a recording sheet originally developed by Marshack (1980) and later adapted by Lindaman et al. (2000).

A scoring sheet was completed for every dyad. Data were thus represented within the four predetermined categories. The next step was to describe the general themes that were prevalent for each dyad in these four categories. This is discussed in Chapter 4. These descriptions were further analysed using the principles of thematic analysis. During this phase, common themes found in the dyads were combined with attachment theory. The data were deduced from the four categories of the MIM. A semantic approach was employed in which the themes were identified. The analysis involved a description on a development form in which the data were simply organised to show patterns in semantic content and summarised; this lead to interpretation by employing attachment theory, which was discussed in the literature review. Together with the theory, there was an attempt to theorise the significance of the patterns, their broader meanings and implications (Braun & Clarke, 2006).

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3.6 Ethical Considerations

This research study was conducted in partial fulfilment for the degree, MA: Clinical Psychology and is published as a mini-dissertation. The researcher obtained permission from the Faculty of Humanities and from the Faculty of Health Sciences at the University of Pretoria. Once approval had been granted from the Ethics Committee of the university, the researcher approached the attending psychologist at the children's ward and she agreed to assist with the collection of MIMs and inform the researcher when there were potential participants who met the research criteria. These potential participants were informed by the attending psychologist about the study. Those that expressed an interest were asked to fill out a consent form (Please see Appendix A). In the study, the researcher did not envisage any activity that could potentially lead to the physical harm and/or emotional harm of the participants. Nevertheless they were encouraged to discuss any issues with their attending psychologist immediately (McIntyre, 2005; Shaughnessy, Zechmeister, & Zechmeister, 2009).

The researcher ensured that the participants were aware that they had a choice to participate in the study and the researcher collected informed consent forms from the participants as well as from the treating hospital (Please see Appendix B). The researcher provided the participants with an opportunity to make an informed choice concerning their participation in the research project (McIntyre, 2005; Shaughnessy et al., 2009). The informed consent was in the form of a signed letter, from the participant's caregiver in a language that they understood. Furthermore, assent was obtained from the participants in a language that they understood. Under no circumstances did the researcher provide the respondents with any false information (McIntyre, 2005; Shaughnessy et al.,2009). All the aims and objectives of the research project were clearly stated in the consent form.

In order not to violate the privacy of the respondents, pseudo names were used. The researcher also handled the information in a confidential manner. Only the researcher had access to the respondents' identifying information. The participants were able to withdraw from the research at any time and if they chose to do so, all their information would be removed from the study immediately.

With regards to further research the recorded data will not be stored, but rather the raw data on the MIM scoring sheets will be kept and stored at the University of Pretoria in electronic format.

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CHAPTER FOUR: FINDINGS

4.1   Introduction

In this chapter, a case-by-case description of each primary caregiver-child dyad that was observed during the MIM is presented. This data are organised in the categories already set out by the MIM: structure, nurture, engagement and challenge.

4.2   Findings

The findings follow the logic of the MIM; the MIM manual organises these observations according to the four categories of structure, nurture, engagement and challenge. Each dyad is discussed separately; a short introduction to each child is provided followed by a description of the primary observations made during their interactions. The findings are descriptions and not interpretations based on the verbal and non-verbal interactions. Some of the activities may differ between dyads, as they may have participated in an MIM assessment before; however, the task still measured the same interactional dynamic.

4.2.1   Luke

Luke was an 11 year old, Caucasian, English-speaking male who was first referred for in-patient treatment when he was six years old, after trying to kill his mother. At the time of the study, he had the following diagnoses: attention deficit hyperactivity disorder, oppositional defiance disorder with conduct features, behavioural problems, epilepsy and anxiety disorder. He resided with his mother and step-father and the whereabouts of his biological father were unknown.

4.2.1.1 Observations of the MIM

The duration of the MIM for Luke and his mother was 41:59 minutes. Luke and his mother entered the room with the attending psychologist. Luke and his mother were told which seats were assigned to them. Luke refused to sit in his assigned chair and sat in a chair away from his mother and the table where the activity cards were placed.

Engagement

The tasks used to observe engagement in this observation were:

- Adult and child take one animal. Have the two animals play together.

- Play a game that is familiar to both of you.

- Adult and child put hats on each other.

There seemed to be a limited amount of fun during their interactions that required engagement; their interaction was out of sync and this seemed to cause dissatisfaction for both of them as they soon gave up the game. Luke's mother said, *"Okay is that enough"* and Luke responded, *"Yes."*

Luke and engagement

Luke did not want to engage from the moment he entered the room; this was indicated by where he sat and his constant refusal to engage in the tasks. With each task his mother had to ask him a few times to interact. When he interacted, he was aggressive and the game was played on his terms. When it was time to move onto the next task, he got up and tried to look for other things to do and told his mother to wait while he played with a hat.

During the task: "*Play a game that is familiar to both of you*" his mother suggested thumb war, but Luke rejected this. Luke wanted to play a board game that she had forbidden them to play. His mother rejected this, then Luke suggested chess, and she again rejected his suggestion. His mother insisted on thumb war and Luke was disappointed, but played along anyway. He was very aggressive during the game and overtly attempted to take charge of the game. It was clear that he wanted to win thumb war.

When trying on hats, Luke was insistent on having it his way. He had been wearing one of the hats throughout the assessment. He was not willing to take it off. His mother eventually managed to convince him to take off the hat and swop it with her hat. He then spent some time putting it on her and trying to make the hat stand up straight.

Mother and engagement

Luke's mother attempted to engage Luke by handing over responsibility to him. She attempted to be excited about the game by saying, *"This is going to be fun."* Luke's mother asked him to read the card, collect the toys and decide on the game they must play. The engagement was on Luke's terms; how they played with the puppets was set up by Luke. For example, during the first task: *"Have the two animals play together"* Luke chose to be the

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crocodile puppet and told his mother to be the teddy bear and she complied with his request. He re-enacted play where the crocodile killed the teddy bear.

Luke's mother did not respond empathically to his aggression. She responded by laughing at the various attacks during the puppet game. She did, however, seem aware of Luke's aggressive behaviour in the situation as she even pretended the puppet was closing its eyes and the crocodile would vanish, and she then told the crocodile to breathe. She, however, seemed unaware of Luke's actual aggressive feelings in the moment. Each time Luke responded to his mother he did so by attacking her. During the hat task, Luke put on a pink hat and his mother teased him and said pink suited him.

Structure

The task used to observe structure in this observation was:

- Adult takes one set of blocks. Hands other set to child. Adult builds a structure with own blocks, then says to child, "Build one just like mine with your blocks".

Luke and structure

Luke attempted to take control of the situation. He initially sat in a different seat to what the attending psychologist directed him to sit in. He then did not want to sit next to his mother and refused even when she asked him to sit next to her. Eventually he moved over to her after she insisted. Luke seemed aloof, and his mother responded by laughing. She encouraged Luke to read the card out loud, but he refused. She responded to his refusal by trying to help him read the card.

Luke acted silly at times and was, therefore, unable to attend to what his mother was saying. He continued to set the pace of the interaction and chose to ignore any structure or directions given by his mother.

Mother and structure

During this interaction, the mother's ability to provide structure and directions seemed limited. For instance, she tried to structure Luke by giving him authority. During the block building task she appeared reserved and this created a lot of distance between them. She tried to provide structure and directions; however, Luke was unable to accept the directions and

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completely ignored her. During the block building there was little communication between them. When Luke's mother realised that he was struggling she changed her block model. She seemed to understand that he needed assistance, but was not consistent in the way in which she communicated directions and in her efforts to provide structure.

Luke's mother seemed to find it difficult to structure him and was not able to organise or regulate Luke during the MIM. This was evident in the way he was restless and fidgeted, and she responded by giggling or sighing. The mother's role observed during the MIM was that she was unable to set limits for Luke and preferred to give him the authority. She was unable to structure Luke and rather attempted to structure the interaction around the activity.

Challenge

The task used to observe structure in this observation was:

- Adult teaches the child something the child does not know

Luke and challenge

Luke attempted to take control of what his mother taught him by requesting that she touched her eyeball; however, due to the nature of the instructions he was not able to take control and was forced to allow his mother to teach him something that he did not know. He seemed anxious at first as he bounced his leg up and down. His mother did not address this anxiety. When his mother began, Luke openly accepted the challenge and really engaged with his mother. He asked questions and really enjoyed the new information. Luke was able to focus and concentrate and wanted to know more. The dyad was facing each other and had good eye contact. Luke was excited and surprised at the new knowledge.

Mother and challenge

Luke's mother initially found it difficult to challenge him and this is where he made an attempt to gain control. She gave him a positive response by saying that it was difficult to teach him something new as she felt he knew so much already. She was seen to be anxious as she bounced her leg up and down throughout the activity. During this observation the mother was seen to be taking control of the interaction and leading Luke. She was aware of his developmental level and was able to meet this and hence, she taught him something that she knew would be interesting to him.

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The dyad appeared to share pleasure in this engagement.

Nurture

The tasks used to observe structure in this observation were:

- Adult and child feed each other.

- Adult and child put lotion on each other.

- Adult tells child about when child was a baby, beginning, "When you were a little baby…"

- Parent leaves the room for one minute without the child.

Observation of child's behavior during separation and at reunion

As his mother read the card out loud: "*Parent leaves the room for one minute without the child",* Luke gave a nervous squeal. When his mother promptly got up to walk out of the room, Luke then attempted to grab his mother and she said, "*No will be back in a bit."* She did not seem to be aware that Luke felt stressed at the thought of being left alone in a strange room.

While his mother was gone, Luke faced the one-way mirror and waved a few times to the mirror. He was visibly anxious as he fidgeted and tapped his legs up and down. When his mother returned he said to her, "*Tha*t *was scary*", and his mother responded saying, *"Why"* and giggled. Luke responded and pretended that the noise of the door had scared him and not because he had been alone.

