Therapists' perceptions on the implementation of Theraplay® in the South African context

by

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Mini-dissertation submitted in partial fulfilment of the requirements for the degree MASTER OF ARTS

(Clinical Psychology)

to the

Faculty of the Humanities

Department of Psychology

at the

University of Pretoria

Pretoria, Gauteng

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2020

Declaration

I, **Deidre Ann du Toit,** hereby declare that this mini-dissertation being submitted for the degree Master of Arts, Clinical Psychology at the University of Pretoria is my own original work. I have not previously submitted this document to another university or faculty. Where secondary sources were used, they have been appropriately acknowledged and referenced in accordance with the 6th version of the American Psychological Association and the University of Pretoria requirements.

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Ethics Statement

The author, **Deidre Ann du Toit**, whose name appears on the title page of this mini-dissertation, has obtained the applicable research ethics approval for the research described in this work.

The author declares that she has observed the ethical standards required in terms of the University of Pretoria's code of ethics for researchers and the policy guidelines for responsible research.

Acknowledgements

I would not have been able to complete this without my faith in God assisting me to persevere, and the immense support and encouragement from the people in my life. I would like to express my sincere gratitude to the following people:

- To my family—Gawie, Karen, and Karla. Thank you for your emotional support, understanding, and motivation with *everything* I have embarked on in my life. I would not be who and where I am today if it were not for each of you. A special thank you to my father for the financial support he has provided me throughout my life to help me achieve my dreams.
- To my supervisor, Mr Ahmed Riaz Mohamed. Thank you for your support and assistance throughout this intense process. If not for your knowledge and continuous guidance, I would not have reached the end of this dissertation.
- To my mentor, Voula Samouris. Thanks to you I embarked on this journey of becoming a clinical psychologist—something that I have never looked back on doing. You have supported and advised me this whole time. I consider you not only a mentor, but also a true friend. Thank you for everything!
- To my close friends, Lara and Tania. Thank you for encouraging and supporting me emotionally throughout this time period. Words cannot explain how much it all helped me to complete this without losing my sense of self.
- To Monique Kock, my co-coder, thank you for the coding that you administered and for the guidance that you provided me with ATLAS.ti. I truly appreciate it.
- Finally, to the participants. Thank you for offering up time in your busy schedules to be part of this study. Ultimately, this study would not have been possible without any of you.

Abstract

Attachment theory is a fundamental framework established to understand mental health and emotion regulation in children and adults. Studies have indicated that disruptions to attachment within caregiver-child relationships can result in several psychological and behavioural challenges in children. As a result, various attachment-based interventions have been developed to remediate these relational challenges within caregiver-child dyads. Theraplay® is one such therapeutic modality that is play-based and involves the caregiver and child within the therapeutic process. Despite its popularity among practitioners, Theraplay® has not received much attention in literature with limited consideration given to its implementation in contexts outside of the United States of America (USA). Therefore, the aim of this study is to explore therapists' perceptions on the implementation of Theraplay® in the South African context.

An exploratory qualitative research design situated within an interpretive paradigm was adopted to explore the perceptions of research participants regarding implementing Theraplay® in South Africa. Through purposive sampling, and secondary snowball sampling, six participants—trained in Theraplay®—were selected to take part in the study. Individual semi-structured interviews were conducted with each participant and transcripts were analysed via inductive thematic analysis. The following salient themes emerged across the data set: 1) overall potential of Theraplay® as a therapeutic modality, 2) applicability of Theraplay® in South Africa, 3) impact of resource availability on Theraplay® in South Africa, and 4) role of caregiver accessibility and influence on Theraplay®.

Overall, participants valued Theraplay® as an attachment-based modality but considered administrative challenges as requiring further deliberation pertaining to contextual and cultural aspects of this therapeutic intervention for South Africa. This may stimulate further research on possible context-specific adaptations or additions to Theraplay® in order

to respond more efficiently through psychological treatment of children's problems within the South African population. It also indicates the need to continue expanding research regarding caregiving practices within diverse cultural contexts such as South Africa.

Keywords: Theraplay®, attachment, caregiver-child, cross-cultural, South Africa

Table of Contents

List of Tables

List of Figures

CHAPTER 1—INTRODUCTION

"Whilst especially evident during early childhood, attachment behavior is held to characterize human beings from cradle to the grave."

— John Bowlby (1979, p. 129)

John Bowlby's research pertaining to the significance of the caregiver-child relationship for survival and personality development of the child, and Mary Ainsworth's complimentary empirical evidence for, and expansion of, his work resulted in the development of attachment theory as it is known today (Hooper, 2007). Over the last half-century, attachment theory and its related theoretical underpinnings offer valuable insights into the essence of early experiences and human relations. The comprehension of this has significantly influenced the development of therapeutic interventions targeting children's difficulties.

This chapter aims to provide an overview of the current study. The context and rationale are discussed, following an outline of the paradigmatic underpinning of this study. The research design and methodology are summarised, before the chapter concludes with a description of the chapters to follow in this study.

Context and Rationale

Attachment-based therapeutic interventions are increasingly being pursued in the treatment of caregiver-child difficulties and various childhood psychopathologies (Julian, Lawler, & Rosenblum, 2017). Since the origination of play therapy through the works of Virginia Axline, Melanie Klein and Anna Freud (Axline, 1981; Donaldson, 1996; Klein, 1955), the integration of play in therapeutic interventions with children (Poynton, 2012) has been taught and applied around the world with increased involvement of caregivers directly in the therapeutic process (Haine-Schlagel & Walsh, 2015). One such therapeutic modality is

Theraplay® that focuses on enhancing attachment through play while involving both the caregiver and child together in the process of intervention (Booth & Jernberg, 2010).

Despite the significance of attachment theory and related interventions, there is a dearth of attachment-related research in general within South Africa, with a few notable exceptions (e.g. Aspoas & Amod, 2014; Blackie, 2014; Cooper et al., 2009; Dekel, Abrahams, & Andipatin, 2018; Meinck et al., 2017; Mohamed & Mkabile, 2015; Rawatlal, Pillay, & Kliewer, 2015; Spies, Sterkenberg, van Rensburg, & Schuengel, 2016; Spies & van Rensburg, 2012; Tomlinson, Cooper, & Murray, 2005). This is even more apparent in relation to Theraplay®, which has received minimal attention in South African literature. As such, scant qualitative research exists which explores therapists' experiences of engaging in Theraplay® as a therapeutic modality.

Investigating the experiences of therapists who use Theraplay® in South Africa may offer insight into the applicability of this therapeutic intervention within a non-Western context such as South Africa which is socially, culturally, and economically diverse (Berg, 2012), and—in many ways—unlike the context in which Theraplay® was originally developed.

Research Aim, Questions, and Corresponding Objectives

The aim, therefore, of this study is to explore therapists' perceptions of implementing Theraplay® as a therapeutic modality in the South African context. Three research questions and correlating research objectives have been identified to further guide an in-depth understanding of the research aim as stated above. The first research question is: How do therapists perceive facilitating factors regarding implementing Theraplay® within the South African context? The corresponding objective entails exploring therapists' perceptions regarding facilitating factors of implementing Theraplay® in South Africa. The penultimate

research question is as follows: How to therapists perceive challenges involved in implementing Theraplay® within South Africa? To explore therapists' perceptions regarding the challenges involved with implementing Theraplay® in South Africa is the related research objective. The final research question identified is: How do therapists consider making possible adaptations, if necessary, to implementing Theraplay® within the South African context? The research objective pertaining to this question involves obtaining the professional opinion of therapists regarding giving suggestions and making possible adaptations, where necessary, to Theraplay® in South Africa.

Paradigmatic Underpinning of the Study

This qualitative research study is located within the interpretive paradigm, which assumes that the only way to understand a phenomenon of social reality is from the perspectives of the individuals involved in it (Willis, 2007). Interpretivism inductively develops patterns of meaning rather than beginning with a theory (Creswell, 2014). This allows for more flexible research structures that are amenable to capturing meaning in human interactions (Willis, 2007). Interpretivism understands that reality is constructed through participants' experiences of phenomena and recognises that the researcher's own background and experiences also have an impact on the interpretation of the research (Haverkamp & Young, 2007). Accordingly, this study has a relativist ontology and a subjectivist epistemology whereby all interpretations are founded within a particular context (Creswell, 2014).

Overview of Research Design and Method

This study used an exploratory qualitative research design, as qualitative methods are appropriate when the phenomenon being studied is not fully understood (Hsieh & Shannon, 2005). Such research designs strive to explore and understand mental experiences and human existence (Brinkmann & Kvale, 2008). They aim to highlight a phenomenon through

developing rich descriptions of the context and the meanings thereof (Oliveira, Sousa, & Pires, 2012).

Although there are no strict guidelines regarding sample sizes for qualitative studies when using in-depth interviewing, Guest, Bunce, and Johnson (2006) suggested that the selection of six interviewees is adequate to obtain data saturation when utilising thematic analysis. Purposive and snowball sampling were used to recruit participants as these sampling procedures are considered acceptable and are regularly used in qualitative research when the aim is to explore, understand, and describe a phenomenon (Gravetter & Forzano, 2012). Participants were registered with the Health Professions Council of South Africa (HPCSA) as independent practice mental healthcare professionals for a minimum of three years after completion of a community service year if required for independent registration. All participants had received at least Level 1 training in Theraplay® and had a minimum of three years of experience using Theraplay® in their clinical practice.

Data was collected through semi-structured interviews which provide adequate structure to address particular subjects, while also allowing opportunities for participants to suggest new insights regarding the phenomenon being researched (Kvale, 2003). Each interview was transcribed verbatim by the researcher (Gill, Stewart, Treasure, & Chadwick, 2008). All transcripts were analysed using thematic analysis according to the guidelines outlined by Braun and Clarke (2006; 2013).

Ethical approval to conduct this study was obtained from the Research Ethics Committee of the Faculty of Humanities of the University of Pretoria. Ethical guidelines proposed by Christensen, Johnson, and Turner (2014), Tracy (2010), and Willig (2013) were adhered to. The study followed the ethical guidelines of informed consent, no deception or coercion, confidentiality, and the right to withdraw at any time.

Lastly, trustworthiness and rigour of this qualitative study were established through credibility, dependability, confirmability, and transferability (Anney, 2014; Pitney, 2004; Tobin & Begley, 2003). The researcher employed reflexivity, an audit trail, and utilised an established research method to ensure rigour. In-depth, contextual information was also provided within the results and discussion chapters.

Delineation of Chapters

It must be noted that throughout this study, the researcher refers to 'caregiver' as any attachment figure such as a parent, family member, or non-familial individual that is primarily involved in the upbringing of a child. The use of 'patient' also denotes any individual seeking psychotherapeutic treatment within the public or private mental healthcare sector. To follow is a brief summary of each remaining chapter.

Chapter 2

This chapter provides an overview of the existing literature relating to attachment theory and the importance of caregiver-child relationships. It also briefly outlines attachment-based therapeutic interventions utilised with children. The chapter continues to focus in-depth on Theraplay®, including which difficulties are indicated for treatment with Theraplay® and the role that the therapist has in this process. Finally, consideration is given to research done within the South African context regarding attachment and attachment-based interventions, with specific attention given to Theraplay®.

Chapter 3

A comprehensive discussion of the research methodology for this study is provided. The rationale, aim, and research questions are stated, followed by a delineation of the research design and approach taken. Description of the research participants and sampling procedures used to recruit them is given. This is succeeded by a discussion of the data

collection procedure and the data analysis utilised. The chapter concludes with addressing ethical considerations and issues of trustworthiness and rigour.

Chapter 4

Chapter 4 presents the results obtained for this study. Each of the four salient themes that were identified are diagrammatically presented and subsequently discussed. Applicable verbatim quotations from the interviews are included here as evidence to illustrate the respective themes.

Chapter 5

This penultimate chapter further interprets the results of the previous chapter in relation to applicable existing literature. This discussion is organised according to the stated research questions and objectives of the study as outlined in Chapter 3.

Chapter 6

The final chapter outlines the most significant findings and understanding of the study. It also discusses the limitations of the study and provides recommendations for future research endeavours.

Summary of Chapter

This chapter provided a brief introduction to the research study. It gave the context and rationale of the study, followed by the paradigmatic underpinning of the study and its methodology. An outline of the research design and methods applied for the study was also provided. The chapter concluded with a concise description of each chapter to follow. Chapter 2 will commence with the literature review of this study.

CHAPTER 2—LITERATURE REVIEW

Introduction

This chapter begins with a brief overview of attachment theory, issues concerning its universality claim, and a discussion of the significance of the caregiver-child relationship. A summary of interventions targeting the challenges experienced within caregiver-child dyads is provided, while a more in-depth exploration of Theraplay®—as the focus of this study—and the notable research surrounding it is discussed. Following that, the chapter encapsulates relevant literature concerning South African research relating to attachment and attachment-based interventions, specifically concerning Theraplay®, to highlight the dearth of research pertaining to this in the local context.

Attachment Theory and Caregiver-Child Relationships

Attachment theory is accepted as one of the most significant contributions to child psychology in the 20th century (Dixon, 2002). It was developed during the 19th century through the collaborative works of John Bowlby and Mary Ainsworth (Ainsworth & Bowlby, 1991). Bowlby was interested in the connection between the deprivation, separation from, or loss of a mother figure, and how it impacted personality development in children (Sullivan, Perry, Sloan, Kleinhaus, & Burtchen, 2011). He used an amalgam of concepts derived from ethology, information-processing, and developmental psychology to develop the fundamental principles of attachment theory (Brandon, Pitts, Denton, Stringer, & Evans, 2009). Complimenting Bowlby's work, Ainsworth was intrigued with the notion of maternal responsiveness to infant signals and the role it has in shaping infant-mother attachment patterns (Bretherton, 1992). She was also captivated by the theory of security (Hooper, 2007). Bowlby and Ainsworth's concerted aim was to elucidate the healthy and purposeful development established between caregivers' attachment relationships with their children (Ludy-Dobson & Perry, 2010). However, attachment theory has been criticised for the

exclusion of cultural variability in child-rearing practices, as no changes have been made to the theory as such since its inception (Keller, 2017). Cultural anthropologists and psychologists have begun questioning the universality of attachment in light of documented cultural variations in caregiving strategies of children (Keller, 2018; Vicedo, 2017).

Contributions by John Bowlby

The interest of the British psychoanalyst, John Bowlby, in human attachment started when he was 21 years old and working in a home for maladjusted boys (Fonagy, 2018). Bowlby's clinical experience of two boys, who had significantly dysfunctional relationships with their mothers, had an overwhelming impact on him (Sullivan et al., 2011). He later investigated the history of 44 juveniles in a study confirming his belief that disturbances in the early mother-child relationship should be considered as an important antecedent to mental illness (Follan & Minnis, 2010). During the 1940s, Bowlby expanded his curiosity in mother-infant bonds by analysing the ramifications of institutionalised young children severely destitute of maternal care that had the propensity to develop symptomology of diminished social and developmental functioning (Bowlby, 1951).

Bowlby was pioneering in his acknowledgement that, akin to baby animals, human infants have a biological proclivity from birth to establish attachments to their primary caregivers and use them as a secure base for exploration (Sullivan et al., 2011). Children starved of such necessities recurrently presented with symptoms of either partial deprivation—signs of depression and an immoderate need for love or revenge—or symptoms of complete deprivation such as lethargy, developmental decline, deceitfulness, and obsessive stealing (Bowlby, 1951). The responses children had to separation were later incorporated into a theoretical underpinning by Bowlby and included: protest → despair → detachment (Bowlby, 1969, 1973, 1980; Fonagy, 2018).

Attachment can be observed on a basic level regarding behaviour that infants partake in to initiate and sustain proximity to their caregivers such as crying, smiling, verbalising, and crawling towards their caregivers in an attempt to draw them near (Duschinsky, 2015). As Bowlby stipulated, along with feeding and exploration of the environment, infants utilise attachment to increase their sense of safety and proximity to their primary caregivers for survival (Ludy-Dobson & Perry, 2010). Attachment theory can therefore be considered as a behavioural and psychological process (Fonagy, 2018).

It has been found that by six to nine months of age, children develop an attachment to a favoured caregiver as discriminated from other adult figures (Fonagy, 2018). This is due to various influences such as the time spent with and quality of care given to the child, the emotional input that the caregiver invests in the child, along with the child's capability to sustain the "availability"—as termed by Bowlby (1973, p. 202)—of their caregiver (as cited in Ludy-Dobson & Perry, 2010). This relates to expectations of caregiver responsiveness and is based on the extent to which children have experienced their attachment figures as available to them (Fonagy, 2018). The more reachable and receptive a child perceives a caregiver to be, the greater the development of a more secure attachment system for the child (Bowlby, 1951).

Children's expectations of their caregivers and the resulting experiences that they may have with them, were posited by Bowlby to become the foundational internal working models, or mental representations of relationships, upon which children build their attachment systems (Duschinsky, 2015). Due to these internal models being mostly unconscious, they do not easily change (Schore & Schore, 2008). However, when exposed to recurring experiences that are different to current working models, they ultimately can be altered to healthier mental representations of relationships (Hughes, 2004).

Children's sense of self and the world are also included in their internal working models (Allen, 2011; Waters, Weinfield, & Hamilton, 2000). The extent to which children feel that their caregivers consider them tolerable or intolerable is a central aspect of this working model. If children experience their caregivers as being dismissive towards them, the children are likely to develop a working model of the self as unlovable and worthless (Fonagy, 2018).

The relational experiences that caregivers themselves had with their own primary caregivers while being raised has an impact upon their engagement with their children (Allen, 2011). This reciprocally affects the way children behave towards their caregivers (Julian et al., 2017). Caregivers that experienced more favourable upbringings are more accommodating towards their children's behaviour (Dollberg, Feldman, & Keren, 2010). It also makes them more inclined to have constructive and optimistic interactions with their children (Dollberg et al., 2010; Lok & McMahon, 2006), facilitating secure attachment.

The conceptual foundations of John Bowlby's work were established in his three-volume series: *Attachment and Loss, Volume 1, 2, and 3* (Bowlby, 1969, 1973, 1980). The series investigated how children's attachment with their caregivers is influenced when they experience separation, loss, and deprivation, resulting in possible adverse consequences (Hooper, 2007). Included within this series was Bowlby's development of the concept of the internal working model and its significance to the caregiver-child relationship (Allen, 2011). The caregiving style adopted is contingent to caregivers' intergenerational attachment relationships (Dollberg et al., 2010). This ultimately has an influence on the interaction and resulting behavioural patterns that children have with their caregivers (Bowlby,1969; Duschinsky, 2015).

Contributions by Mary Ainsworth

Ainsworth started working collaboratively with Bowlby at the Tavistock Clinic in the late 1950s (Bretherton, 1992). She was captivated with the thought of research within the natural environment that focused on direct examinations of human behaviour starting from infancy (Ainsworth, 2010). Ainsworth's pioneering approaches facilitated the expansion of Bowlby's works and provided empirical support for attachment theory (Hooper, 2007).

William Blatz made security theory known to Ainsworth during her graduate years of study (Ainsworth, 2010). One of the central concepts of security theory is whether infants and children consider their caregivers as safe enough to independently venture into their environment (Bretherton, 1992). In her dissertation entitled *An Evaluation of Adjustment Based Upon the Concept of Security*, the then Mary Salter (1940) advanced the notion of attachment figures being a secure base from which infants can safely test the environment around them (Hooper, 2007).

Depending on the quality of care received from caregivers, infants develop differing attachment patterns characterised by specific distinguishing behavioural features (Fishbane, 2007; Ludy-Dobson & Perry, 2010). The Strange Situation Procedure (SSP), a laboratory-based observational measure developed by Ainsworth, is designed to elicit these distinguishing behavioural features so as to assess the nature and quality of attachment within a caregiver-child dyad (Hooper, 2007). Along with this measure, and her original research first conducted in Uganda and later in Baltimore, Ainsworth pioneered the elucidation of three attachment classifications: secure attachment, ambivalent attachment, and avoidant attachment (Ainsworth, 1979; Duschinsky, 2015).

Children with secure attachments have caregivers who usually respond suitably and consistently to their needs (Pearce & Pezzot-Pearce, 2007). Such children view their caregivers as a safe foundation upon which to investigate the environment around them

(Cooper et al., 2013). Ambivalent attachment develops when children have caregivers who are unpredictable in their provision of either appropriate or negligent responses to their children's needs (Hooper, 2007). These children search for closeness before their caregivers leave, are concerned and upset when their caregivers depart, and have difficulty being soothed upon the caregivers' return (Pearce & Pezzot-Pearce, 2007). Caregivers of children with avoidant attachments strongly advocate for independence in their children and rarely, if ever, respond to their children when troubled (Ainsworth, 1979). These children tend to have marginal concerns when their caregivers leave and do not appear interested upon their return (Cooper et al., 2013).

In 1986, students of Ainsworth, namely Mary Main and Judith Solomon, identified disorganised attachment, a fourth classification based on observations of infants who displayed bizarre and disoriented behaviour during the SSP (Main & Solomon, 1990). Children with a disorganised attachment have caregivers who are habitually insensitive and withdrawn from their children (Duschinsky, 2015; Liotti, 2011). These caregivers can portray panicky behaviour and ill-treatment towards their children (Sullivan et al., 2011). They may also display subtle dissociative behaviour or be frightening towards, or frightened of, their children (Abrams, Rifkin, & Hesse, 2006; Cyr, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2010). This creates a contradictory dilemma for these children as their caregivers that are a base of safety are also their source of destress (Granqvist et al., 2017). These children often have bewildered behaviours and stereotypies such as rocking when the caregivers return after a separation (Cyr et al., 2010; Ludy-Dobson & Perry, 2010). Children with disorganised attachment are considered as having the worst prognosis regarding the development of psychopathology, followed by those with ambivalent and avoidant attachments (Levendosky, Bogat, & Huth-Bocks, 2011).

The ability caregivers have to take note of their infants' signals, interpret them correctly, and react to them appropriately and timeously refers to the sensitive responsiveness of caregivers (Ainsworth, Blehar, Waters, & Wall, 1978). The type of caregiving that children receive during their first year of life additionally influences the kind of attachment that they develop (Ainsworth et al., 1978; Levendosky et al., 2011). The early attachments with caregivers and other significant people in their lives "are the prism through which young children learn about the world, including the world of people and of the self" (Thompson, 2002, p. 10). These relationships form the structuring foundation upon which a child learns to regulate emotions through repeated reactions from significant caregivers (Ludy-Dobson & Perry, 2010). Lyons-Ruth and Spielman (2004) posited that the capability of caregivers to modulate their infants' apprehensions and discomforts is essential to facilitating their children's sense of security.

Universality Claim of Attachment Theory

As early as the 1950s, social psychologists and anthropologists began challenging attachment theory and its related assessment tool—the SSP—when ethnographic studies conducted in non-Western contexts revealed a greater diversity in child-rearing behaviour than originally acknowledged by Ainsworth (e.g. LeVine et al., 1994; Mageo, 2013; Mead, 1954; Meehan & Hawks, 2013; Weisner, 2014). However, the criticisms for not integrating cultural diversity in caregiving strategies were not heeded to, and attachment theory has thus far remained relatively unchanged (Keller, 2018; Mesman, van IJzendoorn, & Sagi-Schwartz, 2016; Vicedo, 2017). Possible reasoning for this is due to the fact that the majority of researchers and research participants tend to operate within the Western middle-class framework (Keller, 2016; 2018).

Cultural psychologists and anthropologists have argued that attachment theory is posited on the socio-emotional development of children from Western middle-class

societies—households with first pregnancies later in life, fewer children within the home, higher levels of formal education, and two-generational family environments—and claims worldwide validity while ignoring the child-rearing practices of the rest of the world (Keller, 2018). Often non-Western rural families, for example, have pregnancies earlier in life, lower educational levels, households with numerous children, and multigenerational families living together (Keller, 2013; 2017). These contextual differences could potentially result in adaptations of caregiving strategies in order to maximise the probability of survival (Keller, 2016; Otto & Keller, 2014). Certain attachment researchers have increasingly started recognising that both secure and insecure attachments should be considered as part of a child's adaptation to his or her context (Belsky, Steinberg, & Draper, 1991; Keller, 2016). Such considerations of cultural diversity on caregiver-child relationships and caretaker strategies may therefore be necessary (Keller, 2016; Vicedo, 2017).

