“WHAT DID I DO?”

AN EXPLORATION OF THE INNER EXPERIENCES OF CHILD AND ADOLESCENT PSYCHOTHERAPISTS WHEN TOUCH ARISES IN THE PLAYROOM.

BY

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Abstract

This paper explored the subject of the inner experiences of child and adolescent psychotherapists when physical touch occurs in the playroom. The study was borne out of real- life occurrences, where the researcher was left wondering "What just happened?" when touch arose during play therapy sessions with vulnerable and traumatised children.

Research proved that both internationally and nationally, it appeared obvious that touch occupied an ambiguous area for practitioners working in the field of child and adolescent psychotherapy. It also came to light that it was an area that tended to be "swept under the carpet" because of fears of judgement, litigation and general unease. The researcher speculated about what other therapists did when children sought physical contact, whether consciously or unconsciously? The empirical component was based on interviews with international experts in the field of child and adolescent psychotherapy. To glean evidence from an Irish context the researcher used autoethnographic methodologies, a narrative ethnography and a reflexive, dyadic interview and creative piece with a respected practitioner in the field. Both these elements of the research included creative means such as drawings, journal entries, sand-tray to extrapolate meaning from the realm of therapists' inner experience.

The research showed three main concepts which permeated all areas of the study, and these were safety, danger and vulnerability of both therapist and child. These concerns struck an uneasy balance with current research, and the belief of most practitioners that touch is beneficial. Despite controversy through the years, it cannot be denied that touch has great healing potential when used with care and introspection, especially when working with attachment disruption and early developmental trauma. The research revealed that there is denial that touch happens in the playroom, however, thankfully there appears to be growing commitment and determination to shine a light on it and bring touch out of the shadows. This is a necessary unveiling and is in aid of safe practice for our most vulnerable clients. It is also in aid of safe practice for the therapists who walk the road with them towards healing.

Dedication

I dedicate this piece of work to my family. My husband Paul, and my children Dylan, Anna, Siun and Evie. Thank you for supporting me through this course of study and putting up with my absences and my hours at the laptop. We will all breathe a sigh of relief when it's over, but also celebrate the seeing through of this dissertation to its completion. Anything is possible!

I also dedicate this study to all the amazing children, adolescents and parents I have had the privilege of working with over the years. I have learned so much about the spirit of healing and hope through connection. I have truly been touched by you all in different ways. Thank you for sharing parts of your lives and vulnerabilities with me, and allowing me to witness strength, determination and love in the face of adversity.

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- A word of special thanks to Amanda Donovan, Olive Connaughton and Mary Dunne for providing balance and many light moments in the midst of heavy workloads.

- Thanks to my CTC placement supervisor Majella Ryan for giving me space, support and encouragement to explore my clinical practice, and especially therapeutic use of my own inner experiences.

- To my dear friend Bernie Duggan for proof reading and editing.

Declaration

I declare that this thesis is my own unaided work. It is being submitted for the degree of M.A. in Creative Psychotherapy and Play Therapy (Humanistic and Integrative Modality) at the Children's Therapy Centre.

It has not been submitted before for any degree or examination.

Name of Candidate:

Signature: 

Date: 21 May 2020

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Chapter 1

Introduction

1.1 Prelude

“What did I do?” the little girl said after she kissed me on the cheek. “You kissed me on the cheek,” I said. What more could I say, I had to state the obvious, although we both knew there were layers of meaning beneath it. Why else would a four-year-old girl ask, “What did I do?”.

It was session 25, just before a Christmas break, mid-session. She had been engaged in messy play and I had rolled up her sleeves for her, tentatively and carefully and spelling out my movements at each step. Noticing and observing her reactions. A sadness filled me about why it had to be like this- so pronounced, so deliberate, why in my experience of her was I teetering on the brink of overstepping my mark?

She was not used to care. She was not used to nurturing touch. She came from a place of confused boundaries, of mothering gone awry and of hurt, deep, deep hurt. I cared deeply for her, hence my sadness. I wanted to scoop her up. The mother in me reached out to her, but I curtailed it. This was not a home space, and the beautiful girl was not my child. Two worlds collided in the potential space of the therapy room. Something big had happened.

I brought this to supervision and was met with a room of mixed opinions. “Yes… it was nurturing”, “no… it overstepped boundaries”, “trust yourself in it.” I did trust myself; I knew it was okay, but it stirred up something in me that brought deep feelings, and a need to explore the topic of touch further. And more than that, it called me to study me. It also made me wonder about my colleagues and experts

in the field of child and adolescent psychotherapy: what were their inner experiences of emotive phenomena of touch when it entered the playroom?

1.1.2 Theoretical Background to the Research

The aim of this study is to explore, through qualitative methods, the inner experiences of child and adolescent psychotherapists when touch arises in play therapy sessions. I wish to bring into the open this topic as it is often taboo amongst practitioners.

1.1.3 Unexpected Cultural Context Influencing this Study

During the researching and writing of this study Covid 19 pandemic has erupted throughout our world. On a global level, the disease itself, and the effect it has had on our day to day lives, has wreaked havoc, and left a trail of disaster. Strict rules around social distancing announced by our government on 12th March 2020, have increased to a virtual "lockdown" of all citizens and orders to "cocoon" our elderly and vulnerable population to keep them from harm.

Obviously, this cultural context has heightened my awareness around human contact and our need for touch. The Coronavirus has deprived us of the resource of physical contact, and instead of comfort, touch has the potential to bring us, or our loved ones, close to illness, or even death. Therapy sessions have ended for now in the interests of safety, and a grappling with teletherapy and online resources provide remote contact. How ironic to be writing of touch at this time of social isolation!

1.1.4 A Dearth in the Literature

Touch is a "touchy subject". Eliana Gill describes a dilemma, perhaps familiar to many play therapists, when the child "started climbing on to my lap for a few moments, seemingly to check out if proximity was safe" (Gill, E. in Courtney and Nolan, 2017, p.xxii). Gill, however, tentatively admits that she did not put it in her process notes. Courtney (2017) surmises that there is a dearth of literature, and states that research rarely examines the perspectives of practitioners regarding their experiences of touch in play therapy (Courtney & Siu, 2018). In my own experience touch can leave the therapist, as well as the child, wondering "What did I do?", and fearing they have overstepped boundaries, or feeling fearful about issues of professional liability. Herein lies the crux of the matter: many therapists are unsure about touch. It is true there are many ethical concerns, but there is also a great need for touch in the playroom according to growing research in the area of neuroscience, trauma and attachment (Berendsen, 2017; Courtney and Nolan, 2017; Gaskill, and Perry, 2012; Totton, 2011; Perry and Szalavitz, 2008).

1.2 Focus of Research

The aim of this small-scale study is to explore the inner experiences of child and adolescent psychotherapists when touch arises in the playroom. The following embedded questions will also be addressed in the study:

- How do child and adolescent psychotherapists conceptualise touch in terms of attachment theory?
- How does lack of touch and unsafe touch affect the developing child?
- Why is examination of inner experiences vital for child and adolescent psychotherapists when working with the phenomena of touch in the playroom?

- What are the different models in psychotherapy and play therapy which incorporate touch to work with developmental trauma and attachment difficulties?

1.3 Site, Setting and Participants

In seeking to explore the inner experiences of child and adolescent psychotherapists when touch arose in a play therapy setting, firstly the researcher sought to find participants who would offer insights into both the areas of "inner experience" and also the area of touch as a therapeutic tool. Therefore, the study involved "purposeful sampling" to obtain participants who were especially knowledgeable about the area under investigation. The researcher specifically selected information-rich interviewees for the most effective use of limited resources (Patton, 2002). Zoom was used for the two expert interviewees, as both Lisa Dion and Janet Courtney are based in the USA. The interviews were recorded with consent and transcribed by the researcher. The third piece of research was a "reflexive dyadic interview" (Ellis *et al,* 2011) with Irish child and adolescent psychotherapist, Majella Ryan.

The researcher has a strong personal interest in the topic area, and it was through personal experience as a practitioner that she was inspired to investigate the area of touch in the playroom. Therefore, the research includes a narrative autoethnographic (Ellis *et al,* 2011) element. As part of the researcher's tracking process for this aspect of the research, a journal was kept, and from these notes, the excerpts presented in the autoethnographical piece were collated. A separate notebook containing drawings and written content around the researcher's personal process in relation to touch is also relevant research material.

1.4 Outline of Research Report

Chapter Two presents a review of the literature under main headings. The first section is about how

child and adolescent psychotherapists conceptualise the role of touch in the forming of healthy attachments, especially in infancy, and how these early interactions form a prototype for future relationships.

The second body of the literature review examines the effects of lack of touch (neglect) and harmful and unsafe touch, especially sexual abuse, on the developing child. Again it focuses on understanding developmental trauma and attachment disruption in relation to influential current theorists (Porges, 2011; Perry, 2008, 2009; Schore, 2003; Seigal, 2011, 2014; Van der Kolk, 2014). For children whose experiences of touch are inadequate, absent or abusive, the researcher explores whether new experiences from an attuned therapist provide corrective foundations on which opportunities for growth and healing can be built.

The study of the literature procures viewpoints of experts in the field about how this opportunity for healing in the "potential space" (Winnicott, 1991) of the therapy room can impact the child and adolescent psychotherapist. The research shows that close attention needs to be paid to the dynamics of the therapeutic process especially transference and countertransference.

Finally, the last section of the literature focuses on theoretical models of Child and Adolescent Psychotherapy that use touch in a purposeful way to aid healing and connection, especially between children and their caregivers. The researcher examines the influential model of Developmental Play Therapy (Brody, 2006), Theraplay (Booth and Jernberg, 2010) and FirstPlay (Courtney, 2017).

Chapter Three of the dissertation provides an overview of the specific methodologies employed in this study, as well as a rationale for their selection. Details of sampling methods, participants, ethical dimensions and limitations of the study are also provided. This section also outlines the approaches employed in the data collection and the methods utilised in its analysis.

In Chapter Four the findings of the study are presented and discussed under the following theme headings:

- Lack of Transparency Regarding Touch in the Playroom.
- The Need for Safety – How Neuroception Affects the Therapeutic Relationship.
- The "Vulnerable" Therapist.
- Why Introspection is Vital in Child and Adolescent Psychotherapy When Working with Touch in the Playroom.

Throughout this discussion the findings are related to supporting data, evaluated and linked to relevant literature, previous research in the area and the current research aim.

Chapter Five presents the conclusion and the recommendations arising from this study.

1.5 Conclusion

In conclusion, this introductory chapter has outlined the researcher's reason for carrying out this dissertation and detailed the structure of the study. The research question, and aims and objectives have been set out, as have the research population, and sampling methods.

Chapter 2

Literature Review

2.1 Introduction to the Literature Review

The literature review sets out to identify crucial areas of interest in this study, focusing on the key theories and theorists, and most relevant and current literature and research. The researcher identifies and summarises the key debates in relation to the topic.

2.2 How do Child and Adolescent Psychotherapists conceptualise touch in terms of attachment theory?

Child and Adolescent psychotherapists conceptualise touch as the primary means of contact at the foundation of life. “In the beginning is touch, and touch is the foundation of the real” (Wright, 1991, p.61). Touch is recognised as a key component for healthy attachment (Brody, 2006; Courtney and Nolan, 2017; Booth and Jernberg, 2010). Early players in the evolution of attachment theory paved the way for recognising the importance of touch in early relationships. In the 1950’s British child psychiatrist John Bowlby (1907-1990) and American animal psychologist Harry Harlow (1905-1981) separately conducted research that was instrumental in the formulation of new ideas on the nature of bonding between infants and their caregivers.

Harry Harlow’s early studies looked at the role of touch using new-born rhesus monkeys. This research conducted in 1958 produced ground-breaking empirical evidence for the primacy of the parent-child attachment relationship, and the importance of maternal touch in infant development. Harlow took infant monkeys from their biological mothers and gave them two inanimate surrogate mothers. The outcome was that in both conditions the infant monkeys spent significantly more time with the cloth mother, and even when they went to feed from the wire mother, they returned

immediately to the cloth surrogate to cling to it. Harlow surmised that the soft material simulated the mothers' touch and provided comfort, thereby highlighting that the role of interpersonal touch is just as vital for social and emotional development as the need for food (See Figure 1).

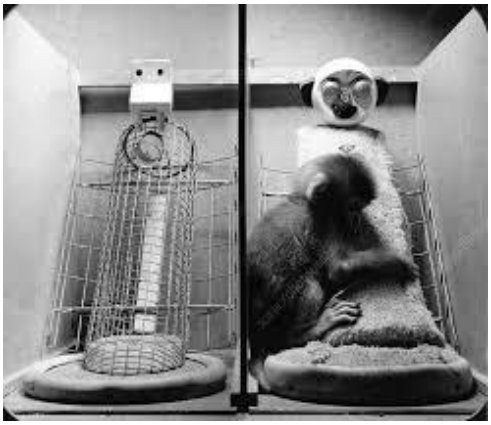

Figure 1 - Harlow's Monkeys

John Bowlby's research (1969) also consolidated the finding, that all human beings were naturally pulled towards intimate contact with other human beings. This was contrary to much psychoanalytic thinking at the time. Influential child psychoanalyst Melanie Klein (1882-1960) upheld the common belief that all behaviour was motivated by inner feelings. However, Bowlby through his research postulated that external relationships are vital to consider in understanding a child's behaviour. Bowlby undermined the psychoanalytic idea that all attachment develops through oral gratification, as popularised by Freud (Brown, 1987, p.21). Harlow's experiments specifically investigated the importance of clinging, and Bowlby cited Harlow's works saying: "Clinging appears to be a universal characteristic of primate infants and is found from the lemurs up to anthropoid apes and human babies...We may conclude therefore that ...clinging is a primary response, first exhibited independently of food" (Bowlby, 1958, p. 366 cited in van der Horst et al, 2008).

Ainsworth (1989) consolidated this finding and was able to demonstrate through her "Strange Situation" experiments that physical contact, particularly between mother and child, was essential for the child's attachment and emotional connection. She was also able to link the child's early attachment

patterns to ability to form meaningful relationships in later life. Ed Tronick's "Still Face" experiment has also become a valid and reliable measurement of infant cognition and behaviour which highlights the role of touch and maternal attunement (Fulwiler, 2013). Interestingly, in recent weeks questions have been raised about mothers of infants wearing face masks because of the Covid 19 pandemic. A mother who was advised to wear a mask noticed a regression in her baby's responses, it was described as an "eternal still face". However, the alternative is separation from the baby if the mother is infected with the coronavirus (Baeza, 2020).

2.2.1 Attachment – A Physiological Perspective

The expectancy of social engagement and relationship in humans is biologically embedded. For babies this engagement typically begins when she is placed upon her mother's chest and finds the way to her mother's breast. Van der Kolk (2014) surmises that as the baby enters the world "someone immediately engages with us, bathes us, swaddles us, and fills our stomachs, and, best of all, our mother may put us on her belly or breast for delicious skin-to-skin contact" (Van der Kolk, 2014, p.110). Both the body and mind are intertwined in the mother-baby relationship, and the physiology strengthens the bond between mother and infant. In a healthy attuned attachment, when the baby latches on to the breast for feeding the he/she receives warm sweet breast milk, the result for the mother is that her central nervous system releases oxytocin. This love hormone is enveloped in reassuring touch, and it brings mother and baby into loving synchronicity. Oxytocin is a powerful hormone and not only does it ensure survival for the pair, but in physiological terms it creates perfect harmony between mother and infant because it clamps down the uterus, thus preventing the mother from haemorrhaging, while simultaneously letting down milk for the newborn (Sanders in Porges & Dana, 2018, p.361). Teamwork at its best!

2.2.2 Attachment – A Psychological Perspective

Bodily contact such as holding, rocking, touching and cuddling between mother and child are a vital part of attachment and help the infant form a secure sense of self. Safe and attuned touch, along with the mother's gaze, form the primary means of communication at this formative time. Indeed, it is through being held and touched that the baby comes to know they exist. "When I look, I am seen, so I exist, I can now afford to look and see" (Winnicott, 1991, p.114).

As mother and baby engage in their "dance of attunement"(Van der Kolk, p.111) through feeding, rocking, gazing and touching, their bond develops and becomes predictable and safe. The duo enjoy secure attachment to each other and are critical co-regulators of the integrity of each other's autonomic nervous system (Sanders, 2018, p.361). Loving gaze, touch of skin and voice prosody accumulate to form the "earliest burst of attachment" (Badenoch, 2008, p.106). The work of Tiffany Field of the Touch Research Institute in Miami has shown that regular use of touch can also lower the levels of the stress hormone cortisol, and that massage can be effective treatment modality for premature babies through to children displaying aggression (Field, 2006. 2014).

However, it is of note that even the best of relationships can be prone to disruptions. Research undertaken by Tronick & Cohn in 1989 through video microanalysis reveals that typical mother-baby relationships are in sync for affective states only one third of the time (Sanders, 2018). The cycle of rupture and repair is as relevant here as in any other dyad. In-fact Winnicott (1991) hypothesized that children need their primary caregivers to fail them in tolerable ways on a regular basis so that they can learn to live in an imperfect world. However, the quicker the caregiver can notice the rupture and skilfully repair it, the better the child will learn to self-regulate. Schore (2003) maintains that resilience is built on tolerance of negative experiences.

2.2.3 Attachment and the Nervous System through a Polyvagal Lens

This need to relate according to Panskepp & Biven (2012) is borne in utero and is ready to be activated in relationship. It is like a match waiting to be struck. So too is the autonomic nervous system waiting to spring into action. It is this system (the autonomic N.S) that controls most of the involuntary visceral activities of the body, such as the infant's first vocal expression and movements involved in feeding, such as oral reach, grasping, releasing, sucking and swallowing (Fearne and Troccoli in Prendiville, 2017, p.102). The autonomic nervous system includes both the parasympathetic and sympathetic divisions, and also the enteric nervous system (See Figure 2).

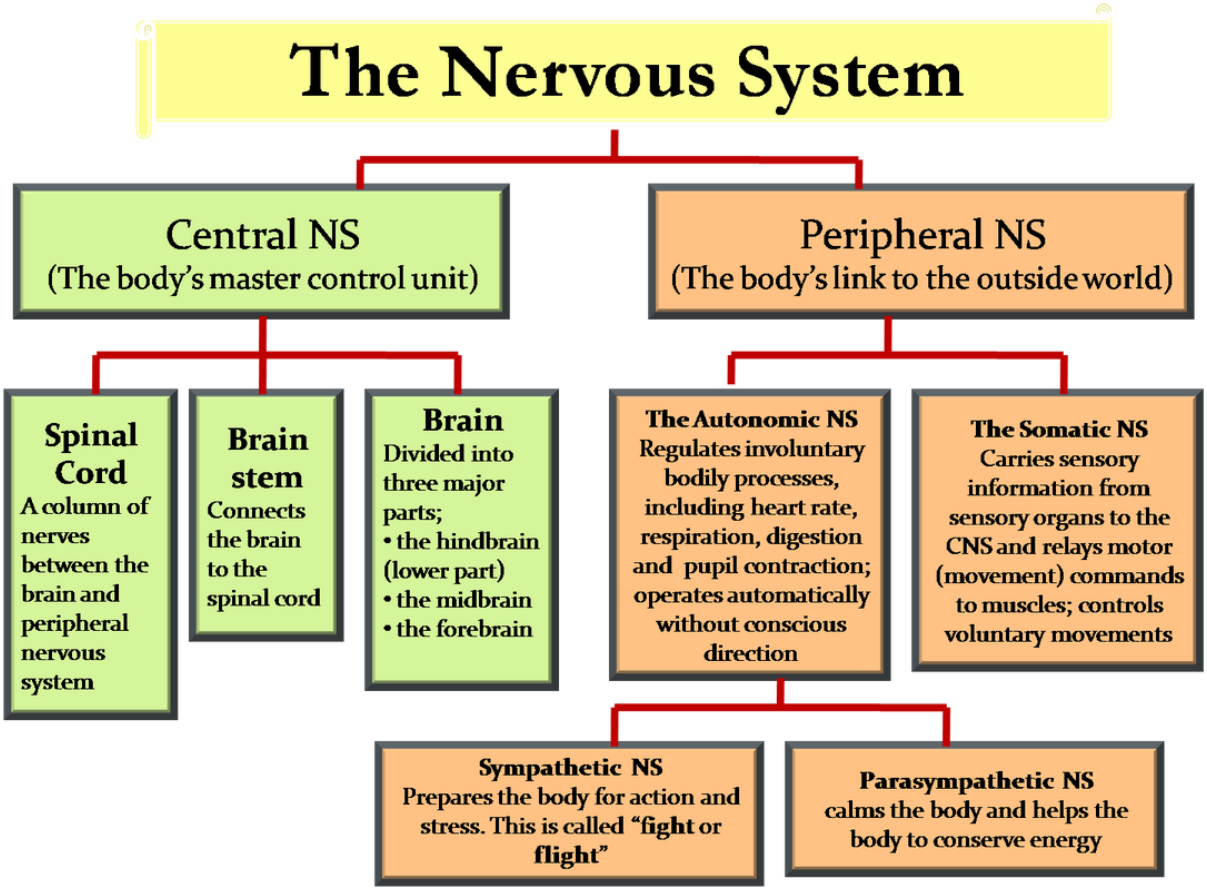

Figure 2 - The Nervous System

The enteric nervous system contains the vagus nerves, and it is through these that the brainstem is informed about the infant's visceral state. Visceral states such as tiredness, hunger, thirst, temperature, and the need for defecation cause anguish for the infant, and they require attuned co-operation from a caregiver to recognise and help ease these deregulated states. Only with the help of a caregiver can the infant establish and maintain homeostasis, and gradually through co-regulation they can begin to integrate the ability to self-regulate. Like the match, it needs someone to strike it! This collaboration is a vital skill for well-being, because we humans *need* homeostasis in order to feel safe, and to function well in relationship with others.

2.3 How Does Lack of Touch and Unsafe Touch (Child Sexual Abuse) Affect the Developing Child?

As we come to understand attachment through a polyvagal lens, we see clearly the need for the primary care-giver to act as a co-regulator, so that the infant can learn to self-regulate, and so maintain homeostasis, feel safe and function well in relationships.

Polyvagal theory can also help us understand the other side of the coin, where early trauma, neglect or stress has disturbed the maturation of self-regulating processes. In stark contrast to the previous subchapter describing secure attachment, here we see how unsafe touch and lack of touch can affect the developing child. A baby who has not been held, not been rocked, not been cuddled, or worse still has been hurt, suffers long lasting detrimental effects. These hurts can stretch far into adulthood, weaving maladaptive threads into relationship, self-worth and often further into self-harm, addiction and into a myriad of dysfunctional coping mechanisms.

Polyvagal Theory (Porges, 2011) describes how trauma changes a person's physiological response to the world. Traumatised children expend huge amount of energy due to living day to day in a hyper-

aroused state (Panskepp, 2004). They have a highly activated fear system and can be preoccupied with non-verbal cues. Porges defines how vocalisations and facial expressions are entangled with the ventral vagal parasympathetic system, and so adults living and working with traumatised children must take care to maintain a neutral tone of voice and facial expression, so the child can experience a safe physiological state, and be able to have maximum access to cognitive resources (Kestly, 2014, p.14). A subconscious system, coined "neuroception" by Stephen Porges, describes how neural circuits in infants (and even in the womb) distinguish whether situations or people are safe or dangerous.

Just as debilitating as hyper-arousal is hypo-arousal. In terms of polyvagal theory, hypo-arousal signals a state of collapse in the individual. Babies who have experienced neglect and lack of loving touch, may sink into this immobilized, collapsed, life threat state. The effect is that the baby loses tone and appears passive and apathetic. They have learned early on that expanding energy for safety brings a poor return on investment, so they give up. This can be seen in Tronick's Still Face Experiments, where the baby gives up reacting to unresponsive caregivers (Weinberg et al, 2008).

Abuse and neglect are so much more complicated when the hurt happens at the hands of primary caregivers. Friedrich (1994) in Kelly & Odenwalt (2008, p.190) note that the "internal working model" (Bowlby, 1969) of a sexually abused child is often shaped by inconsistency and fear, especially if an attachment figure has been the abuser. Research by Devnov (2004) on the long-term effects of child sexual abuse by female perpetrators, high-lighted ongoing difficulties for victims with substance abuse, self-injury, suicide, depression, rage, strained relationships with women and self-concept and identity issues. A female participant from Devnov's research (2004, p.1144) states: "There is a deeper sense of betrayal [with a female perpetrator]. It's like there's no safe place." Sexual abuse also compromises the child's ability to self-regulate because she has no consistent, dependable way of thinking about connections between experiences, thoughts and feelings. Things often seem

jumbled and confusing, and help is needed in the form of psychoeducational interventions to reduce dysregulation and build coping strategies, as well as client-led psychotherapeutic intervention.

2.3.1 Touch and Sensory Processing Difficulties

Children who have been traumatised often have an increased sensitivity to touch (Goodyear-Brown, 2010, p. 32). The sensitivity may cause the child to flinch often or experience light touches as painful. Sensory integration can seem confused. Children who have been repeatedly hurt by touch can become desensitized to pain, because unconsciously they have found a way to disconnect their minds from their bodies in order to cope. Sometimes a differential diagnosis can be made between sensory processing difficulties and physical reactivity associated with trauma (Goodyear-Brown, 2010, p.33). Sensory processing disorder has strong links to exposure to early childhood trauma and neglect because of the intertwined relationship between integration of the senses and attachment (Perry, 2009; der Kolk, 2014; Fearne & Prendiville, 2017). To explain further, this means the sensory memories of unsafe touch will stay lodged in the body. The trauma is coded in implicit images and are both "unrememberable and unforgettable" (Gerhardt, 2004, p.15). We carry our infantile experiences inside, woven into our body and brains, and these imprinted memories inform our expectations and behaviours throughout our lives. "While the mind may not remember as the child grows up, the body remembers" (Stephens, 2018, p.13).