Luke and Nurturance

Luke appeared uncomfortable with the nurture task because he jumped up when his mother read the card. He then tried to act silly and turn the nurture task into a game. He rubbed cream all over his mother's face and she asked him not to put it on her face. However, as Luke continued, his mother was clearly uncomfortable with his persistence and responded by giggling.

When his mother started to put cream on his face, Luke did not take pleasure in the activity. For instance, he pulled away each time his mother put cream on him, shook his head, frowned and then he said that it burned. Luke was visibly uncomfortable with accepting his mother's physical nurturance, tried to reject it and appeared uncomfortable accepting care.

During the task, *"Tell child about when they were a baby"* Luke attempted to take charge of the interaction from the beginning. Even before his mother could begin talking, he started asking her questions about when he was a baby. The following verbatim transcript illustrates this observation:

Luke: What did I eat?

Mother: Milk

Luke: No like bugs

Mother: No you never ate bugs

Luke: Plants?

Mother: You ate every plant you could get your hands on

Luke's mother then tried to take charge and tell her own story about when Luke was a baby. Luke then became distracted as he picked up a hat on the table and put it on, and played with it while his mother talked. His mother continued to tell the story despite his distraction. Luke was then seen to re-engage by turning his body towards her and making eye contact. This was difficult for him as he interrupted his mother and tried to ask more questions. During this specific interaction where she told him about his baby years, he replaced his chair with a much smaller chair. He was now seated much lower than his mother and was unable to make eye contact.

During the feeding activity there was a battle for control. Once again, Luke responded by being silly and joking, and this created distance as there was less focus on the feeding, but on getting him to eat and feed her. He was not comfortable with his mother feeding him and he made several attempts to feed himself.

Mother and Nurture

Luke's mother did not acknowledge or recognise that putting cream on her child was a stressful situation for him as she continued as though Luke was not showing signs of distress. When Luke explained that the cream was burning, his mother responded by holding his head and putting more cream on. She, however, also seemed to be very uncomfortable and responded by giggling during all the nurturing activities.

During the feeding activity there was a battle for control. Luke's mother teased him by bringing the sweet close to him and pulling it away before he could eat it. He responded by biting her finger when she eventually fed him.

4.2.2   Anne

Anne was a nine year old Afrikaans-speaking Caucasian female who lived with her biological mother. Her parents were divorced and she saw her father every second weekend. She was referred to the hospital by a psychiatrist in private practice for admission to the children's ward. The reason for referral was due to severe mood swings which included aggressive outbursts, dysthymic mood, suicidal ideation and decline in her academic work. Her aggressive outbursts included hurting others as well as herself. It was also reported that she struggled to separate from her mother as she was concerned something would happen to her mother if she was not with her.

4.2.2.1 Observations of the MIM

The duration of the MIM for Anne and her mother was 28:01 minutes. When Anne and her mother entered the room with the attending psychologist, she seemed interested in the room. She commented on the one-way mirror and asked the attending psychologist if people could see through that mirror. The psychologist answered yes and explained she would show her.

Engagement

The tasks used to observe engagement in this observation were:

- Adult and child take one animal. Have the two animals play together.

- Play a game that is familiar to both of you.

- Adult and child put hats on each other.

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Anne and Engagement

During the playing of the puppets, Anne chose the crocodile as her puppet. She told her mother that she (the mother) did not like crocodiles. Her mother did not respond, but just looked at her. Anne was forceful in her interaction and forced her puppet (the crocodile) to kiss her mother's puppet (the dog). Even when her mother asked her why she was doing this, she continued and said, *"I am kissing you."* She was aggressive in the manner in which she was playing. Anne then said, *"I am a crocodile and I am going to eat you."* She then aggressively attacked the mother's puppet. Her mother reacted by playing dead.

During the second activity, "*Play a familiar game together*", the dyad seemed to enjoy each other more. This was evident from their body language. They were facing each other, mirroring each other's posture and had good eye contact. Anne enjoyed the game, but soon was eager to move on. Anne said, *"Okay, let's move onto next card."* During the hat task, Anne wanted to go first; she asked, *"Can I go first?" When she began* by putting a hat on herself, her mother said, *"No you must put the hat on me."* Anne was hesitant to put the hat on her mother; she put one on her mother and then directed her mother to put the hat she wanted on her. She was very playful and silly once she had the hat on.

Mother and Engagement

In the puppet activity, Anne's mother retreated and let Anne take the lead. This was evident when the mother asked Anne to read the card out loud, and asked her to choose the toy she would like to play with and what they would play. The mother appeared willing to engage, as she turned towards her daughter and began to act out a scene with the puppets. However, when Anne acted out that her puppet was (aggressively) kissing the mother's puppet, the mother moved back, retracted her toy and asked her why she was kissing her: "*I don't know you, and you must tell me.*"

Although Anne's mother attempted to engage, she appeared uncomfortable with the aggressive nature in which Anne was playing. This was seen when Anne was aggressive. Her mother felt more comfortable during the "*Play familiar game*" as she was able to fully engage and even appeared to have fun. However, when she won the game, Anne soon retracted and wanted to move onto the next task. The mother seemed unaware of Anne's disappointment. During the hat task, Anne's mother seemed eager to move on. She tried on the hats with her daughter, but did not match Anne's playful disposition.

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Structure

The task used to observe structure in this observation was:

- Adult takes one set of blocks. Hands other set to child. Adult builds a structure with own blocks, then says to child, "Build one just like mine with your blocks."

Anne and Structure

It was evident that this activity caused Anne to be anxious as she got up and pulled her chair in closer to the table and while she was doing this she asked her mother, *"What if I get it wrong?"* Anne attempted to build the structure and soon gave up after she got it wrong. She did not look to her mother for directions or structure, instead she gave up. When asked if she thought it looked the same as her mother's, she insisted it was correct by nodding her head and saying, *"It's the same"* and was eager to move onto the next task.

Mother and Structure

Her mother was able to translate the instructions for Anne, but there were limited directions given to her. She appeared to be very task-orientated and serious as she lacked playfulness. No directions were given expect, *"Do it exactly the same as mine."*

When Anne found it difficult to complete the task, her mother asked three times if the two block structures were the same. She then pointed out where Anne was wrong. No praise was offered and in this interaction, Anne's mother seemed teacher-like as she is rigidly focused on the task at hand.

Challenge

The task used to observe structure in this observation was:

- Adult teaches the child something the child does not know.

Anne and Challenge

Anne would have liked to learn a poem; however, her mother decided to teach her the 9-times-table, and she seemed uninterested as she was not able to focus and concentrate for very long and soon gave up. She got the first few correct, but as the challenge became more

difficult, avoided the challenge and wanted to move on. She showed s no pleasure in learning the task or in any of her achievements.

Mother and Challenge

Her mother seemed to expect a lot from this interaction and appeared frustrated when Anne was not able to understand the 9-times-table. She did not acknowledge her child's efforts. She was not able to help Anne handle the frustration of getting the task wrong; instead she persisted by being teacher-like and asking her to continue until it was done correctly. It appeared that this task was not matched to her developmental level.

Nurture

The tasks used to observe structure in this observation were:

- Adult and child feed each other.

- Adult and child put lotion on each other.

- Adult tells child about when child was a baby, beginning, "When you were a little baby…"

- Parent leaves the room for one minute without the child.

Observation of child's behavior during separation and at reunion

Anne's mother was unable to prepare her for separation. This was observed when she read the task instruction to herself and hid the card from Anne. When Anne asked what the card said, her mother responded that there were cards that Anne was not actually allowed to see. She then explained that she needed to quickly leave the room and Anne asked why she needed to do this. In response her mother stood up and mouthed something to Anne before she left the room and announced out loud she was going to the bathroom. During the separation Anne looked confused. She initially sat with her fingers in her mouth, sucking and biting them. Then she started banging her hands against the table saying, "*I am not afraid of you.*" She started tapping her hands against the table and then sang, "*I am not afraid of you, yes you are, yes you are*" and then she hummed for a while until her mother returned. On

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reunion her mother said she could hear her singing and they continued with the next task. Anne was very happy to see her mother.

Anne and Nurture

Anne seemed distressed at the lotion task. When her mother read the card out loud, Anne lent back, shook her head and said, *"No."* Throughout the lotion task, she pulled her face frowned; she said she did not like the smell of the cream and that she was afraid her mother was going to pop her pimples with her hands. She constantly rejected this form of nurturance and was clearly uncomfortable with the engagement.

At times she appeared aloof and even commented on how long the nurturance activity was taking: "*This is going to take a long time.*" When she had to put lotion on her mother, she was aggressive again, was rough, and pinched her mother's skin; her mother responded with, *"Ouch"* and giggled. Anne seemed to enjoy hearing stories about when she was a baby during that time. She expressed her enjoyment by giggling and smiling; however, she never fully turned her body towards her mother during the story; rather, she fidgeted with her hands and tilted her head towards her mother. During the feeding activity her mother tried to tease her by not allowing her to get the food, but she responded by trying to bite her mother when she eventually fed her.

Mother and Nurture

Initially, Anne's mother appeared to be able to provide her with nurturance as she applied the lotion in a comforting and nurturing manner. However, when Anne was not able to accept the nurturance, which she expressed by her discomfort, her behaviour then began to change; she became very 'matter of a fact' in response to this. Anne's mother was not able to acknowledge that this task was uncomfortable and somewhat distressing for Anne: she just continued with the activity even though Anne was expressing discomfort.

Anne's mother appeared to be nostalgic when telling the story about when Anne was a baby. She explained that she was a sweet baby, but that she cried a lot. Her mother explained that Anne never let her mother put her down and she carried her all day long.