Similarly, the "standard-distribution" of attachment patterns as found in Ainsworth et al.'s (1978) Baltimore study of 66% secure, 22% avoidant, and 12% ambivalent attachment has been inconsistent when compared to results of other studies (e.g. Belsky et al., 1991; Keller 2018; van IJzendoorn & Kroonenberg, 1988). The universality of the emotional display expressed in the SSP—anguish when the child is separated from the caregiver and relief upon the caregiver's return—can also vary among cultures (Keller, 2016; Otto & Keller, 2014). In some cultures, children are taught from young ages to show neutral expressions and there are communities where stranger anxiety is not part of children's emotional expressions as they are not exposed to strangers often and are raised by many individuals (Keller, 2018; Keller & Kärtner, 2013). Consequently, inconsistencies in results of Western assessment procedures regarding behaviour may be apparent in non-Western societies (Keller, 2018).

Primary caregivers within Western societies are invariably adults, mainly the maternal figures, with some involvement from paternal caregivers and sometimes a grandmother (Keller, 2016). The relational style is distal where communication is face-to-face, and toys are frequently used to separate the children's space from that of the adults (Keller, 2013; Keller & Chaudhary, 2017). Within traditional rural non-Western communities, the caregiving responsibility is multigenerational where maternal caregivers may have an initial essential role in caregiving of the infant, fathers are generally absent, grandmothers frequently take care of infants, and other children are often the most significant caregivers for infants (Keller, 2013). Children and caregivers relate proximally via body contact and body-stimulation through rhythmic interactions such as carrying infants on their backs, and children are always involved in the social interactions within the household (Keller & Chaudhary, 2017).

Worldwide, families generally value children and attempt to take care of them as best possible to ultimately be able to adaptively function within their local communities, but the expression of caregiving practices varies between cultures (Tamis-LeMonta et al., 2008). For example, averted child eye-contact with a caregiver is considered respectful in certain cultures, but concerning in others (Keller, 2017). Cultural and contextual diversity is integral to adaptation, which is a necessity for survival (Keller, 2013). Acknowledging the importance of the environment and culture is critical to a deeper understanding of individuals and how it influences their life trajectories (Keller & Chaudhary, 2017).

Importance of Caregiver-Child Attachment

The most substantial relationship in life develops between a primary caregiver—generally the mother, although not exclusively so—and an infant; a process already beginning during gestation (Greenspan & Wieder, 2006). Through this relationship, primary caregivers play a vital role in influencing and regulating infants' and young children's future

relational experiences and competencies (Julian et al., 2017; Lok & McMahon, 2006). Early infant attachment is essential in maintaining proximity to primary caregivers, facilitating neural development (Brandon et al., 2009; Winston & Chicot, 2016), and assisting children in their capacity to self-regulate (Dollberg et al., 2010). Caregiver responsiveness towards their children's physical and emotional needs is cardinal in advancing ideal development of their intellectual, social, and emotional capacities (Haltigan et al., 2012; Sroufe, 2005; Stinehart, Scott, & Barfield, 2012).

Caregiver-child interactions are vital to children's brain development as their neurons are strengthened or pruned depending on their early relational experiences (Julian et al., 2017; Winston & Chicot, 2016). Although genetic factors influence the presentation of behaviour, the eventual phenotypic expression of these behaviours is significantly impacted by early interpersonal experiences (Fearon & Belsky, 2016; Propper & Moore, 2006). There are numerous studies indicating that genetic risk is either amplified or mitigated by environmental factors such as child abuse (Byrd & Manuck, 2014) or insensitive caregiving (Ellis, Boyce, Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2011; Slagt, Dubas, Deković, & van Aken, 2016). Unstable and insensitive nurturance during the first three years of children's lives may lessen their social-emotional capabilities due to negative effects on their neural development (Perry, 2009).

Caregivers' sensitivity towards their infants' needs encapsulates being able to reflect on and mentalise their infants (Mohamed & Mkabile, 2015). This is an integral part of modulating emotional states for infants and encourages attachment security (Suchman et al., 2010). Prior to becoming competent in their self-regulatory capacities, attachment figures regulate infants' emotional arousal for them through proficiently responding to their signals and needs (Bernier, Carlson, & Whipple, 2010). If caregivers have a supportive and

receptive approach when responding to their children, it promotes the development of children's self-regulatory abilities (Taylor, Eisenberg, Spinrad, & Widaman, 2013).

Dysregulated and inconsistent caregiving often results in children having deficient self-regulatory abilities (Lok & McMahon, 2006; Taylor et al., 2013). Research indicates that when insecure attachments occur, these children frequently have impoverished affect regulation, poor relationships with peers, and maladaptive behaviours (Julian et al., 2017). Various aspects such as negligence and maltreatment (Jaffee, 2017), premature birth (Montagna & Nosarti, 2016), low socioeconomic status (Evans & Kim, 2013), and caregiver mental illness (Vostanis et al., 2006) can contribute to infants and young children developing insecure attachment styles, which further increases their risk of developing psychopathology (Julian et al., 2017). Such research findings suggest that the nature and quality of caregiver-child relationships influence mental health within the context of possible environmental factors and other risk factors (Fearon & Belsky, 2016; Shaver & Mikulincer, 2002).

The importance of the environment in its influence on attachment was proposed early on by Ainsworth in her research (Fearon & Belsky, 2016). Similarly, Bowlby—influenced by Harry Marlow's work with rhesus monkeys—acknowledged the importance of the socio-emotional environment in relationship development (van der Horst, LeRoy, & van der Veer, 2008). This suggests that the broader socio-cultural milieu can influence the attachment that develops within a caregiver-child relationship, which could result in attachment-related consequences for that child (Williford, Carter, & Pianta, 2016). Given the impact that traumatic relational experiences can have on the neural development of children, in addition to the extensive repercussions of non-optimal caregiving and possible environmental risk factors, highlights the crucial need for therapeutic interventions that can offer children a possibility of improved mental wellbeing (DeKlyden & Greenberg, 2016; Ludy-Dobson & Perry, 2010; Riggs, 2010). To follow is an overview of various therapeutic interventions

utilised for disruptions to the caregiver-child relationship and the resulting behavioural and emotional difficulties. This is followed by a more in-depth discussion of Theraplay® as the focus of the current study.

Therapeutic Interventions

Since the work of humanists such as Virginia Axline, and psychoanalysts such as Melanie Klein and Anna Freud, play has long been a central mechanism of individual psychological treatment for children (Axline, 1981; Donaldson, 1996; Klein, 1955). With growing recognition that play is a child's primary mode of communication (Landreth, 2002), there has been a fundamental increase in the utilisation of play within therapeutic interventions for children (Gordon, 2014; Milteer & Ginsburg, 2012; Poynton, 2012). These interventions frequently integrate behavioural and relational aspects of early caregiving (Dollberg et al, 2010).

Considering the minds of infants as dependant, dynamic, and pursuing of relationships and social information allows for a better understanding of childhood psychopathology (Fonagy & Campbell, 2015). Research postulates that unaddressed attachment difficulties do not dissipate with age (Sigal, Perry, & Rossignol, 2003) and that there are connections between childhood psychopathology and insecure attachments (Sullivan et al., 2011). This has laid the groundwork for substantial advances in interventional development designed to improve caregiver-child relationships (Mohamed & Mkabile, 2015).

Even where primary caregivers are not directly involved, enhancing attachment as a priority in therapeutic relationships can facilitate the efficacy of treatment. For example, a study by Sterkenburg, Janssen, and Schuengel (2008) demonstrated that in cases where the attachment relationship with a therapist was directly addressed resulted in better outcomes for

later behaviour modification treatments when compared to cases where the attachment relationship with the therapist was only indirectly addressed. This indicates the significance of attachment in the psychological treatment of children (Mohamed & Mkabile, 2015).

While the specifics of individual attachment-based interventions may differ from one another, a major thrust of these interventions is a focus on the strengthening of caregivers' proficiencies in terms of responsiveness and intuitiveness to their children's emotional needs (Julian et al., 2017), as well as responding regularly and in a compassionate manner (Dollberg et al, 2010). This facilitates children's self-regulatory abilities within a nurturing environment (Allen, 2011). The goal is to enhance the development of secure attachments for children to improve their developmental trajectories and mental health (Julian et al., 2017).

There are numerous therapeutic interventions utilised to assist with difficulties stemming from caregiver-child attachment patterns. Such interventions include, but are not limited to, parenting skills classes and problem-solving communication training (Buckner, Lopez, Dunkel, & Joiner, 2008), Child-Parent Relationship Training (Cornett & Bratton, 2014), the Video–feedback Intervention to Promote Positive Parenting (van Zeijl et al., 2006), filial therapy (Jang, 2012; Wickstrom, 2009), the Circle of Security project (Marvin, Cooper, Hoffman, & Powell, 2002), Behaviour Management Training (Buckner et al., 2008), and various forms of play therapy (Homeyer & Morrison, 2008). Theraplay® is one such intervention that incorporates dyadic play between caregivers and their children in order to enhance the quality of the attachment relationships (Booth & Jernberg, 2010).

The Fundamentals of Theraplay®

This section imparts an overview of Theraplay® and its history. It provides the reader with a discussion of the various clinical populations for which Theraplay® is indicated, as

well as its therapeutic efficacy. Following that, an outline of the Theraplay® process is presented and the role of the therapist when utilising it as a therapeutic intervention is discussed.

History of Theraplay®

As director of psychological services for the Chicago Head Start Programme in the late 1960s, Ann Jernberg—along with Phyllis Booth—were tasked with identifying caregiver-child dyads that had attachment difficulties and required psychological support (Munns, 2003). Resources to reach all families needing further assistance were, however, limited (Jernberg & Booth, 1999). On account of the complexities of the social context in which they worked, Jernberg identified the need to develop a short-term therapeutic intervention that would be psychologically supportive for these struggling dyads (Munns, 2003).

Jernberg consulted the work of Austin Des Lauriers with children who had autism and schizophrenia and considered implementing the notion of enthusiastic engagement with a child that focuses on the present while in a safe environment (Koller & Booth, 1997). She embraced Viola Brody's idea of the nurturing relationship between the therapist and the child, and incorporated Ernestine Thomas's emphasis on being strongly approving and positive about the child's potential and mental wellbeing (Koller & Booth, 1997). This was how Theraplay® as a therapeutic intervention for attachment difficulties was founded in 1970 (Booth & Jernberg, 2010).

Extending the reach of Theraplay®, Jernberg began training other professionals in the use of Theraplay® (Jernberg & Booth, 1999). This led to the establishment of the Theraplay® Institute in 1971 with the goal to impart further training and services to individuals interested in the approach (Booth & Jernberg, 2010). Presently, Theraplay® as a treatment modality is

practiced in 29 countries worldwide and has organised associations in the USA, Germany, and Finland (Booth & Jernberg, 2010).

What is Theraplay®?

Theraplay® is a structured play-based intervention that seeks to replicate healthy relationships between caregivers and their children through light-hearted and engaging behaviour (Booth & Jernberg, 2010). This is to promote favourable emotional modulation in children (Booth & Jernberg, 2010; Busch & Lieberman, 2007). Theraplay® also shares basic premises with Winnicott's idea of the good enough mother in his Object Relations Theory (Winnicott, 1972, 1987) and Kohut's (1977) Self Psychology (as cited in Booth & Jernberg, 2010).

Advances in neuroscience research demonstrate that the development of an infant's right-brain is intricately tied to the nature of the caregiver-child relationship and thus to attachment (Dollberg et al., 2010; Porges, 2015). Studies have found that the neural networks of children with attachment difficulties can be rewired to form healthier attachments to caregivers when they receive appropriate stimulation (Hong & Mason, 2016; Kay, 2009; Porges, 2015). Theraplay®, similarly, is a therapeutic intervention that is neurologically-informed and has the potential to alter the neural wiring of a child (Porges, 2015) by focusing on the brain-based functions of "attunement, empathy, and reflective function" (Booth & Jernberg, 2010, p. 58).

Early relational experiences that infants have with their primary caregivers influence their neural networks, which impacts their sense of self and personality development (Booth & Jernberg, 2010). It is possible that, as a result of traumatic experiences, children can become fixated at the developmental stage they were in at the time of the trauma (Seligman, 2016). If children have experienced caregiver-child attachment injuries earlier on in their

lives and have not been afforded an opportunity to mend the effects of this, it increases the possibility of difficulties with forming healthy and secure relationships later in their lives (Miller, 2011; Munns, 2013). Where there has been a lack of positive stimulation and validation as well as prior caregiver-child attachment injuries, the purpose of Theraplay® is to strengthen the self-confidence, trust, and attachment in the relational dyad (Booth & Lindaman, 2000; Munns, 2013).

Theraplay® sessions are personal, highly interactive, and involve physical contact aiming to imitate healthy caregiver-child interactions (Booth & Winstead, 2015). Initially, prominence is given to the interactivity between the therapist and the child, but the focus gradually shifts from therapist-child interactions to the caregiver working directly with the child to enhance the caregiver-child relationship (Allen, 2011; Munns, 2003). Therefore, the therapist increasingly takes the role of observer and facilitator for the dyad as the caregiver-child relationship strengthens until termination of the therapeutic intervention occurs (Mohamed & Mkabile, 2015).

There are four crucial virtues upon which Theraplay® is centred that are inherent to functional caregiver-child relationships: structure, engagement, nurture, and challenge (Booth & Jernberg, 2010; Munns, 2013). Structure relates to the trustworthiness and predictability of the caregiver to promote security while setting appropriate boundaries for the child (Bojanowski & Ammen, 2011). Engagement fosters attunement, encouragement of autonomy, and shared joy between the caregiver and child (Booth & Jernberg, 2010). Nurturance involves the caring response of a caregiver to the child's regulatory requisites and the ability for the caregiver and child to empathetically interact with one another through the promotion of developmentally suitable touch and possible eye-contact (Booth & Winstead, 2015). Lastly, the challenge component comprises of children experiencing a sense of accomplishment through the ability of caregivers to set challenges that are developmentally

appropriate for them (Booth & Jernberg, 2010). The clinical decision regarding which domains require attention is determined through the use of the Marschak Interaction Method (MIM) conducted as an assessment of the caregiver-child relationship prior to the commencement of Theraplay® (Bojanowski & Ammen, 2011).

The play-based MIM is preferably video-recorded and comprises of a set of simple tasks, within the four dimensions of Theraplay®, that the caregiver and child engage in (Lindaman, Booth, & Chambers, 2000). After completion, the therapist provides feedback to the caregiver regarding strengths and weaknesses of the caregiver-child interactions (Wettig, Franke, & Fjordbak, 2006). The tasks, which the therapist pre-selects for every session to use for the Theraplay® process, are each designed to tap into one or more of the four Theraplay® dimensions (Booth & Jernberg, 2010). They are based on the domain or domains that require the greatest remediation for each dyad as determined by the previously administered MIM (Bojanowski & Ammen, 2011; Booth & Jernberg, 2010). These tasks also have a regressive nature to take the children back to a stage in their lives where possible attachment conflicts were not adequately resolved in order to allow for reparation thereof by imitating positive caregiver-child attachment experiences (Booth & Jernberg, 2010).

Theraplay® can be implemented within a variety of contexts for several psychological difficulties (Booth & Jernberg, 2010). Although it can be applied to a wide age-range, it is predominantly utilised with children ranging from birth to 12 years of age and has more recently been tailored for teenagers and the elderly (Booth & Jernberg, 2010). Generally, a Theraplay® process involves approximately 18 to 26 weekly sessions lasting from 30 to 45 minutes each (Bojanowski & Ammen, 2011). Upon completion of the Theraplay® intervention, it is recommended to have four follow-up sessions at quarterly intervals over the year following treatment to assess whether the intervention has maintained its effect (Wettig et al., 2006).

Indications for Theraplay® Utilisation

It continues to be emphasised that evidence-based interventions for children and adolescents need to be established and promulgated (Glied & Cuellar, 2003). Theraplay® is such an intervention as it is attachment-based and has started receiving evidence-based support from studies (Booth & Jernberg, 2010). The overview provided below is concerned with outlining the existing research on Theraplay® as a therapeutic modality. It must, however, be noted that this body of evidence can be critiqued for its absence of randomised control trials (RCTs) in evaluating the causal relationship between Theraplay® and positive child outcomes, which influences the rigour of the causal inferences that can be made related to the utilisation of this approach.

Theraplay® is first and foremost an attachment-based intervention and has been found to be useful in strengthening the attachment between caregivers and their children (Bojanowski & Ammen, 2011; Booth & Jernberg, 2010; Weir et al., 2013; Wettig et al., 2006). Although early traumatic experiences cannot be completely eradicated as such, therapeutic interventions using Theraplay® are able to provide a safe and nurturing environment for the healing of caregiver-child interactions (Booth & Jernberg, 2010; Weir et al., 2013). Providing such an environment allows for a possible shift in children's mental relational models from distrust and anxiety to assurance and willingness to embrace healthy caregiving (Bojanowski & Ammen, 2011; Robinson, Lindaman, Clemmons, Doyle, & Ryan, 2009).

Various studies have indicated that interventions using Theraplay® have beneficial effects regarding internalising and externalising difficulties in children with mental health challenges (Booth & Jernberg, 2010; Mohamed & Mkabile, 2015; Wettig et al., 2006). There is research indicating that Theraplay® positively influences the personality structure of children in terms of assertiveness, self-reliance, and self-confidence (Booth & Jernberg,

2010; Bundy-Myrow, 2005). Furthermore, there are findings that the implementation of Theraplay® has diminished the intensity of presenting symptomology in children with attention problems, anxiety difficulties (Brendel & Maynard, 2014), autism (Simeone-Russell, 2011; Wettig et al, 2006), as well as with intellectual and developmental disabilities (Mohamed & Mkabile, 2015; Siu, 2014).

There have been several studies done that have found support for the utilisation of Theraplay® for various populations of children (Simeone-Russell, 2011). Such populations include those related to adoption (Shea, 2015; Weir et al., 2013), domestic violence (Bennett, Shiner, & Ryan, 2006), social developmental skills difficulties (Siu, 2014), disruptive and conduct behavioural disorders (Foulkrod & Davenport, 2010; Lawver & Blankenship, 2008; Weir, 2011), and language disorders (Julian et al., 2017; Kupperman, Blight, & Goodban, 2005). Theraplay® has advanced from being utilised for a small number of psychiatric disorders to being applied to many psychopathologies and emotional difficulties, inclusive of dual diagnoses (Booth & Jernberg, 2010).

Theraplay® can also be applied to a variety of contexts and age groups (Booth & Jernberg, 2010). It can be utilized within community settings, as well as mental healthcare clinics and private practices. In addition, there are studies indicating its efficacy within classrooms regarding assisting school-aged children with learning and strengthening basic needs such as sense of self, relationships with peers, and their ability to constructively get needs met (Myrow, 2016; Simeone-Russell, 2011; Siu, 2014). Theraplay® can be administered by qualified practitioners to infants, children (Booth & Jernberg, 2010), adolescents (Ammen, 2000; Munns, 2005), and elderly individuals (Booth & Jernberg, 2010). Although the research provided within this summary is not exhaustive and does not include RCTs (due to a lack thereof in the literature), it is suggestive of the potentially beneficial effects of Theraplay® as a therapeutic intervention based on attachment theory.

Role of the Therapist During Theraplay®

As is the case with any therapeutic modality, the competence and quality of therapy provided by a therapist administering Theraplay® is crucial (Fairburn & Cooper, 2011). A therapist has a specific role to play in Theraplay® that initially is more active and then becomes more passive, observational, and supportive as the caregiver is guided to increasingly take the more active role as the intervention proceeds towards termination (Munns, 2003).

Along with the child and ideally a caregiver in the room, it is suggested that Theraplay® can be administered with two therapists having differing responsibilities or with one therapist that administers both roles concomitantly (Booth & Jernberg, 2010). It is usually not always possible to have two therapists engaging in the Theraplay® process for various reasons. In such instances, it is suggested that the sessions are video-recorded so that they can be observed during regular feedback sessions with the caregivers (Booth & Jernberg, 2010). If sessions cannot be video-recorded, then the therapist can provide interpretations and suggestions during the session in a way that does not interfere too much with the process unfolding between the caregiver and child (Kottman, 2001).

It is of paramount importance for the therapist to consider the developmental stage of the child seeking treatment. The reason for this is to determine where possible developmental arrests have occurred (Jaffee, 2017; Sokol, 2009). This needs to be taken into consideration as, on occasion, the ages of developmental crises may be notably different to the child's chronological age (Batra, 2013).

Research proposes that, especially with caregiver-child therapies, collaboration and dedication towards the therapeutic process by caregivers is vital to the outcomes of any therapeutic intervention (Hawley & Garland, 2008; Hawley & Weisz, 2003; Kazdin, Whitley,

& Marciano, 2006). The alliance that is built between a therapist and child is as important as the one built between caregiver and therapist (Naidu & Behari, 2010).

South African Context

Given that attachment theory was conceptualised in Westernized countries, namely the United Kingdom and the USA by John Bowlby and Mary Ainsworth respectively, inquiries surrounding its cross-cultural relevance have been raised (van IJzendoorn & Kroonenberg, 1988; van IJzendoorn & Sagi-Schwartz, 2008). This has prompted a number of research endeavours in an attempt to explore the issue of the cross-cultural validity of attachment theory to non-Western settings.

An early meta-analytic synthesis of this research by van IJzendoorn and Kroonenberg (1988) covering 32 studies across eight countries using the SSP found that secure attachment was the most common attachment pattern among countries. There were deviations in the insecure attachment classifications whereby individualistic countries, that support greater independence of persons, had higher levels of avoidant attachments and collectivistic countries had an increased frequency of ambivalent/resistant attachments (van IJzendoorn & Kroonenberg, 1988). This allowed for postulations that there may be attachment characteristics that are universal but that the universality is limited due to the significant inconsistencies in insecure attachments across countries, possibly attributable to variations in culture, caregiving practices, and environmental factors (Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). This is consistent with findings of discrepancies in the emotional display expressed in the SSP between Western and non-Western societies as these expressions can vary among cultures (Keller, 2016; Otto & Keller, 2014). While six of the eight countries had proportionally consistent findings with those found by Ainsworth (Ainsworth et al., 1978), the intra-cultural variations were up to 15 times higher than the cross-cultural differences which could be attributed to socio-economic factors, and stress experienced that

varied between samples within each country studied (van IJzendoorn & Kroonenberg, 1988). This suggests that although attachment is universal, the expression thereof may differ across contexts and cultures.

Although methodologically diverse, studies on attachment have been conducted in various African contexts such as Uganda (Peterson, Drotar, Olness, Guay, & Kiziri-Mayengo, 2001), Kenya (Kermoian & Leiderman, 1986), Democratic Republic of Congo (Morelli & Tronick, 1991), Nigeria (Marvin, van Devender, Iwanga, LeVine, & LeVine, 1977) and South Africa (Cooper et al, 2009; Tomlinson et al., 2005). Overall, using either the SSP or the Attachment Q-Sort, these above-mentioned studies have demonstrated the presence of the attachment patterns identified by Ainsworth (Ainsworth et al., 1978) and Main (Main & Solomon, 1990)—secure, avoidant, resistant, and disorganised—to varying degrees in these contexts. Given that Ainsworth's initial study of mother-infant dyads upon which the SSP is based was conducted in Uganda, this is evidently a logical set of findings (Fearon & Belsky, 2016). Therefore, it can be postulated that attachment theory and the identified attachment patterns of Ainsworth may be applicable within the South African context, but further consideration might be necessary regarding the possible variances in caregiving practices across cultures due to the influence that the environment and culture has on individuals and their life trajectories (Dawson, 2018; Keller & Chaudhary, 2017).

Apart from a few exceptions (e.g. Blackie, 2014; Dekel et al., 2018; Meinck et al., 2017; Rawatlal et al. 2015; Spies & van Rensburg, 2012; Tomlinson et al, 2005), there is a distinct lack of attachment research in South Africa. It is even less so regarding research on attachment-based interventions in general (e.g. Aspoas & Amod, 2014; Cooper et al, 2009), and specifically regarding Theraplay® (e.g. Mohamed & Mkabile, 2015). However, internationally, there is evidence from individual controlled and non-controlled studies (e.g. Bernard, Simons, & Dozier, 2015; Bick & Dozier, 2013; Cassidy et al., 2017; Fonagy, Sleed,

& Baradon, 2016), as well as meta-analyses (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; 2005; Wright & Edgington, 2016), which demonstrate the effectiveness of attachment-based interventions in general.

