

**An exploration of the intrapsychic  
themes in the play of children  
affected by HIV/AIDS using the  
Sceno Test.**

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**Submitted in partial fulfillment of the requirements of a Masters in  
Educational Psychology**

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**December 2001**

## **Abstract**

This study is an exploratory investigation aimed at understanding the intrapsychic themes of children affected by HIV/AIDS, using the medium of the Sceno test. The Sceno test is a play assessment technique. The aim of this research was to ascertain if the Sceno test would be a useful procedure to increase our understanding of children's intrapsychic experience of illness, impending death, and/or the death of their parents.

Four children, between the ages of 7 – 11, who are affected by HIV/AIDS and are living in a children's home, were assessed three times. Two children not affected by HIV/AIDS but who had lost their parents were also included in the study. The assessment sessions were videotaped and then the action and dialogue transcribed. A hermeneutic phenomenological methodology was used within a narrative framework to interpret the 'text' of the children's play.

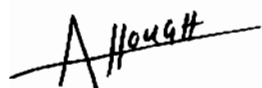
Several important themes arose in analysis. Children were concerned with routines, particularly within the family. This is believed to be demonstration of a need for security and structure. The role of the Mother as caring and nurturing occurred often in the childrens' play. This demonstrates attachment or wish for attachment to this figure. Other important themes were those of organising the environment and having control over the context of the play, and the theme of the doctor and illness. The Sceno was found to be a valuable means of eliciting the intrapsychic themes of these children. Limitations and implications of the study are considered.

## **Acknowledgements**

In completing this study, I have received encouragement and advice from many people. I would specifically like to thank the following people:

- I would especially like to thank Bev Killian for her guidance, understanding, consistent support and supervision throughout this process.
- My mother Judy Hough needs a special thank you for always listening, for creative problem solving, for helping with transcribing and proof reading, and being my closest friend.
- A special thanks to the children who shared their experiences with me through play. You made this study possible.
- Eddie de Vos and Paula from Joseph Baines Children's Home for granting me access to interview the children, and supporting my research endeavours; and for the support that you provide to these children on a day to day basis.
- I would also like to thank Jill Willows for her support and contact with Woodlands Children's Home.
- All those people who listened to my agonizing over this thesis and who have been my emotional support – Merion Grimshaw, Floss Mitchell, Rose Schoeman, Diane van der Westhuisen, and Tamsen Rochat.

**The author hereby declares that this thesis, unless otherwise indicated in the text, is a product of her own work.**

A handwritten signature in black ink that reads "Angela Hough". The signature is written in a cursive style and is underlined with a single horizontal line.

**ANGELA HOUGH  
December 2001**

**As the candidate's supervisor I have/ have not approved this dissertation for submission.**

---

**Bev Killian**

**Date:** \_\_\_\_\_

# An exploration of the intrapsychic themes in the play of children affected by HIV/AIDS using the Sceno test

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1. Contextualising the problem of the effects of HIV/AIDS on children in South**

##### **Africa:**

“AIDS has become a development crisis, reversing the trends in child survival, robbing children of their parents and destroying the economic and social base of many developing countries”

(Ewing, 2000).

Sub-Saharan Africa has been particularly hard hit by the HIV/AIDS pandemic. In South Africa, the Medical Research Council (MRC) report (Swarns, 2001) found that 40% of the adult deaths (between the ages of 15 and 49) last year were caused by AIDS-related illnesses. In South Africa an estimated 420 000 children have been orphaned by AIDS (Foster and Williamson, 2000; McGeary, 2001).

Many children are themselves HIV positive due to vertical transmission, or due to sexual abuse. Others are not HIV positive, but have been orphaned, or care for ill parents or extended family members. Many children growing up in environments characterised by poverty and loss are at risk of developing a variety of emotional and behavioural problems. The HIV/AIDS pandemic exponentially exacerbates the potential risk factors. This research will therefore refer to ‘children affected by HIV/AIDS’ (CABA) as the selected terms to cover the various ways in which children may have been affected by the HIV/AIDS pandemic.

In addition to the statistics on mortality, the psychosocial effects of HIV/AIDS are multiple and far reaching (Marcus, 1999). Some of these include loss of health, employment, income, hope and independence (Nord, 1995). Individual and state

economies are affected by loss of income, losses in productivity, and by the social costs of the disease, such as welfare for orphans, treatment for opportunistic infection and the costs of funerals. Traditional family and community structures are broken down as families are forced to restructure, to accommodate the children who are orphaned, and to care for the ill. Many of these structures have reached absorptive levels with their capacity to cope having been exhausted by the extent of the pandemic (Sherr, 1995).

Accompanying these difficulties is the stigma often associated with HIV/AIDS. Death due to AIDS has been called a “bad death” (Marcus, 1999). It is known as ‘bad death’ because it commonly affects young people. In addition the shame and embarrassment surrounding AIDS deaths are at least partially due to its link to sexual behaviour. Because of this stigma families affected by AIDS, or who are grieving an AIDS related death, face alienation and reduced support. The child affected by HIV, therefore often comes from an environment threatened by loss, separation, poverty and social alienation (Reidy, 1995). “The silent victims of the AIDS pandemic are the children orphaned by their parent’s tragic deaths” (Dansky, 1997, p.2).

The crisis of children affected by HIV/AIDS is one that will need to be tackled on many levels: political, financial, sociological; at a community level and at an individual level. Long-term strategies will need to be developed to deal with the sociological and psychological impact of HIV/AIDS on these children. It is beyond the scope of this research to deal with most of these issues. However, a more precise understanding of the psychological experience, anxieties and intrapsychic concerns of children affected by HIV/AIDS, would be of enormous benefit in providing a framework for understanding what may facilitate resilience and in informing the development of management and intervention strategies for these children. To effectively address the needs of these children we need to know what meanings they attach to their experiences.

There is a large amount of literature regarding children with terminal illness (Kubler-Ross, 1969; Judd, 1989), children and grief (Fogarty, 2000; Grollman, 1995; Raphael and Dobson, 2000), and children’s cognitive understanding of death at various developmental

stages (Fogarty, 2000; Grollman, 1995; Judd, 1989; Reidy, 1995). However, as yet, there is very little literature on the specific intrapsychic experiences of children affected by HIV/AIDS.

“Little seems to have been written about the significance of death or of AIDS or the interrelationship between them on the part of children with HIV...There would seem to be a need to broaden both the psychometric and theoretical purview of work in the domain related to death and the child infected with HIV” (Reidy, 1995, p. 184, 205).

It is widely accepted by psychologists that children are adversely affected by risk factors, but that the degree to which they are affected depends on a variety of mediating factors. (Bowlby, 1973; Rutter, 1966; Rutter and Madge, 1976; Rutter, 1981). Although, there are likely to be commonalities in the experience of loss of a parent, and fear of illness, it is suggested that the death of a parent to HIV/AIDS adds further stress to a child's experience (Reidy, 1995; Madorin, 1999). The particular sociological impact of this disease, the associated stigma, and the fact that in Sub-Saharan Africa this disease is largely affecting under-resourced communities, may contribute to unique responses in children affected by AIDS.

Children affected by HIV/AIDS and in the care system are frequently loss of primary attachment figures, loss of parental guidance for socialisation, loss of a sense of their own history and belonging. Research suggests that many of these children will develop some emotional disturbance, but that this is mediated by what happens before and after the death of the parent(s) in terms of emotional and physical care of the child (Reade, Hunter and McMillan, 1999; Rutter, 1981). Literature on attachment, risk and resilience provides a framework for understanding protective mediating factors for children at risk (Bowlby, 1973, 1980; Grotberg, 1995, Madorin, 1999, Rutter, 1981).

## **1.2. The medium of play used in this research:**

Children present unique challenges in deciding on the medium through which to work. It has been deemed important to ascertain children's construction of their intrapsychic experiences. However, children often do not have the verbal capacity to put their experience adequately into words. Play is therefore often used in work with children, as it is believed to be a child's natural means of expression (Axline, 1989; Lowenfeld, 1935; McMahon, 1992; Winnicott, 1964). "The young child is unable to express himself with the verbal ability of adults...so he uses play as a substitute...Play aids diagnostic, developmental and continuous assessment" (Jeffrey, 1984, p.70). Many practitioners and theorists (Axline, 1989; Klein, 1976; Oaklander, 1988; Schaefer, 1986; Winnicott, 1971) have used play as a means for understanding children's intrapsychic processes, and as an assessment, diagnostic and therapeutic medium. Play is one means through which the researcher can gain insight into a child's perception of his/her<sup>1</sup> experiences. Weininger (1989) in a study of children's conceptual understanding of death, found that children's play often indicated a more developed understanding than did their verbal answers.

The particular play technique used, in this research, is the Sceno Test. The Sceno was developed by von Staabs (1971) as a way to gain insight into a child's unconscious intrapsychic conflicts. The test consists of a box of toys including movable human figures of various ages, animals, coloured blocks and household furniture and items. These toys enable the child to construct scenes or narratives that demonstrate her relation to attachment figures, her environment and to 'show' her experiences.

The Sceno is portable and relatively inexpensive, making the play assessment technique accessible to those children who cannot gain access to playrooms for reasons such as transport and financial constraints, physical illness and disability. The Sceno provides a means of expression that does not rely heavily on verbal skills; therefore it is potentially useful in our multilingual country.

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<sup>1</sup> To facilitate ease of expression, the feminine pronoun will be used from here on when referring to a child. Please note that the research does not intend to be gender specific and refers to both genders.

### **1.3. Statement of aims of the research:**

This study is an exploratory investigation aimed at understanding the intrapsychic emotional themes of children affected by HIV/AIDS, using the medium of the Sceno Test. The aim of this research is to ascertain if the Sceno Test will be a useful procedure to increase our understanding of children's intrapsychic experience of illness, impending death, and/or the death of their parents.

The research will therefore aim to answer two questions:

- 1.) What are the intrapsychic themes of children affected and infected by HIV/AIDS, as expressed using the Sceno Test?
- 2.) Does the data demonstrate the usefulness of the Sceno Test as a play assessment technique?

Many children affected by HIV are cared for in Residential Care Homes. This study is an exploratory study aimed at understanding the intrapsychic emotional themes of four children affected and infected by HIV/AIDS and living in a Childrens' Home. Two children from the Childrens' Home who have lost parents, but not due to HIV have also been included, to ascertain if there are differences in their narrative.

As discussed, children present unique challenges in deciding on the medium through which to work. The Sceno Test has been used as the medium of investigation for this study. An inference from this research may be that the Sceno Test can be a useful means of assessment and intervention with children in South Africa.

### **1.4. Methodology:**

This study uses a qualitative methodology. As the child constructs a narrative scene that requires interpretation, an interpretive methodology has been adopted. Ricoeur (1981) describes how meaningful action may be interpreted as a text, if it is fixed and available for analysis and interpretation. A method for multiple readings of the text was adapted

from Mauthner and Doucet (1998). Each reading had a different focus, to enable a global understanding as well as an understanding of the constituent parts. The first reading involved reading for global understanding and main themes in the manifest plot. The second reading was a content analysis of the text, searching for frequencies in the coded themes of the children's play. The third reading was based on the second research aim, and involved reading the texts for aspects of play as outlined by the literature review.

### **1.5. Outline for the rest of the study:**

Chapter two provides a review of the literature dealing with HIV/AIDS and children, setting the context of children affected by HIV/AIDS and describing the possible intrapsychic phenomena of children affected by HIV/AIDS, illness, death and loss. A brief discussion of the conceptual frameworks of attachment, risk and resilience are provided at this point. Chapter three defines and describes play and gives a rationale for the use of the medium of play for this research. Chapter four outlines methodological issues, the use of video for data collection, and describes the phenomenological hermeneutic methodology used and the multiple readings of the text. Chapter five describes the findings and conceptualises the data in terms of the three readings of the narratives. Chapter six presents a discussion and analysis of the implications and limitations of this study. A critique of the study and recommendations for future research are made. Finally the research is concluded with a brief concluding statement.

## **CHAPTER TWO**

### **REVIEW OF LITERATURE: HIV/AIDS AND CHILDREN**

#### **2.1. Introduction: The HIV/AIDS pandemic**

*For many African peoples, illness and death are part of the fabric of life; crises which are dealt with by preexisting coping mechanisms. Past experience allows adaptation to take place, and rehearsed responses to be used. The AIDS pandemic, however, is different. There are usually no rehearsed coping responses, and limited experience of a disease with such widespread, rapid and cumulative effects. The HIV/AIDS pandemic creates a situation of growing uncertainty and instability at global, family and individual levels. (Ledward, 1997, in Madorin, 1999, p.11).*

Recent statistics concerning HIV/AIDS describe a gloomy picture. McGeary (2001) states that 17 million Africans have died since the AIDS epidemic began in the late 1970's, more than 3.7 million of them children. An additional 12 million children have been orphaned by AIDS. In South Africa, the Medical Research Council (MRC) report (Swarns, 2001) found that 40% of the adult deaths (between the ages of 15 and 49) last year were caused by AIDS-related illnesses. Recent UNAIDS figures on the impact of HIV/AIDS on children reveals that, of the children orphaned by AIDS, 95% have occurred in Africa (Foster and Williamson, 2000). In South Africa an estimated 420 000 children have been orphaned by AIDS (Foster and Williamson, 2000; McGeary, 2001).

Poverty, low levels of education, unsanitary living conditions and limited access to basic services have contributed to the rapid spread of the HIV C strain in Africa, as well as the faster development of the disease process in individuals.

The impact of HIV/AIDS on our society is enormous. Its impact is particularly poignant in the case of children who are being forced to face this crisis. Many will be left orphaned, will have to deal with their own infection and with a range of psychosocial difficulties. These include lack of schooling, depression, homelessness, crime and exposure to HIV infection (Hunter and Williamson, 1998) all compounded by the fact that they reside in vulnerable communities. The HIV/AIDS pandemic has brought new challenges to the caring facilities and to the capacities of all to respond effectively (Sherr, 1995). Although much research has been done into death, dying, and grief (Grollman, 1995, Kubler-Ross, 1969, Judd, 1989), the existing body of knowledge needs to be expanded to accommodate this pandemic. It is also recognised that to effectively address the ramifications of the HIV/AIDS pandemic, we need to know the meanings that people give to living and dying with HIV/AIDS (Skweyiya, 1999, in Marcus, 1999). Hunter and Williamson (1998) argue that before programmes and interventions can be initiated those who intervene must develop a working understanding of childrens' most serious problems, and how they are coping with them.

There are a multitude of effects of the HIV/AIDS pandemic on micro, meso and macro societal levels, which extend beyond the experiences of the individual who is diagnosed as HIV positive.

This chapter, will therefore briefly contextualise some of the broader societal impacts of HIV/AIDS and the impact on children as suggested in the literature. This is followed by an examination of literature on death and children and the potential intrapsychic phenomena associated with HIV and AIDS. The chapter is concluded with a brief discussion on facilitating resilience.

## **2. 2. The effects of the HIV/AIDS pandemic: economic, social and psychological**

### **2.2.1. The Social and economic effects:**

The projected life expectancy of the population has severely decreased. AIDS has a negative impact on child and infant mortality (Hope, 1999). Marcus (1999) in an

exploratory investigation of poor people's perceptions of death and dying in seven communities in and around Pietermaritzburg, found that many had experienced multiple deaths.

The economic costs of the disease are generally estimated as the direct costs to state and individuals of medical care, the indirect costs of labour, and potential loss of income and productivity; and therefore overall economic development (Hope, 1999). HIV/AIDS tends to affect people in their most productive stage of life. Therefore, the country's prime workforce is effected, resulting in productivity decreasing. The economy of the state and individuals is directly affected by the loss of income and the costs of medication, care, treatments, funerals and ceremonies. Large sums of money have to be spent on retraining new employees to take the place of those who are incapacitated. Already limited health budgets have to focus on HIV/AIDS, leaving budgets for other diseases even more under-subscribed (Madorin, 1999). The HIV/AIDS pandemic increases the inequality in distribution of wealth. HIV/AIDS in South Africa tends to impact most detrimentally on those populations that are socially and economically disadvantaged, and serves to disempower those populations further in terms of access to resources (Marcus, 1999).

Marcus (1999) found that families were under pressure to reorganise, either by their reduced numbers or by absorbing additional dependent members. These recomposed families were usually under immense financial strain. The effects of HIV/AIDS deaths were usually found to include deteriorating economic circumstances, withdrawal of children from school, and pressure on aged caregivers to re-enter the already depressed labour market (Hope, 1999; Marcus, 1999).

The aged are forced to take on parental responsibilities as well as the care of the terminally ill. There is a rapid increase in the number of child headed households. Health services become overburdened by the increasing number of HIV/AIDS cases, and Welfare services become overburdened by increasing numbers of orphans. Orphans may be physically cared for, but many grow up without supportive psychosocial networks (Madorin, 1999; Marcus, 1999).

### 2.2.2. Psychological effects:

“The burden of grief is the silent backdrop that looms behind the high profile AIDS and HIV epidemic” (Sherr, 1995. p.1).

The nature of the HIV/AIDS disease is different. People are often grieving multiple losses of family members, friends, lovers and/or acquaintances, and there are various levels of loss experienced through the progression of the disease. These losses include, loss of health; future plans; employment; independence; hope; interest in life; self esteem; sexual freedom; privacy; and potential loss of social support (Nord, 1997; Sherr, 1995). The effect of these losses is cumulative, adding to the burden people must bear and eroding their capacity to cope. The cumulative effect of these losses creates an experience of bereavement overload (Nord, 1997; Sherr, 1995).

Various characteristics of AIDS make this disease unique. The age inappropriateness of its victims, protracted and episodic illness and a societal reaction that is often stigmatising, intensifies the experience of loss and tends to diminish social support for those affected (Nord, 1997). AIDS also affects community clusters: groups of people who socialise together, therefore increasing exposure to loss of various members of that cluster (Nord, 1997). The more loss a person experiences, the more likely are traumatic responses, such as sleep disturbance, anxiety, demoralisation, and psychological distress. These responses often result in sufferers adopting inappropriate coping mechanisms such as sedative recreational substance use, aggressive and suicide ideation; and necessitating the need for psychological services (Nord, 1997).

The Family Health Project (1998) reported that children of mothers who are HIV infected are reported by mothers and/or children to demonstrate more internalising problems (e.g. anxiety, depression), externalising problems (e.g. aggression), and lower levels of social and cognitive competence than children of non-infected mothers.

Many children suffer in ways that are not visible to caregivers. Not much is known about how children construct grief and anxiety in their internal world. Therefore, more research

is needed to investigate this aspect of the HIV/AIDS pandemic (Madorin, 1999). Hence, this research adopts a technique to facilitate eliciting aspects of the child's interior world.

### **2.3. The particular problems associated with children affected by AIDS and HIV**

#### **2.3.1. Children with the disease:**

Between 15% and 33% of babies born to HIV positive mothers will themselves be infected (Madorin, 1999). It is estimated that half of these children die before the age of two. However, there is a growing number of children who survive for considerably longer (Madorin, 1999).

Studies on the preconceptions of healthy children about AIDS showed children often associated AIDS with cancer and death (Reidy, 1995). Research indicates that children's fears about death tend to be inversely correlated to their self-esteem. It may be postulated that this is even more so with children infected with HIV (Reidy, 1995).

Self esteem can be stabilised with positive communication and affirmation, and communication about death (Reidy, 1995). However, infection with HIV is complicated by several factors, as described below:

- Often associated with HIV/AIDS is the fear of telling a child the aetiology of their illness due to a parent's own feelings of guilt, remorse and fear. The anticipated grief of an HIV positive parent is complicated by a parent's grief for herself, for her child, fear of her own ill health and incapacity, the social stigma of being HIV positive and remorse for having inflicted the infection on one's child (Reidy, 1995).
- Children, who are HIV positive due to vertical transmission, might experience frequent separations at stages in life where the formation of a secure attachment is vital for healthy psychological development. (Bowlby, 1973; Reidy, 1995).
- Dynamic attachment behaviours (the mother's nurturing behaviours and the child's attachment activating behaviour) may be threatened when mother or child or both are HIV positive. Illness may make the child less responsive, slower to smile and reach

for attention, and less easily consolable when crying. A mother's own lack of health, depression and anticipatory grief may make her less able to demonstrate positive attachment behaviours. Failure to thrive in HIV positive infants may be due not only to the ravages of infection, but also to poor attachment (Bowlby, 1969; Reidy, 1995).

- In many cases there is stigma and social isolation associated with HIV infection. Children may be shunned from day care, crèche and school facilities, thereby lessening support for the family, and increasing the likelihood of not disclosing one's HIV status.

### 2.3.2. Children whose parents are sick or have died of AIDS:

What happens to orphans depends largely on whether one or both parents die, on who in the extended family is available to care for the children, and on the financial resources of the extended family. Many traditional kinship and family strategies for managing orphans have reached their absorptive capacity. Households affected by HIV/AIDS face several problems. These tend to cluster around these basic areas (Barnett and Blaikie, 1992; Jacques, 1999):

- Children are often not able to go to school. The reasons for this may include the fact that they are caring for sick parents, or they may have to assist in income generation or carers may not be able to afford school fees, uniforms or books. These children could be poorly educated and thus have a reduced chance of raising their socio-economic situation. Traditional skills, such as agricultural knowledge and general knowledge about cooking and hygiene, may not be passed down.
- Many lose the guidance, care, teaching, socialising and disciplining roles provided by parents. The loss of parents means losing parental guidance for assisting in appropriate social development.
- Although a large number of orphaned children have their fundamental needs for shelter, food and clothing met, many others are malnourished and/or homeless.
- Access to health care is usually reduced, while health risks increase.
- Many orphaned children's right to inherit their deceased parents' tenure on the farm, inheritance, or property, is threatened, and unscrupulous guardians and relatives may appropriate properties.

- The loss of a parent in families affected by HIV/AIDS is often accompanied by subsequent losses.
- Psychosocial well being and development are threatened. The illness and loss of a parent are psychologically distressing for a child. The loss of a consistent nurturer can produce serious developmental effects. In addition, there is evidence that foster children are not as well cared for as natural born children (Barnett and Blaikie, 1992; Jacques, 1999; Madorin, 1999).

#### **2.4. Grief Reactions in children**

Children mourn, but often quite differently from adults. The death of a loved one can produce a variety of emotions in a child: fear, anxiety, anger, guilt, sadness, numbness and self-questioning. These feelings vary from child to child, from day to day, and according to circumstances.

##### **2.4.1. Separation, loss and grief:**

Various theorists have recognised a common response to loss and grief, that accompanies all separations e.g. loss of parent, divorce, loss of a limb, termination in the therapeutic relationship etc. These include painful feelings of rejection, apathy towards the outside world, loss of capacity to love and disinterest in activity. Bowlby (1973) and Edelson (1963, in Bloom, 1980) describe three stages in response to loss– the stages of protest, despair and detachment.

The first stage involves a response to the narcissistic wound. The child initially may refuse to believe what has happened, feels rejected and attempts to reattach to the lost person. Tears, anger, rage, panic, disruption in basic trust, a pervasive sense of worthlessness, and behaviours aimed at attaining reattachment, accompany this stage. The child is apathetic to new relationships.

The second stage is that of despair. Initially as the loss is acknowledged, there may be attempts to bargain a better reality, to think 'if only', and wonder if things could have

been different. Then as the child starts to come to terms with the separation, she may be sad, distant and unresponsive. The child deals with feelings of sadness, guilt, and mourning the separation.

The third stage is one in which the child begins to detach from the original love object, which may be accompanied by guilt. There is some acceptance of the loss and acknowledging a need to get on with life. The child begins to engage again in the world and new relationships. This stage may be characterised by desires to please and feelings of competitiveness, jealousy, envy and anxiety. Mourning ends when the libido can be attached to a new love object or to an internalised representation of the love object.

Kubler-Ross (1969) describes five stages: denial, anger, bargaining, depression and acceptance. Categorising different stages merely provides a framework for understanding the grieving process. Movement between stages is not always linear, and stages can be experienced simultaneously. Freud (1917, in Bloom, 1980) believed that in the mourning process, the libido needed to be withdrawn from the love object. However, if ego separation has not been made before the loss, the loss may cause severe disturbance to the individual's self regard. Children who have not yet fully developed ego structures, project parts of the self onto the attachment object. Therefore in the loss, the child loses part of herself.

Fogarty (2000) adapts these stages specifically for children, as set out in Table 1 below.

**Table 1: Stages of emotion experienced by children in grief (Fogarty, 2000).**

The numb and stunned reaction	Initially a child may feel no emotional reaction. She may feel she cannot remember the face or voice of a loved one, or the things they did together. This stage offers initial protection to emotional overload. However, a child may feel guilty or self-deprecating because of her lack of emotion.
Commotion	A child's behaviour in this stage is characterised by excessive energy, attentional difficulties, hyperactivity, tension and fear. Commotion is a means of attracting attention and assistance from adults and indicates a child is mourning.
Attempts to re-create coupled with balancing denial	A child usually feels a strong desire to get their dead loved one back. She may try to re-create situations, activities, and places she shared with the loved one. These attempts usually fail and serve to remind the child that she cannot have the loved one back, therefore balancing against her denial of the death. These attempts should be encouraged.
Anguish	This is the empty feeling a child experiences. It is helpful for a child to share this emotion with others.
Anger	Anger is a common grief reaction. This can be anger at God, the deceased loved one, others, and oneself and for the uncomfortable adjustments, one has to make. This can become revengeful and is a way a child tries to re-empower herself.
Guilt	Feeling bad and trying to make amends for past negative behaviour. This is often accompanied by self-blame for the death of a loved one, and can have negative implications.

Other types of reactions commonly associated with grief in children include: becoming overly compliant and seeking approval, somatising grief such as developing stomach aches, clingy behaviour, aggressive behaviour, regression and feeling stigmatised. Because children have incomplete cognitive development, if these normal grief reactions are not supported, or allowed to happen, children often develop their own inaccurate conclusions. Magical thinking usually involves believing one has the power to be responsible for the loss, the power to fix the loss, or the ability to avoid the mourning process. These can lead to developing negative defence mechanisms (Fogarty, 2000).

Nord (1997) recognised that the impact of multiple AIDS related loss on the community exacerbated the impact on individuals and vice versa. He likened surviving multiple AIDS related loss to surviving trauma, because of the cumulative toll, the ongoing traumatisation, the prematurity of death and the perceived threat to one's life. He describes four stages of surviving multiple AIDS related loss: Shock and denial, overload and confusion, facing reality and reinvestment and recovery.

#### 2.4.2. The concept of death and cognitive development:

As is recognised above, children suffering loss, separation and grief experience various emotions and stages of grief. Children's emotions and understanding of death are also influenced by their cognitive development. As a child's cognitive capacity develops, so her understanding of death as final and inevitable increases. It is recognised that different children mature at different rates according to their temperament, parenting and life experience, and that progression through stages is not necessarily linear and children may reach certain stages and still regress to an earlier stage. Following is a brief description of what the present literature says about conceptions of death at different childhood stages of development. The ages given are approximate. A child's conception of death will depend on her individual level of cognitive and emotional development, her experience of death and loss, socio-cultural factors and various other phenomena.

Ages 0-2 years old:

At this preverbal stage, there is no language on which to attach concepts. The child has no understanding of the concept of time and so cannot understand the permanence of death. However, a child is able to perceive the difference in caregivers and experiences fears and anxieties around separation. It is frightening for the child to be separated from the primary care giver and this will affect her sense of secure attachment as she misses her primary care giver's physical contact, security and comfort. Psychoanalytic studies suggest that infants have a primitive fear of a nameless dread, a fear of disintegration, abandonment and separation, which is equated, with a fear of death. Separation is the ultimate environmental impingement (Judd, 1989; Winnicott, 1964). Klein (in Judd, 1989) describes the infantile fear of death as a paranoia of being killed by her own projected aggression.

The child's distress may be expressed in changes in eating and sleeping patterns, crying and irritability. The child may seem overly dependent or withdrawn, cry listlessly and may not be easily comforted. Toddlers' responses may include outbursts of anger and tantrums, as a way to express a wish to bring their mother back. A child may have no interest in toys or playing and may regress to behaviours that she had outgrown (Grollman, 1995; Lendrum and Syme, 1992; Reidy, 1995).

Ages 3-7 (egocentric and magical thinking):

Children at this stage are not able to define death and therefore use magical explanations for death. Death is seen as temporary or reversible. Children may keep asking when the dead person will return. They believe that like a cartoon character, people can return to life, or that death is like sleeping and the dead person will wake up. However, there is an understanding of death as separation and immobility. The child is likely to be afraid of being abandoned by surviving caregivers. Pre-school children are egocentric and believe that what they wish comes true and that their actions cause things to happen. They can believe that somehow they caused harm to the person because of their misbehaviour or 'bad' thoughts. They often associate death with concurrent events and places such as being in hospital. They may regress to behaviours of thumb sucking, bed wetting, infantile

speech, wanting a bottle, and being very clingy and needing lots of comforting (Grollman, 1995; Lendrum and Syme, 1992; Judd, 1989; Reidy, 1995).

*Ages 7 – 11 (Concrete reasoning):*

Children become conscious of their own subjectivity at this stage. Children now begin to understand death as permanent, irreversible and personal. Children at this age are interested in death, how it will affect their lives, what happens to the body and may express concerns about their own death. Children at this age seek reasons for death and tend to understand concrete explanations for death, such as accidents and illness. Grief may manifest in problems in school, aggression to others, nightmares and complaints of aches and pains. They grieve as older children do, often going through periods of denial, anger, grief and apathy; these emotions present in short bursts. Children at this stage tend to be very superstitious about death (Grollman, 1995; Lendrum and Syme, 1992; Reidy, 1995).

*Adolescence (Abstract thinking):*

Adolescents have a full and realistic understanding of death and understand that death is universal and permanent. However, it is a remote experience compared to the usual adolescent tasks of self-discovery. They often have a pervasive fear of and curiosity about death and should be allowed to put forward their views about what happens after death. They tend to be egocentric at this stage and feel a lot of self-pity. Although intellectually they understand, they may lack the emotional maturity to deal with such loss. Many adolescents are parents and/or HIV positive themselves (Grollman, 1995; Lendrum and Syme, 1992; Reidy, 1995).

Children's progressive understanding of death is not simply linear or cumulative but is dependent on experiences and emotional factors. Children in politically unstable environments typically acquire an advanced concept of death (Reidy, 1995). The greater a child's exposure to death, the more likely a child is to understand death as finite, irreversible and universal.

## **2.5. Brief discussion of residential care**

As the ability of communities to care for children orphaned by AIDS is stretched to capacity, many children are cared for within residential care systems. The children in this study reside in Childrens' Homes. Residential care is subject to considerable variation and serves children with a variety of special needs: orphans, delinquency, learning difficulties and children removed from parents (Ainsworth and Fulcher, 1981). The Permanent Planning movement in residential care, recognises that children need a stable, continuous, nurturing, mutual relationship in order to develop physically, emotionally, socially, intellectually and morally (Hess, 1982, in Maluccio, Fein, and Olmstead, 1986). This is discussed in the following section, 2.6.1.