Initially, Anne's mother seemed to enjoy telling the story to Anne and was nostalgic; however, she became very uncomfortable when she finished the story. She fidgeted with her hands and there was a long pause before she moved onto the next task.

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4.2.3 Ben

Ben was an 11 year old, Afrikaans-speaking Caucasian male who was currently living with his maternal grandparents because of a court order; this was the result of a suspicion of possible physical abuse. Ben's grandmother is his primary caregiver. He was admitted to the hospital because of reports that his behaviour was uncontrollable both at school and at home. He reportedly physically hurt others and intermittently, he cried and felt depressed. There were also reports that he had suicidal ideation. At the time, he suffered from enuresis. He was admitted to the hospital with the following diagnoses: oppositional defiant disruptive disorder; conduct disorder; a mood disorder not otherwise specified; poor attachment; and possible epilepsy.

4.2.3.1 Observations of the MIM

The duration of the MIM for Ben and his grandmother was 15:03 minutes. It is important to note the activities during this MIM as the dyad had previously, a few years earlier, participated in an MIM at another institution. Ben had done the MIM with his grandfather before he completed this one with his grandmother. When Ben and his grandmother entered the room they sat down and she reminded him that they had done a similar "*test*" before. Ben's reply was, *"Oh"*. They began immediately.

Engagement

The tasks used to observe engagement in this observation were:

- Adult and child play Peek-a-boo

- Adult and child sing a song together.

- Adult and child put hats on each other.

Observations of Verbal and Non-verbal interactions during engagement tasks

Ben and Engagement

Ben took the lead in the activities, *"Peek-a-boo* "and *"Sing a song together"* in the interaction between him and his grandmother. For example, during the *"Peek-a-Boo"* task he explained to his grandmother how the game worked, picked the toys and chose the crocodile;

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he attempted to bite his grandmother with the crocodile. During this interaction, it was evident that although he was taking the lead, he was attempting to keep a distance between his grandmother and himself, by sitting further back from his grandmother. By re-enacting the crocodile eating her, he also expressed some aggression.

During the hat task, Ben was attuned to the needs of his grandmother. He saw that she did not want to mess up her hair and stood up to find a hat that would suit her needs.

Grandmother and Engagement

Ben's grandmother was in a rush from the moment the MIM began. She even explained to Ben that they needed to work quickly because they were being filmed. She was very task-orientated and this created a lot of distance between the dyad. She did not read the card, but rather asked Ben what *"Peek-Boo"* meant. She became preoccupied with whether the task was being completed correctly.

She handed over most of the responsibility to Ben. For example, while playing *"Peek-a-Boo"* Ben explained the task picked the toys and during *"Sing a song together"* his grandmother explained that she could not sing and that he must begin. He chose the song and he sang the majority of it. Ben's grandmother was happy with this interaction as while he was singing she leaned over and hugged him. She also complimented him on his singing. During the hat task, the grandmother was concerned about her hair and how she looked; she paid little attention to what Ben looked like and whether it was an enjoyable interaction for him.

Structure

The task used to observe structure in this observation was:

- Adult and child each take paper and pencil. Adult draws a quick picture, encourages child to *"Draw a picture like mine."*

Ben and Structure

Ben was left to find his own direction and structure in this task; this was the pattern seen throughout the interaction. For example, the grandmother did not read the card out loud, but she read it quietly to herself and then moved on to the task. Ben then read the card by himself and asked his grandmother if they needed to draw a picture together. This made the interaction disorganized, leaving Ben to organize himself.

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During this task he attempted to engage with his grandmother, commenting that she was using pink as it was her favourite colour. There was no response from his grandmother; instead she continued to draw. While drawing, Ben tried to show his grandmother what he had drawn. Initially, she ignored him, but when he tried a second time, she then looked over, but then looked back at her own page. Again Ben tried to engage her and said, *"Look Ouma."* She briefly glanced at his drawing before looking back at her paper.

Grandmother and Structure

The grandmother handed the authority over to Ben. She was unable to set limits which are part of structure. The interaction was often disorganised, leaving Ben to organise himself. She drew on her own and she did not communicate verbally with Ben. She seemed to be in a rush and wanted to finish the tasks as soon as she could.

Challenge

The task used to observe structure in this observation was

- Adult says to child, "Tell me what it will be like when you're a grown-up"

Observations of Verbal and Non-verbal interactions during challenge tasks

Ben and Challenge

Ben was asked to talk about what he thought he would be when he grew up. He answered that he would like to be a firefighter. His grandmother asked why he would not want to work at the company that she owns. Ben said that he would try to do both jobs. She then explained that being a firefighter was a dangerous job, but it was his choice. There seemed to be little enjoyment in the interaction. However, Ben was able to handle the criticism and did not argue with his grandmother.

Grandmother and Challenge

Ben's grandmother told him that she was tired of talking and she wanted him to talk. She handed over the authority to Ben and wanted him to do the task alone. She seemed to avoid challenging him. There was no pleasure in the challenge and engagement for her. She seemed to project her own needs of Ben working at her own company rather than acknowledging his needs to work as a firefighter.

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Nurture

The tasks used to observe structure in this observation were:

- Adult and child feed each other.

- Adult and child put powder on each other.

- Adult tells child about when child was a baby, beginning, "When you were a little baby…"

- Parent leaves the room for one minute without the child.

Observation of child's behavior during separation and at reunion

Ben's grandmother read the card and then looked at him for direction, and asked what she should do. He explained that she needed to leave the room for one minute. His grandmother then asked, "*And then what will happen*" and the child told her to come back. This seemed to irritate the grandmother as she said, "*Arg really.*" She then got up and said, *"I will see you in a minute."*

During the separation, Ben looked around the room. He tapped his leg up and down, mumbled to himself, looked around the room again and faced the door for a while. He was happy to see grandmother again.

Observations of Verbal and Non-Verbal interactions during nurturance tasks

Ben and Nurture

Initially when Ben heard about the task of powder to be put on him, he pulled his face into a frown, and asked how this was going to work. He then asked where she was going to put the powder. When his grandmother puts the powder down his t-shirt he pulled a face. Ben appeared uncomfortable with the physical touch. His feelings of discomfort persisted into the next nurturance task of telling a story about when the child was a baby: he fidgeted, was unable to sit still, looked around and struggled to keep eye contact

Grandmother and Nurturance

Ben's grandmother seemed to find it difficult to nurture him. When she initially read the card that instructed her to put powder on him, she sighed out loud and withheld the gratifying

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experience for both of them. When she needed to put powder on him, she threw it down his back and patted him once. She seemed to be uncomfortable with physical touch and touched the child very little during these interactions. When she read the card instructing her to tell Ben about when he was a baby, she sighed and said, *"This is a hard one."* However, when telling him a story she briefly held his hand and when he sang, she gave him a side hug.

4.3 Similarities observed among the dyads

The following section will list the similarities between the dyads. These similarities are explored further in the next chapter.

- The primary caregiver gave the child authority.
- Each child chose the crocodile and aggressively attacked the primary caregiver.
- The children had difficulty accepting nurturance and appeared uncomfortable accepting care and nurturance.
- The primary caregiver found it difficult to prepare the child for separation.
- Each child had developed a strategy to self-soothe.
- The primary caregiver seemed unaware of the child's feelings.

CHAPTER FIVE: DISCUSSION

5.1   Introduction

In the previous chapter, a description of the interactions between the dyads that were observed and recorded on the observation sheets was outlined. In this chapter, the interactional patterns of the dyads are described under the four categories of structure, nurture, challenge and engagement. The discussion of each category begins with a definition given in the MIM manual; a description of each dyad's interaction in that specific category with interpretations of these descriptions follows. Thereafter, an account of the similarities and differences observed among the interactions patterns are discussed. Finally, there is an attempt to gain a deeper understanding of the interactional patterns observed and interpretations made using attachment theory.

5.2   Engagement

According to the MIM manual, primary caregivers provide their children with stimulation, excitement and surprise during engagement in order to keep them alert and engaged. During the engagement, the primary caregiver also has the ability to soothe and calm his/her child when it is necessary so that they will be able to engage again. When engaging with the child, the primary caregiver is careful to engage on a level that fits the child's developmental level as well as his/her current emotional state. While engaging, the primary caregiver and the child are usually attuned to each other's affect (Booth et al., 2011).

Tasks in this category are designed to assess the primary caregiver's ability to engage in an interactive task with the child, which is on his/her developmental and emotional level. An important factor while engaging is that the child is happy and his/her joy is shared in the interaction (Booth et al.,2011).

5.2.1 Luke and mother's engagement

Luke and his mother's engagement seemed to be out of sync: he initially refused to engage with her, by ignoring her, rejecting her suggestions, acting silly and joking around, which created distance as he was unable to attend to the task. His mother handed responsibility over to him in order to get him to engage with her. This strategy was interesting, given that in the past he tried to kill her. It was as though she tried to manoeuvre him into engaging by making him feel more in control, by having power. This strategy seemed to work on a behavioural

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level as he engaged. However, it did not have the same emotional impact on him as he did not enjoy playing and expressed aggression.

Aggression seemed to be his way of communicating his dislike and discomfort with closeness. It could have also indicated what he did with a negotiated role of power between him and his mother. He became domineering and hurtful. Luke then engaged, but he did not appear to be joyful as he was aggressive in his play with his mother. His mother seemed unaware of his aggressive behaviour and feelings, and therefore, was unable to soothe and calm him. It was as though her giggling was a defence against her own anxiety of not being attuned to her child given their relationship. Their interaction seemed to be out of sync as he interacted aggressively and she was laughing.

Luke and his mother's engagement was a disorganised interaction. At first Luke was avoidant; he tried to ignore his mother and refused to sit next to her. After some convincing, he moved closer to her, but became preoccupied in trying on a hat. His mother attempted to get him interested by giving him the responsibility of the engagement. He engaged, but with much aggression and anger. His mother responded by laughing at his aggressive outbursts. She seemed aware of the anger and aggression that Luke expressed, but she was unable to respond possibly either due to her own anxiety of his aggression or she did not know how to respond to this. She was unable to soothe and calm him.