South Africa is unique regarding its vast array of cultures, languages, and ethnicities (Berg, 2012). It includes collectivist cultures such as the amaXhosa, individualistic cultures inclusive of the Afrikaans culture, and inter-relations of individualist and collectivist orientations within cultures (Adams, van der Vijver, de Bruin, & Torres, 2014; Eaton & Louw, 2000). It is necessary that psychologists develop a multicultural competence when working with individuals and families—this includes an understanding of one's own ethnicity and having respect for other cultures, having culturally-sensitive relational skills, and administering therapeutic interventions that are culturally relevant (Johnston, 2015; Lott, 2010). Due to the diversity within the South African population, critique has been levelled in response to the use of Westernised psychology within a non-Western context, questioning the relevance and applicability thereof to such contexts (Sher & Long, 2012).

Although attachment theory has been demonstrated to have cross-cultural relevance, the same is not automatically true of the cross-applicability of various attachment-based interventions, including Theraplay®. The developers of Theraplay® do point out that consideration should be given to the cultural values of families being treated and modifications of the therapeutic intervention should be made accordingly (Booth & Jernberg, 2010). However, research on the views that mental healthcare professionals have on the cross-applicability of using Theraplay® and its vicissitudes in the context of South Africa has not been conducted. Hence, this relates to what this study attempts to address. Such research may contribute to offering insight into the potential context-specific utility of Theraplay®. It may also assist in continuing efforts regarding the development of relevant services to more

effectively address the mental healthcare needs of a multicultural and contextually diverse South African population (Johnston, 2015).

Summary of Chapter

The purpose of this chapter was to provide an overview of the literature pertaining to attachment theory and attachment-based interventions with specific regard to Theraplay®. It attempted to highlight the evidence relevant to Theraplay® as a therapeutic modality when caregiver-child relational difficulties exist or when there are childhood psychological and behavioural challenges. The chapter indicated a lack of research done relating to attachment-based interventions and Theraplay® within South Africa. Although studies suggest that Theraplay® could be a useful modality to utilise regarding attachment-related difficulties, research is needed concerning practitioners' perceptions of implementing Theraplay® as a therapeutic intervention regarding its context-relevance and cross-applicability for the South African population. The following chapter discusses the methodology of this study.

CHAPTER 3—RESEARCH METHODOLOGY

Introduction

This chapter provides a comprehensive overview of the methodology used for the study. In so far as appropriately addressing the research questions, it offers the rationale for the chosen methods, and clarifies the epistemological and ontological positioning of this study. Details are provided pertaining to the research design, data collection method, and data analysis procedure. The chapter concludes with a discussion of the measures taken to ensure ethical practice and trustworthiness throughout the study process.

Research Rationale, Aim, and Objectives

Attachment-based interventions have become increasingly relevant and sought after to treat challenges in caregiver-child relationships, as well as various childhood psychological and behavioural problems (Booth & Jernberg, 2010; Julian et al., 2017). However, within the South African context, there is a shortage of research regarding specifically Theraplay®, in addition to attachment and attachment-based modalities in general, save a few notable exceptions (e.g. Dekel et al., 2018; Fourie, van Vuuren, Venter, & Nel, 2007; Meinck et al., 2017; Mohamed & Mkabile, 2015; Rawatlal et al., 2015; Tomlinson et al., 2005). Overall, qualitative research investigating the experiences of either therapists or patients engaged in Theraplay® is also sparse.

Exploring the experiences of therapists who use Theraplay® in South Africa may be able to offer some insight into the applicability of this therapeutic modality within a non-Western context such as South Africa, which has a wide range of social, cultural, and economic determinants that may impact on the caregiver-child relationship. Therefore, the overarching aim of this study was to explore therapists' perceptions on the implementation of Theraplay® in the South African context. The research questions and corresponding objectives for this study are outlined in Table 1 to follow.

Table 1

Research Questions and Corresponding Objectives for Research Study

Research Question	Research Objective
1. How do therapists perceive facilitating factors regarding implementing Theraplay® within the South African context?	1.1. To explore therapists' perceptions regarding facilitating factors of implementing Theraplay® in South Africa
2. How do therapists perceive challenges involved in implementing Theraplay® within South Africa?	2.1. To explore therapists' perceptions regarding the challenges involved with implementing Theraplay® in South Africa
3. How do therapists consider making possible adaptations, if necessary, to implementing Theraplay® within the South African context?	3.1. To obtain the professional opinion of therapists regarding giving suggestions and making possible adaptations, where necessary, to Theraplay® in South Africa

Research Design

Qualitative studies are often used in healthcare research and are appropriate when the phenomena being studied are not fully understood (Braun & Clarke, 2014; Hsieh & Shannon, 2005; Saunders, Lewis, & Thornhill, 2012). Such studies aim to highlight a phenomenon through the development of rich contextual descriptions and the meanings thereof (Oliveira et al., 2012). The present study used a qualitative research design that was descriptive and explorative in nature, as it was relevant to the aim of exploring the perceptions of therapists who have administered an intervention involving Theraplay® techniques within South Africa. Although a qualitative research design does not attempt to provide definitive information regarding a phenomenon or problem (Saunders et al., 2012), the research participants were asked about possible adaptations to Theraplay® within a South African context as such suggestions could possibly stimulate future research endeavours within this local context.

Research Paradigm

Denzin and Lincoln (2000) defined a research paradigm as a "basic set of beliefs that guide action. […] They define the worldview of the researcher […]" (p.157). A research

paradigm needs to be selected by the researcher before a research methodology can be established for the study (Denzin & Lincoln, 2000; Willig, 2013). This is vital to the research process as the research methodology and subsequent data collection procedures are influenced by the paradigmatic framework selected by the researcher (Crouch & McKenzie, 2006; Mertens, 2005).

This research study was located within the interpretive paradigm, which assumes that the only way to understand a phenomenon of social reality is from the perspectives of the individuals involved in it (Willis, 2007). Interpretivism inductively develops patterns of meaning rather than beginning with a theory (Creswell, 2014). This allows for more flexible research structures that are amenable to capturing meaning in human interactions (Willis, 2007). Interpretivism understands that reality is constructed through participants' experiences of phenomena and recognises that the background and experiences of the researcher also have an impact on the interpretations of the findings (Haverkamp & Young, 2007). Choosing this paradigm allowed the researcher to base the interpretation of results obtained within the social and cultural contexts of the research participants that were interviewed, while acknowledging the role of the researcher throughout the process of the study. The researcher had a close understanding of the research context, and personally conducted and transcribed each of the interviews.

This research study was situated in a relativist ontology. As suggested by Willig (2013), research conducted from a relativist perspective explores how constructs, especially culture, are used to understand the views of participants regarding a phenomenon. Within this study, the researcher attempted to explore and understand therapists' perceptions of implementing Theraplay® as a therapeutic intervention for children and their caregivers within the context of South Africa.

The epistemological stance that was used for this study is subjectivism. Such a position argues that our understanding of the surroundings and its actual existence are not independent of one another (Creswell, 2014). This means that the interpretations of the data that researchers make cannot be separated from their own experiences and existing knowledge, but that their role is continuously acknowledged throughout the study (Scotland, 2012). The elucidations made within this study were all founded in South Africa, which is a unique socio-political context with its interrelated and integrated socio-cultural systems. The role that the researcher engaged in during this study was also acknowledged in a reflexive journal throughout the research process.

Research Participants and Sampling Procedures

There are no firm guidelines with regards to sample sizes for qualitative studies using in-depth interviewing (Fugard & Potts, 2015; Guest et al., 2006). According to Guest et al. (2006), if a sample is selected from a similar context with participants occupying a certain level of knowledge regarding the domain of inquiry, then the selection of six interviewees is adequate to obtain data saturation when using thematic analysis. Six participants were, therefore, recruited for this research study.

Along with purposive sampling, snowball sampling is also considered as an acceptable sampling strategy and both are regularly used in qualitative research when the aim is to explore, understand, and describe a phenomenon (Gravetter & Forzano, 2012; Kumar, 2011; Merriam & Tisdell, 2015). These two non-probability sampling methods mean that not every member of the population has an equal probability of selection due to inclusion criteria being created by the researcher prior to the selection process (Adler & Clark, 2014; Daniel, 2011; Hall, 2008). For this study, purposive sampling was used as the primary mode of sampling, while snowball sampling was the second mode that was utilised. This allowed for participants to be selected that the researcher considered as able to meaningfully contribute to

the enquiry into the phenomenon being researched (Vogt, Gardner, & Haeffele, 2012; Willig, 2013). The advantage was that a small sample size was required to obtain information-rich data (Adler & Clark, 2014; Guest et al., 2006; Wilkinson, Joffee, & Yardley, 2004). Clear and concise selection or inclusion criteria were outlined by the researcher to reduce criticism of researcher bias in the selection process (Daniel, 2011; Higginbottom, 2004; Vogt et al., 2012).

Inclusion criteria for the study were that the participants must have been registered with the HPCSA as independent practice mental healthcare professionals—such as clinical, counselling, and educational psychologists—for a minimum of three years after completion of a community service year where this was a requirement for registration. They also needed to have received at least Level 1 training in Theraplay® and have a minimum of three years' experience using techniques of Theraplay® in therapeutic interventions. The rationale for this was to ensure that the participants had gathered sufficient experience using this modality to allow for meaningful commentary regarding potential facilitating factors and challenges with implementing Theraplay® for children and their caregivers in South Africa. The participants needed to have a basic competence in English as this was the language of administration for the interviews. Individuals of any gender, ethnic group, and age were invited to participate provided that they adhered to the previously stated criteria.

Purposive sampling was carried out via an advertisement (see Appendix A) posted to an online professional referral network of mental healthcare professionals to which the supervisor of this study has access as a registered clinical psychologist. This is a closed referral network located on Facebook, which only independently registered mental healthcare professionals have access to after having been pre-screened by its administrators. The advertisement provided a brief description of the study with its inclusion criteria and requested interested parties to contact the researcher directly telephonically or via email.

The secondary snowball sampling involved the researcher requesting individuals who consented to participate in the study to refer any other mental healthcare professionals who were trained in Theraplay® and met the inclusion criteria as potential participants (Willig, 2013). Before providing the researcher with the names and contact details of individuals who qualified for the research study, three participants contacted these colleagues to determine whether they would be interested in participating in the study and to obtain consent for their contact details to be provided to the researcher.

Subsequently, the researcher contacted potential research participants to explain the study in further detail and to answer any questions that they had. The researcher then scheduled to meet with each participant to obtain signed informed consent (see Appendix B) and to conduct an individual interview in a private venue at their respective workplaces. Table 2 below summarizes the research participants and details each participant's pseudonym, age, gender, ethnicity, number of years practicing independently, and the number of years that they have been utilising Theraplay®. It also includes whether they work in private practice, the public service or both, as well as their level of training in Theraplay®.

Table 2

Summary of Participants for Research Study

Pseudonym	**Age Range (years)**	**Gender**	**Ethnic Group**	**Years of Independent Practice (Years utilising Theraplay®)**	**Current Practice Type (Previous Experience) and Level of Training in Theraplay®**
Mia	35-40	Female	White	7 years (5 years)	Private (Public), Level 1 and 2
Coco	25-30	Female	Black	3.5 years (3.5 years)	Both, Level 1
Nix	35-40	Female	White	11 years (11 years)	Private (Public), Level 1 and 2
Ann	30-35	Female	White	6 years (4.5 years)	Private (Public), Level 1
Talita	30-35	Female	White	7 years (7 years)	Public (Private), Level 1 and 2
Jenna	40-45	Female	White	14 years (14 years)	Private (Public), Level 1 and 2

Although eight individuals volunteered to participate, two were not selected as the persons did not meet all the inclusion criteria due to insufficient training in Theraplay®. As a result, the final sample consisted of six individuals who participated in this study. In summary, all the participants were female clinical psychologists, aged 25 to 45 years, and had approximately 3-14 years of independent practice experience after completing their year of community service. The sample consisted of four participants who were in private practice, one who was in the public service, and one who was engaged both privately and publicly. There were five white participants and one black participant in the selected sample. Four participants had received both Level 1 and 2 in Theraplay® training, while the remaining two participants had completed only Level 1 training.

Data Collection Method

Data collection procedures chosen are dependent on the type of data suitable to answer the research questions of a study (Willig, 2013). Semi-structured interviews are a data collection method that, while providing adequate structure to address particular subjects, also allow opportunities for participants to suggest new insights regarding the phenomenon being researched (Galletta, 2013; Gill et al., 2008; Kvale, 2003). The researcher is also able to enquire further and probe participants for additional clarification or elaboration to explore the intricacies of the subject matter being investigated in greater depth (Kvale, 2003; Maree, 2007). It is recommended that the researcher is aware of wording used and the sequence of the questions asked from one interview to another, as this could introduce possible bias and affect data collection (Myers & Shaw, 2004; Silverman, 2007). Due to this research study aiming to explore and understand how therapists perceive the implementation of Theraplay® techniques with caregivers and their children within South Africa, individual semi-structured interviews were deemed appropriate to attain the necessary data.

Prior to the interviewing of selected participants, the researcher developed a list of possible questions, prompts, and probes that could be asked—the interview schedule (see Appendix C)—to explore the research topic based on the identified literature, as well as the aim and research questions of the study (Robson, 2002). The interview schedule contained broad questions regarding the perceptions of the process of using Theraplay® techniques, how the therapist experienced implementing the approach within the context of South Africa, and whether the participants had any suggestions or recommendations regarding the implementation of this modality in South Africa. These open-ended questions guided the direction that the interviews took and highlighted areas for further discussion, which were explored through clarification and detail-oriented probing strategies to obtain rich data (Kvale, 2003; Maree, 2007; Willig, 2013).

Data Collection Procedure

After participants agreed to partake in the study, the researcher, who was also the interviewer, scheduled the interview for a date and time that suited each participant. For their convenience, the interviews were held in a private room at the respective workplaces of each participant. For the interviewer, a vital part of the interview process was to first build rapport with the participants (Galletta, 2013). Each interview began by welcoming and thanking the participant for partaking in the study. Signed informed consent was obtained from each participant and any further questions from participants regarding the study were addressed at this stage before, with consent, the interviewer initiated audio-recording of the interview (Willig, 2013). Once each interview—of approximately 60-90 minutes—was completed, the interviewer thanked participants for their participation and reminded them that they had the right to withdraw from the study at any time until the dissertation is finalised. The audio-recordings were later each transcribed verbatim by the interviewer (Gill et al., 2008). After

being transcribed, the recordings were securely stored on the researcher's personal computer and password-protection was assigned to each transcription (Willig, 2013).

Data Analysis

The selection of an appropriate data analysis method depends on the focus that the research takes (Guest, MacQueen, & Namey, 2012; Nassaji, 2015). Qualitative data analysis aims to discover patterns and further the understanding of phenomena (Patton, 2002; Vaismoradi, Turunen, & Bondas, 2013).

Rather than focusing on the details of individual experiences, thematic analysis attempts to discover recurrent themes across a data corpus to find meaningful patterns (Braun & Clarke, 2006; DeSantis & Ugarriza, 2000). It is a flexible method of data analysis that can describe and organise data in a systematic manner (Braun & Clarke, 2006; Vaismoradi et al., 2013). This method may be a descriptive analytic tool, but many researchers posit that—like interpretative methods—descriptive approaches also entail interpretation, albeit to a lower level than interpretative methods (Sandelowski, 2010). For this reason, thematic analysis was regarded as suitable for the research study as the aim was to identify themes in participants' perceptions relative to a shared phenomenon—implementing Theraplay® as a therapeutic modality for children and their caregivers within South Africa—rather than concentrating on individual accounts of the phenomenon.

Inductive thematic analysis is used when there are no earlier studies done pertaining to the phenomenon, therefore the resulting themes and coded categories stem directly from the data set (Creswell, 2014; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). Inductive thematic analysis was appropriate to use within this study, due to literature indicating that there is minimal research done relating to Theraplay® within South Africa, and more

specifically, that there is no literature to the researcher's knowledge pertaining to therapists' perceptions of implementing Theraplay® as a therapeutic modality.

Thematic analysis has been critiqued for being too ambiguous (Vaismoradi et al., 2013). However, when a standard and unified analysis protocol is utilised, such criticisms can be overcome (Attride-Stirling, 2001; Gbrich, 2007). To avoid such critique, this study followed the detailed guidelines and structure as provided by Braun and Clarke (2006; 2013). The iterative phases of thematic analysis are described below, along with how the researcher applied these guidelines to this research study.

Familiarisation with Data

During the initial phase, the researcher gained a basic sense and understanding of the research data (Bird, 2005; Willig, 2013). Thematic analysis does not require a specific manner in which transcriptions should be written except that they are verbatim to adhere to the original recordings (Braun & Clarke, 2013). The researcher therefore audio-recorded and transcribed each semi-structured interview verbatim. The researcher read the transcriptions three times over while re-listening to the audio-recordings to ensure accuracy of the transcriptions.

Re-reading the transcripts allowed for the generation of initial ideas and patterns, which were noted by the researcher (Braun & Clarke, 2013). Multiple readings of the transcripts led to new insights being noticed and documented (Vaismoradi et al., 2013). Although this phase focused more on the semantic—or explicit—content of the data, later in the analysis attempts were made to progress from description to low-level interpretation of broader meaning regarding the phenomenon studied (Braun & Clarke, 2006).

Generation of Initial Codes

ATLAS.ti (version 8.4.18.0), a qualitative data analysis package, was used by the researcher during this phase to systematically identify as many codes as possible within the data set that captured the research questions of the study (Vaismoradi et al., 2013). This was done as it was impossible to know during the infancy of the analysis process which codes would be important to use and which would later be discarded (Braun & Clarke, 2013). Each transcript was carefully read, and particular words, phrases, and sentences were identified and labelled—or coded—as being meaningful in relation to the research questions (Braun & Clarke, 2013). As advised by Braun and Clarke (2006), keeping more detailed paragraphs of the original text safeguarded against the context of the paragraphs not becoming misconstrued later in the analysis process. Additionally, it ensured adequate examples for extracts to support each code (Braun & Clarke, 2006).

Searching for Themes

The researcher worked through the initial codes to determine if any codes could be merged or eliminated (Braun & Clarke, 2013). This gave the researcher a possibility for data reduction, and to begin defining codes and collating them into potential themes (Vaismoradi et al., 2013). Braun and Clarke (2013) advocate that it is important for the researcher to consider that the themes and codes identified should capture something of value in relation to the research questions of the study.

Reviewing of Themes

During this phase of analysis, again codes and themes were reviewed for additional refining where needed (Willig, 2013). As suggested by Braun and Clarke (2013), an initial thematic map was created illustrating the themes and corresponding codes. The researcher re-read the entire data set again to ensure that the selected themes on the thematic map sufficiently embodied the data corpus (Braun & Clarke, 2013; Vaismoradi et al., 2013). This

provided the researcher an opportunity to analyse whether any data was not efficiently coded or if further refining of any codes and themes was still possible (Braun & Clarke, 2013).

The study made use of a second, independent coder of the data for the purposes of rigour. Consequently, the use of a co-coder for the study was an attempt by the researcher to reduce the influence of subjective bias, a regular criticism of qualitative analysis (Tracy, 2010). The second coder was familiar with thematic analysis and adhered to the same processes and guidelines for analysis—described above—as the researcher. The researcher met with the co-coder to discuss their respective findings and an intercoder score of 90% was obtained (see Appendix D). Although the degree of agreement achieved is not necessarily vital, it availed the researcher an opportunity to identify potential incongruities or overlooked insights that assisted with further refining of the codes and themes (Barbour, 2001).

Naming and Defining of Themes

After corroboration with the co-coder, the researcher decided on final themes and codes for the study. Each theme selected was provided with a succinct name and description to incorporate the qualitative richness of the data it was defining (Braun & Clarke, 2013). Attention was given to ensure that the names and definitions provided for each theme were able to effectively capture the essence of the contextual meaning that they were describing (Willig, 2013). These names and definitions were added to the thematic map to enhance the visual presentation of the data analysis.

Write-up of the Report

Although the previously mentioned phases of thematic analysis can be returned to at any stage during the analytic process, the write-up is considered to be the final step (Vaismoradi et al., 2013). This involved the researcher selecting pertinent illustrative quotations from the data in a way that remained close to the participants' descriptions in

order to exemplify the codes and final themes selected (Braun & Clarke, 2013). The write-up includes a description of the themes and codes selected in further detail to provide a rich and in-depth exploration of the previously mentioned research aim, questions, and literature regarding the phenomenon being studied (Willig, 2013). This is provided in the chapters to follow.

Ethical Considerations

Ethical approval to conduct this study was obtained from the Research Ethics Committee of the Faculty of Humanities of the University of Pretoria (see Appendix E). Strict adherence was given by the researcher to the ethical principles of informed consent, no deception or coercion, confidentiality, and the right to withdraw at any time (Christensen et al., 2014; Tracy, 2010; Willig, 2013).

Participants were provided with sufficient information regarding the research study and the researcher ensured—through verbal explanation and confirmation—that they understood the contents of the informed consent documentation before they made an informed decision to participate (Christensen et al, 2014). Participants were also afforded the opportunity to ask the researcher any questions they may have had regarding the study prior to agreeing to participate therein (Willig, 2013). No coercion was used, and the participants were recruited on a voluntary basis (Willig, 2013). Consent forms contained pertinent information regarding the purpose of study, adherence to confidentiality at all times, how data would be obtained and stored, and the individual's right to withdraw at any time without negative consequences (Tracy, 2010). If the individuals agreed to participate in the study, they signed the informed consent forms that gave permission to be interviewed and allowed for the interviews to be audio-recorded (see Appendix B). All six research participants gave signed consent to partake in this study.

Direct and indirect deception was avoided at all costs throughout this study (Christensen et al., 2014). Direct deception occurs when participants receive deliberate misinformation regarding important aspects of a study, while indirect deception refers to when the real purpose of a study is not efficiently provided to participants (Willig, 2013). The researcher provided all the relevant information regarding the study in a clear manner to each participant, verbally and in written form, and allowed them to ask any questions they had concerning the research. The informed consent document was composed in an understandable and explicit manner to evade any ambiguity or possible misunderstandings (Willig, 2013).

It was reiterated that participation was entirely voluntary (Tracy, 2010). Participants were informed that they did not need to disclose anything that they did not feel comfortable with (Christensen et al., 2014). They were also informed that they would be able to access the dissertation upon its completion if they wished to do so.

Confidentiality pertains to safeguarding identifying information of participants in any research-related output (Tracy, 2010). Confidentiality was carefully explained to participants and each was given an opportunity to choose a pseudonym that has been used throughout the present dissertation to protect their identities. Where participants did make reference to clinical work they were involved in, no identifying information was shared thus protecting the identities of their clients during the interviews. This was, however, kept to a minimum as the focus was held on the participants' opinions, in general, rather than in relation to specific patients. Any information, including the place of work and any possible patient details mentioned, that could potentially compromise the confidentiality of participants, inclusive of their patients, was therefore altered appropriately within the transcriptions (Christensen et al., 2014). After transcription by the researcher, all interview recordings were deleted (Willig, 2013). The transcribed interviews were password-encrypted and securely stored on the

researcher's password-protected computer whereby no unauthorised access is possible (Christensen et al., 2014). Anonymised transcripts have also been archived securely, under lock and key, in the Department of Psychology at the University of Pretoria for a period of 15 years as is required by the data management policy of the University. The transcripts were viewed only by the researcher, the supervisor, and the co-coder. However, only the researcher was aware of the participants' identities. Both the supervisor and co-coder were only privy to transcripts after the researcher had replaced actual names with pseudonyms and altered all other identifying information. Although only viewing anonymised transcripts, the co-coder was nonetheless required to sign a confidentiality agreement to ensure that confidentiality was maintained.

The researcher approached participants with respect and upheld a professional mien throughout the study (Allan, 2011). All participants were treated equally and fairly throughout the study process (Allan, 2011). During the research process the values, opinions, and emotional states of research participants can be affected and should be taken into consideration and dealt with accordingly (Willig, 2013). It was, however, not anticipated that this study would potentially result in any emotional discomfort for the participants as the research topic and questions related to their professional perceptions regarding a therapeutic technique rather than the experiences of a personal, sensitive, or traumatic nature.