Outlining the effects of institutional living is a difficult task. Any difficulties a child in residential care presents, could have resulted from rejecting and neglectful experiences prior to placement in residential care, the trauma of separation from parents, constitutional differences, or from the effects of childrens' homes conditions (Wolkind and Rutter, 1973). Some of the common variables influencing the development of problems in residential care, may be summarised as follows (Wolkind and Rutter, 1973):

- Complications in pregnancy and birth
- Poor attachment opportunities
- Maternal deprivation due to:
  - Institutionalisation
  - Separation from mother or mother substitute
  - Multiple mothering
  - Distortions in the quality of parenting, e.g. rejection and overprotection
  - Pathogenic child-rearing practices, i.e. Abuse and neglect, and defective role modelling and socialisation
- Socio-economic and cultural disadvantage
- Traumatic events

Longitudinal studies have established that not all children who experience institutional care will manifest with maladaptive behaviour (Yarrow, 1969, in Riess, 1972). Risk and protective factors (as discussed below) influence a child's response to adversity and institutional care.

## **2.6. Attachment, Risk and Resilience**

The concepts of risk and resilience have been recognised as a useful theoretical framework within which to approach intervention with children affected by HIV/AIDS (Madorin, 1999, Grotberg, 1995). These basic theoretical concepts of attachment, risk and resilience will be briefly explored.

### **2.6.1. Attachment theory:**

Bowlby's theory of attachment (1980) was developed as a reaction to the belief that children merely needed their physical needs taken care of. Bowlby (1969) asserts that mother love is as important as physical care.

Attachment theory aims to explain the tendency to form strong affectional bonds with significant others, and the emotional distress and personality disturbances such as anxiety, anger, depression and emotional detachment, which accompany unwilling separation and loss of attachment bonds. Attachment behaviour, defined as any behaviour that seeks to attain or retain proximity to a significant other, is a well-documented phenomenon (Ainsworth and Fulcher, 1981; Bowlby, 1980; Bretherton, 1985). A child seeks attachment when under stress, frightened, fatigued or sick. The attachment figure provides protection, help and soothing.

Bowlby's theory (1969, 1973 and 1979) stated that patterns in developmental attachment relationships, influenced attachment behaviour later in life. A secure attachment between mother and child develops a sense of trust and ability to develop other secure attachments. Attachment is a continuous process and sets the stage for healthy social interaction and relationships (Bretherton, 1985).

Certain characteristics are usually described as necessary for adequate “good enough” (Winnicott, 1971) parenting leading to healthy attachment. Rutter (1981) states that a loving relationship, which is consistent and provides adequate stimulation, and responsiveness to a child’s needs for nurturance, leads to secure attachment. Attachment bonds do not necessarily have to be the bond just between a mother and child. Attachment bonds can also be formed with a child’s father or other consistent caregivers depending on the circumstances. He also states that there are additional aspects necessary for ‘good enough’ parenting, such as discipline, protection, models of behaviour, play and conversation. It is recognised that for bonds to occur they need parental responsiveness, time to develop, and there needs to be a level of intensity in the interaction. For example, a mother who is sensitive to a child’s needs, plays with a child and gives the child a lot of attention, will develop a stronger bond than a child who is just routinely cared for. An unbroken relationship does not imply that healthy separation at the right time, such as going to school, is detrimental. If a child, due to secure attachment, feels safe, she is able to explore and move away from the attachment figure temporarily, with the knowledge that she can return if experiencing stress (Rutter, 1981).

#### 2.6.2. Risk factors and resilience:

Maternal deprivation, premature loss of attachment figures, inappropriate mothering or insecure attachment, and bereavement are believed to put the child at risk for developing conditions such as depression, delinquency and difficulties in attachment (Raphael and Dobson, 2000; Rutter, 1981). Madorin (1999) states that bereaved children are at greater risk to be withdrawn, anxious, have lower self-esteem and experience learning difficulties. However, this does not mean that all bereaved children will demonstrate these difficulties. Risk factors point to the probability of some distress. Exposure to one risk factor will not necessarily be detrimental to a child’s psychological development. However, the greater the amount of risk factors a child is exposed to, the greater is the chance of a child demonstrating some emotional, behavioural or developmental difficulties. Some potential risk factors include:

- Death of parent(s)
- Bereavement
- Separation from siblings
- Poverty
- Abandonment and homelessness
- Parents' loss of employment, and of income
- Parental illness, sick relatives and having to care for them
- Own illness
- Violence

Children suffer in many adverse situations such as poverty, abuse, illness, natural disasters, war and bereavement. However, research has shown that certain children are able to assimilate and deal with these adversities better than others are (Grotberg, 1995). This is known as resilience – “A universal capacity, which allows a person, group, or community to prevent, minimise or overcome the damaging effects of adversity” (Grotberg, 1995, p.7). The consequences of a certain risk are mediated by the presence of individual protective or vulnerability factors dependent on each individual child.

Research has been done to ascertain what factors contribute to building resilience in children. Resilience increases a child's capacity to cope with adverse circumstances. The table below lists possible external and internal protective factors that can contribute to building resilience.

**Table 2: External and Internal Protective factors (Grotberg, 1995; Madorin, 1999; Rutter, 1981):**

<b>EXTERNAL PROTECTIVE FACTORS</b>	<b>INTERNAL PROTECTIVE FACTORS</b>
The availability of external support systems and emotionally safe relationships outside the family (such as school, church, peer group, extended family)	Personality features such as good self esteem, positive self-concept and sense of autonomy.
A secure relationship with an attachment figure/ A caring adult/ A stable emotional relationship.	Being a good oral communicator
Family cohesion, warmth and absence of discord	Having good peer group relationships and positive social orientation and responsiveness.
Food and shelter	Genetic make up.
Safety and security, order and routines.	Good physical health
Access to education and school achievement	Being able to cope with age appropriate developmental tasks, cognitive competence.
Being able to play, have peers, recreation and access to cultural activities.	A sense of being loveable, a positive temperament.
Continuity of values, language, culture and religion.	Older children, if they had secure experiences in early childhood.
Presence of positive role models	Belief in God and morality

In a longitudinal investigation of inner-city families affected by HIV, researchers (The Family Health Project, 1998) hypothesised that HIV infection introduced a new multitude of stressors to families already operating in high-risk conditions, and would increase the risk for psychosocial maladjustment in school-age children. They found that children

whose mothers were HIV positive had more externalising and internalising problems as well as less social and cognitive competence. A follow-up study investigated the family factors that promote resilience despite exposure to stressors of HIV. A positive parent-child relationship emerged as the only significant predictor of child resiliency (Dutra, et al., 2000). The presence of a warm, responsive adult care giver, and an enduring relationship with a family member, as well as the benefits of structure and supervision, during and after major stressors, were recognised as contributing to resilience. High levels of structure in the home and parental monitoring increased the likelihood of resiliency. Masten and Catsworth (1998, in Dutra, Forehand, Armistead, Brody, Morse, Simon Morse, and Clark, 2000, p.483) summarised this as “the attachment relationship between caregiver and child is fundamental to human adaptation and development”.

In interventions with children, we need to consider all the ways in which we can promote resilience. Children need more than just food and shelter; they also need love and trust, relationships that foster friendships and self-confidence. In working to promote resilience we should use language which affirms what children have, can do and are in a positive way, even if those things are limited (Grotberg, 1995). Children also need to have some way of understanding, expressing and assimilating trauma. With some intervention to facilitate coping, children can be remarkably resilient (Grollman 1995, Lendrum and Syme, 1992; Madorin, 1999).

Play combined with interpretation within a trusting relationship, has been identified as an important way in which we can enhance resilience in children. This gives a child an opportunity to express her feelings and experiences and to have these feelings accepted.

A description of why play is used in this research follows, including why children play, theoretical perspectives in play and play as a therapeutic and diagnostic tool.

## **CHAPTER THREE**

### **REVIEW OF LITERATURE: THE MEDIUM OF PLAY**

#### **3.1. Introduction**

Consideration about the usefulness of play is often surprising in terms of notions of play as being either fun, a rest from work or time wasting. Smith (1986) argues that as mammalian play uses up energy and can potentially put the young in danger, it must have other advantages. He proposes that play enhances physical development, enables the animal to practice skills such as hunting and fighting, and enhances both social bonding and role learning. This chapter will explore the literature on the purpose and usefulness of play for child development and as a therapeutic medium. Some theoretical positions about play are described and some of the research evaluating the effectiveness of play as a medium of intervention is described. Finally, the specific technique adopted in this research is explored.

#### **3.2. Definitions of play**

Play is a word that we are all familiar with, but is difficult to define. What passes as play, can be games played by rules, fantasy, repetitive physical activity and /or playing with objects. Play also differs according to age, developmental stage, context and cultural expectations. Smith, Takhvar, Gore and Vollstedt (1986) say that play does not develop in a linear sequence, but that aspects of the following overlapping criteria are useful in defining play. The more of the various overlapping criteria that are present, the more confidently we can describe an activity as play. Smith *et al.* (1986) define play according to five criteria:

1. **Intrinsic motivation:** Play behaviour is engaged in for its own sake, and not because of some bodily need or social demand. "Play is internally controlled, motivated and rewarded" (Weininger, 1989, p.157).

2. **Positive affect:** Play is enjoyable to the child. Play is usually internally controlled, takes time and is intrinsically gratifying (McMahon, 1992).
3. **Nonliteral:** Play behaviour has an 'as-if' or pretend quality.
4. **Means and ends:** A child tends to be more interested in the playing process than in the outcome of the behaviour. The participant is actively engaged (in contrast to daydreaming or idling).
5. **Flexibility:** Play shows some variation in its form and content.

The literature on play and play therapy, demonstrates commonalities in considerations of the purpose of play and its intrinsic value as well as its value as a therapeutic medium.

### 3.3. Why use play?

#### 3.3.1. Play as natural medium of expression:

Play is generally agreed to be a child's natural mode of expression (Axline, 1964). 'Playing out' situations is seen to be a way of thinking, a process of mental digestion for a child (Winnicott, 1971, Reade *et al.*, 1999). As a child's verbal capacity is developing; play is the language through which a child communicates. Communication through play and images enables the child to express feelings, thoughts and memories which "defied words but continue to crave recognition" (Robbins, 1980, in Schaefer and O'Connor, 1983, p. 238). Due to its symbolic nature, play lends itself to expression of preverbal, primary emotions that are difficult to express in words (see play as metaphor). Play is a safe way in which a child can express emotional states and physical sensations, be they positive or negative, without judgement. For example, a child's aggressive feelings often involve a desire to hurt someone, which can be expressed in play without causing pain (Winnicott, 1964).

Play is a useful therapeutic and assessment medium in that it establishes a common language that facilitates interaction that is non-threatening and promotes establishing rapport between therapist and child. A roomful of toys goes a long way to reducing the child's initial anxiety (Oaklander, 1988; Winnicott, 1964).

### 3.3.2. Assimilation of knowledge and making sense of the world through enactment of experience:

Play is one of the most significant ways in which a child learns and makes sense of the world (Singer and Singer, 1990). As soon as a child begins to move around, she encounters the material world and she begins to discover how it works, by testing her experience of reality through play. If the environment is relatively consistent, the child will be able to establish differentiated schemata and scripts. For example, through repetitive games such as peek-a-boo, children grasp what Piaget (1962, in Singer and Singer, 1990) called 'object permanence'. As objects fade from view and memory, and then return, a child is able to establish the constancy of objects and is slowly able to assimilate and integrate them into limited but organised mental schemata. A child therefore begins to interweave new experiences and reactions into existing schemata. These schemata help one to anticipate and understand new experiences (Lowenfeld, 1935).

Play operates as a proximal zone of development, in which the unknown becomes known. Through rehearsal, modelling and repeating stories, sensory experiences and scripts, a child works to understand the external world. Children re-enact ordinary experiences such as eating, sleeping, toilet training as well as more stressful experiences such as being sick, going to school, parental discipline and playing out strong emotions. It is therefore common for a child to be fascinated by urinating and defecating and engage in excretory play. This provides an outlet for this emotionally charged concept. If expression is hindered and play is controlled or prohibited, it may result in a suspension in development as these experiences are not assimilated. By re-enacting events, often in symbolic form, and acting out feelings, a child can gain a sense of mastery over what happens in the outside world (Lowenfeld, 1935; Lowenfeld, 1969; McMahan, 1992; Oaklander, 1988; Ryce-Menuhin, 1992; Weininger, 1989; Winnicott, 1964).

Play is a way for a child to develop her capacity to move her own body and work out her physical capabilities. This is called mastery or practice play (Piaget, 1969, in Smith, 1986). For example, if a child repeatedly jumps across a stream, this helps the child to perfect perception of distance, jumping and landing skills, and balance.

Play is a natural medium for continual learning in which a child assimilates an understanding of the world and practices having control in it (Herbert, 1984; McMahon, 1992; Weininger, 1989). Play also enhances social bonding and role learning. It is a way for the child to try out “new ways of being”, to develop her personality by trying various roles, and rehearsing narratives and experiences (Oaklander, 1988, p.160; Winnicott, 1964). The child develops the ability to think in terms of self and other, to guess the thoughts of others and to formulate meta-representations (Singer and Singer, 1990).

### 3.3.3. Play as oriented towards growth:

An assumption shared by psychoanalytic play theory and humanistic philosophy is that play is intrinsically therapeutic. Reade, Hunter and McMillan (1999) say that an important assumption in play therapy is the belief that a child largely instigates her own therapeutic change. Play in itself promotes resilience and health. “Play belongs to health: playing facilitates growth and therefore health, playing leads to group relationships...” (Winnicott, 1971, p. 41).

The theoretical underpinnings of Axline’s (Axline, 1989; Herbert, 1984 and McMahon, 1992) approach are based on the belief that the primary motivation in human experience is the drive to maintain and enhance growth towards self-actualisation. However, this growth may be inhibited by experiences that force the individual to deny feelings and emotions. A toxic environment or disruption in a child’s environment may apprehend the process of growth and result in pathology. The goal of therapy is therefore to restore the process of self-growth and self-awareness, by ensuring an optimal environment in which a child can express feelings and resolve conflicts through the medium and parameters of play therapy.

#### 3.3.4. Play as catharsis:

By playing out negative situations and experiences, a child is given the opportunity to 'ventilate' those feelings which she suppressed, repressed or projected (Herbert, 1984). Play can provide a catharsis or abreaction for the outlet of physical and psychological tension and help in letting go of some of the emotional charge attached to an event. The child is given the opportunity to express difficult emotions in a safe and supportive manner. It is easier to express hostility through having animals fight or burying a representative figure than by verbalising it. She can enact possible outcomes and alter their ways of perceiving negative experiences, for example no longer blaming herself for her parents' divorce.

Levy (1976) developed what he called 'Release Therapy', in an attempt to help children who had experienced a specific traumatic event. Instead of non-directive play, Levy structured play by selecting a few toys which he felt would facilitate a child's 'working out' particular problems or for re-enactment of a traumatic event. The principle is to recreate a difficult or pathogenic situation in play so that the child can act out and release pent-up anxiety and aggression and gain mastery over the event in which she was originally helpless.

#### 3.3.5. Containment and potential space:

It is generally recognised that sufficient containment is necessary to support the child through therapy (Bion, 1962, in Reade *et al.*, 1999). If a child is worried about day to day survival, emotional exploration through play is minimised. Winnicott (1964) believed that when anxiety became too high for a child to bear, she would be unable to engage in play. Both humanistic and psychoanalytic perspectives therefore see the role of the therapist as providing an environment in which it is safe to express anxiety-provoking material. The therapist must be able to withstand and contain the feelings and behaviours expressed within the therapeutic environment (Bion, 1962, in Reade *et al.*, 1999).

Play was defined by Bateson (1979) not as the activity it describes, but rather the 'frame' for the activities. The participants use meta-communications to announce that play is happening. He studied the phenomenon of play between different mammalian species and found that they gave signals that denoted activities as play. For example: A dog's playful nip denotes a bite, but does not signal what would be meant by a 'real' bite. A child and adult engaging in play make an indication that it is play, setting up different expectations to ordinary interactions. Some examples of these meta-communications are: statements that tell of the orientation of self and others towards activities ("You look after the baby and I'm going to work."); or statements that indicate the non-literality of objects, identities and situations ("The pipe is my gun", "You be the mother", "Now we're at a restaurant").

Winnicott (1971) called the 'space' in which play happens, 'potential space'. He said that play begins with the infant's first use of a 'transitional object'. A transitional object, such as a teddy bear, is used to represent the mother, but does not substitute her. The transitional object is an illusion of mother. It is not the external physical mother, and is not an internal image of mother either. It is a metaphor for mother. The object stands for the breast, but is not the breast and yet it is real and comforting. It is the first 'not-me' possession, and indicates a growing awareness that mother is separate from the self. The mother respects this by not removing the transitional object and by recognising its importance. The potential space is therefore a space in which a child can begin to represent objects and internal emotional experiences in an external world, but without it having to be an interaction with the external world. In this potential space a child can explore and have control over what happens, unconcerned by fear of failure, and without her play being challenged. A child can express anger and anxiety, and she can try out different roles and self scripts and ways of categorising things without her integrity being questioned (McMahon, 1992). The paradox is that although the activity is play, 'pretend', it engages the participant's real affect. Children use objects from the real world to express some aspect of their inner world. This is only possible however, if the child feels that the space is safe and contained (Winnicott, 1971). According to Klein (1976) the transference relationship could only be established, if the analysis was separated from ordinary home life. The child needed the special space in which to overcome resistances to expressing

feelings and thoughts that she feels she should not feel. An important role for the therapist is therefore to provide this contained, safe space.

#### 3.3.6. Play as metaphor (The 'as-if' quality of play):

Because of the containment of potential space, play can include all three levels of the psyche - the real, the symbolic and the imaginary. A child can make believe, allow fantasy and reality to intertwine and allow fantasy to take on the dimensions of reality when playing.

As children develop, so they are able to distort reality, manipulate narratives and use objects, and later ideas, metaphorically or symbolically (such as using a banana to represent a telephone). Pretend play draws a child into working out narratives for herself. Imaginative play is therefore seen to be adaptive, self-healing, competence building and schema expanding. Children develop a sense of being able to cope with real events through manipulating events in a symbolic and miniature, not-so-serious form (Singer and Singer, 1990). Play offers children the tools of representation with which to weave together knowledge and emotion at a representational level, within an environment of safe and benign holding (Slade and Wolf, 1994). Play offers a space for surplus reality, where representation and testing of action can occur and unconscious content can be integrated and transformed (Feldhendler, 1994).

Klein (1976) developed a psychoanalytic play technique, guided by the principles of psychoanalysis (the exploration of the unconscious and the analysis of the transference relationship). The basic principle was to understand and interpret the fantasies, feelings and anxieties that a child expressed through play. She understood all of a child's play, words and actions symbolically. She believed that a child was able to understand that the toys were symbols. She consistently made interpretations, which reflected the psychosexual implications of the play, and were expressed in the language of unconscious desires and transference configurations (McMahon, 1992; Schaefer, 1986 and Singer and Singer, 1990).

According to Lowenfeld, Traill and Rowles (1964) the 'non-verbal thinking' of children starts at the beginning of life and remains at the core of the psyche. Children cannot manipulate language or use words to think until the age of about seven or eight. Yet, a child's life is filled with vivid impressions and emotional experience. These early concepts formed by the infant or young child about herself and the world are powerful and can be incorrect and disturbing. They need expression and understanding. Lowenfeld (1935) believed that children grouped experiences by the quality of the emotional experience associated with it. These clusters are not usually experienced in linear logical form. It is seen to be very difficult to express these pre-verbal emotions and non-verbal problems adequately in words and so the necessity for metaphor, as in the use of representational play, art work, or metaphor in language. She therefore developed the 'world technique' to afford an expression of this pre-verbal experience. (See section '3.6.1. *The development of the Sceno*' below).

### 3.3.7. Play aspects of the dialogical self

Hermans and Kempen (1993) advance the concept of the 'dialogical self'. They propose the self is fundamentally interpersonal in nature. The dialogical self is formed out of the construction and reconstruction of self-narratives in encounters with multiple others. We are an 'I' or 'me' in relation to others. The notion of the social self is a composite of 'characters' or roles that we present in response to context and in reciprocation to the roles of others. The individual perceives of the self from a standpoint in relation to others and is reflexive; the self can be both subject and object. As children develop, they are able to play the roles of certain characters, but also to reverse the roles, e.g. "I am the doctor, you are the child" and then "I am the child, you are the doctor" (Hermans and Kempen, 1993, p.69). A child can address herself as a parent or doctor, therefore representing being another to the self, and assimilating various 'I' positions, in their mutuality. Children learn to take the attitude of particular others towards themselves. "The child says something in one character and responds in another character..." (Mead, 1934, cited in Hermans and Kempen, 1993, p103). In this way play, 'served a function of self revelation' (Winnicott, 1964). Mead (1934, in Hermans and Kempen, 1993) suggests the game stage is required

to develop a sense of a 'whole self'. In a game, a child must assimilate her role as well as the roles of others, as part of a patterned whole, in anticipating action.

The concept of dialogical self shares aspects with Object Relations Theory. The multiple voices in self-narrative has parallels with self- and other- representations of the object relations theorists, which influence the enactment of self in the here and now. It also acknowledges the social and cultural voices that the 'I' can adopt.

### **3.4. Theoretical perspectives of play**

Most of the theoretical perspectives have similar goals for play therapy: the healing of emotional and behavioural difficulties, acknowledgement of a child's feelings and a process of discovering or revealing the meaning of a child's distress. However, the different theoretical perspectives differ in their focus on the role of play in therapy, the extent to which play is used, and the role of the therapist in the therapeutic relationship and in interpreting the play. There are differences within perspectives and between different practitioners too.

#### **3.4.1. Psychoanalytic and object relations therapy:**

Psychoanalytic approaches to play are characterised by the therapist interpreting the unconscious content of the play and interpreting the transference relationships between therapist and child (Schaefer, 1986). Melanie Klein (1976) interpreted the symbolic meaning of a child's play. Her work was based on the belief that a child's relationship to internal objects is reflected in all activities and that the past object relationships that structure her internal world are lived out in the relationship with the analyst. The role of analyst is to point out these transferences in understandable language. Toys can represent special objects in the external world, therefore Klein (1976) kept each child's toys in a separate box. She made many interpretations, which reflected the psychosexual fantasies and anxieties that a child expressed and what the play 'said' about transference configurations. She did not attempt to educate or provide moral guidance to the child. Klein viewed severe inhibition in the capacity to use symbols and fantasy as indicative of

severe disturbance in the child's relation to the external world (McMahon, 1992; Schaefer, 1986 and Singer and Singer, 1990).

The critique of the psychoanalytic approach is that it relies on a complex understanding of theory and on clever interpretation by the therapist. The therapeutic relationship is only regarded as important as a vehicle for making interpretations based on transferences.

Winnicott (1971) described play as beginning with the infant's first use of a 'transitional object', as described above. This is the start of a child being able to use toys to represent inner aspects of herself. Play and creative experience take place in a non-purposive state, in which the child is absorbed in the activity, a formless succession of ideas that is not structured by external demands. In this unintegrated state of the personality, self-exploration takes place and through reflection parts of the self can be recognised and integrated into the organised personality. Winnicott (1971) agreed with Axline (1964) that the significant learning was at the moment when the child surprises himself or herself, realising the figures stand for persons in her real life. Winnicott (1971) felt that interpretation before readiness tends to produce compliance to the therapist's way of thinking rather than spontaneous expression. He therefore makes a plea to therapists to afford the opportunity for formless experience and play, and allowing the child to discover meaning for herself. Intrusion by the therapist is therefore subtle and limited, but gives direction and encourages self-exploration (Singer and Singer, 1990).

Heinz Kohut (1984, in Singer and Singer, 1990) proposed that in play therapy the psychotherapist becomes a new 'object' for the child to internalize. The therapist's warmth and accepting nature as well as promotion of self-exploration becomes part of the child's ways of thinking about herself, so that she develops self acceptance and awareness. The child projects her early object relationships onto the therapist and reacts to the therapist as if he contains all these feelings. The role of the therapist is to contain these projections and strong feelings and to feed back through easy interpretations, which help the child to clarify her thoughts so that the child is eventually able to own the projections as her own (Weininger, 1989).

#### 3.4.2. Child-centred non-directive play therapy:

Humanistic approaches shifted the emphasis of interpreting play therapy in terms of psycho-sexuality to the importance of the struggle between expressing one's individuality and autonomy while still maintaining intimacy with another. Client centred non-directive therapy places its emphasis on the potential for self-healing by providing an environment in which a child feels accepted by a warm and attentive, but non-intrusive adult. The goal of therapy is therefore to restore the process of self-growth and self-awareness by ensuring an optimal environment in which a child can express feelings and resolve conflicts through the medium and parameters of play therapy.

The therapist's role is to empathically understand and reflect the child's experiences in play, and to help a child to recognise feelings that she is unaware of or unable to express. The therapist keeps an eye open for what the child is avoiding and subtly makes this available for the child (McMahon, 1992). The individual is believed to possess insight and an impulse towards growth and maturity which, ultimately, leads the individual child to 'play out' her feelings and move towards solving her own problems. Emphasis is placed on the natural unfolding of play, and reflection focuses on the thematic content and directly observable behaviour of play. Intrusion by the therapist is subtle and limited, but gives direction (Singer and Singer, 1990).

This approach can be used with clients from any developmental level. A greater understanding of the child's life history is needed than in a psychoanalytic approach. Reflections are not as complicated as the interpretations of the psychoanalytic school. The effectiveness of the therapy hinges on the therapist's ability to provide an empathic relationship through which the child can learn more about herself. The therapeutic process is, however, time consuming and unfocussed.

#### 3.4.3. Structured or focussed play techniques:

As described earlier, instead of non-directive play, Levy (1976) structured play by selecting a few toys which he felt would facilitate a child's 'working out' particular

problems or for re-enactment of a traumatic event. The interpretive function of the therapist is reduced. In focussed therapy work, the role of the therapist is not so much to make interpretations about unconscious content, but to respond to a child's communication efforts and to reflect what the child is 'doing'. The child is asked to say what it is the dolls are thinking and feeling. Sometimes the therapist would play with or for the child, to facilitate the release of pent-up emotions. The child may also be asked to repeat or exaggerate certain actions. The child can be asked to speak as a person, animal, or thing. It is a means of emotional purging or ventilation, which releases pent-up fears, conflicts and anxieties (Levy, 1976; Oaklander, 1988).

The advantage of structured play is the specificity of the treatment and the economical use of time. This approach is effective in dealing with specific traumatic events, but does not attempt to change a child's internal psychic structures.

#### 3.4.4. A Narrative perspective:

Narrative therapy is based on the assumption that our humanness is expressed through articulation, communication and language. Stories are an important part of human interaction. People tell stories to entertain, to make sense of experience, to transfer information, to influence people and to celebrate events. "Our lives are embedded in stories" (Avis, Pauw and van der Spuy, 1999, p.172). White (1995) says for an individual to know her thoughts she needs to verbalise or express them. A child does this through play, which acts as a 'symbolic language' to express her experiences and externalise thoughts for which she may not yet have the verbal development and skills.

Narratives have a reciprocal nature. On the one hand, our experiences shape our narratives. What happens to us influences what stories we tell. However, our narratives also shape our experiences. It is not possible to incorporate all our perceptions and experiences into our narratives. Through a process of interpretation and selection, certain experiences become more dominant in our narratives. These more dominant narratives influence our self-perception and our self-narratives. They are constitutive in that the

stories a person tells about herself, influence the decisions and actions she will take and her reactions to events (Avis, Pauw and van der Spuy, 1999).

Our narratives also help us to make sense of experiences and give meaning to them by providing an interpretive structure to the events we experience. For this reason, it is important for people who have suffered a bereavement or traumatic event to tell their story to someone who listens and acknowledges the story as valid. Self-narratives help a person to gain a sense of control over an event.

Play is a child's narrative. From early childhood we listen to stories, enact them in play and eventually tell ourselves stories in private or public. Through pretend play a child repeats narratives, takes on various roles and explores different self-representations. Through play, a child also gives expression or enactment to experiences. These scripts help organise and structure her experiences. Imaginative play provides a child with the opportunity of broadening these scripts, and gaining a sense of control over them. Incongruous events are assimilated and become less strange, and anxiety is reduced. We order and reorder our life experiences through stories. We give disconnected moments of experience an ongoing form and meaning. Narrative enables the basic assumptions about our identity. Children represent self by projecting a relevant personal theme onto the microcosm of a play table. For a child to understand with feeling, she must be able to construct the human drama within and then to interact with the blocks and toys as well as with people in the environment (Coleman, 1999).

In play therapy, therapist and child are co-authors of the meaning of stories or narratives. By being willing to share in the discovery of meaning, a therapist gives coherence and recognition to the child's experiences, and helps the child to build cognitive structures and narrative strategies around their experience. Children therefore are able to express their dilemmas and feelings by creating toy worlds that are under their control, and gradually re-script their own, now more positive, narratives.

Byng-Hall (1997) did research into the importance of having coherent narratives about illness and loss. As is described in the previous chapter, if childrens' questions around illness and death are left unanswered, they tend to develop narratives of their own. These narratives usually stem out of fear and anxiety and can involve destructive magical thinking processes (Fogarty, 2000). "Not telling the full story...can remove the coherence of the story leaving dreadful implications to fill the gap" (Byng-Hall, 1997, p.104). An important therapeutic implication from the research of Byng-Hall (1997) is that it can be healing and transforming to help a family tell a coherent story about its painful experiences, including its illnesses and losses.

In discussing narrative therapy, it is important to acknowledge that narratives are not value free. We interpret our experience within certain frames of intelligibility and according to different contextual meanings. Our interpretation is influenced by culture, previous experience and embedded within a community of shared narratives. What narratives we tell are dependent on the culture of the time, place and environment (Avis, Pauw and van der Spuy, 1999; White, 1995).

Our self-narratives are dynamic. They change with our constant reinterpreting of events. Narrative therapy assists the individual in telling more internally consistent (coherent) narratives, in re-scripting inhibiting narratives within new frames of intelligibility, and in listening for alternative narratives to a negative self-narrative. These narratives ultimately define our social identity, so by re-scripting narratives it may be possible to enable a person to have different experiences or greater resilience within compromising situations. Different people will experience the same event in different ways. The stories we tell have an interpretive, subjective quality to them that influences our experience of an event and our future perception of other events.