5.2.2 Anne and mother's engagement

Anne's mother allowed her to take the lead in the engagement; Anne decided which toy they would play with. Although Anne said the crocodile was kissing the teddy bear, the interaction was aggressive and Anne appeared to be attacking the teddy bear. This made Anne's mother very uncomfortable as she retracted. She did not know how to cope with this interaction and therefore, retracted when her child showed aggression. However, during the second engagement activity the dyad appeared to engage better as they worked together and mirrored each other's body language. However, when Anne lost the game, she was disappointed and wanted to move on, but her mother seemed unaware of her feelings of disappointment.

Anne seemed to have developed a strategy of controlling the interaction, whereby she tried to entertain her mother. However, this was displayed with aggression, which caused her mother to withdraw and she attempted to direct her mother. However, her mother seemed to be out of sync with Anne's needs; for example, when she lost the game and was disappointed, her

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mother did not seem aware of this and appeared pleased with the outcome of the game. When Anne was aggressive she withdrew and did not know how to help Anne with this aggression. Perhaps, she too was uncomfortable with aggression and therefore, needed to retract to signal to Anne that she was not able to engage with this emotion.

5.2.3 Ben and grandmother's engagement

Ben took the lead in the interaction and seemed to guide his grandmother and be in tune to her needs. His grandmother appeared to find it difficult to engage with Ben and the engagement tasks. She seemed to create distance by becoming preoccupied with whether the tasks were completed correctly and not being concerned about if they were having fun.

Ben displayed some aggression with the crocodile, but seemed to be the caregiver in the engagement interactions. He appeared to take the caregiver role and be attuned to his grandmother's need of reassurance in the moment. It is important to note that in the interaction, the primary caregiver and the child contribute to the interaction. It is interesting to think how Ben engaged his grandmother as a child. It must also be noted that this was Ben's grandmother and not his biological mother; their interaction appeared to be somewhat different to that of Anne and Luke.

5.2.4 Similarities and differences observed during engagement tasks

During the engagement tasks the children took the lead from their primary caregivers. The children chose to play with the crocodile and directed aggression at their primary caregivers.

Luke and Anne seemed to take control by being aggressive; however, Luke was more overtly aggressive than Anne. Anne appeared to be less overtly aggressive in her interaction as she explained that the crocodile was kissing the teddy bear, but was actually hurting the teddy bear. One can thus speculate that Luke may have felt comfortable with direct aggression, which is indicative of a pattern in this dyad's relationship. On the other hand, Anne felt that she needed to hide her displayed aggression, to perhaps make it more acceptable to the recipient, her mother.

Ben seemed to be even more passive, even though he grabbed the crocodile and displayed aggression. This aggression was short-lived and he soon went on to acting as the caregiver, guiding and directing his grandmother.

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The primary caregivers did not acknowledge the aggression displayed by their children. Luke's mother responded by laughing, Anne's mother withdrew and Ben's grandmother seemed to completely ignore the interaction and insisted on moving onto the next activity. The primary caregivers showed that they were not attuned to their children's emotional states at the time, and perhaps felt helpless and anxious when having to confront their children's expression of aggression.

5.3   Structure

Structure is the foundation for all the other dimensions. Primary caregivers that are able to structure their children communicate that the dyadic relationship is a trustworthy one and that the primary caregiver is predictable and this helps ease the anxiety of the child. In order to achieve structure, the primary caregivers should be able to set boundaries that ensure the children's safety as well as co-regulate their experience of the world as they help them to make sense of it. When the primary caregiver is able to effectively structure the child's environment, the child is able to feel physical and emotional security; this in turn helps the child to develop the capacity to regulate emotions and self-control (Booth et al., 2011).

Tasks in this category are designed to assess the primary caregivers' ability to structure by their ability to take charge, set limits, and provide an environment that the child is able to understand and feel safe in (Booth et al.,2011).

5.3.1 Luke and mother's structure

Luke's mother's ability to provide him with structure and directions was limited. She gave Luke the authority, thus, leaving him to structure for himself. Luke reacted to this by being aloof; this was a possible negotiate for distance, but what the distance had to do for him was not clear. One may ask whether he wanted his mother to respect the space he put between them or if he wanted her to come and fetch him. His mother responded by laughing; this appeared to be the way she reacted when she did not know how to respond to Luke. The interaction was disorganised, as his mother should have given him structure, but left him to structure himself. He responded by creating distance between them. Once Luke participated in the activity, there was little verbal communication between the dyad.

Luke kept the relationship on his terms, insisting on doing things his own way. His mother struggled to set limits for him, or help him when she saw that he was struggling with the task at hand. Luke was trying to have a sense of power and predictability over his world and the

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interaction with his mother. This appeared to intimidate his mother and left her paralysed, immobilized and an observer rather than a participant in their interaction.

Luke's mother had given the authority to him. Luke had accepted this role and therefore, they were left with what they had negotiated in their interaction, which probably made it difficult for his mother to help him.

5.3.2 Anne and mother's structure

Anne's mother's ability to provide structure and direction was limited. She was able to translate the instructions for her, but she remained s very serious and task-orientated and gave Anne little direction. Anne was anxious about the structure tasks and was concerned she would get them wrong. Her mother provided her with little reassurance, insisting that they were easy and she could not get them wrong. When Anne did a task wrong, she gave up, and did not look to her mother for guidance or directions, but insisted on moving onto the next task instead.

Anne's mother seemed to be in the teacher's role: she was very task-orientated and wanted to get the task done. However, she was unaware that Anne needed directions and structure during this task. Anne felt anxious about getting it wrong as it was clear she did not understand the task. Her mother could not acknowledge the anxiety she was feeling and therefore, did not respond to it. Anne inevitably got the task incorrect, but did not seem comfortable with asking her mother for help. Instead she insisted that it was correct and she wanted to move on. It appeared that Anne's mother found it difficult to address anxiety and therefore, Anne found it difficult to approach her mother when anxious.

5.3.3 Ben and grandmother's structure

Ben's grandmother appeared to need order for herself and seemed unable to provide structure and direction for Ben; instead she read the card on her own and moved onto the task. Ben attempted to engage her by asking questions and asking for directions. He was also very aware of his grandmother and what her needs were; for example, he commented on what her favourite colour was and tried to show her a picture he drew for her. It seemed that by acknowledging the needs he thought she had, he was attempting to retain her attention, even if it was short-lived.

His grandmother was very task-orientated and wanted to finish all the activities in a rush. Ben seemed to want to engage; however, his grandmother seemed unaware of what his needs were even though he appeared to be very aware of her needs. Ben was able to end activities easily and instantly when his grandmother announced that she wanted to move on or that she had had enough. It would appear that Ben did a lot of structuring for himself, and made an effort to sort out directions for himself and looked for signals/cues in his environment.

5.3.4 Similarities and differences observed during structure tasks:

All of the primary caregivers seemed to find it difficult to provide their children with structure and direction, and in turn, all of the children were able to find a way to structure themselves. These children had managed to develop their own strategies when their primary caregiver was unavailable or not able to provide structure and direction. Luke did this by keeping the interaction on his terms and doing what he felt he should. Anne kept the structure for herself by moving on when she felt she was correct, she refused to admit the block structure was incorrect and she wanted to move on. Ben looked for directions for himself by looking for cues in his environment from his grandmother.

Ben showed a marked difference as he seems to be more attuned to his grandmother and her needs and seemed to want to meet these needs whereas Luke and Anne seemed to want to take control in the interactions and move on as they felt quite anxious about their own needs being met in the moment.

5.4   Challenge

According to the MIM manual, primary caregivers who effectively challenge their children are able to encourage their children to do their best at their activities, promote independence and set appropriate expectations for their children. They are able to experience pleasure when their children achieve (Booth et al., 2011).

Tasks in this category are designed to assess the primary caregiver's ability to challenge his/her child by stimulating the child and setting appropriate expectations, which are on the child's developmental level. The primary caregiver is able to find pleasure in his/her child's achievement (Booth et al., 2011).

5.4.1 Luke and mother's challenge

It appeared that Luke's mother found it difficult at first to challenge him. While reading the card she shook her leg up and down anxiously and Luke mirrored this. Luke initially said that she could *"touch her eye ball"*. However, she responded, *"I need to teach you something that you DON'T know."* This seemed to unsettle the dyad and there was a pause in the interaction which helped them to regroup and not act impulsively. It appeared to be the first time during the MIM where Luke could not take control and his mother was forced to take the lead. During this time, Luke's mother shook her leg up and down and Luke mirrored this, which could possibly be a sign of him internalising and mirroring his mother's initial anxiety.

This interaction seemed to prove positive as Luke's mother was seen being aware of his developmental level and setting tasks that he could master. Luke responded well to this and fully engaged in the task. He made good eye contact; he listened closely and was surprised at the new knowledge. The dyad appeared to share pleasure in this interaction.

This interaction was a positive one as the experience challenged Luke and gave both him and his mother a sense of mastery. When his mother was forced to take charge, Luke openly accepted it. This interaction proved that Luke responded well to his mother and took more of the control and furthermore, their interaction could be positive and more enjoyable.

5.4.2 Anne and mother's challenge

Anne's mother seemed to have high expectations of her child; she was very competitive and wanted Anne to master the 9-times-table. She quickly became frustrated when Anne did not get it correct. Anne responded by avoiding the challenge and wanted to move onto the next task. The dyad showed little pleasure during this activity.

