

**The components required to build a therapeutic relationship with children diagnosed
with Asperger Syndrome**

By

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Declaration

I declare that “The components required to build a therapeutic relationship with children diagnosed with Asperger Syndrome” is my own work and that all the sources that I have used or quoted have been indicated or acknowledged by means of complete references.

Edré Gerber

Date

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I would like to express my gratitude to my study leader, Issie Jacobs for her support, guidance and patience and my co-study leader, Prof Van Eeden for her optimism and valuable input. Furthermore, to all the participants for their keen input and interest in the study. My parents, always encouraging me, believing in me and pushing me to be the best I can be. My wonderful husband for your support, patience, understanding and unconditional love.

Language practitioner

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A handwritten signature in dark ink, consisting of a large, stylized capital 'S' followed by a capital 'L' and a capital 'R', all connected in a fluid, cursive script.

S. L. van Rooyen

Preface

The Harvard referencing method was used during this study as seen in the NWU Reference guide 2012, distributed by the Library Services of the North-West University, Potchefstroom campus.

Summary

The aim of this study was to explore and describe the components required to build a therapeutic relationship with children diagnosed with Asperger Syndrome. Through this study therapists and other professionals working with these children could be guided to form functioning and healthy therapeutic relationships with children diagnosed with AS.

An inductive, qualitative method was used to gain insight into the components required to build a therapeutic relationship with children diagnosed with AS by exploring the opinions and experiences of a selection of therapists from different therapeutic contexts that work with children diagnosed with AS. Six participants working with children diagnosed with AS at schools for children with learning difficulties, Autism and AS or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan took part in the study. Participants consisted of Occupational therapists, Speech therapists, Counselling Psychologists and Clinical Psychologists. The researcher used semi-structured interviews to explore and describe the opinions of the participants on the components required to build a therapeutic relationship with children diagnosed with AS.

The results of this study indicated that building a therapeutic relationship with a child diagnosed with AS requires multiple components and a holistic outlook. Preparation in the form of research and being knowledgeable on the AS diagnosis, as well as obtaining thorough background information on the specific child was found to be fundamental. An awareness on the part of therapists and other professionals regarding child-related aspects such as co-morbid disorders; sensory considerations; therapeutic environment; coping with change; obsessions and dependence on the therapist was found to be of value. Other fundamental components that seem to be a requirement for building a therapeutic relationship with children diagnosed with AS were the therapist characteristics: body language and attitude. Therapeutic considerations, such as the importance of setting boundaries and remaining consistent, as well as the teaching aspect involved in building a therapeutic relationship became evident. Furthermore, the education of parents, siblings and other family members, as well as the importance of having fun while building a therapeutic relationship were recognized as important components. Teamwork was another crucial component identified which included parental and family involvement, as well as collaboration with other professionals and teachers.

Keywords

Asperger Syndrome

Therapeutic relationship

Therapist

Child diagnosed with Asperger Syndrome

Opsomming

Die doel van hierdie studie was om die komponente wat nodig is om 'n terapeutiese verhouding te bou met kinders wat met Asperger Sindroom gediagnoseer is, te verken en beskryf. Hierdie studie kan terapeute en ander professionele persone wat met hierdie kinders werk, lei om funksionerende en gesonde terapeutiese verhoudings te bou.

'n Induktiewe, kwalitatiewe metode is gebruik om insig te verkry oor die komponente wat nodig is om 'n terapeutiese verhouding te bou met kinders gediagnoseer met AS. 'n Ondersoek van die menings en ervarings van 'n seleksie van terapeute van verskillende terapeutiese kontekste wat werk met kinders gediagnoseer met AS, is ingestel. Ses deelnemers wat met hierdie kinders werk, of wat as verwysings persone kontak het met skole vir kinders met leerprobleme, outisme en AS in die Nelson Mandela Metropool, het in die studie deelgeneem. Die deelnemers het bestaan uit Arbeidsterapeute, Spraakterapeute, Voorligtingsielkundiges en Kliniese sielkundiges. Die navorser het semi-gestruktureerde onderhoude gebruik om die menings van die deelnemers oor die komponente wat nodig is om 'n terapeutiese verhouding te bou met die kinders gediagnoseer met AS, te verken en te beskryf.

Die resultate van hierdie studie het aangedui dat die bou van 'n terapeutiese verhouding met 'n kind wat met AS gediagnoseer is, vereis verskeie komponente en 'n holistiese uitkyk. Voorbereiding in die vorm van navorsing en kennis oor die AS diagnose, sowel as die verkryging van deeglike agtergrond inligting oor die spesifieke kind blyk belangrik te wees. Die bewustheid van die terapeute en ander professionele persone oor die aspekte soos komorbiede versteurings, sensoriese probleme, die terapeutiese omgewing, die ervaring van verandering, obsessies en afhanklikheid van die terapeut is gevind om van waarde te wees in die daargestelling van 'n terapeutiese verhouding met 'n kind wat met AS gediagnoseer is.

Ander fundamentele komponente noodsaaklik vir die bou van 'n terapeutiese verhouding met kinders gediagnoseer met AS was die terapeut se eie karakter eienskappe, lyftaal en houding. Terapeutiese konsiderasies, soos die belangrikheid van die opstel grense en van konsekwente optrede het na vore gekom as aspekte wat noodsaaklik is. Die aspek dat onderrig van die kind gediagnoseer met AS betrokke is in die bou van 'n terapeutiese verhouding, die opvoeding van ouers, broers en susters en ander familieleden, asook die belangrikheid van pret hê gedurende die bou van 'n terapeutiese verhouding was as belangrike komponente beskou.

Spanwerk was nog 'n belangrike komponent wat geïdentifiseer was en het ouers en familie betrokkenheid, asook samewerking met ander professionele persone en onderwysers, ingesluit.

Sleutelwoorde

Asperger Sindroom

Terapeutiese verhouding

Terapeut

Kind wat met Asperger Sindroom gediagnoseer is

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Chapter 1: Overview and methodology

1.1 INTRODUCTION

Asperger Syndrome (AS) is a developmental disability that influences the way a child interprets and interacts with the environment (Attwood, 2008:15). It is defined under Pervasive Developmental Disorders (American Psychiatric Association, 2000:80) and is one of five conditions found in a group of neurodevelopmental disabilities known as Autism Spectrum Disorders (Attwood, 2005; Attwood, 2008:14; Klin, Volkmar & Sparrow, 2000:25). Asperger Syndrome is characterized by an impairment of social interaction (Lombard, 2004:2; Patrick, 2008:14), a narrow range of interests, and stereotypical behaviours and activities (Attwood, 2008:15).

The characteristics of this disorder causes children with AS to be referred to Play therapy (Jacobsen, 2003:38), Occupational therapy, Speech therapy, Language therapy (Jacobsen, 2003:123, Mertz, 2005:59), Parent-child therapy (Bond, 2004:144), Cognitive behaviour therapy (Docter & Naqvi, 2010:56) and to attend Social skills development groups (Ramsay, Brodtkin, Cohen, Listerud, Rostain & Ekman, 2005:485). Children with AS are further referred to therapy for problems similar to typically developing children. These problems include being bullied, struggling socially (Ramsay *et al.*, 2005:487; Rosaler, 2004:44), difficulty with emotional expression and self-esteem problems.

Research suggests that the success of therapy continuously points to the importance of the therapeutic relationship (Schoeman, 1996:29) which in the end determines the level of therapeutic success Dattilio, Freeman and Blue (2000:230). Within a therapeutic setting, the therapeutic relationship, according to Blom (2006:54), is the most important and fundamental part of the therapeutic process. The importance of a therapeutic relationship is further highlighted in (Dattilio, *et.al.*, 2000:230); Landreth (2002: 79); Ray (2011:63); Scheafer (2011:88) and Van Der Merwe (1996:4). These authors concur that such a relationship is a useful and effective tool to help unlock children's thoughts and feelings. The therapeutic relationship is the key to communication and the cornerstone of therapy; however, to develop such a relationship is one of the most difficult therapeutic interventions (Blom, 2006:54; Dattilio, *et al.*, 2000:230; Van Der Merwe, 1996:22). Landreth (2002:205) adds that building

a therapeutic relationship requires patience, a special interest and a keen understanding of the unique perspective and process of the child.

Building a therapeutic relationship with a child with AS may be particularly challenging due to their social difficulties, such as a lack of understanding of social cues, lack of empathy, lack of theory of mind and difficulty establishing peer relationships (DuCharme & McGrady, 2003:3; Ramsay *et al.*, 2005:487). Children with AS find it difficult to engage with other people and often do not even want to try (Ramsay *et al.*, 2005:483). As a result, it may take longer to build a trusting, functioning relationship with a child with AS and in turn, may take longer for any therapeutic intervention to be effective.

This chapter stems from the research protocol which was submitted as motivation for this study. In this chapter the focus will be on the orientation and statement of the problem, incorporating the discussion of the definition and components of a therapeutic relationship, as well as the aim and objectives of the study. A brief discussion on the research methodology will take place and will be elaborated upon in Chapter 3.

1.2 ORIENTATION AND STATEMENT OF THE PROBLEM

In the researcher's experience, working with children with AS can often lead to feelings of frustration and failure as a therapist and therefore Gibbons and Goins (2008:9) recommend that it helps to consult and collaborate with other professionals. In view of this, the personal motivation of this study is to include recommendations that could help therapists feel less helpless and more effective in working with children diagnosed with AS.

The researcher aims to explore the components required to build a therapeutic relationship with children diagnosed with AS during the research study. This will potentially lead to better quality therapy, which may ultimately lead to better quality of life for children diagnosed with AS. Furthermore, the increase in the number of individuals diagnosed with AS (Frombonne, 2005:6; Gilberg & Coleman, 2000:96; Williams, Higgins & Brayne, 2006:5), the expanding policy of inclusion of such children in mainstream schools (Sanders, 2003:2; South Africa, 1996) combined with the social difficulty that these children face, make it an important topic to explore (Van Vollenstee, 2006:2), as it may increase the success of therapy and in turn, impact on the lives of these children.

The therapeutic relationship is a formal agreement on goals and becomes a working alliance within a therapeutic setting. It is an ever-changing, informal connection between therapist and child. Bordin (in Joyce & Sills, 2006:41), Gilbert and Leahy (2007:25), Hull (2011:14), Kirchner (2009) and Landreth (2002:80) all concur that the therapeutic relationship is defined as being an emotional, trusting bond and active partnership, based on best intentions and respect. Much like a friendship, it encompasses empathy, warmth, genuineness, support, acceptance and appreciation. It is authentic, non-judgmental and dialogic. Inclusion in schools and an increase in the public awareness and diagnosis of children with AS, have put pressure on professionals such as teachers, school counsellors and school psychologists to understand, include and meet the needs of children diagnosed with AS.

Kapp (2011) believes that the therapeutic relationship facilitates motivation for change and generalization of skills learnt during therapy. Kapp (2011) also states that building a trusting, reciprocal relationship is demanding, because children diagnosed with AS struggle with communication, understanding body language, listening skills, compromise and they have limited interests. Furthermore, children diagnosed with AS are concrete thinkers while interpersonal relationships are built on abstract aspects such as language and symbolism with which they have great difficulty (Clarke, 2011). The therapeutic relationship thus offers a context in which such children can develop interpersonal skills and competencies and master some of the difficulties they experience in their interaction with others (Hull, 2011:37).

From the above given discussion, the following research question can be formulated:

What are the components required to build a therapeutic relationship with a child with AS?

1.3 AIM OF THE STUDY

The research problem and the research question will guide the research aim and objectives. The research aim is the ultimate goal the researcher wants to achieve (Fouché & Delpont, 2011:94; Thomas & Hodges, 2010:39; Walliman, 2005:24).

The aim of this study is to explore and describe the components required to build a therapeutic relationship with children diagnosed with AS in order to make recommendations to therapists with regards to these components when building a therapeutic relationship with children diagnosed with AS.

1.4 THEORETICAL POINTS OF DEPARTURE

The theoretical point of departure will involve the concepts of awareness, contact and dialogue as it is understood within Gestalt theory. Yontef (2005:87) highlights that awareness is a process that happens within the therapeutic relationship. Awareness constitutes sensory experience, feelings and thoughts with self-observation, self-knowledge and responsibility at the core. Schaefer (2011:175) states that greater self-awareness can lead to positive change. In order to become aware, a child should be able to make contact. Contact refers to what a child is in touch with, while sensory experience refers to how a child is in touch (Yontef, 2005:88). Yontef and Jacobs (2011:361) state that contact takes place in verbal and non-verbal communication. In such therapeutic communication, the therapist pays close attention to the experience and behaviour of the child and believes that the child's experience is as real and valuable as the therapist's reality (Yontef & Jacobs, 2011:361). The therapeutic aim is to help children feel safe enough to explore their awareness, thoughts, feelings, ideas and behaviour. The key element in developing awareness is the existential dialogue between the therapist and the child and the focus is on actual experience as it is in the here and now (Anderson, 2008:2; Landreth, 2002:86; Yontef, 1993:127). Change and growth are brought about by genuine contact in the dialogue between therapist and child, as well as the child's experiential field. Existential dialogue focuses on I-thou contact in therapy (Blom, 2006:19), experiencing each other as genuine and sharing awareness (Alao, Kobiowu & Adebawale, 2010:108). The therapeutic relationship and contact is dependent on mutual self-responsibility, directness, caring, acceptance and warmth (Anderson, 2008:2). According to Alao, *et al.* (2010:109), the therapeutic relationship emphasises four aspects of existential dialogue, namely inclusion, presence, commitment to dialogue and dialogue is lived.

Jacobs (in Joyce & Sills, 2006:54) explains that the dialogic relationship is one that alternates between I-it and I-thou relating. The therapist might find it difficult to enter an I-thou mode of relating when the experience of the child is foreign, misinterpreted or misunderstood. This could be especially true in the case of children diagnosed with AS, thus Joyce and Sills (2006:55) advise therapists to remain honest and trust that the relationship will be the groundwork for change.