### **3.5. Play as diagnosis and assessment tool**

Play can be a useful assessment tool. However, there are no accurate assessment criteria, due to the need for subjective interpretation of play. It is understood that as an expression

of behaviours within a specific context, play can be useful for gaining insight into a child's world and the issues she is dealing with. Observing a child playing can give us clues as to a child's maturity, intelligence, imagination, cognitive organisation, reality orientation, attention span and contact skills. Play can give a therapist a window into a child's perception of her experiences, which can assist the therapist in making diagnostic hypotheses, which can guide the therapy process (Oaklander, 1988).

Play is also useful in that it provides a means of assessment in the child's natural mode of operation. Play is valuable as an assessment technique for infants, as their inability to respond to language based testing requires alternative means of assessment. Play is therefore useful as a complementary source of information to parent interviews.

### **3.6. Play research**

#### **3.6.1 Brief overview of play research:**

Eysenck (1952, in Casey and Berman, 1985) challenged therapists to prove the worth of their methods. Levitt's work (1957) was prominent in initial reviews of psychotherapy with children. In working with neurotic children, he found that the evidence did not demonstrate the effectiveness of therapy. However, since then several authors have challenged the way outcomes are quantified (Casey and Berman, 1985). "Some psychological theories, such as those of Piaget and Freud, suggest that the developmental differences between children and adults might contribute to differential patterns of treatment outcomes" (Casey and Berman, 1985, p. 388).

Given that, many authors recognise that special methods are required for working with children, as their verbal capacity to express their difficulties is still developing, the same difficulty arises in assessing what benefits have occurred in therapeutic work. How does one measure an outcome? Does one use self-reports, reports from other observers such as teachers or parents? Does one use projective measures, or IQ tests? The therapeutic benefits may also be seen in one area of a child's life or be global. Which outcome does one focus on? Children may also have difficulty with introspection in terms of their

development (Casey and Berman, 1985). Research into the effectiveness of therapy with children is therefore rather complicated.

Casey and Berman (1985) reviewed 75 studies in which children who received psychotherapy were compared with controls. Aggregated results demonstrated that treated children achieved outcomes about two-thirds of a standard deviation better than untreated children. No differences were found to result from treatment characteristics such as the use of play in therapy either individually or in groups. Positive effects were observed across all forms of therapy. Therefore therapy with children is deemed to be effective.

Ray and Bratton (1999) summarised play research from 1942 until, as set out in the table below. However, in reviewing the table it should be noted that only the most significant results were recorded. Categorisation into the various research issues is also difficult as studies often explored crossover issues. The researchers selected for categories, on the basis of what they deemed to be the primary research issue.

**Table 3: Summary of play research conducted between 1942 and 1999 (Ray and Bratton, 1999).**

<b>RESEARCH ISSUES</b>	<b>SUMMARY OF SIGNIFICANCE MEASURED</b>
Social Maladjustment	12 of 14 studies measured some change, such as improvement in behaviour at school, at home and in play therapy; increased willingness to try new tasks, improvement in Children's Self-Social Constructs Tests, increase in positive emotionality, concentration and social interaction.
Conduct disorder/ Aggression/ Oppositional	8 of 8 studies noted decrease in aggression or increased co-operation and emotional expression; and decrease in parental punitive discipline.
School Behaviour	6 of 8 studies noted decrease in behavioural disturbances, 1 increase in social maturity.
Emotional Maladjustment	Out of 9 studies, 3 showed increased reading ability and 1 increased IQ (the rationale behind this is that a child freed from emotional constraint could express his/her capacities more adequately), 2 had low success, 4 showed improved personality adjustment (E.g. Rogers Test of Personality Adjustment)
Physical/learning Disability	8 of 8 studies showed improvement in some area such as improving fine motor and gross motor co-ordination and sensory integrative skills. Therapeutic intervention may provide the child with attention and deal with emotional barriers to learning.
Intelligence	10 studies – 3 increased IQ, 3 increased on other related measures, 4 found no significant changes
Anxiety/Fear	9 studies- 7 of 9 studies showed decrease in anxiety
Self-concept	9 studies: 8 of 9 studies showed significant improvement. 3 of 9 showed significant decrease in control group
Mentally Challenged/ Developmental delay	8 of 8 studies showed improvement in some area. Several measured beneficial effects on verbal scales, and most showed improvement in the ability to complete developmental tasks (Denver Developmental Screening test) and in positive behaviour, co-operation and constructive behaviour.

This table indicates that play is a significantly useful area of research for therapy and diagnostic use.

### 3.6.2. Brief description of play research related to illness and anxiety.

In reviewing play research, some research related to this study has been described below.

In research with chronically ill children, Singer and Singer (1990) found they responded well to imaginative play opportunities and while the therapy continued, showed greater liveliness, more positive emotionality, and developed more creative thought and improvements in perspective taking.

Weininger (1979, in Judd, 1995) studied the way 60 children played with dolls that were described to the children as being seriously ill or dead. His findings confirmed that children's conceptual understanding of death increased with age, but also that their play sometimes indicated a more developed understanding than did their verbal answers. Play therefore seems to be a valuable medium through which to explore children's experience of being HIV positive as well as being a useful intervention strategy.

Clatsworthy (1981) worked with 114 children between the ages of 5 and 12, and found that children who received daily individual self directed play therapy during hospitalisation, exhibited significantly less anxiety than control group as measured by Missouri Children's Picture Series.

61 hospitalised children, aged 5 – 10, receiving two non-directive child-centred play therapy sessions showed significant reduction in hospital fears as measured by Fear thermometer (Rae *et al.*, 1989, in Ray and Bratton, 1999). The play therapy treatment group was compared to a verbally oriented support group, diversionary play, and a control group. In these other groups no reduction of fear was evident (Rae *et al.*, 1989, in Ray and Bratton, 1999).

### **3.7. von Staab's Sceno Test**

Gerhild von Staabs (1971) initially developed the Sceno Test for diagnostic purposes and for understanding the psychological background of emotional disturbances in children and

adolescents. His particular interest was in understanding intrapsychic and unconscious elements of a child's emotional life. von Staabs developed the Sceno as a way to gain a "concrete and quick look at a patient's unconscious problems and conflicts" (1971, p.1). The Sceno Test consists of a box and lid, human figures, animals, trees, furniture and other 'world' toys and coloured blocks. The scenes (hence the name) depicted give the therapist a view of how a child reacts to her environment, consciously and unconsciously. Therefore, it provides information about a child's emotional difficulties and how they relate to the child's context. Von Staabs (1971) believed that therapeutically the Sceno activated affect and repressed drives and allowed the child to display them in a miniature world.

#### 3.7.1. The development of the Sceno Test:

The Sceno Test evolved out of Lowenfeld's 'World Play Test' (1935). Margaret Lowenfeld (1935) developed a play technique that used a sand tray in conjunction with 'world' material, which are objects representative of real life - figures, cars, trees, animals, houses, etc. She encouraged children to construct a series of miniature worlds in the sand tray. The child uses the world materials to describe a scene, to tell a story, or to tell what is going to happen. When the child has finished making the scene, she would ask her to explain it. The World Technique gives a child a means of representation with which to externalise her thoughts and concepts of the world. The scene is then, like a dream, containing manifest content and symbolic content. She believed that world constructions or drawings tend to make accurate statements about what is going on in one's life at the moment; but must be viewed in a context, and only the child can verify the meaning (Lowenfeld, 1935; Oaklander, 1988). The Sceno Test differs from the Lowenfeld World Technique (1935) in that the equipment is limited to a standardised, specified number of elements, transportable in a box, the lid of which acts as the test field.

Other theorists have used the same type of play material. Klein (1976) used toys that were small, simple and non-mechanical, so that they could be adapted for many situations and fantasies. Weininger (1989) also describes using little dolls (mothers and fathers and a variety of children), small and large cars, trains, and aeroplanes, domestic and wild

animals and building blocks in his play technique. Axline (1989) suggested the following list of toys as essential, if on a limited budget and needing portable play materials: a doll family and a few pieces of furniture in the same scale as the dolls, nursing bottles, clay, drawing paper and crayons, a toy gun, toy soldiers, a toy car, puppets, a rag baby doll and a telephone. The actual toys are simple so that the child can use them to represent many different situations or fantasised or actual events (Weininger, 1989).

'Sandplay' is a similar therapeutic medium (Ryce-Menuhin, 1992). Sandplay in therapy provides the therapist and client with non-verbal images that act as a psychological guide to what a person's difficulties are, and provides information and direction for healing. The material expressed tends not to be immediately grasped by therapist or client. The images usually come from preconscious sources. The images therefore become an eye through which to perceive latent meanings, repressed feelings, transferences and new psychological changes. The images in sandplay provide a context and text within which and through which an expansion of consciousness can take place. One is made aware of what one thinks, feels, and does through the images. Once integrated this increases one's capacity to make choices about one's actions relatively free from control by repressed complexes. In creating narratives and images, we get to 'see' the symbolic and projected unconscious. It becomes a means of externalising and sharing one's inner world and experience in the safe confines of the sand tray (Ryce-Menuhin, 1992).

### 3.7.2. The materials:

The Sceno Test (von Staabs, 1971) consists of a number of doll figures, which are between 7 cm and 15 cm in height and represent people of various ages, so that they have the potential to represent people in the child's environment. The limbs can be bent so that they can be made to assume various postures or gestures, and to play out scenes and relations between people. Accessories (such as animals, trees, and vehicles) are added for their ability to create an environment and for their symbolic value. The test includes coloured wooden blocks of different shapes and sizes, which can be used for constructing houses, towers, bridges, interiors, coffins and other structures. The other accessories such as food and household items are used to facilitate action, and the objects given to various

'people' can indicate certain emotional states associated with that person. For example, issues of possessiveness, jealousy and fairness can be explored through observing who gets what and the division of food (von Staabs, 1971). See Appendix A for a full list of objects in the original Sceno, as well as a listing of those objects used in the current research.

Several animal figures are used both for symbolic and realistic use (von Staabs, 1971). For example, aggression, hostility and fear can be represented through the crocodile. The fox is characterised as sneaky and cunning. The large cow is considered to represent a mother symbol and portrays either suffocating or nurturing aspects of the archetypal mother image. Fear and courage are often shown in the way people interact with animals. A desire for tenderness can be represented through caring for a dog, cat or other animal. A monkey could represent playfulness, cheekiness, and mischievousness. The trees and flowers can be used to represent idyllic natural scenes or a love of nature. Individual flowers may decorate rooms, showing a sense of the aesthetic. Trains may demonstrate a desire to escape (von Staabs, 1971).

Other objects such as wands or magical stones may show a desire for magical processes or qualities, or may indicate people whom the child feels are special. The angel may be a guardian or represent moral conscience (von Staabs, 1971).

The toys can be used to represent important internal objects and the child transfers feelings and thoughts to them. Klein (1976) points out that it is important to find out what or whom the toys represent, and what their relationship is to each other. The aim of interpretation is to attempt to make links between toys as a disguise for internal objects and objects in reality (Weininger, 1989). In the sharing of the "picture" narrative, the meaning already becomes clearer. It is important therefore not to assume the meaning of objects, but to verify the meaning of the symbols and objects for the maker (Ryce-Menuhin, 1992).

Fliegner (1995) investigated the frequency with which children between the ages of six to twelve used certain materials in the standardised Sceno Test. He argued that the Sceno Test was a valuable means for working with children, but that the existing standardised version needed to be modernised. He believed that many parts of it were obsolete. He critically examined their usefulness, made some replacements and added new elements. The following suggestions for changes were made:

- 1.) In the original Sceno, the toilet is a wooden block seat with a lid. Fliegner (1995) said that children did not understand this as a toilet and that it should be replaced with a more realistic imitation of a porcelain toilet.
- 2.) The carpet beater would not be recognised as specifically used for punishment, but he felt any stick could fulfill that function.
- 3.) The spade he said was seen as a snow shovel by children. In South Africa that would be meaningless.
- 4.) Previously a carbuncle was used to represent someone special. He felt that this symbol should be replaced with a heart symbol.

Fliegner (1995) suggested several items that should be added to modernise the Sceno Test to fit in with modern children's experiences - a television, radio, clock and a motorcycle. He made suggestions for symbolic substitutes for mother and father figures - the cow as symbolic of mother evoked feelings of nurturance and overprotection. He felt that a cat should be added to symbolise the delicate facets of the feminine archetype, and a spider to indicate the negative aspects. In terms of the male archetype and imagery, a lion, elephant and rhinoceros should be added to the test. The rhinoceros was useful for the phallic stage imagery of wild strong animal, lust, and virility.

### 3.7.3. The Box:

Building a world within the field of the box provides limitations and boundaries to the technique. The box becomes a regulating, containing, and protecting factor for the client's non-rational expression. The limited space of the box enables the child's fantasy to be contained within boundaries, which adds safety to the expression. It also provides time and space restriction for how much can be dealt with in one session. The box therefore

becomes the frame that contains the fabric of the narrative. In the context of the box the child makes the internal external, and this external expression then becomes the text for therapeutic work (Ryce-Menuhin, 1992).

In a therapeutic setting, a contract between child and therapist would establish the place and time and for how long therapy will take place. This establishes a frame within which therapeutic work can take place. In art therapy, the edges of the paper become an inner frame, which can contain unmanageable, unacceptable, previously unexpressed and /or chaotic feelings (Dalley, Rifkind and Terry, 1993). The Sceno box can be seen as providing a frame to contain unconscious material.

The box enables test equipment to be transportable, and therefore accessible to children in hospital or those who are unable to get to play room facilities due to various constraints, such as: lack of financial resources, inability to access resources, transport constraints, physical disability and illness. It is useful for children who are bed ridden for various physical ailments, which may co-exist with emotional disturbance, such as those who are terminally ill or seriously burnt.

### **3.8. Why has the Sceno been used for this research?**

The aims of the research are two-fold. Firstly, what are the intrapsychic play themes of children affected by HIV/AIDS? Secondly, given that children lack verbal skill, will the Sceno be a useful device to increase understanding of children's experience of illness and death? An inference from this may be that the Sceno can be a useful means of therapeutic interaction with children in South Africa.

Because of the play element of the test, it is useful in observing children, as it enables observation of children in their natural mode of action. Schaefer *et al.* (1991) suggest that unstructured play sessions are valuable ways of obtaining information about a child, but the reliability of an unstructured session is dependent on the therapist's skills. They suggest that it is advisable that the sessions be somewhat structured, "at least to the extent

that they present the child with specific materials” (Schaefer *et al.*, 1991, p.145). Using a semi-structured play technique, such as the Sceno, would therefore seem valuable for gathering information to understand intrapsychic variables that affect the child's behaviour (Schaefer *et al.*, 1991). The Sceno offers a means to express an inner experience that does not rely heavily on verbal skills. As discussed above, the Sceno is also potentially useful, due to its portability.

In addition, in the past most therapeutic play work and research in South Africa was conducted with white middle class children. There is a need for research into the utilisation of various play techniques for children from other socio-economic and cultural backgrounds. This will enable us to develop more culturally sensitive techniques for the South African context (Schoeman and van der Merwe, 1996), particularly as the challenge of HIV/AIDS affects us.

### **3.9. Some adaptations**

The standardised test material only consists of white family figures and one black woman figure that is often perceived as the maid or nanny. This is unacceptable in our multicultural society and reinforces stereotypes common in South Africa's Apartheid era. The researcher added a black family group, consisting of mother, father, daughter, son and baby.

The standardised Sceno tends to be dated. Similar changes have been made to those suggested by Fleigner (1995). A television, telephone, modern toilet, gun, heart and dinosaur have been added to this set. A cat, wild African animals appropriate to South Africa, as well as a crocodile to act as menacing animal figures have been added. A coffin has been added, as symbolic of issues to do with death. In the standardised set, there is only a male doctor/nurse. A female doctor/nurse figure has been added (See Appendix A for a complete list of all items).

### **3.10. The aims of the research**

The aim of this research is to ascertain if the Sceno Test will be a useful procedure to increase our understanding of children's intrapsychic experience of illness, impending death, and/or the death of their parents. This study is an exploratory investigation aimed at understanding the intrapsychic emotional themes of children affected by HIV and AIDS, using the medium of the Sceno Test.

The research will therefore aim to answer two questions:

- 1.) What are the intrapsychic play themes of children affected and infected by HIV and AIDS, as expressed using the Sceno Test?
- 2.) Does the data demonstrate the usefulness of the Sceno as a play assessment technique?

#### *1.) What are the intrapsychic themes of children affected and infected by HIV and AIDS?*

Very little has been written on the particular intrapsychic experience of children affected and infected by HIV/AIDS. Many children affected by HIV are cared for in Residential Care Homes. This study is an exploratory study aimed at understanding the intrapsychic emotional themes of four children affected and infected by HIV and AIDS and living in a Childrens' Home. If we can begin to understand the particular experiences, anxieties and intrapsychic concerns of children affected by HIV, we can begin to understand what may facilitate resilience and this can inform our intervention strategies. Two children from the Childrens' Home who have lost parents, but not due to HIV have also been included, to ascertain if there are differences in their narrative.

#### *2.) Does the data demonstrate the usefulness of the Sceno as a play assessment technique?*

Children present unique challenges in deciding on the medium through which to work. Because a child is unable to express herself with the verbal ability of adults, using intricate thought concepts, play is often used as a medium of expression when working with children (Jeffrey, 1984). Play is generally agreed to be a child's natural medium of self-expression and learning (Axline, 1964; Lowenfeld, 1935; McMahon, 1992;

Winnicott, 1964). Therefore play has been used as the medium of investigation for this study. The particular technique used is the Sceno technique. The Sceno is portable and relatively inexpensive, making the play technique accessible to those children whom cannot gain access to playrooms. The Sceno provides a means of expression that does not rely heavily on verbal skills, therefore useful in our multilingual country as well as providing a means to express experiences that are difficult to put into words.

3.) *An inference from this may be that the Sceno can be a useful means of therapeutic intervention with children in South Africa.*

## **CHAPTER FOUR**

### **METHODOLOGY: CREATING THE DATA**

#### **4.1. Introduction to the study**

This study is an exploratory investigation into the intrapsychic experiences of six children affected by HIV and AIDS. As there has been little written on this particular phenomenon, the research is a search for tentative, common experiences. A qualitative methodology has been used as a means to elicit the fundamental meanings a child attaches to the experience of being affected by HIV/AIDS, without initially presuming what they might be. A quantitative approach involves pre-selecting categories, whereas a qualitative approach constructs or discovers categories. The aim of the research is description and conceptualisation, rather than hypothesis testing.

Qualitative designs are not predetermined. In their nature, they have to be 'choreographed' and revised to suit the particular research. In qualitative research, the research design is a flexible set of guidelines to facilitate inquiry and provide methods for analysing data and linking it to theory (a framework for interpretation). Although as Miles and Huberman (1994) indicate, choices that a researcher makes throughout the process, contribute to data reduction and influence the outcome of the research, the important aspect of qualitative research is to make one's choices concerning method explicit, so that a reader may follow the process. The choices made in this research will be discussed in this chapter, including the participants, the interview process, recording the data, the methodology for interpreting the data gathered, and the researcher's position in constructing the data.

#### **4.2. Broad outline of qualitative methodology**

Qualitative methodologies in research have developed as a way to understand the subjective meaning of human experience and interaction. They arose out of the belief in the inappropriateness of natural scientific methods to account for meaning behind human

actions. Blumer (1969, in Patton, 1990) emphasises the importance of meaning and interpretation as essential human processes and believes that qualitative inquiry is the only way of understanding how people perceive, understand and interpret the world. A qualitative research methodology has been adopted in this research, as the aim of the study is to gain insight into the subjects' constructions of their experience of illness, attachment and bereavement related to their lives being affected by HIV.

Only through direct contact and interaction with people in open-minded, naturalistic inquiry, followed by exploration, elaboration and systematisation in inductive analysis can one come to understand the symbolic world of the people being studied (Patton, 1990).

Our interpretations are however, influenced by preconceptions, cultural norms for understanding, and previous knowledge and experience. Therefore qualitative research aims to consider the contextual, social, linguistic, and historical-political influences of certain behaviours. It is seen as important for researchers to be self-reflexive and to examine their own assumptions and presuppositions about the data (Goodenough, 1971, in Patton, 1990).

The fundamental assertions of interpretive science are:

- The approach must be based on the subject's view of what is meaningful as well as the researcher's view
- What is studied is fundamentally social or relational
- Reality is socially constructed
- Construction of reality is ongoing and dynamic (Patton, 1990).

#### **4.3. Preparatory stages**

##### **4.3.1. Preparatory theoretical phase:**

This phase involved a review of literature on play, HIV/AIDS, attachment theory and the theory of risk and resilience. I did this in order to gain an understanding of previous models of behaviour and observations and to examine my preconceptions.

I conducted a pilot study with three six-year-old children from a local primary school. They included one girl and two boys, each from a different race group.

The aims of the pilot study were:

- 1.) To familiarise myself with using and administering the Sceno test.
- 2.) To explore what equipment to use in gathering the data, i.e. video recording, photographic record, audio recording, and/or sketch of the scenes?
- 3.) To ascertain useful ways to ask about and facilitate the child's description of her scene.
- 4.) To explore if having predominantly white dolls effects what toys a child uses.

From the pilot study, I made two decisions:

1. To include a Black figure family. I felt that it was exclusionary and not socially conscious in South Africa to restrict the figures to one colour.
2. To use video recording equipment. This enables the most accurate recording of the whole process, as it was both visual and auditory.

#### 4.3.2. The use of video as a method for recording data:

"There is no reason to introduce video recording into a research situation unless it is the best or only way to record the data..." (Loizos, 2000, p.106). He makes this warning due to several disadvantages associated with video recording, which include (Loizos, 2000):

- Using video recording inevitably distracts informants, until they get used to it.
- The ethical considerations of privacy and confidentiality.
- Camera angles are not always optimum for capturing the most significant details of an action sequence.
- The camera observes from a fixed position.
- Sound quality can be poor.

I experienced some of these difficulties. The tape recording of sessions can have limitations if done on one's own. I would set up the camera to focus on the play box area, before the children came in. I could not stand behind the camera, and give the child

attention and presence. However, this meant I could not check that the positioning of the camera was good. While I set the camera up appropriately before each session, in two sessions, the camera angle changed and therefore the camera does not capture all of the action. These difficulties will be revisited in the discussion.

However, the obvious advantage for using video for collecting data, is its ability to capture multiple actions. "Video has an obvious data recording function whenever some set of human actions is complex and difficult for a single observer to describe comprehensively while it unfolds"(Loizos, 2000, p. 103). I have used video in the current research for two reasons. Firstly, I needed to be present in the interaction with the children. I made reflections on their play, and needed to be a warm, accepting observer to acknowledge what they did. I could not do this simultaneously with making written and diagrammatic records. Secondly, the multifaceted observations required, pointed to the usefulness of a visual and auditory recording method. This would enable recording the positioning of the toys, the interaction and dialogue between play figures, and between the researcher and the children, the character or process of play and the sequence of the content of the play. Video therefore seemed to be the only viable means to record the data.

#### 4.3.3. Procurement of research subjects:

Getting research subjects was difficult for a number of reasons. The research question was changed several times due to the unavailability of subjects. The initial question concerned the experience of terminal illness. I met with the Principal Paediatrician at the local Provincial hospital, to establish a suitable group of children. The initial criteria for the selection of research subjects were:

- 1) Children who were terminally ill, and knew that they were ill,
- 2) Children had to be between the ages of 6 and 11, as this was deemed to be the most psychologically stable age thereby limiting confounding variables.
- 3) Children had to be from lower socio-economic groups, as this was the area in which the least play therapy research had been conducted, and was likely to be the most significant target group for meaningful interaction related to the research questions and aims.

It was finally agreed that children infected with HIV would be used. Further difficulties were experienced, as most children infected with HIV in the hospital were too listless and ill to play or too young to fit the age criteria. We decided I would work in the HIV clinic that was held once a week, as the children attending this clinic were well enough to play. Play interviews were conducted over six weeks at the HIV clinic. This data was however unsuitable because:

- Continuity was difficult, as the interviews were random depending on which children attended the clinic.
- Most children spoke only Zulu and therefore an interpreter was used. This provided an interpretive barrier. As the research involved constructing a shared meaning, my limited understanding of Zulu inhibited my interaction in constructing the meaning. The interpreter, in trying to assist the process, would often ask the child a question, or attempt to make a child answer my reflections, therefore also influencing the interaction in ways I could not control.
- Children were accompanied by caregivers, who often intervened in the process by wanting their children to 'give good answers'. Some caregivers would encourage their children to play. The caregivers also often had important questions to ask about their child's care and status, which could not be ignored, but detracted from the rapport with the child, and I was not in a position to address parental concerns.
- Of all the children interviewed, none of them was aware of their HIV status and the potential terminal nature of their 'sickness'. I did not consider it ethical to pursue this issue.

I sought participants from four organisations working within the field of children affected by HIV/AIDS. Although various stakeholders in these organisations were responsive, there was much resistance to working with specific groups of children for various reasons.

- There has been a lot of funding in HIV/AIDS research. Therefore those children who knew their status had been interviewed many times and had been overexposed to research processes.
- Many organisations were rightly concerned about ethical issues, such as would the research be non-directive or would the children be told of their status.

- Many organisers were also resistant to these children being further stigmatised, and were concerned about sensationalising their plight.
- I also feared creating dependence and expectation of support and provision of resources, that could not be sustained, in some extremely poverty stricken and resource impoverished situations.

Ultimately access was obtained to work with six children from two Children's Homes in Pietermaritzburg. This again changed the focus of the research to experiences of children affected by HIV and cared for in an institution, rather than in the community.

I met with the Principal and social worker from one Children's Home, and met with the psychologist and caseworker at the second Children's Home. Suitable participants and ethical issues were discussed. I agreed to share the information that I gathered, and agreed not to discuss a child's status, but merely to reflect what they brought up in their play. The social worker/case worker for the organisations signed consent forms. I was offered the children's files to read. I declined, as initially I did not want to know biographical information that would influence my conceptions of their play. I wanted to work with an 'openness' to whatever the children might present in their play.

Five of the children came from one Children's Home. The sixth participant, Winnie (pseudonym) came from a different Children's Home. I had interviewed her at the local provincial hospital during the initial data collection, and felt that she was a suitable participant. On reflection, I included her as I had felt connection with her, but also to see if her play was similar to that of the other children. I later discovered that two of the children (Zama and Jabu) from the first Children's Home, were not affected by HIV. In analysing their play I found that their play was qualitatively different. In discussion with the social worker, I discovered that they were refugees. They had lost their parents but not to HIV. I have decided to include these children as a means for comparison.

**Table 4: Brief description of the six participants.**

<b>Participant</b>	<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>HIV status</b>	<b>Brief biographic information</b>
1	Thandi	7	female	HIV + ve	Both parents have died suspected HIV related illnesses.
2	Smangele	7	female	HIV + ve	Mother committed suicide a few months before. She was HIV positive.
3	Zama	11	female	negative	Refugee. Both parents have died (or possibly killed).
4	Jabu	8	female	negative	Refugee. Both parents have died.
5	Mbulelo	10	male	HIV + ve	Mother is very ill (HIV positive).
6	Winnie	9	female	HIV + ve	Mother is very ill (HIV positive).

All participants' attachment relations to significant family members had been affected in some way, either due to their parents' death or parents being ill with AIDS, and therefore they were placed in the Children's Home. Four of the children are HIV positive. Two of these have lost their parents. The other two have mother's who are HIV positive and ill. These children were not aware of their status, but knew they were sometimes ill. Two of the children are not positive, but have deceased parents.

The selection of participants between the ages of 7 – 11 years was based on the beliefs of developmental theory. Piaget (1952, in Sorensen, 1993) says that children between the ages of 7 – 11 are in the stage of "concrete operations" and have evolved logical thought processes and have developed more social communication. This stage in development, called by Freud (in Jeffrey, 1984) the 'latency stage', is a stage in which children are more stable in terms of psychological development, therefore limiting confounding variables. At this age children are able to understand that death is final and irreversible (Madorin, 1999). Children at this age can utilise a wider repertoire of cognitive, emotional and behavioural responses to emotional stressors. They are able to understand the causes of

events, to distinguish between living and non-living things, to express themselves, and to understand that different people react in different ways (Madorin, 1999).

All participants attended primary school. All participants spoke English and attended English language medium schools. All were willing to take part in the research. On-going support for these children would be provided by the resident social worker.

The research explored the meaning that participants assign to particular phenomena. Therefore there is no control group.

#### 4.3.4. Apparatus:

“The young child is unable to express himself with the verbal ability of adults...so he uses play as a substitute...Play aids diagnostic, developmental and continuous assessment” (Jeffrey, 1984, p.70). The particular play technique used, is the Sceno Test, a projective test aimed at exploring the inner dynamics of a child's experience. A list of the Sceno test equipment has been included in Appendix A.

#### 4.3.5. Constructing the ‘corpus’ of data:

The selection of data is inevitably an arbitrary process. However there should be some purpose to the selection. Bauer and Arts (2000) suggest data should be selected on the basis of “relevance, homogeneity and synchronicity”(p.31). I hope that in the literature review, I have made an argument for the relevance of the selected area of research. In terms of homogeneity, I have a thematic focus of working with children affected by HIV and living in a Children's Home. I have chosen to work with one medium of data, the transcripts from videotaped play assessment sessions with the children. I have not included case history data. In terms of synchronicity, data was collected within a time frame of four weeks. The size of the ‘corpus’ (Bauer and Arts, 2000) is dependent on the time and effort involved in data collection and analysis. Three interviews with six children required a substantial amount of time to process.

#### **4.4. The interviews and data collection process**

##### **4.4.1. Preparation:**

I felt the initial set of data collected was unsuitable, as discussed above. However, some changes were made because of learnings from this process. I decided I would sit on the floor with the children when interviewing them, rather than sitting behind a desk, to encourage rapport and make the situation less intimidating for the children being interviewed. I developed a protocol for the verbal introduction to encourage consistency between subjects and interviews (See Appendix C).

The verbal introduction focused the play on their experiences of illness and being in the Children's Home. This may have influenced their productions. However, the assessments remained unstructured and open. I merely responded to what the children did, hoping that this would allow me access to the complexity, variability and uniqueness of their experiences.

I chose to assess each child three times. Gergen and Gergen (1988, in Hermans and Kempen, 1993) emphasise time and coherence as defining characteristics of self-narrative. "We shall employ the term self-narrative...to refer to the individual's account of the relationship among self relevant events across time" (Gergen and Gergen, 1988, in Hermans and Kempen, 1993, p.58). By giving a child three opportunities to create a self-narrative, I could search for consistent and perhaps progressive themes in these narratives.

##### **4.4.2. Contact session one:**

- The initial session was set up so that I could discuss the research with the children, to ask if they were willing to participate and to establish some rapport. It was not videotaped.
- I was introduced to the participants by the social worker/caseworker in the organisation.