The theme of misattunement was repeated with this dyad. Each of them had expectations that were not met from either participant and this frustrated both of them. This frustration could possibly have created affect and communication distance. Initially, Anne wanted her mother to teach her a poem, but her mother wanted her to learn the 9-times-table. Anne's mother appeared to be rigid and this created distance and she was not able to connect with her daughter on a childlike level. When Anne was unable to learn the 9-times-table, her mother became frustrated because Anne was frustrated. Anne wanted to move on, and communicated that the challenge was too difficult for her; however, her mother insisted that they continue until she got it correct.

5.4.3 Ben and grandmother's challenge

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During this interaction, Ben's grandmother insisted that she was tired and was glad that he had to do the talking. Once again, Ben became in charge of the interaction. When he explained that he wanted to be a firefighter, she told him that he should work for her company when he got older. This contradicted the interaction, as at first she wanted him to tell her what he wanted to become. However, when she heard it, she disagreed with him and told him what she thought he should become. There was little pleasure in this challenge and his grandmother seemed to project her own needs onto Ben. It seemed as though his needs and individuality were not being acknowledged.

His grandmother seemed to project her own feelings and needs onto Ben; she also did not acknowledge his efforts and needs during the interaction. Ben tried to please his grandmother by agreeing to work as a firefighter and at her company.

5.4.4 Similarities and differences observed during challenge tasks

The dyads showed different reactions for challenge. For Luke and his mother, this interaction seemed to be the most enjoyable task. Luke responded well to his mother being in control of the interaction. This seemed to provoke anxiety in both as they both shook their legs up and down during the interaction; however, they mirrored their body language and seemed to enjoy the interaction. Even though the anxiety was present, they were still able to enjoy the interaction.

For Anne and her mother, this task was very frustrating and they found little joy in this interaction. Anne's mother seemed to be mistuned to her daughter's needs of wanting to learn a poem and became preoccupied with teaching her the 9-times-table. Ben again seemed to be attuned to his grandmother's feelings and needs, and seemed to try to please her in the interaction by adapting his answers to make her happy. Ben's grandmother seemed oblivious to what his needs where in the moment.

5.5   Nurture

According to the MIM manual, during nurturance tasks primary caregivers are calming, comforting and soothing. They are able to provide a safe environment when the child is stressed or anxious. If a primary caregiver is consistent in providing nurturance for their children, they are able to help their children develop the capacity to nurture, self-regulate and self-soothe (Booth et al., 2011).

Tasks in this category are designed to assess the primary caregiver's ability to nurture by observing the way in which the primary caregiver responds to the child's need for nurturance and the primary caregiver's ability to recognise that the child is feeling stressed or anxious. The primary caregiver is then able to react in a calming manner, and this helps the child cope with the situation and deal with his/her emotions (Booth et al., 2011).

The MIM also allows the observer to note the child's response to the primary caregiver's efforts to nurture the child. In addition, it is important to note the child's own capacity to self-regulate and self-soothe (Booth et al., 2011).

During the task, "*Adult leaves the room for one minute*" the researcher is able to observe the way in which the primary caregiver helps the child to cope with stress. This task is listed under nurturance as the primary caregiver is required to give a nurturing response to the child's anxiety and stress (Booth et al., 2011).

5.5.1 Luke and mother nurture

Observation during separation and reunion

Luke gave his mother specific cues that he was anxious at the thought of her leaving the room. He squealed and attempted to grab her as she left the room. His mother rejected this need and left the room. Luke displayed the ability to self-soothe and self-regulate while his mother was out of the room. Luke faced the one-way mirror and waved a few times to the mirror almost for reassurance that he was not alone. He was visibly anxious as he fidgeted and tapped his legs up and down; this seemed to have the effect of warding off his anxiety and managing his inner anxiety. When his mother returned, he told her that it was scary to which she replied, *"Why?"* Luke's mother seemed unresponsive to his needs during the time of separation. She was unable to properly prepare him for the separation. Upon her return he verbalised that he had been scared when she was gone. She appeared to be mistuned to his needs and feelings as she responded, *"Why?"* It seemed as though she was unable to address his emotional state. She was not able to acknowledge the stress and tension he felt in the situation and found it difficult to respond in a nurturing manner.

Observation during nurturance tasks

During the lotion task, Luke again demonstrated strong non-verbal indications that he was uncomfortable with this interaction. He jumped back when he read the card; he attempted to

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act silly to create distance and distraction, and when his mother put lotion on his face he complained that it burned. His mother's response highlighted her unawareness of his anxiety and tension, as she continued with the task and pulled Luke's face closer and put more lotion on when he explained that it burned him.

Even when his mother related to him about when he was a baby, he interrupted her while she spoke; he became silly and joked around. It was clearly difficult for him to be in this intimate space with his mother. After the nurturance tasks, he appeared so uncomfortable that he changed his chair; he got a smaller chair to put even more distance between himself and his mother. This also highlighted his need for nurturance and this could be seen as a form of regression.

His mother did not react much to Luke choosing a smaller chair; this was possibly a glimpse of infant Luke surfacing for the first time. He put himself in a vulnerable spot, even though at a distance. He seemed to show a need to be taken care of despite rejecting his mother's nurturing at the time. This may also have spoken to his infantile unregulated emotional state and seemed to coincide with his mother's somewhat emotionally unregulated state as she could not acknowledge his emotion.

5.5.2 Anne and mother nurture

Observation during separation and reunion

Anne's mother was unable to prepare her for separation. Her mother actually made the separation even more anxiety-provoking as she hid the card from Anne and said that she could not see what the card said. Anne responded by asking what the card said. Her mother informed her that she needed to leave the room and did not offer any comfort. Anne's mother created an anxiety-provoking situation before she left the room by not preparing Anne and keeping the task a secret. What is interesting to note is that one of the presenting problems was that Anne was not able to separate from her mother without feeling very anxious. This interaction helped to give insight into one of the reasons why Anne possibly felt so anxious when she left her mother.

Anne was able to self-soothe during the separation; she even sucked and bit her fingers for the first few moments after her mother's departure. The latter also illustrated Anne's regression as well as reduced her internal anxiety at the separation. On reunion, her mother simply continued with the next task. She seemed unable to acknowledge the tension or

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anxiety Anne felt while she was gone. This reiterated a previous observation of Anne's mother who was unable to communicate effectively based on Anne's developmental level. This interaction also gave some insight into mother's internal state as she seemed to experience a lot of her own anxiety when having to leave Anne. This appeared to create anxiety in her as she wanted to protect her from reading the card and said she was going to the bathroom.

Observation during nurturance tasks

Anne seemed distressed at the lotion task; when she learned of the task, she shouted, *"No"* and shook her head. She was clearly uncomfortable with the activity; she tried to place a lot of distance between her and her mother as she frowned, complained that it was taking a long time, asked her mom not to pop her pimples and tried to make the task end quickly. Anne attempted to reject the nurturance and was visibly uncomfortable with physical touch. Anne was somewhat more responsive during the baby story task although her non-verbal body language, specifically her posture and fidgeting, illustrated that she remained uncomfortable. It was as though she needed to distract herself from something uncomfortable.

Anne appeared to want the activities to come to an end very quickly and in order to negotiate a safe space for herself, she created distance between her and her mother during the nurturance tasks as she felt uncomfortable.

Anne's mother was unaware of the high level of discomfort Anne was feeling. Her mother was very 'matter of fact' in response to her child. During the nurturance activities her mother also appeared to experience a level of discomfort.

5.5.3 Ben and mother nurture

Observation during separation and reunion

During the separation activity Ben needed to provide his grandmother with structure and reassurance. This task seemed to make his grandmother uncomfortable when she had to leave the room as she said, *"Arg really"* and needed Ben to explain the task to her.

As his grandmother left, Ben did not show any objections to her leaving; however, he did show that he was able to self-soothe and regulate himself while she was gone because as he tapped his leg up and down, he mumbled to himself.

Observation during nurturance tasks

Ben appeared uncomfortable with the powder task as he pulled his face into a frown when he read the card. However, his grandmother illustrated a high level of discomfort and she spent little time on this task. Thus, they were both uncomfortable with this. When she needed to tell him about when he was a baby, she stated that it was not easy for her to do this. Ben and his grandmother were both uncomfortable with this interaction and she was able to verbalise that this was difficult for her. It appeared that she did not know how to work with aspects of this discomfort. This interaction highlighted Ben's grandmother's own role; although she was his primary caregiver, she was not his mother, but his maternal grandmother. This interaction also highlighted the possibility of her attachment style not being a secure one.

5.5.4 Similarities and differences observed during nurturance tasks

The primary caregivers of the dyads were unable to prepare the children for the separation. They seemed unaware that being in a strange room without their primary caregiver might be stressful for the children and they were unable to address or hold the anxiety that was displayed upon their separation.

Luke and Anne illustrated that they did not want their mothers to leave them; Ben, on the other hand, was the only child who had to act as the caregiver, by explaining the task to his grandmother and reassuring her as she left.

All of the children in the dyads showed a capacity to develop strategies to self-soothe and self-regulate during the separation. However, all three children showed that it was difficult for them to actually accept nurturance; all three children had strong non-verbal reactions such as frowning, retracting and verbal reactions such as saying, *"No"* when they found out that their primary caregiver needed to put lotion or powder on them. All of the children illustrated that they were uncomfortable with being nurtured.

There was a notable difference with Ben and his grandmother. He seemed to take the role of the caregiver during the separation and his grandmother looked to him for direction during the anxiety-provoking task. He seemed to be able to bear the anxiety for both of them.

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5.6   Theoretical understanding using attachment theory

As discussed in Chapter Two, Bowlby (1998) explained that the way in which children experience their family will have a profound effect on their personality and attachment style. Within their immediate family environment, they will experience different interactional patterns and develop different attachment styles according to these interactional patterns.