1.5 RESEARCH METHODOLOGY

1.5.1 Analysis of literature

According to Creswell (2003:27), Flick (2009:48), Marshall and Rossman (2010: 77) and Thomas and Hodges (2010:105), the purpose of the literature review is to systematically study the existing literature in order to identify relevant information, build a logical framework for the research, become knowledgeable on the topic and convey the importance of the proposed research study. In this study, the literature review focused on relevant books, articles, research reports, proposals and journals within the field of AS and the therapeutic relationship. The literature was obtained from various university libraries and by making use of internet searches on databases such as EPSCOhost, GoogleScholar, ProQuest, Questia and Pubmed.

An in depth literature study focused on the following:

Asperger Syndrome (American Psychiatric Association, 2000; Attwood, 2008; Attwood, 2005; Docter & Naqvi, 2010; DuCharme & McGrady, 2003; Frombonne, 2005; Gibbons & Goins, 2008; Gillberg & Coleman, 2000; Van Vollenstee, 2006).

Therapeutic relationship (Blom, 2006; Bond, 2004; Datillio, Freeman & Blue, 2000; Landreth, 2002; Ramsay, *et al.*, 2005; Schoeman & Van Der Merwe, 1996).

1.5.2 Research design

Qualitative research aims to understand the meaning people attach to life, and the experiences and perceptions of individuals (Fouché & Delport, 2011:64). In qualitative research the researcher is concerned with understanding the views of small samples of people that are purposefully selected (Fouché & Delport, 2011:64), as in this case with therapists that work with children diagnosed with AS in different therapeutic contexts. Qualitative research uses an inductive approach which focuses on developing insights and generalizations from the collected data (Neuman, 2011:60). The researcher will use an inductive, qualitative method, as the aim is to explore and describe the components required to build a therapeutic relationship with children diagnosed with AS by interviewing purposefully selected therapists in the Nelson Mandela Metropolitan.

According to Neuman (2011:25), applied research is conducted to address a specific concern or to offer solutions to a problem. Applied research focuses on producing recommendations that applies to a specific group, as is the case of this study. Furthermore, according to Babbie (2010:92), there are three common objectives in research: exploration, explanation and

description. Fouché and Delport (2011:95) state that exploratory research is done to gain insight into a situation, individual, phenomenon or community. Descriptive studies aim to create a picture of the details of a situation, social setting or relationship (Babbie, 2010:100; Fouché & Delport, 2011:96). This research aims to gain insight into the components required to build a therapeutic relationship with children diagnosed with AS due to the fact that working with these children pose certain challenges in the process of building a therapeutic relationship. Applied research will therefore be used to make recommendations to therapists about the components required to build a therapeutic relationship with children diagnosed with AS.

The research strategy will be a case study. A case study explores and analyses a process, activity, event, programme, individual or multiple individuals (Fouché & Schurink, 2011:320-323; Nieuwenhuis, 2010:75-76). This study will focus on a sample of therapists and their experience and knowledge to obtain information about the components required to build therapeutic relationship with children diagnosed with AS.

1.5.3 Research method

1.5.3.1 Participants

Strydom (2011:236) describes the population as the individuals who possess particular traits that are of interest to the researcher. For the purpose of this study, the population will consist of different therapists working with children diagnosed with AS in the Nelson Mandela Metropolitan. According to Strydom (2011:236) non-probability sampling refers to a sample that is not chosen at random. Therefore, purposive sampling will be used to select a portion of the population for the study. A purposive sample, according to Strydom (2011:232), is principally chosen because it represents the characteristics of the population of interest.

The sample of this study will be therapists working with children diagnosed with AS at schools for children with learning difficulties, Autism and AS; or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan. For the purpose of this study, the therapists will consist of Occupational therapists, Speech therapists, Counseling Psychologists and Clinical Psychologists. The criteria for inclusion in the sample are the following:

- Therapists working at schools for children with learning difficulties, Autism and AS; or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan
- Therapists working with children diagnosed with AS
- Therapists should be either Afrikaans or English speaking
- Therapists should be prepared to voluntarily participate in the study

1.5.4 Data generation

Semi-structured interviews will be used as the method of data collection in this study. Terre Blanche, Durrheim and Painter (2006:298) describe an interview schedule as a list of topics or questions the researcher develops in advance to guide the semi-structured interview and should not be dictated by it.

Semi-structured interviews are organized around a specific area of interest, while still allowing for flexibility (Greeff, 2011:351). During semi-structured interviews (see Appendix A for semi-structured interview schedule), the researcher will gain a detailed picture (Greeff, 2011:352) of the components required to build a therapeutic relationship with children diagnosed with AS, focusing on aspects such as awareness, contact and dialogue. The researcher will record the semi-structured interviews on a digital video recorder with consent of the participants. This allows for capturing of subtle emotions, body language and information that could possibly be missed during the interview. The interviews will be conducted at the convenience of the participants, at a venue and time of their choice. The collection of data will aim to provide rich detail into the views and opinions of the therapists with regards to the components required to build a therapeutic relationship with children diagnosed with AS. Therefore, the researcher will consider the saturation of data as well. Theoretical saturation occurs when no new information unfolds during analysis (Terre Blanche, *et al.*, 2010:288). Flick (2009:119) states that the saturation of data occurs when no new information is generated and serves as the criteria for stopping data collection.

Before the semi-structured interviews commence the researcher will conduct a pilot study with two voluntary participants in order to determine the trustworthiness of the study, as well as to ensure the effectiveness of the interview schedule. Strydom and Delport (2011:390)

describes the pilot study as contributing to the suitability of the data collection procedure, the evaluation of the study as well as the suitability of the interview schedule.

1.5.4.1 Procedures

The sample of the study will consist of therapists working with children diagnosed with AS at schools for children with learning difficulties, Autism and AS; or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan. The researcher will compile a list of these therapists from professional relationships and a list of references obtained from the different relevant schools. These therapists will then be contacted telephonically to determine who will be willing to participate. A brief outline of the aims and procedures of the study will be discussed upon agreement of participation, as well as confidentiality and participant rights. Appointments for interviews will be made at the convenience of the participants. The researcher will discuss the aims and procedures and ethical aspects (see Appendix C) of the study thoroughly at the appointed meeting, as well as obtain signed, informed consent (see Appendix B). The schedule for the semi-structured interviews will be finalized. Semi-structured interviews will be done and recorded on a digital video recorder in order to gather as much verbal and non-verbal information to be analyzed. Transcriptions will be done using the methods described in Flick (2009:299-303).

1.5.5 Data analysis

Qualitative data analysis is about the detection of the information essential to answer the research question. The researcher is required to define, categorize, theorize, explain, explore and map the information received during the data collection (Huberman & Miles, 2002:309). Data analysis, as described by Lacey and Luff (2009:6), is the process of describing and summarizing the interviews and field notes and linking the relationships of the identified themes. Framework analysis provides systematic and visible stages for this process. The stages are familiarization; identification of thematic framework; indexing; charting; mapping and interpretation (Srivastava & Thomson, 2009:75; Lacey & Luff, 2009:14). Data analysis will be started by familiarisation with the data through review, reading, listening and transcription of the recorded material. The data will be organized and indexed for easy retrieval and identification. The researcher will then code the data and identify themes, after which the data will be discussed and integrated with relevant literature.

1.6 ETHICAL ASPECTS

The ethical aspects described in Strydom (2011:113-130) and Flick (2009:36-44) will be taken into account throughout this study. According to Flick (2009:36) the code of ethics has been formulated to “regulate the relations of researchers to the people and fields they intend to study.” Researchers should therefore be competent and skilled to undertake the research in an ethical manner, according to Strydom (2011:114). The researcher has seven years’ experience working in the field of AS and a thorough literature review was conducted. Furthermore, the researcher will be working under the guidance of a study leader. Great care will be taken to avoid deceiving or doing any harm to the participants, by explaining all aspects of the study, as well as allowing the participants to ask questions. The researcher is of opinion that the topic is not sensitive and does not foresee any participant being uncomfortable or vulnerable to harm. Nevertheless, the participants will be advised that they have the right to withdraw at any time without penalty.

Another important factor will be to inform and assure participants of confidentiality and anonymity. The interviews will be conducted by the researcher who will have sole access to the interviewee information, video recordings and transcribed material. The participants will be asked to sign informed consent forms for the digital video recordings and interviews. The digital video recordings will be stored on a password protected external hard drive and the researcher alone will have access. The findings will be handled in an ethical manner throughout the data analysis process as well as when writing the conclusions and recommendations. The researcher will continue to ensure that participants remain anonymous and the information confidential by storing all the information on a password protected external hard drive and be the only person with access. The ethical clearance number that was obtained for the study is NWU-00060-12-A1.

1.7 OUTLINE OF CHAPTERS

Chapter 1: Overview and methodology. This chapter is an overview of the study, orientation and problem statement, aims and objectives set for this research and description of choice of the research methodology. This chapter places the study in perspective and orientates the reader to the nature of this study.

Chapter 2: Literature review. This chapter is a detailed literature review exploring and defining main concepts such as AS and the therapeutic relationship.

Chapter 3: Empirical research. This chapter describes in detail the empirical research process, the design, participants, generation of data, procedures and data analysis. Ethical aspects and trustworthiness of the study is also described.

Chapter 4: Results and interpretation. The results of the research study are discussed under main themes, subthemes and categories using table format as well as a detailed description that followed.

Chapter 5: Conclusions and recommendations. This chapter consists of the conclusions and recommendations made to therapists and other professionals working with children diagnosed with AS. Recommendations for further research and limitations of the study will be outlined and final conclusions made.

1.8 CONCLUSION

This chapter orientated and set the focus of the research and the research statement. This was done by outlining the orientation and problem statement, aims and objectives set for this research and description of choice of the research methodology. The following chapter of this study will be a detailed literature review discussing and defining the main concepts of the study under the headings of AS and the therapeutic relationship.

Chapter 2: Literature review

2.1 INTRODUCTION

The literature review focuses on existing literature on AS and the therapeutic relationship, exploring relevant information in order to build a logical framework for the research. The aim is to become knowledgeable on AS and the importance of the therapeutic relationship, creating an overview of the possible components required to build a therapeutic relationship with children diagnosed with AS.

2.2 ASPERGER SYNDROME

2.2.1 Diagnostic criteria and definition

Asperger Syndrome is a neurobiological disorder that results from abnormalities in the brain (Rosaler, 2004:6) and interferes with the manner in which children engage with and understand the world around them. Hans Asperger was the first to write about the behavioural symptoms known as AS. He identified a group of his patients who seemed to struggle with social relatedness, the ability to form relationships and empathy (Patrick, 2008:14). Children with AS have social and communication difficulties, engage in repetitive or obsessive behaviour and struggle with motor planning (Attwood, 2008:13; DuCharme & McGrady, 2003:2). Such children may also be characterized by deficits in non-verbal behaviours, inflexibility and difficulty establishing peer relationships (Attwood, 2008:13; Lombard, 2004:2). People with AS have a normal intellectual capacity (Attwood, 2008:13), but they share a unique profile of behaviours and traits that are apparent from early childhood.

Docter and Naqvi (2010:16) assert that psychiatric conditions such as Anxiety Disorders, Mood Disorders, Obsessive Compulsive Disorders, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder can occur concurrently with AS, but can also cause misdiagnosis of the disorder. These co-morbid conditions could complicate the diagnostic and intervention processes, therefore a detailed history should be obtained and direct observation of the child is essential.

The most commonly used definition for AS is found in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*) (American Psychiatric Association, 2000). This definition consists of two primary clusters of characteristics that should be present in order to diagnose AS. The first cluster is designed as a qualitative impairment of

social interaction which consists of four criteria, and of which at least two should be evident (Lombard, 2004:2; Patrick, 2008:14):

- Impairment in social reciprocity
- Difficulty in establishing peer relationships on an age appropriate level
- Impaired ability to understand non-verbal communication, such as facial expressions and eye gaze
- Absence of spontaneous sharing, seeking out friendships and empathy

The second cluster consists of criteria highlighting the narrow range of interests, and stereotypical behaviours and activities. At least one of the following should be present:

- Stereotypical and repetitive motor movements
- Preoccupation with one specific area of interest
- Inflexibility or rigidity in routine

Gillberg's Criteria for Asperger Disorder is another well-known definition and is categorized into six major aspects with underlying criteria to be met (DuCharme & McGrady, 2003:3).

- Impairment of social interaction (at least two of the following):
 - Difficulty interacting with peers
 - Indifference to peer contacts
 - Difficulties interpreting social cues
 - Socially and emotionally inappropriate behaviour
- All-absorbing narrow interest (at least one of the following):
 - Exclusion of other activities
 - Repetitive adherence
 - More rote than meaning
- Imposition of routine and interests (at least one of the following):
 - Affects individual's every aspect of everyday life
 - Affects others
- Speech and language problems (at least three of the following):
 - Delayed speech development
 - Superficially perfect expressive language
 - Formal pedantic language
 - Odd prosody, peculiar voice characteristics
 - Impairment of comprehension including misinterpretations of literal/implied meanings

- Non-verbal communication problems (at least one of the following):
 - Limited use of gestures
 - Clumsy body language
 - Limited facial expression
 - Peculiar, stiff gaze
- Motor clumsiness
 - Poor performance in neurodevelopmental test

Wing (in Attwood, 1998:15) notes the following criteria of impairment:

- Lack of empathy
- Naïve, inappropriate, one-sided interaction
- Little or no ability to form friendships
- Pedantic, repetitive speech
- Poor non-verbal communication
- Intense absorption in certain subjects
- Clumsy and ill-coordinated movements
- Odd postures

Hull (2011:10) expands upon additional symptoms such as:

- Stiff, plodding, one-sided conversational style
- Appearance of lack of empathy for others
- Negative, pessimistic world view
- Difficulty expressing themselves and understanding their own feelings

Aylott (2000:852) highlights that sensory difficulties are common amongst children with AS. Children diagnosed with AS also have problems with organizational skills and time management (Attwood, 2008:19). Attwood (2005) summarizes the definition of AS well in the following paragraph:

“children and adults with Asperger’s Syndrome have a ... strong desire to seek knowledge, truth and perfection with a different set of priorities... There is also a different perception of situations and sensory experiences. The overriding priority may be to solve a problem rather than satisfy the social or emotional needs of others. The person values being creative rather than co-operative. The person is usually renowned for being direct, speaking their mind and being honest and determined and having a strong sense of social justice.”

