

KEEPING THE CHAOS IN:
The application of self psychology
in the treatment of childhood functional faecal retention

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STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature

.....10 March 2005.....

Date

ABSTRACT

This study presents the possible contribution that self psychology might make to understanding, and guiding the treatment of, childhood functional faecal retention. A discussion of self psychology's theoretical perspective on childhood development is provided, including specific reference to the central theoretical issues of optimal responsiveness and mutual- and self-regulation and how these manifest within the psychotherapeutic process. A case study provides the vehicle for the discussion of the applicability and relevance of the central self psychological tenets to the psychotherapeutic treatment of functional faecal retention in childhood. It tentatively concludes that self psychological theory may be useful in informing and structuring the treatment of children with retentive encopresis, and may be especially useful in conjunction with potentially invasive medically and surgically based interventions.

OPSOMMING

In hierdie studie word die moontlike bydrae wat self sielkunde kan maak tot die begrip en behandeling van funksionele ontlastingsretensie by kinders aangebied. 'n Bespreking van self sielkunde se teoretiese perspektiewe op kinderontwikkeling word voorsien, met spesifieke verwysing na die sentrale teoretiese kwessies van optimale responsiwiteit en wederkerige- en self-regulering, en hoe laasgenoemde binne die psigoterapeutiese proses manifesteer. 'n Gevallestudie voorsien die voertuig vir die bespreking van die toepassing en relevansie van die sentrale self sielkunde beginsels tot die psigoterapeutiese behandeling van funksionele ontlastingsretensie in kinderjare. Daar word tentatiewe gevolgtrekkings gemaak dat self sielkundige teorie nuttig kan wees in die behandeling van kinders met ontlastings enkoprese, en dat dit veral nuttig mag wees as dit gesamentlik gebruik word met mediese of chirurgiese intervensies wat as indringend ervaar mag word.

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1. Introduction

This paper takes its impetus from a psychotherapeutic intervention with a child patient diagnosed with functional faecal retention. Borne out of the therapist's own theoretical orientation, self psychological thought was applied to understand the aetiology and underlying dynamics of the patient's presenting problem, as well as to guide an appropriate treatment intervention. It will attempt to explore the possible contribution that psychodynamic ideas might make to understanding and guiding the treatment of this condition, as well as examining the impact of alternative medical treatments from this standpoint.

The literature firstly pertains to a description and overview of self psychology's theoretical perspective on childhood development. It secondly consists of an overview of the central theoretical issues of optimal responsiveness and mutual- and self-regulation and how these manifest within the psychotherapeutic process. Further, a brief description of functional faecal retention is provided. Although the author acknowledges alternative psychotherapeutic perspectives on the treatment of this condition, the details of these are beyond the scope of this paper.

Finally, the presentation of a case study provides an opportunity to explore the application and relevance of the central self psychological tenets outlined in the treatment of functional faecal retention in childhood. It is important to note that the presented case study was initially designed as a therapeutic intervention and not for the purposes of research. As such, the methodology employed was based on a 'life history' approach, which implies a concern for the individuals' subjective reality: an emphasis on process, ambiguity and change: a perspective on totality: and, using the design as a historical tool (Babbie & Mouton, 2001). With a focus on therapeutic issues, methodology included data gathered from several sources: clinical evaluation, projective psychometric assessments, drawings produced by the patient throughout the course of therapy, and the therapist's notes detailing the therapeutic process. This data was analysed in terms of tracking the therapeutic process with the emphasis on interpretations of a self psychological nature.

2. Literature review

2.1 Contributions of psychoanalysis to an understanding of human development

2.1.1 From psychoanalysis to psychoanalytic self psychology

How does a being become a human being? Are the qualities we define as human superimposed on a basically animal nature? Or are the essential features of humanness intrinsic, innate potentials awaiting necessary conditions to emerge? Or is the infant's nature essentially receptive and formless, requiring cultural education and socialization to create and shape unformed potentials into a human being? Finally, does arriving at meaningful answers to these questions require one to make a distinction between "being" human in the sense of acting and looking as though one fits in, and "feeling" human in terms of the quality of one's subjective experience? (Mitchell & Black, 1995, p. 139)

Crucial differences in the answers to these questions define contemporary psychoanalytic schools of thought, and extend into diverse understandings of difficulties in living and treatment. Prior to Freud's time, humans were viewed as the rebel children of the divine, designed in God's image, but Darwin's influence cast a shadow of doubt over the clear cut divide between man and other creatures, no longer allowing man this unquestioned privilege. For Freud, born into a world where the ways of thinking about these questions was in transition, his fascination lay not with the godlike visage of humankind but with the inherent beast in men and women. The process of socialization involved the taming of the beast, with sexual and aggressive energies rerouted into less dangerous socially accepted and sublimated pathways. For Freud, the distinctly human form of being was developed in the process whereby bestial, primitive aggressive and sexual impulses were brought under control. In his view, a painfully guilty conscience reflected a triumph; while psychopathology reflected an imbalance in these conflictual internal forces (Mitchell & Black, 1995).

Heinz Kohut (1923-1981) offered a different vision of human development and experience. He spoke of isolation –of feelings of painful personal alienation, where a person is separated from a sense of his own humanness and experiences himself as being a "nonhuman monstrosity." Kohut envisioned development less as "culture shock," with civilization impinging on and eventually taming bestial humans, but more in terms of "fit." According to Kohut, human beings were designed to flourish in a certain kind of human environment. That the environment must in some way

provide necessary experiences that allow a child to grow up feeling human, energized and connected. Kohut attempted to identify these necessary environmental conditions in a child's early life. With many similarities to the work of Fairbairn, Winnicott and Mahler, Kohut's work shares with object relations theories an emphasis on relationship and a retreat from the Freudian drive model (St. Clair, 1996).

2.1.2 Development of the cohesive self

Man can no more survive psychologically in a psychological milieu that does not respond empathically to him than he can survive physically in an atmosphere that contains no oxygen. (Kohut, 1977, p. 253)

Kohut viewed development in terms of the self, forming in relationship to selfobjects. An infant is born into a human environment and does not yet have a self. The child's self arises as a result of the interplay between its innate potentials and the responsiveness of the adult selves or selfobjects (St Clair, 1996). Similar to Winnicott's concepts of the holding environment and the good-enough mother, a core self or nuclear self is formed through the responsiveness of the child's selfobjects. Kohut and Wolf (1978) liken this process to the body's intake of foreign proteins to build its own proteins.

Within this framework, the self is understood as the "centre of the individual's psychological universe;" the locus of relationships, an active agent performing functions traditionally attributed to the ego; "a unit, cohesive in space and enduring in time, which is the centre of initiative and a recipient of impressions" (Kohut, 1977, p. 99).

Selfobjects are defined as persons or objects that are experienced as part of the self or that are used to provide a function for the self. The child merges with the selfobject, participates in its well-organized experience, and in this merger its needs are satisfied by the actions of the selfobject (Kohut, 1971). Basch (1994) in his exploration of the selfobject concept, states implicitly that a selfobject is not a person, but that it is rather an experience or intrapsychic event. In defining the selfobject concept, he further clarifies that the selfobject function is only called into being at times of threatened loss of cohesive function. Thus, mother and baby are objects for one another and at

times enter into affective or emotional transactions, in which the cohesiveness of the self is not at issue.

For Kohut (1977) there are two central constituents of the nuclear self. A grandiose-exhibitionistic self is thought to become established by the child's relating to a selfobject that empathically responds to their need for mirroring and who looks upon the child with approval and joy, responding to and confirming "the child's innate sense of vigour, greatness and perfection" (Kohut & Wolf, 1978, p. 414). The other constituent being the child's idealised parent imago, which becomes established by relating to a selfobject that emphatically responds to the child by enjoying and permitting the child's idealisation, thereby allowing an involvement with powerful others with whom the child can merge and look up to as an image of infallibility, calmness and omnipotence (Kohut & Wolf, 1978). Finally, Kohut felt that healthy development required twinship experiences with selfobjects who in their similarity and openness to the child allowed the child to feel like the idealized other (Basch, 1994).

For Kohut, immersion in these childhood states is required in order to gradually develop a reliable sense of well-being and vitality. Failures on the part of the selfobject to mirror the growing self and to foster idealisation can lead to the fragmentation of the self or the loss of vitality by the immature self (Tolpin, 1978 quoted in St Clair, 1998). For Brooke (1992):

To suffer fundamental self-pathology is to feel split, fragmented, or precariously unstable most of the time. It is to feel persecuted from within and without. The body frequently feels alien and robot-like and the person may feel depersonalised or unreal. There is little room for thought, feeling, conflict-holding or memory. Ungrounded and with a collapsing memory everything feels discontinuous and contingent: emotions are labile or dead. With little capacity or room for imagination there can only be immediate and concrete solutions, so behaviour seems impulsive and destructive. With poor boundaries, conflict is usually felt to be between oneself and others, and suffering feels caused by the other's behaviour. There is a longing to be understood, yet a terror of being swallowed by the other's understanding; there is a longing to feel autonomous and independent, yet terror of being abandoned. Separation and loss are an unbearable pain. (p. 5-6)

2.1.3 From optimal frustration to optimal responsiveness

Psychic structures are built by a process called transmuting internalisation by which aspects of selfobjects are absorbed into the child's self. Central to this process is the notion that non-traumatic failures in parental responsiveness act as catalysts to the emergence of the nuclear self (Kohut & Wolf, 1978). The child comes to appreciate the unrealistic nature of his view of his parents and himself as he suffers the ordinary disillusionments and disappointments of everyday life. Regarding the idealised object with increasing realism, the child withdraws some of its narcissistic, magical expectations from the selfobject. According to Winnicott, a degree of failure in "fit" is considered necessary as well as inevitable for development; frustration makes objects real, thereby allowing the infant to form an impression of, and relationship to, external objects.

Inevitable yet manageable frustrations take place within a generally supportive environment. The child rises to the occasion, survives the frustrations and in the process internalises functional features of the selfobject. He learns to soothe himself rather than collapse in despair, adjusting to the realities of life, experiencing internal strength despite defeat and finding vitalising pleasure in personal experience (Mitchell & Black, 1995).

To have a self is to feel embodied, spacious, and bounded. To feel embodied is to feel solidly grounded, to feel both the quickening and weight of desire, feeling, passion and natural rhythm. To feel spacious is to feel the self as an open clearing within which thoughts, feelings, fantasy's and memories can occur, an inner realm that can bear conflict, ambivalence and painful memories. It is to have room for imagination. To be bounded is to feel a sense of agency, that it is possible to say yes or no without undue compulsion or guilt. It is the acceptance of separateness and loss, an awareness that the other has her own volition and is not merely the extension of one's fantasy, there for one's benefit. Boundaries are thus also the condition for a genuine compassion, so different from that compulsive giving with its insidious need to control. (Brook, 1992, p. 5)

Thus, frustration is hypothesised to play a central role in the building up of self-structures. The two psychic configurations, the grandiose self and the idealised parental image, although antithetical, coexist to preserve the primary narcissistic experience. Gradually the grandiosity and exhibitionism of the grandiose self become

tamed and integrated into the structure of the personality filling the “emotional tank” with good feelings about the self and about the child’s ambitions and activities (St Clair, 1996, p. 159). In addition, the idealised parental image is integrated as the idealised superego where it serves as a structure to regulate tension and provide idealism. The above-mentioned sequence preparing the self for an eventual shift from early archaic selfobject bond to higher forms of self- selfobject relatedness normally associated with adult life (MacIsaac, 1996).

For Bacal (1985), the view that optimal frustration alone produces internal structures is a hypothesis that needs to be challenged. Bacal (1985) suggests that self psychology cannot assume that all internalising processes occur through frustration, but that rather in a good-enough situation identification and assimilation occur. Considering Kohut’s concept of optimal frustration as an archaic holdover from drive theory, he emphasises his assertion that what is decisive is the responsiveness of the selfobject environment to the child’s reactions and needs. The emphasis thus being shifted from optimal frustration to affective attunement, with the suggestion that this concept be replaced by “*optimal responsiveness*”, the act of communicating responsivity that is most relevant at any particular moment to the child (Bacal 1986, quoted in MacIsaac, 1996, p. 6).