- I met with the children in the chapel, which was the only available quiet space that could be used. This would be where the assessments would be conducted. This may have affected the process, as this is a place of reflection and religious ceremony.
- A brief conversation was held with each participant and participants were asked to do a drawing of themselves, to establish rapport.
- I explained the reason for doing this research and the process of the research. I explained that the sessions would be videotaped, but that they would remain confidential. Only my supervisor and myself would view the videotapes. I explained that pseudonyms would be used in the writing up of the research.

*Angela: I am interested in children and how they feel. I have come to see you because I know you or someone in your family was/is sick. And for this reason you are in the Children's Home. I would like it if you could tell me something about what it feels like using these toys. I will videotape the sessions so I can remember what you played. The research is for the university, but only my supervisor and myself will see the videos. I will then write about what you played and will use a different name for you. Let's look together at what is in the box...people, animals, furniture, gun, heart, have a look and see what catches your attention.*

- The participants were shown the play equipment, and were encouraged to explore what was in the box. They were encouraged to ask questions about the process.
- They were allowed to look through the video lens to see how it would work.

#### 4.4.3. The assessment contact sessions:

- The interview session was introduced using the same protocol for each participant and each successive visit to establish continuity between subjects and between sessions (See Appendix C). Children were asked to play with the Sceno material using the lid as their play space and explaining that they can use the toys to make a story about their life and act it out.
- The children's play was videotaped; brief notes and a sketch of the final scene were made.
- The interactions were guided by Axline's (1989, p.69) eight basic principles of non-directive play therapy. Only behaviours, which could be harmful to the child, researcher, relationship or equipment, would be limited. I aimed to build rapport and provide a warm, friendly, trusting environment, in which there would be a sense of

permissiveness and acceptance, so that the child would believe she could express any feeling she might have. The child set the pace of her play. I aimed to recognise and reflect the feelings expressed in the play.

- The research was conducted by observing what the participants did through a process of naturalistic enquiry and attentiveness (Patton, 1990). I attempted to understand the meaning of their play, through empathic understanding and engaging in dialectic with the participants. Empathic understanding is an attempt to bracket one's preconceived understanding and to listen for the participant's understanding of her experience. This involves paying attention to detail and not taking anything for granted (Patton, 1990).
- I recognised that in the process of observing a child, I would make certain assumptions. I therefore tried to make reflections about the action to establish if my understanding of the play was correct. I questioned the children on the meanings they attached to their play, to establish the assigned identity of the figures being used and in what activities the figures were involved.
- I asked the children for the identity of the figures.

*Angela: "Who are these people?"*

*Zama: "This is the mummy and daddy and baby, and if they want to eat they have to pray first."*

- I made reflections to confirm my understanding.

*Winnie: "The two girls are walking together."*

*Winnie: (As one of the girls #1 in teasing voice) "Check my hair is longer than yours...oooh"*

*Winnie: (As girl #2) "I don't care that your hair is longer, so bushy hair."*

*Winnie: (As girl #1) "I'm not a bushy haired, same like you."*

*Angela: "Do they feel bad?"*

*Winnie: "Ja that's what they do...teasing each other." The girls fight.*

*Angela: "She must feel sad?"*

*Winnie: "She was sad."*

- At times my assumptions were wrong, and the child would let me know.

*Angela: "Tell me what happened in this story today...There was a sick boy..."*

*Thandi: "Not a boy, a baby"*

- There are times in the reflections when I made comments that linked the play to the child's own life. I attempted to use the language that the child had used.

*Angela: "What is wrong with the baby?"*

*Thandi: "His tummy is sick"*

*Angela: "Thandi, does your tummy sometimes get sick?"*

*She nods.*

*Angela: "How do you feel when you get sick?"*

*Thandi: "Horrible"*

- Sometimes the children, Mbulelo in particular, personalised the play for themselves.

*Angela: "Okay can you tell me what is happening?"*

*Mbulelo: "This is a doctor, he's looking after my grandfather but this is the doctor and nurse looking after my grandfather and this is my mother praying and this is the baby and this is my baby sister".*

It should be noted that I found it difficult making interpretive comments during the play. I was aware of 'doing this' for research and therefore not wanting to influence the data. I was at times self-conscious in my interactions, which possibly meant that I did not say as much as I might have in an ordinary therapeutic interaction. It felt as if I needed more proof, before making an interpretation. This had advantages and disadvantages. Wolcott (1994) suggests that for 'validity' in qualitative research, one needs to talk a little and listen a lot. However, the difficulty I had was if I missed a meaningful action or did not explore it further, it was difficult to confirm a meaning with the participants in a later session. Interpretation is based on intuitions about possible meanings, and is confirmed in the dialogue between participant and researcher in an attempt at finding, negotiating and constructing meaning.

#### 4.4.4. Final contact session:

- I met with each of the participants to explain that I had finished my work, and to ascertain if they needed continued support.
- Each child was given a chocolate and a card as a token of appreciation for his/her work.

#### **4.5. Transcribing the interviews from videotape**

“Transcription, ... is useful for getting a good grasp of the material, and ...opens up a flow of ideas for interpreting the text” (Jovchelovitch and Bauer, 2000, p.69).

Although transcription is a time-consuming process, it facilitated developing an in-depth grasp of the data. I had some difficulty in transcribing the play action from videotape into words. There was an interpretive process already happening while I described the action. I interpreted what they were doing in my attempt to describe it. So as not to prematurely reduce the data, I attempted to describe this in as much detail as possible. I also re-examined videos and added to transcriptions things I had missed out. I had to make decisions about how to show play action, dialogue, and when the child speaks as one of the figures, as well as non-verbal interaction such as laughing, nodding, and pointing.

The advantage with tape recorded data however, is that I could review and explore the interaction and potential meanings as my understanding of the texts increased. This is linked to the hermeneutic process of looking at the constituent parts as well as the whole (Bleicher, 1980). I felt that the transcript became depersonalising, or objectifying. It became data or information, rather than an interaction with a child. I found the tapes useful to go back to, to remind myself of the qualitative “feel” of the child and the interaction.

#### **4.6. Data description, interpretation and analysis**

##### **4.6.1. Discussion of the methodological perspective of phenomenological hermeneutics:**

Play with the Sceno is a form of externalising narrative, an objectification of human expression like a text. The child constructs a narrative scene that requires interpretation. The complex task of the interpreter is how to transpose a meaning-complex created by someone else into one’s own understanding of the action (Bleicher, 1980). The researcher attempts to understand the meaning of a child’s play and the significance of the use of various figures and their positioning. A phenomenological hermeneutic methodology,

which focuses on the comprehension and interpretation of the meaning of a text, narrative or action, and aims at explicating the essential experience of a particular phenomenon, is used (Miles and Huberman, 1994; Ricoeur, 1981).

A hermeneutic approach is not a set of prescribed techniques, but rather an approach to research, which focuses on the process of interpretation and is based on certain assumptions. It recognises that participants of research are meaning giving beings, they give meaning to their actions and so the meanings they ascribe to their actions are important for understanding the research. However, the researcher will only know the subject's meaning through his own interpretation, but can also see meanings that the participant cannot yet see (Ricoeur, 1981). Heidegger (1927, in Ricoeur, 1981) says that a person can only know herself in an approximate and tentative way, through externalisations of herself (speech and action) and interpretation of other's reactions to those externalisations. Ricoeur (1991) says, "discourse is the necessary condition for the meaningfulness of experience and behaviour (p. 548)".

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

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

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

Phenomenology therefore focuses on how we put together or express the phenomena we experience. There is no objective reality for people, but only what they know their experience to be. However, phenomenology also assumes that there is an essence or essences to shared experience. These essences are meanings that are commonly understood by people who have had similar experiences. Phenomenological psychology has sought to understand the essences of particular human experiences via description in written and verbal form. The subjective experiences of people are therefore bracketed, analysed and compared to identify commonalities in experiences of a phenomenon.

The problem with data collected with phenomenological methods is that the written text becomes fixed and is atemporalised and decontextualised. Ricoeur (1981) therefore proposed a 'phenomenological hermeneutic' in which psychological data be treated as a text analogue in need of interpretation. Ricoeur (1981) considers the use of text-interpretation methodology as a paradigm for interpretation in the human sciences. He considers to what extent meaningfully oriented behaviour can be interpreted in the same way as text. Can action possess 'readability characteristics' that open it up to

interpretation by unintended 'readers' who are not co-present to the action? (Ricoeur, 1981).

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

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

*The fixation of meaning:*

For meaningful action to be an object of science, it has to be subjected to a kind of objectification, equivalent to the fixation of discourse through writing. Phenomenological data consists of written or tape-recorded protocols that make subjective experience available for scrutiny. Descriptive protocols therefore, become texts or "linguistically fixed documents". They are objectified and made available for scientific inquiry (Ricoeur, 1981). In this research the making of a play product fixes the action like a text, which is preserved by using video and transcribing the action and dialogue.

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

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

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

*The display of non-ostensive references:*

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

*The universal range of addressees:*

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

The reader re-figures the textual meaning by appropriating the text in some personal way. Appropriation is incorporating an understanding of another's words into one's own schema. The reader is enlarged in his capacity of self-projection by receiving a new mode of being from the text itself. For explanation and understanding in phenomenological hermeneutic research the data is in some way appropriated and interpreted by the researcher. A theoretical framework is proposed to explain the actions.

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

Interpretation is a process, a movement back and forth between text and interpreter. The task of hermeneutic inquiry is therefore at the intersection of two directions of language, neither solely with the text, or solely with the reader but in the interaction between the two.

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

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

#### 4.6.2. Multiple readings of the narratives:

In only content analysing the data through the use of coding categories, I felt I was unable to get an overall sense of the meaning of each child’s narrative. Based on analysis of interview narratives, Mauthner and Doucet (1998) developed a method for multiple readings of narratives. Each reading focussed on a different voice in the narrative. I have used and adapted their idea, for multiple readings of my data, with various foci, so that I may grasp an understanding of the whole as well as the constituent parts.

- *First reading: reading for global understanding and emplotment.*

Part one of this reading involves reading for the manifest content of the narratives.

Summaries of the children’s narratives were made (See Appendix D). Part two of this

reading involves making the researchers understanding and thoughts about the interview/assessment explicit (Mauthner and Doucet, 1998). My understanding, interpretations and thoughts about the meaning of the narrative were made under a heading "*Comments*" (See Appendix D).

- *Second reading: Content analysis.*

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

- *Third reading: reading for aspects of play.*

This reading is based on the second research question which is concerned with the usefulness of play and the Sceno technique, as a means of accessing the intra-psychic issues of children affected by HIV/AIDS. The transcripts were read for aspects of play as outlined in the literature review.

#### 4.6.3. Steps taken in the interpretation and analysis of the current study:

- 1.) I watched the video material. The children's utterances, interaction with the researcher, gestures and play actions and activities were transcribed, as described earlier.
- 2.) Initial hunches about the meaning of the play were recorded.
- 3.) Transcripts were 'read' and 'reread' to familiarise myself with the material.
- 4.) First reading: reading for global understanding and emplotment. The play sessions of the participants were summarised (Appendix D). The process of a child's play and character of their play; the content of the play; and a comment about possible meanings of the play was made for each session for each participant. This was done so that I could gain an understanding of the data as a whole.

- 5.) First reading: This was further summarised into commonalities and differences in the main themes and plots, across the participants.
- 6.) Second reading: Content analysis – coding categories are linked to meaning units in the text. I sought advice from my supervisor about certain codes/themes. We watched two children play and recorded possible coding areas.
- 7.) Second reading: I entered the various “texts” searching for meaningful units and segments. Natural meaning units can be described as statements or actions expressing single, delimited aspects of a subject’s expression (Bauer, 2000).
- 8.) Second reading: Coding categories were developed. My coding was defined thematically (Bauer, 2000).
- 9.) Second reading. Again, supervision was sought and various categories revised and refined (see coding categories Appendix E).
- 10.) Second reading: The data was coded. The data transcripts were broken into parts or unit segments and given labels of index words. The purpose of this phase was to organise the raw data into a more manageable form before analysing it from a chosen interpretative perspective. The coding process helps to condense unwieldy discourse into manageable chunks (Bauer, 2000).
- 11.) Second reading: These meaningful units were compared across all participants’ three sessions. The most frequent coding categories, i.e. similarities across participants and sessions, were identified. Patterns of symbolic meaning in the play or emotional attachments were recorded. I explored the categories and the patterns that connected them. I looked for similarities across the participants as well as taking note of differences. By analysing across cases, one is at risk of making generalisations that do not consider the many individual factors influencing action. However, cross-case analyses are necessary if one wishes to explore commonalities in experience across multiple instances of the same phenomena. Conceptualising data is necessary in order to ‘talk’ about one’s research (Bauer, 2000).
- 12.) Third reading: reading for aspects of play. The transcripts were read for aspects of play as outlined in the literature review.

- 13.) Up until this stage, the data analysis was primarily descriptive. At this stage the essential identified themes were interpreted according to a theoretical framework. Themes and symbolic interpretations were compared with existing literature on symbolic meaning of “toys”, play, grief and attachment theory. This required “theoretical sensitivity” - ways of being able to stand back from our initial assumptions and see certain significances in the data. A continual dialogue was maintained between proposing relationships and checking with the data.
- 14.) These interpretations were then checked against the data collected to check their “fit”. Individual transcripts were read in the light of the general themes to ensure that they were reliable. I consulted with a second researcher, to confirm that they agreed with the interpretations I had made.

#### **4.7. Criteria for evaluating interpretative research findings**

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

##### Coherence

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

##### Uncovering

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

### Validation of interpretation by another researcher

Reliability can be ascertained if another researcher comes to the same interpretive conclusions. However, hermeneutics assumes that different researchers will have different fore structures and therefore come to different interpretations. What is important is that other researchers can follow the interpretive logic of the argument.

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

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

A discussion of the above will be offered in the critique of this study. In this research, the transcripts have been made; the coding categories and the summaries of play and my interpretations as the interpretation process proceeded have been recorded. Supervision and feedback were sought. It is hoped that the readers will be able to follow my (the researcher’s) interpretations and in that way validate the research, by seeing for themselves.

## **CHAPTER FIVE**

### **DESCRIPTION OF FINDINGS AND CONCEPTUALISING THE DATA**

#### **5.1. Introducing the children: A brief description of each child's play across the three sessions.**

The themes in the children's play were usually consistent and progressive over the three sessions. These themes also relate to very brief biographic information provided by the social worker after reviewing their play and asking about the two refugee children. As a way of introducing the discussion, the children will be personalised and introduced in a brief discussion.

Thandi: Aged 7, HIV positive. Both parents have died from suspected HIV related illness. In the initial session, the baby is taken to the Doctor<sup>2</sup>. In the second session, the Doctors come to the house to examine the baby. In both scenes, the baby is pronounced well. The third session seems to be a special time (Christmas) when the family all comes together. Thandi says she goes 'home' to her extended family (Granny, Auntie, Grandpa, and Uncle) in the holidays when school closes. Interestingly both the Doctor and Mother are included in these family meals and celebrations. This play seems to indicate a longing for the secure attachments of home, and for everything to be back to normal after the baby is pronounced well. It is also recognised that special days can be difficult for a grieving child, as they trigger memories of the loss (Raphael and Dobson, 2000). It also suggests a fear of being sick (thus the presence of the Doctor) and her wish to be well.

Smangele: Aged 7, HIV positive, Mother committed suicide a few months previously. She was HIV positive. All three of Smangele's play sessions feature meal times and distribution of food and drink according to the size of the recipients of the food and drink.

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<sup>2</sup> Capitals have been used, as far as possible when referring to a specific figure, i.e. Doctor or Mother, as this is used like a proper noun. When the generic is referred to it is not capitalised.

Smangele's play seems to relate to adjusting to life in the Children's Home. It also has as its central theme inequality (shown as inequality in distribution of food, bottles etc.). This may be related to hierarchical relationships in the Children's Home, but which is possibly linked to the inequality in her family relations. There were different circumstances for each child after their Mother's death.

*Angela:* "And do you have brothers and sisters?"

*Smangele:* "I have one brother and one sister. I have two sisters and three brothers".

*Angela:* "And where are they Smangele?"

*Smangele:* "My youngest sister is in the baby block and my oldest sister is with my Granny and my three brothers are with my Granny too. Only one sister came".

Zama: Aged 11, Refugee, parents have died.

Zama's first scene is an idyllic family consisting of Mother, Father and Baby. They pray before eating and going to bed. In the second scene, a Grandmother, Mother and two babies (twins) pray for a home, as they do not have one. In the third scene a farmer cares for, loves and feeds the animals. Although all three scenes seem diverse, at their core there is a theme of having one's needs for safety, a home, food and love met.

Jabu: Aged 8, Refugee, parents have died.

In all three of Jabu's scenes she seems very concerned with making nice houses protected by walls for all the people. In two of the scenes there are visitors and she says, "Some visitors are coming, 'cos if you're hungry and you don't have food, you are poor." Having a safe home would appear to be as important as is feeding visitors who may be poor. This seems significant in Jabu's life and shows the same concern as her sister about not having a home or food. She also says that in the Congo you couldn't have visitors because you had to close the door because they were shooting.

The role of parents in the scenes is also sketchy. In the first scene there are adults just as part of the two families, not performing parenting roles. In the second session a cleaning lady looks after the children and there are no parents in the scene, and in the third session there are parents but they do not perform parenting duties, they listen to the visitors. In all

three sessions there is a garden and animals present. Snakes are present in the last two sessions. In the second session the teacher warns the animals that the snakes can kill them, and in the third session she speaks of snakes as linked to black magic. This narrative seems to link with talking of shooting, and a boy at school who was knocked over. Therefore it seems to be linked with trauma and killing, but the narrative is not yet coherent.

Mbulelo: Aged 10, HIV positive, his Mother is very ill (HIV positive).

All three scenes revolve around a Doctor examining an ill person and the family sitting around the ill person anxiously either praying or waiting. The progression in the theme moves from the first scene being about his Mother's illness, the second scene about his Grandfather's illness, and finally to a desire to be a Doctor himself. The progression of themes seems to move from the present situation in which he is very worried about his Mother's illness, to a past situation in which he was again praying for and worried about a significant person in his life, his Grandfather. However his Grandfather passed away. Scene one and two therefore, with the presence of the Social Worker and his acknowledgement that his Grandfather died, seem to show concerns for the pending consequences of his Mother's illness. In his final scene, Mbulelo is a Doctor helping a sick lady (same doll figure as he used for Mother) and five sick children. This seems to be an expression of his desire to help his Mother, so that he may be less vulnerable and helpless in the face of her illness.

Winnie: Aged 9, HIV positive, Mother very ill (HIV) positive.

In Winnie's first two sessions there is a Mother, Sister and Baby. In the first session she built a safe house, and built up its walls. The house is safe, and protected by an angel, and yet it is still threatened by snakes and crocodiles. This seems to be indicative of awareness of some threat to her sense of security. In the second session the Mother is a nurse. This seems to blend the desire for nurturance, care and treatment when one is sick.

In the first two sessions, family structures and routines such as meals, bathing, going to and returning from school, are important. Particularly important in terms of the excited

affect, seems to be returning home from school and having a Mother greet her children excitedly and with hugs. This seems to be expressing a need for a consistent attachment figure, a warm and consistent relationship with an adult. She needs boundaries in a scary world – walls around the house, routines, an angel to ward off attacking snakes and a Mother who is a Nurse. In the final scene it is a special day at school, but before they can celebrate, she deals with some of the painful aspects at school – eating separately to the other children, and being teased. The friends apologise for their respective fights and are friends again. She expresses a desire to reparate and belong. I wonder, if Winnie feels partly to blame for her Mother’s illness and wishes she could reparate (Klein, 1975, in Weininger, 1989). In this way she could make the other feel better, for something that she felt she might have done wrong.

## **5.2. Reading one – reading for global understanding and employment**

Six children were assessed. Each child played for three sessions. A summary of these sessions can be found in Appendix D. A brief overview of the significant plots is given. Further discussion of each theme will be discussed in the second reading.

**Table 5: Summary of Main themes or plot in children’s play sessions:**

	<b>Session 1</b>	<b>Session 2</b>	<b>Session 3</b>
Thandi	<ul style="list-style-type: none"> <li>➤ Doctor examining child and pronouncing him better.</li> <li>➤ Baby in nurturing environment of parental care and routines.</li> <li>➤ Doctor's needs are taken care of.</li> </ul>	<ul style="list-style-type: none"> <li>➤ A Family meeting about the sick child.</li> <li>➤ Doctor examining child and pronouncing him better</li> <li>➤ Special care of the sick child</li> </ul>	<ul style="list-style-type: none"> <li>➤ Family celebration at Christmas</li> <li>➤ Gift giving</li> <li>➤ Family routines: Meal, bathing, work, leisure (swimming).</li> </ul>
Smangele	<ul style="list-style-type: none"> <li>➤ Routines in the Children’s Home – eating, bathing, sleeping.</li> <li>➤ Division of food and places to sleep according to size.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Family Routines – meal, bathing, sleep.</li> <li>➤ Division of food and places to sleep according to size.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Children’s Home Routines ~ meal, bathing, sleep.</li> <li>➤ Division of food and places to sleep according to size.</li> </ul>

**Table 5: Summary of Main themes or plot in children’s play sessions continued:**

	<b>Session 1</b>	<b>Session 2</b>	<b>Session 3</b>
<b>Zama</b>	<ul style="list-style-type: none"> <li>➤ Family routines – meal time and sleeping</li> <li>➤ Praying</li> </ul>	<ul style="list-style-type: none"> <li>➤ Not having a house, a place to sleep.</li> <li>➤ Praying</li> </ul>	<ul style="list-style-type: none"> <li>➤ Farmer caring for animals including the more vicious animals, the fox and crocodile.</li> </ul>
<b>Jabu</b>	<ul style="list-style-type: none"> <li>➤ Making a houses and pleasant safe home environment.</li> <li>➤ Having a home rather than being homeless</li> <li>➤ Having food if you are poor.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Making a houses and pleasant safe home environment and garden.</li> <li>➤ “Cleaning ladies” care for the children.</li> <li>➤ A hospital</li> <li>➤ A teacher warning the animals of the danger of snakes – an awareness of danger.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Secure home environment.</li> <li>➤ Home routines of eating and sleeping.</li> <li>➤ Visitors come to talk about God.</li> <li>➤ Dialogue about black magic and killings.</li> </ul>
<b>Mbulelo</b>	<ul style="list-style-type: none"> <li>➤ Illness of Mother figure.</li> <li>➤ Praying for sick person.</li> <li>➤ Doctor present to care for/examine sick person.</li> <li>➤ Consequences of Mother’s illness – coffin and social worker’s car.</li> <li>➤ Anxiety about Mother’s possible death.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Illness of Grandfather figure.</li> <li>➤ Praying for sick person.</li> <li>➤ Doctor present to care for / examine sick person.</li> <li>➤ Anxiety about Mother’s possible death.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Hospital scene – Doctor caring for sick people and woman,</li> <li>➤ ‘Parents’ wait worried about their children.</li> <li>➤ Self as Doctor helping sick people and woman.</li> </ul>
<b>Winnie</b>	<ul style="list-style-type: none"> <li>➤ Secure home environment.</li> <li>➤ Children protected by angel.</li> <li>➤ Safety of home threatened by snakes - an awareness of danger.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Routine at home and safe home environment</li> <li>➤ Angel present in house</li> <li>➤ Mother as Doctor/nurse</li> <li>➤ Mother as warm, consistent caring attachment figure.</li> </ul>	<ul style="list-style-type: none"> <li>➤ School scene and routines.</li> <li>➤ Peer relationships – positive – playing together, repairing.</li> <li>➤ Peer relationships – negative- feeling different, being teased.</li> </ul>

In total there were 18 sessions. Of the 18 sessions, ten sessions have as one of their main themes in the narrative the carrying out of various routines such as sleeping, eating, bathing and going to and from work and school. Related to this is the theme of having a secure, safe home environment. This theme is present in ten of the eighteen sessions. The theme is concerned with building safe houses, having an angel to protect the house, and the presence of extended family members in supportive roles. The presence of family members (showing concern for a sick person, meeting to discuss a sick child, praying for a sick person, celebrating at Christmas, and in routine activities such as mealtimes, sleeping, and leisure activities) is the next most important subject in the children's play. It seems significant for children in a Children's Home that they play about home environments with extended family members. Only one of the six children assessed played scenes from the Children's Home. This seems to indicate the importance for these children of their past attachment relationships and their longing for home environments. Significantly, of the two children who were refugees, each discusses in one of their sessions being homeless, being poor and not having food or a place to stay. This did not come up in the other children's play.

Seven of the sessions have a narrative that involves a Doctor examining a sick child or person. This narrative takes on slightly different forms, but the essential theme is the same. Related to this theme is the theme of illness. This theme is related to actions by the family on behalf of the sick person; such as family meetings, waiting in the hospital, praying for, special meals for and recognition of consequences of illness such as the social worker visiting. This comes up as a main theme in six of the narratives. Significantly only one of the two children, who are not HIV positive, has a brief scene in one session that involves a hospital. She sets the hospital scene, but does not role-play any action. Of the four children who are ill, three of them include narratives of illness and visiting the Doctor. Smangele is the exception. Her play is primarily concerned with routines and she seems to show a significant amount of anxiety when discussing her family, to the extent that she is unable to engage in role-playing. Erikson (1977, in Jeffrey, 1984) explained how at times play themes are interrupted at an 'autotherapeutic point' when a child's

anxieties are raised. With support and acceptance a child realises that she can continue and work through the difficult emotions.

For four of the children some aspect of spiritual awareness is brought into their play. This is present in seven of the eighteen sessions. This took the form of praying before meals and bed times, praying in times of trouble, praying for a sick person, having visitors come to talk about God, and having the presence of an angel as protector in a house. The two children who did not include this were Thandi and Smangele. Whether or not it is significant, these are also the two children who do not include the presence of a threat (usually in the form of the snakes, crocodile, or wild animals) in any of their scenes. The threat from dangerous animals was present in five of the eighteen sessions.

Lastly only Winnie has as the main theme of one of her narratives, peer interactions and school. This may be influenced by the verbal introduction in which I introduce the theme of illness. However, it does seem to be an interesting exception to note. Traditionally, in developmental terms this particular age group (7 – 11) is a stage in which children become concerned with peer relationships. The social life of the group becomes predominant. Children are concerned with roles and competence in tasks (Jeffrey, 1984). This might be due to the stronger need to play scenes relating to attachment.

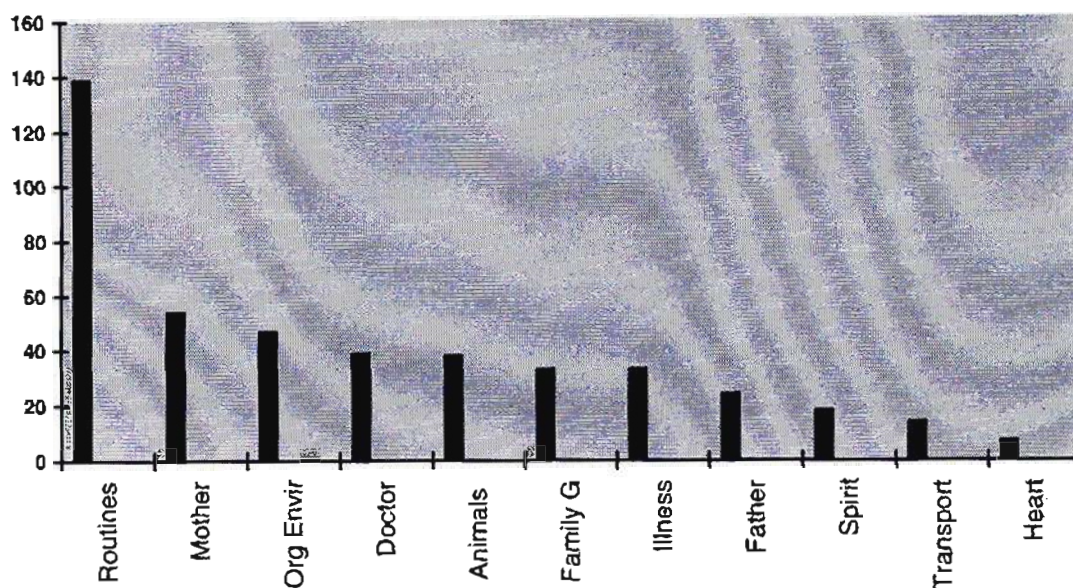
### **5.3. Reading 2 – content analysis.**

#### **5.3.1. Overview of themes:**

‘Routines’ is the theme that is coded most often (139). Following is a list of the other themes and the number of times they were coded, in descending order:

Mother (54), Organising environments (47), Doctor (39), Animals (38) – coded for each animal used, Family gatherings (33), Illness (33), Father (24), Spirit (18), Transport (14) and Heart (7). The frequencies and prevalence of themes is best represented graphically.

Figure 1: An overview of the frequencies of themes in all the children's play.



### 5.3.2. Routines:

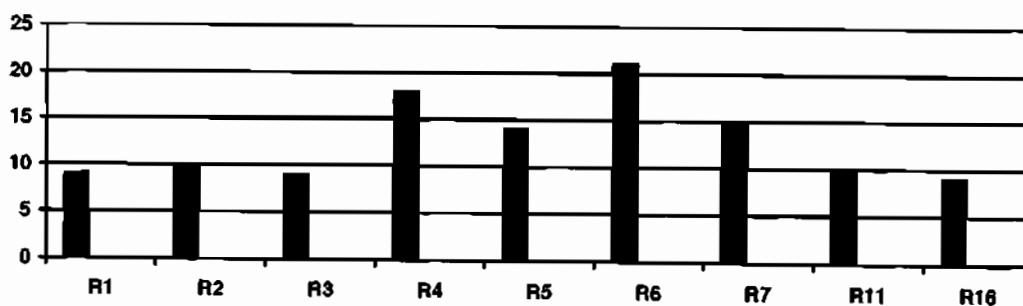
Routines came up as the single most played theme across all three sessions and across all six participants. The exception to this is Mbulelo, who does not play routines. I think routines have been depicted as an important aspect of play for several reasons. It may be the nature of the toys in the box lends itself to building a house, and sitting around a table and eating. However, as can be seen in the graph below, the children also play bath routines, despite the lack of a bath in the set. When consulting my supervisor on this issue, we discussed the prevalence of this type of play in other cases we have worked with. We have tended not to have children playing out routines to this extent (B.Killian, pers.comm, Sept. 24, 2001).

In research into child resiliency, Dutra *et al.* (2000) found that after the central role of parenting in promoting resilience, “monitoring outside the home and routines inside the home were associated with resiliency” (p 483). It is possible that the presence of routines provides structure and containment to these children, who have had to face changes in

their living environment and their familial circumstances. Routines may be one of the few things that have stayed the same, and can be relied upon to avert their feelings of chaos and create predictability in their young lives. Madorin (1999) also believes that it is easier for a bereaved child to accept the loss of a beloved person when the child feels personally safe. In a child's terms this means that their needs are adequately met, and that there are minimal changes in her daily routine. If a child can rely on the stability of these things, she is more able to cope with the facts and feelings of her bereavement (Madorin, 1999). Piaget (1978, in Jeffrey, 1984) describes the stage of development of children seven years and above as the stage of concrete operations and operational thought. Rules, routines and structure are important at this stage.