2.3.2 Early Developmental Trauma, and Its Indelible Print.

For traumatised children the lack of touch (neglect) and unsafe touch (abuse) have an indelible effect on their expectations for future interactions. The emotions and physical sensations that were imprinted during the trauma are experienced, not as memories but as disruptive physical reactions in the present. The trauma can manifest itself in physical reactions: gut-wrenching sensations, pounding

heart, breathing becoming fast and shallow, feelings of heartbreak, speaking with an uptight voice and characteristic body movements that signify collapse, rigidity, rage or defensiveness (Van der Kolk, 2014, p.205). The expression "Neurons that fire together wire together" (Siegel & Bryson, 2015, p.42) explains the phenomena where a child who has experienced unsafe touch during early development will cultivate neural pathways that are predisposed to encoding this information in the future. Neurobiological research (Perry, 2008, 2009; Van der Kolk, 2014) has helped us understand, how repeated experiences of painful touch shape the brain to expect touch to be painful. This hardwired pattern is reinforced by any further harsh experiences of touch, and it takes a lot of reworking for the child to counter-act this stubborn cognitive schema (Goodyear-Brown, 2010).

Research supports interventions that are neurobiologically informed such as Perry's Neurosequential model (Perry, 2008, 2009). Perry draws a comparison about the need for touch, by saying how it would never occur to us to stop touching our dog because it outgrew puppyhood. In his inspiring book "The Boy who was Raised as a Dog", Perry asks foster mother "Mamma P" what she does when her seven year old traumatised son "Robert" rages, and rampages around the house. "I just hold him and rock him. I just love him" is her calm response. When asked about Robert's neediness and clinginess, and whether she gets frustrated or angry, she states: "Do you get angry with a baby when a baby fusses?... No. This is what babies do. Babies do the best they can, and we always forgive them if they mess, if they cry, if they spit up on us." (Perry & Szalavitz,2008, p.95). Mamma P recognised that you don't always interact with children according to their age, but instead respond to them based on what they need. Children like "Robert" had never received the repeated, patterned physical nurturing needed to develop a well-regulated stress response system. Mamma P states of her foster child: "It's just that Robert has been a baby for seven years" (p.95), noticing that he has missed a sensitive stage of development, and had a huge need to be held and touched.

Concurrent with Devnov's research (2004), Peter, (2009) has shown that female perpetrated child sexual abuse leaves an extra deeply etched stamp of betrayal and confusion on the victim. Van der Kolk (2014) also states that incest victims have a profound level of difficulty distinguishing between danger and safety. The imprint of trauma causes them not only to have distorted perceptions of information coming from the outside, but also the organism itself has a problem knowing how to feel safe. A common response to this is that the powerless child often learns to shut down and comply with whatever was asked of them. The experience of dissociation (Figure 3) is common amongst incest victims and in his book Van der Kolk (2014, p.132) describes how his client "put her head in the clouds" when she heard her father's footsteps in the corridor outside her bedroom.

Figure 3 - Dissociation diagram

Terror increases the need for attachment, even if the source of comfort is also the source of terror. Children need to form attachments in order to survive, and they need to see those to whom they are attached in a positive light. Provision of food, clothing, gifts or displays of affection can be seen by the child as proof of the abuser's kindness and concerns for his/her welfare. Abused children can cling to the abuser because they are dependent on them to provide life's necessities (Prendiville, 2016). The Stockholm Syndrome (Julich, 2005) is relevant when looking at the dynamics of sexual

abuse, as it is a condition in which hostages develop a psychological alliance with their captors during captivity.

2.3.3 Touch as a Trigger for Sexualised Behaviour.

Triggers in the environment can cause intolerable thoughts and feelings that provoke a sexualised reaction in children. These reactions are often limited to their own bodies, for example masturbating, exposing or inserting objects into themselves (Gill, 2014). Research by Friedrich (2007) indicates that children who have been sexually abused tend to insert objects into their vaginal or anal openings more than non-abused children (Gill, 2014, p.21). Gill hypothesises on this phenomenon saying:

> Many children who have been overstimulated sexually cannot integrate these experiences in a meaningful way. This can result in children acting out the confusion in the form of more advanced or frequent sexual behaviors, heightened interest and/or knowledge beyond what would be expected of that age (Gill, 2014, p.21).

Gill mentions research by Kendall-Tackett, Wiliams & Finkelhor (1993) that states that pre-school children who have been sexually abused are at particular risk of displaying sexual behaviour problems (Gill, 2014, p.22). At this young age it is likely that often this behaviour occurs outside of conscious awareness, and it can be that they are somatically working out their experiences of sexual abuse.

The sensory element of these sexualised activities can provide comfort on an unconscious level; however, these behaviours can be baffling and unpalatable to the outside world. Lisa Dion speaks of the issue of the sensory experience of soiling for a child who had experienced neglect in her podcast on “Hygiene Issues in the Playroom” (Oct, 2019). Soiling and hygiene issues can be seen in the playroom and are often linked to emotional regression and trauma work. The child to whom Dion refers in the podcast was adopted from a Russian orphanage at age four, and was often left alone, in the crib wearing a soiled nappy for hours on end. The excrement in the nappy, as desperate as it

seems, offered something which became comforting to the child and regulated him in the absence of any external regulator. There was something about that experience that was soothing and nurturing. This severely neglected child was starved of touch, and the "poop" had both heat, smell and a "felt sense" to it, which at least provided temporary comfort in the void of his early life (Dion, 2019).

In summary, we see how sexualised behaviour can appear in children who have been hurt by abusive touch, and we can also see how neglect can bring about sensory-seeking behaviours. Children who have been confused by touch, or by lack of touch (neglect), often bring alive the trauma memory in the playroom. Dion (2019) stresses that it is vital not to shame the child for their behaviours, but instead for the therapist to regulate themselves and recognise the "wisdom" in what is happening. When the therapist needs to set a boundary, it is important to acknowledge and redirect, especially when there is trauma, to avoid shaming the child and causing them to shut down. Challenging occurrences of touch in the playroom require careful handling from the therapist, and a need for examination of her own inner experiences. This leads me to the next section of this literature review.

2.4 Why is Examination of Inner Experiences Vital for Child and Adolescent Psychotherapists when Working with the Phenomena of Touch in the Playroom?

> In a relationship where passing a box of Kleenex can be ill-advised at certain times, touching the patient's body undoubtedly can create a complex web of repercussions. There is no reason to eschew touching. It means, however, that the therapist's goals and reasons must be absolutely clear and uncomplicated by his or her own personal needs. (Mc Neely, 1987, p.78 cited in Totton, 2011, p.117)

Touch in the therapy room is a phenomenon which requires thorough introspection on the part of the therapist. One suspects that touch happens more than anyone dares to talk about. Wilson (1982) states

that many therapists were reticent to admit its use within their practice, often because of concerns about accusations of sexual misconduct. There is no doubt that therapists are unsure about touch. There are many ethical concerns. Some practitioners protect themselves by donning a "white coat" (Totten, 2011) and treating their "patients" in a medical way, supposedly immune from any introspection around transference, or what touch might mean to the client. In doing so they can be accused of objectifying and alienating the bodies in which their clients live. Experts in the field of trauma (Levine, 1997; Van der Kolk, 2014; Minton *et al*, 2006; Ogden, 2020) would argue the opposite, and have proved through their therapeutic models, that trauma is held in the body as much as in the mind. Therapists cannot be in denial of the many layers of meaning inherent in touch. To be in such denial is a dangerous place to be as a practitioner.

The debate around touch in child psychotherapy, and in psychotherapy in general, is around whether touch should be avoided or used with this clinical population. Lawry (1997) states that touch should never be used because of the risk of activation or reactivation of traumatic memories (Rovers et al, 2017). However, there are many studies which support the opposite. Joanne Mc Guirk (2012, p.3) warns: "We're all very good at assessing the risk in touch interventions, but what about the need to assess the risk attached in not touching?" Developments in neuroscience, research on trauma as well as child development leads us to question abstinence as a rule surrounding therapeutic touch. Corness (1997) states: "The use of touch will broach, evoke, and possibly correct the experiences and distortions related to the abuse" (Rovers.et al, 2017).

2.4.1 The Lack of Open Communication about Touch in Caring Professions.

There appears to be a need, expressed by practitioners who work with vulnerable children, to open debate around touch in the caring professions. Research carried out in the Republic of Ireland (Lynch and Garrett, 2010) found that Child and Family Social Workers "desired to have more discussion and

guidance on the subject of physical touch within their work locations" (p.389). Studies have shown that despite touch occurring in many practice areas such as social work, social care, counselling and psychotherapy, education and medical settings, it still remains a subject that is not openly discussed amongst practitioners (Strozier *et al,* 2003). For example, Eliana Gill, as was mentioned in subchapter 1.1.4, felt uncomfortable putting incidences of touch in her process notes (Gill, E. in Courtney and Nolan, 2017, p.xxii). Garett and Lynch (2010) found that out of their eight participants, two expressed strong reservations about taking part in the study because of fears around litigation and self-revelation. The subject of touch was considered ambiguous, and it is said to occupy an "unsure space". A participant "Lorraine" expressed a desire to have more discussion and hence guidance around the subject. Her comment highlights a cultural slant which cannot be ignored when addressing the nuances of touch in the caring professions. "It is almost a typical "Irish" solution to a problem, if we ignore it then it will go away, we know that is not the case" (Garett and Lynch, 2010, p.395).

Research carried out by Courtney and Siu (2018) into practitioner experiences of touch in working with children in play therapy showed that there are gaps in practitioners' professional knowledge related to touch in practice. It was thought this may be because of the "dearth of available literature and research" and the "insufficiency of opportunities for open discussion" due to the taboo nature of the topic. The study outcomes underscored the need for graduate school programmes to incorporate touch-related content within course curriculums and, also to make it a mandatory part of courses for supervisors (Courtney and Siu, 2018, p.100).

2.4.2 Factors for Therapists to Consider When Using or Responding to Touch in the Playroom

Zur (2007) states that there are many factors to consider in the use of touch with a therapeutic goal. These include not only culture, but the therapist's history (e.g. the presence of psychological, physical and/or sexual abuse), gender and sexual orientation, spiritual beliefs and practices and social support

network to name a few. Of course, these factors should also be considered on the part of the client also, and will include also thinking about the presenting issue, the living conditions, the state of health and mobility, the present and past psychological state, prior experience of therapy and general attitude towards therapy. In addition to these variables the contraindications of the use of therapeutic touch must also be the subject of discussion and the power dynamic inherent in the relationship.

2.4.3 Touch in the Playroom – What does it look like?

In Child-Centred Play Therapy (CCPT), or a "non-directive" approach, the therapist allows the child to take the lead and the ethos is based on the belief that children are innately capable of personal wisdom and growth when they are provided with a supportive and accepting environment (Axline, 1969; Landreth, 2012). This approach is drawn from humanistic orientation, and the forming of a strong therapeutic relationship is at the core. When there is "relationship" there is often touch, and in CCPT because the child leads the process, the touch is usually child-initiated. Our clients don't tell us how they coped and survived unspeakable terror, they show us, or project it onto us. Their coping becomes visible in how they approach the play and the therapist. It is inevitable that there is often touch involved in this! Children are embodied creatures, who do not engage in "quiet, reflective conversation sitting in a chair across from the therapist*"* (Gray et al., 2017 in Courtney, 2018, p.93). Be it an accidental collision, a whack with a sword, a handcuffing, a manhandling, a longing to be close, a rolling up of sleeves, tying of an apron or a request to clean hands. The list is endless. The therapist often needs to make quick-thinking decisions, often based on gut reactions, about how to respond to touch, keeping in mind the child's experiences and assessing the benefit or harm of instances of touch. Decisions around engaging in touch in sessions can look very different depending on the experience of the child, and indeed the experiences of the therapist, as stated previously. It is imperative that the therapist understands their own motivations for touching clients, coloured by their

own touch history, societal perceptions, cultural norms and training. “Boundaries between benign and malignant touch are determined by context, intention and meaning” (Rovers *et al*., 2017, p.235).

A central point to consider is not so much what the therapist is trying to communicate through a touch intervention, but what it is likely to mean for the client. A most obvious example is a client that has been sexually abused, where a comforting touch could be interpreted very differently, as discussed in the previous chapter.

2.4.4 Transference and Countertransference in Relation to Touch in the Playroom.

Literature on this topic stresses how the therapist must be very aware of transference and countertransference when using touch with vulnerable clients. They must be very aware of their own experiences and issues around touch (Lesser, 2007, Courtney & Nolan, 2017). Janet Courtney founder of FirstPlay Therapy, an attachment-based, parent-child model of therapy states that a portion of the training focuses on providing experiential activities that afford opportunities for practitioners to examine their own experiences of touch, in order to increase professional self-awareness and examine any countertransference that may emerge. Young (2005) says with regard to training in touch: “One significant aspect of training in this area is to ensure that the therapist’s own needs and issues about touch have either been brought to awareness or preferably dealt with effectively” (Courtney and Nolan, 2017, p.49).

2.5 What are the Different Models in Psychotherapy and Play Therapy That Incorporate Touch to Work with Developmental Trauma and Attachment Difficulties?

There are several models which incorporate touch in a purposeful way, as opposed to how touch unsuspectingly ‘appears’ in Child-Centered Play Therapy. The models I will focus on here are

Developmental Play Therapy, Theraplay and FirstPlay. The latter two models ascribe the primary care givers the role of administering caring, healing and transformative touch to the child. The approaches are particularly suited to children in foster care, and for children who have experienced early developmental trauma and attachment disruptions.

2.5.1 Developmental Play Therapy (DPT).

"The basic principal of Developmental Play Therapy is that a child who experiences touch from a capable toucher will grow toward a healthy maturity and will heal from earlier trauma and neglect" (Brody in Courtney & Nolan, 2017, p.35).

Viola Brody came to base her approach on her conviction that children must feel touched in order to mature in a healthy way. Her belief grew that the goal of psychotherapy was to assist the child to develop a sense of self. The initiatives of the adult in Developmental Play Therapy fall into four categories, according to Brody: "Noticing the child, touching the child, responding to the child's cues and bringing to the attention of the child, in undeniable fashion, the presence of an adult who meets her needs" (Brody, 2006, p.9).

Brody explains that touch leads to seeing and visualising and says that "seeing is touching at distance" (Brody, 2006, p.215). She describes the final session with a little girl called "Mira". Mira requests of her: "Pick me up and carry me like a baby. Pretend I'm your tiny baby". In this request Brody surmises that Mira is making use of her memory of being cradled by the therapist, so that she can take the memory with her. She has internalised this experience of closeness, and of the therapist, who in the words of Stern (1985) has become an "evoked companion". The "companion's" job is to assess ongoing interactions by comparing them with the memory of the earlier experiences (Brody, 2006, p.213). This lays the foundation for the structure of the self to be built.

DPT practitioners believe that touch is not a therapeutic technique but is instead an "expression of love and care by a truly loving and caring adult" (Brody, 2006, p.xi). This is in line with other humanistic approaches that recognise that it is the person of the therapist that makes more of a contribution to the outcome of therapy rather than the techniques he or she uses.

2.5.2 Theraplay

Theraplay is an approach which is confirmed in its inclusion of positive touch as an important part of its treatment model because it uses the parent-child interaction as its foundation. Myrow, describing the value of touch in Theraplay (1997), says: "With the experience of touch from a loving caretaker, the child develops a sense of self; the capacity to relate to other people; essential skills in modulating affect; a sense of being able to master the environment; a belief in his own worth". (p.75)
The Theraplay model acknowledges the perils of today's culture of legislation, insurance claims and false accusations, and surmises that the way to avoid accusations of bad touch is to make sure that all touch is appropriate and meets the needs of the child (Booth and Jernberg, 2010, p.76). In addition to this ethos, in Theraplay all treatment is videotaped so that any question about the appropriateness of touch in any given situation can be verified.

Theraplay as an approach is steeped in safety. Through a polyvagal lens we know that when children feel safe, they display social engagement, and they feel able to play and show loving behaviour (Lindaman and Makela, 2018, p.227). The aim is that the child can build new neural experiences of safety through the coherence of the Theraplay setting, and structured use of child-parent relationship, play and nurture. The therapist's primary responsibility is to create a safe and rewarding experience for all, and in doing so synchronization strengthens between the autonomic and limbic systems in the brain. These carefully managed experiences aim to send cues of safety to the child via neuroception, and the child will begin to trust that the social interaction with carer (often a foster parent) is not like

dangerous or life-threatening interactions they may have experienced before.

Of course, touch is part of these interactions, and especially when re-doing neural pathways of attachment. As always, navigating touch in Theraplay with children who have been sexually abused requires careful handling and self-awareness on the part of the therapist. The healthy intimacy and playfulness in Theraplay can be confusing for these children because they may have been seduced by a playful person they trusted, and now they are being asked to trust play again. This can be a big ask. Theraplay can, however, offer a beautiful reparative experience of closeness, nurturing and play in which healthy boundaries can be articulated and respected, thus helping the child heal and internalise what good touch really is (Booth and Jernberg, 2010, p.393).

2.5.3 FirstPlay Therapy

FirstPlay Therapy is a model that, like Theraplay fosters healthy connections between infants and caregivers. It was developed by Dr. Janet Courtney after 30 years clinical practice in developmental play therapy, and training in Ericksonian-based storytelling. The approach is grounded in attachment theory and it incorporates techniques of baby massage within a metaphorical storytelling framework. Touch is foundational to this model.

In a FirstPlay session a certified practitioner instructs and guides the caregiver to provide touch-based activities by modeling on a baby doll. This method of guided instruction is empowering for caregivers as they become the primary change agents for their infant and learn new ways of relating to their child. It also provides a safe way for practitioners to work devoid of worries about litigation and misunderstanding. FirstPlay recognizes that one of the most important influences for healthy brain development is the need for safety, and this is built into every aspect of this modality.

In essence, FirstPlay is a therapeutic modality focused on infants that recognizes the importance of early formative interactions and how they impact on healthy brain development. FirstPlay teaches

caregivers how to utilize nurturing touch experiences to increase wellbeing for both.

Figure 4 illustrates the supporting theories and literature that inform FirstPlay.

Figure 4 - FirstPlay influences

Chapter 3

Methodology

3.1 Introduction

This chapter outlines the research approaches and methods used by the researcher in this study. It includes the purpose of the study, research design, research methods, population studied, data analysis methods used, and ethical dimensions considered. The study did not set out to test theories, rather its aim was to generate awareness around the taboo-laden topic of touch in the playroom.

3.2 Selecting a Methodology

At the outset, the researcher considered both qualitative and quantitative methods for the preliminary stages of research. Quantitative methods allow for impartially and objectivity as the numerical data collected is not shaped by the researcher research, however it does not allow participants to explain their choices or the meaning of the questions. The researcher thought that this method may not be suitable because of the exploratory nature of this study .

After consideration, the researcher decided to use a qualitative approach. Qualitative research is concerned with seeking to gain rich, comprehensive data from a small number of participants (Denov, 2004), and is less concerned with making inferences about the broader population. This suited the small scale of this study, and its exploratory nature. Davies states when working with a small sample the aim is to “emerge with feelings, ideas, described experiences, opinions, views, attitudes and perspectives that have a breadth and depth to them extending beyond that which a structured questionnaire would deliver” (Davies, 2007, p.152). In qualitative approaches the researcher must aim to achieve a greater degree of closeness to the information provider than is

normally the case in survey research. “You want them to accept you as somebody they are prepared to talk to openly and sensitively” (Davies, 2007, p. 153). This is particularly important for autoethnographical research, especially reflexive, dyadic interviews (Appendix 10). Similar to the subjectivity of the author, it is to be noted that research participants also bring their own experiences, values and perspectives to the research. Braun and Clarke (2013) state that it is “our humanness, our subjectivity” which can be used as a research tool. However, to do qualitative research well, the researcher must be “reflexive”. Reflexivity refers to the process of critically reflecting on the knowledge we produce, and our role in producing that knowledge (Braun and Clarke, 2013, p.37).

3.3 The Research Design – Decisions and Considerations

Purposeful sampling was used by the researcher to obtain participants who were especially knowledgeable about or experienced in the area under investigation. The researcher specifically selected information-rich interviewees for the most effective use of limited resources (Patton, 2002). She also utilized her own experience as a practitioner in the area of child psychotherapy and play therapy, in the form of autoethnographical research, specifically narrative ethnography and reflexive, dyadic interview (Ellis *et al,* 2011).

3.3.1 Characteristics of Qualitative Research and Thematic Analysis

Qualitative research is understood to be a subjective process. The researcher brings their own histories, values, assumptions, perspectives, politics and mannerisms into the research. The subject we find interesting also reflects who *we* are, in other words, our *subjectivity* (Braun and Clarke, 2013, p.36). Davies (2007) stresses a cautionary note regarding researcher bias in qualitative research (p.157), especially if the researcher is embarking on a project in a field where they feel “at

home". He states that the researcher must take on stance of neutrality and don the "mantle of an independent academic researcher" (Davies, 2007, p.157), or at least acknowledge their bias. This was particularly relevant to the researcher in this study, and a journal was kept throughout the process to track personal reflexivity, thoughts, feelings and reflections about the process. Braun and Clarke (2006) echo this sentiment and make clear the active role of the researcher in qualitative research. They state that the researcher should not adopt a naïve view, where they merely "give voice" to their participants (p.80). Instead they draw attention to the fact that it is the *researcher* who identifies the themes and patterns and selects and reports areas of interest to the reader. This is far from a passive role and the researcher does not simply watch out for "themes emerging" (Attride-Stirling, 2001).

The researcher chose to use thematic analysis to select firstly codes, and then themes in the data. Thematic analysis according to Braun and Clarke (2006) is suited to "those early in a qualitative research career" (p. 81), as it does not require the detailed theoretical and technological knowledge of approaches. This is another reason why this approach appealed to the author as a first-time researcher.

3.4 Summary and Rationale of Approach to Data Collection

The aim of the study was to explore the inner experiences of therapists in relation to touch in play therapy settings, and so the researcher sought an expert in the field of "touch", and an expert in the area of "inner experience". Semi-structured interviews took place separately with these experts on Zoom as they were based outside Ireland. The researcher chose semi-structured interview structure because it is a personal approach, and an open flow of conversation was encouraged throughout. In each case sample interview questions were prepared and sent to the interviewee to give a tone of the areas of interest (Appendix 4), however the sequence of questions on the day was free flowing and

not tightly structured. The interviewee was free to explore the question as they saw fit, and each interviewee was encouraged to speak from their personal experience.

3.4.1 Autoethnographic Research

Autoethnography can be described as a merger between autobiography and ethnography; it highlights the researcher and her own reflexivity and reflections as viable data (Cahnmann-Taylor, 2008, p.8). The content of the research can vary in the extent to which it includes not just descriptions of the subject matter, but also thoughts and feelings. There are different strands of approach in autoethnographic research: an analytical, theoretical, objective approach versus an evocative, emotionally engaging, more subjective approach such as that which is utilised by Ellis (1999, 2004, 2009). The latter approach was preferred by the author, as it seemed a better fit to the personal nature of the content.

Ethnographers, like autoethnographers attempt to achieve cultural understanding through analysis and interpretation; in other words, it is not about focusing on self alone, but about searching for understanding of others (culture/society) through self. This is similar to the role of child and adolescent psychotherapist who seeks to understand the unconscious communications of the client through examining her inner impressions and subjective experience. In the context of this research, the researcher seeks to extricate meaning from her own experiences in the playroom, so that she might shed light on the culture of touch in child and adolescent psychotherapy, and on its impact on both child and therapist.

The autoethnographic content of the research was compiled from excerpts from the researcher's personal journal, which contained reflexive processing of her own experiences of encountering touch in the playroom in her work setting, mostly with young children. These reflections included

images and writing which the researcher put into narrative form (Appendix 5). The data also consisted of a reflexive, dyadic interview. The dyadic structure of this interview considers the words, thoughts and feelings of both the interviewee and the researcher (Ellis *et al,* 2011). Although face to face contact would have been preferred for the reflexive, dyadic interview, the restrictions around personal contact because of the Covid 19 pandemic meant that new arrangements had to be made. This presented challenges to the researcher especially about how to weave a creative piece into the interview, and flexibility and ethical considerations were paramount.

3.5 Ethical Dimensions

From the outset, the researcher subscribed to seven main ethical principles, which have been set out in the Research Outline (Appendix 1). The researcher kept in mind the sensitive nature of the topic throughout, and its potential for triggering. This was especially important in the latter stage of the research when writing on the topic of touch became quite ironic in light of the Covid 19 restrictions on social distancing, and lack of touch. Special consideration was given to Majella Ryan, Child and Adolescent Psychotherapist who made a creative piece at home in response to the provocation piece sent by the researcher. Care was taken to find a time that best suited the interviewee to speak to the researcher, and methods of self-care in dismantling the tray were discussed, after the dyadic interview was conducted.

3.6 Limitations

Qualitative data being subjective is thus sometimes critiqued as being unreliable and, as stated previously, the researcher needs to acknowledge their own theoretical positions and values at the outset to avoid undeclared bias. Another limitation is the small scale of the study, the limited sample of participants and the limited time frame. Despite this, however, the researcher ensured that no

unjustifiable claims were made, and the research hopes to be thought-provoking rather than generalizing. More than anything the researcher hopes to peel back the layers regarding touch in the playroom, and to encourage openness on the topic.

3.7 Conclusion

In this chapter, the methodologies employed in this research were explored and a comprehensive rationale for the selection of the methods was presented. The selection of participants, demographics of the participants, data analysis techniques, ethical considerations, research biases and study limitations were also detailed. The research findings will be presented and discussed in relation to the relevant literature in Chapter Four.

Chapter 4

Discussion and Findings

4.1 Introduction

The researcher's main aim in conducting this study was to "explore the inner experiences of child and adolescent psychotherapists when touch arises in the playroom". The combination of semi-structured interviews and autoethnographic approaches yielded a wealth of rich qualitative data. Through thematic analysis four key themes which relate directly to the research question emerged;

- Lack of Transparency Regarding Touch in the Playroom
- The Need for Safety and How Neuroception Affects the Therapeutic Relationship
- The "Vulnerable" Therapist
- Why Introspection is Vital in Child and Adolescent Psychotherapy

4.1.2 Data Analysis

The researcher found the analogy of the "patchwork quilt" described by Braun and Clarke (2013, p.231) to be particularly helpful when organising codes from the data and creating themes. "The patchwork only works if lots of different pieces of fabric (codes) contribute towards creating organised and coherent patterns (themes), which are distinct from other patterns, and which work together to make an overall pattern (the analysis)".