Children diagnosed with AS also struggle with theory of mind, which relates to the understanding of one's own thoughts and behaviour, as well as the thoughts and behaviour of others and understanding that these may differ (Astington & Edward, 2010:1; Attwood, 2008:112). Furthermore, theory of mind is the ability to predict and interpret one's own and other people's social behaviour (Attwood, 2008:112). Astington and Edward (2010:3) state that the development of theory of mind has an influence on social development and social success. Baron-Cohen (in Hull, 2011:16) maintains that children diagnosed with AS do not have the ability to foresee and understand intentions of others and are unable to recognize and give meaning to emotional signals in themselves and others, which is a necessary function in children's interaction with others. This can create difficulties for children diagnosed with AS to build relationships as well as gain insight into emotional control (Hull, 2011:16). Docter and Naqvi (2010:16) further highlight that children diagnosed with AS often seek out adult company as opposed to the company of peers, since adults are usually more accommodating and understanding towards the difficulties this disorder presents with.

2.2.2 Causes of Asperger Syndrome

Ehlers and Gillberg (2006:33) cite that the cause for AS is not fully known, but there are several components that play a role. The most notable components are genetics and development. Gillberg (2002:69) explains that a genetic contribution is clear, with at least half of all children diagnosed with AS having relatives with similar problems. According to the Asperger's Association of New England (2009), there is a strong genetic foundation, involving a number of different genes. Researchers have found that psychosocial factors or childhood experiences do not cause conditions such as AS. Most authors agree that the causes of AS has not yet been researched extensively and new contributions are still being made (Attwood, 1998:141; Ehlers & Gillberg, 2006:33; Johnston-Tyler, 2007:23; Sanders, 2003:26).

2.2.3 Prevalence of Asperger Syndrome

In the 1960's, the estimated prevalence of AS was 4 per 10 000 (Williams, Higgins & Brayne, 2006:5; Fombonne, 2005:6). Fombonne (2005:3) states that the current accepted prevalence rate for AS is estimated at 60 per 10 000, while Gilberg and Coleman (2000:45) state that the prevalence rate is between 26 and 48 per 10 000. Both these references evidently points to a marked increase in prevalence. Attwood (2008:46) is of opinion that the prevalence rate depends on the diagnostic criteria being used. The prevalence rate of AS

when using the DSM-IV-TR criteria has been reported to be between 0.3 per 10 000 children to 8.4 per 10 000 children, while the prevalence rate has been reported to be between 36 and 48 per 10 000 when using Gillberg's criteria. According to the Asperger's Association of New England (2008), the estimated prevalence rate is 40 in every 10 000, but may be higher, as Attwood (2009) suggests that up to 50 percent of people with AS are undiagnosed.

Rosaler (2004:7) indicates that AS is more prevalent in boys. Attwood (2008:46) conducted an analysis of over 1000 assessments and found that a ratio of males to females of four to one. Attwood also found that girls are harder to diagnose due to their ability to adapt socially by adopting a social role and script. They may also develop the ability to remain unnoticeable.

Research on AS is important due to a reported rise in the number of identified individuals with this disorder (Baker & Welkowitz, 2005:2; Fombonne, 2005:4; Sanders, 2003:1). Hull (2011:3) confirms that the diagnosis of children with AS is rising and they are referred to psychologists and counsellors more often. According to Fombonne (2005:4) and Sanders (2003:1), the rise could be due to an increase in awareness or a change in the definition of the disorder.

2.2.4 Treatment, therapy and the reasons for intervention

Lombard (2004:14) states that there is not one specific treatment that has a permanent effect on the basic impairments underlying AS, but the difficulties can be improved by appropriate management and education. Pharmacotherapy may be helpful in managing the symptoms of co-morbid disorders, but are not helpful in treating social impairments (Ramsay *et al.*, 2005:487). The treatment for social impairments requires additional therapeutic intervention. Most treatments focus on behaviour modification of problematic habits and developing prosocial behaviours for use in school, through the use of social skills groups (Attwood, 2003 in Ramsay *et al.*, 2005:487).

As mentioned previously, the features of this disorder cause children with AS to be referred to numerous different interventions (Bond, 2004:144; Docter & Naqvi, 2010:61; Jacobsen, 2003:38; Ramsay, *et al.*, 2005:487) and for problems similar to typically developing children, as well as the impairments associated with AS (Ramsay *et al.*, 2005:488; Rosaler,

2004:44). Hull (2011:3) mentions issues related to school or academics, as well as difficulties related to AS as reasons why children are referred to therapy.

Attwood (in Hull, 2011:26) furthermore lists four common themes that emerge in therapy amongst children diagnosed with AS. The first theme is fear. Children diagnosed with AS often have many fears, mostly related to change in routine, environment, expectations or social situations. Children with AS have been found to have higher rates of fear of physical injury, separation anxiety, panic, agoraphobia and Obsessive Compulsive Disorder (Russell & Sofrnoff in Hull, 2011:26). Attempts to cope when feeling overwhelmed can lead to disruptive behaviour. The family system may reinforce fear by allowing behaviours and beliefs to continue, as it is often easier than to deal with the physical or emotional outbursts that come with opposing the behaviour (Hull, 2011:27).

Secondly, social and relational difficulties are some of the main struggles for children with AS. It can cause ridicule, bullying and isolation which in turn influence the child's outlook on life and self-esteem. The struggle parents experience when developing a relationship with children diagnosed with AS might cause frustration, as well as embarrassment due to the lack of social inclusion. Mind blindness and deficits in joint attention, limits the child diagnosed with AS's ability to successfully interact and understand the behaviour and emotions of others (Baron-Cohen in Hull, 2011:28). The lack of awareness to understand their own social and emotional deficits create even more problems for children diagnosed with AS (Russell & Sofrnoff in Hull, 2011:28).

The third theme, according to Hull (2011:29) highlights low self-worth. Peers often view children with AS as weird, one-dimensional in interest, awkward and unpredictable. Children with AS desire friendships, but lack the knowledge of how to and skills with which to form relationships. Rejection and bullying affects the child's mental and emotional development which leads to low self-worth. Further rejection leads the child to conclude that he is unwanted, unworthy and not valuable. These feelings can cause intense sadness, depression and self-loathing (Carter in Hull, 2011:28), which becomes part of the child's internal processes often resulting in loneliness and isolation that can last well into adulthood. Emotional inflexibility can lead to disruptive behaviour or emotional outbursts, which further isolates the child. Disruptive behaviour or tantrums are a fight or flight response and the

underlying emotion is fear, where the child's brain interprets the situation as being unsafe (Hull, 2011:28).

Lastly, Hull (2011:29) explains that family stress is another recurring problem. The parents, peers and extended family may carry shame and guilt, feel lost and confused. The family may feel rejected and abnormal, isolating themselves from social gatherings. They may be plagued by stress and feelings of desperation when dealing with behavioural, social and emotional deficits as well as co-morbid disorders such as Obsessive Compulsive Disorder. Siblings are stressed and often angry about the physical, emotional and social challenges they have to deal with. Parents state that they have little time for intimacy which can cause marital stress (Hull 2011:30).

Bromfield (2010:8) describes the dilemma children diagnosed with AS are faced with as a triple whammy. First, they are born less equipped to understand others, themselves and their feelings. Then, the children's social world becomes smaller due to these deficits. The way in which they have to protect themselves isolates them further. They are biologically less equipped for connection and rely on more comfortable ways of dealing with anxiety and frustration. Thirdly, their self-reliant and eccentric ways cause others to pull away even more creating very little opportunity for them to learn correct social skills. Bromfield (2010:12) adds a fourth problem that children diagnosed with AS struggle with: they are difficult to understand and therefore receive less understanding, admiring, empathy and confirming, which may cause them to be hard to relate to and are often misunderstood. Children with AS will rarely verbalize feelings of anxiety or discomfort, but rather act out, behave inappropriately or defiantly (Bromfield, 2010:21). Bromfield advises to avoid doing harm by not pushing children with questions, watching your tone of voice, avoid forcing responses or eye-contact. The therapist should remain respectful of the children's space, be patient and furthermore not interpret or correct the children's behaviours.

Bromfield (2010:21) further describes children with AS as suffering from trauma that their neurological deficits bring about, such as misunderstanding, overstimulation, neglect, social isolation and teasing. Children diagnosed with AS often receive negative interpersonal reaction and can be seen as boring, irritable, difficult or rigid. Therefore, therapy should be a safe place where children with AS will not be subjected to further trauma.

2.3 THERAPEUTIC RELATIONSHIP

2.3.1 Definition of a therapeutic relationship

Gilbert and Leahy (2007:25) state that the active ingredients for building a therapeutic relationship are an emotional bond with the focus being on meeting the needs of the child, and agreement on goals and activities. Furthermore, Bordin (in Joyce & Sills, 2006:41) describes the therapeutic relationship as a working alliance, active partnership and trusting bond. The therapeutic relationship is an agreement of cooperation between them and built on the best intentions of both therapist and child.

Joyce and Sills (2006:42) suggest that the therapeutic relationship involves empathy and respect, while Hull (2011:14) states that trust is a core element in the therapeutic relationship and a catalyst for change. Children diagnosed with AS struggle to trust unfamiliar people. Therapists working with such children often have little or no verbal feedback from the child, but should be able to recognize the trust barrier, understand it and overcome it (Hull, 2011:14). Landreth (2002:80) emphasizes that a therapeutic relationship is one characterized by sharing, acceptance and appreciation, while, according to Kirchner (2009), it is also authentic, non-judgmental, and based on dialogue. Kirchner (2009) states that both verbal and non-verbal communication are important aspects of the relationship in order to experience together the awareness, beliefs and typical patterns of contact.

2.3.2 The importance of a therapeutic relationship

The therapeutic relationship is the most significant and essential part of the therapeutic process (Dattilio, Freeman & Blue, 2000:230; Landreth, 2002:79; Ray, 2011:63; Schoeman & Van Der Merwe, 1996:4; Scheafer, 2011:88) that can be implemented successfully to help children and uncover their innermost thoughts and feelings. To develop a therapeutic relationship, however, is one of the most complicated steps in the therapeutic intervention, yet it is essential to communication and understanding in therapy (Blom, 2006:54; Dattilio, *et al.*, 2000:230; Van Der Merwe, 1996:22).

Therapeutic success depends on the strength of a trusting therapeutic relationship and Van Vollenstee (2006:19) believes that therapy with a child diagnosed with AS will be unsuccessful without it. The therapeutic relationship is the element that is most significant and helpful in creating lasting, positive change (Bratton, Ray & Landreth, 2008:584). Children diagnosed with AS, however, have difficulty forming relationships because they see

the world differently and have difficulty with conversation (Hull, 2011:15). Howlin (2003:1) stated that children with AS “see the world in intense and ingenious ways that refuse the existing paradigms of their school and peer culture”.

Kapp (2011) believes that the therapeutic relationship is a platform to practice and teach a child with AS skills such as understanding body language, listening skills and compromise, while incorporating sensory activities to help minimize the gap between mind and body. Clarke (2011) often spends therapeutic time trying to solve a social or emotional issue with a child with AS. Such children’s way of seeing the world, influences their reasoning, willingness to comply, understanding of goals and application of new skills learnt. Their difficulty with language and symbolism also creates barriers to therapy.

Clarkson (2004:19) believes that the main focus and value of the ever-changing encounter between therapist and child is the moment-by-moment process. The goal of the therapeutic relationship, therefore, is a complete and authentic meeting of two people that forms the core of the healing process, which Hycner (in Clarkson, 2004:19) calls the dialogic relationship. Children gain emotional resources, security and freedom during this dialogic relationship and start to view the therapist as someone they can connect with.

2.3.3 The characteristics of the therapist

Deep empathy, unconditional positive regard and genuineness are qualities that are widely accepted as the core conditions for therapists (Cochran, Nordling & Cochran, 2010:49; Raskin & Rogers, 2005:583). Landreth (2002:205) concurs that building such a therapeutic relationship requires patience, a special interest and a keen understanding of the unique perspectives and processes of children.

Hull (2011:25) states that children with AS are often bullied, rejected, ignored and misunderstood and therefore deserve an empathic, patient and understanding therapist with whom to form a bond. In order for such a child to feel safe, the therapist should be willing to observe and participate in a non-threatening and non-reactive way. The world through the eyes of children with AS is already threatening, dangerous and scary, therefore the therapist can expect resistance and should become comfortable with silence, as these children may appear aloof (Hull, 2011:22). Hull also suggests that it can be helpful for the therapist to be willing to follow directions when invited by these children to join in the play, as this creates

an opportunity for them to feel more in control. This creates an opportunity for the therapist to gain insight into that unique child. Hull (2011:25) asserts that using imagination and thinking outside the box is essential for the therapist in forming a connection with children with AS. Building the therapeutic relationship takes time; with children diagnosed with AS, it may take even longer and due to this, parents, teachers or caregivers might think that the process is not effective and consider terminating. Furthermore, the therapist should not allow the pressure to reach therapeutic goals to interfere with building a therapeutic relationship. The therapist might become frustrated or despondent by the lack of progress, but empathy towards children diagnosed with AS remains important (Hull, 2011:25). Crenshaw and Hardy (in Hull, 2011:26) believe that a lack of empathy hinders the relationship and causes the child to distrust the therapist and to remain distant or disinterested.