Issues Regarding the Research Quality

Compared to the relative agreement of best practice for quantitative studies, there is a cornucopia of discrete concepts for what qualifies as good qualitative research (Brinkmann & Kvale, 2008; Tracy, 2010). Nevertheless, it has been agreed that the trustworthiness and rigour of qualitative research are established through credibility, dependability, confirmability, and transferability (Anney, 2014; Pitney, 2004; Tobin & Begley, 2003). Reflexivity on behalf of the researcher is also vital within qualitative studies (Tracy, 2010;

Willig, 2013). The criteria of trustworthiness to ensure research quality pertaining to this study are to follow.

Credibility

Credibility refers to the reasonableness and verisimilitude of research results (Christensen et al., 2014). It indicates that the findings obtained, and the discussion of results provided, reflect the information initially given by research participants and that it was appropriately understood (Anney, 2014). Credibility is accomplished through the usage of triangulation and the application of reputable research methods for a study (Tracy, 2010; Willig, 2013).

Triangulation is used to reduce researcher bias and increase credibility of the results obtained (Pitney, 2004), and includes the option of making use of another coder in the case of thematic analysis (Braun & Clarke, 2016; Tracy, 2010). This study used a co-coder as it stimulated meticulousness regarding systematic data interrogation and analysis (Barbour, 2001). Furthermore, an established research method—semi-structured interviews analysed using thematic analysis—was employed in the study to address the research aim (Brinkmann & Kvale, 2008).

Dependability

Dependability relates to the consistency of the findings being reasonably based on the data collected and transcribed (Anney, 2014). It relates to the stability of results obtained over time within various settings (Christensen et al., 2014). This is indicative that the research process, while adhering to the appropriate rules of the qualitative methodology chosen for the study, was consistently administered (Guest et al., 2012). Although this is difficult to corroborate, triangulation—as described above—and an audit trial, including a

detailed methodological description of the design and data collection method used, were provided for and administered within this study (Anney, 2014; Tracy, 2010; Willig, 2013).

Confirmability

Qualitative researchers should strive to objectively represent findings, yet confirmability pertains to the acknowledgement that qualitative findings are never truly objective (Tracy, 2010). The true experiences of research participants should be adhered to and reported on, rather than focusing on the preferences of the researcher, to remain as objective as possible within a qualitative study such as this one (Christensen et al., 2014). The researcher included a systematic audit trial and used a reflexive journal (see Appendix F) during the process of this study to ensure confirmability (Anney, 2014).

Transferability

The extent to which results of research attained in one context can be applied to another setting relates to the transferability of a study (Gravetter & Forzano, 2012). When subjective realities overlap, transferability has been achieved (Anney, 2014). While it is argued that it is near impossible to reach qualitative findings that are seamlessly transferable to another similar context (Gravetter & Forzano, 2012), such findings can be richly described and written in an accessible manner allowing the readers to determine the applicability of the study to their own contexts (Tracy, 2010). A contextually rich description of this study was provided to illuminate the meanings of the findings obtained (Anney, 2014).

Reflexivity

Due to the requirements of collecting and analysing the necessary data, the researcher is the most essential instrument when conducting qualitative research (Watt, 2007). Reflexivity pertains to the critical and personal awareness of researcher influence on qualitative research findings (Anney, 2014; Willig, 2013). In this study, the researcher

documented the acknowledgement of personal perceptions and assumptions, admitted to shortcomings of the study, and what effect these possibly could have had on the findings in a reflexive journal (see Appendix F). The researcher also attempted to maintain the role of a curious researcher and not of a future colleague in the profession of psychology when interacting with the research participants.

Summary of Chapter

Overall, this chapter demonstrated the fit between the research questions and the methodology chosen to answer those questions. In brief, this study made use of a qualitative research design to allow for an in-depth exploration of data to occur. An interpretive paradigm with a subjectivist epistemology imparted the lens which guided the research and created the foundation upon which the transcriptions were analysed via inductive thematic analysis. The chosen method was critically addressed throughout the chapter. Lastly, the chapter concluded with a discussion of the ethical implications pertaining to the research process and delineated the requirements for a trustworthy study. The subsequent chapters entail the results and discussion of the research findings.

CHAPTER 4—RESULTS

Introduction

Within chapter 4, the research findings relating to therapists' perceptions on the implementation of Theraplay® in the South African context are presented. The themes with their related codes are each diagrammatically presented via thematic maps and are then described in further depth. There are four themes and 13 codes identified across the six interview transcriptions. Although there were more codes produced during the data analysis process, some were discarded due to irrelevance to the research questions and objectives or were collapsed into other codes.

To remain as close to the meaning of the original data as possible and to ensure credibility and confirmability of this study, excerpts from transcripts are included where applicable to further illustrate the themes and correlating codes that emerged. The extracts are presented in italics along with the appropriate pseudonym used by each participant. Omitted words from a selected quotation are designated with an ellipsis (…), and any information added or omitted by the researcher for the sake of adherence to confidentiality and clarity are presented within square brackets. The researcher attempted to keep to the wording of the extracts as much as possible. It must, therefore, be noted that research participants used 'parent' and 'caregiver' interchangeably, and thus, it is denoted as such within the quotations used throughout the study.

Main Themes and Corresponding Codes Identified

Table 3, to follow, provides each identified theme and its related codes in relation to the findings of therapists' perceptions on the implementation of Theraplay® in the South African context (see Table 3).

Table 3

Emergent Themes and Related Codes

Theme	**Code**
Overall potential of Theraplay® as a therapeutic modality	Relevance of theoretical framework and technical structure
	Usefulness and practicality of Theraplay®
	Administration to types of patients
	Regressive nature and level of comfort
Applicability of Theraplay® in South Africa	Cultural and contextual applicability to South Africa
	Need for cultural and contextual sensitivity in South Africa
	Applicability of Theraplay® activities
Impact of resource availability on Theraplay® in South Africa	Few administrative resources needed for Theraplay®
	Lack of resources in South Africa
	Theraplay® training implications within South Africa
Role of caregiver accessibility and influence on Theraplay®	Caregiver influence regarding the therapeutic process
	Theraplay® is understandable to caregivers
	Lack of caregiver accessibility in South Africa

Each theme with its corresponding codes is outlined and subsequently displayed as a thematic map. Thereafter, the theme is discussed in further detail, along with applicable extracts as further illustration. Note must be given that the codes presented in Table 3 above should not be considered as sub-themes. It was deemed that the identified themes did not need further refinement into sub-themes as that can demonstrate hierarchy of meaning within the data and themes (Braun & Clarke, 2006), and no hierarchy was identified within this data set.

Theme 1: Overall Potential of Theraplay® as a Therapeutic Modality

"Overall potential of Theraplay® as a therapeutic modality", as depicted in Figure 1, was one of the themes that emerged across the six transcriptions. This theme is summarised as pertaining to the overall opinions that research participants had of Theraplay® as an attachment-based therapeutic intervention. These considerations were captured by four codes, namely: 1) relevance of theoretical framework and technical structure, 2) Usefulness and practicality, 3) administration to types of patients, and 4) regressive nature and level of comfort (see Figure 1).

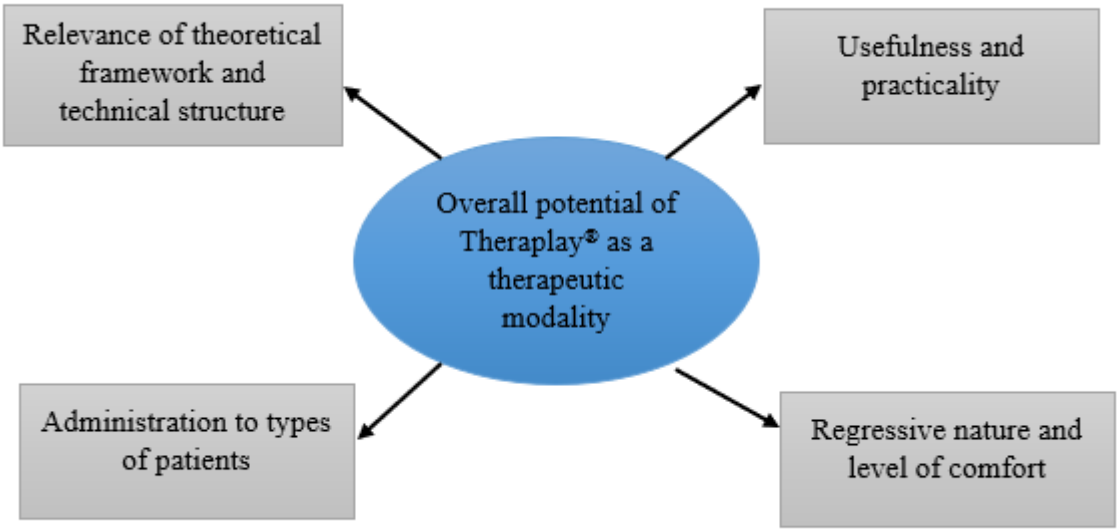

Figure 1 Diagram of theme 1: Overall potential of Theraplay® as a therapeutic modality.

It was appreciated by the research participants that the theoretical framework of Theraplay® remained up to date with current research findings in various domains. They felt that consideration and integration of other perspectives—such as developmental perspectives of trauma therapy and neuropsychology—enhanced the utility of Theraplay®. The reason given was that it ensures Theraplay® continues to be relevant within the psychological field as a therapeutic intervention for the caregiver-child dyad seeking treatment:

> *probably one of the nicest things about Theraplay® is they talk to other people in the discipline […]. So, when you hear Theraplay® you're hearing, you know, other*

> *people like the trauma therapists and the, a-a-a, you know, 'Bessel van der Kolks' of the world. So, they're not rigid in terms of —we don't want to understand how we link to somebody else. […] they're really saying how does it fit in theoretically these days because when Jernberg [originally] wrote the book with Booth […], they didn't know what we know now about neuro-neuropsychology stuff for example.* (Mia)

Similar to Mia's regard of the contemporariness of the model, participants perceived Theraplay® to have a sound framework and theoretical basis. As Coco further mentioned, *"I felt comfortable with the structure [of Theraplay®]. That I always knew why I was doing something, you know, and-and the outcome, the potential outcome of it"*, indicative that—in a practical sense—the technical structure and rationale of sessions additionally provided many participants with increased confidence in the direction of the therapeutic process. Although participants agreed that Theraplay® has a good technical organisation, this was counterbalanced by a caution around how its highly structured process could potentially be too rigid at times. This could result in less flexibility and possibly influence consideration of the uniqueness of, or individual tailoring to, each caregiver-child dyad seeking treatment:

> *I'm a bit ambivalent about how structured it is. On the one hand, it's an absolute relief within the therapist […], but I don't like too much structure. […] I do think there's a lot to be said for formulation and preparation for therapeutic interventions. And what worries me if I look at the way in which it's written on the website and in the books and that, it's starting to become exceptionally formulaic where it's sort of like, step one, step two, step three, […] each child needs an individualized plan, not just —oh this is session one, interview this parent, session two do the following […].* (Mia)

All six participants considered Theraplay® with high regard and *"think it's very, very effective"* (Nix) as a therapeutic intervention. They mentioned that this modality is useful regarding its ability to utilise the theories it is based on and apply it in a practical manner. Participants believed that Theraplay® is authentic in its approach to how caregivers and children engage with one another in a healthy relationship: *"you teach parents how to interact with their children [within the therapy session]. And they can do it at home and can carry on with this process"* (Jenna).

Inclusion of caregivers in Theraplay® was considered beneficial as it facilitated, within a safe therapeutic space, the process of caregivers taking more responsibility. This responsibility includes caregivers better understanding their contribution to the problematic caregiver-child relationship and taking accountability regarding working on improving the relationship:

> *one of the strongest 'ethics' of Theraplay® […] is that it's saying there's no mystery to this. You don't just hand me over your child and I'm Mary Poppins and off you go, now the child is miraculously cured. And when your child hits another speed bump you as the parent don't take any responsibility, you know, you just send them back to me. […] that's where the biggest strength of Theraplay® is, is it's saying in actual fact it's the parent-child dynamic. You [as the caregiver] played a role in the development of the problem and you then also need to play a part in fixing it.* (Mia)

All participants agreed that Theraplay® can be used to treat a wide variety of psychopathological difficulties as there is often a relational dynamic to mental disorders:

> *Theraplay® can go right from neurodevelopmental disorders. […] I see ADHD as an attachment disorder. […] ADHD is on top and underneath is your attachment issues.*

> *[…] I use [Theraplay®] to manage the relational difficulties […]. I definitely use it across the board for diagnoses.* (Mia)

When indicated, the participants stated that they *"do Theraplay® with any socio-economic group that seeks assistance. I apply it to any race as well"* (Anne) and to all ethnic populations requiring enhancement of their caregiver-child relationships. They also considered Theraplay® to be applicable to a wide age spectrum as all individuals, irrespective of their current age, have experienced childhood and possible attachment injuries that might not have been adequately dealt with. As Mia aptly stated:

> *everybody needs nurturing, everybody needs challenge, everyone needs structure and engagement. […] You still have developmental needs that may not have been met. […] I consider [Theraplay®] an adult, child, and-and toddler framework. […] we need to even consider how many mothers out there have postnatal depression and all those other things like domestic violence […] that also has an influence on their relationships with their child. They are maybe not coming for treatment when the baby is still small, but when the relational problems happen later, then they bring them to us.*

There were, however, some apprehensions that participants voiced regarding Theraplay®. This included concerns pertaining to the number of sessions that are prescribed for the implementation of a complete Theraplay® process with caregiver-child dyads. This was voiced by Nix: *"Is it practical in that sense? No […]. And when I say practical, I am meaning the amount of sessions needed as it, as it states in the training and in the text-textbook"*.

There was also unease regarding the focus on physical touch, especially with older children, possibly due to them developmentally becoming more aware of their bodies as they

become older: *"[Theraplay®] really needs to be updated [regarding] touch, […] when the child gets older, […] they need to have a much [clearer] idea of what they're trying to accomplish there and-and-and [be clearer] about what is the developmental goal"* (Mia). Furthermore, Talita highlighted that consideration needs to be given to the traumatic history of a child regarding the manner in which Theraplay® includes the encouragement of nurturing touch, especially in South Africa where violence and trauma are commonplace:

> *a child that experienced a lot of trauma will react differently to touch, even if, you know, it-it's nu-nurturing. Like for example, a lot of our black population in the hands of police and in the townships, experience a lot of physical abuse. […] If you were to work with them straight after 1994, you know, to be mindful that this culture, this population might have experienced a lot of trauma, from previous generational trauma even. […] [It] can be culturally bound due to the-the-the history of-of the country and-and ev-even in the present situation there's still a lot of violence in certain parts of the townships in our country […].*

It was deemed by three participants that Theraplay® evokes a sense of feeling exposed *"because of the infantile nature of the therapy you are going to"* (Mia) and that it impacts not only the caregiver-child dyad, but the therapist as well. Nix verified this when she stated that *"I think also for the therapist, even for myself, you know, you-you get surprised at the difference, it triggers a lot in you"*. Due to the possibility that caregivers may also have unresolved attachment injuries from their childhood, Mia mentioned that much awareness and monitoring needs to go into the vulnerability that caregivers, like their children, might experience during the therapeutic process:

> *because as much as the child goes regressive, […] your vulnerable infant inside of you [as the therapist] is also opened up. Now, obviously we've been trained [to deal*

with it], but the parent hasn't been trained. So, if it accesses something in them? Now what?

Four participants reiterated that as the therapist, Theraplay® is complex to administer regarding the extent of engagement that it demands. This possibly implicated participants' awareness that they, as the therapists, need to be mindful of personal factors that may be triggered while administering Theraplay® to a caregiver and child:

> *The old word for [engagement] in 1979 when the first book came out, [Jernberg] used the word 'intrusiveness', right? […] Now they use the word 'engagement', but I actually think she had a point to say that it actually does intrude upon the defences. [It] goes beyond safe walls of the therapist. You've got to really know yourself. […] it demands a lot in terms of level of comfort with your presence in the room.* (Mia)

Theme 1 summary.

Theraplay® is perceived by participants as useful and practical to administer to a wide diagnostic and age variety of patients. The participants considered it beneficial that Theraplay® is based on a sound theoretical framework and has a good technical structure, but attention should be given to ensure the modality does not become too technically rigid. They also valued that Theraplay® remains up to date with current research findings in various domains to ensure that it continues to be relevant as a therapeutic intervention for caregivers and their children. The participants did highlight the need for consideration pertaining to the developmental goals regarding nurturing touch for when children become older, as well as the regressive nature of the activities for all participating in the intervention.

Theme 2: Applicability of Theraplay® in South Africa

The second theme that was identified is depicted in Figure 2. "Applicability of Theraplay® in South Africa" related to research participants' perceptions regarding the applicability of Theraplay® as a therapeutic intervention within the South African context. Participants' opinions appeared within three codes identified by the researcher as: 1) cultural and contextual applicability to South Africa, 2) need for cultural and contextual sensitivity in South Africa, and 3) applicability of Theraplay® activities (see Figure 2).

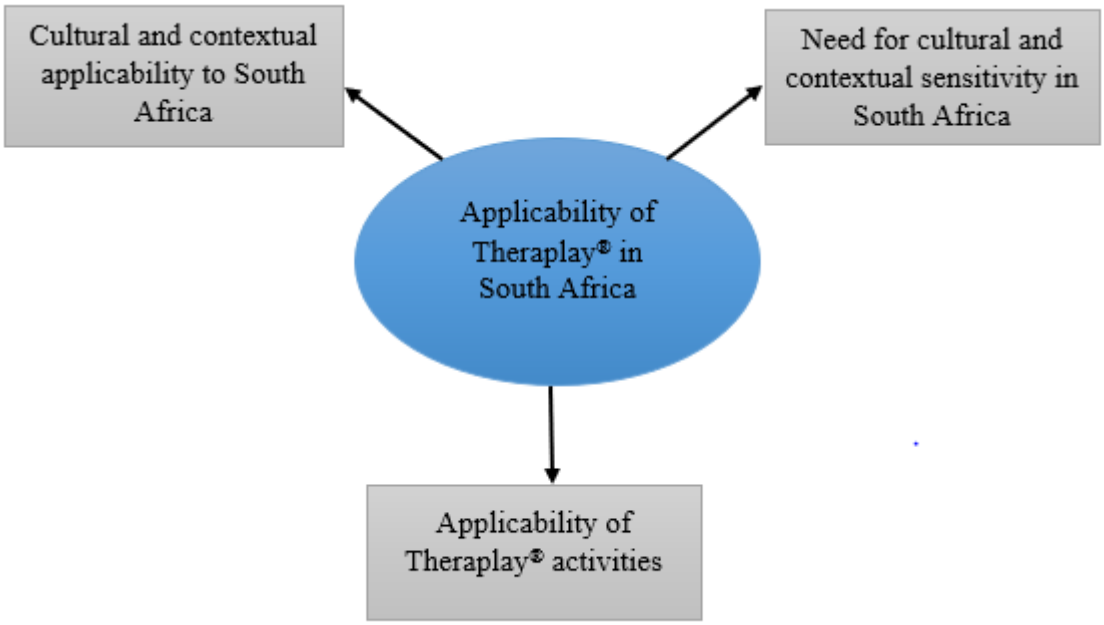

Figure 2 Diagram of theme 2: Applicability of Theraplay® in South Africa.

Research participants reported that they felt Theraplay® *"really has potential for [the South African] population and the attachment problems that we have here, with the violence and trauma and-and-and attachment difficulties and disrupted families and all that"* (Nix). Four participants perceived that this modality has a place within South Africa due to being play-based and not only dependant on language:

> *being a very, very diverse country, something like Theraplay® that is not so heavily reliant on language, comes in really, really handy in [South Africa] with 11*

> *different languages. And a lot of the times, especially in the public service, you find that there's a lot of language barriers, because they have limited resources. […] And I think Theraplay® comes in handy when it comes to, you know, working with that kind of difficulty in therapy […] as language isn't so important, you know, it's more about the [Theraplay®] activity and the-the improving of the relationship.* (Coco)

Participants grappled with the complexity of culture as a concept in general and how various aspects encompass cultural influence on an individual: *"I think every single family does their own interpretation of a culture […]. Then you can argue—well one parent's Greek, one parent's South African but they live in Europe. […] How many cultures are actually influencing the parenting?"* (Mia). Talita felt that culture may play less of a role in comparison to the nature of the specific caregiver-child dyad involved in Theraplay®:

> *I can have two families from the same culture and one activity will work well with one dyad and that same activity will not work with the other dyad. So, I don't necessarily think it's bound to-to-to, that certain activities are more appropriate than others for a certain culture.*

Although there was an awareness that there are many features to any given culture that should be considered, Coco reflected that the constellation of contextual factors, which may also include cultural elements, of each patient should be taken into account when treating them. She further mentioned that assumptions regarding particular cultures and the therapeutic applicability of interventions should be avoided:

> *to take one aspect of a child's culture and kind of use it to be like, okay well [Theraplay®] will not work because we can't make eye-contact, […] that's more of a blanket approach and I-I think each situation needs to be treated individually.*

> *Because remember, in as much as these children come here and they have different cultures […], they're also not well […] the patient becomes more important in the room than the culture.*

Participants believed that irrespective of the intricacies that culture may entail, relationships remain important across cultures: *"if somebody asked me, I would say that I think there [are] a lot more similarities to parenting in this country than we realize"* (Mia). Mia further reflected on this thought based on her experiences within her private practice:

> *if I see a child that is Zulu, they're not expecting me to be Zulu. […] I can only talk about my context and I honestly can say that the children I see, whichever culture they originally come from, […] though the outcomes might not be as good as if they went and saw a-a Zulu therapist, I don't know […]. But I know that they respond relatively in-in the same way, in-in a way that children respond when a parent is paying attention to them. 'Cos it's not really the activity if you think about it. It's actually about the encounter.*

Most of the participants tended to be of the opinion that Theraplay® as a modality *"can be applied […] to any context; [it is not] foreign in that sense"* (Anne). According to participants, South Africa—with its extensive contextual multiplicity and the challenges this introduces regarding aspects such as accessibility to resources—would benefit from the practical versatility of this therapeutic intervention. This was further highlighted by Jenna:

> *I remember when I was a student, I worked at Eersterus, and sometimes I worked in the medication room, in the 'pille-kamer[1]', and sometimes I worked in the kitchen and sometimes I worked under the tree. You know, so-so we get trained with the*

[1] Afrikaans term for a room where the medication and medical supplies are stored within a hospital or clinical setting

> *idea of having a playroom and that's not always the reality here in South Africa. And I think Theraplay® has enabled me to do therapy in very challenging contextual situations.*

All six research participants agreed that there are aspects of Theraplay® that are acontextual, but there remains a need for cultural and contextual awareness and understanding when using Theraplay® in the South African context. Participants felt that within a country as diverse as South Africa, it would be challenging to make adaptations to Theraplay® for each culture, as Coco emphasized:

> *you can't make a different Theraplay® for each cultural group. […] you should rather consider looking at the broader context, […] and look at the whole of South Africa as a context as well, […] so that whatever adaptation of Theraplay® you do, you will be able to serve a majority.*

In addition, Talita mentioned that South Africa not only has many cultures, it also has a wide variety of inter-cultural contexts: *"I don't know how it works if certain cultures stays in certain areas, I think it is mixed as well. Also, people marry between the a, the cultures. So, there is inter-intercultural things too"*.

