

Chapter 1

1. Introduction

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

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

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

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



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

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

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



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

Chapter 2

2. Children with Learning Disabilities

2.1 Introduction

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

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

2.2 Causes of Learning Disabilities

2.2.1 Prevalence and Epidemiology

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

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

2.2.2 Aetiology

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



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

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

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

2.2.3 Family Factors

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

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

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

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

2.3 Defining Learning Disabilities

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

2.4 Manifestation of Learning Disabilities

2.4.1 Cognitive, Motor, Perceptual and Language Manifestation

Learning disabilities are seen to be a heterogeneous group and each person has his or her¹ own combination of symptoms, manifestations and characteristics (Derbyshire, 1991; Gupta, 1999; Silver, 1996). As Lerner (1993,p.20) states it includes a “...cluster of disorders... and no one individual will display all of them.” Although the implications of each of the manifestations are complex, the following groups are seen to have common characteristics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

2.5 Diagnosis of Learning Disabilities

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

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

2.6 Prognosis

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



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

2.7 Intervention with Learning Disabled Children

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

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

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

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

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

2.8 Conclusion

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

Chapter 3

3 Object Relations Theory

3.1 Overview

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

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

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

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

3.2 Object Relations Theory and Attachment

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

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

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



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

3.3 Attachment Theory and Therapy

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

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

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

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

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

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

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



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

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

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

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



3.4 Theoretical Considerations- From Klein to Bion

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

3.4.1 Melanie Klein

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

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

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

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

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

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

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

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

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

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

3.4.1.3 Good-enough Experience

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

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

3.4.1.4 The Depressive Position: Ego Development and Object Relations

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

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

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

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

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

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

3.4.2 Wilfred Bion.

3.4.2.1 Containment and Reverie.

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



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

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

3.4.2.2. Attachment and the Ability to Think.

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

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

or *beta* elements are then unable to be processed by the baby. When the caregiver is inconsistent or unavailable to perform these functions for the infant, or when they are performed in aberrant ways, a trauma is likely to ensue. Consequently, this insecure attachment due to the failure of the parental object results in an inability to develop versatile strategies to deal with feelings evoked by the failure of the attachment figure (Eagle, 1997). This would be the result of unmetabolised *beta* elements.

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

3.5 Klein, Bion and Attachment.

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

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

3.6 Margret Mahler: Separation and Individuation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.8 Donald Winnicott: The Holding and Containing Mother

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

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

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

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

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

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

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

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

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

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

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

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

3.9.1 Attachment and the Failure to Learn.

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

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

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

3.9.2 The Mother-Infant Relationship and the Failure to Learn

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

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

According to Bion (1957), an infant faced with an adverse disposition will potentially have the following features; a preponderance of destructive impulses, a never decided conflict between the life and death instincts, and severe anxiety as well as an intolerance of frustration. An object which is unavailable for whatever reason does not allow for the mother to take in his projections resulting in the object being experienced as an additional external source of destruction, of communication and awareness (O'Shaughnessy, 1992). Bion has suggested that the maternal object who fails to introject, in effect a mother who has failed to absorb the infant's projections, is then perceived by the child as hostile to any attempt at projective identification (Britton, 1992).

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

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

3.9.3 Maternal Containment and the Failure to Think

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

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

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

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

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

3.9.4 Curiosity and the Ability to Learn

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

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

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

Simpson (2002) outlines two significant areas that affect the child's curiosity to learn. Firstly, he believed that children are very sensitive to the way parents show pleasure and interest in the child's curiosity, or they may show embarrassment, hurt, guilt or simply unresponsiveness. "The extent to which a parent can tolerate curiosity in the child if it is coloured with destructive or sadistic fantasies depends upon the individual parent's capacity to tolerate her/his own fantasies in this respect, which is a function of the extent to which they have been able to work through their own oedipal conflict" (Simpson, 2002, p.218). Secondly, a primary concern for children at this stage is the nature of their parent's relationship and the parent's attitude to each other. Thus, how the parents respond to the child's curiosity and how the child experiences the oedipal situation inside his parent's mind can be seen to either impede the growth of knowledge or allow it to thrive.

3.10 Conclusion

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

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

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

Chapter 4

4. Psychotherapy with Children who have a Learning Disability

4.1 Introduction

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

4.2 Emotional Intelligence and Suitability

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

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

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

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

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

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

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

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

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

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



4.3 The Techniques of Clarification, Confrontation and Interpretation

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

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

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

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

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

4.4 Common Therapy Themes

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

4.4.1 Anxieties, Defences and the Concept of Secondary Handicap

Anxieties are seen to be an important part of everyday life, giving the individual warnings when there is possible danger whether it is emotional or physical (Lanyado & Horne, 1999). How the child's anxieties have been contained or exacerbated in the past by parents or caretakers, determines how anxious the child is in life and how they cope with these anxieties (Lanyado & Horne, 1999). Defences are developed and utilised by the ego to protect itself at times of anxiety. Without defences, the individual becomes vulnerable in their interaction and is likely to respond inappropriately or be easily hurt (Lanyado & Horne, 1999). One of the most important concepts of psychotherapeutic work with the learning disabled is that of secondary handicap. The secondary handicap is the particular use the person makes of the original organic or traumatic damage as a defence against the feelings associated with the original handicap (Hernandez-Halton et al., 2000; Sinason, 1992). It is also used as a defence against the reaction of others towards them (Hernandez-Halton et al., 2000).