**Figure 2: Graph showing the prevalence of the different activities coded as Routines**

Key:	
R 1	Sitting around a table/ setting up a table and chairs
R 2	Organising food/cutlery/knives and forks/making food/laying out food in the house
R 3	Meal time routine – even distribution of food to all
R 4	Mealtime routines – distribution of food in rations – big meal for big people
R 5	Mealtime routine cleaning up/washing up/putting away
R 6	Bed time routine
R 7	Bathing routine – cleaning and drying & dressing
R 11	School/ work routine – Going and return to and from work or school
R 16	Leisure routines -TV



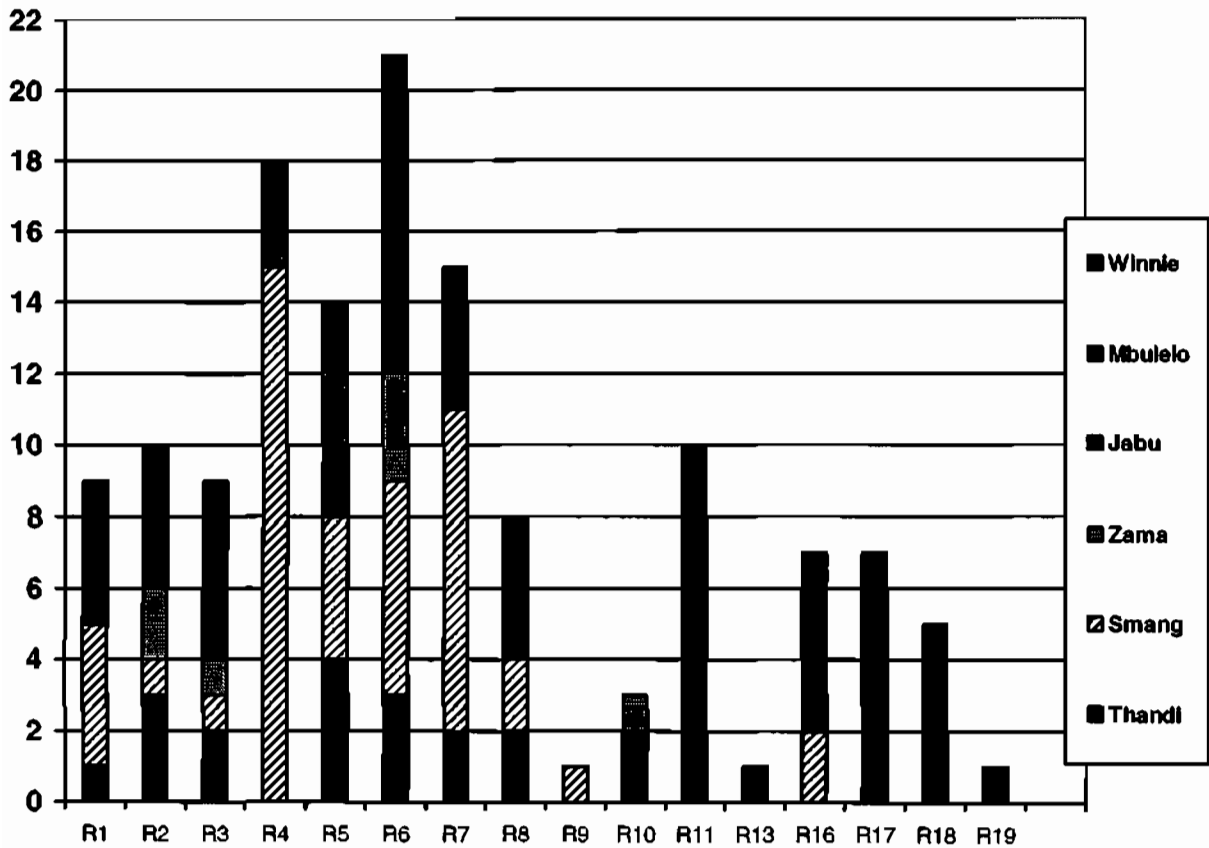


Figure 3: Graph showing activities coded as Routines in each child's play.

**Key:**

- R1 Sitting around a table/ setting up table
- R 2 Organising food/ cutlery/crockery/making or laying out food
- R 3 Mealtime routine – even distribution of food to all
- R 4 Mealtime routine – distribution of food in rations – i.e. According to size
- R 5 Mealtime routines – cleaning up/washing up/ putting food or crockery away
- R 6 Bedtime routine
- R 7 Bathing or dressing routines
- R 8 Toilet routines
- R 9 Wetting the bed
- R 10 Waking up routine/ making beds
- R 11 School/ work routine – going to or returning from
- R 13 Feeding/ taking care of the sick person
- R 16 Leisure routines -TV
- R 17 Leisure routines/activities – swimming, lying in sun
- R 18 Leisure activities – visitors
- R 19 Collecting water

The graph above depicts the breakdown of which routines were played and by which children.

Routine R6, bedtime routines were the most often used. This is an important routine partly because several of the bedtime routines involve being warm, wrapped up, or sleeping next to Mother, Father or a sibling. I think this is a time of feeling safe and secure. However, it can also be a time of fears and anxieties, also alluded to in the presence of an angel as protector at night, or a heart near the bed to show the presence of God, and praying before bedtime. Winnicott (1964) speaks of bedtimes as occupying potential space and therefore they can create anxiety and are very likely to evoke the use of transitional objects.

*Angela: "The baby is happy to have his Mum and Dad." (Pause.) "And to sleep in the middle".*

*Thandi looks at her and nods. Thandi checks that the blankets are covering them properly.*

*Angela reflects: "The people are nice and warm."*

In all of the children's play including bedtime routine, the child/baby sleeps with someone else in the bed, except for Zama's play. In Thandi's narratives the baby sleeps either with the Mother, or between the Mother and Father, or in the final session, the whole family goes to sleep together, the siblings in one bed, adult men in another bed, and adult women in another. Smangele has all the children sharing the available beds. They sleep in a row next to each other. The babies also have bottles, "Only when they cry." Her favourite figure (the doll with blonde hair) "gets two bottles". In the second session which includes the Mother figure, "The mommy must squash up" next to the children. In Winnie's play the sister and baby sister sleep together. This could be related to the fact that there are only two beds in the set, or to real life past circumstances (and pre-Children's Homes) of sharing beds. But possibly is also related to the need for closeness and security. Barclay Murphy (1972) describes play of getting into bed with mother, as evoking some of the comforts of reality, but also through symbolisation as evoking some sense of reunion with mother, "The ability to turn longing into compensatory fantasy in order to cope with loss..." (p.125). Zama, has the girl figure sleep in her own bed, and the parents sleep in the double bed. However, the parents do pray around the child's bed so that she may sleep well.

Routine R4, which incorporates mealtime routines in which food is distributed in rations according to the size of the person, is used the second most frequently. However, only two children use it, with Smangele devoting most of her play across her three sessions to this activity. Her play was particularly concerned with hierarchies within the Children's Home and at home, in relation to food, drink, space in bed. The older ('bigger') the child the more food he/she got. The older, more favoured child got the first place in bed.

Other routines that are very important are meals, giving each person food (R3), the preparation of food (R2), setting up the table for everyone to sit around (R1), and the clearing away after a meal (R5). Food is associated with nurturance, as well as physical nourishment. There are also times in the play when all family members come together to share in the activity of the meal. Mealtimes are also a routine of daily life and therefore punctuate a day. Food also represents nurturance and is related to Freud's (1920, in Jeffrey, 1984) first psychosexual stage of development – the oral stage. Oral gratification is associated with 'mother' love. At the end of Thandi's first session, she even uses the gem-like heart to butter bread, as if dishing out love to all the characters in the form of food.

The next most commonly played routine is that of bathing and dressing (R7). This also seems to be related to (R11) routines associated with going to and from school or work.

Finally another common feature in the play are leisure activities which are carried out together, the most common of these being the leisure activity of watching television. I think this related both to life in the Children's Home and life at family homes.

Sorensen (1993), using a qualitative-quantitative method, sought to explore the stressors and coping resources of 42 children, ages 7 – 11. Coping resources were identified as situations, people, activities that were mediating factors that reduced the effects of stress or enhanced coping. "Organised activity" was the category reported with the greatest frequency. This category included activities such as school, church, scouting activities,

social gatherings in which a child was involved in a family or peer group. This seems to confirm two findings in this research. Firstly that structured and predictable activities are helpful to children dealing with bereavement and stress; but that an important aspect of these activities is that they involve a family or peer group. In all of the themes coded as routine, a family or peer group conducts the routines, whether it be mealtimes, bathing, watching TV, swimming or sleeping. The only session, which involves a solitary figure, engaged in solitary activity, is Zama's third session, in which the farmer is surrounded by animals and cares for them.

Another coded theme, which did not include routines, except meals, but which also had a high frequency were those meaning units coded as family gatherings. This category included those sections of the narrative, which involved a family meeting either with the purpose of discussing or supporting the sick person, or family celebrations. In Thandi's first session Mother, Father, Baby and two Doctors watch TV together before the Doctors examine the baby, while the Mother and Father wait on chairs in the waiting room. After that the Doctor pronounces the baby better and the Mother and Father celebrate and drink champagne. In her second session Grandfather telephones the Uncle to come and join the family for a family meeting about the sick brother. The Aunt prepares food for everyone. At the meeting are Grandfather, Grandmother, Mother, Auntie, Uncle and Doctor. The Doctor calls another Doctor and again the Doctors examine the baby and pronounce him well. In her third session, Grandfather, Grandmother, Father, Mother, Aunt and Doctor are present at a family celebration of Christmas. Four children are added to the scene. The family shares a meal. The Uncle (initially identified as Father) picks fruit for everyone and Father Christmas arrives and gives them all gifts. After that the family are engaged in routines of sleeping, waking, bathing, going to work and school and swimming. The confusion in the role of Uncle and Father may be related to Zulu culture calling one's Father's brother, your small Father, or to the fact that her Uncle (together with Aunt, Grandfather and Grandmother) seems to have taken on the caring role for Thandi when she goes home.

Smangele's play mainly revolves around routines either at home or in a Children's Home. Significantly most of the activities are done together, but with peers and/or siblings, as discussed later there is a notable absence of parental figures.

Jabu has several people present in her scenes and has the family host visitors.

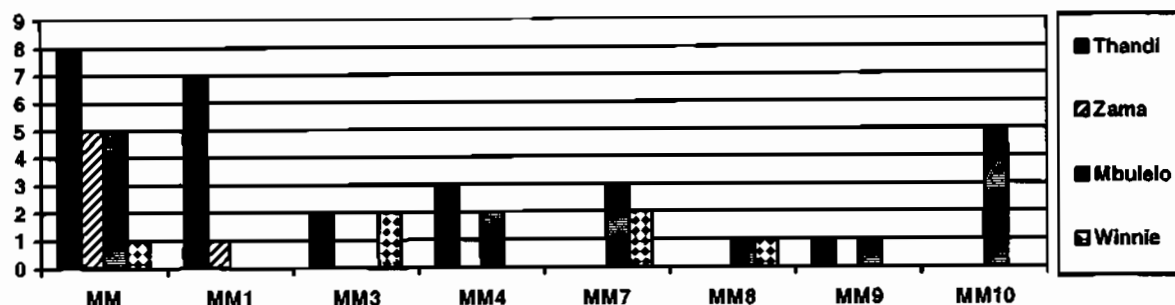
In Mbulelo's first session Father, Grandfather and Son sit around the Mother's sick bed. In his second session, Mother and son pray for Grandfather and Father and Baby Sister sit next to Grandfather who is ill. In his third session parents wait in the waiting room for their sick children or Mother.

### 5.3.3. Mother and Father:

The mother is a predominant figure in most of the children's play. With the exception of Smangele who only uses the mother in one of her sessions. In this session [Smangele] the mother sits with the children and eats a meal, and later sleeps with the children and has to squeeze in sideways in the bed. In her first session she plays a scene from the children's home, and in her last session although the children are at home, significantly there are only the seven children in the scene and no parents. Jabu's play with the mother figure is also limited. In the first session parents are present as a family, but the play is more focused on providing homes for all the child figures, than on the role of parents. In her second session there are no parents, and the children are 'kept' by the cleaning lady. In her third session there is again a set of parents and two children, but the scene again does not focus on any parental role, but rather on the presence of visitors. It is in this scene that she briefly says that her Mother was vomiting a lot.

For the other participants, the mother figure features often. This would seem to indicate that the mother figure was an important attachment figure.

Figure 4: Prevalence of Mother role.



KEY:	
MM	Presence of Mother
MM1	Mother sleeps next to baby
MM3	Mother sits with baby on lap/ hugs baby/ child
MM4	Mother takes baby to Doctor/sitting in waiting room of hospital
MM7	Mother prays
MM8	Mother as Nurse/Doctor
MM9	Mother feeds sick child
MM10	Mother is ill

In Thandi's play the Mother is most frequently placed sleeping next to the Baby (MM1). The possible reasons for this were discussed earlier, but mostly this seems to be a significantly nurturing role. The other three activities her Mother figure engages in are, taking the Baby to the Doctor (MM4), being in the family meeting about the sick baby, and sitting with the Baby on her lap or holding the Baby (MM3). Again these roles demonstrate concern for the Baby's wellbeing and a nurturing role. Combined with the nurturing role of the father and the doctor this seems to indicate a need for a caring, warm adult to look after her.

In Zama's first session the Mother and Father and Baby are present in domestic scenes of eating, praying, and going to bed. In her second scene the Mother and Grandmother and two children pray for a house. In her third scene, there is no obvious parental role - a Farmer/Grandfather cares for his animals.

Mbulelo's play concerning the Mother figure, centres around either the Mother being ill (MM10) and the family worrying and praying for her, or the Mother is worrying and praying (MM7) for the Grandfather.

For Winnie the Mother is present at meals with the children, hugs the children (MM3) and is also in one session a nurse who renders treatment to sick children.

These four children place Mother in a significant caring role. She is imbued with characteristics of being protective, being concerned for the wellbeing of her children and providing comfort and care. It seems to be important that for these children, who have been separated from their Mother, that she is such a significant figure in the play. Four of the children have lost their biological Mother, and for two (Winnie and Mbulelo) their Mothers are very ill and the children have therefore been placed in a Children's Home.

The Father features less often. He only appears in four of the children's play (Thandi, Zama, Jabu and Mbulelo) and usually in scenes in the presence of other extended family members, at family celebrations, mealtimes, and meetings. If he is in a child's scene he is usually performing a role as a parental pair with the Mother. He is only present in the first family scene in Zama's play. In Jabu's play he is present with the Mother as a member of the family, but as discussed her play tends not to focus on the roles of family members, but rather on providing a pleasant and safe home for the figures. In Mbulelo's play the Father is present at the side of the Mother's bed and with the Grandfather when the Doctor visits them. He has a supportive role, but does not engage in any activity. Only in Thandi's play does the Father assume a more active role. He is still present with the Mother in taking the Baby to the Doctor and in sleeping with the child in between the two parents, and in one instance holds the baby. There is no Father figure in Winnie or Smangele's play.

Sorensen's research (1993) as discussed earlier, also found that when discussing seeking social support from others in coping with stress, children quoted either seeking support from 'mother' or 'mother and father' who appeared to be perceived as a unit. None

reported going specifically to 'father' for support. I do not think this relates to a necessary lack on the part of fathers in general, but probably relates to traditional gender roles within families. This has been particularly prevalent in South African Zulu culture.

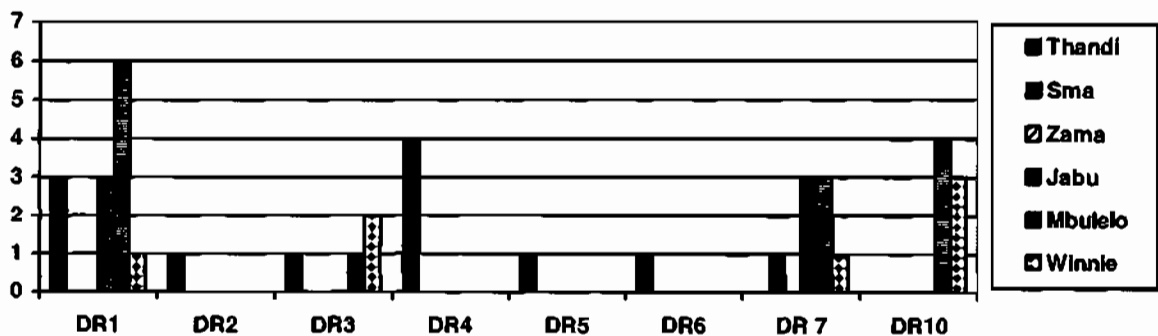
A child lives in great fear of being abandoned by her mother or significant caregiver. Where crying and anger previously were able to bring mother back, after the loss of mother, these strategies no longer work (Bowlby, 1980). After the initial shock, numbness and disbelief, comes separation distress and scanning the environment for the deceased loved one, sometimes hearing their voice, or seeing them. Then the reality of death sets in and depression is likely to occur, with an inability to initiate new attachments or action, until some detachment from the attachment figure (mother or loved one) has occurred. There is a yearning and longing for the deceased person (Raphael and Dobson, 2000). It is important for the child to focus on remembering the person and relationship. Ultimately some resolution and detachment from the loved one occurs and reorientation to a new life can happen (Bowlby, 1980; Raphael and Dobson, 2000). However, death is a type of loss that can never be recovered. We lose an external loved one and only have our internalised part of that person to hold onto, and that internalised relationship continues (Liiceanu, 2000). Children often initially do not believe the dead person has gone. Later they realise the loved one is dead but all their emotions are focused towards the deceased parent. They identify, idealise the parent and need to keep him or her alive inside (Madorin, 1999). Ultimately a child is able to get on with his or her life and form new attachments or bonds with people, but still maintaining an emotional link with the deceased parent (Madorin, 1999). I suspect that the inclusion of the Mother figure particularly for Thandi, falls within the stage of needing to keep her Mother alive inside. The inclusion of Mother in their narratives is also a need to remember and to tell the story of their past. The frequency of the mother figure in the play attests to her role as the major attachment figure in these children's lives, and a need to internalise this attachment, and tell coherent narratives about the loss of that attachment.

5.3.4. Doctor:

The next most significant theme was that of the Doctor, Nurse or Medical Practitioner. Partly this may have been influenced by the verbal introduction, which directs children into showing me how they feel especially about sometimes being sick. However, it is significant that despite the same verbal introduction, Zama does not use the Doctor at all, and her sister Jabu mainly uses the Doctor to demonstrate a hospital setting. Smangele hardly uses the Doctor, but as mentioned earlier a lot of her play is repetitive and seems to be hindered by anxiety. The other children all play significant themes with the use of the Doctor.

Figure 5: The prevalence of the use of the Doctor themes across all six participants:

<b>Key:</b>	
DR 1:	Doctor examining a child/baby
DR 2:	Doctor saying things will be okay/ the baby will be better
DR 3:	Doctor administering treatment or medication or treatment instructions
DR 4:	Doctor being taken care of/ fed
DR 5:	Doctor going home/relaxing/watching TV/having a rest
DR 6:	Doctor nurturing baby – hugging/feeding/putting to bed.
DR 7:	Doctor's equipment – examining table, syringe, stethoscope, and case
DR 10:	Self as Doctor



The most commonly played sequence involving the Doctor is that of the Doctor examining a sick child (DR1), or in Mbulelo’s play a sick parent or grandparent. I think this is related to a concern for their own illness, and the illness of those around them. In Thandi’s play, in two sessions the Doctor examines the baby and pronounces him better

(DR 4), and in the final session the family celebrates all together. Thandi also takes care of the Doctor by feeding him, he goes home to rest, and watches TV. In Thandi's play the Doctor is included in family meals in all three sessions, is fed and cared for, before he does his 'work' of examining the child.

*Angela: "And who is the food for?"*

*Thandi points to the Doctor.*

*Angela: "So you are looking after the Doctor?"*

*Thandi nods in affirmation. Thandi strokes the Doctor's head and continues to feed the Doctor.*

Mbulelo's play progresses from the Doctor examining (DR 1) his ill Mother, to in the second session the Doctor examining his ill Grandfather who has since passed away. In the third session he expresses a desire to be a Doctor himself (DR 10). I think his desire to be a Doctor stems from a desire to help in a situation in which he feels helpless in relation to illness in his family.

Winnie in one session plays that the Mother figure is also a nurse who sees sick children and dispenses treatment (DR 3).

*Angela: "You wish you had someone like your Mother to look after you?"*

*Winnie: "Yes".*

The Doctor in Thandi and Winnie's play becomes integral to the family dynamics.

The other theme of the Doctor is the presence of the Doctor's equipment and the examining table in the scene. Jabu's Doctor play is related to a hospital scene and her dialogue is around trauma. Firstly she discussed a boy at school who was knocked over and taken to hospital. She then discusses the shootings in the Congo and finally discussed her Mother vomiting and taking her Father to hospital, and her Mother was crying. Her Doctor play is therefore meaningful and appropriate in terms of her life experience, but is not specifically related to illness and HIV.

*Jabu: "My Mother was always vomiting every day and my Father was sick."*

*Angela: "Also sick here in South Africa?"*

*Jabu: "Yes"*

*Angela: "Did you wish you could take them to the hospital?"*

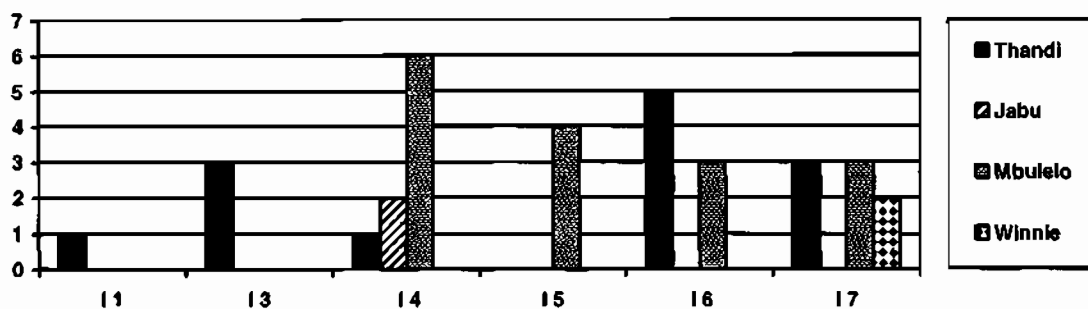
*Jabu: "They take my Father, they take him to the hospital and then when my mum was crying..."*

### 5.3.5. Illness:

Related to the Doctor theme is the theme of illness, which features significantly in both Thandi and Mbulelo's play.

**Figure 6: Prevalence of the themes of illness:**

Key:	
I 1	Illness of children/ child/ self
I 3	Illness of sibling
I 4	Illness of parent
I 5	Illness of grandparent
I 6	Action for illness: special food/ special bed/ praying/ family meeting/ social worker
I 7	Taking to Doctor or hospital/ waiting rooms



Thandi's play mainly features the illness of a Sibling (I 3), and action taken for an ill person such as special food, a special bed and a family meeting about an ill child (I 6), and finally taking a child to hospital for treatment for illness (I 7). Mbulelo's play revolves around the illness of a parent (I 4), his Mother, which is true to his real life; as well as concerns over the illness of a grandparent (I 5). He also uses both actions taken for illness (I 6) in terms of family meetings for the ill person and praying for the ill person, as well as calling the Doctor for treatment of the ill person (I 7). Jabu's dialogue is around the illness of both her parents, while Winnie's play with regards to illness centres around action taken for illness such as going to the Doctor (I 7).

The prevalence of both these themes in the play seems to support the hypothesis that these children experience anxiety around the theme of illness.

### 5.3.6. Heart and Spirit:

I have grouped these together, for although they are different themes, they seem to have a similar function for the children. Each child has either used the heart or some aspect of spirituality whether it is praying, or the presence of an angel. The heart seems to serve the dual role of showing love and of signifying a special place, as well as showing the presence of a transcendent protective being. Thandi, Smangele and Jabu all place the heart near the bedside. This is done to show love, but also seems to serve the purpose of protection. Smangele uses the heart to demonstrate the presence of Jesus in the night.

*Angela: "Who is the heart for?"*

*Smangele: "Jesus. The heart is for in the night."*

Jabu makes the same association:

*She picks up the red wooden heart.*

*Jabu: "These people have God, they are having God in the house."*

Jabu also has an angel present in the garden who talks to the animals, and in her second scene two visitors come from church to tell the family about God.

*Angela: "Who are these people?"*

*Jabu: "They are coming to teach the people that God loves them. And when they was talking, they prayed."*

Winnie places the heart at school.

*Angela: "It seems like school is a special place?"*

*Winnie: "Yes."*

Winnie in two of her scenes also has the presence of the angel. The angel is a protector at night.

*The angel comes to stand next to the sleeping children*

*Angela: "What does the angel say to them?"*

*Winnie: "This one here (pointing to the older child –self representation) saw the angel."*

*Winnie: (Speaking as the angel) "I am coming to visit y'all. I am coming to guard y'all."*

*The angel stays standing next to the children's bed.*

Other aspects of the spiritual are praying at mealtimes and at bedtimes, and praying for sick people or for help. In two of Zama's sessions praying plays a central role. In the first sessions the family pray to say thanks for the meal. Then they pray for the child to sleep

well, then the parents pray before going to sleep. In her second session a Mother, Grandmother and two girls pray for a home.

*Zama:* “And they don’t have a house and they always pray.... And they have to look for where they are going to stay and God will give them a place to stay.”

In two of Mbulelo’s sessions, family members pray for the sick person. In his first session the young boy (self) is in prayer position, praying for the Mother because she is sick. In his second session, both the Mother and young boy (self) are in prayer positions, praying for the Grandfather who is ill.

Again this reconfirms the literature, which suggests that a belief in God is often sought in times of dire stress (Bronfenbrenner, 1979; Herbert, 1984; Rutter, 1981). It seems to be important for the children to believe that there is a transcendent protective and guiding presence, which is able to fend off the scariness of night and in times of need. “Belief in both life after death, which is ‘cosubstantial’ to the orthodox religion and its rituals, and a purpose in life buffers the difficulties of bereavement” (Liiceanu, 2000, p.117).

#### 5.3.7. Animals:

Four of the children use animals in their play. Only Smangele does not. Domestic animals are said to evoke feelings of protection, vulnerability, compliance and dependency. Wild animals are said to evoke aggression, fear, survival, strength and power (Seedat, 2000). Thandi places a cow and cat in her first scene. The cow is associated with nurturance, food and Mothering (von Staabs, 1971). The cow is present in a session with similar themes and concerns for nurturance and caring. The cat is often also linked to ‘feminine’ attributes and evokes comfort and warmth (von Staabs, 1971), which is appropriate to its placement on a chair in the house and in a later session on a towel in the sun with the family. Thandi also puts chickens in the garden, which are said to evoke a need for feeding, caring and nurturance.

Zama, in her third scene, takes the animals out of the storage box, picking up the birds & all of the domestic animals, then the cow & the pig & the piglets and places them around the Grandfather / farmer figure. Then she places the dog and cat, and the geese, all looking

towards the Grandfather. She then takes the fox and the crocodile to place them on the outside of these animals. I am not sure of the meaning of this session, but believe that it alludes to the need for protection and caring which the farmer provides the animals, which he loves. The domestic animals are dependent on him, for love and food, and he provides. He even loves the threatening animals, the fox and crocodile. The presence of the fox and crocodile may allude to some awareness of fear, aggression and distrust, on Zama's behalf, especially as she nervously giggles when discussing these two animals or the need for protection provided by the fox and crocodile.

Jabu in all three sessions lays out a garden and in the garden she places trees, and a pond, and then places domestic animals in the garden and ducks on the pond. I think this evokes a desire for domesticity, idyllic home life and stability. She does comment about this country having different animals. I ask her which ones she likes, she says she likes these ones [the domestic animals]. In the second session, snakes hide behind the other animals. She places a teacher and blackboard next to the animals and the teacher teaches the animals of the danger of snakes. This seems to indicate the need for an adult mediator to 'teach' or help with the things that threaten one's peace. She places the two large cows walking away from the whole scene. This may refer to the retreating maternal influence, while there is a new teacher, guiding one from the threat of snakes who could kill you. In her last scene snakes again threaten the scene. They are used for black magic and to kill people. This narrative comes about when talking about death and trauma. Again snakes threaten her sense of safety.

Mbulelo only uses animals in his first session. The panther and fox are placed outside the box with the approaching car (social worker) and coffin, all approaching the house (box). The scene is the one in which his Mother is ill. The presence of these threatening, fearful and distrustful animals, seems to allude to his fear of the potential outcome of his Mother's illness, and possibly to some anger that he already feels. These things are all outside the box, suggesting that they have not yet been internalised, but that they are on the edge of his awareness.

In Winnie's first scene of the safe house with large outside walls, the snakes and a crocodile come towards the two girls in bed and the angel is positioned above their bed to protect them. The snakes attack the angel. Winnie then searches for something to eat the snakes. First she uses the cow, then adopts the spider (a devouring feminine archetype) to eat the snakes (von Staabs, 1971). This possibly alludes to the need for the Mother to destroy night fears. More sinisterly, it may also have sexual allusions. Either to oedipal thoughts of feminine internalising the masculine phallic snake, or to the threat of snakes (masculine phallic symbols) in the night, that even the angel cannot protect her from. Her spontaneous comments may allude to this:

**Winnie:** "Sssss....eat you.....ssssss." (*Pointing to a snake*) "This is a very long snake."  
*[Does this refer to the toy or to the penis?]*

**Winnie:** "Somebody is going to see the snakes."  
*[Is this a wish that someone will notice?]*

#### 5.3.8. Transport:

Transport is a more minor theme. However it does have some significance. Thandi, Jabu, Mbulelo and Winnie use transport in their play. The car is used eight times, and is primarily used as a means of transport to and from work. Thandi makes a car out of blocks and chairs. The Doctor, Mother, Grandfather and Uncle go to work, and later come home from work in the car. Winnie also uses the car for the Mother to go to work and come home from work. The Mother is a nurse. Mbulelo uses the car to represent the social worker who is approaching the 'home' (scene) where his Mother is ill. The car is useful in showing routines and also as a symbol of 'power' and 'mobility' – the Mother as nurse and the social worker, and for Thandi with the people going to work including the Doctor.