Axline (in Van Fleet, Sywulak & Sniscak, 2010:22) asserts that the therapist should establish rapport and develop a warm and friendly relationship with children. Axline also states that acceptance of and respect for children is important when building therapeutic relationships, while the belief that children have the ability to solve their own problems, take responsibility and make choices is vital in order to facilitate change. The therapist should establish an understanding of permissiveness in order to help children to feel free to express their feelings completely, while being able to recognize and reflect the children's feelings to give them insight into their behaviour (Axline in Van Fleet *et al.*, 2010:25). Children should also be allowed to take the lead with regards to conversations and actions in therapy, while the therapist should be patient and avoid hurrying the gradual process along (Axline in Van Fleet *et al.*, 2010:34).

Schoeman (1996:30) believes that it is important to supply the child with information when necessary to help him understand that the therapist is reliable and to help build the child's self-esteem. The child has the right to knowledge of his environment and situation.

2.3.4 The main stages of building a therapeutic relationship

The therapeutic relationship can be divided into three main stages (Gilbert & Leahy, 2007:27). The first stage is establishing the therapeutic relationship with the engagement process and engagement objectives as main focus. The engagement process requires the therapist to convey empathy, warmth, genuineness and includes negotiating of goals, collaborative framework, support, guidance and affirmation. The engagement objectives are

discussed to conclude what the expectations, intentions, motivation and hopes of therapist and client are. Field theory can be used to elaborate on the first stage from a Gestalt point of view in order to describe and define the important aspects of children diagnosed with AS's field and background information.

The second stage is the development of the therapeutic relationship. From a Gestalt perspective, the phenomenological approach, awareness, contact-making, dialogue and I-thou relating will be discussed during this stage as this constitutes a more complex part of relationship building. The third stage involves maintaining the relationship, which includes relationship satisfaction, a productive working alliance, emotional expression and change in awareness.

2.3.4.1 Establishing the therapeutic relationship

Field theory, as described by Yontef and Jacobs (2011:343), is the understanding of how one's experience is influenced by one's context and perception of that context. Furthermore, Parlett (2005:43) describes field theory as the complete situation of the evolving therapeutic setting; the therapist, child and everything it involves. The therapeutic relationship is therefore directly linked to the field and influences it. The therapist's internal field will be relevant to this study, as well as children diagnosed with AS's field and process.

Field theory, in this case the field of children diagnosed with AS, can be defined by the following four principles:

Firstly, the **principle of organization** states that the meaning derives from looking at the total situation and that everything is interconnected (Parlett, 2005:52). Therefore, the therapist's comprehension and sharing of the children's world view is important, as the therapist forms a part of the field and is not detached from it (Parlett, 2005:47). This principle highlights the importance of having extensive knowledge and understanding of AS in order to enter into a therapeutic relationship with a child diagnosed with AS. Understanding AS can help therapists reduce the emotional distress during therapy for these children and thus makes appropriate education on AS vital. Gilbert and Leahy (2007:27) are of the opinion that the history and background of both the therapist and children are important aspects to consider during the establishment of the therapeutic relationship. Leventhal-Belfer and Coe (2004:132) state that individual therapy may be helpful only when the therapist understands how the child with AS experiences the world. Children with AS

experience the world differently from other children (Attwood, 2008:13; DuCharme & McGrady, 2003:3; Lombard, 2004:2; Patrick, 2008:14), therefore their experience contributes to their field and different ways of interacting, thinking and feeling.

Secondly, the **principle of contemporaneity** states that it is the constellation of influences in the present field that explains present behaviour (Parlett, 2005:52). In order to understand present behaviour, the therapist has to be aware of every aspect of a child's field. A therapist should take into account that these children's behaviour is directly linked to their awareness and understanding of their world, which will be influenced by the symptoms of AS.

Each person and situation is unique and this is the **principle of singularity** (Blom, 2006:19). This is also true of children diagnosed with AS, regardless of the diagnosis, they remain unique. The **principle of the changing process** thirdly states that the field is undergoing continuous change (Parlett, 2005:52). The **principle of possible relevance** lastly states that all aspects of the field are relevant; nothing can be excluded and all aspects should be explored (Parlett, 2005:50). Knowledge of AS, of the specific child and of the child's environment or field is relevant here, as every child is unique and needs to be treated in a holistic way (Reynolds, 2005:159; Van Vollenstee, 2008:19). Reynolds (2005:154) states that the therapist can form a better understanding of the child and his field by using the field phenomenological approach during the development of the therapeutic relationship.

Hull (2011:55) believes that a connection between a child and therapist requires the therapist to be patient and willing to set aside personal ideas of the therapeutic process and traditional ideas of building rapport. Building a therapeutic relationship requires the therapist to avoid pretence, judgment and sarcasm and instead become part of the child's world. Furthermore, Hull (2011:55) also states that children diagnosed with AS can easily recognize patronizing and dishonest behaviour. The therapist should learn what children's interests are and never assume knowing what their needs are. Hull (2011:56) mentions that patience is another important aspect and advises therapists to speak slowly, clearly and in simple, clear language. Furthermore, it seems important for therapists to avoid vague references and accept the children's answers. Therapists should become comfortable with silence and pay attention to non-verbal language and body language, therefore pay attention to how the child shares information in order to learn the language of that particular child. The therapeutic relationship becomes even more important due to their emotional and social barriers and

requires patience and focusing only on being in the presence of the child. Only then will the child feel safe enough to trust the therapist. Every child is unique with different personalities, interests and abilities. The therapist should focus on remaining open, curious and present in order to develop empathy and understanding of that specific child (Hull, 2011:21). Lastly Jacobsen (in Hull, 2011:21) asserts that building a therapeutic relationship can be difficult if one has no experience with children diagnosed with AS.

2.3.4.2 Developing the therapeutic relationship

The phenomenological approach focuses on the here and now, the actual experience of the child, not the concepts, beliefs, ideas and theories (Yontef, 1993:249). This approach helps a therapist explore and experience who the child is in his own perspective. The existential perspective states that people are growing and changing themselves on a continual basis (Dattilio, *et.al.*, 2000:231). Lombard (2004:2) and Patrick (2008:14) highlight that children diagnosed with AS struggle with change and can appear stubborn to it. They seem to have a fear of the unknown and it can often create difficulty during therapy. They might be less reluctant to try new things if they feel comfortable with the therapist (Raskin & Rogers, 2005:583), therefore, Hull (2011:26) suggests that children diagnosed with AS respond best when there is a regular organized routine, thus establishing such a routine will positively influence the development of a therapeutic relationship.

Awareness

In the phenomenological-existential approach the focus is on the children's direct experience of existing as human beings, growing and developing and relating to themselves and to others, according to Yontef (1993:250). Children's experience, development and relating to self and others require awareness. Astington and Edward (2010:1) and Attwood (2008:112) are of opinion that these are aspects that children diagnosed with AS struggle with.

Gilbert and Leahy (2007:98), however, state that in order to develop a therapeutic relationship, children should be capable of becoming aware of themselves, the people around them and the environment. Awareness constitutes sensory experience, feelings and thoughts with self-observation, self-knowledge, responsibility and creativity at the core (Joyce & Sills, 2006:27). Furthermore, Anderson (2008:1) states that awareness can be explained as "being in touch with your own experience while making contact with the world around you and the people you interact with". Awareness is on a sensory, cognitive and affective level and

includes knowing and accepting yourself as well as the world and the people around you. Becoming aware involves the children recognizing that they are responsible for their own behaviour and feelings (Yontef, 1993:181) and helps them to understand the consequences, alternatives and choices they make (Anderson, 2008:2). Awareness of self improves emotional awareness and expression, as well as social interaction (Schaefer, 2011:52). Children diagnosed with AS appear to lack self-knowledge and struggle to communicate creatively, socially and emotionally (Attwood, 2008:13; Lombard, 2004:2; Patrick, 2008:14), creating a barrier in the process to positive change (Schaefer, 2011:175).

Healthy contact-making

Anderson (2008) maintains that awareness arises through the interaction and relation of developing a therapeutic relationship. The interaction within a therapeutic relationship that is essential to facilitating awareness requires healthy contact-making (Blom, 2006:90). Healthy contact-making consists of three components, namely sensory contact-making, bodily contact-making and strengthening of the sense of self (Oaklander in Blom, 2006:89). Sensory contact-making and bodily contact-making refers to how children are in touch with themselves and the world around them (Blom, 2006:90; Yontef, 2005:88). Strengthening of the sense of self, according to Blom (2006:102) is important to children's development. Furthermore, children with a strong sense of self can make healthy contact. Children diagnosed with AS find it difficult to make healthy contact due to their sensory difficulties (Aylott, 2000:852), social impairment (Patrick, 2008:14), lack of theory of mind (Astington & Edward, 2010:1), emotional problems (Blom, 2006:91) and communication difficulties (Attwood, 2008:13; Lombard, 2004:2). Such difficulties could result in contact boundary disturbances within children (Blom, 2006:89).

Blom (2006:31) maintains that contact boundary disturbances occur when children become ill-equipped in maintaining a healthy balance between themselves and their environment. Children can no longer meet their own needs and the disturbance in contact and awareness leads to unhealthy ways of contact-making and relating. Contact boundary disturbances which might be applicable when building a therapeutic relationship with a child diagnosed with AS are defined and subsequently discussed:

- An introjection is the disturbance that arises when children do not critically incorporate the contents of their environment and it remains unprocessed (Blom, 2006:32). Children sacrifice their own opinions and beliefs, accept the environmental

belief and remain unaware. The result is a rigid personality (Yontef, 1993:137) and interference with self-regulation, which leads to unfinished business.

- Deflection, according to Blom (2006:36), refers to avoiding direct contact with others, which reduces awareness of self and the environment. Children diagnosed with AS find it difficult to interact with other people and often avoid social interaction (Patrick, 2008:14).
- Children diagnosed with AS have difficulty with their sensory experiences and awareness (Aylott, 2000:852), which may result in desensitization. They avoid becoming aware of the sensations of their bodies and therefore avoid their emotions (Clarkson, 2004:59).
- Blom (2006:39) explains that egotism hinders children's ability to satisfy their needs. Children are not subjectively or emotionally aware of their experience, thus avoid contact with the self and others. Children diagnosed with AS, try to control the uncontrollable by avoiding emotional contact and spontaneity (Clarkson & Mackewn, 2003:77; Clarkson, 2004:64). Blom (2006:39) believes that children that make use of egotism find it difficult to play spontaneously, do projections and use fantasy during therapy; all characteristic of children diagnosed with AS (Lombard, 2004:2; Patrick, 2008:14).

Contact-making is a prerequisite for experiencing other people's thoughts, feelings and ideas, without which forming a relationship is difficult (Blom, 2006:29). The therapeutic relationship and contact is dependent on self-responsibility, directness, caring, acceptance and warmth (Anderson, 2008:2). Children diagnosed with AS may have difficulty becoming fully aware of themselves and others, understanding their field and taking responsibility for their thoughts, feelings and behaviour due to their difficulties caused by the disorder. The therapeutic goal is to facilitate children to explore their awareness, thoughts, feelings, ideas and behaviour in a safe and trusting environment. In order to improve on the children's contact-making skills, the therapist should be able to focus on verbal and non-verbal communication (Yontef & Jacobs, 2011:361) and accept that the child's reality is an equally valuable experience.

Dialogic relationship

Joyce and Sills (2006:43) consider the dialogic relationship between the therapist and child to be the prerequisite in developing the therapeutic relationship and subsequently, awareness. The dialogic relationship is characterized by a non-judgmental, genuine willingness to understand the child through exploration and experience in the here and now; the present moment (Anderson, 2008:2; Buber in Joyce & Sills, 2006:43; Landreth, 2002:86; Yontef, 1993:127). The therapist should aim to be authentic, validating, understanding and fully present during the development of a therapeutic relationship in order to initiate change and growth. Alao, *et al.* (2010:109) lists four aspects of existential dialogue within a therapeutic relationship:

Firstly, inclusion is the practice of putting oneself into another's situation and experience (Mann, 2010:179; Yontef, 2005:95; Yontef, 1993:218). Buber (in Yontef & Jacobs, 2011:361) states that inclusion is feeling the experience of the other while being aware of one's own self. Inclusion includes the awareness of the therapist's own feelings, reactions and experiences (Joyce & Sills, 2006:46), however, can prove to be challenging with children diagnosed with AS due to their struggle to put themselves in others shoes and their lack of theory of mind (Attwood, 2008:112).

Secondly, Joyce and Sills (2006:45) highlight the influential curative power that confirmation can have when children feel understood and attended to. Yontef (2005:96) states that confirmation is about validation, self-acceptance and forms the foundations of a secure sense of self (Joyce & Sills, 2006:45). Confirmation creates a sense of unconditional acceptance (Joyce & Sills, 2006:46) and supports change (Mann, 2010:183).

Third, the therapist should also be truly present and genuine (Anderson, 2008; Mann, 2010:181; Yontef, 2005:96; Yontef, 1993:219). Joyce and Sills (2006:44) state that therapists should remain in the here and now within their own senses, thoughts and processes, as well as staying present to the child and the therapeutic relationship. Therapists should not pretend to be interested when feeling distracted or pretend to be supportive when feeling annoyed.

Fourth, Mann (2010:185) and Yontef (1993:220) believe that commitment to dialogue enables contact and freedom to an unplanned and unpredictable dialogue during therapy, therefore dialogue is an uncontrolled meeting of two people. Children diagnosed with AS will struggle with these aspects due to lack of theory of mind, social difficulties and communication difficulties. Joyce and Sills (2006:50) list willingness for open communication as another cornerstone of the dialogic relationship, within which sharing of experiences in an honest and authentic way is an essential part of developing the therapeutic relationship.