2.1.4 Self- and mutual regulation

Lachmann and Beebe in their exploration of the interface between Kohut’s developmental concepts and the growing field of infant of research, suggest that Kohut’s notion of internalisation resulting from optimal frustration needs to be expanded into a view of transmuting internalisation as resulting from a multiplicity of routes, including mutual and self-regulation (Mitchell & Black, 1995).

Empirical infant research expands understanding of infant-caregiver interactions: it gives rise to the concepts of self- and mutual regulation as well as a theory of the interactive organization of experience that is based on a dyadic systems view. Within this perspective, organisation is the emergent property of the dyadic system (selfobject and infant) and a property of the individual (selfobject or infant). Simultaneous influences of self- and mutual regulation are thus integrated. Mutual

regulation refers to a model in which both partners actively contribute to the regulation of the exchange, although not necessarily in a like manner or in equal measure. Self-regulation refers to the ability to self-comfort and the capacity to organise one's behaviour in predictable ways and to regulate one's states of arousal (Lachmann & Beebe, 1996).

Mother and infant jointly construct patterns of social relatedness, which guide the management of attention, affect sharing and participation in dialogue. In addition, each partner influences the process through specific contributions to the pattern of the interaction and his or her own self-regulatory style and range. The person's capacity to respond and socially engage depends not only on the nature of the partner's input and on the nature of their responsivity, but also on the person's regulation of his or her internal state. State is used to refer to arousal, affect and its symbolic elaboration. From infancy on individual differences exist in capacity to modulate arousal and to tolerate and use stimulation to organise behaviour in predictable ways. Failures in self-regulation thus affect the quality of mutual regulation. Infants with specific regulatory difficulties may place significant strain on the responsivity of their parents. Whether derived from variation in individual endowment or failures in mutual regulation, difficulties in self-regulation affect the quality of engagement. Similarly, failures in mutual regulation compromise self-regulation (Lachmann & Beebe, 1996).

As will be illustrated in the case to be discussed, affect regulation, tension and anxiety may then be relegated to solitary measures, within a dyadic system of imbalanced mutual regulation. The expectation of chronic misregulation may develop. Rather than an increasing sense of self-reliance and self-sufficiency, a preoccupation with impaired self-regulatory efforts may ensue.

2.2 Contributions of self psychology to an understanding of the therapeutic process

2.2.1 From optimal frustration to optimal responsiveness in the therapeutic process

As previously outlined, a number of theorists within the modality of self psychology have challenged the view that optimal frustration alone produces internal structures. For the purpose of this paper, the author will enter into the conversation about the optimal in the practitioner's response, focusing on guidelines that may help direct the search for the appropriate and useful in the therapeutic process. In doing so, the alternative constructs offered by Bacal and Terman will be discussed.

With the publication of his landmark work, *The Restoration of the Self*, Heinz Kohut (1977), established optimal frustration as a central aspect of the therapeutic (curative) process, as viewed from the perspective of self psychology. However, despite the concept of optimal frustration being central to his theory, his writings fail to capture an inclusive definition thereof. In 1963, while working within the classical psychoanalytic perspective, Kohut initially defined optimal frustration as:

...sufficient delay in satisfaction to induce tension-increase and disappointment in attempt to obtain wish- fulfilment through fantasies; the real satisfaction occurs quickly enough, however, to prevent a despairing and disillusioned turning away from reality. (Kohut & Seitz, 1963, p. 356 quoted in Bacal, 1985, p. 203)

Thus, Kohut at the outset hypothesised that infantile impulses that encounter numerous optimal frustrations are transformed into psychological structure (comprised of transformed or sublimated instinctual drives), but that prohibitions of traumatic intensity, result in the internalisation of frustrating experiences and a barrier of defences that walls off unmodified infantile strivings (Bacal, 1985).

In 1971, with the publication of *The Analysis of the Self*, Kohut reiterated his position, but now focused instead on the importance of optimal frustration for narcissistic equilibrium rather than for drive modification.

For Bacal (1985), Kohut's accurate observation that clinical work with self-disordered patient's is punctuated by disruptions necessitating repair, and that following such

repair the patient seemed improved, was confounded with the sense that it was the frustration itself that was responsible for the improvement and growth of structure. In contrast, Bacal postulated that just because structure building followed optimal frustration and its repair, this did not denote an inevitable cause-and-effect relationship between structure building and moderate frustration. He argued that it was in fact the patient's sense of being understood following the frustration and its repair that created new structure. Thus, understanding in itself was postulated as being therapeutic and leading to psychological growth (MacIsaac, 1996). Bacal (1985) considers optimal frustration as an approach with patients that has as its goal "not complying [with the needs of the patient] but trying just to understand and interpret" (p. 220 quoted in MacIsaac, 1996, p. 5) as its goal. He classifies it as a form of manipulation, in which the analyst makes "calculated errors thought to lead to manageable disruptions...and, thus, to transmuting internalisation through the associated optimal frustration and understanding" (Bacal, 1985, p. 207 quoted in MacIsaac, 1996, p. 5).

In response, Bacal (1985) introduced the term optimal responsiveness into clinical vocabulary, as well as a new set of questions regarding what it means to be responsive and especially what is meant by optimal. Noting that Kohut had himself posed the question about what is optimal in optimal frustration, but had never arrived at a satisfactory answer, Bacal described responsiveness as the therapist's act of communicating their understanding of the patient to the patient; with optimal being considered as that response most suited to that specific patient's developmental capacity and selfobject needs for relatedness. In addition, Bacal presented the newly introduced concept of optimal responsiveness as the umbrella term that would subsume optimal frustration, gratification and provision. Bacal noted that frustration and gratification are both inevitable in the clinical relationship, but that neither serves as an appropriate treatment goal. Rather the appropriate goal in the clinical situation is for the analyst to communicate their understanding of his or her patient through an optimal response (Shane & Shane, 1996).

Bacal (1986) offers the analyst two guidelines toward the optimal response. The first of which derives from Kohut's concept of a developmental line of empathy. Kohut (1981) maintained that the analyst must proceed from understanding to explanation,

from showing that he is attuned to his patient's inner life, thoughts, feelings and fantasies to the next step, interpretation. He described this advance from understanding to interpretation as a progression from what he considered a lower form of empathy to a higher form of empathy. This occurs in response to a progression that the analyst observes in the patient: from an earlier more archaic capacity to feel the analysts empathy, in which a literal holding environment or an experience of merger is required, to a more evolved capacity to feel the analyst's empathy, where a more metaphoric holding environment provided through verbal understanding or explanation is now adequate to serve the patient's selfobject needs (Shane and Shane, 1996). Kohut (1981) illustrates this progression through the explanation of a young child's need for bodily contact, later developing a capacity wherein words alone can achieve the same result.

...a child and the mother are in the park. The child was a young child who clung to the mother. The sun was shining, pigeons were walking around there. All of a sudden, the child felt a new buoyancy and daring and it moved away from the mother toward the pigeons. He goes three or four steps and then he looks back. The general interpretation of that is that he is anxious, he wants to be sure he can come back, to be encased in her arms, cradled, etcetera. That is true, but something more important is true. He wants to see the mother's proud smile: he wants to see her pride [looking] at him walking out now, on his own - isn't that wonderful - and at this moment, something extremely important had happened: a low form of empathy, a body-close form of empathy expressed in holding and touching...is now expressed only in facial expression and perhaps later in words: I am proud of you, my boy. (Kohut, 1981, quoted in Bacal, 1985, p. 212)

The second guideline Bacal offers toward optimal responsiveness also derives from Kohut's writings:

When the patient is in a disrupted state, and the self-selfobject relationship is at an impasse, a different sort of response is called for from the analyst than when the selfobject tie has either been restituted or is perceived as smoothly ongoing. (Shane & Shane, 1996, p. 40)

In agreement with his own thinking, Bacal welcomes Terman's opposition to Kohut's concept of optimal frustration. For Terman (1988), "The shaping, moulding, and structuring of internal states ... occurs by way of the vicissitudes of attunement" and not by way of frustration (p. 118 quoted in Shane & Shane, 1996, p. 41). The point again being that frustration does not build structure, but that it is rather the intactness

of the selfobject tie that permits the resumption of development, not its disruption following frustration. While supportive of Bacal's position, Terman moves beyond him by adding to our understanding of how structure is formed, both in development and in the clinical situation. Terman (1988) argues that it is the repetition of the pattern itself that ultimately builds structure and that "the doing is the making" (p. 125 quoted in Shane & Shane, 1996, p. 41). Thus, the dialogue of construction between parent and child and between therapist and patient is the structure, with there being no two-part process wherein one first experiences and then internalises to build enduring structure. Rather structure is created by the transaction itself, in real time, as the transaction occurs, and it is the repetition not absence or interruption that creates the pattern (Shane & Shane, 1996).

2.2.2 Self- and mutual regulation and the therapeutic process

In this section, principles of self- and mutual regulation, derived from a systems approach to the study of infant-caregiver interaction, are suggested as permitting opportunity for in-depth examination and alternative understanding of therapeutic interaction, and the process of analytic change.

Lachmann and Beebe (1996) suggest that therapeutic action be understood as an interactive process. It is postulated that instead of viewing the therapist and patient as two isolated entities, each sending the other discrete communications, a view of the treatment relationship as a system is preferable. Thus, a theory of the interactive organization of experience based on a dyadic systems view is hypothesised, with the organisation of experience as an evolving property of a dyadic system and a property of the individual. It is suggested that as with mother-infant interactions, therapist and patient jointly construct patterns of relatedness. These patterns of relatedness guide affect sharing, mood, participation in dialogue and management of attention. Each partner (therapist and patient) influences the process of therapeutic interaction through their own self-regulatory style and range, and through specific individual contributions (Lachmann & Beebe, 1996).

In advocating the integration of both self- and mutual regulation in psychoanalytic theory and treatment, Lachmann and Beebe (1996) state unreservedly that this view is

not designed to supersede dynamic formulations. It is rather suggested that the proposed integration can provide the practitioner with a differentiated view of the organisation of experience and the regulation of interactions within the therapeutic process (Lachmann & Beebe, 1996).

Further motivation for this integrated approach is Lachmann and Beebe's (1996) assertion that attention to self- and mutual regulation assists the therapist to "contact difficult to reach patients where the critical cues go far beyond the usual verbal exchange" (p.125). The role of self- and mutual regulation at the level of the modulation of vocal contour, rhythm matching, pausing, gaze regulation and postural matching are thus emphasised in the therapeutic establishment of the selfobject tie. The nonverbal interactions on which Lachmann and Beebe (1996) focus have traditionally been included among noninterpretive analytic behaviours: these interventions have been made when words were considered inadequate to retain a therapeutic connection. However, Lachmann and Beebe (1996) propose that nonverbal behaviours do constitute interpretations, although not packaged in the customary form. The objective being to provide the patient with the experience of mutuality and being understood: thus, providing access to patients who are in state not accessible to more usual forms of therapeutic dialogue (Lachmann and Beebe, 1996).

2.3 Constipation in the child

According to Van Buuren (1991), constipation is a common problem encountered in paediatric practice. Literature available presents a confusing nomenclature. The terms encopresis, soiling and constipation are often used interchangeably and without definition. The term encopresis was first coined by Weissenberg in 1926, suggesting a similarity to enuresis, the involuntary passage of urine (Kelly, 1996). Clayden defines constipation as a delay in defecation leading to distress, which may include pain, overflow soiling and anorexia. He restricts use of the term encopresis to the passing of normally formed stools in socially unacceptable places. This is in contrast to its use in the USA, where it includes episodes of overflow soiling or diarrhoea.

According to Van Buuren (1991), children with constipation fall into two basic categories: functional (primary) constipation, in which there is no underlying

demonstrable disease, and organic (secondary) constipation, in which an underlying disease is evident. Organic aetiology includes gastro intestinal disease, mechanical abnormalities, Hirschsprung's disease, endocrine and metabolic disorders, neurological disorders and drugs use. Functional constipation may be simple (acute or transient) or chronic in duration. Chronic constipation may or may not be associated with overflow incontinence (soiling) and with or without psychological problems. Use of the term psychogenic constipation as a blanket term for chronic constipation, is misleading and implies that all children who are constipated are both soilers and have underlying psychological difficulties, which is not always the case. Van Buuren (1991) therefore suggest that this term be reserved for children whose constipation and soiling is primarily due to psychological reasons. He furthermore reflects on the changing and now broader conception of the term, encopresis and states that the vast majority of 'encopretic' children are simply constipated and have faecal impaction, with soiling as a mere extension thereof.