The train is used six times. In psychoanalytic play techniques, the train is often considered to be symbolic of sexual and oedipal play. The train can also be a symbol of escape. Thandi plays with the train in her first session, making it go around in circles. Later the Doctor goes home on the train. This scene comes after feeding the Doctor and the Doctor putting the child to bed, then the Mother joins the child. Possibly the train suggests some need to escape a painful situation, but also out of recognition of caring for the Doctor so he will remain able to care for her.

Jabu uses the train a lot in her third session. She makes tracks for the train out of coloured blocks. She spends time admiring the train pieces, putting it together and driving around the tracks and under the bridge and through three pillars. She says it belongs to the people of the house and puts one person in the carriage.

#### 5.3.9. Organising Environments:

A significant portion of the play is coded as organising environments. This was play that involved setting up a house, or hospital or school scene. This obviously becomes quite a large part of the play, out of necessity one has to organise the toys into a narrative and the narrative needs a context. In terms of narrative, structuring the environment gives context to the action, to make it meaningful and understanding. Context helps us to frame and read human behaviour or human texts (Forbes and Yablick, 1984). Children learn social interaction by learning general 'scripts' of human action, and scenes and actions appropriate to certain settings. Context therefore is vital for organisation of social knowledge (Forbes and Yablick, 1984). Organising the environment and constructing a scene, also gives the children a sense of mastery over their miniature environment as they structure and order it to their specifications. Erikson (1972) describes this as mastery and structuring and understanding one's cognitions. An example of organising the environment is setting up the house.

*Jabu: takes out all the household furniture first. She lays the pieces of material out in the box (like a carpet). Then she folds the sheet and makes the bed and places it in the corner of the box. She places the food box in the house. Then she makes a table and places it next to the bed and places two chairs around it. She takes the bed out and remakes it with different material. She now rearranges the house again, working quickly, purposefully and meticulously. There is one piece of material with 2 chairs and a table on it. Then there are two chairs, a table, a bed and a cupboard on another piece of material. She has made two houses for the two families.*

#### **5.4. Reading 3: Reading for aspects of play**

##### **5.4.1. Play as natural medium of expression**

Play is a medium through which children can express and process their thoughts, and is useful for establishing rapport between child and researcher (Oaklander, 1988; Winnicott, 1971). Through observation of the process of each child's play, the character of their play, their affect while playing and their interaction with the researcher, it is believed that only five of the six participants really engaged with the medium of play. The exception to this is Zama's play. Initially I will discuss the five participants before returning to the exception in this regard.

Thandi (aged 7) plays quietly, but confidently and with purpose. She seems to know what she wants to do. Thandi appears to engage easily in the play, and plays for a long-time. Her play is unselfconscious, and she does not need prompting to play. She responds to the researcher's reflections, by smiling at the researcher, or looks directly at the researcher, as if to acknowledge the interpretations are correct. She seems to like the researcher taking the time to find out. She also smiles at the researcher in amusement when she asks questions like, "Who is that?" (Pointing to the Doctor). Thandi looks at the researcher smiling as if she should know whom it is and says, "The Doctor."

Smangele (aged 7) likes the toys. The plates and their small size excite Smangele. She spends quite a lot of time exploring the toys. She picks up things and asks, "What's this?" She constantly makes comments about her play, i.e. "it's a towel...shu its big...close the cupboard and put it in... there's a toilet... what's this?" I think that Smangele relates well to the medium of play. She becomes absorbed in what she is doing and sings and hums while playing. However, her play does become distracted and she becomes easily absorbed in sorting behaviour, spends a lot of time organising the environment and plaiting a doll's hair. I think this is related to anxiety, which I will discuss under the heading of containment.

Jabu (aged 8) seems happy to be there. She is chatty in the initial conversation, and says she just wants to start playing. She plays with energy, is quiet and intensely involved and engaged in what she is doing. She seems focused. Her play also progresses over the three sessions. Even in this first session she seems to have a clear idea of what she wants to do. However, as the play goes on and she discovers new things, she faces some indecision and ends up deciding to remake the house. She revises the play as it happens. In the second session she takes out all of the house furniture and lays it on the carpet, preparing again to build a house. She plays methodically and neatly puts down carpets first before laying out the house furniture. Her third session continues this theme of organised purposefulness. However, at the end of this session her narrative becomes much more incoherent, perhaps as she is grappling with difficult issues. She quietly affirms the researcher's reflections and tells me what things are, for example, "This is a hospital." "These two are cleaning the house."

Mbulelo (aged 10) gives an impression of being serious and taking the task very seriously. He plays methodically, deliberately and with purpose. He concentrates intensely on his play. He is quiet, systematic and does not hesitate in setting up his scene. He does not seem to be engaged in 'play', so much as telling me a narrative. He explains the scene in a quick coherent narrative. He seems to value these sessions.

Winnie (aged 9) appears to enjoy the opportunity to play. She is friendly and interacts easily with the researcher. She is keen to play, excited and chatty. Winnie talks softly to herself, describing what she sees or is doing; for example, "There's an angel". She has a young, singsong voice. She presents as younger than nine years old. She is physically smaller than most other nine-year-old children. This may indicate some emotional and physical developmental delay related to her HIV positive status and disruption in home life.

Zama (aged 11) presents as happy, relaxed, and competent and engages with the researcher, but at the same time is self-conscious. Zama's play is meticulous, neat and very ordered. She plays quietly, carefully and efficiently. However, there is a sense of

not being engaged in the play, as if she is playing for the researcher (me) like it is a school task which she is doing “properly” and “co-operatively”. She is not risking revealing any part of herself. Zama does not play for long. She looks through all the doll figures, carefully choosing which ones she wants. She lays these on her lap. Then she places each one with precision.

I suspect that Zama’s reluctance to play is related to her age, as she is older than the other children are. She may have responded better to a verbal interview. However, although, Mbulelo, who is 10, does not play in the same way as the younger children, he is still engaged in the narrative. Therefore I also suspect that Zama’s reluctance is related to being highly defended and possibly overly mature to compensate for the significant losses in her life. Play outside the play-box in two of her scenes seems to indicate disconnectedness from self (von Staabs, 1971).

Three of the children, Smangele, Winnie and Jabu, talk while they are playing. Sometimes this talk is directed to me, and at other times it is as if they are talking to themselves. Smangele talks constantly making comments about her play, but as if to herself, and not expecting a reciprocal interaction, for example,

*Smangele places the pond down and says; “ There is the bathroom.” She takes out the big towel and says, “I’m going to go with one at a time” Picking up one doll, she says “The big one is going first”.*

Jabu says what things are, for example, “*This is a hospital.*” “*These two are cleaning the house.*” Winnie talks softly to herself a lot, describing what she sees or is doing; i.e.

*Winnie: Lays out 4 chairs in a row.*

*Winnie: “ How should I make a table?”*

*She takes out the cylindrical blocks and places the tabletop on them, making a table in front of the row of chairs.*

*Winnie: “I should make a house”*

*She builds up the walls of the play-box (house) with coloured blocks.*

*Winnie: “ I’ll make the house nice now.”*

Weiniger (1989) says that children do this to clarify their thoughts by hearing themselves speak.

#### 5.4.2. Assimilation of knowledge and making sense of the world through enactment of experience

Play is one of the most significant ways in which a child makes sense of the world by testing her experience of reality through play (Singer and Singer, 1990). It seems to be significant that all of the children play things that are related to their experiences. Thandi's themes predominantly centre on illness and actions from family in response to illness of a child. Smangele plays scenes from the Children's Home. She has fairly recently come to the Children's Home. Jabu and Zama both speak about homelessness. Mbulelo plays various themes around illness and illness of significant others. Winnie plays themes of being different at school and of illness. As our self-narratives are based on our experiences, it does seem to be significant that in most of the sessions, the main themes contain aspects of experience that may be perceived as difficult to assimilate and deal with, such as illness, death and homelessness. Through rehearsal and repeating stories, a child can gain a sense of mastery over what happens in the outside world (Oaklander, 1988). Mbulelo in particular seems to want to gain mastery over illness of significant family members, by showing in the last scene his desire to be a Doctor. Thandi's play of the Doctor pronouncing the baby better, could also be one way of gaining mastery over an anxiety provoking situation.

The predominance of routines in the play also seems to relate to this making sense of the world. Routines seem to add structure to a child's world and their sense of security, containment and structure in that world. Routines help a child make sense of the world. Children re-enact ordinary experiences such as eating, sleeping, toilet training as well as more stressful experiences such as being sick and playing out strong emotions (McMahon, 1992).

#### 5.4.3. Play as oriented towards growth

This aspect has been difficult to ascertain without prior or subsequent knowledge of the children, and with only three contact sessions. However, within that limited time, there is progression in the thematic play of the children, which seems to indicate some orientation towards growth and some resolution. For example:

- Thandi's play moves from two scenes in which a Doctor examines a baby and pronounces him better, to her final scene, which is a family celebration.
- Zama's play moves from her first scene being an idyllic family scene, to a scene about being homeless, to a scene in which the farmer cares for the animal. This may suggest coming to terms with someone else other than her parents, taking care of her needs for love and food.
- Mbulelo's play moves from his Mother's illness, to his Grandfather's illness, to himself being a Doctor, an orientation towards growth, which suggests a self-concept of being able to help.
- Winnie's play moves from a scene about home being threatened by snakes, to a scene in which her Mother is a nurse, to a final scene in which two girls make friends again after a fight. In this scene she reparates and makes the other feel better, and seeks support from school and peers, which may be a positive solution, in light of the potential loss of her mother.

#### 5.4.4. Play as catharsis

Play can provide a catharsis or abreaction for the release of psychological tension and can help to "ventilate" some of the emotional charge attached to an event (Herbert, 1984).

*Thandi opens the white heart case so that the red heart can shine through.*

*Angela: "And the baby loves the Mother a lot. That's why the heart's there. And the Mother loves the baby".*

*Angela: "Does the baby miss the Mother?"*

*Thandi looks at her and nods her head.*

#### 5.4.5. Containment and potential space

It is generally recognised that sufficient containment is necessary to support the child through therapy (Bion, 1962, in Reade et al., 1999). Four of the children seemed to have sufficient containment to fully engage in play, and to play out anxiety provoking experiences, such as visiting the Doctor, or having a sick parent. However, Winnicott (1964) believed that when anxiety became too extreme for a child to bear, she would be unable to engage in play. Erikson (1977, In Jeffrey, 1984) called the point of interruption

of play themes due to anxiety, an 'autotherapeutic point'. Smangele's play seems to be scattered and disjointed, not making a single coherent narrative. Her play led me to asking about her family. After these questions she would engage in sorting behaviour (sorting the cutlery and crockery) or distracted play, such as plaiting the doll's hair or shaking the box. With hindsight while transcribing the tapes I recognise that my questioning about her family life and brothers and sisters, was oddly and inappropriately persistent and causing Smangele much anxiety, which distracted her from her narrative. For example, while playing that the children are having a meal, she will suddenly be concerned about the dolls having shoes, then come back to clearing the plates, and then start plaiting a doll's hair. This however, was also a means through which I sought to make 'contact' with her.

*Angela: "Where are the children...are they at the Children's Home or at home?"*

*Smangele: "At home."*

*Angela: "Where's home?"*

*No response.*

*Angela: "Do you have brothers and sisters?"*

*Smangele: "I have 2 sisters and 3 brothers."*

*Angela: "And where are they?"*

*Smangele: "They are with my Granny."*

*Angela: "And is it just you who came here [the Children's Home]?"*

*Smangele: "And my one other sister."*

*Smangele again starts singing and sorting the plates and shaking the box, and banging it.*

*Angela: "It must have been funny coming here without your brothers and sisters?"*

*Smangele: sighs*

*Smangele: "Where's another knife?"*

*She again begins counting, sorting and singing.*

*Angela: "What happened to your Mother?"*

*Smangele: "She died."*

*Angela: "When did she die?"*

*Smangele: No response, she starts humming a hymn.*

*Angela: "Do you miss her?"*

*Smangele sings and starts to plait the long blonde haired dolls hair. (+/- 10 minutes).*

Smangele would need more structure, time and containment before exploring these issues. She however, did like sitting in my presence. In all three of Smangele's sessions, I had to bring the play to a close because of time constraints. This would seem to indicate that

Smangele would benefit from further intervention, but that she would need more time to feel safe in expressing these anxiety-provoking emotions.

#### 5.4.6. Play as metaphor (The 'as-if' quality of play)

As children develop, so they are able to manipulate narratives and use objects, and later ideas, metaphorically or symbolically. Thandi engages in fantasy and is able to represent objects, such as making a bath out of coloured blocks, a car out of four chairs and coloured blocks, and a swimming pool using the pond and four blue blocks.

Preverbal emotions are seen as very difficult to express, hence the necessity for metaphor, as in the use of representational play, art work, or metaphor in language (Lowenfeld, Traill and Rowles, 1964). A lot of the play, which involves animals, seems to indicate primitive fear, and a need to 'beat' it.

*Winnie picks up the 3 snakes and puts them on the floor going towards the bed.*

*Winnie: "Sssss....eat you.....sssss." (Pointing to a snake) "This is a very long snake."*

*She also puts the crocodile into the house, making it go for the children and the angel.*

*Angela: "Lots of scary things are coming...the crocodile even ate the angel."*

*Winnie puts the crocodile away/back in the toy box.*

*Winnie: "Somebody is going to see the snakes."*

*She takes the cow, making a growl-like moo to attack the snakes. The she puts the cow back and looks in the toy box.*

*Winnie: "What eats snakes?"*

*She takes out the spider and she makes growling noises and the spider says, "What are you doing?" to the snakes. The spider and a snake fight. "They're eating each other."*

*Angela: "Fighting."*

*Winnie: "It eats the snake. It is in its stomach."*

*Angela: "The spider eats the snakes and protects the people."*

It is interesting in this scene that the two animals that come to the rescue are the cow and spider. Both these animals are identified (von Staabs, 1971) as archetypally representative of feminine qualities. This could be an expression of the need for attachment and protection from mother.

#### 5.4.7. Play aspects of the dialogical self:

The self is seen as fundamentally interpersonal in nature (Hermans and Kempen, 1993).

As children develop, they are able to play the roles of certain characters, but also to reverse the roles, therefore learning to take the attitude of particular others towards themselves and assimilating various 'I' positions (Hermans and Kempen, 1993).

In Thandi's first session there is a reversal in the caring role, where Thandi cares for the Doctors before they examine the Baby. The Doctors are given food and time to rest and watch TV. This seems to be Thandi's way of ensuring that these people will be able to care for the Baby, a representative of self, and demonstrates a sense of empathy at understanding that the Doctors need caring to enable them to do their work. It also provides a way of taking various "I" positions, and integrating a projected need for caring. The need is initially projected onto the Doctor and then drawn back into the child.

Mead (1934, cited in Hermans and Kempen, 1993, p.103) reflects on the child's representation of the dialogical self in play "The child says something in one character and responds in another character..."

**Winnie:** *"The two girls are walking together."*

**Winnie:** *(As one of the girls #1) "Check my hair is longer than yours...oooh" (teasing voice).*

**Winnie:** *(As girl #2) "I don't care that your hair is longer, so bushy hair."*

**Winnie:** *(As girl #1) "I'm not a bushy haired, same like you."*

**Angela:** *"Do they feel bad?"*

**Winnie:** *"Ja that's what they do...teasing each other." The girls fight.*

**Angela:** *"She must feel sad?"*

**Winnie:** *"She was sad."*

*The girl sits by herself.*

**Angela:** *"And she is all alone."*

**Winnie:** *(As Girl #1) "You can't just do your hair like this." And she is gone.*

**Angela:** *"She must feel sad and cross with the other girl."*

Winnie is able to move from dialogue with me, and back into the role playing dialogue with ease.

**Winnie:** *She plays that sick people are coming to the Mother (who is a nurse).*

**Winnie (As nurse/Mother):** *"Okay you can come to me."*

**Angela:** *“How does that boy feel when he’s sick?”*  
**Winnie:** *“He feels angry”* [Dialogue with researcher]  
**Winnie (as nurse):** *“Hello, how are you?”* [Role play as nurse]  
**Winnie (boy):** *“I’m fine”* [Role play as boy]  
**Winnie (nurse):** *“OK let me check your chest.”* *The Mother listens with the stethoscope.*  
**Angela:** *“What’s wrong with him?”*  
**Winnie:** *“He’s sick.”* [Answers as Winnie]  
**Winnie:** *(In acting voice, as boy) “My chest is sore.”* [Answers as boy in role play]

Winnie is able to move between non-play metacommunication with the researcher, about the play, and imaginative communication in the dialogue between figures (Bateson, 1979; Goncu and Kessel, 1984). Bateson (1979) calls this ‘framing’. A child understands the signals between different levels of language, text and context. Dialogue is conceived of as a process in which the participants continually orient themselves and others to a negotiated meaning (Vygotsky, 1962).

## **CHAPTER SIX**

### **DISCUSSION**

#### **6.1. Researcher's assumptions:**

Qualitative research recognises the researcher as an instrument in the research process, and that no inquiry is value free. In view of this I acknowledge my own assumptions associated with this study. These assumptions influenced my selecting this research and way of working.

Firstly, I believe that play is a valuable medium for working with children. I believe that play has symbolic value as well as literal value. What a child plays or sometimes significantly does not play, is often indicative of intrapsychic 'conflicts' they are dealing with. I also assume that children will play what their present intrapsychic concerns are, and that these have continuity in theme across sessions (Erikson, 1972).

Secondly, I believe that children of this age range are able and willing to comply with the requirements of the research. I believe that they are able to play as the verbal introduction requested them to. I also believe that children will respond as openly and honestly, as they are able to, from their own personal life perspective, and that it is important to gather information from the child's perspective.

Thirdly, in terms of theory and methodology, a qualitative enquiry attempts to preclude presupposed theoretical frameworks, "we always know something already, and this knowledge is intimately involved in what we come to know next" (Kaplan, 1964, in Sorensen, 1993, p. 81). Prior knowledge of the theories of risk and resilience and attachment has contributed to my conceptualisation of this research.

## **6.2. Revisiting the aims:**

The aim of this research was to ascertain if the Sceno test would be a useful procedure to increase our understanding of children's intrapsychic experience of HIV/AIDS related illness, impending death, and/or the death of their parents.

### **6.2.1. What are the intrapsychic themes of children affected by HIV and AIDS, as expressed using the Sceno test?**

The highest frequencies of themes were:

- Family routines and therefore the need for structure and the presence of significant others in one's daily activities to provide a sense of security and belonging,
- The Mother figure, who is traditionally the primary attachment figure, and therefore the loss which is most threatening to the child's sense of self,
- Organising the environment. This was due to actually setting out a scene, but also provides a child with mastery over a miniature world,
- Illness and activities associated with illness such as being examined by the Doctor, going to hospital, having a special meal and praying for a sick person. This is appropriate for children who are HIV positive. However, it raises an interesting question. These children have not been informed of their status or prognosis. Do they have an intuitive fear of being ill because family members have died from being sick? It would be an interesting question to investigate, but is thwart with ethical dilemmas, and beliefs about when and if to tell a child of their status. Most present research suggests that it is best to inform the child, as children have fears and anxieties about their illness, and need to be able to talk about and deal with these (Madorin, 1999; Marcus, 1999; Sherr, 1995). However, for many people working in this field this is a difficult thing to do, and many fear telling a child early and then making them anxious when they still have a long time to live.

The findings confirm much of the literature on attachment, loss and separation (Bowlby, 1980), and risk and resilience (Rutter, 1981; Madorin, 1999). Certain external factors are

necessary in promoting internal mechanisms that help a child to be more resilient (Grotberg, 1995). As is seen in a lot of the play and in previous research (Dutra *et al.*, 2000; Grotberg, 1995) a stable attachment to a caring, consistent adult who can support the child and her needs is vital for resilience. Therefore, although it is recognised that play is very important, other structures to support resilience need to be put into place too. A child should have a warm, consistent emotional attachment to a trusted person who can acknowledge and have empathy with the child's concerns, anxieties and fears (Bowlby, 1980; Rutter, 1981). Peer support and relationships are also important. Having daily structure and planned activities, as well as attempting to keep a child's routine as similar as possible to before the loss, is helpful in facilitating coping (Madorin, 1999). They help the child to feel safe and 'contained'.

Helping a child to keep the memory of the deceased loved one alive, helps children to internalise the relationship with a lost loved one (Liiceanu, 2000; Madorin, 1999). Helping a child to tell the story of their illness and their loss is important in creating a coherent narrative, which facilitates resilience (Byng-Hall, 1997). Play is also recognised as being an important means for a child to construct self-narratives (Hermans and Kempen, 1993). Children in this age group, if given the opportunity, will play to relieve the tensions associated with bereavement, loss, illness, and to express strong feelings that are difficult to express in words (Madorin, 1999).

#### 6.2.2. Does the data demonstrate the usefulness of the Sceno as a play assessment technique?

As discussed in the previous chapter, this study demonstrates aspects of play as outlined in the literature. This would seem to indicate that it is useful as a play assessment technique. The themes that arose out of the study were also significant and supported the literature and research already available in this field. The research was effective in describing the particular intrapsychic themes of these six children, and many commonalities were found.

As discussed in the literature review, play is the natural medium for children to communicate through. I found that all children responded well to this medium of

expression, except for Zama who may have responded better to a more verbal approach. However, all of the participants' play assessments yielded rich data. Even in the case of Smangele who was possibly too anxious to play, the absence of a coherent narrative points to extreme anxiety and the need for further containment and support around these issues. In Zama's case, even in her short play sessions, the play indicates similar patterns in themes and still points to intrapsychic concerns, of having a secure, safe home and someone to look after her needs. Erikson (1972) describes similar engagement in play, using comparable play equipment, to what I observed in the children of this study.

It is a common experience, and yet always astounding, that all but the most inhibited children go at such a task with a peculiar eagerness. After a brief period of orientation when the child may draw the observer into conversation, handle some toys exploratively, or scan the possibilities of the set of toys provided, there follows an absorption in the selection of the toys, in the placement of blocks, and in the grouping of dolls which soon seems to follow some imperative theme and some firm sense of style until the construction is suddenly declared finished (Erikson, 1972, p128).

Erikson (1972) suggests that play is in some way influenced by a need to communicate, to confess, to exercise growing faculties and also serves as mastery of complex life situations. By manipulating a world in miniature form a child can gain a sense of mastery over her life circumstances and inner conflicts by constructing and integrating or assimilating a more coherent narrative. "In order for a child to understand something, he must construct it himself, he must re-invent it" (Piaget, 1972, p.27).

### **6.3. Implications of findings for the narrative framework:**

Byng-Hall (1997) investigated how security of family attachments hindered or facilitated care of ill or disabled members of a family. He, as in this study, links narrative, attachment and illness. Illness elicits attachment behaviour. If attachments in the family

are secure, then the caregiving is appropriate. However, if the attachment is insecure, it may lead to inadequate care of the sick person or a smothering care, to the extent that the ill person cannot recover. Therefore, it may be beneficial to help families to tell coherent narratives about their painful experiences, including their illnesses. A coherent narrative has internal consistency (the elements of the narrative do not contradict each other) and it is plausible. Therefore traumatic incidences have been incorporated into a person's self and although painful, sense is made of it. Incoherent narratives include misinterpretations and multiple models for the same situation that are contradictory to each other. For example a child who saw a parent commit suicide, but is told he died in a car accident may believe the two conflicting models. If these conflicting narratives are unresolved, there is no movement forward. Therefore helping families to tell coherent narratives about their illness and loss, helps in facilitating secure attachments, and these in turn facilitate developing coherent narratives and resilience.

As the children played significant themes to their life experience, an inference from the study is that this telling of one's story and constructing a coherent narrative about one's experience and loss, is beneficial to a bereaved child, or child affected by HIV/AIDS. Whether one could prove this ethically with having a control group, who weren't offered support, is questionable. Literature on loss supports the value of narrative. At a fundamental level, loss cannot be conceived of without the human need to structure a narrative over time, in which one is able to appreciate the past when you had something, to the present when that thing or person is lost (Neimeyer and Levitt, 2000). It is also recognised that the telling of a story and having it validated, is healing to a person experiencing loss, and contributes to meaning and sense making (Neimeyer and Levitt, 2000).

Acknowledging the importance of narrative and meaning construction in grief work, and recognising that dialogue is a process by which participants actively orient themselves and others to meaning (Vygotsky, 1962), the dialogical nature of the interaction between researcher and child is seen to be useful. However, it also raises further research ideas about the value of social imaginative play for children affected by HIV/AIDS.

#### **6.4. Implications of the findings in terms of developmental play:**

Jeffrey (1984) proposed a developmental play assessment and therapeutic technique. She presents a model for assessment using various developmental theories to explain the complex play patterns, which a child presents in play sessions.

**Table 6: Play related to developmental phases and developmental theories (Jeffrey, 1984, p.70):**

Phases of therapy	Approx. Chronological age	Psychophysical (Hellersberg)	Analytic & Psychosexual (Freud & Peller)	Erikson	Piaget
Phase I	0 – 1	Sensory /tactile	Oral / narcissistic	Basic Trust v Mistrust Autosphere	Sensorimotor
Phase II	1 – 3	Motor	Anal/ pre-oedipal	Autonomy v Shame and doubt Microsphere	Symbolic/pre-conceptual thought
Phase III	3 – 6	Representational Constructive	Genital/ Oedipal	Initiative v guilt Macrosphere	Intuitive thought
Phase IV	6 +	Constructive games	Latency/ Post-oedipal	Industry v Inferiority	Operational thought Concrete operations

Using the above table helps one to assess in which phase a child is in, and gives a framework for understanding the progression of play. For example, Smangele may need to engage in sensory play and play that structures her environment, before she can role play anxiety provoking situations. Emotionally deprived children will often regress to re-experience interactions and stages in development at times of stress, or to re-experience stages that have not been satisfactorily resolved. Howarth (1964, in Jeffrey, 1984) indicates that children can become fixated in a particular developmental stage or regress to earlier stages, which need to be worked through again.

Barclay Murphy (1972) says that children from the age of three upward project in their free play the basic time-space patterns of their lives. Most of the children in this study are engaged in organising the environment and playing out space-time sequences.

It is important in play that children are able to turn passive experiences into active mastery. Turning a passively endured experience into an active one helps the child to master the stressful experience. For example, Thandi needing to care for the Doctor before he examines the child, it is assumed gives her some sense of mastery over the situation. In the same way as Mbulelo's expression of the desire to be a Doctor may be the same. "I do what you do to me" (Barclay Murphy, 1972, p 125). In the same way as children are able to play "going to the doctor and getting into bed next to mother and her new baby" (Barclay Murphy, 1972, p 125) such play invokes some of the comforts of reality and evokes reunion with mother. Therefore this longing is turned into a compensatory fantasy in order to cope with loss. However, if these basic needs are not met, play will remain aimless and focused on sensory play.

#### **6.5. Limitations of play and the Sceno as method for assessment and research:**

##### **Advantages:**

The advantages of play and the Sceno Test for assessment and research have been discussed in detail in the literature review (Sections 3.3, 3.5 and 3.6) and under Reading 3 (Section 5.4) of the discussion. An additional advantage of this method was that it enabled me to directly access the children's intrapsychic experiences, as opposed to concerns reported by others, such as parents, careworkers or teachers.

##### **Limitations:**

In terms of the Sceno materials, sometimes the children would struggle to make the figures stand in the places where they wanted them to be. The younger children struggle to make the figures bend in the right place to enable them to sit. In addition, I believe that it might be beneficial to have a table and two more chairs made, as often the children

wanted to include more people around a table for food or a meeting. Chairs and tables made with the coloured blocks would often fall over, therefore disrupting the flow of play.

The difficulty with a play session was, if the meaning or significance of some action or toy was missed out or not explored, it was difficult to confirm that meaning with the participants in a later session. I was reliant on the initial interaction and on being able to look for meaning in the context of the two other sessions, and being able to review the video material.

Another aspect of this, which relates to the difficulty of using play as an intervention and assessment technique, is making interpretations while the child is playing. I only came to realise the meaning of some of the play after much engagement in the text. How is one able to do this immediately in the play session? It is assumed that with time and consistent working on one's 'therapeutic' notes, seeking supervision and with experience this becomes easier. But it does require training and practice. This may limit who can practice this method as an intervention. However, there is also substantial literature on the benefit of playing, and having the play accepted and reflected without the need for complicated interpretations (Axline, 1989; Singer and Singer, 1990).

This thesis investigates treatment of children on an individual level. It is recognised that as a treatment method in light of this crisis, this may not be economically viable as the only means of addressing the issues of children affected by HIV and AIDS. There are valuable programmes being developed that work with children in groups, for example, Madorin (1999) has developed a 16-module programme for working with children affected by HIV/AIDS in groups. He believes that sharing experiences with others that have had the same experience is valuable for the children, and facilitates building self-esteem and coping or resilience. The Salvation Army's Masiye Camp in Zimbabwe, offers children affected by HIV/AIDS a 10 day camp in which they learn lifeskills and develop self esteem through adventure, which is also proving to be a valuable intervention (UNAIDS case study, July 2000).

However, it is believed that the experiences of the six children interviewed can give insight into some of the experiences that may be shared by other children affected by HIV. It is also believed that individual play sessions are valuable, particularly if the group programmes are not enough.

#### **6.6. Limitations of the research methods: data collection and creating the data:**

Returning to the concerns associated with video recording, raised by Loizos (2000):

- Using video recording inevitably distracts informants, until they get used to it.

I am unable to say how the children felt about being filmed. They appeared to engage in the play and be relatively unselfconscious about the video. The children showed interest initially in the camera, but this appeared to be curiosity rather than concern. However, I myself (as researcher) was self conscious in the research process. This was probably less to do with the video, than to do with my own concerns of doing this 'right', not influencing the children's play and by how much to 'question' the children. This will be discussed further under the heading '*My role as researcher*'. However the video contributes to this by making one's interaction public. Although this would only be viewed by my supervisor and myself, if I felt some trepidation, it can only be assumed that the children did too.

- The ethical considerations of privacy and confidentiality.

As suggested above, video makes children's confidential interaction available for potential public consumption. I had to be particularly careful about viewing the video material in solitude. This takes a special type of vigilance and is an important ethical consideration in working with video data, which can be publicly viewed. I feel I have been vigilant in this regard.

- Camera angles are not always optimum for capturing the most significant details of an action sequence.

The video recording of sessions has limitations if done on one's own. I was not able to stop and check in the middle of a session if the video was focussed at the best possible angle to capture the action. To do so would be disruptive to the child's play session, and would limit my presence as a non-judgemental, accepting, warm adult observer (Axline,

1964). As a result two of the recorded sessions were not as clear as I would have hoped. However, I was able to see most of what the children played and recorded all of the verbal dialogue. To not include this data would be disruptive to the sequencing of their play, and I could not ask the children to repeat what they had done. Thankfully I had also made a sketch of their final scene, and notes after the sessions.

- The camera observes from a fixed position.