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

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

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

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

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

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

4.4.2 Transference

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

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

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

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

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

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

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

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

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

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

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

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

4.4.3 Counter-transference

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

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

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

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

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

4.4.4 The Interaction of the Internal and External World

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

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

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

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

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

4.5 The Role of the Parent in Child Analysis

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

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

4.5.1 The Initial Consultation

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

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

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

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

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

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

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

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

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

4.5.2 Continuing Consultations with Parents

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

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

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

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

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

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



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

4.6 Parent-Child Problems in Relation to Learning Disabilities

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

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

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

4.6.1 Cognitive and Affective Aspects

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

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

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

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

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

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

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

4.6.2 Family Boundaries

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

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

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

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

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

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

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

4.7 Conclusion

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

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

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



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

Chapter 5

5. Research Methodology

5.1 Introduction to the Study

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

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

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

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

5.2 The Research Methodology

5.2.1 A Broad Outline of Qualitative Methodology

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

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

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

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

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

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

5.2.2 Phenomenological Hermeneutic Philosophy

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

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

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

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

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

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

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

5.2.3 An Outline of the Methodological Perspective of Phenomenological Hermeneutics

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

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

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

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

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

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

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

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

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

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

The fixation of meaning:

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

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

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

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

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

The display of non-ostensive references:

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

The universal range of addressees:

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

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

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

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

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

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

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

5.2.4 Multiple Readings of the Narratives

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

Mathner and Doucet (1998) outlined the following method:

First reading: reading for global understanding and employment.

Part one of this reading involves reading for the manifest content of the narratives. Part two of this reading involves making the researcher's understanding and thoughts about the interview/assessment explicit (Mathner & Doucet, 1998)

Second reading: Content analysis.

In content analysis the data/text is broken down into thematic meaning units and coded according to predetermined coding categories. The advantage of content analysis is that it is a systematic and public way of conceptualising the data (Bauer & Arts, 2000). However, in separating the units of analysis, one can lose the global understanding of the data, as well as the sequentiality of the text, and by focussing on frequencies one can miss the rare and absent in data, which is often considered a strength in qualitative research (Bauer, 2000). For this reason, the other readings are done to compensate for this.

Third reading: reading for the meaning of psychotherapy

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

5.2.5 Evaluating Interpretative Materials

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

Coherence

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

Uncovering

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

Validation of interpretation by another researcher

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

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

1) *Illumination*

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

2) *Thickly Contextualised Materials*

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

3) *Historical and Relational Grounding*

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

4) *Process and Interaction*

An interpretative account must be both processual and interactional.

5) *Engulfment of What is Known*

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

6) *Prior Understanding*

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

7) *Coherence and Understanding*

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

8) *Unfinished Interpretations.*

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

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

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

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

5.3 The Steps to Interpretation

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

5.3.1 Choice of Participants

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

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

5.3.2 The Mothers, the Children and the Therapists

The following was required from the participants: -

The Mothers

- 1) Written consent from the mother was obtained to do all three interviews (see appendix C). This also involved explaining the research as well as the confidential nature of the research. It also included a letter to each mother, which explained the research, which they could then read thoroughly at their leisure.
- 2) The mothers were not to be in the field of psychology as this may have influenced their responses.

The Children

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

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

- 2) The children were all assessed on the Wechsler Intelligence Scale for Children-Third Edition (WISC-III) and were required to have at least an Average Full Scale Overall IQ score.
- 3) The children all had the experience of being in therapy with a psychoanalytic therapist for at least 6 months.
- 4) The children were to be between the age of seven and eleven. The reason for this would be so that they could verbally articulate their experience of the therapy and secondly the focus of the study is on children. The selection of the age is also based on the beliefs of development theory. Piaget (1952, in Sorenson, 1993) says that children between the ages of seven and eleven are in the stage of concrete operations and have evolved logical thought processes and have developed more social communication. Children at this age are able to understand the causes of events, to express themselves, and to understand that different people react in different ways (Madorin, 1999).
- 5) Before the interview, the process of the interview was explained to the child to ensure that they were firstly, willing candidates, and secondly, to explain to them the confidential nature of the interview and to reduce their anxiety as to the process of the interview.

The Therapists

- 1) The therapists were all trained in a psychoanalytical approach to therapy and had practiced this approach with the participants. The therapist's had been in practice for a minimum of two years.
- 2) The therapist's consent to be interviewed was obtained.
- 3) The process of the interview and the confidentiality of the research were explained to the therapist, in particular that the mother or the child did not have access to the interviews.

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

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

5.3.3 Procedure

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

5.3.4 Data Collection

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

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

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

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

5.3.5 Transcribing the interview from audiotape

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

5.3.6 Preparatory Stages

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

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

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

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

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

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

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

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

Tell me what it was like to be in therapy?

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

Tell me what you used the therapy time for.

How did you feel about your therapist?

Tell me about having a learning disability?

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

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

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

5.3.6.2 The Pilot Study

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

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

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

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

5.3.7 The Research Questions

Research Questions for Mother Participant

Question:

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

Reason for the Question:



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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

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

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

Research Questions for Child Participant

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

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

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

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

Question:

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

Reason for the Question:

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

Research Questions for Therapist Participant

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

The importance of the therapy focusing on learning disabled children has been previously discussed

Question:

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

Reasons for the Question:

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

Question:

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

Reason for the Question:

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

Question:

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

Reason for the Question:

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

5.4 Conclusion

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