There was an overall agreement that due to Theraplay® originating within the context of a developed country—namely the USA, certain factors that apply to developing countries were not considered in its conception. As Talita stated, one such consideration was the high rate of poverty within the South African population:

> *in my [Theraplay®] training, difficulties that […] came across in different countries, but which is also applicable to South Africa, is countries that [have] a lot of poverty. […] For example, one of the games is to throw marshmallows at one another […]. And that is extremely hard for children [where] food is very rare.*

Another factor that participants felt should be taken into account was the discrepancy in the level of education in South Africa as compared to the USA. This could possibly influence the understanding of Theraplay® activities, which may impact the domains that the activities are intended to tap into:

> *Theraplay® was developed in a country where the education system is standardized […]. Whereas, in South Africa, you have public schools, you have private schools, you have rural schools, so the children are not all on the same level. […] Here, you might find a five-year-old who knows Jingle-Bells, and another one who doesn't. […] You can't overlook it, because I think the concepts that come with Theraplay®—there's just this assumption that all kids will-will know, will understand. […] I know some of [the activities] you teach, but even the types of actual elements that you use, like a beanbag […]. You might find the child doesn't know a beanbag. And before they can even start throwing it around, they wanna know what is this thing, which can influence the outcome of using the activity for a specific do-domain.* (Coco)

All participants mentioned that, as much as they felt there needs to be cultural and contextual sensitivity regarding the application of Theraplay® as an intervention in South Africa, *"the Theraplay® do-domains are universal, [...] it is [more about] how you adapt and apply the activities more to the context"* (Jenna). A statement made by Coco suitably contextualised the situation in South Africa pertaining to using techniques and tools developed elsewhere and adapting them accordingly for the local context, as should be the case when administering a Theraplay® process:

> *we make an effort to try and adapt [assessments developed in other countries] to our context. Because we realize the value in those assessments, and you realize*

> *how they can assist us when we do adapt them here and there. I think it should be the same with-with Theraplay®. I-I think you don't need to put yourself in a corner, and feel that you need to do everything to the T. […] It is a completely different context in South Africa, completely different population. So, you need to adapt it, but like I'm saying, […] we-we don't then chuck it away because it's not applicable. We […] try and work with it, because we understand the inherent value in the actual intervention strategy.*

Suggestions made to possibly facilitate the process and development of a more culturally and contextually sensitive Theraplay® within South Africa included observing how caregiver-child dyads from various cultures engage with one another in a healthy manner:

> *look at how a child is raised from naught […] until, let's say, before you go to school. Like video-record them or-or-or something like that. What is the definition of healthy parenting in a context whether you're Afrikaans-speaking, English-speaking, coloured, or whatever. […] What are they doing naturally that can be adapted into a Theraplay® activity?* (Mia)

Another proposition was given by Anne, suggesting that *"you go to different families […] and ask them some games that they play that they feel are quite engaging or […] challenging or nurturing or structuring to get some [Theraplay® activity] resources like that from actual South African families"*. The implications of these suggestions would, consequently, allow for Theraplay® activities to be contextually and culturally better suited for the South African context. Additionally, this would mean that the activities would be more relatable to caregivers and their children.

The predetermined Theraplay® activities were regarded by all the participants as an integral part of the therapeutic process. The activities provide opportunities for caregivers to

joyfully engage with their children while allowing for healthy relational experiences: *"it's saying we're going to do a third object, the activity is a third object, who cares whatever the activity is, […]. It's about saying - I want us to connect"* (Jenna). Furthermore, Mia remarked that the activities are concrete and simple, which *"communicates a powerful covert message to children […]. I don't care what we do, as long as you know I'm focused on you. That is the power of the right-brain, right-brain connection that Theraplay® offers more than any other therapy"*. Ultimately, this suggests that Theraplay® activities are a means for caregivers to be present with their children and relate to them within a safe therapeutic space.

There were several Theraplay® activities that participants regarded as universally applicable and therefore made use of in the manner as prescribed by Booth and Jernberg (2010). The participants considered these specific activities to be relevant to the context of South Africa as they regarded them to be universal. Examples of these activities included the *"weather report"* (Nix) and, as Coco mentioned, *"the lotion one […], and I think also the nurturing one—the feeding"*. Additionally, Jenna highlighted that:

> *I think there's many activities that's […] really universal and I always think of this example of I was standing in New York and there were children behind me, and they were playing exactly the same clapping game [used in Theraplay®], the same song, the same movement, millions of miles away.*

There were, however, certain Theraplay® activities that research participants have adapted to make them more applicable to the South African context. Participants felt that making some of the activities *"more culturally and contextually specific [would make them] more relatable to the parent and-and the child"* (Anne). Examples of activities that have been adapted include *"rather singing a Zulu song instead of twinkle-twinkle [little star]"* (Mia) or "*make the parent say the 'harms' that they saw instead of touch them too if that was*

a problem for their culture" (Coco). Furthermore, Talita suggested that communication with the caregiver about issues of their culture is essential. She also offered the consideration that therapists should not assume a caregiver-child dyad subscribes to certain cultural norms simply because they appear to belong to a particular ethnic group:

> *it's very important to-to speak to the caregiver to really understand […] their culture and to do the activities with the caregivers to find out if this is appropriate for them or not. […] If eye-contact is a difficulty, but dancing […] works more where like cultural dancing is still incorporated […], something like bringing in a djembe drum—a small drum like that—and using that for the rhythm or-or for the dancing […]. But I don't think now you must see this child as a black child and now therefore I'm gonna bring in a-a djembe drum. You know it must be appropriate for them. Because that is assu-assuming quite a lot. You know, and-and at the end of the day you could be wrong.*

Every participant was of the opinion that the Theraplay® Institute *"need[s] to revise and increase the number of activities. Not so that it's unwieldly, but definitely, because otherwise it becomes highly repetitive for the children. And, which is not a bad thing, but it needs to be therapeutically repetitive"* (Mia). Part of the reason for suggesting an increase in the number of activity options was because some of the participants, such as Anne, have other obligations that are time consuming:

> *I do my own admin, so I unfortunately don't have time to go in the evenings and spend time […] to go and research games. So, I would love to have some sort-of list of-of suggestions [to] choose from. A list that has a bigger variety and includes like up to date stuff or like a Zulu game or song or Afrikaans songs or, you know.*

Similar to Mia, most participants also felt that the *"games that they have there, that was my babyhood, […] those were the games that were familiar to my, to my mom and her friends […]. So, it comes from a Western parenting approach, like Peek-a-Boo and all"*. Expanding the list of Theraplay® activities would allow for a greater variety of activities that caregivers and their children can better relate to; that are contextually familiar to them.

Theme 2 summary.

This theme related to the applicability of Theraplay® to the South African context. Participants perceived aspects of Theraplay® to be culturally and contextually suitable to South Africa, such as its non-reliance on language. There were, however, other factors that participants regarded as needing revision in order to make Theraplay® more culturally and contextually relatable to South Africa. This theme also incorporated participants' considerations of the applicability of the Theraplay® activities. Some activities were regarded as universally applicable but there was an expressed need for additional activities and for some existing tasks to be updated.

Theme 3: Impact of Resource Availability on Theraplay® in South Africa

Theme 3, as shown in Figure 3, is "impact of resource availability on Theraplay® in South Africa" and reflected the impact that resources have in relation to Theraplay® in this local context. This theme had three codes that defined it, namely: 1) few administrative resources needed for Theraplay®, 2) lack of resources in South Africa, 3) Theraplay® training implications within South Africa (see Figure 3).

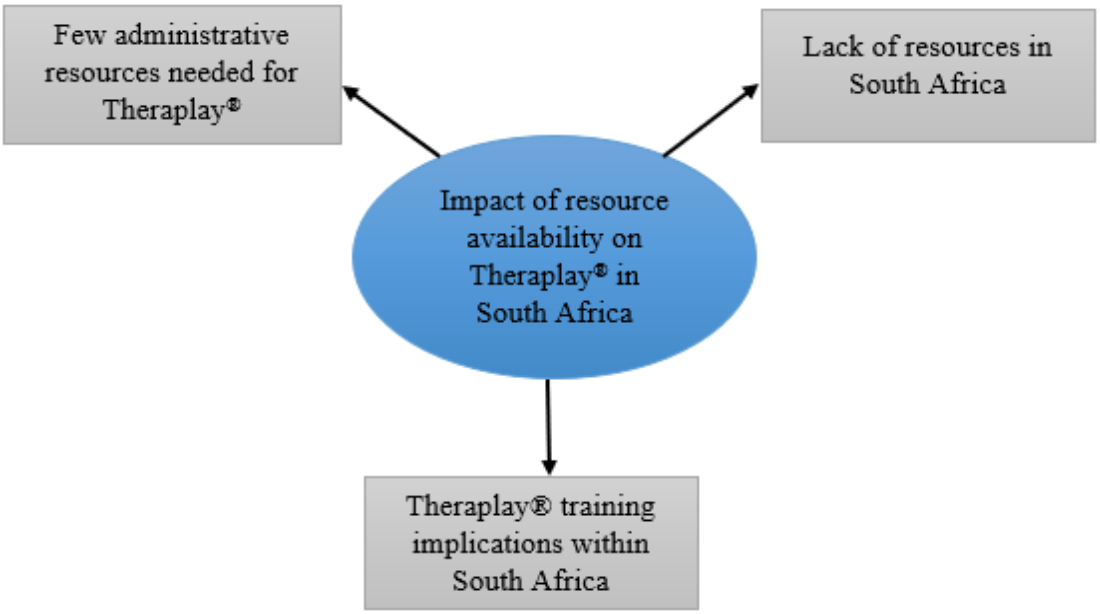

Figure 3 Diagram of theme 3: Impact of resource availability on Theraplay® in South Africa.

The overall opinion that the research participants had about Theraplay® was that it is an inexpensive therapeutic modality that *"requires very little to administer"* (Jenna). This was further supported by Mia's perception that Theraplay® is a technique which involves *"showing parents that they don't need to go do extravagant stuff or even spend much money to engage and connect with their child, even just for like-like half an hour a day"*.

Similar to Nix, participants agreed that:

> *in terms of the venue and that, you just need a room, […] just anywhere […] where you can put, sort of lean your back against something. So, it's what I like, is that you can do it in a rural sort of village next to a tree or you can do it in a fancy office.*

They also appreciated that the Theraplay® activities:

> *don't require a lot of money […] to-to-to buy the stuff needed, like the newspaper or cotton wool or whatever. […] I think it can be quite, it, it's easily accessible, I don't think anybody [in South Africa] gets denied access to any of the activities for financial reasons.* (Nix)

This was an indication from the perspective of the participants that within a context such as South Africa that does not always have easy access to ample physical resources, Theraplay® is a viable therapeutic alternative due to its non-reliance on costly resources or settings.

Mia commented on the fact that *"we are sitting in a third world country with huge, huge unemployment and many dysfunctional families where parents are stressing about so many things. […] And not enough time is spent on the future of this country—the children"*. Participants acknowledged the psychosocial problems as well as obstacles to accessing and adhering to treatment linked to the high rates of unemployment and poverty within the South African population. Nix suggested that to overcome the challenges that the high prevalence of poverty introduces is possibly to engage more with communities—to go out to meet the population in need, rather than expect them to come to therapists:

> *psychologists sit on high horses and-and their perches and in their fancy offices and-and-and expect people to come to them. I think that there could be a lot of benefit if we would go to […] the communities and actually make ourselves more accessible. We would reach many, many more in need, often where the majority of the problems are and-and the assistance is needed.*

Taking Theraplay®, which is a versatile therapeutic intervention—regarding being cost effective and easy to administer in various contexts—into the communities of South Africa could assist with breaching some of the challenges that accompany poverty.

Although Theraplay® was considered as valuable with reference to its cost-effectiveness, concern was raised regarding the inaccessibility to other forms of resources that would allow for *"the full benefit [of Theraplay®] within the South African context"* (Nix). Reasons for this include that the extent of poverty in South Africa influences the ability to implement, in a purist manner, therapeutic interventions—inclusive of

Theraplay®—that have been established within developed countries where there is a greater access to various resources:

> *the impression that [the Theraplay® Institute gives] is that they are much more well-resourced. So, they have so many professionals working together. I recall them saying—oh but just get the social worker involved with that aspect […]. It's not that easy here. The system [in South Africa] is not that well integrated and it's extremely expensive to get more and more people involved. […] They're definitely more resourced there [in developed countries].* (Anne)

It was reported by four participants that caregivers are often not able to afford bringing their children for the ideal weekly Theraplay® sessions as is prescribed:

> *The ideal [number of prescribed sessions] is a really long time. Either for people to take off work […] because they-they [are] bringing the children to therapy or to pay trans-transport money […] for completion of the Theraplay® sessions. […] We try to refer to closer to home, […] but there's not always a psychologist in the community or that is trained in Theraplay®.* (Talita)

Nix stated that she attempted to compensate for the amount of sessions required through *"a reduction in-in-in the number of sessions, which I don't think is probably as beneficial, but it can become too drawn out if you only have the amount of sessions that the medical aids are-are willing to […] pay for"*. This suggested that participants would appreciate an adapted type of Theraplay® that required fewer sessions in order to address the financial struggles related to medical aid constraints, or lack of medical aid, as well as transportation costs in South Africa.

Although participants agreed that there is *"huge potential for Theraplay® here [in South Africa]"* (Mia), Anne did mention that Theraplay® is not *"a centralised thing that's*

government sponsored like overseas, you know, or the government that at least contributes to it or anything like that". It was felt that within developed countries such as the USA, guidelines for the national implementation of this therapeutic modality are already incorporated into policies and various organisational structures, which is not the case in South Africa. This further reiterates how a lack of funding influences the accessibility of intervention utility within a developing country such as South Africa. As Nix highlighted:

> *that means you've got to take this even a level higher […]. It's to go to the people that are sitting in the positions of power and authority and say, but this is the programme, this is why it's so beneficial, you need to start spreading it or you need to start implementing it. It comes down to financial input again if you think about it.*

Research participants commented that there are *"certain shortcomings in terms of training [of Theraplay®]"* (Jenna). Some of the limitations mentioned related to training exposure, training costs, and training opportunities afforded to them. It was felt by participants that there was insufficient exposure to Theraplay® as a therapeutic intervention during their years of professional clinical training, such as it only being *"during my masters, but it was a very, very brief mention"* (Anne), or during internship, or their community service year. The participants felt, as reflected by Mia, that:

> *there's a lack of formalized training. […] [I found out about Theraplay® though] a book in a library sitting in Port Elizabeth. People love Theraplay® but nobody's training it and we only get exposed to it late in our training, if we even get exposed to it actually.*

It was stated that accredited Theraplay® training workshops were *"kind of far and few between"* (Coco), and that these workshops were considered as costly to South African practitioners, possibly due to *"the rand-dollar exchange rate that changes quite often with*

our political circumstances in South Africa" (Talita). The participants commented that there are a limited number of practitioners that have done training in Theraplay® and though *"[the Theraplay® Institute is] great regarding getting in contact with [people who went for training via] emails and […] on their Facebook page and all of that […], it's blossoming on the other side of the world, not here"* (Nix). Furthermore, Anne stated that:

> *I always get the email to say—okay there are lots of supervisions happening, and I never joined it just because I feel I prefer some[one] local […]. I [would] feel more free then to […] explain the situation because I sometimes feel [Theraplay® Institute trainers] don't properly understand what we have happening here, you know, like our unique context in this country.*

This highlights the importance that availability of resources—in terms of more training workshops to qualify more practitioners—as well as contextual understanding and appreciation plays in therapeutic endeavours.

Suggestions were offered as to how the presence of Theraplay® within South Africa could be strengthened considering that the participants felt it is a beneficial therapeutic intervention for this local context. These suggestions included *"that [the Theraplay® Institute] train ten people in South Africa. Those ten people train ten people, […] then we have a lot of Theraplay® therapists, but all of them still have to pay the Institute to be part of Theraplay®"* (Talita). Other recommendations were that *"it would be great if they could come, you know, more regularly"* (Nix), or that *"there needs to be international buy in. […] you've got to have a very powerful representative, who, who's willing to do all the work and not necessarily for payment—to create a very strong link"* (Mia). These suggestions indicate that in order to decrease the reliance on international Theraplay® trainers which makes the training more expensive, there needs to be increased skills development and further capacity-

building with local practitioners. If an international Theraplay® therapist was willing to be a representative and become a local trainer, it would also decrease the cost of training which would be beneficial for South Africa where affordability of training is a significant challenge. This would also increase accessibility to practitioners and, ultimately, to patients.

Theme 3 summary.

An advantage of Theraplay® is that it is less demanding on resources requiring only minimal space and inexpensive items. Although this is beneficial to a developing country such as South Africa, there are other resource obstacles within this local context. This includes financial difficulties for patients, such as transportation expenses and medical aids covering a limited number of therapy sessions. Resource obstacles also influence training in Theraplay® within South Africa relating to access to training and supervision opportunities, as well as the cost of the training towards becoming a fully qualified Theraplay® therapist.

Theme 4: Role of Caregiver Accessibility and Influence on Theraplay®

"Role of caregiver accessibility and influence on Theraplay®" was the final salient theme. As depicted in Figure 4, it covered research participants' opinions on how accessible Theraplay® is to the caregivers involved and the influence that caregivers have regarding the therapeutic process of Theraplay®. These perceptions were outlined in three codes: 1) Theraplay® is understandable to caregivers, 2) caregiver influence regarding the therapeutic process, and 3) lack of caregiver accessibility in South Africa (see Figure 4).

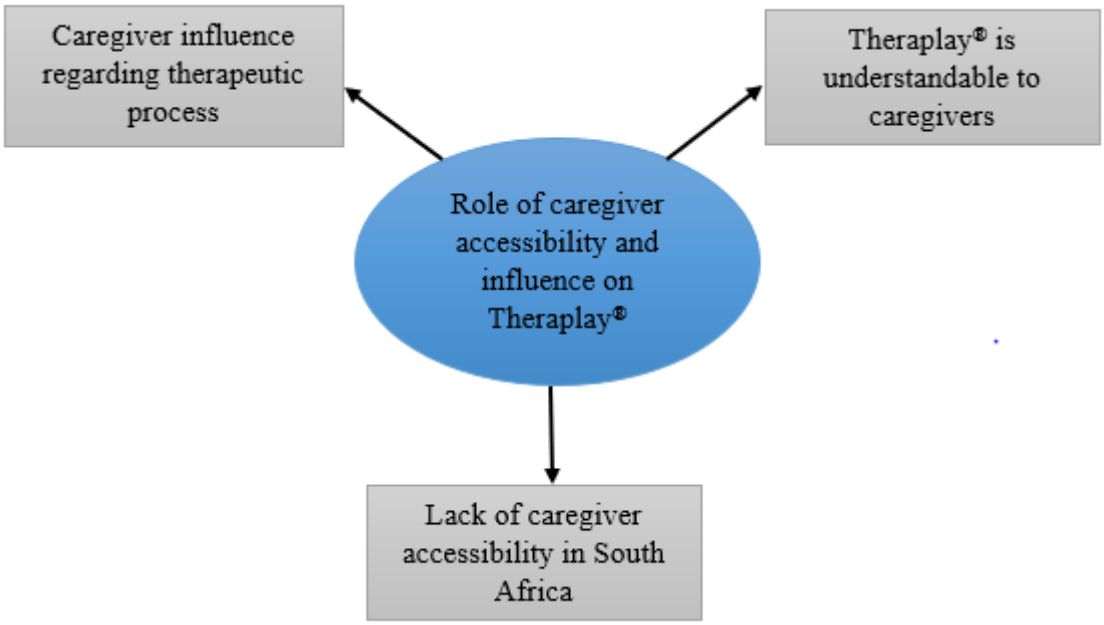

Figure 4 Diagram of theme 4: Role of caregiver accessibility and influence on Theraplay®.

Theraplay® directly involves caregivers in the process, as the focus is on the caregiver-child relationship. As Mia stated, it is imperative to include caregivers within the therapeutic process with their children because *"when you consider a child, it doesn't exist without a parent […]. Wherever you see a pram you see eyes following the pram"*. There was consensus among participants that *"parents are playing like a huge role in terms of what the children are presenting with"* (Nix), which further supports the importance of including caregivers in the therapeutic process. This was reiterated by Mia's perception that:

> *where Theraplay® has a greater strength than any—don't get me wrong, I do every type of therapy—I do sand tray, I do sand play, Gestalt. […] But where Theraplay® has the cutting edge is saying what I achieve in an hour can be undone the rest of the week. It is actually better for me to skill the parent. […] There's without a doubt, we have to move more towards the parent-child dynamic.*

Participants felt that Theraplay® made intuitive sense to caregivers as this therapeutic modality was *"not asking them to do something unnatural in order to assist their child"*

(Mia). They stated that the rationale of the intervention was comprehensible and accessible to the caregivers when explained to them:

> *It's almost like, […] especially the mothers, who are 99% the ones bringing their children. The insight they get from it, the awareness they generate from it is phenomenal. […] I think that is the biggest benefit definitely, the accessibility to the parents.* (Nix)

However, as Anne mentioned, consideration also needs to be given as to whether *"there [is] an emotionally available and obviously physically available parent to do Theraplay® at home"* when determining if this modality would be suitable for the caregiver-child dyad seeking treatment.

The participants commented that by having caregivers as part of the Theraplay® sessions, the caregivers felt more included in the therapeutic process:

> *caregivers can find quite a relief, you know, on how simple it can be. […] It's nice for them to have that structure and it's […] something they can take home, not always know that behind a closed door there's this mysterious psychology stuff that's happening.* (Anne)

Not only do the caregivers feel more involved, Mia commented that *"It's affirmation for them that there is stuff they do actually already do right"*, which would give caregivers some confidence in their caregiving abilities, rather than just focusing on what is problematic in terms of the way they take care of their children.

Some participants felt that more thought should be given to how caregivers experience their involvement in Theraplay®, as caregivers are *"often highly anxious and may even have stigmatised ideas about the psychological struggles that their child is presenting with"* (Mia). Involving caregivers in the therapeutic process means that consideration should

be given to what their perceptions are of mental illness, what their expectations are of the therapeutic process, the role that they play, as well as the effect of being part of Theraplay® has on them as the caregivers in the room. Caregivers frequently do not know what to expect from being part of therapy, as they are often accustomed to not being involved in the therapeutic process of their child. Talita mentioned how she attempts to address potential uneasiness experienced by caregivers:

> *[doing] the activities on a separate time with the parents alone for them to experience that activity and to find out their comfortability with the-the-the activity and then to determine whether their comfortability […] is about culture, […] how they were brought up, or is about their own insecurities.*

In addition, Mia highlighted the importance of rapport with the parent within the therapeutic relationship:

> *parents can either make the therapy or break it. […] it is exceptionally difficult to manage two people in the room plus yourself, plus try and manage everything else. […] In my experience, [it] is the parents have to get on with you. So, your rapport has to be very strong with the parents in order for them not to feel, you know, criticized, hyper-vigilant, you know.*

A reservation expressed by four participants about having caregivers involved in the process was that *"sometimes parents expect a lot more from a clinical psychologist especially—should you not be doing more than just teaching me how to play with my child?"* (Anne). Participants stated that often the Theraplay® process necessitates an explanation of this process and its rationale to caregivers:

> *Theraplay® can be misunderstood by parents as this idea of indulgence [with the children]. […] That's why I get nervous with the parent in the room. It looks*

> *like—oh, we're just having fun […]. Yes, we are, but we're also not because it's also what [the therapists] do not do. […] It's not so much—please do the following. It's also saying to the parent—don't do the following. […] The fact that I haven't lost my temper with the child, […] the fact that I have a level of spontaneity with the child, the fact that I go onto the child's level […].* (Mia)

Although some participants did state that *"parents that are really involved will take what I suggest and they will use the homework activities that I give them and they will implement it at home"* (Nix), there were other participants who commented that *"parents don't do the-the homework that I give them, even though it only requires like half an hour, 45 minutes max"* (Anne). It was also mentioned that there are occasions where *"the caregivers also terminate before the process is actually over […], which obviously then impacts the effectiveness of the Theraplay® intervention"* (Coco). This highlighted how important it is to consider the impact that caregivers can have on the therapeutic process of Theraplay® as a whole.

According to participants, there are various factors that influence the availability of caregivers regarding the therapeutic process of Theraplay® indicating that *"the parents aren't always accessible"* (Nix). These included psychological and environmental factors which interplay with one another and hinder the caregivers' abilities to *"understand how important connection is, to prioritise connection, to know how to play with their kids"* (Anne).