According to attachment theory, the likelihood of children forming secure attachments to their primary caregivers (and in turn secure and healthy interactions) has been linked to the primary caregivers' sensitivity. The latter refers to the primary caregiver's ability to accurately identify and appropriately respond to the child's emotional and behavioural cues (Ainsworth & Bell, 1970). Observation of the three dyads in this study found that the primary caregivers seemed to lack this sensitivity; the primary caregivers seemed to have a limited ability to accurately identify and appropriately respond to the children's emotional and behavioural cues during the tasks.

The way in which the child is handled with regards to sensitivity, availability and predictability will contribute to the child's emotionally prominent beliefs and expectations. In addition, the affection, direction from the caregiver, stress tolerance of the caregiver, interruption of emotional contact (separation), identification, communication and playfulness all contribute to the individual's development of self (Parritz & Troy, 2014). This is something that was lacking in all the interactions observed. During the MIM, the researcher noted that the primary caregivers often found it difficult or at times were unable to direct the child during the activities.

Affection in the interactions was often lacking. For example, during the nurturance tasks, not only did the primary caregivers have trouble in providing nurturance, but the children also had strong negative reactions to the affection. One must keep in mind that it is both the primary caregiver and child who contribute to the interactions in a dyad. Affection is important in the development of the child's emotionally prominent beliefs and expectations (Parritz & Troy, 2014).

When Luke heard about the lotion activity he jumped up, acted silly and turned the nurturance task into a game. When his mother started to put cream on him he pulled away, shook his head and frowned. Anne reacted in a similar way to Luke; she became distressed when she heard about the lotion task. She leaned back, shook her head and said, *"No!"* Ben

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frowned when he heard his grandmother was to put lotion on him. This illustrated that even when the primary caregiver attempted to provide nurturance the children seemed to be distressed and uncomfortable. This can be seen as potential defensive adaptions that have resulted from the negotiations during the dyads' interactions (Hennighausen & Lyons-Ruth, 2007).

The primary caregivers seemed to hand over responsibility and direction to the children during most of the tasks. The children structured themselves, chose what to do to and comforted themselves. The children seemed comfortable with being in charge and this could be indicative of how the interaction between the dyad is usually managed. Luke ensured that he was in control of the activities right down to where he sat. Anne did not look for direction from her mother when she built the structure incorrectly or could not learn the 9-times-table. Ben helped lead his grandmother through every task. Structure and direction communicate to the child that the relationship is a trustworthy one and helps ease the anxiety of the child as the primary caregiver is perceived as predictable (Booth et al., 2011).

The primary caregivers seemed to be unable to hold the stress or the anxiety displayed by their children in an appropriate manner; this was observed when the primary caregivers had to leave the room. Luke squealed and grabbed onto his mom, but she pushed him away and left the room. Anne's mother seemed anxious and was not able to prepare her child for separation. Ben had to prepare his grandmother to leave the room; this left Ben to deal with his own anxiety without support from his grandmother. However, he was able to deal with the stress and hold it for both of them. Ben ensured that if his grandmother was fine, he would be fine. Holding stress and anxiety for young children is important as in the long run this can help children develop the capacity to take over these functions for themselves (Booth et al., 2011). All of the children displayed difficulties with emotional regulation and this was one of the main reasons for all of them being admitted to the psychiatric hospital.

Communication was present during the interactions; however, it seemed out of sync for the dyads. Ben, for example, was seen trying to interact with his grandmother when trying to show her his picture. However, he had to repeat himself three times before she looked up. Luke was seen struggling with the block building and was not able to verbally communicate to his mother that he needed help. She indicated that she did recognise that he needed assistance. Luke's mom did not verbalise this, but instead changed the structure to make it easier for him to build the same structure. Anne wanted a poem to be taught to her, but her

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mother wanted to teach her the 9-times-table. The communication was present, but appeared to be out of sync. When the dyad is out of sync, there seems to be a failure in communicating what is needed in the interaction between the dyads. The child is not able to verbalise he/she needs help and the primary caregiver is unable to verbally communicate that they are available when the child needs help. The interaction is characterised by limited engagement with, a marked avoidance of, and failure to seek help and comfort from the attachment figure (Dorothee et al., 2009).

There was a marked lack of playfulness in almost all of the tasks and with all of the dyads. Playfulness is important as it is seen as one of the factors that contribute to the individual's development of self (Parritz & Troy, 2014). The primary caregivers did not engage in play, but rather saw the activities as tasks that needed to be completed and each of them said at one stage that this was something that they had to do and they had to get through. Ben's grandmother said, *"We are being filmed so we need to get through this.*" Luke's mom at times created a lot of distance during the activities and this seemed to not allow space for playfulness. Anne's mother seemed task-orientated and serious. The primary caregivers appeared to find it difficult to be with the children and to play with them; the interactions were unbalanced.

According to Dorothee et al. (2009), an unbalanced interaction can develop into an unbalanced primary caregiver–child relationship. This is likely to manifest in emotional and/or physical withdrawal as well as unresponsiveness from the primary caregiver and/or in negative, hostile and intrusive behaviours (which was part of the children's diagnosis). These behaviours, along with the primary caregiver's incapacity to repair their disruptions, leave the child in a state of extreme fear and put the child at risk of developing a mental illness.

A clear example of the primary caregivers' incapacity to repair disruptions during the MIM interaction was when they left the room for one minute and returned. Each primary caregiver moved straight onto the next task, failing to acknowledge the child's distress. Luke expressed that it had been a scary experience; however, his mother could not understand this and asked, *"Why?"* He seemed unable to verbally communicate why he was afraid when she left and he did not even try to attempt to explain, but the dyad continued with the next task. Anne's mother and Ben's grandmother continued with the next task in an anxious manner. They all appeared to have felt the anxiety that the separation brought up in each of them and tried to ward it off by continuing with the next task.

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Contradiction and inconsistency leaves children feeling constantly afraid to the point that they feel they are able to lose emotional and behavioural control, but they are unable to source adults for help as they do not see them as a solution to their chronic stress. This puts the child at risk of developing a mental illness (Main & Solomon, 1990). This is supported in this research study as all the children were diagnosed with more than one mental illness.

The interactions that were observed appeared disorganised. According to Allan et al. (2012), children develop controlling strategies of interacting with their primary caregivers. These controlling strategies can be understood as the children's frantic efforts to reconstruct their relationship. These strategies of control can take two different forms:

1) The children are controlling and punitive, and they become aggressive both physically and verbally with their primary caregivers. The child will attack and humiliate the primary caregiver in order to manage the relationship (Allan et al., 2012).

Luke and Anne displayed more aggression towards their primary caregivers during the interactions. Luke initially did not want to sit with his mother; he ignored her and refused to sit next to her. When he interacted, he was overly aggressive. He was persistent in his attacks on his mother. She responded by laughing.

During the game of thumb war, Luke again was overly aggressive and determined to beat his mother at this game. During the nurturance activity, he put cream all over his mother's face and continued to do this even though she asked him to stop. His mother responded by giggling. During the feeding activity, his mother teased him and he responded by trying to bite her fingers.

Although Anne pretended that her puppet was kissing her mother's puppet, the interaction was rough and thus, displayed aggression. Her mother retracted from her. She then said, *"I am a crocodile and I am going to eat you"* and subsequently, aggressively attacked her mother. During the separation, she tapped her hands on the desk and sang, *"I am not afraid of you."* During the lotion activity, she put on the cream roughly and pinched her mother's skin who reacted by laughing. During the feeding activity, she immediately tried to bite her mother's fingers. This seemed to be the way in which the children maintained their relationships. This can be indicative of a disorganised interactional pattern and alludes to a disorganised attachment style.

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2) The complete opposite may develop whereby the child becomes controlling in a care-giving manner. According to Allan et al. (2012), in order to maintain the relationship the child will attempt to entertain, direct, organise or reassure the primary caregiver.

This pattern could be seen with Ben. Although he was slightly aggressive during the initial task, he went on to try to meet his grandmother's needs. He helped to direct her during the tasks; he read the cards for himself and was able to direct himself and his grandmother if needed. He attempted to engage her during the structure task by acknowledging her favourite colour. He changed his career choice to suit what she would like and attempted to entertain her by drawing pictures he thought she would enjoy.

Overall, a major theme that was observed was that all the children in the dyads took control of the interactions the majority of the time. This can be understood as a controlling attachment pattern. According to Hennighausen and Lyons-Ruth (2007), the child will learn by the age of three to six to understand and reason about the primary caregiver's emotional states and therefore, for the children in these dyads, they had already learned to understand and reason their caregivers' emotional states and had further negotiated a way in which to manage them. For example, it appeared that Anne's mother found it difficult to address anxiety and therefore, Anne experienced it as difficult to approach her mother with anxiety.

Hennighausen and Lyons-Ruth (2007) explained that by middle childhood the disorganized attachment behaviours of many infants have been replaced by controlling forms of attachment strategies. These strategies, as discussed above, can be seen as controlling in a punitive manner by the child or controlling in a care-giving manner by the child. Both of these disorganized attachment strategies in middle childhood have been seen to be associated with school-aged aggression and psychopathology in childhood. This is something that is confirmed by this study: all three children in the dyads were referred for aggression both at home and at school, and had been diagnosed with a mental illness.

Hennighausen and Lyons-Ruth (2007) expressed the opinion that these attachment processes are different from the child temperament and seem to exist in primary caregiver and child interactional patterns and not in the primary caregiver alone or the child alone. It can be seen as a dance between the dyad that is learned and repeated over and over during each interaction.

However, it is important to mention that psychopathology does not rest solely on interactional patterns with primary caregivers. An interaction that is disorganised that interplays with the child's own biological vulnerability and therefore, might produce psychiatric symptoms as a reaction is likely to contribute to psychopathology (Hennighausen & Lyons-Ruth, 2007).