For Barker (1988), the term encopresis, is used interchangeably with that of faecal soiling, and is defined as the passing of faeces in the clothes rather than in the toilet. Within this conception, encopresis is classified as retentive or non-retentive, depending on whether or not faeces have accumulated in the colon and rectum in abnormal quantities. Retention of faeces is considered to have either physical or emotional origins, physical causes including anal fissure and Hirschsprung's disease. The emotional state most frequently associated with faecal retention is anger, although encopretic children are also postulated as harbouring much repressed anxiety. Subsequent negativistic refusal to defecate may result in faeces accumulating in the large intestine, which becomes distended and the faeces in it becomes hard and impacted. Physical examination reveals the rectum to be enormously dilated and packed with faeces, with liquid or semi- liquid faecal material leaking from the anus, the child having no voluntary control over this (Barker, 1988).

According to Kelly (1996) chronic constipation and faecal retention is a common under-recognised condition that can be severe in its physical, psychological, social and familial consequences. Treatment can be prolonged; time consuming and expensive if repeated hospitalisations are required. The potential for savings both financially and in terms of global health gain for the child and family, if those

children who do not respond to normal management could be identified early and offered alternative specialist assistance being evident.

With many questions regarding the development, progress and outcome of chronic constipation, remaining unanswered Kelly (1996) highlights the need for further research to elucidate the complex influences of developmental factors within the child, the nature of the parent/child relationship and the quality of the family environment.

3. A case study

3.1 A self psychological child therapy approach

In the above literature review, it is suggested that a self psychological child therapy approach with its focus on empathic attunement, optimal responsiveness, and self- and mutual regulation might offer an alternative, rich model of treatment in the work with children with retentive encopresis, in contrast to a purely medically based intervention. It is hypothesised that a purely medical intervention may be experienced as traumatic and invasive for certain children who present with this condition, most specifically when the aetiology is considered predominantly psychological in origin.

The purpose of the case material is to illustrate how self psychology as a theory may provide an appropriate framework and model of treatment for children with functional encopresis. The case presented demonstrates the process of a client's individual therapy, which utilised play therapy, verbal and nonverbal interactions, interpretations, and shared experiences. It further demonstrates that a combined treatment approach that includes collaborative parental involvement is preferable. The work with the client's mother demonstrates the (inherent) value in mobilizing a different set of responses within the child's environment to facilitate age-appropriate growth and development. The work with the client was based on empathic attunement and the provision of an optimal treatment environment, which allowed for the emergence of fluctuating idealising, mirroring and alter-ego selfobject transferences and responses (Suth, 1996).

3.2 Background to the intervention

The client, Jason¹, age 8, was referred to medical psychology by paediatric surgery. He presented with recurrent abdominal distension with faecal impaction. Jason had been thoroughly investigated by paediatric surgery for this recurrent problem and no organic cause had been established. Voluntary faecal retention was suggested by a recent Manometry study. At the time of referral, Jason had undergone surgery and had been fitted with a colostomy bag. Of particular medical concern was that Jason continued to retain faeces, contracting his abdominal muscles to prevent expulsion of faeces into the colostomy bag. In light of the suggested psychological aetiology of Jason's condition, a thorough psychological evaluation was requested to assist with further management.

Discussion with Jason's paediatric surgeon revealed a medical view that a surgical procedure involving the removal of a strip of Jason's internal sphincter muscle in combination with the dilation of his external sphincter muscle, to prevent voluntary retention, should be undertaken.

3.3 Clinical evaluation

Initial assessment included two individual consultations with Jason's mother, and two individual consultations with Jason. In line with Jolly's caution against what he referred to as a "bucket and spade" attack on an emotionally inflamed part, (Jolly, 1976, quoted in Kelly, 1996), projective play, art and apperception techniques were administered during sessions with Jason in order to gain an understanding of what might lie beneath his defensive façade.

At the time of the first consultation, Jason's mother provided a detailed description of his retentive pattern, but reported significant confusion regarding the possible aetiology of these difficulties. She described frequently observing Jason in extreme discomfort, holding onto his bed with his legs crossed, while struggling to prevent himself from passing a stool. This effort to withhold faeces was also observed while

¹ Name has been changed to protect patient confidentiality.

he was asleep. She reported Jason's difficulties as having begun in June 2003, and reported that he had been admitted to hospital on a number of occasions since this time.

She described Jason as playful and stated that he did not appear to be an anxious child. She however expressed concern and confusion regarding what she described as temper tantrums that were chaotic and unpredictable in nature. She reported that Jason would become oppositional, aggressive and angry and stated that she felt overwhelmed by this behaviour, and was unaware of how to intervene effectively at these times. She reported her belief that Jason's behaviour would be unmanageable if she did not remain in the hospital with him.

During the course of the clinical assessment Jason's mother provided the following history. Jason is the first born of two children. He was born full-term, by a normal vertex delivery after a complication-free pregnancy. Jason's mother was fourteen years old at the time. There were no complications during delivery; however, because she had lost a great deal of blood during the birth she received a blood transfusion. Upon her return from the hospital to her mother's home, Jason's mother learned that her sister had been killed in a tragic accident, three days after Jason's birth.

Jason was breast fed by his mother for the first month of his life before he was given into his grandmother's care. Despite the fact that Jason's mother continued to live in the same household with Jason and his grandmother, she was unable to provide a detailed account of his developmental history. She could offer no information regarding the ages at which he learnt to sit, crawl, stand, walk or talk. Her report did reveal that Jason's cousin was born when Jason was a year old, diverting much of his grandmother's attention to the newest addition to the family. When Jason was three years old, his grandmother insisted that his mother become more involved in his care and so returned responsibility for him to her. By this time Jason was not fully toilet trained. While he was able to indicate to his mother when he needed to urinate, he was unable to do the same for defecating and so frequently soiled himself. After several attempts at verbal explanations, Jason's mother resorted to physical punishment in response to his soiling. Jason began hiding his soiled clothing from his mother.

At the age of four Jason was sent to a crèche. After one month, Jason's mother was asked to remove him from the school as he was soiling himself and was "smelly". During this time his paternal grandparents, who had lived next door, and with whom Jason had shared a good relationship relocated some distance away. Within the same year, Jason and his parents relocated to a house that Jason's maternal grandmother had inherited from her sister. According to Jason's mother, their move was largely motivated by discomfort they had experienced as a result of her uncle's presence in her mother's home. Her mother's brother was reportedly an alcoholic who had become increasingly inappropriate in his behaviour, often becoming aggressive and making sexually inappropriate remarks to members of the household.

The following year, at the age of five Jason was admitted to pre-primary school. This has been identified as the period in which the retentive pattern began. Teachers reported no difficulties but remarked that he would avoid going to the toilet during school time. As a result, Jason would often soil himself on the way home. His home life appeared to be fairly disrupted during this time as he lived between two homes: during the week while his mother was employed as a seasonal worker he would stay with his grandmother and on weekends his mother would collect him to stay at home with her. In 2003, Jason was hospitalised for the first time with severe faecal impaction. He was treated medically and discharged. In December of the same year, he was again admitted during which time he was fitted with a colostomy bag.

In 2004, Jason attended only one month of school due to his illness. In addition to his physical difficulties, he developed a reluctance to attend school due to being teased by his peers. He would reportedly show his colostomy bag to newly acquired friends only to become the victim of ridicule. Early in the school year, Jason's father moved out of the family home due to having found employment in the city. Since then his contact with Jason has been sporadic and unpredictable depending on his financial circumstances. Jason's mother later revealed that his father would frequently make promises only to renege upon them.

3.3.1 Session one

Jason's mother brought him to our first individual consultation. Although initially demonstrating some resistance to the impending separation from his mother, he separated easily, responding to assurances that his mother would be waiting for him outside of the playroom. Upon entering the playroom, Jason's manner was compliant although responding to the invitation that he could play freely in the playroom, he appeared somewhat timid and inhibited, with there being little evidence of vitality and spontaneity in his behaviour.

Jason stood quietly looking around the playroom, moving over towards the stacked rows of white plastic containers on the playroom shelf after a few seconds had passed. He carefully lifted the lid of each, peering inside, taking care to close each container afterwards. Having examined the contents of each container, he selected a box of cars, and came to sit on the mat in front of me to play. He began by neatly lining the cars next to one another in a row, with meticulous attention to detail and order. Having completed this task, each individual car was driven around the mat (in order of position), coming to rest again at its allotted place in the orderly and precise row. A careful investigation of each car ensued, followed by the container being returned to its original position on the shelf (Session 1)².

The use of formal projective art techniques was planned to assist with assessment. However, Jason spontaneously began to draw during our initial consultation, and the decision was made to allow him to continue with this spontaneous expression rather than to impose an external structure.

He settled himself at the drawing table, and immediately began to draw a circle that he divided into segments. Jason appeared to give great thought to each colour that he selected, as though having an image in mind that he was now giving shape to on the paper before him. Once satisfied with his creation, he turned the page over and drew a large multicoloured tree, a person, and flowers and birds, in the sunshine. I noticed

² Process notes written after each session; italicised throughout.

with interest that both tree and person were suspended in midair, the tree having no grounding and the figure having no feet on which to stand (Figure 1, Session 1).

3.3.2 Session two

In our next session, the Robert's Apperception Test for children was administered. Upon arrival, Jason again separated easily from his mother and was cautious, timid and inhibited in his interaction with the therapist. He was silent and sat relatively motionless, with his hands folded and initially responded to all requests that he tell a story about the cards shown with silence and the occasional shake of his head and a mumble that he did not know. After some time Jason reluctantly began to tell stories in response to the cards shown, and appeared to become progressively more relaxed, with his stories becoming increasingly spontaneous in contrast to prior mere descriptions of people, objects and activities represented.

The prevailing tone of Jason's narratives was one of anxiety and aggression, with a repeated theme of rejection epitomized by what appeared to be a punitive environment. An extension to this theme appeared to be an internalization of this punitive environment whereby Jason made frequent reference to him being labelled as rude ("onbeskof"). In addition, Jason's stories appeared to lack resolution and closure, suggesting interpersonal and intrapsychic conflict. Themes of depletion and scarce resources in the face of need are furthermore evident.

Card 6B

Jason: Umm...die kinders praat saam met mekaar... (laughs) oor hulle ma en hulle pa. Hulle ma en hulle pa slaan hulle, en hulle wil nie meer by hulle ma en hulle pa bly nie.

Therapist: Sjoë. Met wie wil hulle bly?

Jason: By ander mense. Toe slaan daardie mense ook vir hulle... en toe bly hulle op hulle eie. Toe het hulle nie kos nie, en toe gaan werk hulle.

Therapist: En dan?

Jason: Dis al.

Card 9

Jason: Hierdie kind het vir hom geslaan, toe slaan hy een vir hom terug. (Patient points to figures in the picture.) Toe huil hy. Toe voel al twee ongelukkig, en toe moet hulle huis toe gaan.

Card 16

Jason:

Die kind vra vir die pa. Hy wil 'n leesboek hê, want die pa lees ook. Gee die pa vir hom 'n leesboek. Die volgende dag toe is hy klaar met die leesboek. Gee hy vir sy pa die boek, toe gaan vra hy vir sy pa nog 'n boek. Toe gee hy vir hom eentjie. Die volgendes dag toe is hy klaar met daar eentjie ook, en toe hy vra sy pa nog 'n boek. Toe sê hy nie daar is nie een nie.

3.4 Psychodynamic Formulation

In light of the clinical material, and the Kohutian assertion regarding selfobject needs in childhood, one may hypothesise a 'faulty' interaction between Jason and his selfobjects, with a lack of empathic response to his need to be mirrored and to find a target for idealisation.

Clinical assessment and projective techniques revealed themes expressing Jason's longing for the protection and acceptance of idealised adults, as well as a wish for more shared experiences with his father, which would provide him with a feeling of mutuality and kinship. As in card 16, mutuality in sharing is sought ("Gee die pa vir hom n boek"), however, resources are short and his need remains unsatisfied ("Toe sê hy nie daar is nie een nie").