Braun and Clarke continue by saying that it is the researcher's role to choose the pieces of fabric (codes) and work out how best they fit together to make a pattern (theme), culminating in a finished quilt (analysis). The researcher, coincidentally being an avid quilt-maker, found this way of understanding the concept of thematic analysis helpful, and set about making "analytical quilts" (Appendix 6). This process of refinement continued until the overarching themes, themes and sub

themes became clear (Figure 5).

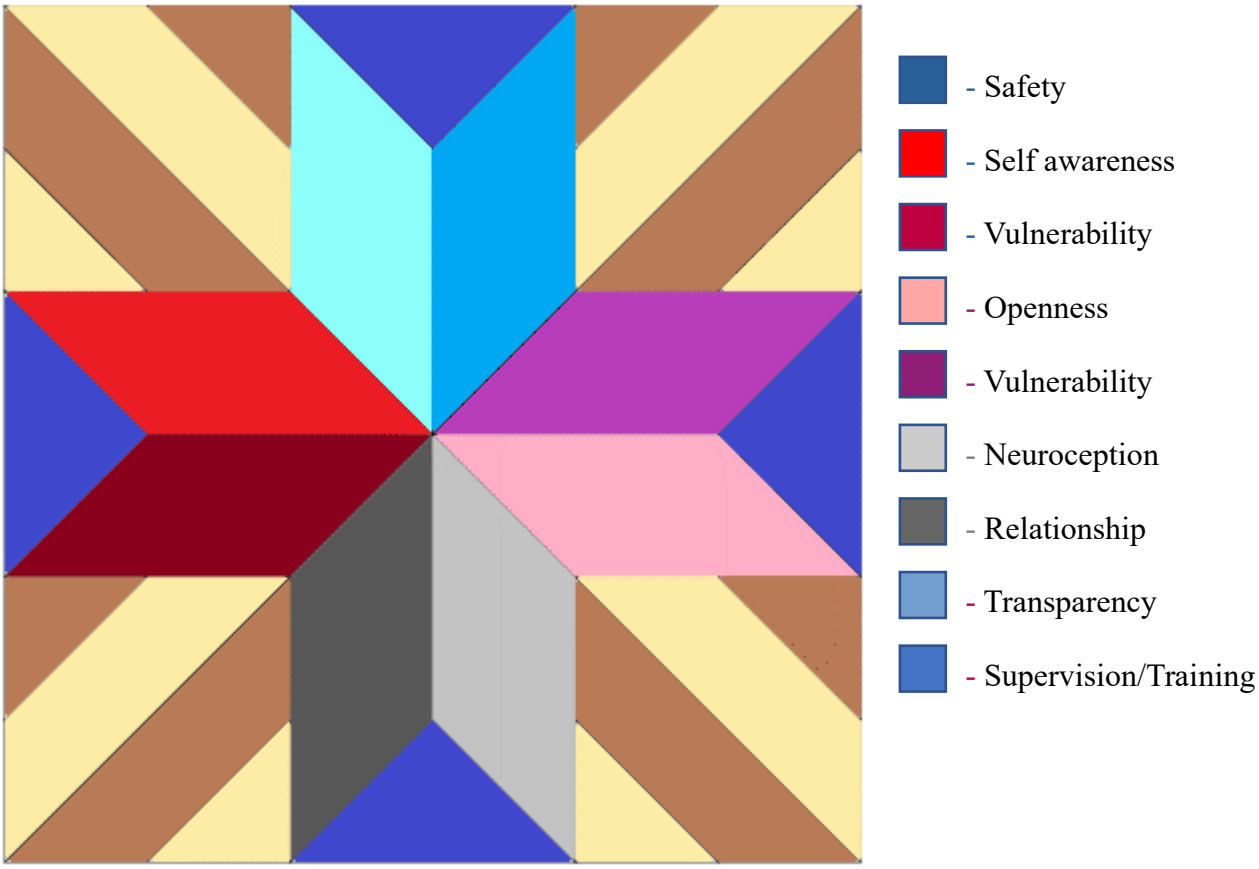

Figure 5 - "Quilt" of Codes

The researcher used a deductive approach, in that she came to the data with preconceived themes that she expected to find reflected there, based on theory and existing knowledge. This fits a constructionist approach whereby broader assumptions and structures are theorised as underpinning what is actually in the data (Braun and Clarke, 2006). The Six Step Approach was utilised in the analytic process.

4.1.3 Six Step Approach (Braun and Clarke, 2006)

The Six Step Approach to using thematic analysis is a "recursive" process rather than a linear one, and even though the stages are explained in sequence, there is much movement back and forth through the phases. The phases are as follows:

- Familiarisation (the researcher transcribed the audio herself hence becoming very familiar with it),
- Coding (See Appendix 7),
- Generating themes (See Appendix 6 for "patchwork quilt" of codes and "emerging" themes),
- Reviewing themes,
- Defining and naming themes,
- Writing up.

Braun and Clarke (2013) again stress the active role of the researcher in the selection of themes, all the time defining the search towards the research aim, and what the researcher wants to find out.

4.2 Findings

Current research findings on the topic of Touch in Child and Adolescent Psychotherapy tend to lean towards the belief that touch is beneficial, and indeed necessary when working with this population (Porges, 2011; Perry, 2008, 2009; Schore, 2003; Seigal, 2011, 2014; Van der Kolk, 2014). Indeed, to exclude touch, or deny it from young clients in therapy, could even be judged to be neglectful (Mc Guirke, 2012; Dana, 2019). However, debate around the "safety" of using touch with vulnerable children and young people, especially with those who have been sexually abused, is still at the forefront of the conversation (Courtney, 2017, 2018; Booth and Jernberg, 2010; Zur and Nordmarken, 2009). Overall, the findings show that although the majority of child and adolescent psychotherapists

value the healing potential of touch highly, especially in the area of attachment disruption and developmental trauma, however there are many issues that need careful consideration (Perry, 2008, 2009; Van der Kolk, 2014; Dana, 2019).

4.3 Theme 1: Lack of Transparency regarding Touch in the Playroom

As stated in the introduction, touch is a "touchy subject". In the course of this study the researcher has both formally (through research methodologies), and informally (through discussing with peers) gleaned a rounded perception of instances of touch during play therapy sessions. She notes that in her fifteen years of practice as an art therapist, before she came up to speed with neuroscience in her play therapy training, she was a lot less circumspect about touch in her practice. She made moulds of hands, faces, rubbed paint off, rubbed paint on, cleaned and dried little hands. The instinctive use of touch with children and adolescents in the private space of the therapy room, is the topic of discussion here. In hindsight, the researcher admits to discomfort in not handling touch more carefully in the past, so she can relate on a personal level to the fear of judgement which surrounds the issue.

4.3.1 Fear of Judgement

The lack of transparency about touch happening in the playroom is due to various factors, one of which is the fear of being judged in a negative way by other professionals. In an Irish context, a study carried out by Lynch and Garrett (2010), into touch practices in child and family social work, states that: "The literature available clearly indicates that some form of physical touch inevitably occurs in practice settings with children: in social work and social care, in counselling and psychotherapy…. Nonetheless, despite occurring in practice, touch remains a subject that is not openly discussed …." (p.391).

The legacy of child abuse in Irish society has left an indelible scar on the touch landscape of many affected by it or associated with it. There are fears around being accused of having unsafe practice with vulnerable minors. A participant in the aforementioned study surmises by saying: "We had our "heads in the sand", believing that Ireland was a "good catholic country" and that sort of thing didn't happen here" (p.393).

Secrecy and "burying one's head in the sand" made it difficult to even get practitioners to participate in Lynch and Garret's study. In her interview with the researcher, Janet Courtney explains this reluctance, referring back to the study: "They are afraid to talk about it. …... there was a lot of anxiety and nervousness about this topic" (Appendix 8, lines 30-33).

The researcher also speaks of fear of judgement amongst peers in her autoethnographic writing, and the self-consciousness of laying her practice open to scrutiny in supervision. "I write in my notes of "accidental touch". But I'm not sure. I bring it to supervision but hear myself insisting it's accidental...but deep down I'm not sure" (Appendix 5, lines 50-52). The uncertainty of the therapist/researcher trying to decipher what kind of touch happened in the playroom, reiterates the "unsure space" (Lynch and Garrett, 2010, p.391) that physical contact inhabits, especially when working with traumatised children. It is challenging for the therapist to own such confusing and impactful interactions in the playroom. One wonders if some choose, consciously or unconsciously, to "sweep them under the carpet" and say nothing?

If therapists are not bringing their stories about touch in the playroom into the light, there is little wonder that there is a "dearth of literature" (Courtney and Siu, 2018) on the subject. Janet Courtney in her interview with the researcher explains that the authors in her book "Touch in Child Counselling: Ethical and Clinical Guide" (2017) found it difficult to find material on touch and child psychotherapy (Appendix 8, lines 37-41).

4.3.2 Touch - “It’s not Black and White.”

As difficult as it is for child and adolescent psychotherapists to expose their practice to scrutiny, it is a necessary component in safe practice, especially where touch is concerned. Current research details the importance of bodywork in psychotherapy, and how the body stores implicit memories (Van der Kolk, 2014, Ogden & Goldstein, 2020). Thus, therapists need to be in touch with themselves, their bodies, and their own internal state, including countertransference, defences, enactments and so on (Ogden & Goldstein, 2020) so they can be in a safe relationship with their clients. Safety is the foundation of all therapy, and especially where touch is involved. Lisa Dion explains the risks inherent in not being open about touch, and letting fear of judgement take over: "I experience that clinicians, because they are afraid of what will happen to them, where they’re afraid of the powers that be, loose their own attunement in the room, they lose their own intuition in the room and then they react rather than respond (Appendix 9, Lines 224-228).

Dion says of touch in the playroom, that “none of it is black and white...it’s all very grey” (Line 223). The researcher shares the same thought through an image made in her personal journal contemplating on the complexities of touch in the playroom (Figure 5).

Figure 6 - "Touch-it's not black and white"- image made by researcher

Janet Courtney re-iterates the point in her interview, that there is a great need for more transparency about touch in the playroom, and acknowledges how it can be anxiety-provoking for therapists, bringing it into the open:

> I'd like to think that I'm one of the people that is bringing that growing consciousness about touch to the table, that we can make it an open conversation, and not, not documenting about it in the notes because you're afraid that that might come back to you in a certain way, or where talking to your supervisor about it seems to bring a lot of anxiety (Appendix 8, lines192-196).

4.4.1 Theme 2: The Need for Safety and How Neuroception affects the Therapeutic Relationship

The second theme to arise from the research was safety, not just the therapist's fears about touch and litigation, but also safety in the therapeutic relationship. Themes of fear, danger and safety permeate the bulk of the research and could be described as "overarching themes" (Braun and Clarke, 2013). Safety is mentioned *throughout* the research by *all* the participants.

4.4.2 What is "neuroception"?

Neuroception is a term coined by Stephen Porges to describe the way our autonomic nervous system scans the environment (and people in the environment) for cues of safety and danger. This scanning is a subconscious activity that happens below the radar of our thinking brains (the prefrontal cortex). According to Polyvagal theory:

> The detection of a person as safe or dangerous triggers neurobiologically determined prosocial or defensive behaviours. Even though we may not be aware of danger on a cognitive level, on a neurophysiological level, our body has already started a sequence of neural processes that would facilitate adaptive defence behaviours such as fight, flight or freeze (Porges, 2011, p.11).

Earlier in subchapter 2.2.3 we looked at the Autonomic Nervous System (ANS), especially the enteric branch to help us understand attachment, and here again, we examine the ANS, especially the parasympathetic branch to understand safety, or at least 'perceived' safety.

4.4.3 How Trauma affects Neuroception

Safety is more than the absence of risk. Safety describes the trust that our relationships will do us good, that our bodies will be able to give themselves over to rest, nurture and sleep, and that the neural circuits that are activated in our interactions will provide physiological renewal and growth. This steady and affirming connection with our bodies projects out into our psychological experience in the world. How we are in our bodies influences how we live and how we believe relationships will work.

For a child who has been hurt, especially by people who should provide care for them, they may well have formed unyielding physiological patterns which serve to protect them from danger. These patterns can linger well after the danger has passed but live on in the child's body. For a child whose carer has also been their abuser, it is particularly hard for them to access regulatory resources which might bring their nervous system back to equilibrium, to physiological and psychological safety. Their home environment may be full of triggers, and their senses are often constantly overloaded. Children who live like this are in a constant state of mobilization, ready to defend themselves at all times. In terms of polyvagal theory;

> For all abused children, their visceral experience is overbalanced to danger and their physiologies' reaction to it. Threat permeates the tension in their muscles, the rhythm of their heartbeat, their breathing, their digestion – the very feeling of their body. They inhabit the two older phylogenetic responses to peril - mobilization and immobilization with fear.
>
> (Porges cited in Tucci et al., 2018, p. 95)

This is a tiring way to live, and it is no wonder that they often have little energy to adapt to new situations and environments. An understanding of neuroception can prevent assumptions and negative labelling of challenging states and behaviour of "difficult children".

The researcher writes in her journal of pace in the therapeutic process, and how healing trauma takes different amounts of time for different children. PACE is also an acronym for "playful, accepting,

curious and empathic" and is a model developed by (Hughes, 2006) for children who have experienced abuse or neglect. The researcher describes the "slow" process with a child, and her attendance to neuroception in the therapeutic space: "The child that is allowing himself to be seen. Who is allowing himself to trust…albeit in miniscule measures. I will not rush him. I rally against feelings of "what am I doing?" I bring them to supervision. "Keep doing what you're doing". Relief" (Appendix 5, lines 68-71).

This demonstrates the need for therapists to use supervision as a steadying force to support their practice, and this in turn supports the neuroception in the therapeutic relationship through co-regulation. Another steadying force for the therapist is staying up to date with theoretical knowledge and current research, especially in the area of neurobiology. This can help practitioners to frame behaviours in context of the child's therapeutic journey. Lisa Dion explains in her interview:

> …I think that's an important thing for me when I look at touch: Can the child handle it? Where are they in the brain? Where are they in the process? Are they showing in the moment that they can handle it, are they showing a moment when they're in their prefrontal cortex, are they in empowerment...? (Appendix 9, Lines 156-161).

Majella Ryan in her interview, draws attention to the steadying force of training and knowledge to aid the therapist's process, in relation to the researcher's autoethnographic narrative: "...maybe fear did take over, you were able to settle yourself, you know you had the nice quotes that you were surrounding yourself with to remind yourself of certain things that supported you and allowed you to hold hope..."(Appendix 10, lines 89-93).

4.5.1 Theme 3: The "Vulnerable" Therapist

"We find safety in the embodiment of our vulnerability in the heart of a loved one" (Tucci, J. et al., 2018, p. 93).

Child and Adolescent psychotherapists are often met with children and young people who show us their rage, anger, frustration, irritability, sadness and withdrawal in the "potential space"(Winnicott, 1991 p.103) of the therapy room. This is both a privilege and a challenge. It is a challenge because children who have been badly treated often have narratives filled with fear, rejection, isolation, shame and humiliation (Tucci et al, 2018, p.95). In time, these children come to believe these narratives about themselves, they believe themselves to be unworthy of love, respect and care, and as a result they come to expect little from relationships. They communicate the internalisation of their pain by activating the threat systems of those around them. *"*They are ungrateful. They push us away. They are argumentative. They do not listen. They try to control everyone around them. They are manipulative. They will never learn. They are unlovable (Tucci et al, 2018, p. 95).

Figure 7 - Majella Ryan's sand-tray close-up of mid section

Majella Ryan expresses this contradiction in her sand-tray pictured above, the dilemma faced by children who most need love, but do not know how to go about getting it. Figure 7 shows symbols which show the inner turmoil of the child who presents a hard, challenging exterior, tended to by the "skeleton nurse", who is "anything but maternal" (Appendix 10, line 44). It is not hard to imagine how a fear-based response to the world has developed, where it is easier to say, "fuck off" than "help me". As Ryan put it: *"*...because you can only see fear, like you know that lovely Marian Williamson saying, "the opposite of love is fear", and how when we feel fear we can't feel love" (Appendix 10, lines 80-81).

This relates to Porges' phylogenic responses to fear (mobilization and immobilization) in which he elaborates that traumatized children shut out the world, and in particular those who pose a threat. For a child who has been hurt, neglected or abused by a caregiver, it seems as if there is no one safe in the world, *everyone* poses a threat (Denov, 2004).

The researcher shares an example in her narrative ethnography, of how fragile the sense of self can be in traumatised children, and in turn how the impact of this fragility can be felt by the therapist. In allowing herself to feel the child's vulnerability, the therapist is also faced with her own vulnerability.

> "The little girl cried. She was eight years old, but here in front of me was a baby. A baby who needed to be held together, a baby who needed to know she was worthwhile, accepted and loved, warts and all*"* (Appendix 5, Lines 22-23).

The therapist felt vulnerable as a practitioner, and vulnerable as a person, as she disentangled aspects of her own childhood in her personal process. It highlights the need for supervision and self-awareness, as people who care for and support traumatised children are often left feeling confused, overwhelmed and unsafe.

Lisa Dion describes the fine line therapists must tread regarding staying attuned to the child but also maintaining somatic and cognitive self-awareness:

> I think the skill of the clinician…..is to really recognise what that felt sense is, what is it that's coming up, and if I have my own history with that I'm going to have to be more alert, more attuned to those feelings that are happening in my body, because there's an interplay between what the child is giving and then our own history that's right there in the present moment, and so to be able to regulate through that, and sit with that, and be mindfully present with that, so that our own defensive patterns don't kick in (Appendix 9, lines 187-196).

Lisa Dion describes this as "one foot in and one foot out" (Dion, 2018, p.100), an ability to "feel" the child's play but not get lost in it. In neurobiological terms it means that the therapist must possess an ability to track the felt sense (right hemisphere) and conscious awareness (left hemisphere) simultaneously (Kestly, 2014). In doing this the therapist maintains a neuroception of safety in the midst of the dysregulation that often arises in the play.

Ryan echoes this sentiment in her interview with the researcher, she states of the therapeutic process:

"And if you, feel it, you know, allow yourself to feel the full impact of it, it can feel like a lot to hold. And yet if you don't allow yourself to feel it well then, I don't think you can do the work. So that's the dilemma isn't it" **(**Appendix 10, lines 95-97).

Traumatised children need to work through their trauma, endure their grief, feel their loss and accept their anger and rage. This can bring vulnerability and doubt to the therapist, and there are many moments of "not knowing" and feeling lost. It is worth remembering that no matter how benevolent the setting, it may not be enough, because the child's capacity for having normal and satisfying object relations has either not developed, or otherwise has been altered or malformed (Lesser, 2007, p.26). Ryan recognises that expecting children who have been traumatised to trust the therapist is a "big

ask", however there is always hope. It is this optimism that sustains the therapist in the work. She states: "It's a very big ask of kids, but I think the fear is there...we have to acknowledge it and move into love. And we have to hold the love, and we have to hold hope*"* (Appendix 10, lines 87-89).

Figure 8 - Majella Ryan's sand-tray

Indeed, the symbol of hope (yellow stone) can be seen Ryan's sandtray (Figure 8). It is situated among other symbols of hope and sustenance and such as the lighthouse (guidance), the artist's palette, the piano(creativity), the bridge, the owl (wisdom) and the happy heart. In among these, however, is also the symbol for pain: *"*I have the hope in the candle, but I have pain…. 'cause as soon as you open yourself up to hope comes pain. So, it's not that simple" (Appendix 10, lines 183-185).

Herein lies the vulnerability of both therapist and client to tread the precarious path between confronting pain and trauma but keeping safety. Tucci et al (2018, p.101) refer to the meeting point

at the edge of the activation of the child's fight or flight/collapse response, where corporeal experiences of danger change to embodied experiences of safety. Taking children to the edge of their experience requires the therapist to maintain attunement and regulation, so that the child can practice and learn experiences of deep safety. The therapist must not rush to break down defences too quickly that have served the child's survival thus far; however, the aim of therapy is to loosen these tight binds that restrict movement and growth towards healing. The researcher describes this in relation to a child client: "The strong banks that have served to hold him together, but which have also restricted him. The one-way rushing flow of survival, not allowing for anything different, not trusting anything (or anyone) to break through" (Appendix 5, lines 74-76).

The medium of play in which we work helps maintains this balance of safety. In fact, the Association for Play Therapy has just released a paper entitled: "Why Play Therapy is Appropriate for Children with Symptoms of PTSD: 6 Reasons Why Play Therapy is an Effective Treatment Choice for Children with Trauma" (April 2020), which supports the work of play therapists.

4.5.2 Transference, Countertransference and Vulnerability in the Playroom

In the playroom children are constantly on the move, engaging in dramatic play, symbolic play and asking us to observe what they create. The therapist is continually picking up on conscious and unconscious communications, which are firing from the various states of activation of the child's autonomic nervous system (ANS). This activation sets off an automatic chain reaction in the therapist, as the two nervous systems connect. If the child experiences sympathetic activation or dorsal parasympathetic activation, the attuned therapist will feel this shift somatically in her own body also. This shared experience is known as transference and is an unconscious communication not to be overlooked in the playroom. The researcher in her authoethnographic narrative describes this phenomenon: "I notice after his sessions I have an urge to run. I feel jangled and jittery with nervous energy" (Appendix 5, lines 64-65). As she tunes in to the somatic experience, she realises

that she is holding the nervous energy of the child, who has no internalisation of safety and security. At the least hint of relationship in the therapy room, he has mobilized resources, his visceral experience is overbalanced to danger and his physiology has reacted to it.

Sometimes there are dual unconscious processes at play in the therapy room. Ryan explores this in relation to her sand-tray. She explains: "What I was thinking was, that this darkness is also the darkness in us as therapists too, so we end up holding some of this for our clients. This is touching off our darkness and it's about owning these parts of ourselves" (See Appendix 10, lines 129-135).

Attending to one's own countertransference is of critical importance in the therapeutic relationship. It requires a level of openness and vulnerability from the therapist to open to parts of herself which may be painful, unsettling or uncomfortable. Countertransference however is a valuable resource, because it can shine a light on the unspoken communications of the traumatised child.

Janet Courtney refers to children who have experienced sexual abuse and describes how their transference can present in the therapy room: "...some children that have been sexually abused can adopt sexualised behaviours, …. it's not their fault, it's just what happens, it's the trauma, it's the child's transference onto the therapist" (Appendix 8, lines 245-248).

Sexualised behaviour of a child in the therapy room can put the therapist in a very vulnerable position. Is it any wonder that such fear and controversy surrounds touch in the playroom? However, the bulk of the research from this study suggests that the positives far outweigh the negatives regarding touch. In the words of Janet Courtney:

> "…. if I was a child and I had been sexually abused ...what do I need? somebody not to touch me, or hug me, or show respectful touch to me? I mean...are they going to avoid me ... You have to think of *that child***,** because that child might really be the child that needs it the

most, needs the good, caring, respectful touch the most "(Appendix 8, Lines 253-256).

Most importantly though, "it always goes back to how do we set safe parameters in a session with the child, to provide for some need in a good, caring way, meeting their emotional needs*"* (Lines 261-2).

4.5.3 Not Being "Good Enough" in the Transference.

A common theme in the research among the participants is the vulnerability of "not being enough". This mirrors the experiences of children who have been hurt and traumatised, especially by primary "care-givers". Ryan states at the outset of the conversation, after being asked to participate in a creative piece for the research: *"*I know you asked me to do some creative piece around what you shared with me, but I don't know what you're looking for in that really..." (Appendix 10, Lines 2-3).

What Ryan's comment shows is that exposing oneself to the creative process, is revealing by its nature : "There was a vulnerability, and I think that 'I don't know what you wanted from me' was part of the process too" (Lines 7-10).

This unsure stance is characteristic of children and young people who have experienced trauma and have not developed a secure sense of self (Brody, 1992). Ryan notices a theme in the sand-tray where she could not find the right symbol for a nurturing presence. This symbolises the difficult journey many children endure, who have experienced early developmental trauma, abuse and/or neglect. They navigate a "torn map of the world" (Van der Kolk, 2014). Ryan explains:

> "I was also thinking about kids who've had a lot of abuse in their history and a lot of neglect, and how that process is for them. And so, I was thinking…. I chose the symbol in the back-left corner, of the skeleton nurse who looks anything but maternal or nurturing or caring with the baby, and the menacing character beside her" (Appendix 10, lines 42-45).

The transference of the child, who is trying to catch up developmentally, and function against the odds, with no secure base and little sense of self is projected on to the therapist. The frustration, vulnerability and heartache of the child can be felt in Ryan's "furious" yet fruitless search for a nourishing symbol:

> And yes, as busy as the tray is, I still couldn't find the right symbol. So as part of my process in it, and in particular.. when I say the right symbol, I couldn't find a nurturing symbol that I wanted. And I was furious about that, and I went to a place of... I have all these dark symbols, but I don't have light symbols. Or you know, I don't have nurturing or loving symbols. (Appendix 10, Lines 22-26)

The feeling of not being 'enough' is again highlighted, as the researcher points out to the interviewee that in *her* opinion she had in fact selected several symbols of nurturance and connection, such as the three bears on the boat, the "playful" mice, and the mother and baby gorilla. Ryan responds:

> "Yeah and that's very telling that I couldn't get to the nurturing piece that I needed, so even though I found *some*, I couldn't get what *I* needed. But I don't know if that's part of that child's process, or your process in some way, or just my way of thinking it, and maybe all of the above" (Lines, 170-172).

This examining of the child's process through therapeutic use of self is of great importance in child and adolescent psychotherapy, and thus it is vital that the therapist maintains self-awareness, introspection and self-care throughout the therapeutic process.

4.6.1 Theme 4: Why Introspection is Vital in Child and Adolescent Psychotherapy?

An exploration of the inner experiences of child and adolescent psychotherapists is the aim of this dissertation, and so the researcher strived to find a way to 'capture' the inner experiences in an

unprocessed state before they are translated into words. It is inevitable that there is always something 'lost in translation'. With a background in Art Therapy the researcher felt "at home" with creative activities and recognised the immediacy, spontaneity and truth inherent in the mediums of artmaking and sand-tray. "Introspection" is defined as "the examination or observation of one's own mental and emotional processes", and in this case we are examining these processes in relation to touch in the playroom. So first it is important to acknowledge that there are many different types of touch in the playroom. Janet Courtney adds in her interview with the researcher:

> ...touch will happen whether you want it to happen or not. Because they (children) will step on your toe, or they'll pass you a crayon and your hands will touch, or you're moving in the playroom and your elbows will hit each other. There's always some type of issue related to touching, or the child will be hitting you or attacking you in some way, and a lot of times it's really unexpected. (Appendix 8, lines 45-49)

Lisa Dion throws light on the topic of unexpected and "inappropriate" touch in the playroom:

> ... they're doing it as part of their therapeutic journey, they're not doing it because they want to freak the therapist out…. our role is to help facilitate awareness about that, and so going back to make sure we're not adding shame, that's the trauma showing up and playing out, and how we help them navigate that landscape is huge. (Appendix 9, Lines 305-308)

The researcher also speaks of different types of touch from sessions in her autoethnographic content (Appendix, 5) – "steadying touch*"* and what could be described as" testing touch".