The dialogic relationship is described by Jacobs (in Joyce & Sills, 2006:54) as alternating between I-it and I-thou relating. Kirchner (2009) states that the therapist should be present, genuine, inclusive and aware of the client's needs and in doing so create an I-thou relationship. Furthermore, Blom (2006:89) asserts that contact-making facilitates the I-thou relationship. I-thou contact in therapy is offered when the principles of the dialogic relationship is practiced (Joyce & Sills, 2006:53; Yontef in Blom, 2006:19) and contributes to the dialogic relationship (Mackewn, 2004:82). Buber (in Joyce & Sills, 2006:43) believes that an I-thou moment is the result and highest achievement of a dialogic relationship. Therapist and child experience each other as they truly are and share awareness during I-thou contact (Alao, *et.al.*, 2010:108; Mackewn, 2004:82). Trust is a key element in an I-thou relationship, as well as equality between the therapist and child (Van Vollenstee, 2006:19), therefore, Joyce and Sills (2006:53) suggests that the therapist attempts to refrain from analysing or manipulating. The therapist might find it difficult to enter an I-thou mode of relating when the experience of the child is unfamiliar or misunderstood, as in the case with children diagnosed with AS (Joyce & Sills, 2006:55). Mackewn (2004:85) states that I-thou moments arise as a subjective connection between therapist and client and is balanced by I-it moments. Joyce and Sills (2006:54) describe an I-it relationship as our previous experiences of life, therapy and relationships. This is how we spend most of our time relating to our environment. This encompasses our own field and interpretations of situations, relations and communications. Effectively predicting situations, behaviours and consequences depends on I-it relating and entails the more practical side of our lives and therapy. I-it relating is important and the therapist should be aware of and modulate the intensity of their presence and communication to serve the child optimally.

2.3.4.3 Maintaining the therapeutic relationship

Gilbert and Leahy (2007:31) describe maintaining the therapeutic relationship within four main aspects. Firstly, the maintenance depends on the children's continual satisfaction of the therapeutic relationship. This requires constant evaluation by the therapist in order to determine if the children's needs are being met (Gilbert & Leahy, 2007:31). Furthermore, the therapeutic relationship should be a helpful and positive working alliance based on quality and strength. Thirdly, Gilbert and Leahy (2007:32) emphasize the importance of the increase in the ability of the children's emotional expression. Maintaining the therapeutic relationship should lead to an increase in self-awareness, an understanding of self and a positive change in way of thinking. Lastly, the maintenance of the therapeutic relationship should encompass helping the children exploring alternatives to their behaviour, way of thinking and viewing the world (Gilbert & Leahy, 2007:32). This, in turn, will facilitate the children's experience of self and a change in the view of self with others.

2.3.5 Challenges therapists may experience while building a therapeutic relationship with children diagnosed with Asperger Syndrome

Hull (2011:13) is of opinion that it is emotionally and mentally challenging to work with children diagnosed with AS and that therapists should be willing to modify their approaches. The therapist can feel lost and confused when beginning to try to connect with children diagnosed with AS. Accepting the lack of traditional verbal and social reciprocity and becoming comfortable with it, helps ease this process. Some resistance is expected, but therapists are not used to being completely ignored or dismissed. The therapist should keep in mind that the therapy room can provoke feelings of anxiety for children diagnosed with AS, as the therapeutic environment does not fit into the mental, emotional or social context of the children (Hull, 2011:14).

Therapists should remain aware of the fact that parental input is another essential part of building a therapeutic relationship with a child diagnosed with AS (Bromfield, 2010:13; Sanders, 2003:13). Parents provide important information with regards to the child, their experience and coping skills that is beneficial to the early stages of therapy.

Parental beliefs also influence the working relationship and attitude towards therapy (Hull, 2011:29). Frustration within the therapist may occur due to pressure from the parents to bring about change and, furthermore, a family unit under stress or parental unit struggling to cope can be challenging for the therapist to work with (Hull, 2011:3). Hull also believes that

therapists should be weary of getting discouraged, but rather encourage and educate family members on AS, the therapeutic relationship and healthier ways of communicating. Parents do not always understand the time and effort it takes to build a therapeutic relationship with a child diagnosed with AS. The therapist needs to be an advocate for parents and family members so that they can better understand the process as well as form part of the solution. The family members need to participate and actively be involved instead of creating barriers through ignorance (Hull, 2011:18). Strengthening of the family unit is important since children cope better when the family unit is strong and they use healthy coping skills.

Another important aspect to consider when building a therapeutic relationship according to Gibbons and Goins (2008:7) is collaboration and consultation with other professionals. Alliance with other professionals can provide insight into AS, the specific child as well as methods of building a therapeutic relationship. Regular contact with other professionals helps therapists come up with creative plans and ideas to assist in establishing, developing and maintaining a therapeutic relationship. This is of particular value when the other professionals know the child. A good support system and regular meeting can help alleviate some of the frustration and feelings of inadequacy that are often experienced by the therapists. Sanders (2003:3), agrees that knowledge shared amongst professionals is valuable in increasing the understanding of AS in order to build a therapeutic relationship.

DuCharme and McGrady (2003:3) are of opinion that the social difficulties children diagnosed with AS experience, makes building a therapeutic relationship challenging. Their difficulty with engaging causes such children to be reluctant to try to form relationships, often feeling despondent and frustrated (Ramsay *et al.*, 2005:488). This pattern may influence the trust and functioning of a therapeutic relationship with children diagnosed with AS, and in turn, may take longer for the therapy to be effective. They suffer from a deficit in joint attention which is an important element in building relationships (Hull, 2011:15). Children diagnosed with AS stay in the egocentric toddler mode on a social level (Hull, 2011:16). They assume that everyone is there to attend to them. Gillberg (2002:125) asserts that children diagnosed with AS are sensitive to ordinary aspects and stressors of life, emphasizing the importance of a relationship to provide an environment that can be helpful. Hull (2011:15) is of opinion that insight-oriented therapies are unsuccessful due to the lack of perspective-taking and that children diagnosed with AS struggle to see other people's viewpoint. Their one track thinking, such as repetition of conversation and behaviour, creates

relationship barriers and can be frustrating for the therapist. Children diagnosed with AS tend to ignore or shut down when the topic does not interest them and can ramble on about their topic of choice (Hull, 2011:15).

Neuro-typical children have the ability to foster relationships through eye contact, reciprocal facial movements and body language from an early age and it continues to expand and develop. Children diagnosed with AS struggle continuously with the signals getting crossed and the learning process being disrupted and delayed (Hull, 2011:15). Therapists are trained that communication flows and that children respond to questions, which is not the case with AS. The information shared by children diagnosed with AS may be confusing or irrelevant to therapy (Hull, 2011:4).

2.4 CONCLUSION

The literature highlights the difficulties children diagnosed with AS face, as well as a recommendation of a variety of treatment options. Treatment focuses on the correct management of these children and education of professionals, teachers and parents. The literature further points to evidence of the challenges of building a therapeutic relationship with children diagnosed with AS, that the therapist should be aware of and consider more in order to achieve success during therapy by using the therapeutic relationship.

Chapter 3: Research methodology

3.1 INTRODUCTION

The focus and aim of this study is to explore and describe the components required to build a therapeutic relationship with children diagnosed with AS. The research methodology that guided this study was outlined in Chapter 1 and will be elaborated upon in this chapter in order to demonstrate how the research methodology was implemented to answer the research question (see 1.2).

3.2 RESEARCH PROCESS

Research process, according to Taylor (2005:77) is a circular design that starts with a question or problem and ends with an answer or solution to that particular question or problem. The process, furthermore, involves a series of steps that begin with the literature review, design and data collection and ends with analysis and interpretation of data (Jackson, 2010:27). The general purpose or aim of research according to French, Reynolds and Swain (2001:5) is to expand knowledge and understanding of the problem by analysing data collected. In this study, the researcher aimed to explore which components are required to build a therapeutic relationship with a child diagnosed with AS.

3.2.1 Analysis of literature

An examination of the main concepts in the study was done in the literature review in the previous chapter. The literature was obtained from relevant books, articles, research reports, proposals and journals, as well as internet searches on databases such as EPSCOhost, GoogleScholar, ProQuest, Questia and Pubmed. AS was defined and the diagnostic criteria were summarized. The causes and prevalence were discussed in depth using a variety of different up to date sources. Treatment, therapy and reasons for referral were explored and discussed. The therapeutic relationship was examined by focusing on the definition of the therapeutic relationship from different sources, as well as the importance of a therapeutic relationship and the characteristics of the therapist that contribute to building a therapeutic relationship. The latter is an important aspect as the therapist forms an integral part of the therapeutic relationship building process and can influence children's responses. The stages of a therapeutic relationship proposed by Gilbert and Leahy (2007:27) were examined and Gestalt concepts were incorporated to add knowledge and understanding to the components required to build a therapeutic relationship. Then, the challenges therapists may face during

the forming of a therapeutic relationship such as, emotional and social aspects, parental involvement and involvement of other professionals, were investigated.

3.2.2 Empirical investigation

This section explains the research design, describing the framework and rationale of the design chosen. An in-depth description of the participants is also done.

3.2.2.1 The design

According to Jackson (2010:101), a qualitative research approach will be used when a researcher is not interested in quantifying, simplifying or objectifying data, but instead focused on interpreting findings. Furthermore, qualitative research intends to develop insight into the perceptions and experiences of a specific group of individuals or small samples of individuals that are purposefully selected (Fouché & Delpont, 2011:64; Taylor, 2005:104). According to Howitt and Cramer (2011:307), this form of research provides extensive, detailed data. Furthermore, an inductive approach used in qualitative research focuses on developing insights and generalizations from the collected data (Neuman, 2011:60; Taylor, 2005:101). The researcher used an inductive, qualitative method to gain insight into the components required to build a therapeutic relationship with children diagnosed with AS. The researcher therefore explored the opinions and experiences of a selection of therapists from different therapeutic contexts that work with children diagnosed with AS.

Jackson (2010:15) describes applied research as the study of psychological matters of practical importance and potential explanations. Neuman (2011:25) adds that applied research is conducted to address specific problems or concerns and in order to generate possible solutions and recommendations. According to Shaughnessy, Zechmeister and Zechmeister (2012:49) the aim of applied research is to potentially improve a selected group of people's lives. The concern that working with children diagnosed with AS may pose a challenge to build a therapeutic relationship is chosen as the psychological concern in this research study. The researcher believes that this study could create awareness of the components required to build a therapeutic relationship, as well as create awareness of the challenges faced by therapists with regards to the therapeutic relationship.

Babbie (2010:92) lists three common objectives in research: exploration, explanation and description. Exploratory research is performed to gain insight into a situation, individual,

phenomenon or community (Fouché & Delport, 2011:95). Descriptive studies aim to create a picture of the details of a situation, social setting or relationship (Babbie, 2010:100; Fouché & Delport, 2011:96). The researcher aimed to explore and describe the opinions of therapists working with children diagnosed with AS in order to gain insight into building a therapeutic relationship with these children. The researcher strived to create a detailed picture of the relationship and make recommendations to therapists working with children diagnosed with AS.

Shaughnessy *et al.*, (2012:282) maintain that a case-study is a thorough description and examination of an individual or a small group and is a source for gathering ideas and information about behaviour (Shaughnessy *et al.*, 2012:285). Jackson (2010:102) describes the case-study design as a thorough investigation of a group of individuals to reveal similarities and common perceptions to the bigger population. It is often used as hypotheses for further studies or ways of gathering information on uncommon phenomena. The case-study design explores and analyses an individual or multiple individuals (Fouché & Schurink, 2011:320-323; Nieuwenhuis, 2010:75-76). In this case, a sample of therapists and their experience and knowledge was explored and analysed to obtain information about the components required to build therapeutic relationship with children diagnosed with AS.

3.2.2.2 Participants

The population of a research study refers to individuals in the universe that fit the selection criteria and consists of all the individuals of interest (Gravetter & Forzano, 2011:138). The population of this study consisted of therapists working from different disciplines with children diagnosed with AS in the Nelson Mandela Metropolitan. The sample is selected from the population and is intended to represent the population (Gravetter & Forzano, 2011:138). The sample of this study was different therapists working with children diagnosed with AS at schools for children with learning difficulties, Autism and AS or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan. For the purpose of this study, the therapists consisted of Occupational therapists, Speech therapists, Counselling Psychologists and Clinical Psychologists. The list of therapists was compiled from professional relationships and a list of references obtained from schools for children with learning difficulties, Autism and AS in the Nelson Mandela Metropolitan.

Strydom (2011:222) differentiated between probability sampling and non-probability sampling. Probability sampling is based on a random selection procedure. The probability of a sample is one in which each sampling unit has the same probability of being selected. Non-probability sampling is based on the judgment of the researcher; it saves time and is more cost-effective (Gravetter & Frozano, 2011:151). The participants were selected in terms of their willingness and availability to participate. A portion of the population was selected for the study by using purposive non-probability sampling. A purposive sample is particularly chosen because it consists of most characteristics of the population of interest (Howitt & Cramer, 2011:237; Strydom, 2011:232).

The criteria for inclusion for the purpose of this study were the following:

- Therapists working at schools for children with learning difficulties, Autism and AS or therapists who form part of the referral teams of these schools in the Nelson Mandela Metropolitan.
- Therapists working with children diagnosed with AS
- Therapists should have at least two years' experience in working with children diagnosed with AS in order to ensure that the therapists have a high degree of understanding of AS
- Therapists should be either Afrikaans or English speaking and be prepared to voluntarily participate in the study
- Therapists should be willing to participate

3.2.3 Data generation

For the purpose of this study the researcher used semi-structured interviews to generate data. A semi-structured interview is considered to be a balance between a structured and unstructured interview where open-ended questions are used as part of the interview schedule, to not restrict the participants' choice of answers, yet are focused enough to discuss the topic in detail (Srivastava & Thomson, 2009:75). Qualitative research aims to describe the characteristics of data gathered through semi-structured interviews with a group of individuals with a common trait (Howitt & Cramer, 2011:294). The focus is on conversations during interviews and is concerned with human experience and interaction (Howitt & Cramer, 2011:296).