Furthermore, observation of exchanges between mother and son over the course of therapy indicate that Jason's mother, due to her own insecurely established self (difficulties with self-regulation and her own merger hunger), has been unable to respond to the needs of her child (Jason's need to be mirrored and to merge with an idealised selfobject). This results in her responding to the needs of her own tentatively established self, rather than those of her son. In addition, it is postulated that Jason tries to meet his mother's needs for being mirrored.

It is hypothesised that the above absences may have prevented Jason from building up the appropriate psychic structures capable of dealing with anxiety, self-soothing, regulating tension and the experience of internal strength despite defeat. The consequence of these hypothesised developmental failures resulting in an overburdened self that has not been provided with the opportunity to merge with the calmness of an omnipotent (idealised) selfobject, as well as one that has suffered the

trauma of unshared emotionality. As such, Jason may be understood as lacking an appropriate self-soothing capacity that protects him from being traumatised by the spilling over of his emotions, especially the spreading of anxiety. In addition, his external world, lacking self-soothing objects may be experienced as adverse, hostile and dangerous. Thus, both internal and external worlds are experienced as dangerous, chaotic and frightening.

Jason emptied the box of soldiers and cars onto the mat. He immediately arranged the jeeps and trucks in a neat line. He attempted to stand all the soldiers up in an arc shape on the mat. As the soldiers toppled over, he continued with determination, but appeared to become despondent and disappointed.

Giving up on this task, Jason began to pack the soldiers away, placing them carefully into the box, one at a time (Session 3).

In an attempt to manage his feelings and his external world without sufficient internal structures, it is hypothesised that Jason, with the unconscious expectation of chronic misregulation, developed a reliance on drastic and impaired self-regulatory efforts, as manifested by his extreme over-regulation. It is postulated that “letting go” of one’s “messy bits” in a hostile world with no appropriate capacity for self-regulation and soothing, may be experienced by Jason as terrifying, and not unlike the experience of fragmenting and the loss of his sense of continuity of self.

3.5 Treatment plan

The initial treatment plan included an ongoing assessment and formulation of the aetiology of the client’s difficulties, in conjunction with a Child Therapy Self Psychological treatment intervention. In light of the earlier medical investigations which indicated no underlying organic cause for Jason’s condition, and the observations of the initial psychological assessment, it was posited that further medical treatment in the form of surgery might be experienced by Jason as invasive, representing a loss of control in an already intrusive and overwhelming world.

After much deliberation regarding what might constitute, as suggested by Bacal (1985), an optimally responsive treatment intervention, a Child Play Therapy Self Psychological intervention was seen as most appropriate. The underlying assumption being that further medical surgery would constitute further traumatic frustration of Jason's unmet selfobject needs.

Play, posited as a spontaneous activity by which children express their understanding and experience of their world by means of symbols, was considered the optimal vehicle for therapeutic process. As the voice of the child's inner world, it was furthermore thought that this would provide opportunity to gain access to and communication with Jason's inner world.

3.5.1 The symbolic meaning of play

For the purpose of this paper, play will be considered as a spontaneous activity by which children express their understanding and experience of their world by means of symbols. It will be suggested that play provides opportunity for self-regulation and adaptation, as well as providing the observer with a glimpse of, and a means of communicating with the child's inner world.

We ought to look in the child for the first traces of imaginative activity. The child's best loved and most absorbing occupation is play. Perhaps we may say that every child at play behaves like an imaginative writer, in that he creates a world of his own or, more truly, he arranges the things of his world and orders it in a new way that pleases him better. It would be incorrect to say that he does not take his world seriously; on the contrary, he takes his play very seriously and expends a great deal of emotion on it. (Freud, 1953, p. 173-174)

Play is a curious and central activity of childhood, occurring in all places and at all times. It is spontaneous, voluntary, and intrinsically complete and assimilates the external world to match the individual child's concepts. For Piaget (1962) play bridges the gap between concrete experience and abstract thought. Concrete objects become symbols for the experience and feelings of the child. It incorporates the physical, mental and emotional self in creative and concrete expression of the child's inner world (Landreth, 1991). Play, in this meaning, affords the child with opportunities to "act out" that which is disturbing, confusing and conflicting (Woltmann, 1964, p. 174 quoted in Landreth, 1991, p. 8).

The most normal and competent child encounters what seem like insurmountable problems in living. But by playing them out, in the way he chooses, he may become able to cope with them in a step-by-step process. He often does so in symbolic ways that are hard for even him to understand, as he is reacting to inner processes whose origin may be buried deep in his unconscious. (Bettelheim, 1987, p. 40 quoted in Landreth, 1991, p. 13)

In addition to its intrinsic value as a developmental process of adaptation, play gives 'voice' to the child's inner world. Children's feelings are often inaccessible at a verbal level. Developmentally they lack the cognitive facility to express what they feel and are emotionally not yet able to focus on what is felt, to enable its expression in a verbal exchange (Piaget, 1962). Thus, toys become words and play the language of childhood. Children feel through the toys that they choose and their story is acted out, giving the observer access to their internal landscape.

3.6 Description of the therapeutic process

During the course of the therapeutic intervention, significant shifts in Jason's behaviour were observed. These changes will be described below in a short overview of the therapy sessions.

With the commencement of the therapeutic intervention, Jason continued to separate easily from his mother. Despite this, he appeared to experience difficulty moving into the therapeutic relationship. Although cooperative and compliant, Jason continued to appear timid and inhibited in his response and interaction with the therapist. Upon entering the playroom, Jason would immediately follow a quickly established routine, investigating boxes on the shelf, moving onto the mat to play with the contents of one container at a time, ending the session with drawing, cutting and pasting. However, no attempt to spontaneously interact with or engage the therapist in his play was evident. Overtly Jason barely acknowledged the therapist's presence, although he occasionally responded to her tracking his activities and reflecting his affect with a nod, or quick sideways glance. Questions or enquiries were responded to with silence, his looking away or even turning slightly away from the therapist. In terms of self- and mutual regulation, Jason may be understood as having brought a narrow range of tolerable arousal and engagement to the therapeutic process. The therapist may be understood

as partially restricting and monitoring her responses to Jason, in response to his constriction. This form of response from the therapist was evident in the third session (for which a process note extract was provided earlier), wherein Jason spent a significant amount of time arranging the toy soldiers with careful determination and persistence:

I noticed that I was holding my breath, afraid to breathe, feeling intensely aware of the tenuous footing of each soldier and the large number of soldiers remaining that would be made to stand. Perhaps I had identified with his fear of impending disaster through his loss of control, having sensed his own 'tenuous footing' (Session 3).

The observed immobility of Jason's soldiers symbolised a disrupted state of extreme self-holding and regulation and a predominant need for structure and control. History taking and observations of parent and child interactions indicated traumatic frustrations due to inconsistent and chaotic interaction between Jason and his selfobjects, with a lack of empathic attunement and response to his need to be mirrored and to find a target for idealisation. The tenuous footing of Jason's soldiers in turn influenced the therapist's rhythm and restricted her range of activity to a less intrusive, gentle, and slow tracking of his activities.

As the therapeutic process unfolded, Jason devoted the greater portion of his time in the playroom to drawing. This change in focus initially occurred within the routine that he had established at the outset of therapy, but progressed into a new routine, whereby Jason would enter the playroom and immediately seat himself at the drawing table. Drawings became an invaluable tool throughout therapy, in that they reflected how Jason experienced himself and the areas in which he was struggling. As such, they were also an indicator of the changes taking place within him.

The drawings that Jason produced in the early part of therapy appeared to be graphic representations of his inner experience of instability, powerlessness to act on his environment, discontinuity between himself and his external world and his experience of disconnection from stable objects. An early picture showed a house, a person and flowers in the sunshine, (depicted as an almost imposingly large orange and yellow smiling sun). The picture depicted in Figure 2, reveals a house and person again

suspended in midair, the figure having no feet on which to stand and no hands to use to act on his world. However, with the progression of the therapeutic process, Jason's drawings became more prolific and less controlled in execution. Now devoting the entire session to drawing, Jason divided his time between making drawings with intricately designed wrappings for friends and family, and making reams of 'loose' drawings ranging in subject matter that would remain with the therapist (Figures 3, 4, 5, 6, 7, 8 & 9). Amongst his frenzied production of drawings, Jason became preoccupied with ensuring that he had written his name, age and standard, on the back of each drawing perhaps as an attempt at ownership of connectedness to his internal objects with his increased 'letting go'. He was observed to check on numerous occasions during the session that he had labelled each drawing in this way. The discovery of a drawing without these details would result in him painstakingly checking all his drawings again, perhaps symbolic of a fear that the external world could not adequately hold his by-products and that these would float in space as he had done in his previous drawings. Drawings for friends and family incorporated hearts and the person's name in the composition. All enquiries about the relevance and importance of the people for whom these drawings were for were met with silence, although Jason nodded at the reflection that they looked like they were made for people that he loved very much.

At the outset of the seventh week, the emergence of a mirroring and idealising transference became apparent. Jason devoted a session to making a blue and red Christmas tree (Figure 10), which he carefully cut out, painted and decorated. Assuming that this was a present for a friend, the therapist enquired whether Jason wanted to take his tree with him at the end of the session. Jason in response shook his head and indicated that she should keep the Christmas tree with her instead. In the sessions following, Jason continued to leave all his drawings with the therapist, no longer making drawings for significant others outside of therapy. A picture produced in the eighth week includes the word, Doctor ("Dok") referring to the therapist written across the page, with a row of flowers drawn below (Figure 11). In addition, Jason appeared to become more vital, explorative and spontaneous in his behaviour in the playroom. Although continuing to devote the majority of his time in the playroom to drawing and painting, Jason began to move about the playroom more freely, taking what appeared to be breaks from drawing, by playing with a pair of tennis balls that

he had discovered. While there may be many interpretations of this shift the therapist hypothesised that Jason's experience of increased connectedness allowed him to move more freely, as well as allowing him to regulate the space between himself and the therapist. Jason would bounce one of the balls for as long as he could with one hand, as well as seeing whether he could bounce the ball to the height of the ceiling. Crawling under the playroom table and under the therapist's chair, Jason appeared to make more overt attempts to engage the therapist.

With the emergence of the idealising transference, increased spontaneity and vitality were also evident in Jason's art. The picture depicted in Figure 12 reveals a red heart with the word, "Doc" written in the middle, surrounded by a multitude of coloured dots and curves. Figure 13, reveals a series of shapes including stars and a heart, surrounded and partly covered over by lines and dots of paint. *Noticing that paint had dripped onto the page, Jason continued with this, dripping paint freely over his painting (Session 26).*

With the progression of the therapeutic process and the development of the therapeutic relationship (ninth week), Jason continued to tolerate greater engagement with the therapist allowing his internal world to become more transparent to her. In addition, his experience of moments of increased self-cohesion through the 'living through' of an affective experience with a selfobject that provided a sensitive attunement to his self-states were revealed, as shown below:

Jason entered the playroom and sat down on the chair at the drawing table with his back turned towards me. He responded to my usual morning enquiry as to how he was with silence and neither a nod nor shake of his head. I reflected that he looked angry and wondered whether he felt this way because I had been late for our session. Jason nodded that he was angry, but grunted in disagreement at the mention that he might have been angry because I was late. He nodded his head and mumbled; "Mm" at the suggestion that he may be angry with his mother, (I had noticed at the outset of the session that both Jason and his mother appeared quiet and disgruntled). I suggested that he might want to make a drawing to tell me about how he was feeling that morning. Jason immediately began to draw the picture depicted in figure 14. He drew the outlines in pencil first and then coloured over these with crayon. I reflected that it

appeared as though he was doing this because he wanted to be careful. Jason nodded in agreement, his expression pensive. I noticed with interest that Jason drew a three-dimensional boy (naked), smiling and standing firmly on the grass (with both hands and feet) underneath the stars, clouds and sun. I reflected that the boy looked happy and wondered aloud what the boy's name was and whether it might also be Jason. Smiling broadly, Jason nodded his head firmly in agreement.