Introspection and awareness of one's own "self" in the therapeutic relationship is critical according to all the participants of the research. Lisa Dion describes an occurrence in the playroom where a child approached her in a seductive manner (Lines 200-203), and when another child put his hand on her breast. She explains how the process of introspection helps her respond to the touch, rather than

react: “If I’m not able to stay connected to myself in that moment, and work with my own activation, I’m going to react to the child, instead of respond to the child. And to me it’s the difference of having that become a loving, compassionate, reparative moment versus adding shame into the child’s story” (Lines 206-210).

She continues: “It’s the difference between grabbing the child’s hand and saying, “We don’t do that in here” or “That’s not appropriate” …. versus…. saying “there’s a part of you really wants to be close right now...this is your way of trying to be close, I want to be close too, let’s find another way where we can be close.” (Lines 212-216)

When two people are present in a setting, there is always an interaction between them, be it conscious or unconscious. It is the therapist’s professional duty to ‘mind herself’ in these interplays and be aware that she is not a blank canvas, but a living breathing person, as much as the client is.

Self-care is not a luxury but a necessity. The researcher in her interview with Ryan (Appendix 10) explored the subject of dismantling the sand-tray after the creative activity. Ryan states; “I noticed when I finished it...I often get this after sessions...the energy, where there’s a lot of energy...my hands buzz.” In the interests of debriefing, the researcher explored how might Ryan feel after the dismantling of the tray offline. Ryan states: “...what I usually do after a session, when I have that is I em...I wash them in cold water, I just rinse them” (Lines 306-310).

Introspection on a somatic level is an important part of the therapist’s process. Ryan shared thoughts with the researcher on how she felt during the making of the sand-tray:

> “So this was about how I was feeling as I did it...shortness of breath at times...and actually I notice this as I went through it again, my breath feels a bit caught at times here, ...almost like it’s hard to breathe...deeply...which for me, often would indicate anxiety” (Lines 283-288).

She also shared feelings of sadness: “I had sadness. Feelings of sadness .... of not being good enough” (Line 290).

Therefore, we see that the process of introspection is a valuable tool in understanding the unconscious communications of the child, and countertransference can be experienced in different ways including somatically – in the body as well as in the mind. In summary it seems clear that the therapist should remain open to exploring the countertransference, in supervision and in personal process, to maintain safe practice.

4.6.2 The Therapy Space as a Meeting Place

"There can be no openness to the child's experience if there is no openness to one's own experience" (Tucci, J. et al., 2018, p. 97).

All the research participants stressed the importance of introspection in child and adolescent psychotherapy. Therapy is a meeting point between two people, and so is touch. Lisa Dion states: "So touch for me is a meeting point …connection between two people*"* (Appendix 9, lines 40-41). Janet Courtney draws attention to the joint aspect of the therapeutic relationship also, drawing on the work of Carl Rogers and the Humanistic perspective: *"*They recognise, I'm human, you're human, we're all in this kind of together, we're all serving it out and I'm not the expert but I'm here to assist you along your path and I'm working on mine too" (Appendix 8, lines 211-215). To journey alongside the client requires the therapist to have therapeutic presence (Geller, 2018). This involves being in the moment, receptive, and attuned with clients on multiple levels. Research demonstrates that therapeutic presence is necessary to facilitate positive therapeutic relationships and effective therapy.

Figure 9, an image made by the researcher, depicts the meeting place of the therapy room, the "potential space" that both the client and therapist inhabit. "The potential space between baby and mother, between child and family, between individual and society or the world, depends on experience

which leads to trust. It can be looked at as sacred to the individual in that it is here that the individual experiences creative living" (Winnicott, 1991, p.100).

According to Winnicott's thinking, individuals live somewhere in between their inner world, and external reality. This space he refers to as "the potential space", and if the infant has had experiences of trust, play, discovery and creation with 'an other' (usually the mother), the child feels able to live creatively, play and symbolise. If a child has had an impoverished start in life, like the one symbolised in the sand-tray, tended to by the "skeleton nurse" (Appendix 10, line 44), they may not have developed an ability to play. There may be an extinction of curiosity and imagination, as the world of fantasy is impoverished or numb (Lesser, 2005).

In the context of the 'potential space', the playroom can be a setting where the child can grow in trust with 'an other', and thus have a developmental second chance to internalise safety and trust, and in turn learn to create and play. Living creatively is essential for well-being. As Lesser (2005) surmises, "if the encounter turns out well, we would expect the renewal or emergence of the patient's inner world – a wider spectrum of emotions, thoughts, desires and, ultimately, hope" (p.27).

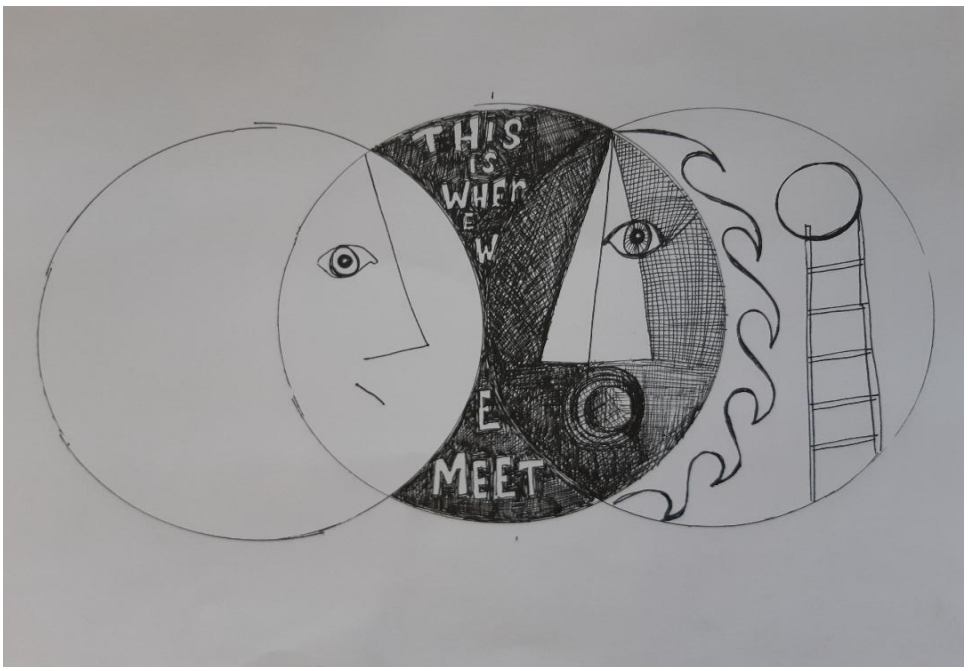

Figure 9 - "This is where we meet" – image made by researcher

4.6.3 All Research is Me-search (van der Kolk, 2014, p.109)

Courtney and Gray (2014) researched practitioner's experiences of Developmental Play Therapy, and the implications for touch. The research proved that the participants were emotionally triggered by very simple exercises such as holding hands for example. Courtney in her interview states in relation to this: *"*We've gotta really start addressing potential countertransference that can emerge for the therapist unaware when touch experiences happen in sessions. Could be that they haven't looked at their own issues around touch, how they were touched (Appendix, 8, Lines 19-24). She states point blank that: "I think, you know, a hundred per cent that therapists need to have their own personal therapy, period (Line 168). Lisa Dion echoes the same sentiment regarding self-awareness to prevent "defensive patterns kicking in*"* (Appendix, 9, Lines 192-196).

The researcher explores her own early relationship with touch (Appendix 5) and wonders about the experience of being a premature baby, and how this may have shaped her relationship with touch. Field's research into the benefits of massage therapy with incubated infants shows how medium pressure touch correlates with increased weight gain and increased cardiac vagal tone (Field, 2006); one can only imagine that this touch, carefully administered, may soften the neuroception of danger present in the hospital environment, with bright lights, buzzers and alarms, triggering the infants sympathetic nervous system. An environment aptly captured by William Blake in his poem entitled "Infant Sorrow" and captured in Figure 10, an image from the researcher's journal.

Figure 10 - Incubator Image made by researcher

Chapter 5

Conclusion

5.1 Summary of Conclusions

The aim of this study was to explore the inner experiences of child and adolescent psychotherapists when touch arises in the playroom. Through semi-structured interviews and autoethnographic approaches the study endeavoured to answer the questions central to the exploration and the embedded questions. A brief overview of the findings for each of these questions provides a summary of this study's main conclusions.

5.1.2 How Do Child & Adolescent Psychotherapists Conceptualise Touch in Terms of Attachment Theory?

This study has identified that touch is recognised by child and adolescent psychotherapists as a key component for healthy attachment (Brody, 2006; Courtney and Nolan, 2017; Booth and Jernberg, 2010), and healthy attachment provides the foundation on which the "self" is built. This co-dependency is highlighted in the words of child psychoanalyst Donald Winnicott: "There is no such thing as a baby...if you set out to describe a baby, you will find that you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship" (Winnicott in Klein, 1987, p.230).

Central to the process of attachment is the role of touch, and as such, touch sets the course and the trajectory for life. Not only does touch provide warmth, comfort and security, it ignites great activity in brain growth and development (Field, 2014). Overall, this study strengthens the idea that children *need* touch, and that the safety of the playroom can create sensory rich environments where this can happen.

5.1.3 How Does Lack of Touch and Unsafe Touch Affect the Developing Child?

The review of the literature and the research carried out in this study strongly highlights that lack of touch, and abusive touch can have damaging psychological and social effects. Traumatised children have a hard time regulating their emotions, and modulating touch. The interviewees speak of incidences of touch which are confusing for both child and therapist. Touch in the therapy room aims to reach the child's subjective experience and re-establish sense of self through meaningful rapport with "an other". Common themes in the research are confused boundaries, impulsivity and reactivity. Neural pathways of traumatised children have been predisposed to expect hurt, and so the playroom serves as a safe space to re-do these patterns of attachment, and lead towards a more secure sense of self for the child, and in turn more satisfying relationships.

5.1.4 Why Is Examination of Inner Experiences Vital for Child and Adolescent Psychotherapists When Working with the Phenomenon of Touch in the Playroom?

When a child arrives in the playroom the therapist has an understanding of her history from the intake procedure, however it is in the throes of the therapeutic process that the nuances of traumatic experiences and early emotional deprivation come alive, and can be grasped. These silent nuances and communications bear heavily on the therapist activating intense emotions and fantasies (Lesser, 2005). This research has provided deep insight to this phenomenon through the literature and the participants data. Creative activities were shown to be helpful agents in extricating the "silent nuances" or in other words transference and countertransference. The research promotes the use of creative modalities in training and supervision to encourage introspection.

Research participants echoed the experience that encounters with traumatised children intensify countertransference reactions. All agreed that the therapist's capacity to be aware and work through

her own feelings is a key factor in enabling such work. This stance was consolidated by the literature, and going further, to be unaware could be considered negligent and even harmful.

"If counter transference reactions are not able to be made conscious and reflected upon, there can be many forms of harmful enactments or verbal communications to patients or avoidance of emotional contact with them and their problems" (Martindale, 1997 cited in Lesser, 2005, p.25).

In the area of touch, the research shows that it can present challenging countertransference reactions and it is widely agreed that this needs to be brought into the open in training settings and supervision. Traumatic experiences lack a clear narrative, especially where touch has been involved, or lack of touch. In can be a painful path, set with traps and triggers along the way, but the therapist has chosen to walk it, with the child at their pace. Good walking shoes come in the guise of supervision, adequate training, self-care and self-awareness.

5.1.5 What Are the Different Models in Psychotherapy and Play Therapy Which Incorporate Touch to Work with Developmental Trauma and Attachment Difficulties?

The empirical findings of this study provide an evolving understanding of the intricacies of touch in the playroom, and especially how touch impacts the therapist. The research demonstrates that touch happens a lot in child-led, non-directive approaches and not just in purposeful approaches, such as Theraplay and FirstPlay. This means that therapists are required to "think on their feet", sometimes without adequate understanding of touch, and its layers of communication. The modalities of Theraplay and other attachment building models are cushioned in safety, because of the structure and specialised training required, and rightly so, when trying to rebuild neural pathways of vulnerable children. The addition of the caregivers in these approaches' envelope the work in reassuring security and healing touch.

5.2 Recommendations

These findings provide insights for future research which include a need for openness and guidance on both personal and professional levels. On a professional level it was noted that more teaching on the topic would be beneficial in training courses (Courtney and Siu, 2018), and more openness would be welcome among practitioners who use touch in the areas of trauma and abuse (Lynch and Garrett, 2010). During the course of this study the researcher has got a sense that there is a long overdue need to open up debate around touch in the playroom (Courtney and Siu, 2018, Courtney, 2017). Although this study is small in scale, it is rich in meaning and the researcher has noticed an eagerness to talk about touch in the playroom among colleagues.

Courtney and Siu (2018) suggest that future research could be carried out on different types and frequency of touch that happens within play sessions – child initiated, therapist initiated, accidental, assistance, amongst other types – which would again encourage an opening up of the conversation. Or "how do practitioners make decisions about whether to touch a client or not" would be another potential research question (Courtney and Siu, 2018). These are areas very much of interest to the researcher, but unfortunately beyond the scope of this small study.

Another area of interest to the researcher would be to find out how children in the care system feel about their touch experiences. Due to the ethical concerns of conducting research with children, it would be more appropriate to carry out this enquiry with adults recalling their experiences. This would add another layer to the 'touch' debate around working with children who have experienced attachment disruption and developmental trauma.

Finally future research might include looking at the after effects of the Covid 19 pandemic, and how lack of touch has affected well being and relationships. An unfortunate reality of this situation has

been that the grieving process has been disrupted and touch has been denied to the sick and dying. This is bound to have profound effects in the times ahead. Touch is the first sense we develop in the womb and the last one to leave us when we die, and it is a universal language central to our very existence (Purvis,2020). This research has proved that it is very much alive in the playroom also.

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List of Appendices

Appendix 1 Research Outline and Ethical Approval

Children's Therapy Centre
Research Outline 2018

PLEASE COMPLETE THE FORM USING TYPESCRIPT
(do not handwrite)

Student name:	Sonya Joyce
Date:	12 November 2019
Programme:	MA Creative Psychotherapy (Humanistic & Integrative Modality)
E-mail address:	quinn_sonya@yahoo.ie
Title of proposed research:	"What did I do?" - An Exploration of the Inner Experiences of Child and Adolescent Psychotherapists when Touch arises in the Playroom.
Name of supervisor:	Maggie Fearn

1. What is the main research question your project will address? Please also describe any embedded questions. Ensure your research questions are clear and achievable.
Research Question "What did I do?" - An Exploration of the Inner Experiences of Child and Adolescent Psychotherapists when Touch arises in the Playroom. Embedded questions. • How do Child and Adolescent Psychotherapists conceptualise touch in terms of attachment theory? • How does lack of touch and unsafe touch (CSA) affect the developing child? • Why is examination of inner experiences vital for Child and Adolescent Psychotherapists when working with the phenomena of touch in the playroom? • What are the different models in psychotherapy and play therapy which incorporate touch to work with developmental trauma and attachment difficulties?.

2. What is the aim of this study? What potential contribution might this research make to policy, practice and/or theory? Be realistic in terms of any design limitations (such as small sample size).

Aim

The aim of this study is to explore, through qualitative methods, the inner experiences of child and adolescent psychotherapists when touch arises in play therapy sessions. I wish to bring into the open this topic as it is often taboo amongst practitioners. Eliana Gill describes a dilemma when the child “started climbing on to my lap for a few moments, seemingly to check out if proximity was safe” (Gill, E. in Courtney and Nolan, 2017, p.xxii), however, tentatively she admits, that she did not put it in her process notes. Herein lies the crux of the matter, many therapist’s are unsure about touch. There are many ethical concerns. Touch can be nurturing, comforting and warm, however it can also be invasive and violating. Humans are tactile beings and touch is the first form of communication. For children whose whos experiences of touch are inadequate, absent or abusive, can new experiences of touch from an attuned therapist provide corrective foundations on which opportunities for growth and healing can be built? Stammers (2017) states that metaphorically, touch becomes the bridge of healing between therapist and child when either the bridge has never been built or some catastrophe has washed the bridge away.

“Bridge building” can be a formidable task for children whose boundaries regarding touch have been so violated, and close attention needs to be given to the dynamics of the process especially the phenomena of transference and countertransference. The therapist’s own feelings can shine a light on the unspoken communications of the traumatised child. Hence the therapist must listen to herself, and realise that it is she who is “the most important toy in the playroom”(Dion, 2018).

My study will contain an autoethnographic piece focused on my work with children who have been sexually abused. This reflexive approach reflects how my interest in the research question evolved and grew. I noted how touch which arose in non-directive play therapy sessions left me feeling confused, unsure and vulnerable. Through self-examination and supervision I wondered was I holding a large amount of my client’s unconscious communications. I also wondered how should I respond to touch in these fleeting moments, bearing in mind the unique individual and situational nuances of every touch both given and received.

As well as the reflexive piece, I hope to engage with other experienced therapists working in the field. I wish to focus on the therapeutic use of self, in understanding the unconscious communications of our young clients, and so I will seek an expert interview from an experienced humanistic and integrative psychotherapist renowned for using this approach. I also wish to conduct a conversational semi-structured interview with a colleague, where we can explore together experiences around touch and contact seeking behaviour during play therapy sessions. Focusing on how touch is experienced by the therapist unconsciously, somatically and through counter-transference, and ultimately how does one respond to it and does it influence the course of therapy.

The study will examine literature on the subject of therapeutic touch, highlighting current good practice. It will explore the taboos around the subject, and also the rationale for integrating touch into non- directive and integrative play therapy sessions.

After analysing all the data, the discussion will centre on whether this small study can contribute to current research on the benefits of therapeutic touch in the field of child psychotherapy. It may

provide evidence which will shape how play psychotherapists practice and provide reassurance having opened up area of touch which is laden with taboo.

Dion, L. (2018) Aggression in Play Therapy:A Neurobiological Approach for Integrating Intensity. W.W. Norton & Company.

Stammers, L. (2017) The Neurobiology of Touch; Developmental Play Therapy with a Child Diagnosed with Sensory Processing Disorder in Courtney, J. A and Nolan, R. D. (2017). *Touch in Child Counseling and Play Therapy : An Ethical and Clinical Guide.* . New York & London, Routledge Taylor and Francis Group

3. In no more than 500 words, please present a summary of the literature to provide a suitable rationale for your proposal.

Research has shown that touch is essential in forming secure attachment between parent and child, as it fosters physiological development, reduces stress and promotes positive body image (Booth & Jernberg, 2010; Field, 2014).

"*In the beginning is touch, and touch is the foundation of the real*" (Wright, 1991, p.61). Bodily contact (holding, touching, rocking, cuddling), communication (smiling, talking and responding) and attuning (feeding, changing) are the things that lay the foundation for a secure sense of self (Wright, 1991). Safe and attuned touch, along with the mother's gaze, form the primary means of communication at this time.
"When I look I am seen, so I exist, I can now afford to look and see" (Winnicott, 1991, p.114).

Infants and children who have experienced abuse and neglect may never have had attuned experiences in the "potential space" (Winnicott,1991). The "potential space" according to Winnicott, describes the space between the inner world and outer reality, and it is the area, that if a child has had experiences of attunement that their sense of self develops.

My research is focused on clinical use of touch within the "potential space" of the therapeutic relationship, and this has led me to wonder whether healthy, safe touch is essential for clients who's past experiences have been impoverished, violent, or lacking in empathy and physical affection. Is it true that the therapist, like the mother, must be fully present with the child in therapy, responding to their cues in a way which enables the child to become aware of their own existence (Brody, 2006).

When used appropriately touch can promote health and healing, however when misused it can impede healthy development and cause harm. The efficacy of physical touch in psychotherapy has long been debated, and nowhere is it more controversial than in it's use with children who have experienced abuse and neglect (Courtney, 2017). Touch is such a powerful and complex communication that therapists must carefully evaluate and understand their own relationship with touch, and their motivations for using it, or not using it with children.

Theorists such as Brody (2006), Field (2003), Courtney and Nolan (2017), Booth and Jernberg (2010), Heller and LaPierre (2012) have been pioneers in developing models of using touch in clinical psychotherapy with clients, and it is these practitioners I look to for exploration of safe and appropriate touch in play therapy settings.

Therapists must use supervision and practice self-awareness to bring to light any potential countertransference related to touch in the playroom (APA, 2019). Literature on this topic stresses

how the therapist must be very aware of transference and countertransference when using touch with vulnerable clients. They must be very aware of her own experiences and issues around touch (Lesser, 2007, Courtney & Nolan, 2017). Developmental Play Therapy (DPT) describes touch not as therapeutic technique, but instead as "*expression of love and care by a truly loving and caring adult"* (Brody, 2006, p.xi). This is a beautiful and true certitude, however research, including my autoethnographic piece hi-lights that caution and transparency are needed, especially when working with trauma. Humanistic approaches such as DPT and Synergenic Play Therapy, amongst others postulate that it is the person of the therapist that makes the biggest contribution to the outcome of therapy, rather than the techniques used. Because of this we must ensure we are competent not only in technique, but in authenticity, congruency and self awareness. As Beatrice Beebe states "*most research is me-search*" (Der Kolk, p.109), and this is true, requiring the mirror to be held up to the therapist to reflect back her attitudes to touch.

Booth, P.B., & Jernberg, A. M. (2010). *Theraplay:* Helping *Parents and Children build better relationships through attachment-based play.*

Courtney, J.A., & Nolan, R.D. (2017). *Touch in Child Counseling and Play Therapy: An Ethical and Clinical Guide.* New York, NY: Routledge.

Van der Kolk, B. (2014) *The Body Keeps The Score, Mind, Brain and Body in the Transformation of Trauma.* London, Penguin Random House UK.

Winnicott, D.W.(1991) *Playing and Reality. 3rd ed.* London: Routledge.

Wright, K. (1991). *Vision and Separation.* London, Free Association Books Ltd.

4. Please describe *and justify* your research sample. Where will your research will take place and why? Which participants will be involved and why? How you will gain clearance to access this setting.

I will be using autoethnographic data as part of my study. Auto-ethnography is a creative and reflective qualitative research methodology where researchers offer personal narratives to explore and articulate cultural experience (Coffey, 2017). My rationale for using this reflective research methodology I believe is justified, because it explores my own experience as a therapist over the past 14 years. My experience as a therapist (art and play) has provided many experiences of touch in the therapy space. As my training and learning expands towards psychotherapy, I have become intrigued to look at touch through a neuro-developmental lens. I am driven to understand what my clients might be trying to communicate to me through touch, and what responses their touch elicits in me. Journal entries and personal narrative will be shared in the research to illustrate my **own** process around touch in sessions, and my attempts to extricate meaning about the therapeutic relationship and the "potential space"(Winnicott, 1991) of the therapy room.

Any identifying information, by association or otherwise will be avoided, and the bulk of the data will focus on my own internal experiences and responses.

I will also be exploring therapeutic use of self in relation to touch, through an expert interview with an experienced child and adolescent psychotherapist. I will use zoom to conduct interview if interviewee is located outside the country. I will send interview questions in advance by email, and will audio record interview on my laptop.

I would also like to facilitate a semi structured conversation piece with a respected colleague in the field of child and adolescent psychotherapy on the topic of inner experiences in relation to touch in the playroom. If consent is given, this will take place at a location convenient to the therapist, and will be recorded on an audio device. A creative piece may be used in this interview, sandtray or art making, if it helps the interviewee settle into the subject matter and gain access into inner experience.

Coffey, P. (2017). *Beyond the Silence - Autoethnography An Act of Will.* Plymouth, Devon: Self Published.

Winnicott, D.W.(1991) *Playing and Reality. 3rd ed.* London: Routledge.

5. In no more than 350 words, please describe the methods of data collection you will use and how this data will be analysed. Give details of all measures to be employed, whether these are standardised or, if they are to be developed, how this process will be achieved. Consider why you have chosen particular methods of data collection and analysis. Ensure it is clear to the reader how these methods will enable you to answer your research question/s.

This study will be evaluating and comparing current theory through:

- The literature review, developing from the preliminary literature as outlined above,
- A autoethnographic piece using journal entries and personal narrative to explore the researcher's inner experiences in relation to touch in her own clinical work,
- Expert analysis from child and adolescent psychotherapist on topic of inner experiences and use of self in relation to touch in the playroom.
- Semi- structured conversation with experienced practitioner exploring use of self and responses to touch in the playroom.

The interview questions may develop in relation to the literature review, please see Appendix 3 for a sample of interview questions.

All names and settings will be coded to ensure anonymity.

6. Please provide a timeline for your research.

4th – 11th November 2019 : Finalise Research Outline and Ethical Approval Application Form.

Ongoing : Autoethnographic research through personal narrative in journal entries and images.

12th November 2019: Submit Research Outline and Ethical Approval Application.

End of November 2019 : Literature Review to be completed.

December 2019 : Carry out and audio record interviews.

January 2020: Personally transcribe interviews, familiarising myself with content.

Analyse data: Complete data analysis and write up by end of April 2019

Submission: 21st May 2019

Children's Therapy Centre

Ethical Approval Application Form

PLEASE COMPLETE THE FORM USING TYPESCRIPT
(do not handwrite)

Student name:	Sonya Joyce
Date:	12 November 2019
Programme:	MA Creative Psychotherapy (Humanistic & Integrative Modality)
E-mail address:	quinn_sonya@yahoo.ie
Title of proposed research:	"What did I do?" - An Exploration of the Inner Experiences of Child and Adolescent Psychotherapists when Touch arises in the Playroom.
Name of supervisor:	Maggie Fearn

Please demonstrate how your research will meet the ethical code of conduct. You must consider all elements of ethical practice, even if you feel they do not relate to your project. Indicating that you have considered all issues, is important. Subheadings are provided.