Three participants that work within the private sector felt that one of the challenges that they have experienced is where *"a lot of the kids are not always dropped off by parents. So, because the parents are working, au-pairs are dropping them off—so that also makes it difficult"* (Nix). Although participants agreed that focus should be given to both individuals

within the caregiver-child dyad, there is caregiver avoidance at times, such as Mia's reflection:

> *parents don't want to come in. […] They say they do but the minute you say—okay, I do parent-child together, suddenly they're like, ja, about that—I have work, shopping to do […]. Because in actual fact on one level [the caregivers are] like, no, I want to know. But they don't really want to know. All they want is their child to be fixed but they don't realise that it's actually the parent-child relationship.*

Participants gave possible reasons for caregiver avoidance as self-blame, guilt, stigmatisation, and emotional exhaustion:

> *most parents go from work, start cooking, give food, bath time, put them to bed without a-a time for really for connection with their child. […] Sometimes they even feel embarrassed […] for actually coming to get help for problems they feel they should know how-how to solve as parents on their own, or-or they are stigmatised by others or even themselves.* (Talita)

All of this could make it more difficult to fully engage within a therapeutic process, particularly when the therapeutic intervention emphasises the engagement of the caregiver-child relationship. For that reason, participants agreed that they need to assess and be aware of the caregiver's state of mind, as it could be detrimental to the outcomes of the Theraplay® process.

> Participants reflected on the fact that they:
>
> *often work with single mothers although Theraplay® encourage that both parents should be there, but in […] South Africa, I think that is a reality that-that a lot of people are not together either because they never married or because they divorced or work […] or-or even death, maybe both are even dead.* (Talita)

This concern was further contemplated by Coco:

> *We have a lot of children who don't have parental figures in South Africa. A lot of child-headed households in South Africa, often because of the HIV/AIDS epidemic we sit with here […]. So, you won't always have the luxury of sitting with the mom and the child in therapy.*

The social problem of child-headed households in South Africa emanating from the spread of HIV/AIDS has a significant impact on various levels, including leaving children without caregivers (Kuo, Operario, & Cluver, 2012) which implicates the inclusion of adult caregivers in the Theraplay® process. The participants had differing opinions regarding this matter.

There were some participants who felt that Theraplay® without the caregiver could still be applicable, as they would ideally want children to experience a different type of relatedness—with the therapist—to that which they have been exposed to:

> *I would want that for a child-headed home, a child without any parents, […] that this Theraplay® experience means that there's more people out there that they can […] bond with, and that they don't have to go into relationships that's abusive or abandoning.* (Jenna)

Coco also reiterated that Theraplay® could be a different and more positive experience for the child:

> *Where once a week, you go to a place where you're with someone who provides you with a different reality. […] you are able to-to feel different emotions and you are able to experience something different. And I'm well aware that, you know, with a lot of these children you might find that they are going back to a context where whatever traumas they're experiencing, whatever emotional difficulties*

> *they're experiencing, are just, you know further perpetuated. But I think that experience, that containment, that once a week […] experience that happens will be something meaningful for the child.*

Nix offered an alternative perspective, believing that Theraplay® may not be as useful without the involvement of a consistent caregiver:

> *where are these children? […] Are they living on the street? […] There must be somebody who's taking care of them. […] Is Theraplay® then applicable? I don't think so, […] because I feel, you know, the-the attachment relationship is important. And that person has to be there walking a road with the child. So, to just have a distant aunt coming in and doing it? No, I don't think it's beneficial then to the child. I think for you as the therapist to take that role is also not the best for that child.*

It was felt that in such instances where there was a dire need to work on relational difficulties, it would be better to *"incorporate more [of a] Theraplay® group kind-of mind-set because there [the] focus there is to form positive interaction and not-not necessarily the-the attachment process"* (Talita).

Theme 4 summary.

Theraplay® is a therapeutic modality that focuses on the caregiver-child dyad (Mohamed & Mkabile, 2015); it is intended to involve the caregiver and the child in the intervention. Therefore, it was postulated that caregivers have significant influence on the utility of the intervention. This theme included the impact that caregivers have on the therapeutic process of Theraplay® regarding their expectations and perceptions of the process. Although the research participants considered that Theraplay® is comprehensible and accessible to caregivers regarding understanding of the rationale behind the modality, there

needs to be consideration of instances where there is a lack of caregiver accessibility due to social circumstances, various life stressors, and avoidance. It was also noted that South Africa has many child-headed households for numerous reasons, which has an impact on the efficient implementation of Theraplay® within the South African context.

Summary of Chapter

This chapter presented the findings that emerged within the research study. Through thematic analysis of six interviews exploring how therapists perceive the implementation of Theraplay® within South Africa, four prominent themes were identified. These included Theraplay® as a therapeutic modality, South African perspective and Theraplay® applicability, considerations regarding resources within South Africa, as well as caregiver accessibility and caregiver influence. The following chapter discusses the research results by further relating the above-mentioned themes to the research questions outlined in Chapter 3. In doing so, the themes are discussed by referring to relevant literature.

CHAPTER 5—DISCUSSION

Introduction

The current study sought to provide insight into therapists' perceptions of implementing Theraplay® in the South African context. In this chapter the results, as presented in Chapter 4, are further discussed in light of existing literature. The discussion is organised according to the research questions and corresponding objectives of the study: 1) facilitating factors of Theraplay® implementation in South Africa, 2) challenges regarding Theraplay® implementation in South Africa, and 3) adaptations made and suggestions for Theraplay® within South Africa.

Facilitating Factors of Theraplay® Implementation in South Africa

Based on the findings of the current study, there was an overall consensus regarding the strengths that Theraplay® has as a whole. Furthermore, there was an agreement that it incorporates certain aspects that are culturally and contextually applicable to the diverse South African population. Research pertaining to the implementation of Theraplay® is still in its infancy in South Africa, but the limited available literature has indicated potential for its use in this context (e.g. Fourie et al., 2007; Mohamed & Mkabile, 2015).

Overall Therapeutic Modality of Theraplay®

Evidence from the growing attachment literature suggests that attachment insecurity is implicated as a predisposing factor to mental illness (Gormley & McNiel, 2010; Mikulincer & Shaver, 2012). Therefore, attachment-based interventions may serve as an important avenue of intervention, which is something that the participants in this study have expressed in relation to Theraplay®. There was an appreciation that Theraplay® has a good theoretical basis to treat attachment-related psychopathology and that it strives to remain updated with current research. In addition, it is essential that therapeutic modalities remain up to date concerning research within their domain while attempting to be more rigorous regarding

evidence-based findings on their effectiveness (Weisz et al., 2017). Theoretically sound therapeutic modalities that remain up to date with research are necessary to assist practitioners regarding decisions about selection of the most applicable and cost-effective therapeutic treatments for patients (Fairburn & Cooper, 2011). Stewart and Chambless (2007), for example, conducted a survey with clinical psychologists relating to the method they employed when making therapeutic treatment decisions, and found that practitioners rely predominantly on empirically supported interventions and clinical experience. As participants reflected, and is further supported in literature, Theraplay® stays updated on research within its field and continues to further its research on evidence-based findings (Booth & Jernberg, 2010, Munns, 2013). This enables Theraplay® to remain an informative therapeutic modality for clinicians to utilise with patients when indicated.

Participants perceived Theraplay® to be a broad framework that can be applied to any age from toddlers to elderly individuals (Booth & Jernberg, 2010) as everybody has been a child, goes through childhood, and needs nurturance. The study findings have further emphasised that Theraplay® is applicable to treat various psychological challenges when such challenges are rooted in attachment difficulties. This is supported by a number of international studies, which have found positive effects of Theraplay® in treatment of attachment disorders (e.g. Foulkrod & Davenport, 2010), internalising and externalising behavioural difficulties (e.g. Wettig et al., 2006), attention challenges (e.g. Brendel & Maynard, 2014), and intellectual disabilities (e.g. Sui, 2014), among others. In addition, the high rates of violence and trauma in the South African context increases the risk for the development of mental health conditions (Fincham et al., 2009), where childhood exposure to such conditions is associated with the development of insecure attachment styles (Ludy-Dobson & Perry, 2010). This is particularly concerning given the limited focus on mental health both in terms of policy and service provision in South African communities (Turner &

Honikman, 2016). The administration of an attachment-based therapeutic intervention—such as Theraplay®—that covers a wide spectrum of psychopathologies and ages may therefore be beneficial.

Healthy attachment relationships are vital to the physical, neural, and psychological development of children (DeKlyden & Greenberg, 2016; Ludy-Dobson & Perry, 2010). As results of the study indicated, healthy attachment and consequently, optimal caregiving is of paramount importance to the future of South Africa—the children. This underscores the importance of caregivers in the relational dyad (Connors, 2011; Julian et al., 2017), hence also in the therapeutic processes.

Participants therefore recognised the advantage of Theraplay® being understandable and accessible to caregivers. An easy-to-comprehend therapeutic modality could be beneficial to the South African population as it undercuts the influence of education. The results additionally reflected that if the experience of Theraplay® feels familiar to caregivers, it may facilitate their relatability to the intervention, possibly further influencing their willingness to engage in the therapeutic process. Novick and Novick (2011) argued that caregivers are less hostile towards therapy and tend to engage more within a therapeutic space when therapeutic interventions are more experiential. This is possibly due to caregivers feeling more included and understood within the process; they perhaps can relate more to the rationale of the intervention. Given that participants perceived Theraplay® to be experienced by caregivers as ‘natural’, this quality of the process may serve as a facilitating factor in engagement of caregiver with the therapy, potentially enhancing the benefits they may find therein. This might also influence the translation of these therapeutic benefits to the home environment, thus promoting the generalisability of the relational skills developed in the Theraplay® process to settings outside of the therapy room (Booth & Jernberg, 2010).

The findings highlighted that caregivers are often not completely aware of their influence on the presenting problems of their children. Theraplay® aims to assist caregivers in gaining insight into the role that they may play in the attachment-related difficulties experienced by their children (Booth & Jernberg, 2010). Furthermore, the current study reflected that the inclusion of caregivers in the therapeutic process facilitates their taking responsibility for their children and the psychological challenges that they present with. Research asserts that although it is valuable for caregivers to gain such insights and accept greater accountability for their children, caregiver responsibility can be a culturally and psychologically complex concept to take into consideration due to variations in the definition of caregiver responsibility (Waldfogel, 2006). This is deliberated on further in the discussion pertaining to challenges regarding Theraplay® implementation in South Africa.

Cultural and Contextual Considerations of Theraplay®

The South African population is diverse, representing a vast array of languages, cultures, religions, practices, and values (Berg, 2012; Ntuli, 2012). Therefore, cultural applicability of attachment and attachment-based interventions come into question within a context as culturally diverse as South Africa. Numerous studies have demonstrated relatively consistently that attachment and its various patterns are observable across a wide variety of cultures (e.g. Bakermans-Kranenburg, van IJzendoorn, & Kroonenburg, 2004; Candelaria, Teti, & Black, 2011; Ding, Xiu, Wang, Li, & Wang, 2012; Fearon & Belsky, 2016; Posada, Carbonell, Alzate, & Plata, 2004). An example of a study suggestive of attachment relevance to the South African context was conducted in Khayelitsha, a peri-urban settlement in the Western Cape, by Tomlinson et al (2005). The findings were consistent with the literature in terms of the distribution of attachment patterns along with the associations between attachment and caregiving quality (Tomlinson et al., 2005). Furthermore, Cooper et al (2009) conducted an RCT with 449 pregnant women in the same settlement to assess the efficacy of

a home-visiting intervention intended to improve the mother-infant relationship and attachment security of infants to their mothers. The study findings indicated a substantial improvement in mother-infant relationship quality for the intervention group assessed at six months and 12 months post-partum, as well as increased attachment security of infants to their mothers at 18 months, as compared to the control group (Cooper et al., 2009). Consequently, such findings suggest the presence of attachment patterns in South Africa and that the implementation of attachment-based interventions—akin to Theraplay®—may very well be applicable within this local context, aligning with the perceptions of the participants in the present study regarding the utilisation of Theraplay®.

The core concepts of Theraplay®, based on theory and research, focus on the essential traits of healthy caregiver-child interactions that lead to secure attachment and improved mental health (Booth & Jernberg, 2010). These concepts provide a framework for the Theraplay® activities that tap into the four domains—structure, nurture, challenge, and engagement—which are utilised within treatment according to the psychological needs of the caregiver and child dyad (Booth & Jernberg, 2010). Consequently, the concepts also influence the caregiver-child attachment relationship (Shaver & Mikulincer, 2002). This relates to the findings of the current study suggesting that different children respond similarly to Theraplay® activities and that caregiver-child relationships have comparable improvements irrespective of their cultural backgrounds. Due to globalisation and migration, it is possible that rapid social changes have occurred globally, which may impact these similarities in the nature of relationships across cultures, as individuals are exposed to and come into contact with influences from various parts of the globe (Johnston, 2015). Additionally, this possibly explains the perception that participants had regarding the similarity in response to and the outcomes of Theraplay® of children from various cultural backgrounds, as individuals are influenced by global social changes.

The findings of this study suggest that Theraplay® is not heavily reliant on language and has a greater emphasis on the actual activities and the caregiver-child relational experiences as they happen in the moment. Within South Africa, where practitioners may be faced with language differences in relation to the caregiver-child dyad receiving therapeutic treatment, this would facilitate the administration of Theraplay® in the local context and enhance its accessibility. The aforementioned is in line with literature asserting that, within the South African context, often language differences are considered a significant barrier to accessing contextually and culturally relevant healthcare services and resources (Maree & van der Westhuizen, 2011; Petersen & Lund, 2011). With 11 official languages, linguistic barriers are commonplace in this local context where most psychologists are white and English-speaking, while the majority of the population is black and for whom English is often a third or fourth language (Busch, 2010; Johnston, 2015). Theraplay® operates at an experiential level, engaging children using the language of play (Munns, 2003). This could serve to facilitate its applicability and utility in contexts where language differences may otherwise create barriers to accessing therapeutic services.

Theraplay® was viewed as cost-effective in the sense that the materials required for the activities are relatively cheap. This could allow greater transferability of activities from the therapeutic space to the home environment. According to Ward et al (2014), despite the need for cost-sensitive evidence-based interventions, there is a dearth of these modalities that involve caregivers and their children in developing countries such as South Africa where poverty is prevalent. Theraplay® may be one such intervention that is theoretically grounded with growing evidence, although the absence of RCTs in this regard is notable, allowing for only tentative conclusions regarding the efficacy of Theraplay®. Nonetheless, the existing evidence, alongside the experiences of the participants in this present study regarding the

cost-effectiveness of its implementation, offers a promising avenue for further research and intervention in the South African context.

Although the participants, at the time of the interviews, had not practiced within rural community contexts, they all had previous experience working in the public sector and two currently still do. Findings reflected participants' perceptions of the practical or pragmatic flexibility of Theraplay® in that it can be administered within a range of settings from rural communities against trees to medication rooms and office spaces. Complexities related to poverty, such as needing to focus on basic survival needs, often makes accessing services difficult due to challenges related to finances, transportation, and the prioritisation of medical treatment over psychological concerns (Petersen & Lund, 2011; Ruane, 2010). Consequently, the adaptability of Theraplay® pertaining to the physical space required for implementation is advantageous. This increases the possible accessibility of Theraplay®, which has the potential to meet a need for the mental healthcare of children in difficult-to-access locations within South Africa. Furthermore, conducting therapeutic interventions in familiar surroundings such as, for example, the home setting not only facilitates accessibility to services, it may also serve to enhance the transferability and generalisability of the therapeutic effects. This element of caregiver-child relational intervention was advocated for and implemented as early as the 1970s by Fraiberg, Adelson, and Shapiro (1975), and has become a key feature of a number of attachment-based interventions such as the Attachment and Biobehavioral Catch-up (ABC) intervention (Dozier & Bernard, 2017; Dozier, Roben, Caron, Hoye, & Bernard, 2018), as well as the Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2017) and its variations, among others.

Challenges Regarding Theraplay® Implementation within South Africa

As previously discussed, Theraplay® was considered by participants to be a useful modality with various strengths regarding its implementation in South Africa. Nonetheless, it also has challenges that need to be considered. There was concern regarding the impact that the implementation of Theraplay® has on therapists, as well as caregivers involved in the process. In addition, although the domains of Theraplay®—structure, challenge, nurturance, and engagement—were considered by participants to be contextually and culturally applicable to South Africa, the study indicated that there are elements regarding the application thereof that may require greater cultural and contextual sensitivity for the local context.

Influence of Theraplay® on Caregivers

As previously emphasised, caregivers play an integral role in the outcomes of the therapeutic process (Dollberg et al., 2010). The current study highlighted the importance of considering the impact that caregivers directly and indirectly have on the effectiveness of a caregiver-child therapeutic intervention. This includes caregivers' expectations of the therapist and the intervention, rapport with the therapist, and—as recognised by Bowlby and Ainsworth—the influence of various environmental factors on their mental wellbeing and ability to care for their children (Fearon & Belsky, 2016; Williford et al., 2016).

The study found that due to Theraplay® ideally including the caregiver and child, the effects of the therapy influence both the caregiver and the child in the dyad seeking treatment. The literature suggests that the relational experiences that caregivers had with their own caregivers while growing up may influence the way they take care of their own children (Allen, 2011; Dollberg et al., 2010; Julian et al., 2017). Furthermore, unresolved relational/attachment trauma from within the caregiver's own caretaking history may intrude into their contemporary caregiving practices in insidious ways (Baradon, Biseo, Broughton,

James, & Joyce, 2015; Fraiberg et al., 1975). This links with findings from the present study that Theraplay® activities may cause regression in caregivers to a developmental stage where they possibly experienced unresolved attachment injuries during childhood. Although research postulates that therapeutic regression can be beneficial to the therapeutic process (Fairburn & Cooper, 2011), this potential reactivation of attachment trauma may interfere with caregivers' capacity to mentalise and reflect on their child (Dollberg et al., 2010; Julian et al., 2015), which can serve as a barrier in the Theraplay® treatment if not efficiently dealt with. In addition to therapists being trained to be aware of regression and such intrusions during psychotherapy (Holdsworth, Bowen, Brown, & Howat, 2014), Theraplay® assists caregivers with developing skills of being more mindful and reflective of their children's emotional states (Mohamed & Mkabile, 2015). This further encourages attachment security and promotes children's self-regulatory abilities (Taylor et al., 2013). Therapists may therefore need to give greater consideration to caregivers' childhood attachment injuries, if any, before embarking on Theraplay® with the caregiver-child dyad to assist caregivers with the development of mentalisation skills.

The study reported that caregivers are often uncertain about psychotherapy involving their children regarding their own role in the therapeutic process. Nock, Ferriter, and Holmberg (2007) have found that caregivers believe that their role is to seek out therapeutic treatment for their children, provide consent and payment for the treatment, and to ensure that their children attend the required sessions. Caregivers are therefore not accustomed to being directly involved in the therapeutic process beyond the traditional provision of periodic progress feedback (Nock et al., 2007; O'Connor & Zeanah, 2003). This is unlike the case with Theraplay®, where the explicit focus of intervention is on the relationship between caregivers and their children, in vivo (Booth & Jernberg, 2010). Due to the departure of Theraplay® from traditional play therapy regarding caregiver involvement, it is necessitated

that specific attention be given to realigning caregiver expectations in order to navigate potential resistance, or even practical considerations such as leave from work, to mitigate against the potential negative impact of these factors on the Theraplay® process. Accordingly, more time should be spent by therapists ensuring that caregivers understand their role regarding the Theraplay® process (DeFife & Hilsenroth, 2011), as this will assist with helping the caregivers know what to expect of the therapy (Novick & Novick, 2011).

The study revealed that caregivers often have high expectations of therapy either relating to what they think will happen within the Theraplay® sessions or that therapists should be doing more than just teaching them, as caregivers, how to play with their children. This may relate to the possibility that caregivers can become defensive as they may be feeling shame and blame themselves for the psychological difficulties that their children are presenting with (Sanders & Burke, 2014). Literature proposes that the therapeutic relationship is the most significant aspect within any therapeutic modality and would assist in the unease and level of defensiveness experienced by individuals during therapy (Holdsworth et al., 2014). Likewise, this holds for caregiver-child psychotherapies. As King, Currie, and Petersen (2014) indicated, the therapist needs to build strong rapport with the caregivers and their children as it provides a sense of non-judgemental understanding for the caregivers and influences their willingness to engage in the therapeutic process.

The necessity of spending considerable time with caregivers to build rapport during the initial phases of therapy was underscored in this study as it can influence therapeutic outcomes. Similarly, findings of several studies indicate that, although various factors can contribute to premature termination of child and adolescent therapies, problems of engagement such as ineffective therapeutic relationships have a major impact on adherence to and optimal clinical outcomes of caregiver-child therapeutic interventions (King et al., 2014; Ruane, 2010). Ensuring that caregivers understand the rationale of the intervention assists

them with their expectations regarding therapeutic outcomes and to know what their roles are within the process (DeFife & Hilsenroth, 2011). It also allows caregivers to feel more supported, respected, and acknowledged for their integral part within the therapeutic process (Nock et al., 2007). This influences caregiver involvement during therapeutic sessions and engagement with homework given by therapists (King et al., 2014), which was also a concern within this current study regarding caregivers' unwillingness to practice Theraplay® skills outside of the therapy room. Although it is important for all child psychotherapies that practitioners ensure caregivers understand the rationale behind and intricacies of a modality, it is perhaps particularly vital for dyadic interventions such as Theraplay® where caregivers are directly involved and vital to the treatment process and success thereof (Booth & Jernberg, 2010). This may enhance the credibility of the Theraplay® process for caregivers which could influence their expectations, motivation to engage within the sessions, and possibly increase treatment adherence (Hawley & Garland, 2008; Naidu & Behari, 2010).

While, ideally, primary caregivers should be involved in Theraplay® sessions, the present study indicated that within private practice contexts children are often brought to therapy by au-pairs. Findings specified that this complicates the therapeutic process, as it prevents caregivers from becoming involved. Furthermore, it was derived from the results that sometimes caregivers avoid being part of the therapeutic process with their children under the pretext of being kept away by other obligations. Consistent with previous research, this study highlighted that caregiver avoidance of being involved in psychotherapy could include stigmatisation, psychological turmoil, work responsibilities, and family worries—all of which may influence the caregiver-child attachment quality and behavioural challenges that the children might present with (Watkins, Pittman, & Walsh, 2013).

As mentioned, this study considered stigmatisation as a possible reason for caregivers' circumventing therapeutic involvement with their children. Song, Mailick, and

Greenberg (2018) found—for example—that higher levels of stigmatisation and embarrassment related to seeking treatment were reported by caregivers with children who had mental health difficulties compared to those who did not, indicating that stigma regarding mental illness may have a profound impact on clinical care and help-seeking behaviour. This is significant given that children with behavioural problems who are not receiving treatment become more treatment resistant and may develop comorbid psychopathology (Dempster et al. 2015). Consistent with findings of this current study, caregivers frequently believe that their children will be personally impacted by stigmatisation for seeking mental health treatment but they, as caregivers, often also experience self-stigma and self-blame (Song et al., 2018), which could impact access to, and adherence with, psychological treatments.

Dempster, Wildman, and Keating (2013) surveyed caregivers with children attending a rural clinic and found that caregivers with higher levels of self-blame and guilt were less likely to seek treatment for their children. This is comparable to findings of the current study that, in the participants' experiences, caregivers frequently express feeling partially or fully responsible for their children's behavioural difficulties and resulting psychopathology. Moses (2010) found that the reasons caregivers gave for their self-blame included genetic transmission of problematic genes and their own psychological struggles, deficient caregiving, insufficient attentiveness to their children's mental health, and negative familial environments. Caregivers experiencing guilt and self-blame often feel that they are insufficient caregivers, which further complicates the already multifaceted responsibilities encompassing caregiving in general (Eaton, Ohan, Stritzke, & Corrigan, 2016). Clinicians should consider explaining to caregivers that their relationships with their children are reciprocal and that both the caregiver and the child play a role in influencing the relationship and its corresponding complications (Dempster et al., 2013). While Theraplay® focuses on enhancing the caregiver-child relationship, it may possibly provide insight to caregivers

regarding the reciprocal nature of their relationship with their children. This could facilitate a reduction in caregivers' feelings of guilt and self-blame for their children's behavioural difficulties, possibly further assisting treatment adherence and encouraging caregivers to continue seeking treatment for their children if needed (Moses, 2010).

Findings of this study emphasised that often caregivers present with their own mental health concerns and are frequently physically and emotionally exhausted when bringing their children to therapy. As the study by Cooklin, Giallo, and Rose (2013) indicated, increased caregiver fatigue due to domestic and employment responsibilities is related to adverse caregiver practices and greater irritability within caregiver-child interactions. This may impact the ability that caregivers have to meaningfully partake in the Theraplay® sessions with their children due to their own experienced fatigue.