Having completed the first drawing, Jason peered around the playroom as though deciding what he should do next. With great concentration he began to draw again (Figure 15), looking up and out of the window every now and then. I sat feeling puzzled as to what had caught his attention outside. Looking out of the window I suddenly realised that he was drawing the hospital building opposite and exclaimed spontaneously, "I know, you are drawing the windows outside!" ("Ek weet, jy teken die vensters daar buite!") Jason smiled and nodded and a game of tracking began.

Jason peered around the room once more selecting another object to draw. He began to draw the clown puppet on the windowsill (Figure 16). In response to my reflection that he was drawing the strange clown ("snaakse nar") on the window, Jason nodded his head and spontaneously began to giggle and laugh (Session 29).

His increased willingness to move into the therapeutic relationship and begin to share his internal landscape was also evident in his numerous drawings of animals in groups and pairs (Figures 17, 18 & 19). Although animals had featured strongly in Jason's drawings throughout the preceding weeks, these animals had been represented as solitary beings. Now Jason represented a school of fish swimming together, and dinosaurs and zebras grazing.

Reflecting back on the process, the closing of week nine appeared to herald a turning point in the therapeutic process; a new atmosphere entered the therapy room, marked by inconsistency, frustration and an urgent need for the therapeutic intervention to be completed in order that the patient and his mother could return home. In discussion with the paediatric surgeon it was decided that Jason would undergo surgery the following week to remove the colostomy bag. Medical reports indicated that Jason was no longer restricting the flow of faeces into the colostomy bag. It was furthermore

decided that Jason would remain in hospital after the procedure and would continue with therapy.

However, previous consistency and routine gave way to sudden irregular and chaotic attendance, with Jason arriving reluctantly in tears on one occasion after he had been sent to the hospital school for a short while only to be disrupted midway into an activity on the computer to attend his session. The following day Jason arrived half-an-hour late for his session after his mother had left him on the ward and had requested that the hospital staff bring him to therapy. On the Monday of the following week, Jason did not arrive for his session once more and the therapist received a message that she should collect him from the ward as his mother had gone out. On her arrival on the ward, she was informed that Jason had been taken to the school although nursing staff reported that they were aware that he was due to attend a therapy session. In an attempt to maintain the consistency of the therapeutic process, the therapist decided to fetch Jason from school, as he would be expecting to attend his session. On her arrival at the school, Jason was seated at a long table with a number of children and was preparing to cut and paste. He left the session unwillingly, and walked for the duration of our journey back to the child psychiatry ward in a side ways manner facing the wall, leaning slightly against it so that his back was towards the therapist. Jason pulled his hat down over his eyes avoiding all eye contact. At the end of the session, Jason left taking all the drawings he had produced with him.

In light of changes described, the therapist in discussion with the paediatric surgeon suggested that the surgical intervention be delayed, in order to re-establish the therapeutic relationship as a consistent and safe space. The therapist's motivation being the provision of the 'perfect' platform from which to introduce changes that would be potentially traumatic. In addition, the therapist discussed her concerns with Jason's mother, highlighting the need for Jason to be brought to therapy regularly and consistently. The importance of therapy remaining a safe and consistent place for Justin was explained and it was suggested that suitable arrangements be made with the hospital school to prevent Jason's school time and therapy times from clashing.

However, the therapist's concerns regarding the therapeutic space being contaminated increased when Jason presented for therapy the following day.

Jason arrived for his session carrying a large bag of drawings. His mother escorted him to the playroom door at which point he turned away from the therapist and began to cry. With much resistance, Jason entered the playroom and sat down at the drawing table with his back turned away from me. Sitting on the floor next to Jason I attempted to reflect his heart ache and anger, as well as his potentially feeling out of control in a system that was able to make decisions on his behalf. All reflections that Jason felt powerless and frustrated were met with increased crying.

In an attempt to demonstrate acknowledgement and understanding of Jason's pain and desperation, I sat down on the chair next to him and tentatively began to draw him looking tearful and unhappy. Jason looked up and began to carefully inspect the rockets and spaceships on his pyjamas, after which he peered over at those that I was drawing in my representation of him. He looked inside the packet of drawings that he had brought and took out a drawing of a mother duck with her ducklings that he began to colour in, all the time paying careful attention to what I was doing. After a little while, Jason began to unpack the bag of drawings that he had brought onto the table. I felt saddened by this gesture, as though he was bringing me everything he had (all of his drawings despite the scarcity of his resources). I reflected that he had brought me his drawings to show me how hard he had worked. Jason responded by bringing more and more drawings out of his bag. As the session drew to a close Jason looked over at the drawing of himself and in response to my wondering whether he wanted to take this drawing with him, nodded with a large smile and stated clearly that the bag of drawings were for me to keep. For a moment, I sensed that something painful had been restored by my empathic reflection of his helplessness against more powerful forces (Session 35).

At the close of the tenth week Jason's mother announced that she would leave Jason at the hospital if he did not have the awaited surgery on the following Monday. Thus, an ultimatum was given with no room for compromise, again reflecting there being little room for Jason's needs, especially in the face of his mother's experience of traumatic frustration. Jason having overheard this discussion appeared to become

withdrawn. In further discussion with Jason's mother regarding the need to contain her own disappointment and frustration, she revealed that she had told Jason that he was not working hard enough in therapy, directly blaming him for the delay in their return home. She believed this to be the reason that he had brought all his drawings to therapy that day.

I felt outraged, desperate, anxious and saddened. I wondered how I would restore the therapeutic relationship that we had worked so hard to establish. I felt I was watching it unravel before my eyes and felt powerless to salvage the remains. I have begun to suspect a need within his mother to sabotage the therapy or perhaps the relationship I have with Jason, and yet I am keenly aware of her own struggle to contain her overwhelming needs. In carefully maintaining my alliance with Jason how do I set about providing containment for an entire system (Session 37)?

On the advice of her direct supervisor, the therapist agreed to meet with Jason and his mother on a long weekend. It was felt that Jason's mother was in desperate need of containment. In an attempt to rescue her alliance with Jason and perhaps resolve the disruption, the therapist requested that a colleague accompany her whose sole purpose would be to provide some containment and support to his mother. The therapist felt concerned that this might be reinforcing his mother's manipulative behaviour and mirroring her needs just as he had always needed to do. However, having considered potential loss of therapeutic progress and long-term consequences, she decided to proceed with what felt like a crises intervention. After the meeting, her colleague reported that Jason's mother had spoken at great length about her frustrations and conceded that a therapeutic process of her own would be beneficial to herself and Jason. She appeared to understand the potential physical danger for Jason in a premature discharge and of her own volition agreed to remain in the hospital with him and support the therapeutic process.

Despite this agreement, the following week Jason's mother again stated that she would return home with Jason if he did not have the surgery that week, and that they would possibly only return the following year. By this time, the therapist felt that her relationship with Jason had developed a withholding and punitive tone, as she had been repeatedly placed in the position of having to disappoint him by telling him that

he could not go home. With due consideration (and perhaps to justify it to herself) she began to feel that she was perhaps naively waiting for a perfect moment for him to undergo the surgery to remove the colostomy bag; a moment in which she could declare him healthy and psychologically fit. At the very least, she had hoped to restore the damage left by disruption in the therapeutic process. This was not to be and Jason underwent surgery five days later.

In the days preceding the surgery, Jason exhibited a deep reluctance to attend therapy often crying through out sessions. His drawings were dominated by themes of a home nestled in mountains (Figures 20 & 21). He would frequently lie with his head on his arms on the desk in the therapy room. It appeared that attendance at therapy had become a prerequisite to receiving permission to go home. It was clear that Jason had begun to mirror what he perceived to be the therapist's needs and had entered a forced compliance.

Jason spent the week following the surgery in recovery, unable to attend therapy sessions. During the therapist's visits to him, his mother reported that he had asked to come to therapy and had suggested that he would use a wheelchair when told that he would not be able to. Being unable to consume solid foods, he had also reportedly told his mother that the therapist would bring him juice ("sappie") and yoghurt. On his return to therapy at the end of the week Jason was again distressed and in tears. His mother reported that he was crying because he wanted to go home and that he had successfully passed a stool that morning. She further reported that she had had a heated confrontation with the staff on the ward when they requested that Jason move beds to accommodate another child. Jason's mother was once again advised of the threat to Jason's health that premature discharge would bring. She agreed to remain on the ward, however on the following Monday the therapist discovered that she had returned home over the weekend but had not returned on the Sunday evening as she had agreed to. The therapist was informed that Jason had tried to telephone his mother at six o'clock on the Sunday evening to establish her whereabouts, but that his mother had been busy at the time and had not answered his call. Jason's mother returned to the hospital the following morning. That day Jason was reluctant to attend therapy, but was forced to attend by his mother. He reported that he wanted to go home ("ek

wil huis toe gaan”) and spent the session crying and banging his fists on the drawing table.

The following day his mother reported that a doctor on the ward had told them that Jason was making good progress and could be discharged that day. This doctor was not aware of the discussions and agreements that had taken place between the therapist and Jason’s surgeon. His surgeon understood the importance of Jason remaining in the hospital to facilitate appropriate therapeutic termination. The doctor who had advised his mother that they could go home was not aware of these agreements. By way of a compromise it was agreed that Jason would be discharged on the following Monday to allow time for further monitoring and appropriate therapeutic termination. This decision was again met by significant distress from Jason. The therapist and Jason began addressing the issue of termination immediately by drawing a train with the number of coaches signifying the remaining number of sessions, at which time Jason appeared to settle and began playing with the tennis balls. His play appeared to reflect an attempt to distance himself from the therapeutic process, or possibly an attempt to comply with the remaining requirements. The sessions that followed before the last one, were marked by the same disengagement. However, in the last session Jason returned to drawing. His pictures depicted angry faces with the inscription: “This is Jason” (“Dit is Jason”). This inscription was repeated on the chalkboard. He nodded in agreement at the reflection that he looked angry. He also assented to the therapist’s interpretation that even though he really wanted to go home, it still felt difficult to say goodbye.

3.7 Discussion of the therapeutic process

The material presented demonstrates the treatment with a child patient from a self psychological vantage point. Borne out of the therapist’s own theoretical orientation, the therapeutic work was based on a self psychological appraisal and model of treatment. The central thesis being that it is the patient’s sense of being understood that is therapeutic and leads to psychological growth. The goal of therapy being the communication of this understanding to the patient in a response most suited to the particular patient’s developmental capacity and selfobject needs.

Initial assessment revealed Jason's reliance on drastic and impaired self-regulatory efforts, as manifested by extreme over-regulation. The therapist considered what might constitute an optimally responsive treatment intervention suited to Jason's developmental capabilities. This consideration highlighted concerns that the medical fraternities proposed surgical intervention might be experienced as extreme, invasive and traumatically frustrating for the patient. The loss of control in a hostile world without first developing alternate capacities for self-regulation and soothing would be experienced as terrifying. The development of incontinence would be tantamount to the experience of absolute vulnerability in the face of adversity, hostility and unpredictability.

Assessment had indicated a disrupted state with a self-selfobject relationship at an impasse. This required a different sort of response from the therapist. It became clear that verbal interpretation alone would not alone satisfy Jason's selfobject needs. Using Kohut's concept of a developmental line of empathy it is clear that the therapist needs to consider his/her vocabulary of response so as to serve the patient's selfobject needs best. Because Jason's experiences had been invasive with little consideration of him, verbal engagement was also regarded with suspicion and as potentially invasive. With critical cues moving far beyond the usual verbal exchange, nonverbal interactions at the micro level of rhythm matching, pausing, postural matching, modulation of vocal contour and gaze regulation allowed him to feel understood and to experience mutuality.

Thus, Jason may be understood as having brought a narrow range of tolerable arousal and engagement to the therapeutic process. Predominant themes of structure and control in Jason's play indicated Jason's experience of chronic misregulation in his external and internal worlds and his ensuing preoccupation with self-regulation and the management of negative affect. The mother-son relationship, described previously, depicts patterns of extreme imbalanced mutual regulation that tilted Jason towards solitary and extreme imbalanced self-holding and regulation. In essence, drastic self-regulation attempts substituted for a balanced integration between self- and mutual regulation.