This generally did not limit my data in terms of observation of the children and their play, as the wide angle of the focus was able to capture the child, the play area and the storage box, but was close enough to view the action. However, by focussing on the child, I was not captured in the frame, which may have limited my appreciation of my contribution to constructing meaning, by not being able to view my gestures and facial expressions.

- Sound quality can be poor.

I did not experience this problem.

In addition to these concerns, I experienced some concern in transcribing the play action from videotape into words. In this process, interpretation is already happening. Although, other researchers (Goncu and Kessel, 1984, Forbes and Yablick, 1984) report using video recording of children's play as a method for data collection, I could not find any literature of specific methods for transcribing this data. To compensate for my concerns and to make sure the transcripts were 'good', I transcribed the action and dialogue as fully as possible, and went over the transcripts to pick up anything that had been left out or was recorded incorrectly. Several revisions were made.

The data collection and processing, in particular watching videos and transcribing, followed by typing the transcriptions was time consuming. It gave me an in-depth knowledge of the children's play sessions, but limited the database. I therefore had qualitative data that was rich in meaning giving potential, but the database needs to be increased for more generalisable knowledge.

Despite the limitations discussed above, I have no doubt that video recording was the only means to capture the complex, detailed, multifaceted data that I did. I also experienced many advantages to the video data collection.

The advantage with video recorded data, is that one can re-watch and explore the interaction and potential meanings and develop new interpretations based on watching other sessions. This fits in with Schleirmacher's (in Bleicher, 1980) concept of the 'hermeneutic circle'. One cannot understand the constituent parts without a global understanding of the 'text', and an understanding of the constituent parts informs the global understanding. As my level of understanding of the data corpus deepened, I could re-explore constituent parts, and confirm if my understanding was consistent with the data.

Working with transcripts one begins to feel alienated from the child who is affected by HIV. I felt that the transcript became depersonalising, or rather objectifying. It became data or information, rather than an interaction with a child. I found the tapes useful to go back to remind myself of the qualitative 'feel' of the child and the interaction.

#### **6.7. Limitations of the research methods: data analysis and conceptualising the data:**

I was unable to ascertain to what extent the verbal introduction influenced the play. My assumption from the play literature is that children play out their intrapsychic concerns (Axline, 1964; Klein, 1972). In consulting the Sceno test literature I have found a great variety in the themes that children play (Fleigner, 1995; von Staabs, 1971). As there were many consistent themes between participants, it seems to suggest some link to the 'essence' of these children's particular experience of living in a Children's Home and being affected by HIV/AIDS (Brooke, 1993). I consulted with my supervisor on this issue. She has worked with many children using this technique, and has not found such a consistent use of the routines and the Doctor figure (B. Killian, pers.comm., 24 September 2001).

Although the data yielded rich information, it does not involve a comparison with other methods of data collection, interpretation, or other means for working with children.

The difficulty with the content analysis in reading two, was how to break up the meaning units, and how often to give a code to a particular action. For example, if one breaks a coding unit up thematically, quite a long section can be devoted to one activity hence just be coded once. The activity may however engage the child for quite long and may be an important overall theme in the play, whereas another code may be used briefly but come up quite often. As this study is qualitative and has not used statistical frequencies, the frequencies have not been used for accurate statistics but rather as a means to reduce and conceptualise the data. The coding gave the researcher a means for understanding the basic frequency of use of various toys and activities. Two other 'readings' of the data were also made (Mauthner and Doucet, 1998) to consolidate findings. In addition, meaning units were broken into the main theme of that unit, but were also coded with several coding categories if they fitted that meaning unit. This also allowed for greater accuracy in working out frequencies of themes. For example:

MM 8            Mother as nurse  
 T 2             Car  
 T3              Transport to & from work/school  
 R 11            School or work routine

<p>The Mother puts her white nurse's coat on. Winnie finds a car for the Mother.</p> <p><b>WINNIE:</b> (talks to the Mother in a baby voice- playing a role) "Is Mother going to work?"          She puts the doctor's case into the Mother's hand.  <b>WINNIE:</b> (Speaks as if she's the Mother) "Ooh my car, I'm going to work."          The Mother drives to work. Winnie makes driving sounds. "Drrr. Erh. Mmmh."</p>	<p>Winnie 2</p>	<p>MM 8          T 2          T3          R 11</p>
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### **6.8. Reflecting on my role as researcher and “therapist”:**

I found it difficult making interpretive comments during the play. At times I asked too many direct questions, rather than using story-eliciting approaches. For example I could have made use of naivety more often and the ‘whisper technique’ (B. Killian, pers. comm. 24 September, 2001) such as, “I don’t quite understand, won’t you whisper to me what is happening?” I could have asked more questions about events such as, “What happened before/after?” (Jovchelovitch and Bauer, 2000). Jovchelovitch and Bauer (2000) also suggest not asking questions directly about attitudes and opinion. In some sessions, in particular Thandi session 2, I ask her several times how she was feeling. This is difficult for a child to answer directly. The play is her way of demonstrating this. It might have been more useful to reflect how characters were feeling as I did with Winnie, session 3.

*Winnie: “Ja that’s what they do...teasing each other.” The girls fight.*

*Angela: “She must feel sad?”*

*Winnie: “She was sad.”*

I think that some of the reasons for this were related to self-consciousness about ‘doing this research right’, and also related to being a training practitioner and again being inhibited by ‘doing it right’. I was aware of the interaction with the children as being for research and therefore not wanting to influence the data, but this meant that it was a less natural engagement with the children than in an ordinary therapeutic interaction. I was less open to relying on intuitive feeling about the narrative and dialogue, and trusting my interaction with the children and that they would tell me if my reflections were right or wrong. Constructing meaning and coherent narratives occurs in the dialogue between ‘client’/participant and ‘therapist’/researcher. Because I was doing research, it felt as if I needed more proof, but this is what the construction of meaning is.

However, I was also able to elicit meaningful narratives, to connect with the participants, and make reflections that were acknowledged by the participants. It was also important and useful to inquire about the identity of figures, and to reflect on what I thought was happening in the action of the play.

## **6.9. Discussion of validity:**

Ricoeur's (1981) suggests 'adjudicating' between opposing interpretations and evidence. Criteria for mediating between contesting interpretations (Packer and Addison, 1989) are discussed below.

### **Coherence**

Coherence refers to a sense of consistency between the themes and the data and whether the account is plausible. As the same themes occurred in the overall reading of the texts and in the content analysis, I think a certain degree of consistency was reached. I believe that the third reading for aspects of play is intelligible in terms of the frame of reference used.

### **Uncovering**

The three readings proved to be valuable in terms of getting an overall picture of the data, as well as an understanding of the constituent parts in the content analysis. The content analysis further confirmed main themes in the overall reading, contributing to consistency, but also facilitating uncovering meaning in the texts.

### **Validation of interpretation by another researcher**

In writing this thesis, working out coding frameworks and in interpreting the data, I was in constant consultation with my supervisor, who has confirmed these interpretations. I have tried to be as explicit as possible in describing my method, including sections of transcript and in being self-reflexive. It is hoped that other researchers and readers will follow the interpretive logic of the argument.

In terms of Wolcott's (1994) criteria for making sure qualitative research is true to the data, I have tried to stick to the following steps.

- In collecting the data, I tried to reflect only what the children played to confirm the meaning of their play. Questions were asked about the identity of figures so that I did

not misconstrue their meaning. Further reflection on this process is given in a previous section. I attentively listened and was able to return to the original data to listen again.

- Because of using videotape, I was afforded the opportunity to take time to record the data accurately. Gestures, play action, dialogue and tone were recorded as accurately as possible. Initial hunches were also recorded so that they could be examined as bias or as helpful hints to meaning.
- I have described the data and methods for interpreting the data as fully as possible, and have included summaries of the play so that the readers may 'see' for themselves.
- I have consistently sought feedback from my supervisor and others on the process of my research and the interpretations of the data.
- I have tried to achieve a balance between presenting the data and the contradictions in the data, and fitting the data into a theoretical framework.

Finally, the research did 'measure' what it set out to 'measure'. As an exploratory study, I did find significant themes related to children affected by HIV/AIDS, and the usefulness of the Sceno as a method of play assessment was explored.

#### **6.10. Further questions raised by the study and recommendations for further research:**

In terms of research questions – this study fits into a history of research into individual play (Goncu and Kessel, 1984). Another useful area of research in the field of HIV is that of social imaginative play, group activities, and self and peer dialogues, especially in terms of recognising play as communication and language, and language and narrative as self construction. Imaginative play dialogue has been found to expand childrens' conceptions, as well as facilitating a growth towards social-cognitive development and conversational coherence (Goncu and Kessel, 1984). Would group interaction help to increase children's understanding of being affected by HIV/AIDS? Are social and group play useful therapeutically?

Would greater familiarity with the researcher and interaction over a longer period of time improve the richness of the results?

It was interesting to note that the children seemed to use the Black and White figures interchangeably. Assumed chronological age seemed more important than colour of the figures. However, this investigation did not explore that, and a proper experimental and control group study would need to be set up to explore this.

My hope is that the results of this study will lead to:

- 1.) Further descriptive exploration
- 2.) Hypothesis testing
- 3.) Programme development that recognises the literature on risk and resilience, and grounded in data about the needs of the children from their own perspective.

## ***CHAPTER SEVEN***

### ***CONCLUSION***

In this study, an exploratory investigation was conducted to ascertain what the intrapsychic themes of children affected by HIV/AIDS and living in a Children's Home were, and whether the Sceno was a useful technique for eliciting such information.

Firstly the context of HIV/AIDS in South Africa was described, followed by consideration of the issues that children affected by HIV/AIDS and children who are terminally ill or bereaved face. Potential intrapsychic concerns were considered. The literature suggested that children affected by HIV/AIDS were often already living in high-risk situations and that AIDS further exacerbated this. Living with AIDS often resulted in a compounding of multiple loss, and was also associated with stigma and alienation. The theoretical framework of risk, resilience, and protective factors has been used to conceptualise helping children who face adversity worldwide. This framework as well as that of attachment, loss and separation has been used to conceptualise this research.

A consideration of the use of play as an assessment technique and the theoretical issues surrounding play were considered. Play is considered to be a valuable means of working with children for the following reasons. It is a child's natural means of communication. It is a means for children to assimilate learning about the world. It provides catharsis healing and growth. It develops and allows use of metaphor and symbols. It helps children to integrate and explore the multiple aspects of the dialogical self.

The aim of the research was to establish the intrapsychic themes of children affected by HIV, by using the Sceno test. A hermeneutic phenomenological methodology was used within a narrative framework to interpret the 'text' of the children's play.

The aims of the research were met. In terms of the themes of the research the most predominant theme was that of playing routines, particularly within the family. The

second most predominant theme was the role of the mother as caring and nurturing, which demonstrates significant attachment or wish for attachment to this figure. As all the children are in a Children's Home and therefore separated from their mothers, or their mothers have died, remembering this attachment and needing to form another significant attachment is important. Other important themes are that of organising the environment and having control over the context of the play, and the theme of the doctor and illness. This seems to indicate concern for one's own illness and the illness of significant others. The presence of a spiritual figure is important in four children's play. These themes all confirm previous writing on factors promoting resilience, and concerns about separation.

The Sceno play assessment technique was explored in terms of what the literature says about the usefulness of play. Many aspects outlined in the literature were found in the data.

However, there were also limitations to the study and these were discussed, and further research suggestions were made. Despite these limitations, it is believed that this research has been useful as an initial study with regards to children affected by HIV/AIDS and their intrapsychic themes in play.

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## APPENDICES

### Appendix A:

<b>SCENO TEST EQUIPMENT : list of contents</b>			
<b>Original Sceno</b>		<b>Sceno used in current research</b>	
<b>People / Figures</b>			
<b>Description</b>	<b>Number</b>	<b>Description</b>	<b>Number</b>
Grandfather	1	Grandfather	1
Grandmother	1	Grandmother	1
Father in suit	1	Father (White)	1
Father in shirt and pants	1	Father (Black)	1
Mother in woollen suit	1	Mother (White)	1
Mother in cotton dress	1	Mother (Black)	1
Doctor	1	Doctor female	1
Servant girl	1	Doctor male	2
Princess	1	Aunt	1
Small boy	1	Small boy (white)	1
Small girl	1	Small boy (Black)	1
Schoolboy	1	Small girl (white)	1
Schoolgirl	1	Small boy (Black)	1
Twin blue	1	Teenage girl	1
Twin red	1	Teenage boy	1
Baby		Twin babies	2
		Baby (white)	1
		Baby (black)	2
		Extra baby figures/dolls	3
<b>Animals</b>			
Cow	1	Cow	2
Crocodile	1	Crocodile	1
Fox	1	Fox	1
Goose	1	Goose	1
Dog	1	Dog	1
Stork	1	Stork	1
Pig	1	Pig	2
Piglet	1	Piglet	1
Hen	1	Hen	1
Chicks	2	Chicks	2
Monkey	1	Monkey	2
Bird	1	Bird	1
Snake	1	Snakes	3
		Horse	1
		Sheep	1
		Rooster	2
		Ducks	2
		Rhino	1
		Cat	1
		Panther	1

<b>Symbolic figures</b>			
Snowman	1	Snowman	1
Dwarf	1	Father Christmas	1
Angel	1	Angel	2
Peter Pan	1	Peter Pan	1
<b>Furniture and articles of daily use</b>			
Armchair	1	Chairs	4
Deck chair	1	Table tops	2
Poster-column	1	TV	1
Wash-tub	1	Telephone	1
Milking pail	1	Cupboard	1
Carpet beater	1	Beds	2
Slate, Blackboard	1	Blackboard	2
Baby Bottle	1	Baby bottle	4
Eating utensils (mugs, plates, cups)		Eating utensils	
Fruit	1	Food & Drink	
Piece of cloth	1	Piece of cloth	4
Piece of fur	1	Piece of felt	2
Toilet	1	Toilet	2
'Potty'	1	Milking pail/bucket	1
Spade		Glasses	6
<b>Trees and Flower beds and flowers</b>			
Big fir tree	1	Big fir tree/ Christmas tree	1
Small fir tree	1	Small fir tree	1
Poplar tree	1	Poplar tree	1
Apple tree	1	Apple tree	2
1 grass bed	1	1 grass bed	1
Flower bed	1	Flower bed	1
Blue (pond) surface	1	Blue (pond) surface	1
Daisy flower	1	Daisy flower	1
Tulip flower	1	Tulip flower	1
Forget-me-not flower	1	Forget-me-not flower	1
<b>Vehicles</b>			
Railway train	1	Railway train	1
Passenger car	1	Passenger car	1
Racing car	1	Helicopter	1
<b>Other symbolic toys</b>			
Heart	1	Heart	1
Gemstone/Magic jewel	1	Gemstone/Magic jewel	1
Wand	1	Gun	1
		Coffin	1
		Dinosaur	1
		Medicine bottle	1

<b>Other materials</b>			
Wooden box with lid which serves as play area	1	Wooden box with lid which serves as play area	1
Compartments for subdividing the box	1	Compartments for subdividing the box	1
Coloured building blocks – rectangles, cylinders, squares, bridge etc.	Many	Coloured building blocks – rectangles, cylinders, squares, bridge etc.	Many

Appendix B:

Angela Hough  
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To whom it may concern

I am doing research in play therapy for my psychology Master's thesis. The question I want to ask is two-fold:

- The first question is to investigate the utility of the Sceno play materials for use in South Africa.
- The second question is to explore what is the essential experience of the children interviewed who are identified as being HIV positive, or affected by AIDS.

South Africa is characterised by a diversity of languages and cultures. The Sceno test is potentially a very useful play technique for use in South Africa, due to its portability and relative low cost. It can be taken to children who are unable to get to a playroom due to financial and or transport constraints. It can also be taken to children who are terminally ill, disabled, and or hospitalised.

In terms of the second question; South Africa is currently struggling with the pandemic of HIV/AIDS. Many children are affected by HIV/AIDS (such as losing a parent) and many are infected themselves. There is literature about healthy children's conceptions of death and illness and some related to children with leukaemia and cancer. However, the HIV pandemic results in different social circumstances, but there is very little literature on what children who are HIV positive experience.

The particular medium I will use is a box of toys made up of human figures, animals and coloured blocks, called the Sceno test. I would like to see what children who have been affected by HIV/AIDS do with the play material. I would like to interview your child and give him or her a chance to play with the material three times. I will not use your child's name or any identifying details. I just want to use my recordings of what they say and do for my research. Their play will be filmed using video equipment. I will then write down what they play. My supervisor and myself will only see the video. Otherwise it will remain confidential.

I hope that playing with the play material will also in some way be beneficial your child in that it will allow him/her to express some of his/her feelings about being HIV positive or sick, or affected by HIV.

If you are willing for me to interview your child, could you please sign this consent form. I thank you for your co-operation.

Yours sincerely  
Angela Hough  
Intern Psychologist

**CONSENT FORM FOR PSYCHOLOGY MASTERS RESEARCH**

---

I \_\_\_\_\_ (name of  
parent/caregiver/guardian) give consent for my child  
\_\_\_\_\_ (name of child) to  
partake in this research project examining the usefulness of the Sceno Test. I am  
aware that my child will be interviewed three times and that his/her name and  
identifying details will not be used in the research.

Signed:

Date:

\_\_\_\_\_

\_\_\_\_\_

Appendix C:

**Verbal Introduction for first interview:**

Hello my name is \_\_\_\_\_. I am interested in children and how they feel. I have come to see you because we know that sometimes you feel sick. I would like it if you could tell us something about what it feels like using these toys. Let's look together at what is in the box...people, animals, furniture, gun, heart, have a look and see what catches your attention.

Now can you build something in this box that tells me how you are feeling about yourself.

**Verbal Introduction for second and third interviews:**

Last week we played with the toys in the box to show us how you were feeling. I would like it if you build something else in this box again that tells me something about you and how you are feeling about yourself. Do you remember the toys in the box? ...People, animals, furniture, gun, heart, etc. have a look and see what catches your attention.

Now can you build something in this box that tells me how you are feeling about yourself.

## Appendix D:

### ***Summaries of children's play***

In terms of discussion of the findings of this research, the researcher has made several readings of the transcripts (Mauthner & Doucet, 1998). The first reading is for plot. It looks for the broad manifest content and main themes of the text. This appendix provides a condensed description of each child's play and a preliminary interpretive comment on each session. Pseudonyms have been used for the participants to preserve confidentiality. It is hoped that this will give the reader an idea of the types of play in which the children engaged.

## **Participant 1**

### **Session 1:**

#### Process:

Thandi is initially shy, but she is confident in her play. She seems to know what she wants to do. She plays quietly, but responds to the researcher's reflections. She smiles at the researcher's reflections as if to acknowledge they are correct. Thandi appears to engage easily in the play, and plays for a long-time. She does not need prompting to play.

#### Content:

She lays out food, plates, knives and forks. She places a heart next to the food. She puts the cow and cat in the box. She plays with the train outside the box. She puts the baby on the examining table and the doctor examines the baby. She feeds the doctor, looking after the doctor outside the play box. Then she places the doctor back at the side of the baby and gives both the baby and the doctor coke to drink. The doctor puts the baby to bed, and then the mother lies next to the baby. The doctor goes home on the train. In the play box she has placed the food, baby, and mother in bed, the cow and the heart, and now places the toilet in the box. Outside the box she seats the doctor in front of the TV and

places a second baby in the doctor's arms. The mother and baby go to visit the doctor and her baby. She feeds them all. She also puts a male doctor into the scene and a black male father into the scene. Now she puts all of them to bed – the black family shares one bed and the doctor family shares another. The baby goes to the toilet. She puts the heart above the bed that the black family is in. The dolls are washed and again placed in the chairs and all fed again while they watch TV. Now she places the male doctor in the play box. The mother brings the baby to see the doctor. The doctor examines the baby. Then all dolls are placed sitting in the box – she takes out the champagne bottle and all have something to drink – they are happy because the baby is better.

**Thandi explains:** “In the morning they wake up, they get something to eat. Then these two go to work (pointing to the doctors). They go to the hospital. They [parents] take the baby to the doctors. Then they come back and have something to eat.

**Angela:** “What is wrong with the baby?”

**Thandi:** “His tummy is sick”

**Angela:** “Does your tummy sometimes get sick?”

**She nods**

**Angela:** “How do you feel when you get sick?”

**Thandi:** “Horrible”

Comment:

The significant part of the first play session seems to be the Doctors' examining of the baby and the supporting behaviour around the baby. The baby is cared for, as demonstrated by the structure of the family routines of feeding, sleeping, and toileting and the presence of the heart in the house scene; and the presence of Mother and Father, while the baby is being examined. The presence of the cow in the box, out of context in terms of the box representing a house in Thandi's play, seems to indicate the need for maternal protection or attachment. According to von Staabs (1971) and Lowenfeld (1935), the cow is symbolic of nurturing and protective mothering qualities. The result of the examination is that the baby will get better, and the mother and father celebrate this. This seems to be a demonstration of a wish to be better. Around this central exam is a

reversal in the caring role, where Thandi cares for the family and Doctors. The doctors and the mother, father and baby are given time to rest, eat, watch TV and receive visitors. This seems to be Thandi's way of ensuring that these people will be able to care for the baby, a representative of self. The importance of caring for significant others and the doctors seems to be a way of ensuring that the possibility of abandonment by these figures does not happen. Possibly she fears her own illness, especially after losing her mother, and so wants reassurance that the baby will get better. The session opens and closes with making food – a significant nurturing and survival need, especially as the heart is placed near the food in the beginning and the end.

Main themes/plot of narrative:

- The baby being examined by the doctor and pronounced better.
- The baby in nurturing environment of parental care, concern and routines.
- Making sure the Doctor's needs are taken care of.

Session 2:

Process:

Thandi again plays quietly. However, she looks directly at the researcher if she gets the right interpretation. She seems to like the researcher taking the time to find out. She also smiles at the researcher in amusement when she asks questions like, "Who is that?" (Pointing to the doctor). Thandi looks at the researcher smiling as if she should know whom it is and says, "The doctor."

Content:

Thandi makes a circle of chairs and seats a doctor, mother, aunt and grandfather in the circle. She puts a telephone just outside the circle of chairs. She places a young boy in the circle. They are having a meeting about the boy (her brother) because he is sick. They are upset because the brother is sick. The grandfather gets up to telephone the uncle to come to the meeting. The aunt prepares food and feeds all adult members in the circle. She clears away the plates. The little boy is not given food, as he is sick. She props him up on

a pillow and makes him a cup of tea, as he is sick and coughing, and therefore could not eat. Now the mother doll feeds him special food.

Then the play moves into the doctor examining a baby (exchanged for the little boy). The doctor came to visit, looked at the baby, and said that the baby was better.

Comment:

The central feature of this session is a family meeting including uncle, aunt, grandpa, and mother, and the doctor because the brother is sick. The little brother that is ill eats a special meal. It is not clear whether the meal being vegetables is significant, i.e. If Thandi feeds him vegetables because that is what sick people get to build immunity, or whether its because that is what is available in the toys. Again, as in session one, the baby is examined and is judged to be better. Being sick and being pronounced better is significant in Thandi's play. The tentative interpretation is that Thandi is fearful of being sick and wishes she were better. Otherwise, it may be possible that another sibling was or is sick in the family.

Again, in this session as in the first, Thandi hesitates around saying that the woman figure is the mother. As the researcher, I believe I may have asked too many questions. However, at other times I had a feeling that Thandi would look at me almost wanting me to prompt her, or say something for her. It sometimes feels as if I have not quite got what she is saying, for example, I have not made explicit that she is afraid of being sick.

Main themes/plot of narrative:

- A Family meeting about the sick child.
- Doctor examining child and pronouncing him better
- Special care of the sick child

### **Session 3:**

#### **Process:**

Thandi is more relaxed in her interaction with the researcher. Her play is unselfconscious. She plays with direction and purpose. She engages in fantasy and is able to represent objects, such as making a bath out of coloured blocks, a car out of four chairs and coloured blocks and a swimming pool using the bond and four blue blocks. She however, does not speak as the characters. She rather tells me what they say. (Developmentally appropriate?) Thandi in the beginning has problems with knocking the box and the people on the chairs fall over, disrupting the play, and she has to put the scene back together.

#### **Content:**

Thandi again lays out chairs around a table. She seats the Doctor, Aunt, Grandpa, Grandma, Mother and Uncle ("special people"). It is Christmas Day, so there they sit around a Christmas Tree. There is a tablecloth on the table. Christmas is special. Thandi prepares a meal and places plates in front of all members of the family. Then she places four children around the table of significant adults, and they all get food. The Uncle picks fruit from the tree outside and dishes out a piece to each person after the meal. Then Father Christmas arrives. He gives each person a gift and then flies away. Thandi then puts the children to bed. She clears away the chairs and makes beds for the adults. The men sleep together and the women sleep together. The mother gets up to water the plants before she goes to sleep. She puts a cat to sleep on one chair in the house. Thandi then seems to begin another sequence of play. She builds a bath and a swimming pool outside of the box. First, she takes the children and dips them in the bath one by one, and then she dries each one on the towel. Then, she puts all the adults in the bath and dries them individually too. She makes a car. Grandpa, Mother, Uncle and Doctor all go to work. Auntie and Granny stay behind. The children go to school. When they come back from school they all jump into the swimming pool, with the Auntie and Grandma. When the other adults come back from work, they get into the pool. Then all the family members – children and adults lie out on a big towel in the sun. The cat lies with them on the towel.

Comment:

Thandi's session starts again with a 'family' sitting around a table. In session one, Thandi plays with a doctor, mother father and child. However, the significant family members in session 2 and 3 are Grandpa, Grandma, Auntie, Uncle and Mother, and the Doctor. These seem to be the people representative of significant attachment figures in Thandi's life. The play in all three sessions includes playing with similar people. Thandi also uses the same dolls to represent the same people throughout all three session. Therefore, showing continuity in the play, this would seem to indicate that the play is meaningful and not just arbitrary. There is continuity in theme too. In the initial session, the baby is taken to the Doctor. In the second session, the Doctors come to the house to examine the baby. In both scenes, the baby is pronounced well. This seems to indicate a fear of being sick and her wish to be well. The third session seems to be a special time (Christmas) when the family all comes together, when Thandi goes home. This play seems to indicate a longing for the secure attachments of home, and for everything to be back to normal after the baby is pronounced well. The garden and Christmas seem to be indicative of an ideal state or day. The Uncle and Father Christmas bestow gifts on all the family, doctor and children. In the last session other siblings are also added to the scene. The cat sleeping on the chair in the house while the family is sleeping, and again on the towel when the family are lying in the sun, would appear to indicate comfort and pleasure. However, there is ambivalence around the Mother figure. Each time Thandi names the mother in a circle of people, she hesitates when saying whom the mother is. It is the aunt in the final two scenes that makes the food. In the final scene, the mother also does not participate in the caring for the children. This may be representative of roles adopted in the real situation at home, before Thandi's mother died; or may be indicative of Thandi's ambivalent feelings towards her mother – wishing for her mother, but recognising that she has died. The last section of the last session seems to change direction. It seems to be an acknowledgement that life goes on, and showing the routines of life of going to sleep, waking, bathing, going to school and work. There also in this section of the play seems to be a blending of her life at the children's home, where she has a swimming pool and the routine's of her life take place, with the longing for her family. Routines are also

acknowledged in bereavement literature as important for providing a child who has lost a significant other, with a sense of security and containment (Judd, 1995). The last session seems to be a wishing for all the things that make Thandi happy and secure: celebration at home, the family all being together, and routines and fun activities all together.

#### Main themes/plot in narrative:

- Family celebration at Christmas
- Gift giving
- Family routines: Meal, bathing, work, leisure (swimming).

## **Participant 2**

### Session 1:

#### Process:

The plates and their small size initially excite Smangele. She spends quite a lot of time exploring the toys, before she begins to play. She picks up things and asks, "What's this?" She appears to be quite confident, as she talks a lot and loudly. However, she also seems not to engage fully, as in she talks constantly, but as if to herself, not expecting a reciprocal interaction. Smangele plays outside of the play box. She constantly makes comments about her play, i.e. "it's a towel...shu its big...close the cupboard and put it in... there's a toilet... what's this?" Her play seems to be scattered and disjointed, not making a single coherent narrative. She is easily distracted. For example while playing out the children having a meal, she will suddenly be concerned about the dolls having shoes, then come back to clearing the plates, then plait a doll's hair. She shifts from one thing to another. If she is not talking, she sings to herself.

#### Content:

Smangele examines and explores the toys in the box asking what different things are. She sets up a table with four chairs around it. She puts four young girl dolls around the table. She places 2 beds and 2 toilets in the scene. She then places plates and cups in front of

each doll – making comments on the size of the plates according to the size of the child, i.e. “This one must get a small one because she is a small one.” She pours each girl a cup of juice, making sure the biggest child has the biggest cup. She divides the food in the same way – the biggest child gets the biggest portion of food. She clears away the food, then realises they did not get pudding – she gives them all pudding. She clears away the food but leaves one child still eating – the biggest one. She puts blankets on the beds, then says there is no shower. She makes one. She begins washing the children one at a time. She then finds the dummies/bottles – she distinguishes the colours according to what is inside and different children get different things, i.e. one gets juice, one gets milk and one gets water. They only get the bottles when they are crying. She finds a fourth bottle and says this one (pointing to the doll with the long blonde hair, “her favourite” and says this one gets two. She plaits the hair of this doll. She lines up chairs in front of the TV.

**Angela:** “The children are in a Children’s Home”

**Smangele:** “Yes”

**Angela:** “And the one with the blonde hair is the favourite one”

**Smangele:** “Yes”

Comment:

Smangele smiles when the researcher says, “This is like the Children’s Home.” This would seem to indicate that the interpretation is correct. She shows a lot of concern with distinguishing what different children get according to size. Possibly this is related to hierarchical life in the Children’s Home?

Main themes/plot in narrative:

- Routines in the Children’s Home – eating, bathing, sleeping.
- Division of food and places to sleep according to size.

## **Session 2:**

### **Process:**

A lot of this play is a time-consuming organisation of the environment.

### **Content:**

Again Smangele begins the play by exploring the toys and asking what each of them is. Smangele puts two beds into the box, with a cupboard in which she has placed a towel. She then puts six chairs in a circle with two tables in the middle, "because there are a lot of people... they are going to eat". She finds a cup and plate for each person dividing the food saying, "the oldest ones get two". As there are only four plates, "someone has to wait until they are all finished or one is going to share with someone else". She gives each a drink, "only the big one can have coke, the others have juice". She chooses four dolls, saying she only used for last time, now she wants more and next time she will use even more people.

**Angela:** "You like having lots of people?"

**Smangele:** "yes."

She identifies a mother and the "big one" – an older girl. Around the table, there is a mother and five children. Smangele says they are the mother's children and they are at home, then she says a boy and girl and says they are the mother's children and the others are friends. Angela asks if she has brothers and sisters. Smangele says, " I have one brother and one sister. I have two sisters and three brothers... my youngest sister is in the baby block (of the Children's Home) and my oldest sister is with my granny and my three brothers are with my granny too. Only one sister came." She gives the people drinks and clears up. Se picks up the two hearts.