Additionally, research indicates that, depending on their gender and own mental health status, caregiver psychopathology has varying effects on children (Ireland & Pakenham, 2010). A review by Reupert, Maybery, and Kowalenko (2013) found that maternal psychopathology is habitually more detrimental than paternal disorders regarding the development of children's behavioural issues. This is particularly significant since the caregiving burden is largely on maternal caregivers (Keller & Chaudhary, 2017). As was found in this study, it is essential to assess the mental state and availability of caregivers before commencing with Theraplay®. If the therapist suspects that one caregiver may be experiencing psychological distress, it could be beneficial for the child to rather engage in Theraplay® with the other caregiver as the alternate relationship could serve as a protective factor, buffering the child against the potentially negative impact of the mental illness of the other caregiver. This is consistent with the findings of Watkins et al (2013) in their study on the impact of caregivers' psychological wellbeing on their children. However, difficulties arise when—as highlighted in the current study—it is usually maternal caregivers that bring

their children to therapy and often paternal figures are not available to attend therapy sessions. As a result, therapists are challenged, potentially, to make a clinical decision as to whether the child would benefit from the strengthening of the caregiver-child relationship with the mother who is mentally unwell, or to implement Theraplay® without the caregiver in the room, which is also not ideal.

The current study emphasised concern relating to the impact of environmental influences such as marital turmoil and divorce have on caregiver-child relationships and on engagement in Theraplay®. These concerns are supported by literature illustrating correlations between marital conflict and behavioural problems in children (e.g. Brock & Kochanska, 2016; Cummings, George, McCoy, & Davies, 2012; Watkins et al., 2013). Research by Brock and Kochanska (2016), for instance, has shown that the repercussions of marital discord and divorce influence the emotional security experienced by everyone within a family system. In such a context, children's emotional regulatory abilities are impacted, which increases the presentation of behavioural problems (Brock & Kockanska, 2015). The caregivers involved often experience psychological turmoil and might possibly not have the capacity to spend sufficient time—qualitatively and quantitatively—with their children, which could influence the caregiver-child relationship (Cummings et al., 2012). This is consistent with Fearon and Belsky's (2016) contention that the causal relationship between caregiver sensitivity and attachment security may very well be mediated by contextual factors such as marital discord and domestic violence. This highlights the complexity of intervening therapeutically in the caregiver-child relationship given the potential interference of the effects of marital conflict and divorce. While the relationship between caregivers and their children is influenced by possible incapacitation of caregivers to spend sufficient time with their children indicating the need for caregiver-child interventions such as Theraplay®, the involvement of caregivers directly in the therapeutic process may be challenging to negotiate.

Caregivers might not be fully present in the here-and-now experience within therapy sessions, which is a core concept of Theraplay® (Booth & Jernberg, 2010), due to them struggling with their own psychological turmoil. Furthermore, the amount of time dedicated to implementing and practicing Theraplay® activities in the home between sessions may also be influenced by untoward and volatile home contexts, which could potentially hinder the therapeutic outcomes of Theraplay®.

Contextual and Cultural Concerns Regarding Theraplay®

Psychotherapy is a mental healthcare practice that tends to be confined to specific cultural contexts and psychotherapeutic interventions, consequently, need to be culturally and contextually sensitive when utilised within contexts other than where they were developed (Benish, Quintana, & Wampold, 2011). South Africa is a country that is unique in its diversity regarding context, culture, ethnicity, race, religion, and language practices (Berg, 2012). Therefore, the utilisation of therapeutic interventions that accommodate for the context is of paramount importance (Johnston, 2015), as it makes the intervention more relatable to individuals seeking treatment (Novick & Novick, 2011).

Theraplay® processes are highly structured starting with the administration of the MIM before commencing with sessions (Booth & Jernberg, 2010). Which activities are used, how sessions should generally begin and end, feedback sessions, the number of sessions required, and the frequency and length of sessions are all prescribed (Booth & Jernberg, 2010). These guidelines not only facilitate the therapeutic process and structuring of sessions by therapists, they also ensure that Theraplay® is administered in a relatively uniform manner across setting and contexts. The current study indicated that such technical structure can be relieving to therapists, but there was also some concern from participants that it can become too structured, losing the flexibility of a more personalised therapeutic process regarding contextual and cultural aspects for each caregiver-child dyad seeking treatment. In line with

this, Norcross and Wampold (2011) found that efficient therapeutic relationships are those in which the therapeutic process is tailored according to the individuals seeking treatment as it empowers patients and increases treatment adherence. Therefore, flexibility is seemingly an important feature in successful therapeutic engagements and is something that Theraplay® does not readily allow for. Although the domains requiring attention and their corresponding Theraplay® activities can vary depending on the needs of the caregiver-child relationship, there is little room for deviation from the weekly protocol as planned exclusively by the therapist. Participants expressed some reservations about this level of structure, suggesting instead that Theraplay® introduce greater flexibility as it may assist with further empowerment of caregivers and aid in their motivation to continue with therapy due to caregivers feeling more understood regarding their individualised needs (Norcross & Wampold, 2011).

As Bowlby (1969) proposed, all individuals have a desire for intimate contact such as touch, which usually begins with the maternal figure. Touch within psychotherapy is featured in certain therapeutic traditions such as humanistic psychology but, according to findings by Harrison, Jones, and Huws (2012), is considered as taboo in many others. This is significant given that the importance of nurturing touch is promoted in Theraplay® as being essential to the facilitation of emotional regulation for children (Booth & Jernberg, 2010). Despite nurturing touch being regarded as therapeutically beneficial (Harrison et al., 2012), the current study reported that greater consideration should be given to this aspect in the South African context where exposure to trauma—inclusive of physical and sexual abuse—is frequent, and violence against women and children has risen by 146 reported incidents since 2017 (Statistics South Africa, 2018a). The participants in the present study expressed concern that the indiscriminate use of touch could, in fact, be countertherapeutic when associated with trauma due to the potential for re-traumatisation and triggering of intrusive

post-traumatic reactions. The use of touch should therefore be considered more carefully and on a case-by-case basis to avoid this. This could have implications for Theraplay® where nurturing touch is often a central component of many of the activities such as, for example, the weather report or applying lotion to one another. Booth and Jernberg (2010) do, however, suggest the gradual introduction of nurturing touch to children that are tactile defensive but, according to the findings of the present study, greater caution should be used in this regard within a country such as South Africa where the rates of abuse against children are high (Johnston, 2015).

This study reiterated the effects of the drastically high rates of poverty, inequality, and insufficient resources within South Africa as compared to developed countries. Petersen and Lund (2011), for instance, found a persistence in the service delivery gap and inequity in mental healthcare utilisation especially within rural communities in South Africa. Reasons for this included the inability to afford treatment, high transportation costs, and the inadequacy of resources to sufficiently provide for community-based services (Petersen & Lund, 2011). As previously discussed in the chapter, Theraplay® incorporates the utilisation of easily accessible props that are meant to be at caregivers' disposal to facilitate the generalisation of skills to the home environment (Booth & Jernberg, 2010). This may be an attempt to take financial constraints, if any, into consideration. However, the complexities that are evident due to poverty in South Africa have resulted in approximately 75% of the population who require mental healthcare not being able to afford treatment opportunities or access such treatment, and consequently not receiving treatment (Schneider et al., 2016). This points to the dire need for cost-effective and readily accessible mental healthcare facilities and services within South Africa which needs to be further addressed in public policy as a whole. As was suggested in the current study, this would also impact Theraplay® practitioners, as many families that could benefit from Theraplay® treatment may not able to

do so due to difficulties with accessing such services as a result of poverty or service delivery related challenges in rural and peri-urban communities.

Overall, participants were perturbed with the lack of resources in the South African mental healthcare system, which influences the access individuals have to appropriate treatment. This is consistent with findings made by Lund et al (2011), who found that although the South African context was comparatively better resourced than many other African countries, there continues to be numerous challenges that are present within the mental healthcare sector. One such challenge is the human resource restrictions regarding the number of adequately trained mental health professionals (Lund et al., 2011). Similarly, the current study found that there are a limited number of professionals trained in Theraplay® within South Africa which often means caregiver-child dyads cannot be referred to facilities closer to home to access the Theraplay®. State funding tends to prioritise other public concerns such as general healthcare above mental healthcare (Petersen & Lund, 2011; Lund et al., 2011). This links to participants' perceptions that for there to be a greater presence of Theraplay® as a therapeutic intervention in South Africa, there needs to be increased funding for the required training and governmental level input to support it, which in turn would require a greater focus on mental health in general.

The present study found the HIV/AIDS epidemic in South Africa as potentially having an influence on the use of Theraplay®. The joint United Nations Programme on HIV/AIDS (UNAIDS) reports that between 1990 and 2018, 1.2 million children under the age of 17 were orphaned due to HIV/AIDS in South Africa (UNAIDS, 2019), leading to a proliferation of child-headed households (Kuo et al., 2012). A study by Cluver et al (2007) investigating the psychological impact of AIDS-orphanhood in urban townships in Cape Town, documented that these children had increased depression, relational difficulties with others, post-traumatic stress, and conduct problems in comparison to children orphaned for

other reasons as well as non-orphaned children altogether. The need for intervention is therefore strongly underscored. However, as a result of the orphan status of these children, dyadic interventions such as Theraplay®—which require the active participation of a primary caregiver—may not be readily applicable without due consideration of circumstances. Although alternative caregivers may step in to care for children orphaned by AIDS, these people regularly have their own families and may not have the physical, psychological, or time resources (Sherr et al., 2014) to actively engage in intensive therapeutic endeavours such as Theraplay®. The burden placed on these substitute caregivers is often significant as demonstrated by Kuo, Cluver, Casale, and Lane (2014) study. They found that the psychological wellbeing of the substitute caregivers of AIDS orphans in KwaZulu Natal was negatively impacted as reflected in higher levels of anxiety and stress that influenced their relationship with the children when compared to caregivers in general (Kuo et al., 2014). Although a therapeutic intervention may be beneficial in such cases, again the consideration of the physical and emotional availability of caregivers for Theraplay® sessions could pose a challenge in such instances.

The present study further emphasised that although Theraplay® is experienced as a beneficial treatment, it contains aspects that may require adaptation to enhance its applicability to the cultural context. In a meta-analysis of therapeutic interventions that have been culturally modified compared to interventions that have not, Benish et al (2011) found that culturally adapted therapy has better therapeutic outcomes than psychotherapy that had not been adapted, which aligns with the perceptions expressed in the current study. Specifically in the context of attachment-based interventions which emphasise the role of caregivers, the influence of culture on caregiving practices is crucial in order to provide services that are aligned with, or sensitive to, cultural norms and variations (Keller, 2018).

Caregiving and caregiver responsibilities have a moral foundation that can be considered conventional to an extent, but that are entrenched in social and legal institutions of caregiving within a specific context (Knudsen & Andersen, 2013). In addition, cultural variations can occur across settings and within individuals of a culture (Tamis-LeMonda et al., 2008). This draws attention to the dynamics of culture and how it influences every-day living, including caregiving and attachment behaviours, and therefore needs to be considered when interacting with individuals (Johnston, 2015). For example, eye-contact and maintaining proximity to caregivers are considered to indicate greater attachment security (Zeanah, Berlin, & Boris, 2011), but are basic forms of non-verbal communication that are interpreted differently interculturally within South Africa (Ntuli, 2012). Both may be considered disrespectful, especially to adults, within African cultures but are tolerable under certain circumstances in Western cultures (Ntuli, 2012). As highlighted in the present study, such differences in the cultural influence on child-rearing practices in South Africa need to be considered when administering Theraplay®, such as the utilisation of Theraplay® activities that focus on eye-contact and direct pointing. Although Booth and Jernberg (2010) do mention that the cultural values of a caregiver-child dyad are crucial to consider, it is more complex within the South African context given its diversity of cultures and ethnicities (Berg, 2012). Accordingly, greater consideration and guidance should be given to these aspects in order to increase the access to and relevance of Theraplay® to a broader pool of potential beneficiaries.

It is also important to note that, in comparison to more Western communities in South Africa, a specific and prevalent social issue among peri-urban and rural communities is the absence of paternal figures in the upbringing of children (Madhavan, Townsend, & Garey, 2008; Mavunga, 2013). Although, as reflected in the findings of the current study, it is mostly maternal caregivers that bring their children to therapy, concern arises if the father is

absent and the mother is assessed by the therapist to be experiencing psychological turmoil. In such situations, practitioners are faced with the clinical dilemma of considering whether to implement Theraplay® with a mentally unwell caregiver or without a caregiver present. Both instances are not ideal as Theraplay® focuses on enhancing the caregiver-child relationship (Booth & Jernberg, 2010), whereby absent or emotionally unavailable caregivers will be unable to fully engage in the potential benefits of the Theraplay® process with their child.

Although there are possibly cultural and contextual variations in caregiving practices, attachment theory has remained moderately unchanged (Keller, 2016; Vicedo, 2017). Therefore, it may follow that because Theraplay® is based heavily on attachment theory, it too does not take adequate account of cultural variation. Due to the structure of South African communities varying between individualism and collectivism, these configurations may impact relational styles and the nature of caregiver-child relationships (Adams et al., 2014; Keller & Chaudhary, 2017) in a way that may need to be factored into interventions targeting the caregiving relationship. Attention may also need to be given to the utilisation of the MIM that was developed in Western, more individualistic societies which may result in possible inconsistent findings when applied in non-Western contexts such as South Africa (Keller, 2018). This could influence the nature and direction that the therapeutic procedures of Theraplay® may need to follow due to the risk of pathologising culturally appropriate relational dynamics due to the use of potentially culturally inappropriate measures. Within South Africa, the Western customs of white people continues to be dominant irrespective of black individuals being at least 79.4% of the population (Adams et al., 2014). This further validates the concern that participants had regarding the need to make Theraplay® more culturally relevant for the diversity of the South African population. Additionally, this supports the dire need for increased research regarding attachment and its relationship to caregiver-child dynamics in this local context.

Adaptations and Suggestions for Theraplay® in South Africa

As previously discussed, interventions that take cultural aspects into consideration and adapt them accordingly have shown to have better therapeutic outcomes (Benish et al., 2011). In this regard, participants made a number of adaptations and recommendations regarding their use of Theraplay® to align it more suitably for a South African population.

Alterations made to Theraplay®

As per the latest *General Household Survey*, up to 82 in every 100 South African citizens do not have medical aid insurance and consequently rely on public healthcare (Statistics South Africa, 2018b). Furthermore, medical aids have limits to the number of sessions that they will cover and do not always pay for the full cost charged per session (Statistics South Africa, 2018b). Participants such as Nix have therefore adapted their approach by reducing the number of Theraplay® sessions compared to the prescribed 18 to 24 sessions (Booth & Jernberg, 2010). This adaptation is in response to the identified challenge of financial difficulties, transportation struggles, and compensation for limited sessions covered by medical aids. Although it is acknowledged that reduction in the amount of sessions may not be ideal regarding the ultimate therapeutic outcomes that could be achieved, it is reasoned that fewer Theraplay® sessions is more optimal than no treatment.

All the participants have made adaptations to the prescribed Theraplay® activities, where applicable. These included, for example, singing a Zulu song instead of twinkle-twinkle-little-star or making caregivers say the ‘harms’ when doing the ‘checking-in’ activity if touch is problematic for a caregiver-child dyad. These adaptations were deemed necessary in order to make Theraplay® activities more relatable to caregivers and their children. As previously mentioned in the study by Norcross and Wampold (2011), tailoring treatment of psychotherapy to patients increases the therapeutic outcomes and adherence to treatment,

which is similar to the effect of altering Theraplay® activities to modify the treatment for each caregiver-child dyad seeking treatment.

Recommendations for Theraplay®

Suggestions in the study were made that included more direct contact with communities in South Africa to breach the financial difficulties related to transportation costs incurred as a result of traveling to clinics, hospitals, and private practices, as well as the fees for therapy sessions (Ruane, 2010). This links to the inadequacy of the mental health care system that exists in South Africa as it hinders the ability to access these mental healthcare facilities (Petersen & Lund, 2011; Turner & Honikman, 2016).

Many South African individuals seeking mental healthcare services either pay for it privately due to absent medical aid coverage (Statistics South Africa, 2018b), or make use of overburdened state-run facilities when they are unable to afford services privately. It is for this reason that participants recommended a shorter form of Theraplay® as compared to the number of sessions prescribed by Booth & Jernberg (2010) in an attempt to address any financial complications—such as transportation costs and limited medical aid funding—related to accessing the required therapeutic treatment.

For therapists, limited access to international trainers is also costly, and therefore influences the number of trained Theraplay® practitioners in South Africa, which in turn limits the number of dyads that can access this therapy. Therefore, it was unanimously recommended by all participants that the Theraplay® Institute provide more frequent training workshops and attempt to increase the number of qualified Theraplay® therapists within South Africa. Ultimately, this would increase the human resources as there is a need for attachment-based interventions to address the caregiver-child relational ruptures that result from the consequences of poverty, exposure to community violence, and various forms of

abuse (Lund et al., 2011; Ward et al., 2014). This would further enable practitioners to refer caregiver-child dyads to clinics closer to home, which may be more financially beneficial for them.

Participants recommended that the Theraplay® Institute develop a wider variety of activities considering various cultural nuances that can be implemented according to the context where it is being utilised. They offered suggestions of video-recording families engaging with their children from infancy until they are older. This could include exploring with caregivers the everyday activities that they partake in that are nurturing, challenging, structuring, and engaging as ideas to incorporate into updated or new Theraplay® activities that would be more familiar to the South African context. As previously reiterated, the more familiar a therapeutic context is for those receiving therapy, the more likely they are to partake in the therapeutic process and the better the therapeutic outcomes could be (Norcross & Wampold, 2011; Novick & Novick, 2011). This may also apply to implementing Theraplay® in South Africa.

Summary of Chapter

To summarise this chapter, all the research objectives outlined for this study were considered and further discussed in light of existing literature. The first research objective was to explore participants' perceptions regarding facilitating factors of implementing Theraplay® in South Africa. Exploring therapists' perceptions regarding the challenges involved with implementing Theraplay® in the South African context was the second research objective. The last research objective was to obtain therapists' opinion regarding possible adaptations or recommendations that they have pertaining to implementing Theraplay® in the South African context.

The current study found Theraplay® to be a beneficial therapy due to it being theoretically grounded, up to date with current research, and able to treat a wide spectrum of pathologies and ages. The accessibility of Theraplay® to caregivers regarding the inclusion of them in the treatment process and it being understandable was considered a strength. Additionally, within the diverse South African context, the present study highlighted the advantageous versatility of Theraplay® regarding it not being language or location dependant.

Findings of the study suggested that lack of caregiver involvement and the expectations that they may have of the therapeutic process may be challenging to deal with. There were concerns regarding the protocol rigidity of Theraplay® that could influence the flexibility of tailoring the process to each caregiver-dyad seeking treatment. Furthermore, the present study considered the lack of resources pertaining to transportation costs, medical aid coverage, and insufficient funding for Theraplay® training for therapists to pose challenges to the implementation of Theraplay® within the South African context. Regarding the cultural diversity of South Africa, the study found that further consideration needs to go into cultural influences as attachment patterns may differ within and across cultures. Although the study found that the overall domains of Theraplay®—nurturance, challenge, structure, and engagement—are deemed to be universal, the cross-applicability of the Theraplay® activities used may need to be culturally adjusted to compensate for differences in the manifestation of caregiving and attachment behaviours across cultures and contexts.

The study indicated that certain Theraplay® activities can be adapted to make them more culturally applicable for the caregiver-child dyad receiving treatment. Theraplay® sessions are also shortened to compensate for financial constraints, if any. Further recommendations were posited such as increasing the number of therapists who are qualified to administer Theraplay®, that the Theraplay® Institute broaden the number of activities

available to use during sessions, and to video-record or enquire from caregivers interacting with their children to broaden the activity possibilities based on these observations made.

To follow is the concluding chapter of the research study. It consolidates the study by providing the key findings, limitations, and future research recommendations for this study.

CHAPTER 6—CONCLUSION

This concluding chapter highlights key findings and discusses the limitations of this study. It also includes possible avenues for future research pertaining to Theraplay®.

Summary of Noteworthy Findings

The overarching aim of this qualitative study was to explore and describe in detail therapists' perceptions on the implementation of Theraplay® within the South African context. This was achieved by addressing the research questions and objectives outlined through the exploration of therapists' opinions regarding facilitating factors, challenges involved, as well as possible suggestions and adaptations pertaining to the utilisation of Theraplay® in South Africa. In-depth individual interviews were conducted with six practitioners trained up to at least Level 1 in Theraplay® and thematic analysis was applied to the interview transcripts resulting in four salient themes: 1) overall potential of Theraplay® as a therapeutic modality, 2) applicability of Theraplay® in South Africa, 3) impact of resource availability on Theraplay® in South Africa, and 4) role of caregiver accessibility and influence on Theraplay®.

Addressing the first research objective, participants perceived it beneficial that Theraplay® is developed upon a sound theoretical framework, remains updated with current research within its field, and is able to treat a wide age spectrum with a range of attachment-related psychopathologies. This assists practitioners with their decision-making regarding selection of applicable treatment modalities and broadens the patient population that it can be utilised to treat. The study considered the accessibility of Theraplay® to caregivers as a strength regarding it being understandable and inclusive of the caregivers in the therapeutic process. It was found advantageous that Theraplay® allows children to experience being young again within a safe space while the caregiver takes more responsibility. Findings underscored the benefit of Theraplay® focusing on preverbal right brain experiences rather

than depending on language that tends to be a therapeutic barrier in the diverse South African context. The versatility regarding location needed, cost-effectiveness, and similarity in therapeutic outcomes of Theraplay® processes across cultures were also reported as beneficial to the local context.

In consideration of the second research objective, the study found caregiver expectations and lack of involvement in the therapeutic process as difficult to manage at times. Findings indicated that greater attention should be given to caregivers possibly experiencing regression when partaking in Theraplay® activities as they are not trained to work through such experiences as therapists are. A lack of caregivers due to avoidance, absence, or child-headed families caused by the HIV/AIDS epidemic was considered challenging in South Africa as Theraplay® ideally includes both the caregiver and child in the therapeutic process. It was found that caregivers can be defensive due to feelings of shame, guilt, self-blame, and stigmatisation regarding the psychological difficulties that their children are experiencing which could further influence caregiver avoidance. Study findings indicated that marital conflict, divorce, personal psychological struggles, and exhaustion can affect caregiver involvement in Theraplay® sessions and possibly influence the willingness to continue the Theraplay® skills at home. Further consideration regarding the rigidity of the Theraplay® protocol was highlighted as it reduces the ability to tailor therapeutic processes to individual caregiver-child dyads receiving treatment. It was also emphasised that in South Africa, where violence and trauma are commonplace, more deliberation is needed with regards to the incorporation of touch in Theraplay® activities. Another difficulty raised was that, although Theraplay® is considered a cost-effective modality, it unfortunately does not accommodate for the possible inability to access psychological treatment due to insufficient financial means as experienced in South Africa with the high prevalence of poverty and unemployment. Findings highlighted that the lack of resources in South Africa poses a

challenge as it impacts available funding provided for mental healthcare affecting training opportunities inclusive of Theraplay®. This further influences the number of qualified Theraplay® practitioners, affecting the number of caregiver-child dyads that are able to receive this treatment even when it is clinically indicated. The study indicated that while the domains of Theraplay® were considered universal, this intervention needs further investigation into how the manifestation of attachment and relational dynamics may differ across cultures.

The final research objective was addressed through exploration of how therapists have adapted Theraplay® for the South African context such as altering certain activities to make them more relatable to this local population. Therapists also shorten the number of Theraplay® sessions to take financial constraints of transportation costs and inadequate medical aid coverage into account. The participants recommended that the Theraplay® Institute should train more practitioners and increase training opportunities as it would give more patients the chance to receive Theraplay®. Consideration of the development of a shorter Theraplay® version would be advantageous as it would take the financial constraints that patients may experience in South Africa into account. It would also be beneficial if the Theraplay® Institute broadens the variety of activities to allow for a greater inclusion of cultural variations. Suggestions were made to video-record families interacting with children from infancy to when they are older or to enquire from caregivers about the activities that they do with their children that may be structuring, nurturing, challenging, and engaging. The reasoning behind this was to possibly incorporate those observations and enquiries made into existing Theraplay® activities or to develop additional activities. This would enhance the relatability and familiarity of Theraplay® activities to the caregivers and children, which may impact their willingness to engage in the therapeutic process and to facilitate the transfer and generalisation thereof into the home environment.