There is much variability in the behavioural profiles of children diagnosed with psychopathology; for example, all the children were referred for aggressive outbursts, however, they all behaved differently during the MIM. Luke was more overtly aggressive than Anne and Ben, and Ben was far less aggressive than Luke and Anne. This suggests that multiple etiological models are needed to understand the development of each diagnosis. One must consider the children's exposure to different experiences of loss, abuse and different hostile relationships that may all lead to different behaviours (Hennighausen &Lyons-Ruth, 2007). However, this was not the aim of this study and therefore, is discussed in Chapter Six as a recommendation for further research. Rather, the present study intended to describe, compare and understand the interactional patterns of the dyads by employing attachment theory.

Rholes et al. (2006) explained that attachment styles might be transmitted from one generation to the next. Each primary caregiver seems to hold their own anxieties with regards to their interaction with their children; this was seen during the MIMs. One could interpret that their own attachment style and the way in which they interacted with their children had been influenced by the attachment style that they had had with their own primary caregiver. One example is that the primary caregivers appeared to find it difficult to be with the children and to play with them; one could question whether the primary caregivers knew how to play and whether they played as children.

Another example, one of the reasons for Anne's referral, was that she was extremely anxious when separated from her mother and feared that her mother would not be fine without her. When Anne's mother prepared her for the separation, she seemed to have her own anxiety as she was unable to explain that she needed to leave the room for one minute, but instead she hid the card and told her she needed to go to the bathroom, almost protecting her from the truth. It appeared that Anne's mother did not think this was appropriate for her daughter and even verbalised that she did not want her to read some of the cards. In this chapter, the five categories of interaction that have been set out by the MIM manual were outlined. Every category was defined and illustrated by means of examples from the researcher's thematic

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analysis of the original data. These examples attempted to illustrate the categories set out by the MIM. The researcher then discussed the main findings from the categories as they relate to relevant theory and attempted to make possible links to current attachment theory.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1   Introduction

In this chapter, a summary of the findings discussed in Chapter Five with regards to the interactional patterns of primary caregiver-child dyads of children admitted to a psychiatric hospital is presented. This chapter also focuses on the contributions made by the study as well as factors that limited the study. Finally, the chapter is concluded with recommendations for future studies.

This research study followed a qualitative research approach and therefore, the researcher understands that an individual's experience is his/her own subjective experience and is real to the individuals. Consequently, it should be taken seriously. The researcher attempted to understand the experiences of the dyads by interpreting the interactions and language expressed during the MIMs.

In addition, this study followed an exploratory design as the researcher set out to explore aspects of the interactional patterns set out by the MIM. The study subscribed to relativist ontology and therefore, the researcher acknowledges that there is no singular truth and what was observed may have multiple realities and truths. The epistemology was subjectivist and thus, it is acknowledged that reality cannot be known objectively and therefore, the understanding and interpretations made about the dyads' interactional patterns were influenced by the researcher (McLeod, 2011; Willig, 2013).

6.2   Summary of findings

The primary caregivers showed similarities in that they were unable to react sensitively to their children's aggression and that at times they were not attuned to their children's emotional states. The way in which the primary caregivers reacted to their children with regards to sensitivity, availability and predictability contributed to the children's emotionally prominent beliefs and expectations; for example, in order to maintain the relationship with their primary caregiver they need to be in control of the interaction (Parritz & Troy, 2014).

The primary caregivers seemed to find it difficult to provide their children with structure and direction; they were also unable to prepare the children for the separation. Furthermore, the primary caregivers seemed unaware of the fact that being in a strange room without their primary caregiver might be stressful for the children. The interactions were often seen to be

disorganised and characterised by inconsistency and contradictory behaviours. As discussed in Chapter Two and in Chapter Five, a child that has suffered a disorganised interaction from infancy will begin to develop a blue print of how relationships will be (Parritz & Troy, 2014). For example, in the case of these dyads the children believed that they needed to be in control of the interaction in order to maintain the relationship.

Parritz and Troy, (2014), highlighted the importance of the primary caregiver's capacity to provide affection, direction and stress tolerance. This is something that the primary caregivers in this study found difficult to do and was lacking in the interactions observed.

The children in the dyads showed similarities in that they took to the lead in the interactions. According to Allan et al. (2012), these are controlling strategies that the children have developed as a desperate effort to reconstruct the relationship.

The children chose to play with the crocodile puppet and all three children directed aggression towards their primary caregiver. The findings of this study support the notion that in the case of aggression the child may have internalised the belief that others are hostile and that social relationships are stressful. The child internalises that they are unworthy of care. Holding onto these distorted assumptions he/she tends to interpret ambiguous behaviour as hostile and therefore, acts out defensively to protect him/herself (Steele, 2003; Parritz & Troy, 2014). One could, therefore, assume that the children admitted as in-patients interpret certain behaviours as threatening and could be acting out simply to protect themselves.

There were positive interactions during the dyads, even though many were short-lived; for example, Anne and her mother enjoyed the second engagement activity. They were seen working together and mirroring each other's body language. When Luke's mother had to challenge him, this proved positive as she was able to reach him on his developmental level and set tasks that he could master. Luke responded well to this interaction and fully engaged in the task.

The children in the dyads showed a capacity to develop strategies to self-soothe and self-regulate during the separation. Luke, for example, fidgeted and tapped his leg up and down when he felt anxious, Anne sucked and bit her fingers, and Ben tapped his legs up and down and mumbled to himself. All these are seen as attempts to help ease the internal anxiety they felt. This could be an indicator that the child is able, at times, to regulate emotionally. However, the children showed that it was difficult for them to actually accept nurturance; the

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children had strong non-verbal reactions when they found out that their primary caregiver needed to put lotion or powder on them; these included frowning, retracting and verbal reactions such as *"No."* All of the children illustrated that they were uncomfortable with being nurtured.

It is important to note that the researcher was interested in not only in the way in which the primary caregiver interacted, but the way in which the child interacted with the primary caregiver. During the nurturance tasks, it became clear that the children found it very difficult accepting nurturing from their primary caregivers and this, in turn, could have made it difficult for the primary caregiver to give nurturance. Hennighausen and Lyons-Ruth (2007) explained that the disorganisation in the dyadic relationship seems to exist in primary caregiver and child interactional patterns and not in the primary caregiver alone or the child alone.

Ben showed a marked difference as he seemed to be more attuned to his grandmother and her needs, and appeared to want to meet these needs. Luke and Anne, on the other hand, seemed to want to take control in the interactions and move on as they felt quite anxious about their own needs being met in the moment. This supports the findings that dyads that are seen as disorganised can take two different forms. Children are either controlling in that they are controlling and punitive. The child in an effort to manage the relationship will at times attack and humiliate the primary caregiver (Allan et al., 2012). This pattern was observed more in Luke and Anne.

The second form is that the child will attempt to maintain the relationship by being more of the caregiver to the primary caregiver by entertaining, directing, organising or reassuring the primary caregiver (Allan et al., 2012). This pattern was displayed more by Ben than the other two children observed. It is important to note that Ben's primary caregiver was his maternal grandmother and not his mother; this could be an explanation for the difference in his behaviour.

The researcher observed disorganised interactional patterns, but this may not have been the reason the children were admitted as in-patients. It simply means that it could contribute to the development of a diagnosis. Other factors such as biological vulnerability and trauma may also contribute to the development of psychopathology. One must also keep in mind that many other factors are at play in their immediate environments and this could have added to their interactional patterns with their primary caregivers.

6.3 Contributions of the study

1. This study succeeded in achieving its aims set out in Chapter One. The interactional patterns of the dyads were described, and the researcher was able to identify both similarities and differences among the dyads.

2. The findings indicate that the children who were admitted to a psychiatric hospital for in-patient treatment had disorganised interactions with their primary caregivers. This has implications for the psychological understanding of the interactional patterns of children who have been admitted and as a consequence, suffer from a formally diagnosed mental illness. Understanding the way in which the primary caregiver and the child interact may add to the therapeutic process as the child often displays the same interactional patterns with other individuals who are involved in the treatment of the child.

3. The findings are supported by current attachment theories that have also found that children who have interactional difficulties suffer from psychopathology.

4. As discussed in Chapter One, there is a lack of research conducted on children admitted to a psychiatric hospital, and how their environment and interaction with their primary caregivers has an influence on their mental health. This study has added to the development and enhancement of understanding in this area.

5. The results of this study provided an indication that the MIM can be employed as a qualitative method to investigate interactional patterns of children by providing rich information and detail.

6.4 Limitations of the study

1. The size of the sample was small and was a very specific population and therefore, it attempted to give an ideographic generalisation.

2. The study was conducted in South Africa; the country's population is multicultural and diverse. The sample was very limited as all the dyads were from an English or Afrikaans-speaking Caucasian ethnic group. The children available at the time were from this ethnic group and unfortunately, provided a limited representation of the culturally diverse population in South Africa.

3. The quality of the research was heavily dependent on the skills of the researcher and could have been easily influenced by personal biases. The researcher acknowledges that her own interactional history and attachment history with her

own primary caregiver at times influenced her interpretations. To protect the study from this bias, the researcher ensured that she was in her own process of self-reflection and made use of a co-interpreter in the form of her research supervisor.

4. Without an in-depth history of the primary caregiver and child interaction, the researcher was unable formulate the etiology of the interaction between the dyad. However, this was not the aim of the study; the aim was to describe, compare and understand interactional patterns.

6.5 Recommendations

In this section, recommendations for future researchers are discussed. These include recommendations based on the interactions observed for children admitted to a psychiatric hospital.

6.5.1 Recommendations for future researchers

1. Further research regarding interactional patterns of children admitted to a psychiatric hospital and their primary caregivers might wish to conduct a case study or multiple case studies. This will enable the researcher to not only describe the interactional patterns observed, but also explore the individual's history and provide an in-depth analysis of the primary caregiver and child interaction since pregnancy. This may provide the researcher will an etiology of the interactional patterns developed over time.