Flick (2009:156) describes subjective theory as the participants having an extensive knowledge on the topic discussed which includes assumptions and unique thoughts that can be used to add to the researcher's subjective knowledge. The information is reconstructed during the interviews by using open-ended questions which allows for considerable information to be obtained. The researcher compiled a semi-structured interview schedule (see Appendix A) consisting of open-ended questions which was used to guide the interviews. Howitt and Cramer (2011:314) explain that the interview schedule is a basic outline of what the researcher intends to cover. The researcher referred to the interview schedule to ensure that all the topics were covered. The questions were developed in terms of the requirements of the research and were adjusted to take into account the new information learnt through earlier interviews. The questions were structured in a sensible manner in order to create structure and simplify analysis of data. The researcher probed and clarified in such a way to extend to the detail of information gathered during the interview. Basic information such as years of experience, current position and qualifications, were recorded in a standardized manner.

Howitt and Cramer (2011:301) assert that the qualitative researcher uses video-recording and an extensive amount of open-ended interviews to ensure that complete representation is included. These authors also emphasize the importance of recording and storing the semi-structured interviews on reliable equipment and in an ethical manner. A digital video camera of good quality was used to record the interviews and the recordings were stored on a password protected external hard drive. The researcher conducted the interviews at the participant's homes or offices for their convenience.

3.2.4 Procedures

A pilot study allows the researcher to draw conclusions about certain elements of the study, as well as determine which adjustments to make (Terre Blanche, Durrheim & Painter, 2006:94). It also contributes to the suitability of the interview schedule, data collection procedure and evaluation of the study, as stated by Strydom and Delpont (2011:390).

The pilot study was conducted with a small sample of the population consisting of two therapists that participated in the study, to determine the trustworthiness and effectiveness of the study (Strydom & Delpont, 2011:391). Two therapists were selected that fit the criteria of

inclusion as referred to in 3.2.2.1. The semi-structured interviews were done and changes were made to the interview schedule before the empirical investigation began.

The sample criteria allowed for eighteen participants to be approached of which six agreed to participation. The appointments were made by telephone at the convenience of the participants. The aims and procedures were discussed upon agreement of participation. Ethical aspects such as anonymity, confidentiality and right to withdraw were discussed and an informed consent form was signed at the first contact (see Appendixes B & C).

The interviews were done over a period of one month and subsequently, the digital video recordings were used in order to transcribe the interviews. The transcriptions were done using methods described by Flick (2009:299-303). These methods involved aspects such as transcribing exactly what a participant said, indicating turn-taking, breaks and body language, as well as ensuring anonymity of participants and data. Flick (2009:299) describes the transcriptions as an important step in analysing and interpreting the data. Much care was taken to transcribe the content of the video recordings as exact as possible.

3.2.5 Data analysis

Qualitative data analysis involves the researcher examining and interpreting the data collected through extensive notes and transcriptions. It is a conceptualizing process that involves searching for patterns in order to create themes (Jackson, 2010:106). Lacey and Luff (2009:14) and Srivastava and Thomson (2009:75), describe Framework analysis as a flexible way of sifting through data in order to chart and sort the data into relevant themes, by providing organized and visible stages for the analysis process. The stages are familiarization, identifying a thematic framework, indexing, charting and mapping, and interpreting (Lacey & Luff, 2009:13; Srivastava & Thomson, 2009:75). Framework analysis is based on the observations of the individuals being studied and the process is comprehensive which allows the researcher to gain a detailed picture of the participant's opinion (Srivastava & Thomson, 2009:77). Srivastava and Thomson (2009:77) consider this method to be ideal for a study of limited scope with a predetermined sample population that aims to generate recommendations to the population.

The researcher familiarized herself with the data by methodically transcribing the video recorded material, carefully reading through the transcriptions and taking detailed notes. This process allowed the researcher to become aware of the themes and important concepts. Identification of themes involved making judgments about meaning, relevance and importance of the transcribed material. The researcher focused on recurring ideas to identify the themes. The themes were indexed by applying colour codes and texts to the themes and grouping these together in chart form for each participant. The charts list the main themes, subthemes and extracted text from each interview. A summary of all the themes and subthemes were compiled into one document. Lastly, the vital characteristics were analysed in order to provide a schematic map of the information. The researcher searched for patterns, associations, defined concepts and explanations in the data. The research question was kept in mind and the important characteristics identified, reflected the true thoughts of the participants. The analysed data is discussed and integrated with relevant literature in chapter 4.

3.3 ETHICAL ASPECTS

Rubin and Babbie (2010:78) describe ethics as being linked to morality and indicative of what is right and wrong. Furthermore, Terre Blanche *et al.*, (2006:61) state that “Research ethics should be a fundamental concern of all social science researchers in planning, designing, implementing, and reporting research with human participants.” The following ethical considerations were applied throughout the research process:

3.3.1 Harm to participants

The researcher has an ethical obligation to ensure that no physical or emotional harm came to the participants and the nature of the research should be changed in order to prevent harm, where necessary (Babbie, 2010:66; Flick, 2009:41; Strydom, 2011:115; Terre Blanche, *et al.* 2006:67). Sensitive and personal information about the participants was not included, unless it was crucial to the research. Due to the nature of the research, there was minimal risk of emotional harm and no risk of physical harm; however, the research was conducted in a respectful manner.

3.3.2 Informed consent

According to the Health Professions Council of South Africa's guidelines (2007:5), informed consent is when participants are given adequate information to facilitate them to exercise their right to make informed decisions about their participation. Furthermore, Babbie (2010:72) states that written consent should be obtained and all possible risks should be discussed. Flick (2009:41), Strydom (2011:117) and Terre Blanche, *et al.* (2006:71) emphasises the importance and necessity of informing the participants of every aspect of the study, including the goal, procedures and credibility of the researcher. The information on the informed consent form was accurate and complete and allowed participants to fully comprehend what the study is about, as required by Flick (2009:41). Strydom (2011:116) emphasizes that participation should be voluntary and that the participants have the right to withdraw at any time, which the participants were informed of. The participants had to be legally and psychologically competent to give consent (Terre Blanche, *et al.*, 2006:71). The researcher ensured that all the participants that were involved were legally and psychologically competent to give consent by considering their professional positions and ages. The researcher ensured that the information given was clear, complete and in a language understood by the participants. It was important to allow adequate time for participants to ask questions. Written consent (see Appendix B) was obtained to do the interviews as well as digital video recordings of the interviews. An offer to provide participants with a summary of the research findings was made, as is suggested by Neuman (2011:136).

3.3.3 Deception of participants

Thomas and Hodges (2010:84) highlight the importance of honesty and truthfulness during research. No information should be withheld or represented incorrectly as to deceive participants to comply (Flick, 2009:37; Strydom, 2011:119). The researcher informed participants about every aspect of the study as the research objective was to make recommendations to the therapists after the study has been completed.

3.3.4 Anonymity and confidentiality

Babbie (2010:565) states that anonymity implies that neither the researcher, nor the readers of the research results can determine the identity of the participants. Strydom (2011:120) maintains that informed consent and promise of confidentiality is necessary to ensure the privacy of the participants will respected and the identity of participants will be protected,

and the researcher adhered to these aspects in every possible way. The data was stored in a safe place where only the researcher had access as suggested by Flick (2009:42). Due to the qualitative nature of the study whereby the participants partook in semi-structured interviews, complete anonymity is possible, but the participants' anonymity and confidentiality were maintained and respected by withholding the names of the participants in the collected data and research report. The digital video recordings were viewed only by the researcher in order to protect the participants' identity.

3.3.5 Actions and competence of researcher

The researcher should be adequately skilled and competent to have done the research (Strydom, 2011: 114) and Thomas and Hodges (2010: 84) state that the researcher should be fair, objective and unbiased in the case of personal relationships and interests as to avoid conflict of interest. The researcher's personal values and interest should not influence the research methods or findings (Thomas & Hodges, 2010:85). The researcher is a registered counsellor and is working under supervision and has received training in the Master's programme to enable her to conduct the research competently.

3.3.6 Release of findings

The research findings are released in the form of a dissertation that was compiled as accurately and objectively as possible. Plagiarism, as cited in Babbie (2010:524) and Thomas and Hodges (2010:86), was avoided by giving recognition to all sources used during the research process. According to Strydom (2011:126) the researcher should admit to errors and limitations of the study and remain objective and sensitive when findings are released. The limitations of the study will be discussed in chapter 5.

3.4 TRUSTWORTHINESS

Nieuwenhuis (in Maree, 2007:113), expresses the importance of trustworthiness in qualitative research. Terre Blanche, *et al.*, (2006:90) describe trustworthiness as the extent to which the research findings are reliable and is determined during the research process. Furthermore, the researcher is responsible to search for inconsistencies in the data and ensure that the findings are valuable and reliable (Terre Blanche, *et al.*, 2006:91). Nieuwenhuis (in Maree, 2007:113) states that the assessment of trustworthiness involves testing the data analysis, the results, interpretations as well as the conclusions of the study. The results of the study should correspond with the data gathered. Therefore, the researcher consulted Nieuwenhuis (in

Maree, 2007:114-115), Terre Blanche, *et al.*, (2006:91-92), Shenton (2004:64-72) and Thomas (2003:4-7) for strategies to guarantee the trustworthiness of this qualitative research study. These strategies together with Guba's (in Shenton, 2004:64) four key concepts were kept in mind throughout this qualitative research study.

3.4.1 Credibility

The credibility of the findings refers to how accurately the data has been recorded and how compatible the findings are with reality (Nieuwenhuis in Maree, 2007:114). A thorough literature review was conducted using a variety of resources to build a sound knowledge base on the subject. The use of a variety of resources to obtain knowledge ensures that the findings will be accurate (Nieuwenhuis in Maree, 2007:114). The researcher used reliable and correct research methods throughout the research process in order to contribute to the credibility of the study.

Honesty formed part of building rapport with the participants and anonymity and confidentiality of the participants contributed to the credibility of the data (Nieuwenhuis in Maree, 2007:115). The credibility of the data was checked by the study leader and co-study leader throughout the duration of the study, and feedback from participants were obtained by conducting member checking after data gathering. Member checking involved three participants reading through their transcripts and checking for accuracy. The themes were also verified by the three participants.

3.4.2 Transferability

Guba (in Shenton, 2004:69) and Terre Blanche, *et al.*, (2006:91) explain that transferability or generalizability is the extent to which the findings can be applied to the greater population. Furthermore, Malterud (2001:485) explains that transferability refers to the limitations for the application of the findings beyond the context of the study. Qualitative research findings are specific to a small number of individuals and therefore it is difficult to demonstrate that the findings and conclusions are applicable to other situations and populations, or generalizable (Shenton, 2004:70). Therefore, generalization of findings is not the main goal in qualitative research. Instead, the focus is on gathering information about the participants' perspectives in order to come to conclusions and make recommendations (Nieuwenhuis in Maree, 2007:115). Jackson (2010:102) cites that the information gathered through the case study

method might be atypical and generalizations made to the general public would be flawed or invalid. Researchers might also be biased in their interpretation of the data, only focusing on the data that support the researcher's theory. Therefore, the researcher remained cautious to only interpret data for what they are, relaying exactly what was said and verifying the facts by doing member checking. The responsibility of gathering sufficient information was a priority throughout the data gathering and analysing stages. Guba (in Shenton, 2004:71) suggests that background information should be gathered to establish context and a detailed description of the study should be made. A detailed literature review was conducted in order for the reader to make conclusions about the transferability of the results. The boundaries of the study was also made clear by including detailed information about the sample, restrictions of the sample, number of participants involved, the data collection methods used, the number and length of the interviews as well as the time period in which the data was collected (Guba in Shenton, 2004:70).

3.4.3 Dependability

Terre Blanche *et al.* (2006:92) describe dependability as "the degree to which the results are repeatable." Therefore, the results will be consistent if the study was to be repeated (Guba in Shenton, 2004:71). Dependability refers to the changing environment within which the research takes place and the researcher's ability to consider this changing environment (Lincoln & Guba in Schurink, Fouché & De Vos, 2011:421). The researcher remained aware and respectful of the unique perceptions and opinions of the participants. The dependability of the research study was also maintained by a detailed description of all the research methods used in order to enable repetition of the study. A description of the research design, implementation of procedures, data gathering as well as an evaluation of the effectiveness of the process were included.

3.4.4 Confirmability

Guba (in Shenton, 2004:72) states that the confirmability of the study is concerned with the objectivity of the researcher. The researcher made use of bracketing during the gathering, analysis and description of data in order to ensure that the conclusions are the result of the experiences and ideas of the participants rather than the preference and bias of the researcher. Bracketing involves separating one's own experience, thoughts and feelings from the data being gathered and the subject is analysed, as far as possible, without prejudice (Huberman & Miles, 2002:256; Terre Blanche, Durrheim & Painter, 2006:353). In order to ensure the

confirmability of the data gathered, member checking was done as described above. The disclosure of the limitations of the study will also be included in chapter 5.

3.5 CONCLUSION

This chapter focused on describing and explaining the research methodology of the study in detail. The research methodology was described in a step-by-step manner by looking at the methods, procedures and empirical investigation. The empirical findings will be discussed in the following chapter.