Informed consent:

All those who are invited to take part in the interviews will be fully informed of the purpose of the research, and the methodology, by letter initially sent by email (See Appendix 1). Participants will have the same amount of time to consider whether they would like to take part, and they will have the opportunity to ask for more time if needed. Consent will be granted by signing and returning a hard copy statement (Appendix 2).

Withheld information or deception:

I will not intentionally withhold information or deceive anyone during the course of this research study. A summary of findings will be available for all participants at the end of the MA programme,

Opportunity to withdraw:

Participants will be given the right to withdraw from the study. This will be stated clearly in the consent form and also again in the process of setting up interviews. The interviewees will be contacted individually and I will explain the purpose of my study to them. I intent to contact two interviewees well ahead of the planned interview time. In the case that one, or both withdraw I have a shortlist of other experts to contact as replacement. If a participant chooses to withdraw retrospectively after the debriefing, their decision will be respected and no pressure to take part in the research will be put on them.

Data protection:

Interviews will be recorded and saved in a password protected file. The transcripts will be transcribed by the researcher, and no third party shall be involved. All files relating to the research data will be destroyed after 6 months of completing the research.

Anonymity and confidentiality:

As an ethnographic researcher I am the focus of the research, my own inner experiences in relation to touch in the playroom. However in sharing my narrative,. I will touch upon other people's stories. I have not sought consent for this, and will take utmost care to anonymise any identifying information

The expert interviewee will be asked whether they want to be named or remain anonymous in the research. In the conversational semi-structured interview the interviewee will remain anonymous to prevent identification of clients by association.

Protection from harm:

No person shall be harmed during the course of this research. The researcher is aware of the responsibility to safeguard the wellbeing of the research participants and will strive to create an atmosphere in which they feel safe enough to share. The limits of confidentiality will be stated at the beginning of the interviews, stating that the only reasons for breaking confidentiality, would be if the interviewee stated that she was a danger to herself or others. In this case the researcher would contact her dissertation supervisor to report her concerns, and seek advice on how to proceed. The interviewee would be informed of the process. Any requests for advice will be addressed openly and with generosity of time and care.

Debriefing:

The therapists involved in the research will be well experienced, and are selected because of their expertise and knowledge in the field of child psychotherapy, and therapeutic use of self. Thus they will probably be aware of self care around the emotive topic of touch. The researcher will offer space and time to debrief if required after the interview, and signpost to other services if need be.

****RESEARCH MAY ONLY COMMENCE ONCE ETHICAL APPROVAL HAS BEEN OBTAINED****

Ethical Approval Application: Feedback and Approval

[Staff use only]

Supervisor Checklist:

Summary and methodology				**Areas requiring work**
Has the rationale for the research been adequately expressed?	**Yes**	No	N/A	
Is the research question clear and achievable?	**Yes**	No	N/A	
Are the methods clearly explained?	**Yes**	No	N/A	
Is the indicative literature current, useful and relevant?	**Yes**	No	N/A	
Protection from harm				**Areas requiring work**
Has the student identified all potential risks associated with the proposed study?	**Yes**	No	N/A	
Are adequate protocols in place for dealing with all risks?	**Yes**	No	N/A	
Informed consent				**Areas requiring work**
Does the study involve participants who are particularly vulnerable or unable to give informed consent?	Yes	No	**N/A**	
Are good ethical procedures in place for gaining consent ?	**Yes**	No	N/A	
If applicable, does the student have an up-to-date Criminal Records Bureau Check?	Yes	No	N/A	
Is the student aware of how to respond if they have concerns in relation to safeguarding?	**Yes**	No	N/A	
Anonymity & Confidentiality				**Areas requiring work**
Is the student aware of the confidentiality and anonymity issues their project raises?	**Yes**	No	N/A	
Do they have procedures for dealing with data securely?	**Yes**	No	N/A	
Have they informed participants of the limits of confidentiality?	**Yes**	No	N/A	
Giving advice				**Areas requiring work**

Has the student considered when participants might ask for advice?	**Yes**	No	N/A	
Have they devised a plan for dealing with these questions?	**Yes**	No	N/A	
If applicable, has the student identified where they might gain evidence that the participant has a psychological or physical problem which they are currently unaware of?	Yes	No	**N/A**	
If applicable, has the student prepared a protocol to deal with this risk?	Yes	No	**N/A**	
Withheld Information and Deception				**Areas requiring work**
Is the student intending to withhold information ?	Yes	**No**	N/A	
Has the student explained the need for any deception?	Yes	No	**N/A**	
Has the student considered whether revealing deception is likely to cause any discomfort/anger from participants?	Yes	No	**N/A**	
Has the student put a protocol in place for dealing with this which protects the dignity and autonomy of participants?	Yes	No	**N/A**	
Debrief				**Areas requiring work**
Does the student have a clear idea of the information required at debrief?	**Yes**	No	N/A	
Does the student have plans in place for participants to retrospectively withdraw after debrief?	**Yes**	No	N/A	
Has the student thought through how to provide support should it be needed?	**Yes**	No	N/A	

SUPERVISOR'S OVERALL FORMATIVE FEEDBACK:

Approved: This is a well considered and interesting study that seeks to open up a conversation about a sensitive topic area of relevance to play therapists and psychotherapists. All ethical considerations have been addressed. Ethical approval is recommended,

Resubmit: *work on the areas outlined above and resubmit to your supervisor*

Second comment

An excellent application on a very interesting topic. This application is thorough and all ethical applications have been addressed.

Agree

Supervisor's name: Maggie Fearn	Date: 12.11.19
2nd comment signature. Rachel Hoare	13/11/19

Appendix 2 Initial Letter (For Expert Interview and Semi-structured Interview)

Carragh
Belclare
Tuam
County Galway
Ireland
H54 ND80

Mobile : 00353 (0) 86 6012413
Email : quinn_sonya@yahoo.ie

Date:

Dear

I am currently carrying out research in fulfillment of an MA in Creative Psychotherapy and Play Therapy (Humanistic and Integrative Modality) with the Children's Therapy Centre, County Westmeath, Ireland. My research is an exploratory study into the inner experiences of child and adolescent psychotherapists when the phenomena of touch arises in play therapy sessions. The title is :

"What did I do?" - An Exploration of the Inner Experiences of Child and Adolescent Psychotherapists when Touch arises in the Playroom.

I am drawn to this topic because of my clinical work with children, both as a trainee child and adolescent psychotherapist, play therapist and an art therapist. I have been working therapeutically with children for the past 14 years. I am intrigued by incidences of touch which occur in sessions with children who have experienced loss, trauma and attachment difficulties. I am compelled also to understand the responses elicited in me by touch in the playroom. My own inner experiences will be explored through an autoethnographic peice in the research. I am reaching out to you as I wish to explore the inner experiences of other practitioners in the field of child psychotherapy, in relation to this often taboo topic of touch.

I am writing to you ---------- to invite you to be an expert interviewee/take part in a semi-structured interview on the topic. I would welcome your participation, as your clinical approach pays high regard to therapeutic use of self, drawing on the inner experiences of therapist to inform clinical work. This is the crux of my research and requires a high degree of introspection and awareness of transference and transference, and somatic experiencing.

The interview would probably last between 45 minutes to 1 hour and it would be audio recorded. Zoom/or face to face, would be the preferred method of contact. You would have the option to remain anonymous if you wish and the interview recording would be saved on a password protected file. I will be transcribing the interview myself and no third party shall be involved. If you agree to take part in the research I will forward you on the consent form to sign, and you will have the opportunity to see the questions in advance of the interview. You also have the right to withdraw at any time throughout.

I hope you will consider my request to be interviewed, however please do not feel under any

obligation to participate. Do take time to think about it, and if you let me know before the end of December 2019 that should be fine. If you wish to obtain any more information about the study to inform your decision, please do not hesitate to contact me either by email or telephone.

I look forward to hearing from you.

Warm Regards

Sonya Joyce. PgDip Art Therapy, PgDip Play Therapy.

Appendix 3 Consent Letter.

Carragh
Belclare
Tuam
County Galway
Ireland
H54 ND80

Mobile : 00353 (0) 86 6012413
Email : quinn_sonya@yahoo.ie

Date:

Dear

Thank you for agreeing to be interviewed for my research study entitled : "What did I do?" - An Exploration of the Inner Experiences of Child and Adolescent Psychotherapists when Touch arises in the Playroom.

- The interview will run up to one hour. It will be conducted through Zoom/or face to face, and it will be audio recorded.
- The interviewee may withdraw at any time and may refuse to answer questions, in which case the researcher will move on to the next question.
- The questions are open ended and designed to elicit responses that allow you to share your knowledge and experience.
- The researcher will keep charge of the time.
- You will have the option to remain anonymous if you prefer.
- The interview will be recorded and saved in a password protected file.
- The researcher will transcribe the interview herself. No third party shall be involved.
- If creative activities are used by the interviewee during the face to face semi-structured interview, permission to photograph will be sought.
- All files relating to the research data will be destroyed after six months of completing the study.
- You will be sent a summary of the research findings after the MA programme has ended.
- Time for contact to debrief will be offered after the interview should it be required.

On receiving your signed consent form I will be in touch about arranging a date and time convenient to yourself to make contact possibly in December 2019 or January 2020. I will send you the interview questions in advance of this so you can familiarise yourself with the themes of my study.

I consent to take part in the interview with Sonya Joyce, and I understand that I am free to withdraw at any time and am under no obligation to answer the questions.

Signed _____

NAME (in block capitals) _____

Contact Details : Email _____

Telephone (inc code) _____

Appendix 4 Sample Questions for Expert Interview and Semi- structured Interview.

The interview be conducted through Zoom and will begin with a short welcome and overview of the interview process. The interview will last up to one hour and will be recorded. The interviewee can withdraw at any time and can decline to answer questions, in which case the researcher will move onto the next question. The questions are open ended and are designed to illicit responses that will allow the expert to share her knowledge and experience.

Regarding the Semi-structured interview (which will likely be face to face), the interviewee will be invited to use creative means to access inner experiences or to explain or regulate throughout the interview. The creative modalities offered will be either sandtray and minatures or art materials. If used permission will be sought to photograph them at end of interview. Space and time to debrief will also be offered.

- What are your perceptions of the use of touch in therapy with young children.
- Do you have a theory-driven decision making model regarding the use of touch in therapy
- Under what circumstances do you think the use of touch is appropriate with children and adolescents, and why?
- Have you done any specific training in touch based modalities which inform your work as a child and adolescent psychotherapist.
- Do the messages you received around touch in your own upbringing, impact you now in your therapeutic work.
- Do you feel it is necessary to do personal work around this topic to be able to embrace it fully in the playroom?
- What do you feel would be the potential feelings and counter-transferences that could possibly emerge when working with children for whom touch as been harmful or absent.

Have you experienced somatic reactions when working with touch in the playroom

Appendix 5 Coded Autoethnographic Research and "Provocation Pieces" for interview.

Excerpts from Researcher's journal entries

~~The image of the incubator comes. The holes in the incubator where hands would be pushed through to change the baby, maybe to stroke a tiny hand, or side of the face act as a cold plastic barrier preventing real, warm human contact, with a mother. Will anyone come? When will anyone come? What will I do in between? Hold myself together.~~

The coronavirus hits. How long will this last? The uncertainty, the unknown feels unsettling, and familiar. I was never good with waiting. I need to know what's happening. ~~To be left in a void is unbearable but now I know ways to pull myself together.~~ To breathe. I am not alone. I own myself now. Not at the mercy of others...will they come?...when will they come? I'm self contained again.

~~I realise I need to look at my early touch experiences,~~ I don't know what they were in real cognitive terms, I don't ask. ~~But I think my body remembers, words like flailing, and images of swaddled babies appear and re-appear in my dreams. To be swaddled, held together in absence of human holding. Flailing (especially of arms and legs) "to move energetically in an uncontrolled way." My experiences are rather innocuous. My young clients have had a harder time. *We come with our experiences, with our "selves", whatever shape these little "selves" are in. Are they formed at all? We meet in the potential space of the play therapy room.*~~

Steadying Touch (Provocation piece for Creative piece and interview with M. Ryan)

The little girl cried. "He said I was bold". The tears flowed down her cheeks, the tears that cried for her mother, **for her great loss of any foundation which might provide her with a sense of self.** She was eight years old, but here in front of me was a baby. A baby who needed to be held together, a baby who needed to know she was worthwhile, accepted and loved, warts and all.

I couldn't just sit there and look at her cry. My tone was soft, our eyes connected, and I asked (awkwardly but not daring to proceed without permission) "can I put my hand on your back"? A nod, and deep eyes. I placed my hand firmly but softly as she sat close, but not touching. I don't know what I hoped for in that moment, I felt flooded and a bit angry, but when I look back on it, there was an immense need for touch. To hold back against my inner truth, and authenticity as a therapist, and as a person, would have neglectful to this little girl in this moment. The touch was firm, my hand placed flatly, unmoving, took up a large part of her tiny back. As I write, a memory comes… of holding babies firmly, to get their wind up, to support their internal workings. The connection through touch steadied her. I felt gutted to see how easily this child could disintegrate before my eyes, how fragile she was. The shards of sharp words had splintered her fragile sense of self which was only beginning to be born in *the potential space between us.* I told her **wholeheartedly,** she was **not** bold.

She blew her nose and said "it's stuck". She looked washed out, though a watery smile had appeared. She jumped up to get a tissue, then jumped around, I jumped with her. We did star-jumps. I was thankful for the inherent knowledge in our bodies, which showed us how to regulate. The moments softened, the tears were shed, and announced she wanted to use clay. She made a clay dinner.

"All they do is play football" (Provocation piece).

Back and forth the ball goes, back and forth... for 35 sessions...back and forth. Whack, wallop, thump, crash goes the ball. Cheers, victory dances, disputed scores, disgruntlement, jubilation, all the time checking safety. “Is this a house?”, “So if it’s a house are there bedrooms upstairs?”. “No, in this place there are no bedrooms, and nobody gets hurt”. And on it goes, back and forth but changes happen. Slowly. “Do they only ever play football in there?” asks the social worker.

I have a heightened sense of awareness, I notice for a few weeks a hand on my back, on my chest, a brushing past on my breast...in the throes of the game. I write in my notes of “accidental touch”. But I’m not sure. I bring it to supervision but hear myself insisting it’s accidental...but deep down I’m not sure. It happens again, and I cringe, and struggle but I name it. “It doesn’t feel comfortable to me when you bang into me when we’re playing football and it touches my body..my chest”. “Okay” he says. And it stops. No more of it, and a change happens in the therapy. The air is cleared, he asks can he move the furniture to make more space for the football...and for the relationship. Another test has been passed. No bedrooms….tick, she doesn’t respond to provocative touch….tick. **But what is this all about, I imagine he asks himself, what is this new ground I am treading on?**

I ask myself the same question. I notice after his sessions I have an urge to run. I feel jangled and jittery with nervous energy. He has never disclosed. He is holding so much. I am left holding too. I know I need to take care, and not carry the toxic energy of all that has happened him. I separate it from the child that he is. **The child that is allowing himself to be seen. Who is allowing himself to trust…albeit in miniscule measures.** I will not rush him. I rally against feelings of “what am I doing?”, I bring them to supervision. “Keep doing what you’re doing”. Relief.

Debs Dana’s words stick with me. I print it out and put it beside my desk. Like an ally, to defend myself against the pressures of outside forces, or the forces of doubt within myself.

Another 10 sessions pass, back and forth, Real Madrid, Barcelona, Arsenal, Chelsea, Young Boys (I feel uncomfortable). “**The boy’s a star”, he yells. He is empowered. Toddler football on our bums crawling around the room, playing football with baby voices and movements.** He **dares** himself to sing. “**Fuck you, and you, and you…I hate your friends and they hate me too”**. Venom and daring all mixed into one, an expression of something. I feel worried about the swear words, but deep down…glad. Something has changed, I feel a shift like a rivulet breaking through the banks of a strong river. The strong banks that have served to hold him together, but which have also restricted him. The one-way rushing flow of survival, not allowing for anything different, not trusting anything (or anyone) to break through.

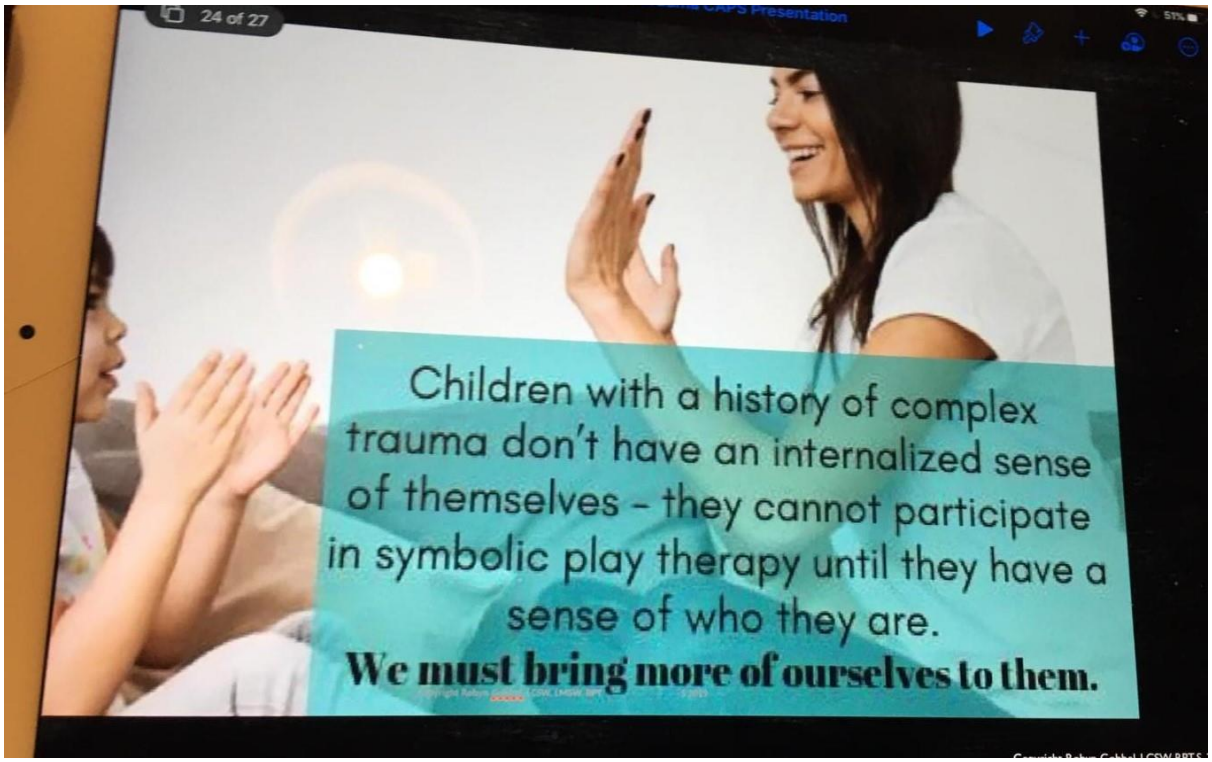
I bring music to the next session…just in-case. And yes, the music comes again, the rivulets break through, however it is too much. The force of the energy in the song makes me worry as I stand on the brink of the overflow. I knew it was risky, but I trust the process because I know it came from him. I struggle to strike a balance between expression and regulation. I wondered before the session about the risk of trauma memories at the sight of an adult with a phone, but I went with it. I did not let him see the phone until the music arrived from him, and then I facilitated it’s continuity. Would I have done anything differently? I don’t think so.

His words punched me in the stomach “Ya filthy bitch”. His feathers ruffled like a proud peacock. I grappled for words, but I knew the feeling, it was sick, it was shameful, it was utterly defeated. He knew those feelings, and now he was letting me feel them. I held onto my authenticity and said gently that it didn’t feel good to be called that, it really hurt. I reassured him nonetheless that I accepted, and even welcomed, all bits of him here. The angry bits, the confused bits, the raging bits,

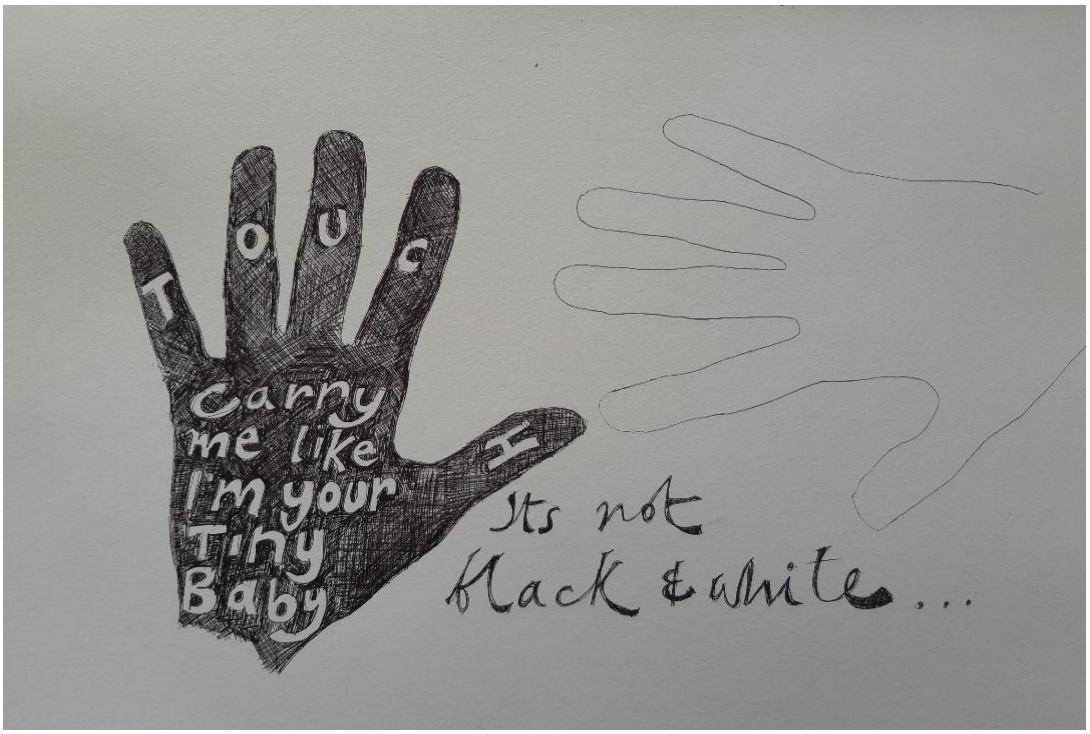
the sad bits. *This room was not like other places, he would never get in trouble*. I did not look for apology, and still he kept his feathers ruffled as he left the playroom. **He glanced at himself in the mirror checking he was still there.** We had both held together through this massive expression.

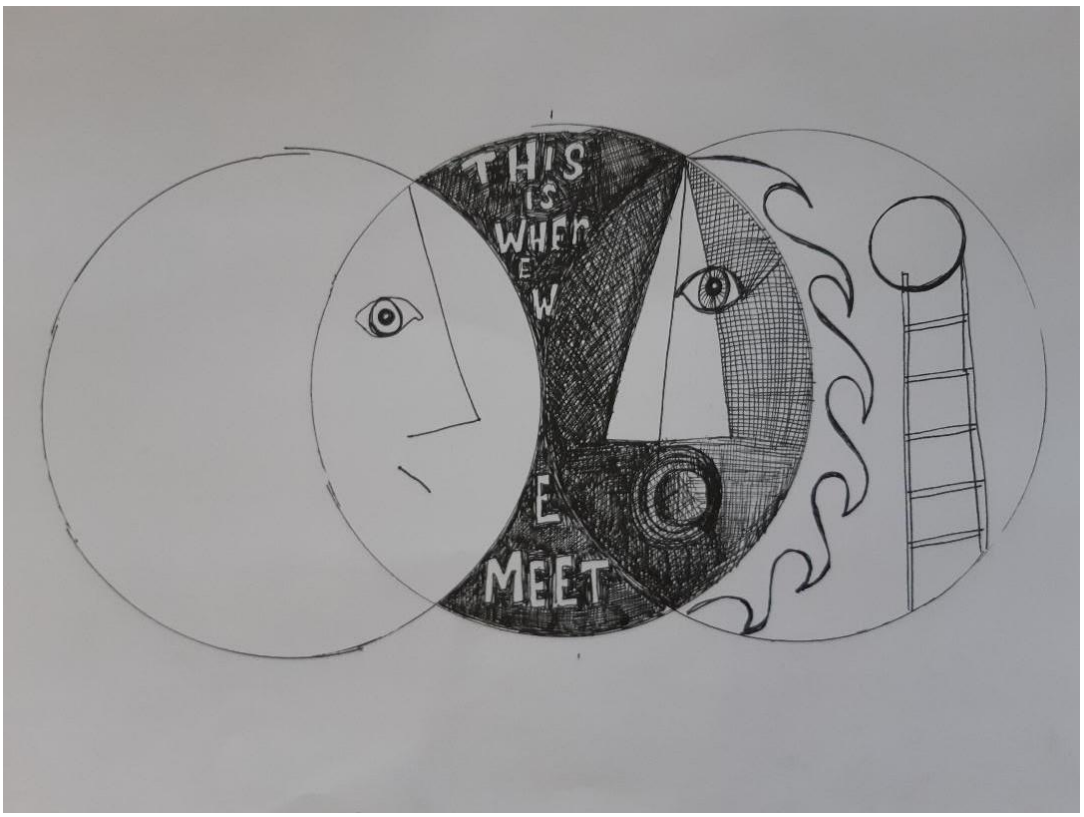
Another quote arrived at the right time and I printed that out too, to join the other guiding words at my desk!