Facilitating factors of Theraplay® are aspects deemed to enhance and support the implementation of the intervention, while challenges are factors that are considered to hinder or complicate the implementation of Theraplay®. Adaptations and recommendations for Theraplay® have been considered through perceptions of individuals who have been practicing this therapeutic intervention for at least three years. Understanding of the facilitating factors and obstacles regarding the implementation of Theraplay®, and consideration of recommendations and alterations for Theraplay® in South Africa, would be crucial when considering possible improvements of the therapeutic intervention in various contexts in addition to where Theraplay® was developed. This would benefit many caregiver-child dyads requiring enhancement of their relationship.

Limitations of the Study

A limitation of the current study is its small sample size, even though Guest et al. (2006) suggest that data saturation can be met if the sample selected is of similar context and the participants have a certain level of knowledge pertaining to the phenomenon of study. The opinions of the therapists in this study may not have represented the perceptions of all therapists within South Africa who implement Theraplay®. Replication of this study may, therefore, yield different results. However, as the researcher used an interpretive paradigm with a subjectivist epistemology, generalisability was not the intention of this study.

There were eight individuals who volunteered to partake in the study, but two of them did not meet the full inclusion criteria prescribed for the study. Therefore, the final sample size included only female clinical psychologists, which does not represent all mental health practitioners that utilise Theraplay® within South Africa. The sample size also had five white participants and only one black participant, which also limited the cultural and racial diversity of the sample possibly skewing the results or limiting the ability of participants to comment

meaningfully on cultural factors at play in the use of Theraplay® in South Africa. Another critique is that none of the participants worked in a rural community context. The perceptions explored in this study, therefore, were rooted in experiences of their working environments which consisted exclusively of the private practice and urban public sector mental health services. A more representative sample may have provided richer data and possibly added another dimension to the study. Consequently, this should be considered for future research endeavours.

Additionally, the researcher was a novice researcher. She did not have any previous exposure or experience in conducting semi-structured interviews or qualitative research. Rather than the research methodology being a weakness per sé, her restricted experience may have introduced limitations. Semi-structured interviews are frequently utilised in qualitative research (Galletta, 2013), but the questions that the researcher asked during the interviews may have influenced the data collected. She may have missed opportunities for follow-up questions to gain richer information.

It must also be noted that with qualitative research and thematic analysis, the results produced are participants' perspectives influenced by the researcher's interpretation thereof. The study utilised the guidelines as posited by Braun and Clarke (2006; 2013) for the thematic analysis of the data. However, the researcher's personal influence on the results and discussion cannot be denied and another researcher may have analysed the data differently. The researcher did attempt to bracket her opinions and beliefs as much as possible and made use of a reflexive journal throughout the research process to reduce her influence on the final write-up produced.

Recommendations for Future Research

A consideration is to provide feedback to the Theraplay Institute® through the submission of a brief report on the results obtained from the present study, in addition to any published articles that may arise. Additionally, the current study hopes to pique scholarly interest in furthering research relating to Theraplay® as a therapeutic modality and particularly with regards to its implementation in South Africa. Overall, any furthering of ethnographic research relating to attachment and attachment-based interventions within the diverse context of South Africa—such as video-recording families engaging with one another to determine what kinds of activities may possibly fit into the four Theraplay® domains—would be an advancement in local knowledge. As literature on this topic has suggested, there remains a drastic need for research regarding attachment-based interventions that include both the caregiver and child (Julian et al., 2017). This is essential for the South African population with its high rates of poverty, where research has indicated that increased poverty places caregivers at higher risk for inadequate caregiving abilities which may lead to child maltreatment (Ward et al., 2014).

Future research that utilises a more representative sample regarding gender, ethnicity, culture, and mental healthcare practitioners might impart more in-depth perceptions of the implementation of Theraplay® within the South African context. It may provide further insight into the cross-applicability of the intervention regarding addressing contextual and cultural parameters to make it a more scientific and ethical intervention within this local context (Kelley, 2018). Including more context-specific research pertaining to therapists' perceptions of implementing Theraplay® within rural communities in South Africa would also potentially allow for more integrated and representative findings. Making use of focus groups may also be beneficial as it allows members of a group to interact and possibly

influence one another while discussing perceptions and ideas regarding the research topic (Willig, 2013).

Attachment theory may be pioneering in providing a framework for psychotherapy (Liotti, 2011), but to effectively deal with the intricacies of the clinical realities within the diverse South African context, the systemic and ecological influences should also be considered when regarding human interpersonal relationships and behaviour. It could be beneficial to conduct a study that analyses perceptions of Theraplay® implementation within South Africa through the lens of attachment theory and systems theory, as Theraplay® is an attachment-based intervention but it also includes aspects of being part of a system. Caregivers and their children are embedded within larger interrelated systems that all directly and indirectly influence them. Taking this into consideration would possibly allow for a more holistic view of socio-cultural and environmental factors that may impact on caregiver-child relationships.

Increasing focus is being given to the significant role that caregivers play within interventions for children (Julian et al., 2017; Williford et al., 2016). Consideration regarding how caregivers experience being part of the therapeutic process of Theraplay® may be useful. Research into a deeper understanding of how caregivers experience being present in the therapeutic space, what their expectations of the therapy are, and concerns that they have regarding the implementation of the therapy may facilitate therapists' engagement with them in the Theraplay® intervention. This could aid in treatment adherence and motivation to participate within the sessions as caregivers might feel more understood and respected by the therapists.

Future researchers might consider exploring which attachment-based interventions mental healthcare providers prefer utilising. Expanding on whether professionals know about

Theraplay® or not would be beneficial. If they do know about this therapeutic modality but prefer not to implement it, determining the possible reasoning for this could also be enlightening. Considering that all the participants agreed on the benefit of Theraplay® as a therapeutic intervention for South Africa, insight into reasons for preferring not to use this modality or to utilise other attachment-based interventions may be of value to the Theraplay® Institute regarding possible improvements in training and interventional adjustments.

Conclusion to the Study

Chapter 6 served as the conclusion to the study of therapists' perceptions on the implementation of Theraplay® within the South African context. An overview of the key findings identified, limitations of the study, and possible recommendations for future research were provided. The findings of this study contribute to the body of literature regarding therapists' opinions of the administration of an attachment-based therapeutic intervention, specifically Theraplay®, in South Africa. Considerations of facilitating factors and challenges when utilising Theraplay® within this local context were explored. However, it is clear that in South Africa there is still a great need for the furthering of research on this topic, with specific focus on cultural cross-applicability.

Attachment and attachment patterns are vital to the understanding of human nature and mental wellbeing. Therapeutic interventions, such as Theraplay®, that address attachment injuries are therefore of paramount importance to facilitate the strengthening of caregiver-child relational dyads and resulting mental health of those involved in the relationships. Overall, Theraplay® is considered to be a beneficial therapeutic modality in South Africa where there are many families with dysfunctional relationships. The cross-applicability of the Theraplay® activities may require further investigation in order to make them more applicable to a wider variety of cultures within this local context.

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Appendix A: Advertisement

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Request for Research Participants

My name is Deidre Ann du Toit and I am conducting a research project as part of my Clinical Psychology Masters' degree at the University of Pretoria. I am looking for participants to take part in the study which is entitled *Therapists' perceptions on the implementation of Theraplay® in the South African context.* I would like to ascertain what the local experience has been of implementing Theraplay® in order to highlight the facilitating factors as well as challenges involved that may be context specific. I will do this through doing one-on-one interviews with South African therapists trained in Theraplay®.

If you are a HPCSA-registered clinical, counselling, or educational psychologist with at least 3 years' experience (post-internship) who has received at least Level 1 training in Theraplay®, you are eligible to participate in the study. Interviews will be conducted in English, which will require you to have a basic command of English.

If you are interested in participating and/or would like more information about the research, you can contact me directly using the mobile number or email address below.

Deidre Ann du Toit (PSIN 0148067)

Mobile: 082 307 7762

Email: deidredt@gmail.com

Appendix B: Information Sheet and Informed Consent Form

UNIVERSITEIT VAN PRETORIA
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Faculty of Humanities
Department of Psychology

Information Sheet and Informed Consent Form (Addendum C)

Dear Participant

This is a letter to kindly invite you to partake in a study exploring the perceptions of therapists that use and implement Theraplay techniques as therapeutic interventions within South Africa. This study is being completed by Deidre du Toit, a Clinical Psychology Masters' student at the University of Pretoria.

Title of the Study

Therapists' perceptions of the use and implementation of Theraplay as a therapeutic intervention in South Africa.

Purpose of the Study

While there are mental health professionals (largely psychologists) who have been trained in Theraplay in South Africa, research on the process of using this therapeutic intervention, and its vicissitudes, in this context has not been conducted. Generally, qualitative research exploring the perceptions of either therapists or clients engaged in Theraplay is lacking. Exploring the perceptions of therapists who use Theraplay in South Africa can shed some light on the facilitating factors and challenges involved in using this therapeutic modality. These experiences may, ultimately, be able to stimulate further research which may offer potential context-specific adaptations or additions to Theraplay in order to more effectively and efficiently treat clients, using this approach within a non-Western context such as South Africa. Given the importance of attachment in the mental health of children, attachment-

based interventions such as Theraplay can make a significant contribution to children's psychological wellbeing. Exploring how Theraplay can be best utilised and optimised in local contexts is therefore essential. The overarching aim of this study, therefore, is to explore therapists' perceptions of the use and implementation of Theraplay as a therapeutic approach in the South African context.

Study Procedures

If you decide to participate in this research study, you will meet individually with the researcher, Deidre du Toit, at your place of work. During this time, you will engage in a semi-structured interview with her for approximately 90 minutes. You will be allowed to freely discuss your personal experiences being trained in and administering therapeutic interventions using Theraplay techniques. Before the commencement of the interview, the researcher will ask you if you will be comfortable with the interview being recorded for research purposes only.

Possible Risks

It is not anticipated that this study will result in any emotional discomfort for you as the research topic and questions relate to your professional perceptions and opinions in regard to a therapeutic technique rather than to experiences of a personal, sensitive or traumatic nature.

Possible Benefits

It is possible that talking about your experiences of administering therapeutic interventions using Theraplay techniques with children and possibly their caregivers may contribute to our knowledge within this field of work. Your information shared will not only be beneficial to this study but may be valuable to others who have had similar experiences or for future research opportunities. The information you are willing to share during this interview will be included in a final report/mini-dissertation written by the researcher that will be made available to other students and professionals. A copy of the final report will be left at _____ if you wish to see and read it.

Rights of the Participant

Participation in this research study is completely voluntary. If you choose to participate and at a later stage decide to withdraw from the process, you can do so with no negative consequence to you. Your personal information will be kept confidential at all times irrespective of whether you decide to participate or not.

Confidentiality

It is assured that your identity and personal information will be kept confidential at all costs. Pseudonyms will be used and therefore you are encouraged to choose another name that you will feel comfortable with the researcher using for the study report. Your pseudonyms will be used for the entire interview transcript.

If you give permission to do so, the interview will be recorded as a means to help the researcher remember your experiences of administering interventions using Theraplay techniques on children and possibly their caregivers. The information you provide within the interview and that which is voice recorded will be accessible only to the researcher and her supervisor at the University of Pretoria - Mr Ahmed Mohamed. The voice recording of your interview will be kept and transcribed by the researcher. It will be kept and saved on a password-protected computer that only the researcher will have access to in order to ensure confidentiality. If you decide to withdraw from the study at any time, your interview recording, and transcript will immediately be destroyed.

The only limit that there is to confidentiality during this research study is if you inform the researcher that you are considering harming yourself or others. This will need to be reported to her researcher and applicable measures will need to be taken.

Use of data

The interview that has been voice recorded will be transcribed by the researcher and then the recording will be deleted. The transcribed data will be accessible only to the researcher and her supervisors for the sole purpose to be used for this study report. Once the final report has been completed, it will be made available to the University of Pretoria, the public, scientific journals, conference papers, and the research participants of this study in the form of a Clinical Masters' research mini-dissertation.

Rights of access to the researcher

If you have any questions regarding the research study and procedures that will be followed, please feel free to ask the researcher. You are also welcome to contact the researcher or her supervisors at the University of Pretoria if you have any concerns.

Sincerely,

Deidre du Toit: 0823077762 / deidredt@gmail.com

Ahmed Mohamed: ahmed.mohamed@up.ac.za

INFORMED CONSENT

I have thoroughly read the previous pages and I am satisfied regarding my understanding of the study, as well as its possible benefits and risks. I understand that my participation within this research study is voluntary and that I am entitled to withdraw my participation at any time without any consequences for doing so.

I hereby give my consent to participate in this research study concerning my experiences of administering therapeutic interventions using Theraplay techniques to children within the South African population.

_____ _____

Name of participant Signature of participant

_____

Date

_____ _____

Name of Researcher Signature of Researcher

_____

Date

I hereby also give permission for the voice recording of the interview.

_____ _____

Name of participant Signature of participant

_____

Date

_____ _____

Name of Researcher Signature of Researcher

_____

Date

Appendix C: Interview Schedule

Interview Schedule

Research Title

Therapists' perceptions on the implementation of Theraplay® in the South African context

Introductory paragraph (5 minutes)

Good morning/good afternoon Ms./Mr. xxx, I am Deidre Ann du Toit and I am the researcher who will conduct this interview with you. I want to thank you for consenting to participate in my research and for being able to make time to see me today. Am I correct in saying that I see you have consented to the voice recording of this interview on your consent form? The information you provide to me will be accessible to only my research supervisor at the University of Pretoria and to me. May I turn the voice recorder on now?

Before starting, I would please like to ask that you give verbal responses to all the questions I will be asking you so that the voice recorder is able to pick up your response. You are here at your place of work seeing me today because you have been identified as a therapist who is fully qualified at the HPCSA and has been practicing for at least three years. You have also been trained in Theraplay® up to at least Level 1 and administer it to children during therapeutic interventions using Theraplay® techniques. Is that correct? Today I will talk about how you experienced this process starting off with a brief description of yourself, how long you have been practicing and where you received your training of Theraplay®. I will then go deeper into your experiences of administering such a therapeutic intervention within a South African context and will end with me asking you whether you would recommend any changes regarding this Westernized intervention used within a non-Western context.

If you have any questions that you would like to ask regarding the research - such as confidentiality, how the research will be interpreted or any other related matters - please feel free to ask me.

Please also remember that your participation today is completely voluntary and that you have the right to withdraw or stop the session at any time with no consequences for doing so. To adhere to confidentiality, you can choose a pseudonym for yourself that will be used throughout this research project

Demographic Information (This section is to be filled in by the researcher) (5-10 minutes)

1. Name of participant (Pseudonym):_____
2. Gender of participant:

Male	Female

3. Ethnicity of participant:_____
4. Number of years you have practiced as a fully qualified psychologist (post-Community Service): _____
5. Are you in private or public practice or both?

Private	Public	Both

6. Place where you received your training in Theraplay® and Level of training received: _____

Themes and Probes

Theme 1: Brief History of participant (10-15 minutes)

1. How did you hear about Theraplay®?

   Prompt: Where did you hear about Theraplay®?

2. What was it that made you decide to seek out and attend training in Theraplay® techniques?

3. What is the reasoning for you incorporating Theraplay® techniques into interventions with children within your place of work?

   Prompt: Why do you use Theraplay® techniques in your work with the patients/clients that you treat?

Theme 2: Experiences of administering interventions using Theraplay® techniques with children and possibly their caregivers (30-50 minutes)

1. What are some of your thoughts on how Theraplay® works? And specifically, within South Africa.

2. Tell me about your experiences of using Theraplay® with clients in your work.

   Prompt: Could you briefly describe the type of patients/clients who you would provide Theraplay® techniques to in an intervention? And the reasoning for administering it to them specifically?

3. Professionally, do you think these interventions assisted the patients/clients with the difficulties they were struggling with?

   Prompt: Do you think the interventions worked for these patients/clients? Why or why not?

4. Do you feel that techniques using Theraplay® are useful tools to implement change in parent-child relationships in the South African context?

5. What is the reason for your answer to the previous question?

   Prompt: What is your reason for saying "yes/no"?

6. What about these techniques is useful/helpful to families in our context? Reason for your answer
7. Are there parts of the process that you have found do not work that well? What are they?
8. (If answered yes to 7) What do you think is the reason for the element(s) not being as efficient?
9. Do you alter or adjust the elements that you think do not work so well? Examples
10. What are your thoughts on the applicability of the techniques of Theraplay® to the South African population specifically, considering that Theraplay® was developed in a different context (such as USA)?

    Prompt: Do you think Theraplay® is applicable in a non-Western context such as South

    Africa?

11. What is the reason for your answer to the previous question?

Theme 3: Suggestions and Recommendations (20-25 minutes)

1. What do you think should be considered when administering interventions using Theraplay® techniques within a context such as South Africa, specifically…If anything?

   Prompt: What do you think could change to make Theraplay® techniques more relevant for a context such as South Africa?

2. In what ways do you think this would make Theraplay® more contextually relevant?

Theme 4: **Is there anything else that you would like to tell me about your experiences of administering interventions using Theraplay® techniques to your patients/clients that you feel I have not touched on? (5-10 minutes)**

Concluding reflections and summary (10-15 minutes):

1. Reflect back to the participant what I have heard and understood about his/her experiences administering interventions using Theraplay® techniques.
2. Thank the participant again about being willing to participate in the interview.
3. Ask if there are any questions he/she possibly has.

Appendix D: Inter-rater Certificate

LIMINAL
RESEARCH CONSULT

24 March 2019

INTERCODER RELAIBILITY AGREEMENT.

Intercoder reliability is calculated by examining the degree to which coders agree across a fixed set of units (Kurasaki, 2000). The goal of the study was to *identify therapist's perceptions of the use and implementation of Theraplay as a therapeutic intervention within the South African context.*

The coding process consisted of free coding based on the fundamental principle of identifying the common themes or code patterns. The analyses thus integrated a process of breaking down all the data into their smallest component parts known as the codes, and then re-structuring and grouping these codes into units or categories known as themes (Archer, 2018). As an outcome of code merging, two thematic themes were identified. For each of the two thematic themes, the co-coder developed descriptive labels to represent the intended meaning of each code.

Intercoder reliability was then calculated by checking the agreement between the coders in the text whereby a form of consensus was reached between the co-coder and the researcher on this particular project.

It has been found that an intercoder reliability score of 90% was in agreement related to similar codes.

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Appendix E: Ethical Clearance

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

7 September 2018

Dear Ms du Toit

Project:	**Therapists' perceptions of the use and implementation of therapy as a therapeutic intervention in South Africa**
Researcher:	**DA du Toit**
Supervisor:	**Mr AR Mohamed**
Department:	**Psychology**
Reference number:	**29109893 (GW20180819HS)**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** at the meeting held on 6 September 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Mr AR Mohamed (Supervisor)
Prof T Guse (HoD)

Appendix F: Example of Reflexive Journal

Reflexivity

I am a white South African woman born in 1990, have South African caregivers and have resided in this country for my entire life. I went to a multi-cultural high school and having friends from various cultures, I have always believed that I give space for cultural variation in my life. Being a psychology student, we are also already taught from undergraduate studies to be non-judgmental and all-inclusive of religion, gender preferences, and cultural beliefs, which I considered to have accomplished.

While being aware that I am a novice researcher, conducting the interviews was considerably difficult for me as I needed to balance occupying the space of an interviewer and that of a psychology student wanting to gain further insight and knowledge from the participants. Being an avid student, I needed to constantly remind myself to remain a curious researcher and not an enquiring student and future colleague. I often found myself resonating with my own opinions regarding the research topic but was very aware of attempting to not allow that to influence the interview process.

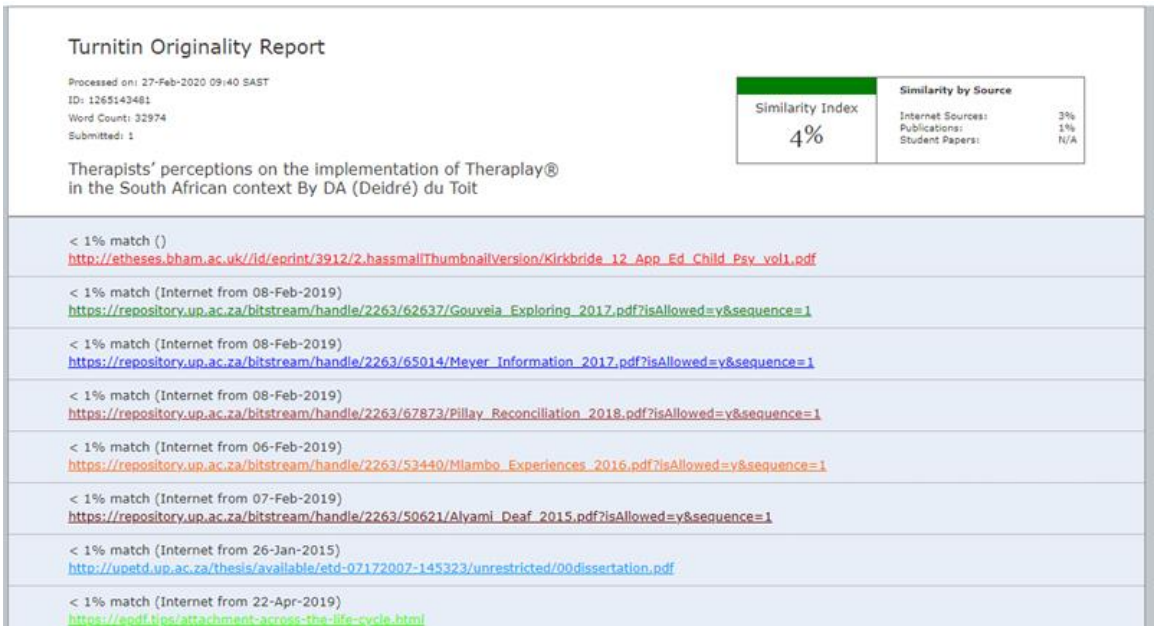
Naturally, my own personal opinions regarding Theraplay® and culture in general would have influenced my analysis of the data and filtered through to the write up and discussion. Although I felt that I understood what was being communicated by the participants, I soon realized that my comprehension seemed rather superficial on occasion through the back-and-forth editing with my supervisor during the write up of the results and discussion. He made me start digging deeper with the data and emerge myself further into the perceptions of the participants. There were times that I was trying to convey something about the data and the feedback I would receive would indicate that the wording I used was not communicating what I had intended. This made me further appreciate how complex

language and communication can be, that there are various ways to convey a message across to an individual, and the importance of communication in one's mother tongue as it possibly could result in knowledge being lost in translation. This made me doubt my ability to do justice to participants' perspectives and made me wonder about the amount of information that I possibly missed in this process. I also needed to acknowledge that four of the six participants did not partake in the interview using their mother tongue. It made me further appreciate the fact that Theraplay® goes beyond the need for language through the utilization of activities that rather focus on the relational experience between a caregiver and child.

This process was emotionally difficult and taxing for me. As much as I enjoyed doing the research, writing it up started becoming personal for me in the sense that it gently was bringing to my attention that my idea of how liberal I thought was might not be completely a true reflection of me. I thought I had a good general understanding of culture but feedback from my supervisor indicated that much reading to further my understanding of culture within South Africa was needed. My supervisor being a different culture to my own additionally assisted me in becoming aware of this. It made me realize that I need to further work on myself in this regard, particularly in relation to my future profession. I also started becoming aware of the possibility that due to my 'whiteness' I do not fully comprehend the effects and influences of culture as other minority ethnicities do, and that potentially my ethnicity has resulted in a form of protection from needing to further emerge myself into these influences that culture has as it has not affected me as such. This started evoking a sense of guilt in me regarding how privileged white South Africans truly are and increased my empathy towards the minority of this country. It has further spurred my desire to want to increase research in South Africa to make psychotherapy more culturally and contextually inclusive for our diverse country as each of us have a right to healthy mental wellbeing and to effective treatment thereof if so required.

Ultimately, the extensive editing and numerous drafting of this dissertation between myself and my supervisor was essential to ensuring that the results, discussion, and overall study is trustworthy and rigorous. I hope it does justice to the voices and perceptions of the participants.

Turnitin Report



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