Reflecting on the therapeutic process, the patient's rigid self-regulation may be understood as having had a powerful affect on the therapist. The therapist responded to Jason's constriction by partially restricting and monitoring her responses, allowing herself to be influenced by his rhythm. The limits imposed by Jason's narrow range of affect narrowed the therapists own, as evident by her restricting her range of activity and adopting a soft and less intrusive tone. Initial comments remained within the limits of reflecting and tracking the concrete activities of Jason in the playroom, with questions and enquiries experienced as intrusive and responded to with silence.

With the progression of the therapeutic intervention, Jason's tolerance increased. He became increasingly spontaneous and willing to engage with the therapist and his environment. Slowly the therapist was able to move in to sit closer to Jason at the drawing table. Verbal exchanges, including the reflection and elaboration of his feelings and reactions, were tolerated and responded to with a nod, shake of his head or laughter. Sessions were begun with the therapist asking how Jason was feeling thereby allowing her greater access and understanding of his subjective internal world.

As their relationship developed, the therapist sensed that Jason felt increasingly comfortable and safe with her. Although he was still very intense, he was more relaxed and increasingly spontaneous in his engagement with the therapist. Within the provision of this optimally responsive environment, idealising, mirroring and alter ego transferences emerged. For Jason the relative absence of selfobject experiences that could have provided for his needs gave rise to a longing for a structure- building relationship with an idealised selfobject.

A central theme in Jason's therapy is the unfolding of an idealising transference. The decrease in Jason's extreme self-holding and regulation was evidenced by his increased spontaneity and indicated the growth of a more balanced and less extreme capacity for self-regulation through the idealisation of the therapist.

In addition, Jason's participation in hospital school activities with other children on his ward gave him a sense of belonging, kinship, acceptance and mutuality with his peers. Collateral reports indicate that the children at Jason's previous school had

teased him and called him “smelly.” It was reported that Jason had experienced himself as different to the other children because of his colostomy bag.

Reflecting on the therapeutic process it is hypothesised that through the process of therapy in an optimally responsive environment with its inevitable frustrations, a situation of balanced mutual regulation was established and Jason was able to internalise appropriate selfobject responses. This resulted in the further development of self-structure and an experience of an improved sense of vitality, resiliency and well-being.

Jason’s drawings, a diagnostic tool throughout the process, (reflecting the patient’s experience of himself, the areas in which he was struggling and the changes taking place in his self-experience), indicate the development of a more three dimensional boy, by the name of Jason, with hands and feet to act on his environment.

4. Conclusion

4.1 Summary of findings

This paper has argued that a self psychological child therapy approach with its focus on empathic attunement, optimal responsiveness, and self- and mutual regulation might offer an alternative, rich model of treatment in the work with children with retentive encopresis in contrast to a purely medically based intervention. It is hypothesised that a purely medical intervention may be experienced as traumatic and invasive for certain children who present with this condition, most specifically when the aetiology is considered to be predominantly psychological in origin. The case study outlined above has demonstrated an attempt at the practical application of this idea. The patient, Jason aged 8, was referred to the Department of Medical Psychology by Paediatric Surgery with a diagnosis of voluntary faecal retention. Of particular medical concern was that although Jason was fitted with a colostomy bag he continued to retain faeces by contracting his abdominal muscles to prevent their expulsion. It was the medical opinion that a surgical procedure involving the removal of a strip of Jason’s internal sphincter muscle in combination with the dilation of his external sphincter muscle should be undertaken.

In light of the Kohutian assertion regarding selfobject needs and the information obtained through clinical assessment and projective play, art and apperception techniques a 'faulty' interaction between Jason and his selfobjects was inferred. The consequence of these failures resulted in Jason's reliance on drastic and impaired self-regulatory efforts, as manifested by his extreme over-regulation. After deliberation regarding what might constitute an optimally responsive treatment intervention, a Self Psychological Child Play Therapy intervention was planned with the underlying assumption being that the proposed medical surgery would constitute further traumatic frustration of Jason's unmet needs.

i) Overview of the process

Jason initially appeared to experience difficulty moving into the therapeutic relationship. He was timid and inhibited in his response to the therapist, barely acknowledging her presence. He made no attempt to spontaneously interact or engage with the therapist, but responded to her tracking his activities with a nod or a quick sideways glance. All questions or enquiries by the therapist were responded to with silence and nonverbal responses which indicated that Jason experienced these acts as intrusive. In addition, there was little evidence of spontaneity in Jason's play.

As described in the material presented, several shifts were then noticed in Jason's behaviour, which has been ascribed to the influence of the therapeutic relationship, empathic attunement and the provision of an optimal treatment environment that allowed for the emergence of idealising, mirroring and twinship selfobject transferences and responses. While Jason's drawings initially depicted his sense of disconnection and his experience of being ungrounded, they increasingly began to symbolise moments of self-cohesion. In addition, Jason's increased sense of connectedness was observed to enable him to move more freely within the therapeutic space.

However, week eight brought with it significant frustrations and a change in the therapeutic relationship and the atmosphere within the playroom. Jason was observed to become increasingly uncontained in response to his mother's unmet needs, which resulted in her becoming increasingly uncontained. Attempts to restore the therapeutic

relationship and to reinstate therapy as a safe and containing space outwardly appeared to fail and the therapist sensed that Jason had entered into a forced compliance, attending therapy as a prerequisite to being allowed to go home, and in this way mirror his mother's needs. As such, the decision was made for Jason to undergo the surgical removal of the colostomy bag with the hope that he had been able to internalise something of the stability and the provision of a balanced mutual regulation within the play therapy, despite the rupture encountered.

ii) Assessment

Upon reflection it is the therapist's view that a self psychology approach provided a rich understanding of Jason's difficulties and his experience of his world, thereby assisting the therapist in her consideration of the possible consequences of the proposed medical intervention. In addition, it informed the planning of what is hypothesised as a psychologically more appropriate treatment intervention.

Jason's play and drawings indicate an increased spontaneity, vitality and experience of self-cohesion. This suggests that through the provision of an optimal treatment atmosphere idealising, mirroring and twinship transferences and responses emerged. Through this process, Jason was able to begin to internalise appropriate selfobject functions resulting in the reorganisation and further development of self-structure. The implication is that self psychological knowledge can be used to inform and support the treatment of children with retentive encopresis, in contrast to a purely medically based intervention that may be experienced as intrusive and a further attack on an already inflamed part.

However, this intervention was not free from its own inevitable ruptures and frustrations, which may have been a function of the particular context in which the therapeutic process took place. Jason's in-patient status for the sole purposes of psychotherapy left the therapist with the unfortunate responsibility of ascertaining his fitness for discharge. With Jason's ability to function in the dyad with his mother being directly proportionate to his ability to sufficiently mirror his mother, his requests (which were most frequently expressed by his mother) to be discharged often appeared to be solely based on the need to maintain the dyad. This presented the

therapist with a dilemma regarding optimal responsiveness. By holding his greater need for physical and medical safety for both Jason and his mother, the therapist, on several occasions, frustrated his need to mirror his mother, by denying requests for discharge. Under these circumstances questions are raised for the therapist regarding what constitutes the optimal response: To grant what was presented as the patient's own request for discharge and thereby facilitate a fulfilment of the patient's need to mirror his mother? Or, to frustrate this need by considering what appeared to be a greater need, that of his medical and physical wellbeing? Would compliance with Jason's need to mirror his mother imply a lack of separate thinking, forced compliance, and capitulation to his mother's needs, effectively rendering his chronically denied needs as secondary? Or, would a denial of his overtly expressed needs reflect an acknowledgement of needs separate to his mother, providing him with the potential opportunity to regain ownership of these denied aspects of himself?

4.2 Shortcomings of the intervention

i) The intervention as therapy

The sole purpose of the patient's extended admission to hospital was for psychological intervention. His only access to appropriate health services was as an in-patient as he and his family reside a substantial distance from the hospital making it impossible for him to commute. This posed several difficulties in the therapy. The patient was seen outside of his daily home life with therapeutic input coming to an abrupt end with his discharge from hospital, with no extension of the intervention into his daily life but for what he had internalised himself and could take home with him. Due to his treatment as an in-patient, therapeutic intervention was by necessity brief and intense and it is likely that the patient would have benefited from a sustained long-term therapeutic intervention.

In addition, as the therapeutic intervention progressed the power and continuing influence of Jason's parents in the here and now became apparent. The therapist acknowledged Jason's intrapsychic conflicts and developmental difficulties stemming from his hypothesised history of traumatic frustration of his needs. However, observed incidents within the therapeutic process demonstrated a view of conflicts not

as sequestered and circumscribed within Jason, but more importantly as ongoing and interactive with the significant people in his intimate family environment. The need for a combined treatment approach that included collaborative parental involvement in an effort to help them acquire parenting skills and provide selfobject functions that are age appropriate and developmentally attuned to Jason was, thus, highlighted.

The need for this was highlighted on several occasions during the course of therapy. A particular example, which appeared to encapsulate the importance of facilitating a concurrent therapeutic process for Jason's mother, occurred in the later stages of therapy. Jason arrived at this session unhappy and tearful. In the playroom, he reluctantly sat down to draw and was restless and unable to settle as he moaned and repeatedly scratched his head. He began to draw a figure with club-shaped hands (Figure 22). Having completed the figure, he appeared dissatisfied with his representation of the head, repeatedly erasing the lines to begin with another attempt. This action was repetitive and marked by heightened distress. The therapist's attempts at reflecting his discomfort were met with an outburst of: "My mother hit me on the head!" ("My ma het my op die kop geslaan!"). This incident appeared to underscore his mother's power and continued influence on his experience of himself in the here and now. His drawing appeared to reflect the loss of his sense of self, in response to his mother's persecutory behaviour.

ii) The intervention as research

The predominant shortcoming of the presented Child Play Therapy is that it was designed as a therapeutic intervention, and in this way, the validity of the data is limited. In addition, the data although revealing, is difficult to systematise and is therefore only marginally useful in terms of research.

4.3 Implications for future therapy and research

i) Therapy

It is suggested that future interventions adopt a combined treatment approach that includes collaborative parental involvement in an effort to help parents to acquire

parenting skills and to provide selfobject functions that are age appropriate and developmentally attuned to their children's needs.

In addition, a movement towards a more sustained therapy is suggested with the therapist looking beyond the therapy room to access resources and supports within the community and system of the child, in an attempt to provide for the unmet selfobject needs of the child and their family. An extension of therapeutic work into the field is thus advocated if work is to be sustained.

ii) Research

This paper has proposed one model of journeying into the life of a child with retentive encopresis. Self psychological thought is recommended as a useful tool for future interventions through its provision of the core concepts as outlined in the above case study. This is considered to be especially so in the case of young children, with severe restrictive behaviour and where accurate self-report is limited.

It is also proposed that future research focus on further insights gained from the study of mother/infant behaviour and attachment theory. The author suggests that the principles of psychodynamic infant observation could be useful in gaining further insight into the behaviours of children with restrictive encopresis and their caregivers. In addition, this focus may assist with assessing appropriate interventions around caregiver responses.

Finally, the author has suggested one possible perspective from which to understand the case, where there are likely to be many other approaches to its interpretation. In addition, the case examined in this paper presented a profusion of rich and profound material and data, the extent of which has resulted in many questions remaining unanswered and interpretations left unproffered. Even within the conceptual framework of self psychology, the exploration of the case is limited to aspects that have been concentrated upon select central tenets of the theory, and by no means represents a comprehensive discussion of the case material.