**Angela:** Who's the heart for?

**Smangele:** "Jesus. The heart is for the night." She places the heart near the bed.

She then squeezes the five children and the Mommy into the bed. It is important for everyone to have his or her space. She also washed each child.

Comment:

Smangele's play is quite literal, because there is one towel she as they use one towel, she cannot assume the towel can represent several towels. Alternatively, this is a literal practicality of her life. Both ways it shows concern with the practicalities of life and routine. She is very absorbed in organising the environment, to the extent that it becomes time consuming. Her play is again concerned with division of food and drink according to size.

Main themes/plot in narrative:

- Family Routines – meal, bathing, sleep.
- Division of food and places to sleep according to size.

Session 3:

Process:

Smangele appears to be down this session. She plays despondently, and becomes increasingly distracted in the play. She sings and hums and engages in sorting behaviour, sorting the cutlery and crockery, shaking the box, and then plaiting the doll's hair. My questioning is strangely persistent around her family life, her brothers, sisters and mother.

Content:

Smangele lays out 7 chairs and seats seven children (2 boys and 5 girls) on the chairs. They are each given food. He food is divided and distributed according to size, i.e. biggest child gets biggest food. They each get something to drink. She then sorts the cutlery and crockery as described above. Most of the rest of the session is this distracted play.

Comment:

All three of Smangele's play session feature meal times and distribution of food and drink according to size. There is continuity in theme. However, in this session she appears to be more distracted and anxious. In this session, my questioning is oddly

persistent, and seems obvious in transcribing how uncomfortable she was with any discussion about her mother or brothers and sisters. I believe that she was not ready to talk about these issues and that I was too persistent. With hindsight I think this adds to her distracted play. I think that the questions about sisters and brothers and her mother dying have caused Smangele a lot of anxiety, to the extent that she is unable to role-play. Winnicott (1974) and Klein (1973) assert that a child who is too anxious cannot engage in meaningful play. I am also not sure whether Smangele's 'despondency' is related to her being sick last week and possible fears about illness and possibly death. I did not make this reflection. I think it would have been too intense and anxiety provoking. There seems to be some desire to surrounding herself with people, as last session she said she would have more people this week and she did. There is possibly safety in having more people around you for fear of losing them, or is it related to her family size? Smangele again also seems to be playing routines of the Children's Home, mealtimes, and bedtime. She is again concerned with distributing food and drink according to size.

Main themes/plots in narrative:

- Children's Home Routines – meal, bathing, sleep.
- Division of food and places to sleep according to size.

## **Participant 3**

### Session 1:

Process:

Zama giggles at the start of the session, especially when I ask if she remembers my name is Angela. She presents as competent and engages with the researcher, but at the same time is self-conscious. Zama's play is meticulous, neat and very ordered. She plays quietly and efficiently. Although she is self-conscious, she is relaxed. She plays quickly but there is a sense of not being engaged in the play, as if she is playing for the researcher (me) like it is a school task. She is competent and co-operative, but she is not risking revealing any part of herself.

Content:

Zama takes two beds (double bed and single bed) and places them close to each other. She makes a table with three chairs and places a mother, father and young girl doll on each chair. She places plates in front of the adult dolls and a bowl in front of the girl doll, then gives each some food. They pray first and then they eat. She clears away the food. Then she puts the little girl to bed in the single bed. The mother and father stand on either side of the child's bed and pray.

**Zama:** "They are praying for the baby to sleep."

**Angela:** " So they're really caring for the baby."

**Zama:** " Yes."

**Angela:** "Did your family pray a lot?"

**Zama:** "Yes."

**Angela:** "Do you miss your family?"

**Zama:** "Yes."

The parent dolls then pray before lying in the double bed. All the family wakes up in the morning and again sits around the table and food is placed on the plates in front of each person.

Comment:

I feel that it is significant that she plays outside of the box, which in Jungian sandplay and Sceno interpretation is representative of the core self (Menuhin, 1995 and von Staabs, 1971). She is not risking revealing any part of herself.

Main themes/plot in narrative:

- Family routines – meal time and sleeping
- Praying

## Session 2:

### Process:

Zama does not play for long. She seems to play out of politeness.

### Content:

Zama chooses a white woman, grandmother, twin babies and a young girl dolls. She stands them against the outside of the box putting the young dolls in between the grandmother and mother dolls.

**Zama:** “These are a family, and this is the mummy and the children and this is the granny.”

**Zama:** “They don’t have a house, they always pray, and they have to look for where they are going to stay...They are sad because their children have no clothes and they do not know where to sleep.”

**Angela:** “Did you ever not have a house to stay in?”

**Zama:** “Yes. When we was coming here to South Africa.”

### Comment:

Zama is resistant to playing. She even builds her scene outside of the box, as if it is a way of distancing herself from expressing any part of herself. As she is 11-years old, she may also be resistant to the medium of play. In this scene she plays about not having a house. This seems to be significant to her real life experience, as they were refugees from the Congo. Again praying is central to Zama’s play

### Main themes/plot of narrative:

- Not having a house, a place to sleep. Home for homeless.
- Praying

### **Session 3:**

#### **Process:**

Zama plays carefully, “properly”. She looks through all the doll figures, carefully choosing which ones she wants. She lays these on her lap. Then she places each one with precision.

#### **Content:**

Zama places an old man in the box. Around him she carefully places the pig and piglets, cow, dog, cat, geese and all the birds and chickens. On the outskirts of this circle of animals she places the fox and crocodile facing the other way. She puts flowers in a row near the outside of the box.

**Zama:** “Grandfather is the farmer. He owns the animals. He looks after them. He likes to wake up early in the morning to try and find them and he loves them.”

#### **Comment:**

This scene seems ambiguous and elusive. It is as if she plays this scene to avoid the anxiety of playing something about her self. There seems to be something significant about the fox and crocodile. Zama was awkward around discussing these animals. They seem to indicate a pervasive knowledge of danger. However, Zama does not acknowledge them as such.

#### **Main themes/plot in narrative:**

- Farmer caring for animals including the more vicious animals, the fox and crocodile.

## **Participant 4**

### **Session 1:**

#### **Process:**

Jabu 's play initially seems focused, but as the play goes on and she discovers new things, she faces some indecision and ends up deciding to remake the house. Jabu is quiet in her

play. She is very engaged in the play, and revises the play as it happens. Even in this first session she seems to have a clear idea of what she wants to do. She quietly affirms the researcher's reflections.

Content:

Jabu experiments with different pieces of material. Finally she lays pieces material on the bottom of the play tray to act as carpets. She lays out two houses, with chairs in one house and beds and chairs in the other. She puts four chairs in a circle, next to the TV. She lays two babies on a piece of felt. She puts the doctor's jacket, bag, and a towel into the cupboard. She lays out the food box. Outside the box she lays out a garden with lawn, trees and flowers and puts the angel in the garden. She puts a pig in the garden and a bucket, "Some people will have to use this to carry water." She puts the heart in the house. A white family of dolls she points to saying, "There are lots of visitors." She points to the Black family as living in the house. She gives them the wine bottle and says, "Some visitors are coming, 'cos if you're hungry and you don't have food you are poor." There are two houses. House One has a White family with 5 inhabitants. House 2 has a Black family with 4 inhabitants and 2 White visitors.

Comment:

This scene is about making houses for the dolls. The examining table is placed in the white family's house (the doctors') house. She seems very concerned with making nice houses protected by walls for all the dolls. All dolls have a nice home to stay in and there is food for visitors. Having a safe home would appear to be important as is feeding visitors who may be poor. This seems significant in Jabu's life and shows the same concern as her sister about not having a home or food.

Main themes/plot of narrative:

- Making a houses and pleasant safe home environment.
- Having a home rather than being homeless
- Having food if you are poor.

## Session 2:

### Process:

Jabu takes out all of the house furniture and lays it on the carpet, preparing again to build a house. She plays methodically and neatly puts down carpets first before laying out the house furniture. She makes a house and a hospital in the play box. She is quiet but tells me what things are, i.e. "This is a hospital." "These two are cleaning the house."

### Content:

Jabu takes great pains to make things just right often rearranging the furniture, in her play. She lays out material on the floor of the box, as carpets. She places the food in the box. She folds sheets to make the beds. One piece of material has two chairs and a table on it. The other piece of material has two chairs, a table, a bed and a cupboard on it (identified as house). A third piece of material has the examining table on it and two chairs next to each other facing the examining table (identified as hospital). "The doctors are looking after the child." She places two women identified as 'cleaning women' in the corner of the box, next to the two chairs. "She is keeping the child." She puts a small child and baby next to the bed in the 'house'. "This girl is playing with the baby." She puts a small girl on the examining table. She puts three doctors into the hospital section. She makes a garden outside the box, putting flowers in the garden, a pond, ducks, and goose next to the pond. She then places other domestic animals in the garden – cat, dog and pig.

**Angela:** "Jabu what did your mother and father do?"

**Jabu:** "My mother was vomiting every day and my father was sick."

**Angela:** "Did you wish to take them to the hospital?"

**Jabu:** "They take my father, they take him to the hospital and then my mum was crying..."

**Angela:** "Your mum was crying when they saw him?"

**Jabu:** "Yes they bring the [can't hear rest]..."

She places the snakes behind the animals

**Jabu :** “The snakes kill for the animals and then the animals just hide and then they can't see them.

Now she places the school board beyond the animal and puts a male teacher and chair next to it.

**Jabu :** “ He is teaching the animals, to be careful if they are going to kill them.”

She places two large cows walking away from the animals. She puts the TV in the house. She puts a spider, dinosaur and crocodile on the outskirts of the animals.

**Comment:**

Again, Jabu plays house. Making a safe environment is important. However, a significant aspect this time is that there are no parents, but rather a “cleaning lady” and her friend care for the children. This mirrors Jabu’s real life situation, as she has no parents. In the box are also a hospital, two doctors and the examining table. The theme of sickness is important, and Jabu speaks of her father and mother being ill, and when her father was in hospital her mother cried. The snakes in session, as in session one, threaten the security of the garden. In this session there is a garden and a lot of animals, as in session one. The teacher warns the animals of the danger of the snakes.

**Main themes/plot in narrative:**

- Making a houses and pleasant safe home environment and garden.
- “Cleaning ladies” care for the children and wait for the children at home.
- A hospital
- A teacher warning the animals of the danger of snakes – an awareness of danger.

**Session 3:**

**Process:**

Jabu seems happy to be there. She is chatty in the initial conversation, and says she just wants to start playing. She plays with energy, is quiet and intensely involved in what she is doing.

Content:

Jabu spent a lot of time neatly organising a house. She places carpets on the floor, makes up two beds, and places a cupboard next to the bed. She puts a table with two chairs around it and takes the food out of the box. Then she puts the baby on the bed. She makes a train track outside the box and then drives the train along the track. She spends time readjusting the train and the tracks & testing it out. She puts the TV, chalkboard, cupboard and toilet with a screen around it, into the house. Then she puts the two small adult figures into the main bed. She makes a garden outside the house. Ducks and chicks are placed around a pond. "The train is going to fetch people." She puts the dolls onto the train carriages. Two elderly people from the church come to visit the couple in the house, to speak to them about God.

**Angela:** "Who are these people?"

**Jabu:** "They are coming to teach the people that God loves them."

**Angela:** "And was your family like this back in the Congo?"

**Jabu:** (hesitatingly) "No. There were guns & shooting. We had to close the door or they would shoot us."

**Angela:** "You must have been scared. Do you hope it will one day be nice like this?"

**Jabu:** "Yes. I was still small when they were shooting at us."

She packs the food away, puts the adult figures in bed with the babies. She places the heart in the bedroom. Then she drives the train around the garden & the pond. She re-packs the doctors kit & puts it in the cupboard, then packs up the garden. She asks about the coffin & puts it back.

**Jabu:** "You are not allowed to walk near the tracks...At our school, someone got hit by a car & was taken by ambulance to hospital...He was bleeding when they took him to hospital."

While speaking, she takes the maternal cow figure, & walks it through the garden, rocking it.

She throws the snakes out of the box. She then begins telling me a story from TV about a snake and people that make magic, they take the heart & they change it into a devil. So the witch doctor and the snake they make the person bad and then he dies.

**Angela:** What does that story make you think of?

**Jabu:** “Lots of people are already dead.”

The narrative becomes incoherent.

Comment:

The scene starts off idyllically, in which people come to visit to speak about God, there is a garden and comfortable house. She says how the Congo was not like this. They had to close their door because of the shooting. She was scared. Visitors seem to indicate kindness and lack of fear. In her first session poor people/visitors are given food. In this session again visitors feature – preaching about God, but she suggests in the Congo people couldn't have visitors as they had to close their doors. The last section of the play is difficult to follow; the narrative becomes incoherent, but seems to follow on from the theme of shooting. She speaks of a boy at school getting knocked over that day, then a story of killing and black magic from TV. It feels as if it is related to the horrors of her life before coming to South Africa. Jabu seemed to want to continue talking. Although it was difficult to follow her narrative, I made reflections about the possible feelings, which she acknowledged. I think it is related to wanting to externalise some of these horrors, but they do not have coherence yet.

Main themes/plot of narrative:

- Secure home environment.
- Home routines of eating and sleeping.
- Visitors come to talk about god.
- Dialogue about black magic and killings.

## **Participant 5:**

### **Session 1:**

#### **Process:**

Mbulelo plays deliberately and with purpose. He is serious and plays methodically.

#### **Content:**

He lays a bed in the corner. He lays the white mother doll in the bed. He then lays chairs around the bed and places people on the chairs. He places a young boy next to the bed in a praying position. The doctor stands at the side of the bed. He is checking that the mother is going to be okay.

Outside the box, Mbulelo puts wild animals and a fox. Then he puts the car and a coffin. When asked about the car he says, "That's the social worker coming". When asked about the woman in bed, he says that this is his mother and that she is very sick. In addition, the people sitting around are the family hoping that she is going to be okay.

#### **Comment:**

Mbulelo has taken literally what was required in the introductory pattern. His narrative is a coherent story about his mother's illness. His mother is HIV positive and sick. It appears to show that he is concerned about the eventualities of his mother's illness and possibly some consequences around her illness that have already occurred. The reference to the social worker may have been indicative of the decision making process which led Mbulelo to coming to the Children's Home.

#### **Main themes/plot of narrative:**

- Illness of mother figure.
- Praying for sick person.
- Doctor present to care for/examine sick person.
- Some recognition of consequences of mother's illness – presence of coffin and social worker's car.

- Anxiety about mother's possible death.

## **Session 2:**

### **Process:**

Mbulelo gives an impression of being serious. He concentrates intensely on his play. He is quiet, methodical and does not hesitate in setting up his scene. He does not seem to be engaged in play, so much as telling me a narrative. He explains the scene in a quick coherent narrative.

### **Content:**

Mbulelo places two chairs in the box. He seats a grandfather and father in the chairs. He puts a little girl child next to the grandfather, sitting on the floor. At the father's feet, he puts another doll (identified as a doll). He places a baby on the examining table and stands the male and female doctor in front of the father and grandfather. He places a boy child in prayer position next to the baby on the examining table, and a mother in prayer next to a bed.

**Mbulelo:** " This is a doctor, he is looking after my grandfather. This is the brother, he is praying and the baby sister, and this is my mother praying and this is the baby."

**Angela:** " Okay so your grandfather is not very well?"

**Mbulelo:** "mmh, but that was a long time ago"

**Angela:** " And that is you and your mother praying that your grandfather is not going to die?"

**Mbulelo:** "Yes"

**Angela:** "And what happened to your grandfather?"

**Mbulelo:** "He passed away."

### **Comment:**

The need to tell this story seems to relate to the first session, when he showed a scene of his mother being ill. This is another time in his life, when he has worried about someone close to him being sick and being close to dying. The researcher did not make this

connection conscious in the interaction. This may have revealed further feelings and information. He says, "That's a long time ago" when saying his grandfather was ill. Although this is factual, it may also be a defense against feeling these feelings again. It may be an expression as an extension from last week's narrative about anxiety about mother's possible death, as the last person in the family who was very ill, died too.

He identifies the brother as himself. The researcher is not clear, about whom the baby on the examining table is. Mbulelo says it is the doctor's baby. It might indicate some concern with being sick himself. There does not seem to be much emotional investment in the father figure, he is hesitant in saying who it is and quickly just says who it is with no further comment. Mbulelo does not engage in play, but rather makes a scene and describes a narrative. This is probably age appropriate, as he is 11 years old. However, he takes the task seriously, and it seems to be a meaningful interaction.

Main theme/plot in narrative:

- Illness of grandfather figure.
- Praying for sick person.
- Doctor present to care for / examine sick person.
- Anxiety about mother's possible death.

Session 3:

Process:

Mbulelo plays quickly and determinedly. He seems to enjoy these sessions, yet at the same time he is slightly nervous.

Content:

In this scene Mbulelo has a doctor and a nurse centrally placed. In front of them, there are 3 (hospital) beds. The single bed contains a sick woman. In the other two beds are 5 children. Behind the doctor and nurse are chairs and a bench on which six adults

“Parents” sit (2 men, 2 women, a grandfather and a grandmother). Michael explains that he wants to be a doctor.

Comment:

Mbulelo gives me the impression of being a high achiever who wants to do well. I think that through his play he expresses concern over his ill mother and a desire to be able to help her, so that he may be less powerless in the face of her sickness. All three scenes revolve around a doctor examining an ill person and the family sitting around the ill person anxiously either praying or waiting. The progression in the theme moves from the first scene being about his mother’s illness, the second scene about his grandfather’s illness, and finally to a desire to be a doctor himself.

Main themes/plot in narrative:

- Hospital scene – doctor caring for sick people and woman, ‘parents’ wait worried about their children.
- Self as doctor helping sick people and woman.

## **Participant 6:**

Session 1:

Process:

Winnie talks softly to herself a lot, describing what she sees or is doing; i.e. “There’s an angel”. She appears to enjoy the opportunity to play. Winnie has a very young voice. It is high pitched, singsong, baby like voice. She presents as younger than nine years old. She is physically smaller than most other nine-year-old children are. This may indicate some emotional and physical developmental delay related to her HIV positive status and being placed in a Children’s Home. She is friendly and interacts easily with the researcher. She responds well to the researcher’s confirmation of meaning and interaction.

Content:

Winnie makes a house. She puts four chairs around a table that has a tablecloth and a TV on it. She then builds up the walls of the playbox (house) with coloured blocks.

**Angela:** "They are all safe in the house."

**Winnie:** "All safe in the house." (Singsong voice).

She lays the rug on the floor, and puts the "two small babies" (one older girl and a baby) on it and then covers them with a blanket. The angel comes to stand next to the sleeping children. The older girl child sees the angel.

**Winnie:** (Speaking as the angel) "I am coming to visit y'all. I am coming to guard y'all."

Winnie picks up the three snakes and puts them on the floor going towards the bed. She also puts the crocodile into the house, making it go for the children and the angel.

She takes the cow, making a growl-like moo to attack the snakes. She puts the cow back and looks in the toy box. She takes out the spider and she makes growling noises. The spider and a snake fight. "The spider eats the snakes and protects the people."

She takes out all the bad things (snakes and crocodile) and puts more people in the house, saying there will be lots of people in the family. She puts the toilet in the house. She then takes everything out the box, wanting to remake the house. "I'll make the house nice now." However, it is time to go for her appointment.

Comment:

Winnie built a safe house, and built up its walls as a barrier from the eyes of the researcher and other threatening things. The house is safe, and protected by an angel, and yet it is still threatened by snakes and crocodiles. This seems to be indicative of awareness of some threat to her sense of security.

Main themes/plot of narrative:

- Secure home environment.
- Children protected by angel.
- Safety of home threatened by snakes - an awareness of danger.

## Session 2:

### Process:

Winnie recognises the toys from the last session, and settles easily into playing. She is keen to play, excited and chatty. She engages easily with me despite it being awhile since she saw me last. She does however ask for toys from the other Sceno test. I used a different set in the interviewing at local hospital. This is a fault in the continuity with Winnie, but also serves to indicate the kind of impact the toys made on her.

### Content:

She puts two beds next to each other, "For the mommy and the small baby." She then adds an older sister. There is an angel in the house "for decoration". They have a meal and bath. The mother goes to work as a Nurse/ doctor. The girls go to school. The mother sees various children who she treats. The mother/nurse dispenses tablets and treatment. The mother then finishes work. She waits at home for the children. They come home from school and are greeted happily by the mother with hugs. They all sit down for a meal.

### Comment:

The mother is both nurse and mother. This seems to blend the desire for nurturance and care and treatment for when one is sick.

**Angela: "You wish you had someone like your mother to look after you?"**

**Winnie: "Yes".**

The sister figure, is the doll Winnie selects as her favourite in other sessions. It may be a wished for self identity, as this doll has long blonde hair. This doll also sleeps with the baby. In the Children's Home, Winnie shares a bed with a young child. Family structures and routines such as meals, bathing, going to and returning from school, are important. Particularly important in terms of the excited affect, seems to be returning home from school and having a mother greet her children excitedly and with hugs. This seems to be expressing a need for consistent attachment figure, a warm and consistent relationship with an adult. Winnie swaps the Black mother figure for a white doll. I am not sure if this

is significant or what it's meaning is. Winnie speaks as different characters and makes eating noises for the characters. This suggests she is able to engage in imaginal play and is able to take various 'I' positions (Hermans and Kempen, 1993).

**Main themes/plot in narrative:**

- Routine at home (eating, bathing, going to and from work and school) and safe home environment
- Angel present in house
- Mother as doctor/nurse
- Mother's presence as warm, consistent caring attachment figure.

**Session 3:**

**Process:**

Winnie recognises the toys from the last session, and settles easily into playing.

**Content:**

Winnie plays a school scene. Two boys share a desk, and two girls share a desk. The teacher has a desk at the front. "Its civvies day at school...Valentine's day." Then she places a Christmas tree in the corner, saying it is Christmas.

**Angela:** "It seems like school is a special place?"

**Winnie:** "Yes."

*She takes out food, places plates in front of the teacher and learners, and puts food on the plates.*

**Angela:** "Do you eat at school?"

**Winnie:** "No, the other children eat... I eat my lunch from.... (Children's Home)."

She gives them all something to drink, cuts up food, and feeds them all.

Winnie then plays out a scenario of the children dropping their food and spilling their drinks and the teacher getting cross. Then one girl teases the other about her bushy hair. The girl is hurt, sad and alone. The two boys argue over who will win a football match. All the children go home to sleep. The next day at school, they make up, and agree not to

tease each other. They sit back at their desks. The girls swap places. The teacher says they will not do work today, only tell jokes.

Comment:

Winnie engages easily in pretend play or role-play. She speaks in different voices for the various characters. She also sometimes acts herself for the characters, i.e. Lying against the chair herself, to show that the dolls are sleeping. This is age appropriate, and is a positive indication. Literature suggests that if a child is too anxious, they are unable to engage in pretend role-play (Winnicott, 1971; Klein, 1935).

The theme of her play in this session is a school theme. She indicates some attachment to school, and enjoyment of school. She mixes two special celebrations at school – Christmas and Valentine’s Day. Some of the play however, also shows the more difficult aspects of school. She does not eat school lunch like the other children; she has to take hers in a lunch box. She also plays themes of isolation and being teased by other children. She expresses a desire to reparate and have friends and make up after being teased. She wants to fit in. In my brief interaction with the psychologist before working with Winnie, she said that Winnie was often ill and had to miss school. Winnie hated missing school. The words to the clapping song seem significant. “Candy store, candy store. Hey mom I’m so sick. Doctor, doctor will I die. I count up to five and I’ll be there.” This may just be the only words she knows or chance coincidence. However, if we take all interactions in a therapeutic session as significant, this would seem to indicate concern with her illness and fears of death. Again, routines and food are important themes. This indicates a need for structure and to know that her physical needs will be met. This is supported by literature on grief and illness, which suggests that a child needs routine structure to feel secure, especially in times of stress. She needs boundaries in a scary world – which follows from the first session, building walls around the house, and similar concerns for routine in the second session.

The children swapping places at school could indicate some desire to change her situation and be another child at school. Winnie evokes the researcher's need to protect and nurture her. She presents as friendly, but also very small and vulnerable.

In all three sessions Winnie plays out routines of eating, clearing away and washing plates, and bathing, sleeping, going to and from work and school. The progression in the plot moves from in session one, the children sleep and are protected by the angel, but snakes attack the angel. In session two there is a closer family interaction, and the mother is able to be nurturing and care for the sick. In session three she plays out her concerns about peer relationships.

Main themes/plot in narrative:

- School scene and routines of eating, bathing, sleeping and going to and from school.
- Peer relationships – positive – playing together, repairing.
- Peer relationships – negative- feeling different, being teased.

## Appendix E:

### ***Coding categories***

#### **DOCTOR/NURSE/ MEDICAL PRACTITIONERS**

- DR 1 Doctor examining a child/baby or ill person
- DR 2 Doctor saying things are okay/ baby will be better/ -making people better
- DR 3 Doctor giving medicines/treatment/ treatment instructions
- DR 4 Doctor being taken care of/ fed
- DR 5 Doctors going home/relaxing/having a rest/ watching TV/ time out from doctor duties
- DR 6 Doctor nurturing the baby/ hugging or feeding the baby and/or putting baby to bed
- DR 7 Examining table and medical equipment i.e. Doctor's case, syringe
- DR 8 Doctor with own baby
- DR 9 Doctor visits family – social visits.
- DR 10 Self as Doctor

#### **MOTHER**

- MM 1 Mother sleeps next to baby
- MM 2 Mother feeds baby/children
- MM 3 Mother sits with baby on lap/hold baby/ hugs baby
- MM 4 Mother takes Baby to Doctor
- MM 5 Mother prepares/makes/gives out food
- MM 6 Mother goes to work
- MM 7 Mother prays
- MM 8 Mother as Nurse/ Doctor
- MM 9 Mother feeds sick child

#### **FATHER**

- FT 1 Father sleeps next to baby
- FT 2 Father feeds baby/children
- FT 3 Father sits with baby on lap/hold baby/ hugs baby
- FT 4 Father takes Baby to Doctor
- FT 5 Father prepares/makes/gives out food
- FT 6 Father goes to work
- FT 7 Father prays
- FT 8 Father sitting next to mother/supporting mother
- FT 9 Father as Doctor

#### **BABY (yellow)**

- B 1 Baby being examined @ hospital/ by Doctor or Nurse
- B 2 Baby sick - Baby being cared for /fed special food/ sleeping in middle of room because ill
- B 3 Baby being fed
- B 4 Baby in bed with mother
- B 5 Baby in bed with Mother and Father

## **FAMILY ACTIVITIES**

FM	Family meal
FC	Family celebration
FP	Family prays
FG	Family gathering/meeting re illness of a family member
FS	Family sleeps

## **ROUTINES**

*To distinguish these routines in different environments, SCH will be added in parentheses to show routines at school, CH will be added to show these routines at home, HOSP will be added for hospital. All other routines are those occurring in the Home (extended family) environment.*

R 1	Sitting around a table/ setting up a table and chairs
R 2	Organising food/cutlery/knives and forks/making food/laying out food in the house
R 3	Meal time routine – even distribution of food to all
R 4	Mealtime routines – distribution of food in rations – big meal for big people
R 5	Mealtime routine cleaning up/washing up/putting away
R 6	Bed time routine
R 7	Bathing routine – cleaning and drying
R 8	Toilet routine
R 9	Wetting the bed and associated routine of changing sheets and bedding
R 10	Waking up and making beds
R 11	School/ work routine – Going and return to and from work or school
R 12	Feeding baby
R 13	Feeding/ taking care of the sick person
R 14	Taking care of medical figures
R 15	Taking care of parental figures
R 16	Leisure routines -TV
R 17	Leisure routines/activities – swimming, lying in sun.
R 18	Leisure activities – visitors
R 19	Collecting water

## **EXTENDED FAMILY MEMBERS**

GF	Grandfather
GM	Grandmother
AT	Aunt
UC	Uncle
MM	Mother
FT	Father
BR	Brother
SS	Sister
B	Baby
SI	Self ‘I’
Cou	Cousin
CG	Siblings as group/ children in the family/children group
TW	Twins
CLR	Cleaning ladies, baby sitters, carers

## **SPIRITUAL**

- S 1 Praying over sick person
- S 2 Praying as a family
- S 3 Praying @ mealtimes
- S 4 Praying @ bedtimes
- S 5 Praying for help
- S 6 Angel in home
- S 7 Angel/Jesus as protector (especially at night)
- S 8 Angel in garden
- S 9 Spiritual teachers/ people coming to talk about God

## **ENVIRONMENTS:**

- OE Organising environments – setting up home, making beds, arranging furniture
- HM Home / houses of figures
- HOSP Hospital
- SCH School
- HL Homeless
- G Garden
- CH Children's Home

## **ILLNESS:**

- I 1 Illness of Children/ child/ self
- I 2 Illness of baby
- I 3 Illness of sibling
- I 4 Illness of parent
- I 5 Illness of grandparent
- I 6 Action for illness: special food/special bed/praying/family meeting/Social worker
- I 7 Taking to doctor or Hospital/ Waiting rooms

## **TRANSPORT**

- T 1 Train
- T 2 Car
- T 3 To and from work/school
- T 4 Escape

## **ANIMALS**

- A 1 Cat
- A 2 Cow
- A 3 Dog
- A 4 Crocodile
- A 5 Spider
- A 6 Snakes
- A 7 Wild African Animals
- A 8 Fox
- A 9 Animal attack (figure or animal attacked put in brackets)
- A 10 Chickens and hens
- A 11 Birds

A 12 Pig & piglet

### **MAGIC/ SPECIAL EVENTS**

- M 1 Father Christmas
- M 2 Christmas Tree
- M 3 Gem stone
- M 4 Gifts
- M 5 'Black' magic

### **LOVE / NURTURANCE**

- H Heart
- F Food

### **PEER RELATIONSHIPS**

- P 1 Positive interactions/ games/ songs/ activities with peers/ friendships
- P 2 Negative interactions/ bullying/ teasing/ fighting
- P 3 Favourites
- P 4 Difference/ outcast
- P 5 Making up/ reparation

### **SCHOOL**

- SCH 1 Teacher scolding
- SCH 2 Teacher instructing/teaching/greeting
- SCH 3 Special days at school – Civvies day/ Christmas/ Valentines Day

### **DEATH**

- X 1 Coffin
- X 2 Death of parent
- X 3 Death of grandparent

### **OTHER**

- TP Telephone and telephone conversations
- IP Introductory patter
- ET Exploring Toys
- DRA Distracted/ repetitive play/ anxiety/ measuring sizes
- BIOG Biographic, personal details