Chapter 4: Results and Interpretation

4.1 INTRODUCTION

The goal of this study was to **explore and describe the components required to build a therapeutic relationship with children diagnosed with AS by exploring the opinions of therapists working with these children**. Framework analysis, as described previously in 1.4.5 and 3.2.5, was used during this study to identify main themes and subthemes. This chapter consists of a discussion of the main themes and subthemes (refer to table 4.1) that were identified during the data analysis. The participants in this study will henceforth be referred to as participant A, B, C, D, E and F.

Table 4.1 Main themes and subthemes

MAIN THEME	SUBTHEME
Preparation as a requirement to build a therapeutic relationship with a child diagnosed with AS	<i>Become knowledgeable on AS</i>
	<i>Obtaining background information on and history of the child diagnosed with AS</i>
The therapist's awareness as a requirement to build a therapeutic relationship with a child diagnosed with AS	<i>Child related aspects that therapists should remain aware of</i>
	<i>Therapist related aspects that therapists themselves should remain aware of</i>
	<i>Therapy related aspects that therapists should remain aware of</i>

Teamwork as a requirement to build a therapeutic relationship with a child diagnosed with AS	<i>The involvement of parents, siblings and other family members</i>
	<i>Other professionals and teachers</i>

4.2 RESULTS

The results of this study will subsequently be discussed as follows: firstly, under each main theme, in table format the subthemes, relevant categories and verbatim quotes from participants will be indicated. Thereafter a discussion on the main themes and subthemes will follow, using relevant literature to support the findings.

4.2.1 Main theme 1: Preparation as a requirement to build a therapeutic relationship with a child diagnosed with AS

Wilson and Ryan (2005:24) state that preparation and planning for therapy are important aspects in building a therapeutic relationship with a child, since research has shown that these aspects promote trust. Preparation, according to Schaefer (2011:126), entails obtaining background information and a thorough history on the child in order to begin therapy. Porter and Smith (in Schoeman & Van der Merwe, 1996:22) consider good knowledge of child development and emotional development as helpful to the therapeutic relationship. From the data it becomes evident that in order to build a therapeutic relationship with children diagnosed with AS, and to fully comprehend all aspects of such children, therapists should not only become knowledgeable on the topic, but also obtain a thorough background on and history of the child diagnosed with AS.

4.2.1.1 Subtheme 1: *Become knowledgeable on AS*

Table 4.2: Subtheme 1, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Become knowledgeable on AS</i>	Being educated on the latest research with regards to AS	• <u>I think you need to know about Aspergers.</u> You can't just look at the diagnosis and say, okay, this child has Aspergers and run in there. You need to know, because initially when I first saw kids with Aspergers, <u>I had to do my research</u> (Participant D) • I think that is <u>also important to do your research on AS</u> (Participant A) • Knowledge is power...if you don't <u>know what you are working with</u> you don't know what to do with it (Participant A) • <u>Have knowledge of what you are dealing with</u> (Participant B) • When I diagnose a child with AS...<u>if you don't understand what he's got, you can't understand his world...you can't deal with him</u> (Participant B) • <u>You have to understand the world he lives in...</u>slightly different from the world we live in (Participant B)

		• And the <u>things that they need and all their systems and their process and everything is very different</u>, so it's the human factors more than the diagnosis (Participant E) • <u>Each child is unique and the therapist should consider the child's whole personality, system and process in order to build a therapeutic relationship</u> (Participant F)
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From the data gathered it became evident that research with regards to what the AS diagnosis entails, possible problem areas and what the therapist can expect, is required before a therapist can build a therapeutic relationship with such a child. Therefore, Bond (2004:145) articulates the importance of therapists having a good understanding of AS, being educated on the latest research with regards to AS and being knowledgeable on the communication patterns, the developmental and atypical behaviour of children diagnosed with AS, in order to build a therapeutic relationship with such children. Furthermore, Stokes (2002:2) suggests that all professionals that want to build a therapeutic relationship with children diagnosed with AS should receive training on the unique characteristics and needs of these children. Attwood (2008:317) and Leventhal-Belfer and Coe (2004:132) are of opinion that children diagnosed with AS may benefit from therapy and a therapeutic relationship only when the therapist has a thorough understanding of such children's communication patterns and self-concept, while Gillberg (2002:120) believes that good insight into AS is a prerequisite for building a therapeutic relationship and communicating with these children.

Being knowledgeable about AS is important in order to approach the relationship from a holistic point of view (Hull, 2011:29). According to Schoeman (1996:36), approaching therapy is through a holistic approach is the best way since thoughts, feelings, behaviour, culture and social interactions all form part of a unified picture which is the child. In order to gain a holistic understanding of the child, the therapist should therefore become aware of all aspects of the child, including the AS diagnosis. Holism involves considering a child's entire

field. In this regard, Stevenson (2011) explains that the individual's field can be defined as the total being that is derived from the collection of parts of the person's psychological environment. Thus, the significance of a person can only be gained by considering the whole being, within coexistence and interdependence of that person's experience, context and perception of that context. Children diagnosed with AS are unique, their perceptions and reality differ from other children and therefore all aspects of the child, including the AS diagnosis, remains relevant, according to the participants. Bromfield (2010:8) highlights the importance of knowledge about the problems children diagnosed with AS specifically face as experienced in their biological, social and emotional fields, in order to relate to them therapeutically.

The participants are of the opinion that building the therapeutic relationship will take much longer if the therapist has limited knowledge on AS, the specific characteristics of these children, as well as the challenges they face. The longer the therapeutic relationship takes to establish, the longer it delays the helping process. Therefore, it is essential that therapists prepare themselves by doing research on AS and becoming knowledgeable on all aspects of this disorder. This will enable the therapist to form an understanding of the child and gain true empathy and insight for the child's situation.

4.2.1.2 Subtheme 2: *Obtaining background information on and history of child diagnosed with AS*

Table 4.3: Subtheme 2, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Obtaining background information on and history of the child diagnosed with AS</i>	Obtaining information on the child through consulting with parents, teachers, other therapists and siblings	• <u>Speak to people close to the child</u> like the parents, possibly siblings, teachers, other therapists that see the child <u>so that you can get a good picture of what you will be seeing</u> (Participant A)

		• <u>Background information of your client</u> to know if there were issues possibly at birth, what the family history looks like, what happened to the child prior to you seeing the child (Participant A) • <u>Have there ever been any other interventions</u> and also to investigate if someone else maybe has used different therapy techniques and how you can maybe apply that (Participant A) • I think definitely it (background information on the child) is important, because <u>you need to know how that child functions in all types of environments</u> (Participant B) • <u>Getting collateral.</u> Uhm, finding out what the child is like at home, at school and what types of things they like, what types of things they don't like. What helps in, say the mom, the mom's got a fairly good relationship with the child, what facilitates that relationship, so you can see how you can also use that in therapy (Participant D) • <u>Look at family dynamic and how they interact with their siblings</u> (Participant C)
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		• Having a child with a disorder is challenging, it's not just the child that is affected, but everyone else around him...<u>looking at the family dynamic is important; working with the parents</u> (Participant C)
	Obtaining information by doing psychological assessments, scholastic assessments and by studying assessments done by other professionals	• <u>Do a good assessment so that you can know what you are going to deal with</u>, because you can only make a plan if you know what the actual problem areas are (Participant A) • Even though it is a child with Aspergers and there are certain diagnostic criteria not all of them will fall into the same bracket, so <u>it is very important to see in which areas they are affected</u> (Participant A) • <u>Assess the areas that aren't as critically and emotionally involved and look at those</u> as you go along because the <u>social and the emotional difficulties are part of the diagnosis and you have to identify that in the assessment as well</u> (Participant F)

The data obtained during the interviews points to the importance of therapists gathering background information on the child diagnosed with AS in order to build a therapeutic relationship. In the opinion of the participants, background information includes what the

child struggles with, strengths and weaknesses of the child, co-morbid disorders and sensory difficulties the child suffers with, obsessions, likes and dislikes of the child, communication styles and behaviours of the child, significant relationships the child has and any other relevant information that can guide the therapist to make a connection with the child.

The participants were further of opinion that cooperation from everyone involved with the child is important in order to gain background information, context and related insights. In this regard, Hull (2011:29) mentions that in order to gain a detailed picture of what a specific child's characteristics are, therapists should plan their sessions well, which includes a thorough history on the specific child by talking to parents, caregivers, siblings, teachers and other professionals working with the child. Stokes (2002:2) supports this aspect by stating that therapists should understand and become familiar with the unique strengths and needs of every child through consulting with teachers, Speech and Language therapists, Occupational therapists and the parents. Gibbons and Goins (2008:7) and Sanders (2003:3) highlight the value of the partnership with and knowledge shared amongst professionals to increase insight into AS, as well as gaining information and obtain an understanding of a specific child. The participants are of opinions that gathering information on other important and successful relationships between the child diagnosed with AS and teachers, family members and other therapists can help create ideas to strengthen the therapeutic relationship. Participant D believes that consulting with everyone involved with the child to find out what the child is like at home and school can be useful in order to gain insight and information to assist the therapist in building a therapeutic relationship with the child.

The first stage of building a therapeutic relationship, the engagement process (Gilbert & Leahy, 2007:27), consists of defining the expectations, goals and hopes of the client and therapist. Gaining background information on the child diagnosed with AS may be helpful during this stage, as the information may define the goals and expectations more clearly. Participant A is of opinion that background information on the child can be helpful to determine the therapeutic goals as well as to plan and use the therapeutic relationship in order to optimally benefit the child. Gilbert and Leahy (2007:27) and Simon (2012:259), state that background information on the child, communication patterns in the family and about other therapeutic processes, can be helpful in building a therapeutic relationship and all the participants in this study agree. Gestalt Field theory may be helpful in understanding the child's background information and why the background information is significant especially

in building a therapeutic relationship. According to Blom (2006:19), Parlett (2005:43-52), Yontef and Jacobs (2011:343) the field theory explains that children are not separate from their background, interactions and environment, that every aspect of the child should be considered when building a therapeutic relationship and that substantial knowledge is an important factor. The child's field includes his or her personality and process and is described by Oaklander (in Blom, 2006:51) as:

“who they are, what they feel, what they like and do not like, what they need, what they want, what they do and how they do it.”

Blom (2004:79) further explains that a child's process consists of how they portray themselves to their field, how they meet their needs as well as their unique personality.

Participants A, B and D are of opinion that a thorough assessment and a proper diagnosis can assist in gaining background information, knowledge and an understanding of the child diagnosed with AS in order to build a therapeutic relationship. A thorough assessment should be done about the behavioural history, symptoms, communication patterns, social competence and neuropsychological functioning of the child in order to establish the most effective way of building a therapeutic relationship (Autism Speaks Inc, 2010:15). These aspects all influences the child's way of relating, communicating, socializing and interacting, which in turn, influences the therapeutic relationship. Participant E asserts that the AS diagnosis, cognitive functioning and level of development of the child are important aspects to consider in order to build a therapeutic relationship. Background information and knowledge can also be gained by reading through assessments done by teachers and other professionals. The data also revealed that building a therapeutic relationship, assessments and the therapeutic process with children diagnosed with AS usually take longer than with other children. The participants agree that the assessment of children diagnosed with AS takes longer and that the therapist should do assessments over more than one day in order to gain a realistic picture of the child. The assessment should, however, also remain non-threatening and enjoyable for the child.

It seems evident that a thorough intake procedure of gathering the history, background information and previous assessments is essential in order to build a functioning and meaningful therapeutic relationship with a child diagnosed with AS and all these aspects are also supported by Blom (2006:19), Newman (2006:86), Simon (2012:259) and Yontef (1993:112).

4.2.2 Main theme 2: The therapist's awareness as a requirement to build a therapeutic relationship with a child diagnosed with AS

Perls, according to Clarkson and Mackewn (in Blom, 2006:52), described awareness as the ability to be in touch with one's environment, one's existence, one's inner self, as well as other people. Knowing and understanding one's thoughts, feelings, senses and behaviour, as well as taking responsibility for these aspects of the self, requires awareness.

Furthermore, Yontef (in Schoeman, 1996:30) explains:

“Awareness is a form of experiencing. It is the process of being in vigilant contact with the most important event in the individual environment field with sensorimotor, emotional, cognitive and energetic support.”

Contact-making is a prerequisite of awareness and Oaklander (in Blom, 2006:89) mentions sensory contact-making and bodily contact-making as elements for healthy contact-making. Sensory and bodily contact-making requires children to be able to make healthy emotional contact, for example to form relationships, through the use of all their senses and understanding how their bodies react to emotions (Oaklander in Blom, 2006:91). According to all the participants in this study, children diagnosed with AS struggle with sensory and bodily contact-making and awareness, therefore these children often struggle to build relationships. Furthermore, building a therapeutic relationship, becoming aware and making contact, according to Schoeman (1996:32), requires dialogue and yet communication is another aspect that children diagnosed with AS find difficult (DuCharme & McGrady, 2003:3; Lombard, 2004:2; Patrick, 2008:14). Keeping awareness, contact-making and dialogue of the therapist and child in mind, the following aspects should be considered when building a therapeutic relationship with a child diagnosed with AS, according to the participants in this study.