2. A similar research study could incorporate a larger sample of participants and this will add value in that it may support or dispute the findings of this study.

3. A similar research study could include dyads from different ethnic groups. This could also allow a comparison of interactional patterns for different ethnic groups which could yield interesting findings.

4. A similar research study could specifically look at children with the same diagnosis and their interactional patterns with their primary caregivers.

6.5.2 Recommendations regarding in-patient treatment

1. Unless specifically recommended, in the experience of the researcher the primary caregiver and the child are usually assessed separately by a multi-disciplinary team. A recommendation is that the primary caregiver and child

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not only be assessed separately, but also together. Furthermore, other individuals that may have an influence on the child's life such as a father or older sibling should be assessed.

2. Understanding the way in which the primary caregiver and the child interact may add to the therapeutic process as the child often displays the same interactional patterns with other individuals. For example, this study showed that the children's aggression may have a purpose, namely, they wanted to stay in control of the relationship. Thus, this understanding could aid all staff members in their own understanding of children and the way in which they behave.

3. In addition, the therapist will benefit particularly from understanding the child's interactional patterns with his/her primary caregiver as this may influence the therapeutic relationship with the therapist and may assist in providing guidance for the therapist regarding the type of therapy from which the child would benefit .

This study has shown that the way in which the dyad interacts can have an impact on their daily functioning. It is recommended that in addition to individual therapy for the child and their primary caregiver, where possible, the dyad should engage in attachment-based interventions.

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APPENDICES

INFORMATION LEAFLET AND INFORMED CONSENT

TITLE OF STUDY: Interactional patterns of children admitted to a psychiatric hospital using the Marschak Interaction Method

Dear Participant

1)   INTRODUCTION

We invite you and your child to participate in a research study. This information leaflet will help you and your child to decide if you want to participate. Before you and your child agree to take part you and your child should fully understand what is involved. Please keep this leaflet and if you and your child have any questions that this leaflet does not fully explain, please do not hesitate to ask the consultant psychologist.

2)   THE NATURE AND PURPOSE OF THIS STUDY

The purpose of this study is to utilise the Marschak Interaction Method (MIM) in order to discover and describe the interactional patterns of primary caregiver-child dyads of children admitted to a psychiatric hospital. You as a parent/primary caregiver and child pair are a very important source of information on caregiver and child interaction when a child has been admitted to a treating hospital.

3)   EXPLANATION OF PROCEDURES TO BE FOLLOWED

For this study the Marschak Interaction Method is used. This means that you and your child will be asked to do nine tasks together. For instance, you may be asked to draw a picture together. These tasks will be written down on task cards and you and your child will be able to complete them at your own pace. Each of these tasks involves both you and your child and allows a researcher to understand different aspects of your relationship.

To do these tasks of the Marschak Interaction Method takes about 30 minutes to an hour in total. It is this interaction that will be video recorded. This video will allow the researcher to again look at the tasks you did together to best

understand your relationship. Your video recording will stay the property of Weskoppies Psychiatric Hospital and will remain confidential.

The only information that will be included from your child's hospital file will be demographic information and the reason for admission to the hospital and confidentiality and anonymity is assured.

4)   RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study. The interview and measuring session will take about an hour of your time.

5)   POSSIBLE BENEFITS OF THIS STUDY

Apart from getting the results from your tests, there will be no other direct benefit for you. However, the results of the study will enable researchers and medical professionals to understand your experiences better. This may in turn help us to develop more effective therapy.

In the event of questions asked, which will cause emotional distress, then the consultant psychologist is able to refer you for debriefing and further psychotherapy where needed.

6)   WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the activity without giving any reason. Your withdrawal will not affect you or your treatment in any way.

7)   HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from both the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria, telephone number 012 420 2329 and the Faculty of Health Sciences at the University of Pretoria, telephone numbers 012 3541677 / 012 3541330.

8)   INFORMATION AND CONTACT PERSON

The contact person and researcher for the study is **Holly van Rooyen**. If you have any questions about the study please contact her at the following telephone numbers **078 XXX XXXX.** Alternatively you may contact research supervisor at telephone numbers **Adri Prinsloo: 072 XXX XXXX.** The results of the data and the research will be stored at the University of Pretoria for the next 15 years.

9   COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10   CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your hospital

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UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports and may be used for further research in the future. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect any treatment in any way.

I have received a signed copy of this informed consent agreement.

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Participant's name   ……...(Please print)

Participant's signature: ....…………………   Date.............................

Investigator's name ....……………………..(Please print)

Investigator's signature   ....…………………
Date…….........................

Witness's Name   ....…………….................(Please print)

Witness's signature   ....…………………...
Date.…….........................

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report and may be used for further research in the future. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect any treatment in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name   ....………..(Please print)

Person seeking consent   ....……..............(Please print)

Signature   ....……………............Date.................................

Witness's name   ....……………...........(Please print)

Signature   ....………………………Date…….........................

APPENDIX B

ANALYSIS OF THE MARSCHAK INTERACTION METHOD

STRUCTURE
1. Parent provides structure/directions.

2. Child accepts structure/directions or is child defiant, insisting on doing things his own way.

3. Parent's efforts to structure and organize help regulate the child.

4. What role does the parent take?
   - Parent in peer or child role.
   - Parent unable to set limits.
   - Parent turns authority over to child.
   - Parent in teacher role (pedantic, rigid, focused only on task at hand).

Observations of Verbal and Non-verbal interactions that support conclusions about:
Child & Structure:

Caregiver 1 & Structure:

Caregiver 2 & Structure:

ENGAGEMENT
5. Parent able to engage the child and how.

6. Child's response to parent's attempts to engage.

7. Parent responds empathically to the child.

8. Parent and child are physically and affectively in tune with each other.

9. Parent matches level of stimulation to child's ability to tolerate it

10. The two are having fun together.

Observations of Verbal and Non-verbal interactions that support conclusions about:
Child & Engagement:

Caregiver 1 & Engagement:

Caregiver 2 & Engagement:

NURTURE
11. Parent provides nurturing contact (touch, physical contact, care giving).

12. Child accepts nurturing contact.

13. Parent asks child to take care of him/her.

14. Parent recognizes and acts upon child's need for help in calming/having stress reduced.

15. Child accepts parental help for calming/stress reduction.

16. Child is able to soothe self.

Leave the Room Task
17. Parent prepares child for separation.

Note: Describe child's behavior during separation and at reunion   _____

_____

Tell about Baby/Came to live with Task
18. Nature of story

19. Reflection about parent/child feelings

20. Child's response

21. Parent attunement to child's response

Observations of Verbal and Non-Verbal interacts that support conclusions about:
Child & Nurutre:

Caregiver 1 & Nurture:

Caregiver 2 & Nurture:

CHALLENGE
22. Activities chosen by the parent are developmentally appropriate.

23. Child responds to the task.

24. Parent makes mastery appealing.

25. Child is able to focus and concentrate.

26. Child is able to handle frustration.

27. Parent helps child handle frustration.

Observations of Verbal and Non-verbal interactions that support conclusions about:
Child & Challenge:

Caregiver 1 & Challenge:

Caregiver 2 & Challenge:
GENERAL QUESTIONS:

What would it be like to live twenty-four hours a day with this child?
_____

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What would it be like to live twenty-four hours a day with this parent?

_____

Would living with this parent/child make you feel good about yourself as a child/as a parent?

_____

Other comments/notes:

PARENT FEEDBACK
- List specific positive observations about child and caregivers.
- What overall messages you plan to share with the caregivers about the interaction with their child?
- What questions do you have for the parent based on your observations?
- Which tasks do you plan to show the parent(s) during the feedback session?

TREATMENT PLANNING
- Based on your analysis of the MIM and the information gathered at the feedback, what do the child and the caregivers need?
- Which dimensions will be the primary focus of treatment to meet those needs?

APPENDIX C

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THE
Theraplay®
INSTITUTE

Building Better Relationships

Holly Starling

1 October, 2015

The purpose of this letter is to confirm that **Holly Starling** completed:
Level One Introductory Theraplay and Marschak Interaction Method Training
consisting of 26 CE credit hours.

The workshop was held in conjunction with both Weskoppies Hospital and the University of Pretoria and held at:

> Pretoria, South Africa
> 28 September- 1 October, 2015
> 9:00 a.m. until 5:00 p.m.

The Theraplay® Institute is approved by the American Psychological Association to offer continuing education for psychologists. The Theraplay Institute maintains responsibility for the program. The Theraplay Institute is an Association for Play Therapy APT Approved Provider (number 95-008). The Theraplay Institute has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6470. Programs that do not qualify for NBCC credit are clearly identified. The Theraplay Institute is solely responsible for all aspects of the programs. The Theraplay Institute is approved by the State of Illinois Department of Regulation for Licensed Social Workers, Licensed Clinical Social Workers (CE Sponsor #159-000177), Licensed Professional Counselors, Licensed Clinical Professional Counselors (CE Sponsor #197-000003), Licensed Marriage and Family Therapists (CE Sponsor #168-000134) Illinois State Board of Education for teachers (provider #101133) and the Illinois Early Intervention Program. The Theraplay Institute, ACE provider number 1318 is approved as a provider for social work continuing education by the Association of Social Work Boards (ASWB) through the Approved Continuing Education (ACE) Program. The Theraplay Institute maintains responsibility for the program. ASWB approval period through March 16, 2016.

Donna Gates, MA, LCPC, and Mary Ring, MAMFC, LPC-S, LMFT-S, RPT/S taught the Level One Introductory Theraplay® and MIM training. Donna and Mary are Certified Theraplay® Therapists, Trainers, and Supervisors. They were assisted by Lanel Mare, Clinical Psychologist.

Gayle Christensen

Gayle Christensen
Executive Director

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