Bringing yourself is hard, but sometimes that is all we've got in the confines of the play therapy space. It's like starting over. **Like the mother of a newborn, learning a new language of attunement, from which the emerging self is borne.**



Images from researcher's journal

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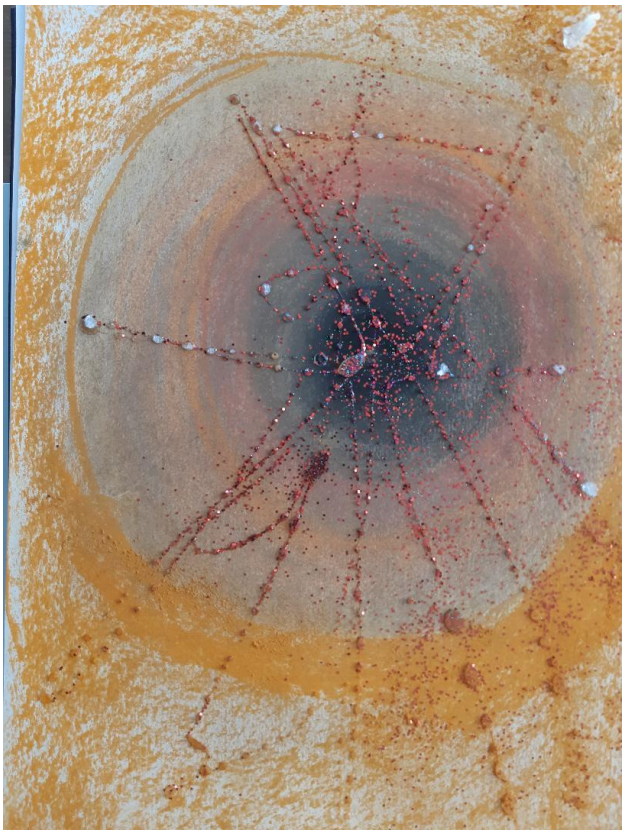
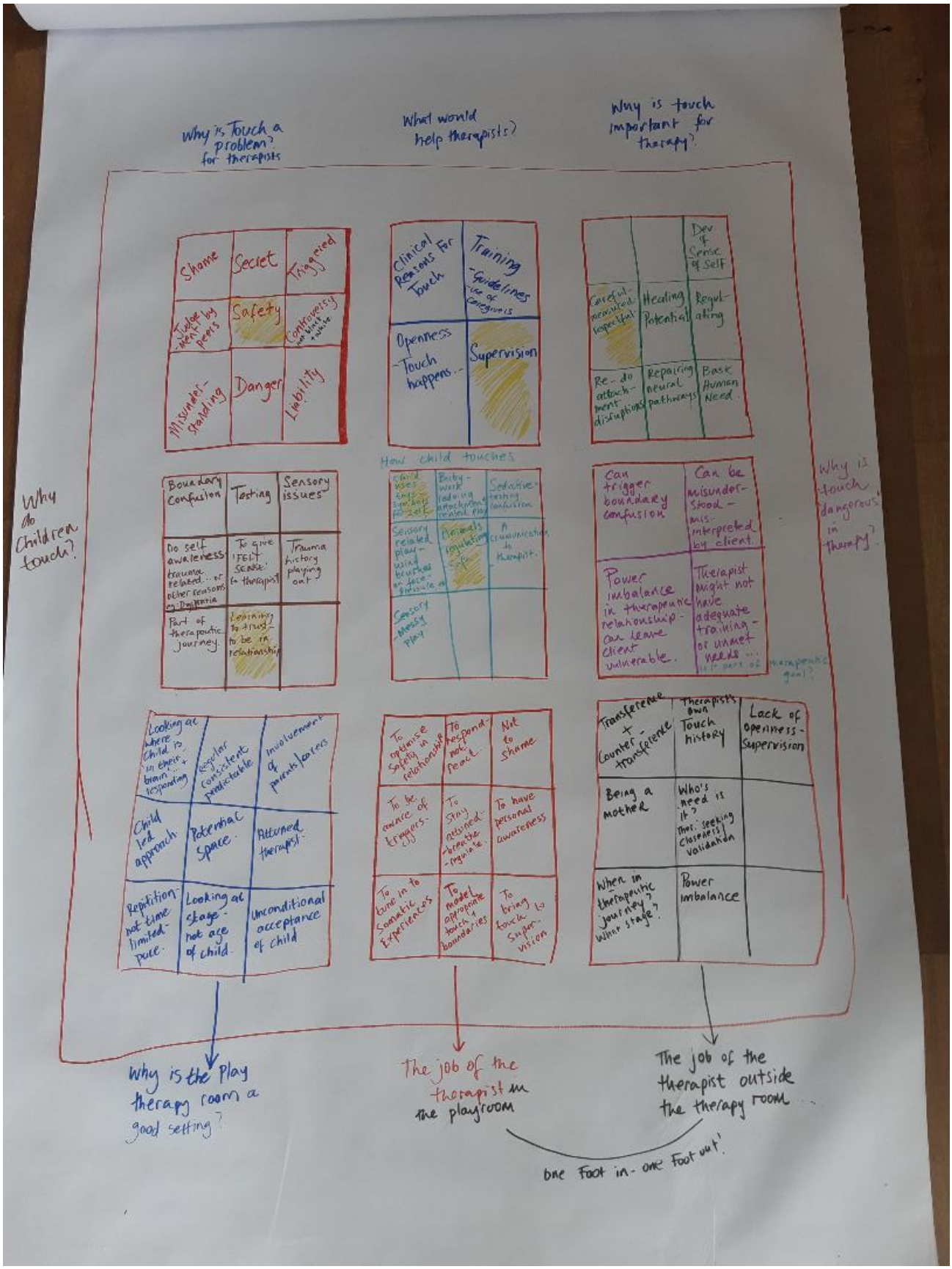
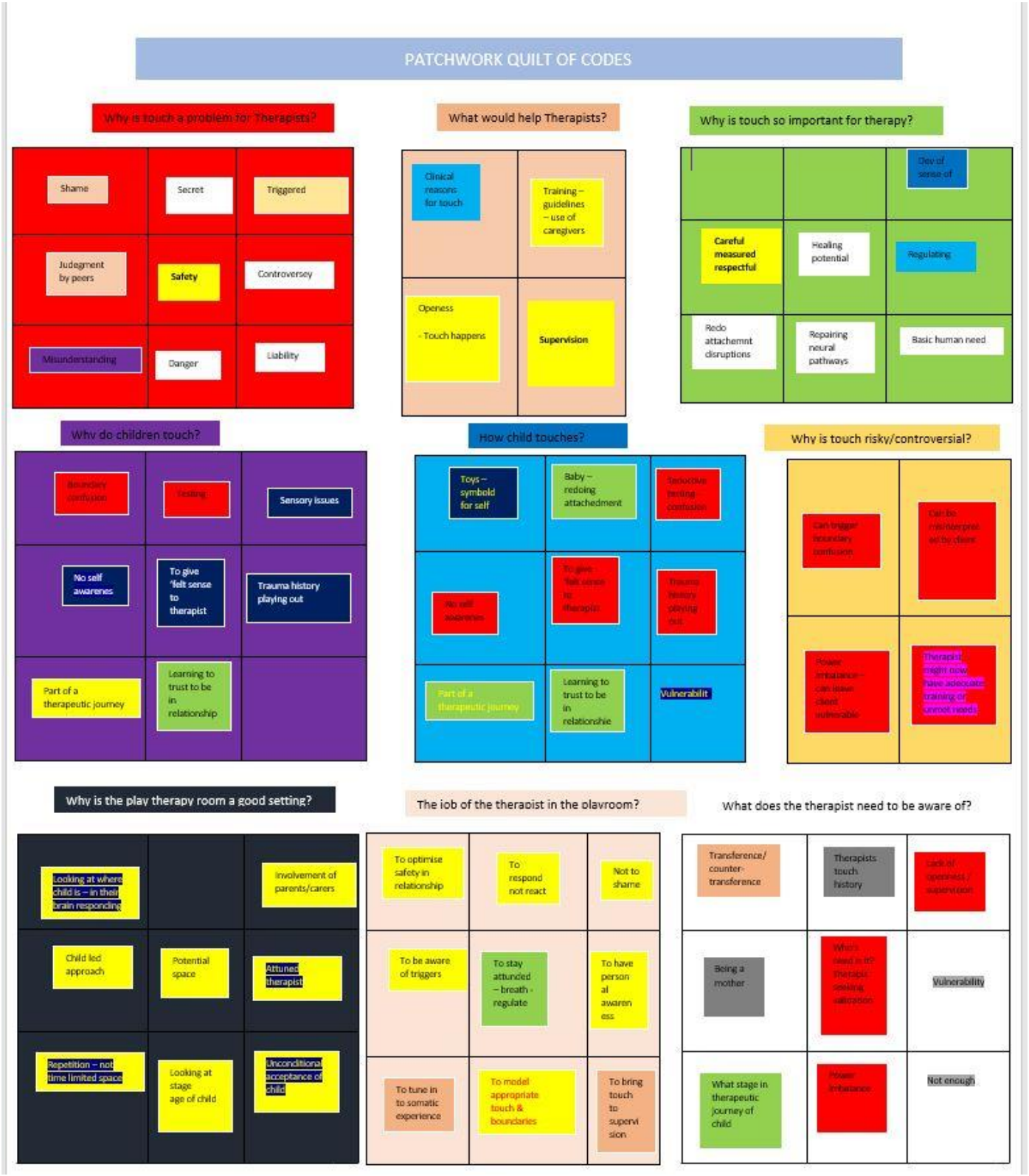
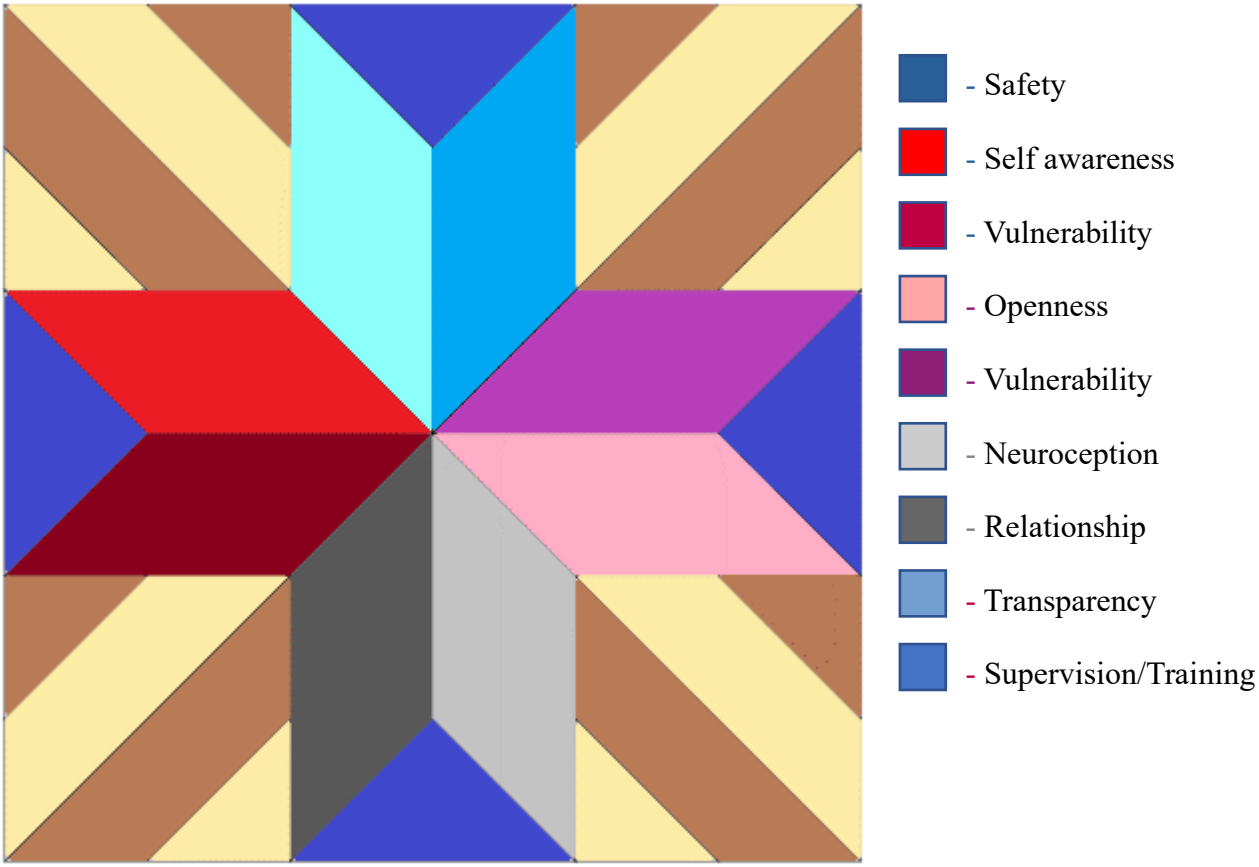


Appendix 6 Quilt of Codes




PATCHWORK QUILT OF CODES
Why is touch a problem for Therapists?
Shame
Secret
Triggered
Judgement by peers
Safety
Controversey
Misunderstanding
Danger
Liability
What would help Therapists?
Clinical reasons for touch
Training – guidelines – use of caregivers
Openess - Touch happens
Supervision
Why is touch so important for therapy?
Careful measured respectful
Healing potential
Regulating
Redo attachemnt disruptions
Repairing neural pathways
Basic human need
Why do children touch?
Sensory issues
No self awareness
To give 'felt sense to therapist
Trauma history playing out
Part of a therapeutic journey
Learning to trust to be in relationship
How child touches?
Toys – symbold for self
Baby – redoing attachedment
Part of a therapeutic journey
Learning to trust to be in relationshie
Vulnerabilit
Why is touch risky/controversial?
Why is the play therapy room a good setting?
Looking at where child is – in their brain responding
Involvement of parents/carers
Child led approach
Potential space
Attuned therapist
Repetition – not time limited space
Looking at stage age of child
Unconditional acceptance of child
The iob of the therapist in the playroom?
To optimise safety in relationship
To respond not react
Not to shame
To be aware of triggers
To stay attunded – breath - regulate
To have person al awaren ess
To tune in to somatic experience
To model appropriate touch & boundaries
To bring touch to supervi sion
What does the therapist need to be aware of?
Transference/ counter-transference
Therapists touch history
Being a mother
Vulnerability
What stage in therapeutic journey of child
Not enough


- Safety
- Self awareness
- Vulnerability
- Openness
- Vulnerability
- Neuroception
- Relationship
- Transparency
- Supervision/Training

Appendix 7 Codes for Thematic Analysis

Blue Therapist's reaction to Touch

Pink Need for training in touch

Blue Font Safety and danger in Touch

~~Font~~ Therapist's own relationship with trust

Orange Reasons WHY touch happens

Italics Touch as meeting point "potential space"

Purple font Clinical Reasons for touch – or not, why the therapist touches

Brown Font Touch with Toys/ objects in the playroom

Underlined HOW the child touches

Green Touch as healing

Yellow Controversy and fear re Touch

Power dynamic re touch – on side of therapist

Bold Touch in development of self

Red The importance of touch in early attachment

Green font Early developmental trauma linked to touch

Red font Being a mother and touch

Appendix 8 Expert interview with Janet Courtney

Interviewee : Hi good to meet you.

Researcher : You too Janet, thank you for taking the time. I was reading one of your pieces of research, published in 2014, "Experiences of Developmental Play Therapy and Implications for Training in Touch" . I was struck by in that research how the participants were moved emotionally by the whole experience, it was quite moving even to read it.

Interviewee : Oh really..

Researcher : Yeah….I suppose it's just how people who, have left a lot of their early touch experiences behind, or maybe they're not used to it in their day to day lives, how the exercises were so impactful, and even the lullabies and the rhythms

Interviewee : I went into it without any preconceived notions about what I would get out of that research, so I think I'm glad that ~~I asked the question about their qualitative experiences, what were you thinking and feeling, what was your overall experiences, but I asked them did this remind you of any of your childhood attachment relationship experiences, or any of your experiences now. I'm glad I asked that question because that question revealed to me just how powerful, what I thought were quite benign exercises of touch, or holding hands with someone for 3 minutes would have deep just in that three minutes, one being a giver and one being a reciever, and how not to take that lightly...bridging that to the play therapy sessions and play therapy room...how much of that is unconscious material, so that's where I realised we've gotta really start addressing potential countertransference that can emerge for the therapist unaware when touch experiences happen in sessions. Could be that they haven't looked at their own issues around touch, how they were touched, you know we've all had human experiences, some people have been abused or sexually abused and you can go into this work because of that. But how much work have we done on ourselves, because if we don't that could cause potential harm.~~

Researcher : Yes. Well that's kind of the crux of my interest in this topic because I work with very vulnerable clients, and when touch comes into the playroom it really struck me, and I had to examine what happened there? So it takes a lot of introspection and I wanted to broaden it out ...to open up the subject with colleagues about touch in the playroom. It seems so many people are afraid to talk about it.

Interviewee : They are afraid to talk about it. There is a study which I think I listed in the 2014 article, but there was an Irish qualitative study, what they said in that research, when they were trying to interview practitioners, it was hard for them to even find practitioners because there was a lot of anxiety and nervousness about this topic. I mean it really is, and I will say to you, that as I was writing my book, Touch in Child Counselling: Ethical and Clinical Guide, what we found, and what I knew was true going into the book, and that's why I knew it would be like filling in some of the gaps in the literature, what I did know there was a lot more literature around touch related to adults. There was very little literature related to touch and children, and so I had these beautiful, wonderful authors in the book who were writing their chapters, I was recieving these emails saying "I'm not finding a lot of literature on this topic", and I said "Yeah, I know!". They were saying I'm seeing it for adults not for children.

Researcher : And as I've heard you say, or I've read it, there's so much touch that happens in the playroom. You can't be with a child without touch happening .

Interviewee : Yes it happens, that's the thing. Practitioners say "Oh, I'm never gonna touch the child", "Well hey, guess what touch will happen whether you want it to happen or not. Because they will step on your toe, or they'll pass you a crayon your hands will touch, or you're moving in the

playroom and your elbows will hit each other. There's always some type of issue related to touching, or the child will be hitting you or attacking you in some way, and a lot of times it's really unexpected. And then there's the different kind of touches where the therapist initiates touches, or the child initiates touches, somewhere like, "can I have a hug?" so there's some co-operation and you may have a little bit more control over. I think it's just wise for us as practitioners to examine all the different ways it can show up, just so that it can be there to prepare us all.

Researcher : Janet tell me, so you trained in Developmental Play Therapy and you created FirstPlay after that and Kinesthetic storytelling. Was that the sequence? Did touch happen for you in the playroom in a non-directive, child-led way first? And did that lead you then to go on and train in more purposeful touch...or what way did it happen?

Interviewee : Well, I do have a long story and I'll give you the short version.

Researcher : I'd love to hear it.

Interviewee : This is a really good question and I love talking about because I think to understand FirstPlay at all, we need to go back in time. The way I want to explain it is...I originally started working in foster care and adoption and I was working with infants mostly, babies and really young children. I was very fascinated and the agency I worked for understood a lot about attachment and bonding, and that's when I was introduced, not just in graduate school, but also in my work setting on how do we build attachment, what happens when there's disrupted attachment, how do we help to heal that. At he same time I was also learning about play therapy , in the 80's now. I think the 101 entry into play therapy is client-centered play therapy, where we're learning more about the understanding the "Dib's in Search of Self", Axline approach, and it's beautiful work it really is . Well in 1993 this is when my paradigm shift came about and changed my life forever and I didn't even know, I attended my first play therapy conference with the Association for Play Therapy. And while I was at the conference there were three different trainings that I went to that helped me understand my work with children, older children, not just young ones. Since I had been working with the babies I was drawn to Viola Brody's approach because it was talking about attachment and all of that. So when I went there it was kinda like, I felt like such an alien, what she was talking about was not the toys or the themes, but what she was talking about was the kind of play that **came before, t**he pre-symbolic play. So the pre-symbolic type of play that just happens between a parent and a child where theres no play items, it's the first type of relationship, it's the first type of play that children have in life...FirstPlay. Back to this moment where I'm in this workshop with Dr. Brody she was talking about her approach using the word touch , so as I'm sitting there and she's talking about the importance of touch, and how touch is the change agent of how children need to **develop a felt sense of self and a bodily sense of self,** so I raise my hand and said "Dr Brody", and she's like "Yes?", "What about the concerns about practitioners touching children?" Now to understand her answer you have to understand the time frame, she was eighty-six years old by the time I met her. She'd been working with children back in the 30's, 40's right up to the 80's and back then it wasn't such a big issue and concern about it in society's mind about therapists touching children. But in the 1980's then there was more of an understanding when people working with children abused these kids ...coaches, teachers, therapists it really came to the foreground. And that is a really good thing, and I wish it could have happened earlier, so we could have had more solid ways about how we could screen these people who were coming in, because basically the only people who touched children in these ways were paedophiles . Her answer though was "Oh I never had a problem with it". So then I was very interested in Developmental Play and I attended her trainings, and she came to my area and put on trainings and supervision, so I really learned this work, I really got it. She was on my dissertation commitee and she died in 2003. After she died I felt a strong pull that I needed to carry on her work because I knew how valuable and important it was, and how children really can change through this work, and as I began teaching it then I started getting the same questions, "Dr Courtney" "Yes?" "What about the concerns around practitioners touching children"? And then I started realising , this is so true, this is a problem. If I can develop a

model where we can understand how important touch is but we understand the concerns of liability, because that's real, and we work so hard for our credentials , that God forbid you hugged a child and they misconstrued it and they say some thing, like you know, that never happened, and that could come back to you in a really negative way. So anyway, I thought ..we know about touch and how powerful it is, and how healing it is, and transformative, so what if I developed a model where we used the available care team, caregivers to provide the good caring touch to the child, so it's the foster parents, the grandparents, parents and so on, with someone to guide them in attunement, so they learn to attach and bond and teach them those FirstPlay **type** activities and also to do it through storytelling, so that was how I combined the kinesthetic piece with the storytelling. So anyway it just evolved that I had been involved with **Eriksonian based play therapy and my work with Joyce Mills, and storytelling and also understanding Viola Brody's approach**, so I kind of moulded those two and together I say they're like the peanut butter Reece's cup, the chocolate and the peanut butter taste good, the therapeutic story telling with the kinesthetic piece. So basically what I did was develop it for two different developmental stages, one is for the infants, and that is birth to two years old, and the other one is like two or three and above for the kinesthetic story telling. It's the same thing that we're doing with the older children, like we're modelling on a stuffed animal, and with infants we're doing it on a baby doll. So I model on my baby doll while the parent touches their own baby. So we have story telling plus in connection to that they learn that they develop other games.

Researcher : uh huh

Interviewee : There's the baby tree hug story, and for the older children, like there's ready made stories, and also we teach FirstPlay. I break it up into three different levels for teaching knowledge, I'm glad that (inaudible at 27:42-43) if I'm teaching it on line which is really hard, so it's different. It's much better if you can do it in person, I'm playing with that for myself, learning to do that...distance learning versus in person...in person reflecting consultation online so..it's, it's tricky

Researcher : Yeah

Interviewee : to do it

Researcher : I'm imagining it's tricky when it's touch

Interviewee : Exactly, because if we're you know, together then, and I will say by the way , for the older children another underlying literature support that I use for the kinesthetic story telling is, I turn to the peer to peer massage that's happening in the UK and in England too, I'm not sure if you know Jean Barlow. Are you familiar with her?

Researcher : No

Interviewee : Jean Barlow and her child to child peer massage programmes in the schools, so you can probably look her up, I think she lives in Manchester.

Researcher : O right.

So when I was in England I got to go over and hang out with her, we're friends. Actually in my Touch book she and David Palmer wrote the chapter together, chapter 15, it's about the schools and massage

Researcher : Yes

Interviewee : So you go back to the book and you'll see, then you'll learn a little bit more about how they're doing that within the school system, you can borrow some of that too for the kinesthetic story model.

Researcher : Sounds like the models were kind of born out of the culture of the time, the 80's, the fear about being sued around touch, it was a lovely kind of evolving from fears around that, and also bringing in the primary care givers which is the way to go really, isn't it. Emm

Interviewee : So in the 90's I was actually using storytelling in Eriksonian work as a separate modality and intervention and then Viola Brody's , you know, because I used them as I needed them and then, so then after Viola Brody died

Researcher : O yeah

Interviewee : that's really 2003 , that's kinda when the conceptualisation of putting those two modalities together came about, it was already in place when I was doing my dissertation, you know I started my doctorate in 1997

Researcher : Uh huh

Interviewee : (Laughs)...it took me a long time to get through cos I was teaching at the university and it just added to the expansion of getting my degree done . It was all good, you know, I learned a lot

Researcher : Emmm it sounds like it's your life's work really.

Interviewee : Yea didnt know that when I signed up, you never know where you're going (laughs).

Researcher : Uh huh, yeah. Emm would you feel that therapist's have to do a lot of their own personal work around touch to be comfortable with it, to help watch out for the countertransference, and you know, to mind themselves in it?

Interviewee : ~~I think you know 100 per cent that therapists need to have their own personal therapy. period.~~

Researcher : Yeah

Interviewee : ~~Whether we're just talking about the issues of touch or because of issues, like they're stuck in their anger with their mother, that we still need to. Like their are different reasons why we do it : one, I need to feel what it feels like to be the patient,~~

Researcher : Yeah

Interviewee : Number two that I do have areas that I didn't even know. When I started therapy back , I started when I was twenty-five I think, I had no clue that I had so many issues that I needed to work on (laughs).

Researcher : (laughs) yeah.

Interviewee : ~~I mean really (laughs again). So it was good, but I needed it, for sure. It helped me grow and deepened my own connection with myself and helped make me, at least I think, a better therapist.~~

Researcher : Yes, yeah. Emm

Interviewee : ~~I must say if you're using a touch based therapy as an intervention I do think that has to be priority, the countertransference of touch, you see what I mean, that is a must~~, I want to answer the question that way too.

Researcher : Yes, I think it is a must. And also I think there seems to be a lack of emm, training around touch in some of the courses aswell, again there's that kind of fear. In my course for example there's not much around touch which is surprising because it is a very good course and it's very introspective and all. But in a lot of courses touch isn't mentioned that much, and I'm finding

that surprising in this day and age really. The controversy still goes on and on, doesn't it really, around touch.

Interviewee : Yes I think that's very true but I do think it's changing and I'd like to think that I'm one of the people that is bringing that growing consciousness about touch to the table, that we can make it an open conversation, and not not documenting about it in the notes because you're afraid that that might come back to you in a certain way, or where talking to your supervisor about it seems to bring a lot of anxiety ..and therapist's and practitioners just deciding about the work (inaudible).