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Figure 1



Figure 2



Figure 3

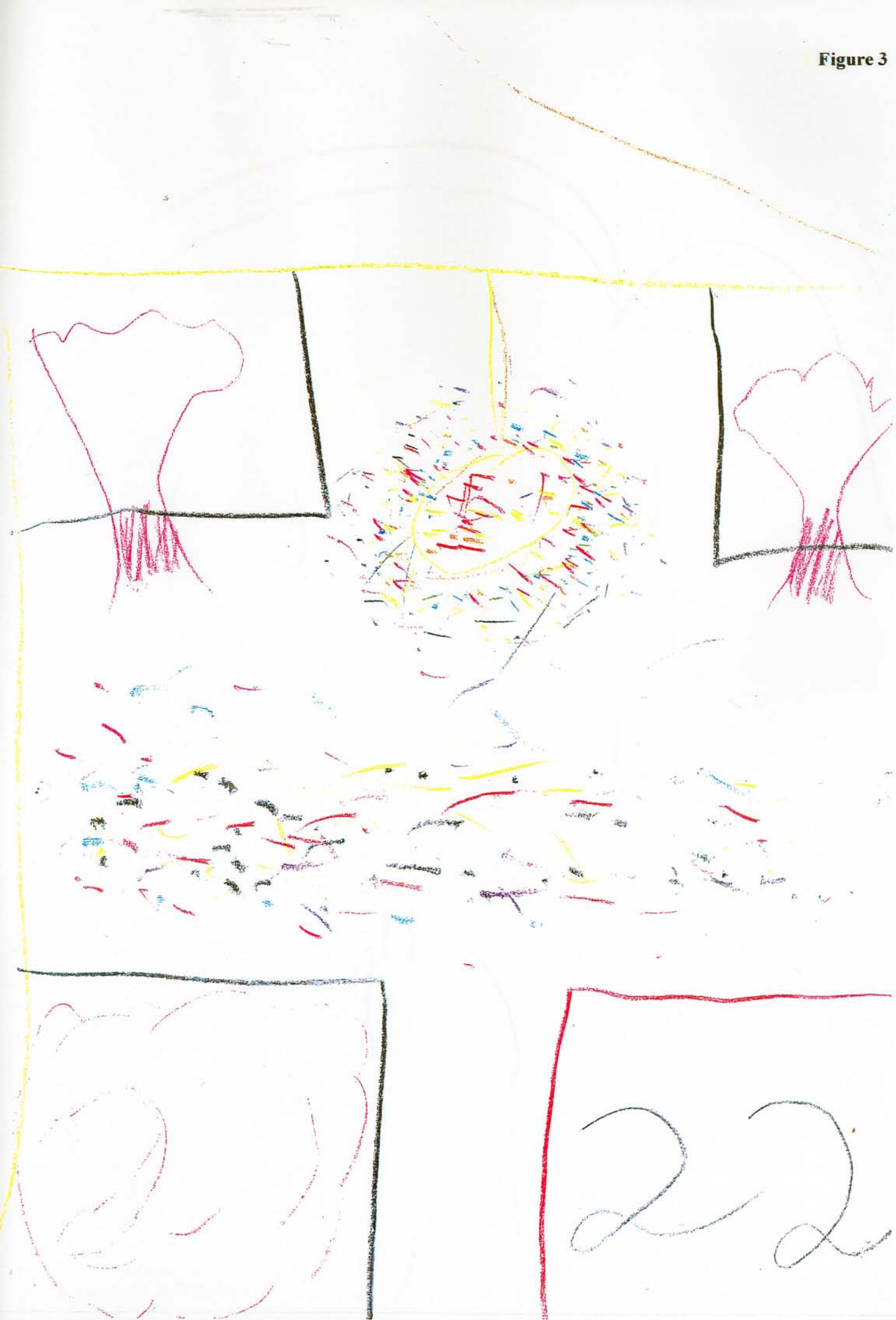


Figure 4



Figure 5

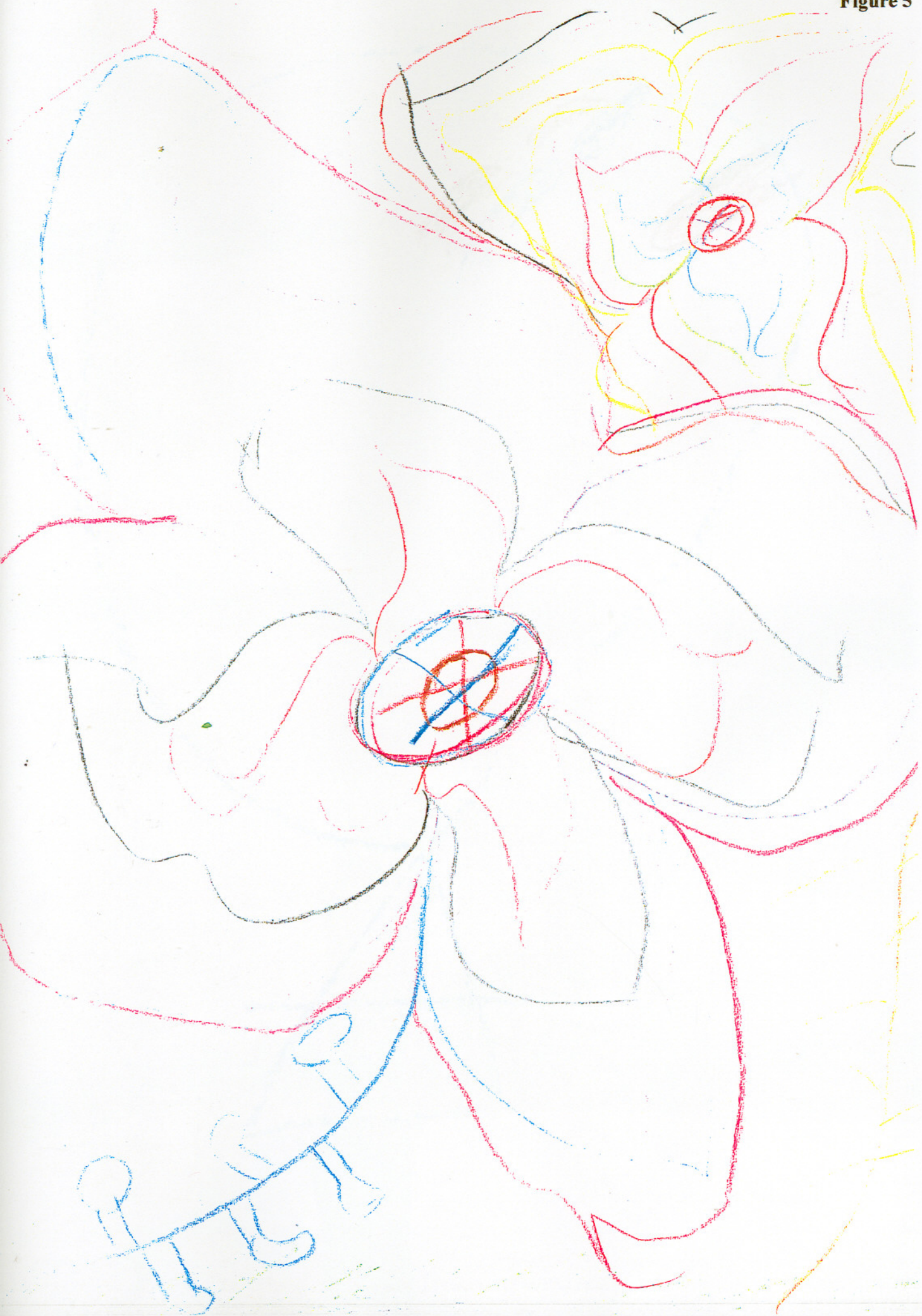


Figure 6



Figure 7



Figure 8



Figure 9



Figure 10



Figure 11



Figure 12





Figure 14



Figure 15

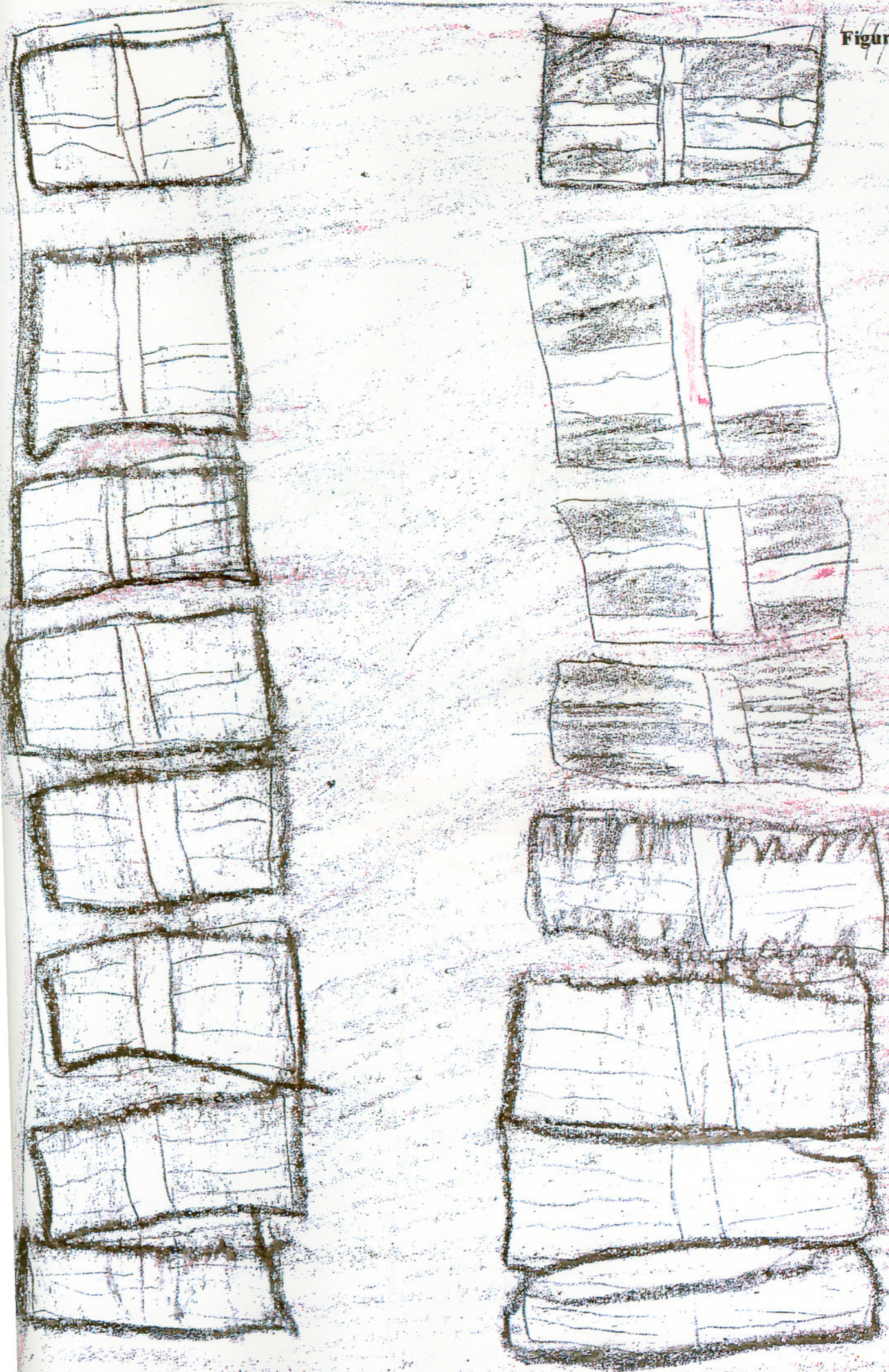


Figure 16



Figure 17

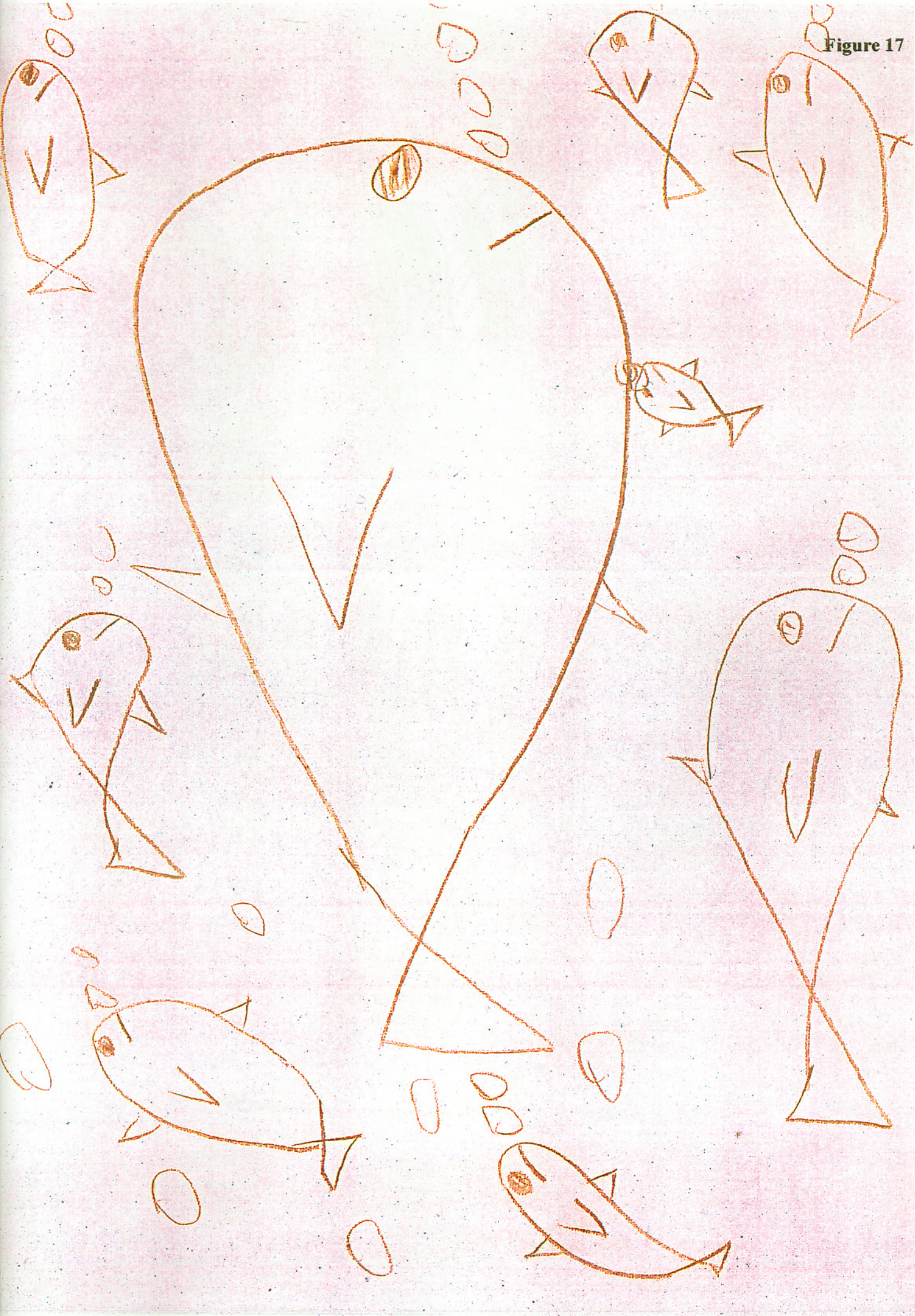




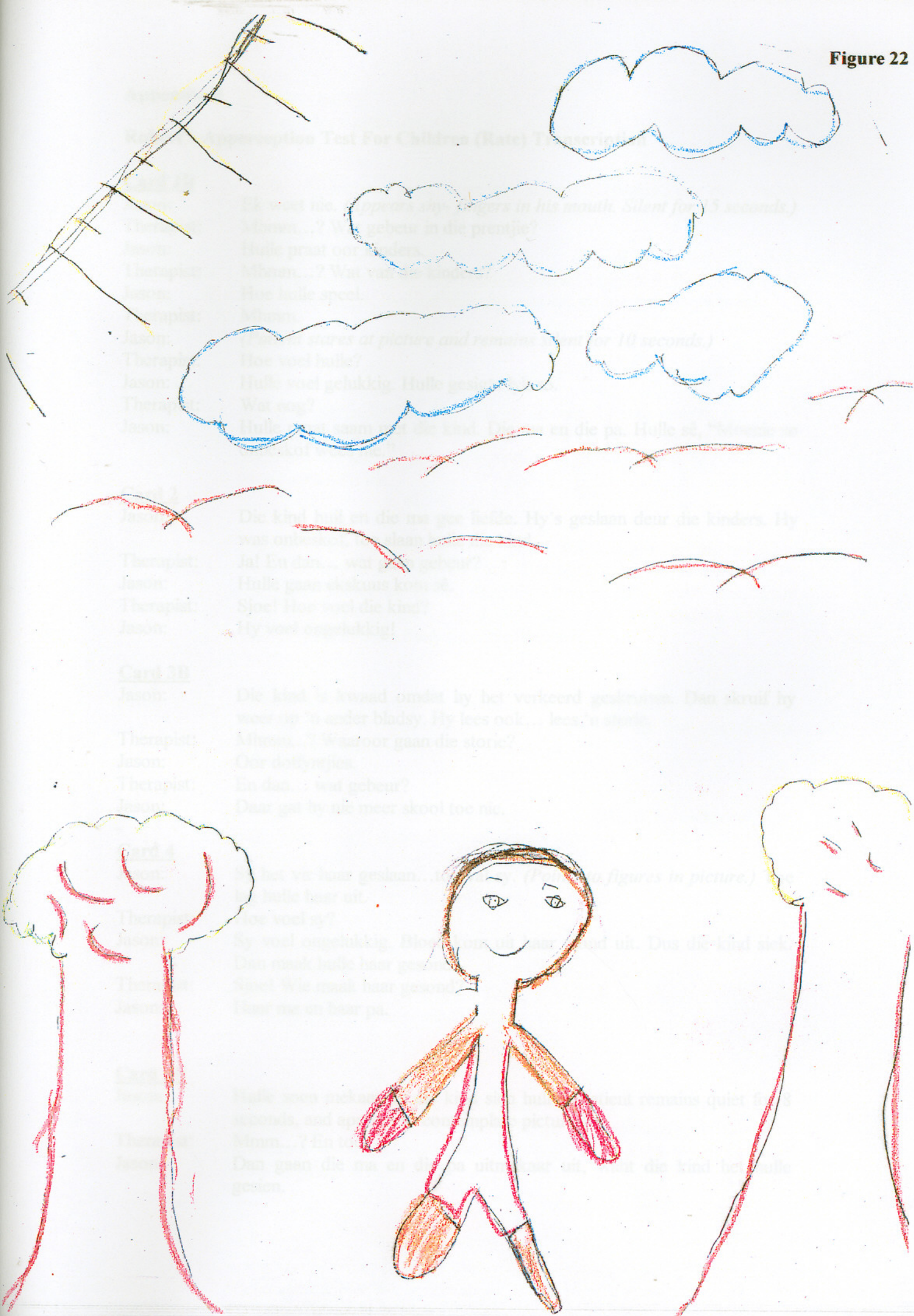
Figure 19







Figure 22



Appendix B

Robert's Apperception Test For Children (Ratc) Transcription

Card 1B

Jason: Ek weet nie. (*Appears shy- fingers in his mouth. Silent for 15 seconds.*)
Therapist: Mhmm...? Wat gebeur in die prentjie?
Jason: Hulle praat oor kinders.
Therapist: Mhmm...? Wat van die kinders?
Jason: Hoe hulle speel.
Therapist: Mhmm.
Jason: (*Patient stares at picture and remains silent for 10 seconds.*)
Therapist: Hoe voel hulle?
Jason: Hulle voel gelukkig. Hulle gesigte lyk so.
Therapist: Wat nog?
Jason: Hulle praat saam met die kind. Die ma en die pa. Hulle sê, "Moenie so onbeskof wees nie."

Card 2

Jason: Die kind huil en die ma gee liefde. Hy's geslaan deur die kinders. Hy was onbeskof, toe slaan hulle die kind.
Therapist: Ja! En dan... wat gaan gebeur?
Jason: Hulle gaan ekskuus kom sê.
Therapist: Sjoe! Hoe voel die kind?
Jason: Hy voel ongelukkig!

Card 3B

Jason: Die kind is kwaad omdat hy het verkeerd geskruie. Dan skruif hy weer op 'n ander bladsy. Hy lees ook... lees 'n storie.
Therapist: Mhmm...? Waaroer gaan die storie?
Jason: Oor dolfyntjies.
Therapist: En dan... wat gebeur?
Jason: Daar gat hy nie meer skool toe nie.

Card 4

Jason: Sy het vir haar geslaan...toe val sy. (*Points to figures in picture.*) Toe lag hulle haar uit.
Therapist: Hoe voel sy?
Jason: Sy voel ongelukkig. Bloed kom uit haar mond uit. Dus die kind siek. Dan maak hulle haar gesond.
Therapist: Sjoe! Wie maak haar gesond?
Jason: Haar ma en haar pa.

Card 5B

Jason: Hulle soen mekaar en die kind sien hulle. (*Patient remains quiet for 8 seconds, and appears to contemplate picture.*)
Therapist: Mmm...? En toe?
Jason: Dan gaan die ma en die pa uitmekaar uit, want die kind het hulle gesien.

Therapist: Hoe voel hulle?
Jason: Ek kan nie sy gesig sien nie.

Card 6B

Jason: Umm...die kinders praat saam met mekaar... (laughs) oor hulle ma en hulle pa. Hulle ma en hulle pa slaan hulle, en hulle wil nie meer by hulle ma en hulle pa bly nie.
Therapist: Sjoë. Met wie wil hulle bly?
Jason: By ander mense. Toe slaan daardie mense ook vir hulle... en toe bly hulle op hulle eie. Toe het hulle nie kos nie, en toe gaan werk hulle.