Researcher : I was reading something that Eliana Gill wrote and it was something about the child sitting on her lap, but she wrote in brackets I did not put that in my process notes, you know someone even as wonderful as her like still had that "I didn't put it in my notes" you know...

Interviewee : Yes she actually wrote that for the forward of my book

Researcher : O yeah

Interviewee : Yes and I really appreciated her honesty in that, she's so transparent and she models by being so real, she models that for all of us. To take risks like that to be able to say in a book, to admit that, she allows herself to be open and vulnerable in some ways. You know that pays off I think, a lot.

Researcher : I think we all have to be open and vulnerable when meeting our clients aswell so that it's a genuine kind of meeting, we're not always experts, we are all in it together in a way, you know.

Interviewee : ~~**That's the humanistic point of view, and that's the difference between the humanistic stance. They recognise, I'm human, you're human, we're all in this kind of together, we're all serving it out and I'm not the expert but I'm here to assist you along your path and I'm working on mine too.**~~

Researcher : Yes it's really important that we work on ours too. And yeah it's great that there are so many different trainings now that are purposefully looking at touch, like your own trainings, and theraplay, even though I say it doesn't seem to be present in some of the general play therapy trainings, you would nearly need a module on touch I feel within all trainings.

Interviewee : Oh good, I'm with you on that.

Researcher : Because children touch, there's no getting away from it, and children need touch , so I think we, you know, really need to be comfortable with it, do use it purposefully and integrate it, and just get away from that terrible fear that people have around it, because it's so healing.

Interviewee : It is healing, it's important to recognise that. I've trained in Reiki, I wanted to learn more about **Reiki** because it's a healing touch type of modality, but I wanted to understand touch from all different points of view, you know what I mean like, understanding it as a healing modality, also you know, working with children in sessions how in reiki do we provide that, that insightful touch. There's reiki 1, and reiki 2 and reiki 3, so anyway that was helpful to me. You think of society all along in ancient times they talk about the laying on of hands. That just happened historically, there are many different (inaudible) as a modality, now we can get a massage, but we had that years ago too.

Researcher : Janet have you any particular thoughts on working with children who have experienced unsafe touch, or neglect and lack of touch? I think you said that children who have experienced unsafe touch, some people will say "o no we can't touch them, they're too fearful, but

they are precisely the one's who need to rebuild those neural pathways around touch, but it's a very tentative precarious area.

Interviewee : Yeah, right, it is a fine line, there are practitioners, authors who wrote the chapter in the Touch book about children who were sexually abused, I really think they handle the question very well, and hi-light how we approach ethically children who have been sexually abused. I actually learned a lot from that chapter that they wrote for the book, but I always go back to...cos sometimes people think..they do have a fear for the child that comes to the sessions and they've been sexually abused, and that maybe they're more heightened in the concern of liability of touch with that child , and certainly some children that have been sexually abused can adopt sexualised behaviours, to where...especially if they're working with a male therapist or something...it's not their fault, it's just what happens, it's the trauma, it's the child's transference onto the therapist, so how do we set ~~good, safe boundaries with that population ourselves okay like we're sitting..you can't sit on my lap but you can sit next to me, if you're~~ gonna give a hug we're gonna give side hugs and not maybe frontal ones. And that goes back to all the mediating factors like the age of the child, what was the abuse, who was the abuser, you really have to take in all the different angles, all the mediating factors that affect that particular child. Now then I think too, well if I was a child and I had been sexually abused and then I um...you know...was going for therapy ...what do I need, you know, somebody not to touch me or hug me, or show respectful touch to me, I mean...are they going to avoid me, you know, how to set healing for me, do you know what I mean? You have to think of **that child,** because that child might really be the child that needs it the most, needs the good, caring, respectful touch the most.

Researcher : Yes

Interviewee : So it's like we're depriving the child that needs it more than the other ones because we're afraid. It always goes back to how do we set safe parameters in a session with the child, to provide for some need in a good, caring way, meeting their emotional needs. I mean I'd a child asking for a hug, do I say "O sorry no I can't hug you", I mean that could be even more harmful for the child because they're getting rejected, that I'm pushing them away, so you definitely hafta have some training around that. Like this man that I worked with and he worked with children who were sexually abused, he would say that and think of ways to work with the child, like sometimes he would have some barriers , like actual barriers like if they were playing a board game, so the board game would be like an actual barrier. Or if he was sitting on the couch and the child would ask to sit next to him, he would get a pillow and put it in between them, so it was a natural buffer that was there.

Researcher : Did he do that discreetly, like did he build it into his way of being with the child?

Interviewee : I don't know did he do it discreetly or not , he said that...cos he worked in a residential setting, it wasn't like it was his office and there were people coming to him. So he , he was actually in a residential centre, and it was mostly girls that he was working with. said that when he started working with them he would tell them , ~~what I appreciated about him that he had to be true to himself, what his own comfort level was.~~ And he told me sometimes he would tell them sometimes you are going to come to me asking for a hug and I'm gonna be okay with that, and I'm gonna be able to give you a hug, and sometimes when you ask me I'm gonna say no. So I really appreciated that he in the beginning of the relationship recognised that he needed to set parameters for guiding that because he worked with older teenagers in a residential, so he had to set some really strong boundaries with them up front, but at the same time he was doing it and so maybe if something happened, he would say "well you remember when we had a conversation, you know, and I said sometimes I'll be okay with that and sometimes it's not, well this is one of the times when I'm not, but at least it set the tone for, ~~I'm not rejecting you, I'm just honouring how I felt, and I thought that was pretty genuine,~~ to be able to do that, I thought. And I really respected him.

Researcher : Sounds like learning a language of boundaries, to say sometimes I might feel like it, sometimes I'm not. And it's okay to say no. And to be authentic is so important.

Interviewee : (Inaudible) meant to them what they need to know, and I really appreciated that.

Researcher : So there's no hard and fast rules when you're working with children with abuse histories, you know, as you say you have to take into consideration every individual case. Their whole circumstances , and just be careful with it, really, I think.

Interviewee : Yeah we hafta be careful about it, especially if the children are highly traumatised, they do have some sexualised behavious, they may try to act this out. I actually did have a child , she was in a residential centre, so sad, it really was a sad situation, her mother was on drugs and she'd sell her daughter for drugs on the street, she'd use her daughter to get the drugs. So anyway the first session , of course I didn't know what I was getting into, when she came in, she didn't know who I was and she started undoing her pants, and I'm like, of course...she went over and she sat on the couch and she started doing...well...she wanted to hump. Thank godness they had the aide that brought her to the session so I had to go out and like open the door and say can you come in please, so as soon as she saw the aide she went like this....so I realised after that session, this is a child that I could never be alone with.

Researcher : Okay yeah

Interviewee : Never be alone with. Her boundaries were all over the place, she was so traumatised, She was 10 years old, so traumatised, (sighs), so traumatised. So then once I established that boundary, then the aide would always be in the room with me, then we were able to do a lot, traditional type of play therapy. She liked to do role plays.

Researcher : Uh huh

Interviewee : Anyway I don't think I could have gotten beyond that, of course I had to talk to her about boundaries and things like that (inaudible), then I just realised for my own safety and for the child's safety, emm, I just could'nt be alone. So I think that it's a good point that there may be (inaudible) that you may never be able to be alone with, to have another present with you.

Researcher : It's really sad to think their boundaries can be so all over the place, isn't it, that when they first meet an adult that they think that that might happen, that they have to do that.

Interviewee : That was one of the most traumatised I've ever met.

Researcher : I've met some like that aswell. It's very sad.

Researcher : You know I think that's all. I didn't go through the questions rigidly as such but I think we've kind of covered everything that I really wanted to know.

Appendix 9 Expert Interview with Lisa Dion

Researcher : I'm writing my dissertation on the inner experiences of therapists when touch enters the playroom, and I've been listening to your podcasts and I suppose so much of your work is around knowing yourself and your own internal experiences, and I really love that. So have you thought about it, and what are your thoughts on when touch enters the playroom, or have you had it much.

Interviewee : Absolutely and I've been like going through your questions. Yes I have thought about it a lot and I think it's an important topic, controversial in many ways. Touch is such a basic human need that yeah it's needs a really good discussion and I'm excited about this interview.

Researcher : Great. It does seem to be not really touched on that much, and in my own experience of working with children who have experienced sexual abuse, touch has come into it, and it's been so tentative. I've brought it to group supervision and its been met with discussion around breaking boundaries, or is it nurturing. It really brings up a lot.

Interviewee : Or is it repairing pathways and giving a new experience.

Researcher : So can we start and maybe go through some of the questions, if that's okay. Firstly what age group do you mainly work with Lisa?

Interviewee : So, two to twelve. Sometimes I work with the little, little ones but in that case it's really more of the dyadic work, usually it's mom and an infant, and there's a lot of touch there (laughs) when that happens but usually it's two to twelve.

Researcher : Okay. So…would you like to tell me a little about your perception of touch when working with children from two to twelve..

Interviewee : Yeah, absolutely. So as I was sharing..I think it's a really important part of therapy, and that's not to say that touch has to happen but sometimes it **does happen.** And I think it's one of those things that happens in the playroom that we **have** to talk about, just like aggression happens…or challenging play happens…touch also..happens. And there's reasons why touch happens so I think that it's important as a clinician that we understand **how** to use touch therapeutically with children, and **when** to use touch therapeutically with children, what it brings up in us…umm…who's needing it…is it the child, is it the therapist…who's need is it?

Researcher : Yeah.

For the touch I think that's one of the bigger pieces that warrants the discussion. And then there's the touch itself in the playroom, I work with a lot of children where the touch in their lives has not been safe touch, and so the only kind of touch they know…really the boundaries around their own touch is not necessarily appropriate, so they either get too close…or actually they don't touch enough. I think we have to talk about that too, not just that there is touch but for some kids there is also the lack of touch which is also problematic in some ways. And then there's also the use of touch, **how** the child touches. So does the child touch appropriately, does the child touch inappropriately…all of that is reflective of their process, what they're working through on their particular journey. And then the same thing is true of the clinician, they are also going to have their own experiences too. *So touch for me is a meeting point …connection between two people*…and there is a biological need…if we go back to babies…babies need touch. If a baby doesn't get touched, babies can't thrive. We know this from so much research, and so to say in the playroom don't touch the child might actually be going against a very primitive, biological aspect of our human nature that **actually needs touch in order to feel connected, that may need touch because it helps them know that they are in their body, it helps them feel their own emotional connection to themselves** so…em…I know I kinda went around the board because there are so many angles on this topic that are important to discuss. I guess what I'll say is, if it's needed, then it's needed.

Researcher : Yeah

Interviewee : And the question is how do we go about doing that therapeutically.

Researcher : Uh huh…and I think…what you said is so important, about whose need is it. You

know we have to know ourselves really well to know is it our need, and we need to examine our relationship with touch as-well. Do you feel that is important?
Interviewee : It's key. It's key. Yeah.
Researcher : Yeah.
Interviewee : I've seen therapists use it around…when they want to be closer to the child…so maybe something as simple as…they're asking for hugs at the end of a session, or they're trying to sit closer to the child, and it's not necessarily part of the therapeutic goal…that's being worked on therapeutically, and you can tell that the clinician doesn't want to say goodbye and is hanging on…or yeah there's a part of them who just wants closeness and validation in some way. They can get that validation through the hug, the physical connection in some way. And I think that you know, that's one category, and the other category is when there's inappropriate touch on the side of the clinician but what I even just talked about …what about the hug that often happens at the end of a session...you know that's a common thing but who's need is that really?
But I suppose if it's initiated by the child it's a very different experience, isn't it…the hug at the end of the session…
Researcher : Yeah
Interviewee : Yeah
Interviewee : Just as you're speaking I'm thinking…you're a mother, and I'm a mother, do you think that, kind of comes into it with touch with younger children. And I guess we very much have to mind ourselves in that aswell.
Researcher : I do. I was really thinking through some of the questions about…~~I love the question about does our own history with touch and our own upbringing influence~~,,, and I thought that was a really beautiful and astute question. You know I feel blessed that I was raised in a home where touch was very safe, and so I'm really comfortable with touch. Touch isn't something that I , with my daughter, think a lot about. Me and my daughter we touch a lot. She's fourteen, we still cuddle, you know some are like "eughhh get away" (Laughs)
Researcher: (Laughs) "You're lucky".
Interviewee : (Laughs) Give me one more year.
Researcher : I have a thirteen year old daughter and she's like, "eughh go away" (Laughs)
Interviewee : I try not to do it in front of her friends.
Researcher : But there is that motherly thing to be aware of, it is appropriate for me to be like that with Avery because of the relationship and the bond that she and I have, and so in the playroom, that for me is one of the guidelines is what is the nature of the relationship I have with this child. How safe is this relationship? *What are all the things that happen relationally between myself and the child that have let me know that touch would be appropriate,* that touch is safe, and that the child would be responsive to touch, and that the child's not going to misinterpret my touch. Just because a therapist has really great intentions it doesn't mean that it's going to be interpreted that way either. Just the way that Avery is not going to misinterpret my touch because of our bond, well I have children in the playroom with whom I have a strong bond, and I feel secure to know, and to trust that if there's a hug or if I sit closer……
One child that really came to mind, actually I speak about her in the Aggression in Play Therapy book, have you read the book?
Researcher : I have it right here, I haven't read it all yet.
Interviewee : Did you read the story about the little girl who's nervous system….she didn't know how to settle. Her nervous system wasn't able to settle and integrate.
Researcher : I don't think so.
Interviewee : I'll share this, and when you read it…
Researcher : Yes
Interviewee : A little girl who came to see me, she was adopted early on and she came to see me with a multiple diagnoses of Reactive attachment disorder, for ADHD, attachment issues…it was like a cocktail
Researcher : Yes

Interviewee : A cocktail of stuff. There was also suspected some earlier abuse, but not known what kind of abuse, there was a trauma history for her. This little girl her nervous system was …couldn't settle…she walked around the world in a pretty active fight or flight response, and part of what we worked on in therapy ..was simply to be able to rest.
Researcher : Emmm
Interviewee : To just be able to help the nervous system pause and just rest.
Researcher : Yeah.
Interviewee : Because her nervous system just lived in a trauma state, and as we were able to do that therapy…I mean there were many sessions where she would lay down on the couch or she would want to play baby, and there were times when I would sit next to her, and you know, I would ask her "can I put my hand on your back?" , and I would put my hand on her back and maybe I would sing her a song, or hum her a song, as she's lying there quietly. So that was a time when I did touch but it was very intentional and very purposeful, and it was done in the context of what I knew we were working on therapeutically. So knowing that my hand on her back, the safety and touch that had been built between us, that that would have been a repairing experience in her nervous system, I did not move my hand, I simply placed my hand, just to help her do what you just did...to take a breath...**and just to feel connected and feel her body a little bit more.** I think that it's important to look at it through these frameworks .
Interviewee : So using that example that wasn't my need in the moment, that was really looking at her progression in therapy, and feeling this would be an important moment for touch in the relationship.
Researcher : Yeah. That sounds lovely. It sounds really careful and respectful, and that you were...you know...helping her regulate, and small children so often need touch to do that.
Interviewee : Exactly. What was interesting was that she was actually twelve years old...but she was a baby.
Researcher : Yeah, yeah....
Interviewee : And she needed touch because she was a baby.
Researcher : Absolutely. It sounds like pace is very important...I don't know how many sessions you had with that child, but in my work I find pace is so important.
Interviewee : Yeah, I think the odds of me touching a child in the first couple of sessions is pretty low (Laughs). It is, back to your point, there's is a pacing, there's a timing. Part of what I also keep in mind is that if I'm gonna use touch I often use it in a moment when the child is demonstrating to me what I would call empowerment in the session, or they're in a process of a re-do of a pattern, so I don't tend to do the touch when the child is in the midst of the trauma work itself, or in the depths of the hard stuff. So with this little girl, she was resting...she had gained empowerment over not being able to rest...
Researcher : And to be able to rest with an-other sounds really important, even to allow herself to lie out...
Interviewee : Exactly
Researcher : So her system was a bit more organised in order to handle that, but had I tried to touch her in the very first session on my own..no.. however in the very first session we were playing and she had an experience with one of the dolls, and emm..., she was also on the spectrum as well, and she had a moment where she got like..."oh I gotta go, I gotta go" and she walked out of the playroom, and I walked with her , and we just proceeded to walk outside , and we just walked...and at the end of it she came over, and put her arm in my arm, and so that was her initiating touch, as an example and it was just me staying steady, like saying I'm here, *this is safe touch.* So in that session there was touch, in the first session but it was initiated by her. Now once again we were moving, we were back in the prefrontal cortex, the system had settled a little bit, we weren't in high activation. So I think that's an important thing for me when I look at touch, can the child handle it? Where are they in the brain? Where are they in the process? Are they showing in the moment that they can handle it, are they showing a moment when they're in their prefrontal cortex, are they in empowerment...I think that's a part too.

Researcher : Uh huh. And for example with that little girl would she have initiated touch much in earlier sessions, that was the first session and she linked her arm with you, but would she have continued to initiate touch?

Interviewee : Maybe just one other time, it wasn't a repeated pattern. But where touch was demonstrated ...we did a lot of baby work. So there was a lot of touch through the baby, so there was a lot of babies in my arms, and me rocking the baby, which we know is really her, and so in sense in her field of vision I'm touching her, right, I'm rocking her, I'm holding her, I'm talking to her, I'm being with the young part of her. And I think that can be , when we're talking about touch, can be a beautiful alternative for children who can't handle the actual physical touch, you can actually create nurturing experiences of touch through the toys, through the play, so the child actually sees you ass the therapist relating to something, to establish the safety.

Researcher : Absolutely.

Interviewee : And if it's the self object, even better.

Researcher : That's really interesting, I never really thought of it that way. Thy are testing the safety as you say, you know watching ..how does she handle the doll..or this little part of me. So speaking about touch initiated by the child, have you ever had any really strong somatic reactions to touch , and what has happened in your body when touch has come up that is maybe felt a bit like how do I explain this?

Interviewee : So for me, it's when the boundary isn't clear with the child, usually it's the children who have had...for whom touch did not go well in their experience, and that's what we're working on in the playroom, and so in my work as a clinician I'm a believer that there's a resonance that happens in the playroom between ourselves and the client, and you've probably heard me talk on the podcast about this concept of set up an offering of a call where the child will engage with you in a particular way that offers you a felt sense of what it feels like to be the child. And so the somatic experience I've had many times with the child who may try to approach me in a strange way and I start to feel..."oooohhhhh , something about this doesn't feel safe", or something about this feels a little off. Which is a beautiful way for the child to help me understand what that has felt like as-well. I think the skill of the clinician and the mindfulness of the clinician is so key to help really recognise what that felt sense is, what is that that's coming up and ~~if I have my own history with that I'm going to have to be more alert , more attuned to those feelings that are happening in my body, because there's an interplay between what the child is giving and then our own history that's right there in the present moment, and so to be able to regulate through that , and sit with that, and be mindfully present with that , so that our own defensive patterns don't kick in and we don't respond in a way that historically how we responded when that happened, whatever that may be~~. I've had that happen many times , I've had children who , even like the way they're walking towards me (Lisa imitates swagger), you know... and you're like "Okaay", and then maybe they get really really close. I had one kid that did that and he came over and sort of like brushed my hair (Lisa imitates this movement) in this sort of like, seductive way of course this provokes some kind of a response in me (laughs), but it's the difference...this is the key... I'll give you another example then I'll explain the key. Another child who had sexual abuse in his history, at the end of a session we were sitting on a couch and he had asked me to read him a story and so I'll pull out the book and as we're reading the story , the next thing you know, his hand is on my breast. Okay so we have this kind of a thing , a hand on my breast. If I'm not able to stay connected to myself in that moment , and work with my own activation, I'm going to react to the child, instead of respond to the child. And to me it's the difference of having that become a loving, compassionate, reparative moment versus adding shame into the child's story.

Researcher : Yeah...yeah.

Interviewee : It's the difference between grabbing the child'd hand and saying "We don't do that in here" or "that's not appropriate" ...which is the therapist's attempt to set the boundary but the shame that probably got integrated for the child versus grabbing the kid's hand and saying "there's a part of you really want's to be close right now...this is your way of trying to be close , I want to be close too, let's find another way where we can be close", "here maybe just sit a little closer and

have our arms touch right here". I'm basically saying you can be close but we don't have to be sexually close. This was the boundary confusion for this particular child. When a child does something like that...wow.. I'm not even sure how I feel about what just happened...I'm just gonna take a breath here, and just being present with it rather than adding in more shame. Because I feel like so much of our training as clinicians is that touch is bad, and that we have such strong boundaries and they make it like a black and white thing, just like transference and countertransference , its a black and white thing. None of it is black and white ...it's all very grey and I experience that clinicians, because they are afraid of what will happen to them, where they're afraid of the powers that be, loose their own attunement in the room, they loose their own intuition in the room and then they react rather than respond and they get confused about the child about why the child shut down, or pulled away and the repair has to happen, and it's a big repair.

Researcher : It sounds like a real tightrope to walk to really mind yourself so well in it to not react, and not to shame which is so important. It's reminding me of the podcast you did on Issues of Hygiene in the Playroom and the little boy who pooped himself, and again minding not to shame the child and in that case you were trying to educate the mum that it was the felt sense of the poo was actually comforting to him at one point in his life, and I guess that's a hard concept for people to get their head around. That's another thing around touch, the sensation of bodily secretions for the child who's had no touch and that was something for them.

Interviewee : Yes, yes. And as we're talking about touch another thing that I don't hear talked about often is children with sensory issues and touch , and I think sometimes as play therapists we aren't cautious enough at really looking for are there potential sensory struggles , it doesn't have to be because the child has a trauma history, maybe the child has a tactile sensitivity, and so touch that may seem fine may actually be triggering to the nervous system because it's too much. Even the hug, the pressure of the hug, how tightly you squeeze the kid or when we're talking about touch there are so many ways of creating touch in the playroom, the child putting their hands in the sandbox that's such an experience of touch, and even there so often we assume that that feels good for the child but sometimes it feels awful to the child, absolutely awful. So I think we also need to be aware of the child's sensory needs.

And here's another one they actually need the pressure. I'll give you another example...a little boy that I worked with came in struggling with a lot of anxiety, who really had a hard time connecting to himself, we're probably way past fifteen sessions in at this point in where we're going here, and he had a moment in the play where he was doing some empowering work. I have a lot of sensory objects in my playroom and he had grabbed a sensory brush and he was using it on his arms (Lisa demonstrates the movement) and I simply asked him would you like me to show you a way where that might feel better, and he was like...sure. And so, it was then me showing him different ways he could use the sensory brush, and then I purposely, *because he was tolerating that and because the relationship was open, I got him to extend his hand and I touched his hand, and put a little touch here (arm), and a little touch here (upper arm) helped him relax his sensory body*...and that was fifteen sessions in, and we're at empowerment and once again I know the relationship.

Researcher : You seem to use touch in a very integrative way. Is it mostly in a non- directive way, child-led way that you work...integrating purposeful touch into it.

I took a course by Viola Brody, Developmental Play, Viola wasn't the teacher I met, it was someone else taught the class and that's the course that put touch on my radar. I was watching these beautiful videos of Viola playing games with kids, with their fingers...she did a lot of stuff with lotion which today would be very provocative in some circles of thought. She really believed in touch, and that really got me thinking about the importance of it and maybe letting go of some of what I learned in graduate school (laughs).

Interviewee : There is such a culture of legislation and people afraid of getting sued. So Lisa did you do any other courses in purposeful touch? So you did developmental play...

Researcher : Yes I did Developmental Play and I'm also a certified Gestalt therapist, and touch is not something that is shied away from in Gestalt work. Even though we didn't have specific training in how to use the touch. It was very much part of the training and there was a lot of

conversation about...when do you, when do you not, but it was in a larger context, it wasn't necessarily about when do you touch, when do you not touch, it was more like part of the philosophy in so many ways. I'll just leave it at that that my Gestalt training was an influence for me around touch, making me ponder on it, and think of it in different ways.

Interviewee : Just something that has come to my mind about personal experiences of touch, I know that you have said that you're a twin

Researcher : Yes

Interviewee : Do you think that has made you more easy with touch, I suppose you have been close to an-other in all of you're formative years?

Researcher : Maybe? I mean I know I feel grateful that ~~I've had an external regulator next to me since I came on the scene, being a twin has certainly helped me understand that concept a lot.~~ Quite possibly...but you know, just as you say that, ~~another big one for me growing up was my animals. I had cats in my home, and there was a lot of touch with my cats, and I think the animals offered a safe place for touch.~~ A lot of the therapists I work with are also equine therapists talk about that, working with horses, some of the children, because it's an animal, obviously with dogs too, a child who can't handle the touch with the person, can handle the touch with the animal.

Interviewee : Have you ever found with any client's that you've worked with that you feel like blocking touch or you're fearful of the touch, or uncomfortable.

Researcher : It's with those children that I believe are offering me that felt sense of what it felt like for them and usually they're the ones with a trauma history , when my own internal radars are going like this touch isn't safe and so my own protective patterns go "Oh my gosh" this kind of touch doesn't feel good to me.

Researcher : And Lisa would you name that with the child when that occurs , I know the example that you said about when the child put his hand on your breast, would you actually name it, or do you just try and regulate yourself and then offer an alternative or would you kind of say, I don't feel safe with that touch or...

Interviewee : I think it depends on the child and it depends on the context in which it's happening. I think those kind of moments it's important that they're not scripted. I think for some children it's important to say "wow, I'm not feeling really safe right now, I'm not trusting what's happening around me" and I think the language is really important too because I'm not saying in that moment "you're making me feel unsafe" or "I'm not trusting you" . I really, really believe that the child in the playroom is initiating touch , and it's not necessarily appropriate touch , they're doing it as part of their therapeutic journey , they're not doing it because they want to freak the therapist out , that's not the intention behind it , and that part of our role is to help facilitate awareness about that , and so going back to make sure we're not adding shame , that's the trauma showing up and playing out, and how we help them navigate that landscape is huge. I try to educate the child about the felt sense versus making it a personal response, if that makes sense. It's not about the child it's about the felt sense right now that something is not feeling safe in my body, I'm noticing that my body wants to protect right now. I'm noticing...it's a beautiful level of awareness, and then there's some children that might be, like, a lot, too much with that child it may be saying more like "wow ...like I'd one kid who came up to me invading the space (Lisa demonstrates the child coming right up to her face) and I remember just saying to the child "I want to see you" "I want to see you, but I can't see you when you're this close, and I can't see you when there's so much touch but you're so important I want to see you". And as the child began to back away I said "O my gosh there you are, now I can see you". And it was a gentle way of saying "Hey buddy watch my boundaries and my space, this is really uncomfortable for me and I don't like this and I'm getting flooded and overwhelmed. It was a kind way of saying lets work on appropriate distance and boundary relationship. In order for me to be in relationship with you I need you to be right back there, but again it was done in a kind way that was gentle to the child.

Researcher : I'm hearing such a gentleness in your approach , it's really lovely. I suppose for the children who are avoiding being seen and being touched, they get that close that you can't see them. It's such a gentle response and so careful not to shame. I think that's really lovely.

Interviewee : I'm a huge fan of honouring and redirecting rather than using the word "no" in the playroom.

Researcher : And not retaliating, watching your own experiences so much that you don't jump to a retaliation response.

Interviewee : I know we didn't say this directly , I know it's implied but it might be useful for what you are writing, I think we have to be aware when we have a similar trauma history as the child we're working with, if I had a disruptive touch experience myself in my history, and a child comes towards me of course it's going to activate me in some way, look I'm a human being. I think the real importance beyond the responding rather than reacting is the recognising that the part of me in the moment that has been triggered or needs the protective pattern, is the part of me that's responding to the perception of a perpetrator, and so if I respond from that place I'm really setting the child up to be a perpetrator. I have decided in my head this child is trying to hurt me, this child is perpetrating on me energetically, and that's quite the message to give to a child who's trying to tease out their own past trauma, and so I think that's important for us to remember when we do get activated. That it's a child in front of me it's not a perpetrator, it's not my history in front of me, this is a child in front of me. I talk a lot about, in Synergenic Play Therapy of this concept of one foot in, one foot out, meaning I have to be able to feel it, I have to feel the activation to really attune to the child but I also need to be able to hold a larger awareness simultaneously , so in my work as a clinician, and when we're working with touch, and challenging moments of touch, can I notice the activation, recognise I have a historical relationship with the activation, mindfully take a breath in the moment and remind myself this is a play therapy session. This is a child in front of me working out their trauma. Can I hold that larger context otherwise I'm going to be swept up and I'm going to push back, or else I will then do something interesting with touch , or whatever I just have an unusual response of some kind. And then it's important to mention, if that happens there's always beauty in repair.

Interviewee : Absolutely.

Interviewee : I think sometimes therapists need to be reminded that sometimes one of the most powerful parts of the whole journey.

Researcher : Thank god for rupture and repair as a therapist and a parent (Laughs).

Interviewee : Exactly (laughs).

Researcher : It's showing how important it is to "know thyself" as they say, and have worked through your own personal process because it's really tentative and precarious to have that one foot in, one foot out, but I think being authentic is so important and that's why I really admire your work. Even you know, if boundaries are crossed I find sometimes you have to name it because you have to be authentic to yourself so that you don't go to a deregulated place with the child as well, but always to be gentle, and to not shame, that is the key.

Interviewee : Definitely, beautiful.

Researcher : Lisa I think we've covered most of the questions , I thank you for your time.
If anything comes up as you put this together please reach out, and I look forward to reading your paper

Appendix 10 Transcript of Interview with Majella Ryan.

Interviewee : I know you asked me to do some creative piece around what you shared with me, but I don't know what your looking for in that really, you know. Anyway, if you to go with what I did, I'll explain that to you.
Researcher : And Majella did you feel kind of unsafe in that in any way, that just from when you said you "don't know what you wanted from me", there's a kind of vulnerability in that ..?
Interviewee : There is a vulnerability in doing it and I think that's just a part of what I've written outside, but I'm not saying that in any way blaming you. I think it's part of that work anyway, like I think part of the process of it. There was a vulnerability, and I think that I don't know what you wanted from me was part of the process too.
Researcher : Yes.
Interviewee : I don't feel that in any way blaming, you know I'm not saying that in any way.
Researcher : I know.
Interviewee : But that was the first thing that came up on me.
Researcher : It's a very strong statement, isn't it, and it does make me think of clients that we've worked with "I don't know what you want from me."
Interviewee : Yeah yeah, that came in to it, and I can feel the vulnerability of that even as were talking now you know. So, I suppose, I went straight into that place, and I thought, okay don't think about it, just do the tray. So, I had no bother in the main choosing symbols. I chose an awful lot of symbols. If I made a tray normally I wouldn't chose so many. So, the tray is very full.
Researcher : It is, it's very busy.
Interviewee : Very busy. And that would be very unusual for me doing a tray. And yes, as busy as the tray is, I still couldn't find the right symbol. So as part of my process in it, and in particular when I say the right symbol, I couldn't find a nurturing symbol that I wanted. The nurturing symbol that I wanted. And I was furious about that, and I went to a place of, I have all these dark symbols, but I don't have light symbols. Or you know, I don't have nurturing or loving symbols.
Researcher : Yeah.
Interviewee : So I kind of had this feeling of what does that say about me. So again, I suppose the vulnerability. The darker side of the tray was much easier for me to find symbols for.
Researcher : And which side of the tray would you say was the darker side?
I**nterviewee** : I'd say the left side to me was the darker side.
Researcher : Okay yes.
Interviewee : And I felt the tray was moving from left to right. So, if there was movement in the tray I would say it moved from left to right. I did the left, I started at the left, and moved to the right.
Researcher : And do you think…when I look at the left I'm thinking of my provocation piece that I wrote. Do you think that would have influenced any of your tray?
Interviewee : It was very much based on that. Well it was also then, I suppose as I did it, I was thinking about, so it was very much this came from your provocation piece that you sent me. Like all of it came from that because I have symbol musical symbols as well because you talked about it introducing music. And I know he had said, "fuck you" and you know, I can't remember the words he used now, but angry words. But I was also thinking about kids who've had a lot of abuse in their history and a lot of neglect, and how that process is for them. And so, I was thinking I chose the symbol in the back left corner, of the skeleton nurse who looks anything but maternal or nurturing or caring with the baby, and the menacing character beside her. And then I chose, and I had a black…here… I chose…do you see the little symbol of the…that's like a little mummy, mummified.
Researcher : Which one is that?
Interviewee : In front of the nurse. Far left corner, come down…yeah that one.

Researcher : That little one in front of the skeleton nurse is a mummy baby is it?
Interviewee : Mummy baby yes.
Researcher : Okay.
Interviewee : Like a mummified baby.
Researcher : Oh yeah okay. They're very strong symbols. I can feel a very strong reaction to them…it's a "desperate start", that's what it feels like.
Interviewee : And when you think of mummified, all the layers of bandages, they're held together and protected almost in that way like. But if you're thinking about touch, then you ant get near the skin. In a way you can't touch them.
Researcher : Yes.
Interviewee : I think the stones with the words the "fuck off"…I might just look here… Interesting here Sonya, I just noticed that I don't remember positioning it here that way. You see where it says the "fuck off" that stone.
Researcher : Yes these two stones say "fuck off" do they?
Interviewee : No, this one says "fear". And do you see the pink one in front of it. Well I didn't realize I had turned it away. But what it says is "help".
Researcher : Okay, "help".
Interviewee : But the "help", is kind of unconscious….Turned away, okay, it's turned into that corner.
Researcher : Right, yeah.
Interviewee : So even in that it really fits for me. Cause even help would be too vulnerable almost.
Researcher : So it's easier to say "fuck off" and show a spiky side.
Interviewee : Yeah.
Researcher : There seems to be a story even in that left side from the birth to the child whose saying "fuck off" but really they need help but its turned away.
Interviewee : Yeah. The child is turned away. This one says fear, you see here, but when you turn that around, it says love.
Researcher : Oh okay. So, is that one black on one side and pink on the other?
Interviewee : Red on the other.
Researcher : Oh cause you can't see that side at all.
Interviewee : No, because you can only see fear, like you know that lovely Marian Williamson saying, "the opposite of love is fear", and how when we feel fear we can't feel love.
Researcher : Yes.
Interviewee : It's much harder for us to access love when fear is present.
Researcher : Yeah, it makes us unable to trust that there will be anything there. It really feels very relevant to the children that we would have worked with. It's that big leap of faith into trusting that there could be anything there.
Interviewee : It's a very big ask of kids, but I think the fear is there, but we have to acknowledge it and move into love. And we have to hold the love, and we have to hold hope, and I think what I noticed what I read in part of your provocation, is that you were holding hope. And even at times there may have been moments when you may not have been able to access that, where maybe fear did take over, you were able to settle yourself, you know you had the nice quotes that you were surrounding yourself to remind yourself of certain things that supported you and allowed you to hold hope I think.
Researcher : Cause the impact is big sometimes I think working with these children.
Interviewee : Very big yeah. And if you, feel it, you know, allow yourself to feel the full impact of it, it can feel like a lot to hold. And yet if you don't allow yourself to feel it well then I don't think you can do the work. So that's the dilemma isn't it.
Researcher : Yes absolutely.
Interviewee : Because we have to be able to use ourselves in it, cause if were not able to do that then were not really able to successful in it.

Researcher : And again that vulnerability comes into it, to bring it to supervision, to say "I'm struggling with this, what is this?" And especially in the area of touch. If touch happens in the playroom do you feel as if you can bring it? Have you done something wrong? Touch happens, there's no doubt about it.
Interviewee : Touch happens. And its the kind of touch. I mean you brought up two very different kinds of touch. So, you brought up touch that is the nurturing supportive touch and making contact with another to soothe. And you brought up the so called, accidental touch, like the sexualized touch that the child is bringing, as they are trying to make sense of this relationship with you. They're two very different kinds of touch that can appear in the work.
Researcher : Yeah, I think I read a quote, "touch isn't just black and white", and it's definitely not. There's so many different types of touch, and there's so many layers within every touch.
Interviewee : Yeah and then there's the whole permission and consent piece of touch. And I might be comfortable with different things in terms of touch, in comparison to what you're comfortable with.
Researcher : Yeah, it's our own personal story around touch that colours what were comfortable with.
Interviewee : Yeah that's right. But I was also thinking about a lot of these symbols here Sonya, and even as were talking I'm thinking about them too, about how, and I put in the "I am ugly" one, because I was thinking of how you talked about the shame that had arose, I think did you name it as shame? Something that arose in the session, after he was calling you names, and you mentioned shame. I took shame from it anyway. So yeah maybe I was left with something around that. And that symbol I put in was to represent shame I suppose.
Researcher : Yeah, where is that one on the sand tray Majella I can't figure that one out.
Interviewee : You see where "fuck off" is?
Researcher : Yeah, beside that?
Interviewee : Yeah.
Researcher : And is that hope beside that?
Interviewee : Yeah, and that one next to the hope here in front is a candle illuminating.
Researcher : Okay. So there seems to be a bit of a journey going on from this darkness to a little bit of hope and light.
Interviewee : Yeah and what I was thinking was that this darkness is also the darkness in us as therapists too, so we end up holding some of this for our clients. This is touching off our darkness and it's about owning these parts of ourselves. Like I'm not saying this for you, but there's many times in the work place I may feel like saying "fuck off, and leave me alone" or "don't touch me" and "get away from me". And that they would not just be part of the clients, they would be a part of the client's process, but they would also touch parts of me. Deeper darker parts of me... that would want to own that place too.
Researcher : Yeah because it's a two way process, there's two people in it. It's that meeting place of two people.
Interviewee : And it's all co created isn't it, were co creating that space.
Researcher : So is there any kind of journey in the making of the sand tray, what way does it go? You kind of start it on the upper left?
Interviewee : The video of me making it might of been helpful...
Researcher : Well that was something we lost but i suppose with all our to-ing and fro-ing with COVID 19, that couldn't be helped.
Interviewee : It just didn't occur to me to video it.
Researcher : Well I didn't think to ask you either, I kind of thought, we will do what we can with it.
Interviewee : What I realize now is it would of been helpful cause I don't remember exactly the sequence of laying the figures. What I can tell you, the bulk of the figures I chose before I started to lay them. So, I chose most figures. And the ones I went back for were the bears in the boat, the monkey, the little mice beside it, and this little warrior figure here on the far right over with the

yellow hair. I went back and chose those at the very end, and they were part of my quest. I would have loved some kind of mother and baby symbol, like a nurturing symbol. So I didn't have the symbol I wanted in my head.
Researcher : Was there something from these symbols though, that you wanted at the end?
Interviewee : I think it was about connection, with the family, and fun like if they were more playful. Like the two mice and they're quite playful characters. And I thought the gorilla or monkey was a mother baby kind of symbol.
Researcher : Okay, so that's a little monkey on the back is it?
Interviewee : Yeah. so I was looking for more nurturing symbols. But out of the dark side I chose musical symbols cause you had talked about music. And I chose an artist pallet to represent creativity. So music and creativity. You see the big dark figure here in between the baby and the cot. That's actually a lighthouse. So, again a symbol of hope for me that despite all the darkness there is light and a symbol of hope.
Researcher : So there's light and creativity and hope coming in in this area.
Interviewee : And there's also an owl for wisdom. I also put in a couple of baby symbols. And you see that symbol at the back, the pheonix. That's actually a baby feeding on a mother's breast.
Researcher : I'm struck by you saying you couldn't find the right symbol of nurturing. And yet when you describe a lot of them symbols, there is a lot of comfort in some of them symbols. There's playfulness, there's companionship with the two bears, there's the mother and baby, they all feel really nurturing, so I'm struck that you couldn't find something that was enough for you.
Interviewee ; Yeah and that's very telling that I couldn't get to the nurturing piece that I needed, so even though I found some I couldn't get what I needed. But I don't know if that's part of that child's process, or your process in some way, or just my way of thinking it and maybe all of the above.
Researcher : Just what I'm thinking from the beginning about a desperate start you know you can bring all of this stuff to it, but the desperate start is hard to overcome. Like is anything to me ever going to be enough?
Interviewee : And will it be enough, and will it be experienced as enough, and will it meet in the right way?
Researcher : At the right time and with the right person.
Interviewee : And yet there's hope, there's the word hope, there's the candle, there's the lighthouse.
Researcher : And is this a bridge in the middle?
Interviewee : Yeah., so the bridge is really connecting the two sides and for me is symbolizing the journey. But, also here at the front I have an owl which for me would symbolize wisdom. I have the creativity, I have the hope in the candle but I have pain. Cause as soon as you open yourself up to hope comes pain. So, its not that simple.
Researcher : And what's this bit here?
Interviewee : That's a smiling heart, while back here I had a black heart, hence the journey here to a happy heart.
Researcher : I'm really struck by this symbol of the baby in the red bed, it's very striking.
Interviewee : I did go back actually, I had a lot of little baby symbols they came in a set. And they're all in different poses, but I chose that one in particular because there's something very vulnerable with that baby with its arms out stretched. And that bed is actually a hospital bed from a medical set. Now I don't know if it was the only bed, I had so I'm not saying its particular but I am saying I'm struck. And again in your reflection you had talked about the child asking about the bedroom upstairs, and I think it provoked that in me, because there is something powerful about the baby in the bed, and the vulnerability of that in a very unsafe environment. And so I think that inspired me to choose them. But when I placed them I didn't place them over here in the danger, I placed them in the middle and what struck me as I placed it was actually more about rebirth. So I didn't feel I placed it for that reason so I don't know what that means Sonya, but when I was placing it, what I thought really was more a symbol of rebirth to me, that this baby almost needs to

be reborn. This baby needs a new start, a new experience, and then I had over here the baby feeding off the breast. They're still apart like they're not really together.
Researcher : But it feels as if this little baby who was all wrapped up in bandages has kind of broken out.
Interviewee : Yeah it's emerging.
Researcher : And this leads over to the phoenix this kind of...
Interviewee : yeah, and the phoenix I chose very early on, I didn't place it very early on but I chose it.
Researcher : And what about this figure in front of the phoenix?
Interviewee : She's a dancer.
Researcher : Okay.
Interviewee : I chose her cause you talked about movement. I don't know if you talked about dance, but you talked about movement, and I was thinking about the kind of freedom in the body that's needed to dance. And the importance of that, so I chose that dance figure.
Researcher : I think I wrote about how our bodies inherently know how to regulate in relation to the little girl. You know the way they hop up... that children seem to know what to do, and it comes at the right time.
Interviewee : Yeah
Researcher : Yeah
Interviewee : Movement. Interestingly I didn't choose her...I was trying to find a dancing figure, and I have another dancing figure but she's a Spanish Senorita
Researcher : Uh Huh
Interviewee : And I put her back, she wasn't right...and I felt that she was too sexy
Researcher : Okay
Interviewee : I didn't overthink it, but these were the thoughts that came in...no, she's not right, much too...you know the Spanish Senorita
Researcher : Yeah, yeah, kind of...too provocative...fancy...yeah,
Interviewee : Yeah
Researcher : Okay
Silence
Interviewee : I'm wondering what's that little figure in front there? It's a little black...uh...black baby, (Laughs) I don't know is that a racist comment these days
Researcher : (Laughs) I know..
Interviewee : It's a little black baby, but it's a happy , it's a cherub-y .....cute little baby
Researcher : There's a lot of little babies dotted around the place isn't there
Interviewee : It feels to me, like em, that the babies need to emerge, and that symbol there, you see, you see the green and pink and blue, that's a baby aswell
Researcher : Uh huh
Silence
Interviewee : There's a lot of babies
Researcher : I dunno....something that's coming to me is, you know, all these little babies around the place...are they kind, of a bit aimless there?
Interviewee : Uh huh
Researcher : Or are they....you know when babies are learning to toddle off and play by themselves for a while but the secure base is there and they check in and they toddle off, something I'm wondering is...what kind of babies are these.....
Interviewee : I don't know, I didn't.... to me they were babies that were ....they looked more thriving babies. I mean I notice they are on their own, that they don't have a mother
Researcher : Uh huh....hmmmm
Interviewee : But this one, the monkey one, em....., mother and baby, and this one is feeding on the breast one, and this one up here....the front right...is a mother holding a baby in her arms
Researcher : Okay....yeah....

(Silence)
Interviewee : And the one behind it ...it's a symbol I love, it's a warrior, it's a woman or a girl, with a ....it's looks a bit like a weapon, to me she's always a warrior, she's doing a bit of a dance, you know.
Researcher : Uh huh
Interviewee : I like her as a symbol, she symbolises strength and movement
Researcher : Yes, yeah. She seems to have strong feminine energy.
Interviewee : Yeah, yeah
Researcher : Uh huh (Coughs) Yeah...I mean now that you've explained everything there seems to be a reason for everything in it.
Interviewee : Ya, ya
Researcher : You know, emmm.....and there seems to be a flow to it aswell
Interviewee : Ya, Yeah....it definitely felt like it was flowing, it had flow and direction.
Researcher : Uh huh. Is there anything else you want to say about it Majella, like looking at it now, or having talked about it, or....(silence)
Interviewee : Emmm....I think theres a lot of pain in it.....pause, but I think there's a lot of hope in it too
Researcher : Uh huh
Interviewee : ...and I think that's what I felt doing it, that there was a lot of pain and there was a lot of hope..and emmm...(silence) ....yeah, and a lot of vulnerability I think.
Researcher : Yeah, I get the feeling there's a lot of finding one's way in it. A lot of journeying , finding a way through
Interviewee : It very much felt like a journey
Researcher : Even for like, all these little babies, you can imagine them scrambling through the sand, you know, there's movement in it
Interviewee : Yeah
Researcher : A quote that's coming to my mind is the "torn map of the world", Van der Kolk, that sometimes children who've had traumatic histories have a torn map of the world, nothing is as steady as a fixed map that they can follow. There's a lot more scrambling around, finding their way.
Interviewee : It's emmmm....yeah true, I suppose really...there is a lot more....scrambling and finding your way, there's a lot of pain to find your way out of.....I'm just going to run out because I wrote down a few words.....
Researcher : Thank you
Interviewee : So this was about how I was feeling as I did it.....so shortness of breath at times, and actually I notice this as I went through it again, my breath feels a bit caught at times here,
Researcher : Uh huh
Interviewee : ....almost like it's hard to breathe.....deeply
Researcher : Yeah
Interviewee : Which for me, often would indicate anxiety.
Researcher : Okay
Interviewee : Emm....I had sadness. Feelings of sadness....of not being good enough. So feeling sad doing it at times, feelings of not being good enough, I don't know if I'm doing the right thing, what is this? You know that bit that we talked about at the start.
Researcher : Uh huh, uh huh.
Interviewee : I don't know if this is what Sonya wants.
Researcher : Yeah
Interviewee : You know, I don't know.....I don't know what I'm doing. ....Unable to find the right nurturing symbol, it's not there, and then moving into a kind of negative place, my symbols are all.....full of negativity, dya know so....
Researcher : Yeah.....hmmmmm

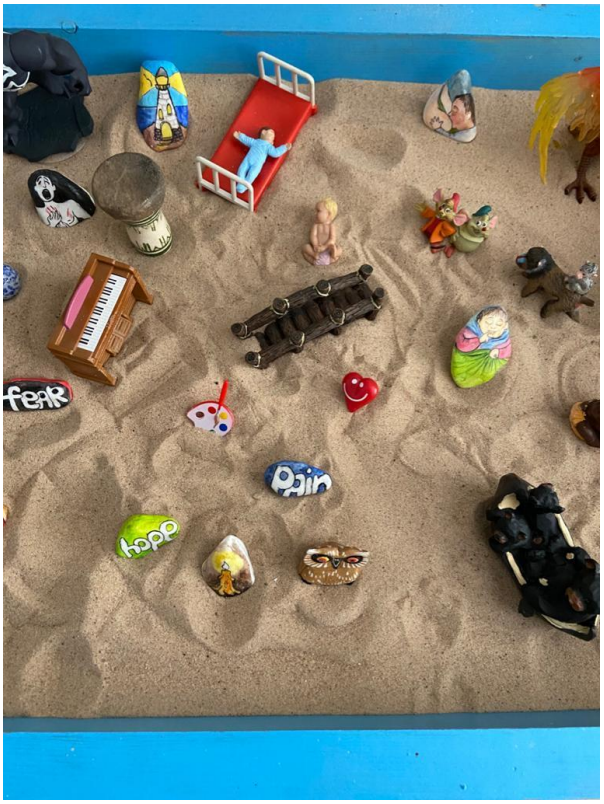
Interviewee: The criticism I had of myself, that I have all these negative symbols. Now that wasn't on the tray...that was my collection (laughs)I don't know if you know this room, but I've a lot of minatures (laughs)
Researcher : (laughs)
Interviewee : I've a lot of symbols, so it's not natural to say they're full of negativity, but emmm that's what I was saying, they're all full of negativity. None of these are the symbols I need. God almighty I've all these dark symbols....I noticed when I finished it...I often get this after sessions...the energy, where there's a lot of energy...my hands buzz
Researcher : Okay
Interviewee : in my hands, and what I usually do after a session when I have that is I em...I wash them in cold water, I just rinse them. I noticed when I made the tray I had to go and do that.
Researcher : Right, okay
Interviewee : But I do notice that when the energy kind of flows, if I have a session where the energy flows I have to go and wash my hands
Researcher : Uh huh, that's a really interesting concept of your hands buzzing, it sounds really alive..
Interviewee : That I'm holding some kind of energy
Researcher : But it sounds like you have to put a stop to that with the cold water
Interviewee : Like it feels like it belongs to the client usually, it is some kind of energy that's flowed through the session belonging to that client so I don't need to keep hold of it, yeah,
Researcher: Yeah, okay
Interviewee : Pause. Emmm and I felt like I could leave the tray until today, but I knew I'd be working in the room, obviously there are no clients here at the moment. Technically I could leave the tray for a week, but I felt I didn't want to leave the tray for a week.
Researcher : Yeah...yeah
Interviewee : ..that didn't feel right
Researcher : Yes
Interviewee : That's why I said to you "let's do this today", emm, I didn't want to be coming into this room and seeing that tray
Researcher : I can understand that, and I think I suggested to you, that if you wanted to talk directly after you'd made the tray aswell
Interviewee : Ya
Researcher : I'm noticing that there could be something in it, it can bring up powerful stuff, that you know, might, uh huh
Interviewee : Yeah
Researcher : Majella, I'm just aware of time and I'm wondering does this click off after an hour
Interviewee : No, no, only if there's more than one
Researcher : So, how do you feel about dismantling the tray now yourself, what do you need to do to make sure you're alright
Interviewee : Yeah, no I'm fine, I'll dismantle it and I'll do something to let go of it. I'm alright. I will try and photograph it again. I'll see if I can show it to ya.
Researcher : O great cause I couldn't really see that figure at the left. He's quite menacing, isn't he/
Interviewee : Yeah he's very menacing
Researcher : And he's really overshadowing that whole area
Interviewee : Yeah he is. And in front of it there is a symbol, I dunno, in front of that menacing symbol, I dunno if you can see it in the sand, it's a black and white, but that's a screaming figure, it's kind of self harming, scratching it's own body...we didn't talk about that one
Researcher ; Uh huh
Interviewee : To me that's like that really desperate pain, and tearing...the flesh is bleeding, it's tearing it's clothes to the flesh
Researcher : God it's got such energy, now that I see it there

Interviewee : The energy felt really powerful Sonya, as I did it.
Researcher : That darkness is a force to be reckoned with, now that I see it close up
Interviewee : Yeah....yeah.....and this was a symbol of the football cause you said about playing football
Researcher : Yes...looks a bit like an egg
Interviewee : It does...and it's actually a marble, hard and glassy. Can you see closer?
Researcher : O yes, I see your warrior now. Gosh there is such a different feeling at the other side
Interviewee : Yes
Researcher : Thank god (laughs)
Interviewee : Thank God is right.
Researcher : Yeah...(sighs) dark and light
Interviewee : Dark and light.
Researcher : That's amazing , thanks Majella.

Full sandtray image

Left side of sandtray

Right side of sandtray



Middle section of sandtray

Appendix 11 Infant Sorrow Poem

Infant Sorrow

BY WILLIAM BLAKE

My mother groand! my father wept.
Into the dangerous world I leapt:
Helpless, naked, piping loud;
Like a fiend hid in a cloud.

Struggling in my fathers hands:
Striving against my swaddling bands:
Bound and weary I thought best
To sulk upon my mothers breast.