Therapist: En dan?
Jason: Dis al.

Card 7B

Jason: Die kind het gedroom, toe skrik hy waker. Agterna slap hy weer, toe skrik hy nog wakker. En toe staan hy op en sê vir kinders dat hy het gedroom van iets. Slang. Toe gaan slaap hy weer die aand, en toe het hy nie gedroom nie.

Card 8

Jason: Die ma en die pa praat saam met die kinders. Hulle moenie onbeskof wees nie. Die kinders het gespeel. Toe hulle die aand in hulle huis is, dan slaan die ma en die pa vir hulle. Toe sê hulle, hulle moes gaan slap. Toe hulle nie die oggend skrik nie, skrik hulle middag wakker. Toe druk hulle, hulle klere aan en gaan speel.

Card 9

Jason: Hierdie kind het vir hom geslaan, toe slaan hy een vir hom terug. *(Patient points to figures in the picture.)* Toe huil hy. Toe voel al twee ongelukkig, en toe moet hulle huis toe gaan.

Card 10

Jason: Die ma en die kind loop met die baba. Hulle gaan nou dokter toe want hulle baba is siek. Agterna toe is sy weer gesond.
Therapist: Hoe voel hulle?
Jason: Hulle voel ongelukkig.

Card 11

Jason: Die kind skrik want sy sien 'n spoek.
Therapist: Mmm...? En toe?
Jason: Toe hardloop sy en gaan sê vir haar ma en haar pa, en die kinders. Die aand slaap sy en toe droom sy ook van spoeke.

Card 12B

Jason: Die ma en die pa voel ongelukkig want hulle het nie kos nie. Toe gaan werk die ma en die pa...toe los hulle die kind alleen by die huis. Toe kom hulle in die aand huis toe, toe koop hulle kos en toe is hulle nie weer ongelukkig nie.

Card 13B

Jason:

Die kind gooi die stoel stukkend...en toe skel die ma en die pa vir hom uit in die aand. Toe moet hy weer die stoel reg maak. Toe sit hulle op die stoel, toe val die stoel in mekaar in... en toe moet hy weer die stoel reg maak. Toe sit hulle op die stoel, toe is die stoel reg.

Card 14B

Jason:

Die ma sien hoe mors die kind met die paint, en toe moet hy hom ander klere aantrek, en ander pant aantrek, en die muur was. Die volgende dag toe is hulle muur reg.

Card 15

Jason:

Die kind sien hoe was die ma vir haar. Toe lag hulle haar uit. Toe sê die ma, die aand vir die pa. Toe gaan sê die ma en die pa vir hulle. Toe slaan hulle ma vir hulle.

Card 16

Jason:

Die kind vra vir die pa. Hy wil 'n leesboek hê, want die pa lees ook. Gee die pa vir hom 'n leesboek. Die volgende dag toe is hy klaar met die leesboek. Gee hy vir sy pa die boek, toe gaan vra hy vir sy pa nog 'n boek. Toe gee hy vir hom eentjie. Die volgendes dag toe is hy klaar met daar eentjie ook, en toe hy vra sy pa nog 'n boek. Toe sê hy nie daar is nie een nie.