4.2.2.1 Subtheme 1: Child related aspects that therapists should remain aware of

Table 4.4: Subtheme 1, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Child related aspects that therapists should remain aware of</i>	Co-morbid disorders	• <u>(Co-morbid disorders seen with children diagnosed with AS are) Anxiety Disorders, Mood Disorders, ADD, ADHD (Participant F)</u>
	Sensory considerations	• <u>Consider the child's sensory ability, motor functioning and basic cognitive abilities...you will have to see how you can modify it...make sure that the room is nice and quiet (Participant A)</u> • <u>With an Aspergers child, that could put them off completely, the touch, coming into their personal space (Participant D)</u>
	The therapy room and therapeutic environment	• <u>Our environment needs to be plain (Participant C)</u> • <u>Make sure they are comfortable within the therapy room (Participant A)</u> • <u>You have to give them something to do and you are going to see what they feel comfortable with and you do that so that they feel competent in their environment and in the relationship with you (Participant D)</u>

	Obsessions, routines, coping with change and dependability on therapist	• <u>He gets obsessions about things</u> (Participant B) • <u>They are very specific and obsessive over what they like and what they don't</u> (Participant D) • I think what was key for me in establishing that relationship initially was to <u>find what they like and what they don't like, because as we know, they are very specific and very obsessive over what they like and what don't</u> (Participant D) • <u>Routine, it is very important that they know what they're going to do next</u> (Participant B) • They have to come to you and nobody else will do – <u>dependence on therapist</u> (Participant B)
	Social behaviour pertaining to contact-making skills of the child	• <u>They do silly things, they get themselves into trouble with their peers...humiliated</u> (Participant B) • <u>I think that the fact that they are in their own world, makes it quite difficult to make that contact.</u> It is difficult, it is almost like they're in a bubble and you are on the other side and you, you can't almost get the two to connect. Emotionally, especially initially, I think, once they are more comfortable with you and all the rest then you can, sometimes get those moments when you connect (Participant D)

		• <u>They do not always acknowledge that you are there</u> (Participant F) • <u>It is important that they still learn to function within an appropriate social boundary...yet to accommodate to the extent that they can function and cope...in social situations</u> (Participant A)
	Communication and relational aspects pertaining to the therapeutic relationship and contact-making and dialogue skills of the child	• <u>Open communication...communication is important...on their level that they can understand</u> (Participant C) • <u>They are so literal...you have got to be very specific and...be careful what you say...not because they might not understand you...you can't make comparisons of, you know, figurative, in figurative ways that they wouldn't understand. So...you have got to mean what you say and be very specific...and be very direct in your dialogue</u> (Participant D) • <u>Show an interest in them...equal sharing of thoughts and ideas</u> (Participant F)

	The child's personality	• <u>Asperger children are all different, displaying different behaviours and react differently to who you are (Participant A)</u> • <u>Those type of things does hinder the relationship if you if you don't take into consideration that child's feelings, or that child's personality (Participant A)</u> • <u>You have to look at the child and see what type of personality that child is...you have to change your, not change your personality as in to say you do things completely differently, but you need to be flexible enough and adjust to that child (Participant C)</u>
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The data indicates that in preparation of therapy with a child diagnosed with AS, there are certain physical aspects pertaining to the child, as well as environmental aspects of the therapy room, that the therapist should remain aware of. According to the participants of this study, therapists should be aware of physical aspects, such as co-morbid disorders and sensory integration dysfunction, which may influence how a child makes contact and the process of building a therapeutic relationship. The data also reveals that environmental aspects of the therapy room, being comfortable and feeling safe are essential aspects to consider. Children diagnosed with AS's obsessions with routine and fixations, struggle to cope with change and dependability on the therapist or therapy are also aspects the therapist should remain aware of in order to build a therapeutic relationship with these children.

Docter and Naqvi (2010:31) state that one in four children diagnosed with AS suffer from other medical conditions that are known as co-morbid disorders. This fact points to the importance of awareness of the special needs of children diagnosed with AS (Gillberg, 2002:46). The prevalence rate for children diagnosed with AS to have a co-existing disorder

such as Obsessive Compulsive Disorder is 75-80%, 70% for Anxiety and Depression, and 60-70% for Attention Deficit Hyperactivity Disorder (ADHD). Other co-morbid disorders listed by Docter and Naqvi (2010:32) are behaviour disorders, epilepsy and tic-related disorders. Thus, co-morbid disorders should be taken into consideration and therapists should be aware of children diagnosed with AS' anxiety level, signs of depression and Attention Deficit Disorder (ADD) or ADHD, as suggested by participant B and F. Children diagnosed with an Anxiety disorder can be restless, have difficulty concentrating, be irritable and tense (Barlow & Durand, 2009:128). The therapist should approach these children more calmly and accommodate for the fact that they might be worrying about things the therapist might not even be aware of. Attwood (1998:100) states that a child diagnosed with AS and Anxiety may be anxious about building a therapeutic relationship and socializing, thus the therapist needs to remain aware of this and proceed with an understanding attitude. Attwood (1998:133) further suggests that some sensory exercises can be incorporated in order to alleviate the anxiety and help build the therapeutic relationship. McGrady and Wagner (2003:84) are of opinion that depression can delay the development of the therapeutic relationship and therapeutic change. Children diagnosed with depression can feel sad, lonely, tired and may be tearful or irritable (Barlow & Durand, 2009:208) and the therapist should approach the therapeutic relationship with patience and understanding of such aspects. Children diagnosed with ADD or ADHD might require the therapist to incorporate more physical activities while building a therapeutic relationship, as well as consider the level of concentration of the child, according to the participants of this study.

Sensory difficulties that are common amongst children diagnosed with AS are sensitivity to smells, textures and sounds, as well as sensory seeking behaviour (Docker & Naqvi, 2010:115). An assessment done by an Occupational therapist might help in order to understand the extent of the sensory integration difficulties, according to Docker and Naqvi (2010:122), which should be taken into account when building a therapeutic relationship. Participants C and E deem it important to consider the sensory difficulties children diagnosed with AS face in order to build a therapeutic relationship and suggests using calm, low tones when speaking, as well as making environmental changes where necessary. According to the participants, the main reason why the therapist should consider these sensory difficulties when building a therapeutic relationship with these children is to know which sensory play activities to avoid so as not damage the trust the child will be developing with the therapist. Children diagnosed with AS do not develop as other children with regards to personal space,

touch and other sensory stimulation, and according to participant D, not being aware of this and expecting a child to behave in a typical way, may damage the therapeutic relationship. Inappropriate behaviour of the child may be a result of the need to seek tactile stimulation. Wing (in Simon, 2012:259) therefore emphasises the importance of exploring a variety of reasons for difficult behaviour and to use a variety of creative treatment approaches, yet it is important to be knowledgeable about anything specific that the therapist should bring to therapy or avoid due to its impact on the child on a sensory level.

The data highlights the importance of a safe, non-threatening environment when building a therapeutic relationship with children diagnosed with AS and this aspect is confirmed by Attwood (2008:246). A quiet, non-intrusive environment can ease sensory difficulties experienced by these children and make the therapeutic experience more pleasurable which in turn will encourage children to participate and return (Attwood, 2008:56). Children diagnosed with AS may need more time to relax in order to adjust to new experiences and environments, thus therapists should create a relaxed atmosphere with minimal pressure (Attwood, 2008:283). Blom (2004:154) suggests taking a simple and slow pace in order to help children become comfortable which is a prerequisite of building a therapeutic relationship. Stokes (2002:3) is of opinion that visual aids and support strategies should be used in order to assist children diagnosed with AS to better understand their environment and changes that will be occurring. All participants suggest ensuring that the child is comfortable with the therapist and the room from the first session by making adaptations and accommodations where necessary with regards to routine and sensory adaptations. It could be helpful to forewarn children of changes to the environment, for example when using a different room (Attwood, 2008:233). However, it is important to find a balance between creating a secure, safe environment and helping these children cope with change. The therapist should be aware of this problem and prepare the child diagnosed with AS in advance in order to avoid confusion, which in turn can help build trust in the therapeutic relationship.

Participant C and D not only highlight the fact that children diagnosed with AS struggle with flexibility, to cope with change and adjust to boundaries, but also share how these children can become fixated and obsessed which can slow down therapeutic progress. In this regard, Gillberg (2002:44) states that children diagnosed with AS can become dependent on and obsessive about routines. They seek control and predictability (Attwood, 2008:65). The

participants are of opinion that therapists should be aware of and sensitive to special rituals and routines such as always sitting in the same chair or always wanting to play a certain game, but also be careful of dependency on these rituals and routines. It is important to find a balance between comforting and challenging them to cope without the rituals and routines. The therapist can slowly desensitise the child by using the trusting therapeutic relationship, to show the child how to cope in everyday life. Attwood (2008:75) suggests using the child's special interests to build the therapeutic relationship and to encourage the child diagnosed with AS to eventually form friendships through these interests. Even though working with the children's interests can assist in building a therapeutic relationship, participant D and E warns that it is unwise to allow children diagnosed with AS to become obsessed or fixated on one particular subject for too long.

Another aspect of which therapists need to be aware of is the tendency for children diagnosed with AS to become dependent on the therapist (Gillberg, 2002:113; Kaduson, 2006:18). Even though a therapeutic relationship is of utmost importance, a dependence on the therapist or therapy can also become dysfunctional. As participant E pointed out, children diagnosed with AS struggle to generalise what they have learnt in therapy and may become dependent on the therapist to fulfil the need for friendship. Bonding and building a therapeutic relationship is healthy, but dependence on the therapist for support may counteract the therapeutic goals and strategies (Harpur, Lawlor & Fitzgerald, 2004:126). Participant B highlights this fact by pointing out that children diagnosed with AS often only want to go to one therapist. Docter and Naqvi (2010:64) suggest finding a balance between bonding with children and fostering dependence by facilitating children to monitor their own awareness and abilities, thus helping them find meaning in other interpersonal relationships.

Therapists should remain aware of the social and communication difficulties children diagnosed with AS struggle with which include difficulty understanding social boundaries, interacting and communicating clearly, respectful and appropriate communication and difficulty fitting in with peers. Children diagnosed with AS are often emotionally and socially immature (Attwood, 2008:254) and their concept of relationships also develops slowly (Attwood, 2008:58). The data and literature revealed that children diagnosed with AS lack social awareness and reciprocity, often not acknowledging the therapist's presence and refuse to participate in therapy at times. Thus, the therapist should find a balance between accepting socially inappropriate behaviour, as well as teaching them correct ways of

responding as these methods may add to the process of building a therapeutic relationship. Gallo-Lopez (2006:252) adds that the therapeutic relationship is encouraged by how the therapist relates and interacts with the children.

Children diagnosed with AS have difficulty with the social and conversational aspects of therapy and minimizing that may be helpful in relieving stress for the child and therapist (Attwood 2008:319). Therefore, open, honest communication should take place on their developmental level in order to build and strengthen the therapeutic relationship. Only then will the therapeutic relationship be of value in order to practice these social skills. The participants believe that it is difficult to communicate successfully, build trust and change unwanted behaviour in children diagnosed with AS due to the social and communication difficulties these children face. The therapist should therefore be direct and specific, using few comparisons, idioms and language that could confuse children diagnosed with AS, according to participant D. Gillberg (2002:120) agrees that concrete communication with little symbolism is key in communicating with these children. Furthermore, participants A and D mention that children diagnosed with AS are literal and that it is difficult for them to understand abstract reasoning. The therapist should remain aware of the fact that they want to know exactly why they need to do something and how they need to do it, as they are often unsure of what it is that is expected of them. The literature and data have revealed an urgency of therapists being aware of these social and communication difficulties in order to be able to build, strengthen and use the therapeutic relationship to teach these skills, optimally. The participants are of opinion that the therapeutic relationship can play a crucial role in alleviating some of the social difficulties, through practice and modelling correct and socially appropriate behaviour. Therefore, the therapist's awareness on these aspects is of the utmost importance and should continually be considered when building a therapeutic relationship with such children.

Attwood (2008:267) further warns that inappropriate behaviour and bad habits may cause children diagnosed with AS to be isolated by family members or their peers. They can come across as rude and socially inappropriate as they struggle with social situations. According to some of the participants, therapists should remain aware of these inappropriate ways of communicating and behaving and not be offended by it; reminding themselves that the therapeutic relationship is an appropriate place to practice correct ways of interacting and communicating in order to alleviate frustration, embarrassment and humiliation for children

diagnosed with AS. Although, Participant E is of opinion that the social behaviour learnt during therapy is hard to integrate into reality, to make it part of their daily lives and that the social motivator for communication is lacking in children diagnosed with AS. Feelings of anger and subsequent aggression may further alienate children diagnosed with AS from their peers (Attwood, 2008: 146). The participants further warn that aggressive behaviour should not be a deterrent factor for the therapist; the therapist should try to continue to work with the child in a calm and respectful manner in order to create a bond with the child.

When building a therapeutic relationship with a child diagnosed with AS, therapists should remain aware of the child's personality and emotional challenges these children face. The participants agree that it is important to get to know each child, because every child is different and there is no specific recipe or rule that will suit all children diagnosed with AS. Due to the fact that children's personalities should be taken into account when building a therapeutic relationship, the participants recommend that therapists should find a balance between being accommodating to their special needs and unique personalities.

4.2.2.2 Subtheme 2: *Therapist related aspects that therapists themselves should remain aware of*

Table 4.5: Subtheme 2, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Therapist related aspects that therapists themselves should remain aware of</i>	Characteristics of the therapist that are helpful in building a successful and meaningful relationship with a child diagnosed with AS	• <u>Your attitude towards the child...that makes the biggest difference</u> (Participant F) • I think <u>your body language and your expression of how you are experiencing the situation is important</u> (Participant A) • <u>Our personality also play a part in dealing with these children</u> (Participant A)

		• Trust is a big one. And <u>I think with children, you need to build trust through play</u> (Participant E) • I think <u>being patient is important because it is not going to come naturally to them like it does with other kids</u>. I mean, with other kids you can connect in one session and they've formed a bond with you and, uhm, that is not going to necessarily happen (Participant D) • <u>Non-judgement...not trying to make them be like all the other kids</u> (Participant B) • I can <u>accept them the way they are</u> (Participant B) • I think <u>it comes down to compassion and being able to kind of share an interest</u> (Participant E) • <u>I approach them with more sympathy</u> (Participant B) • <u>Keep yourself motivated and push through</u> (Participant F) • <u>Do not take their lack of interest in you personally</u> (Participant F)
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Attwood (2008:318) deems the therapeutic relationship crucial to the therapeutic process and states that careful consideration should be taken when choosing a therapist for children diagnosed with AS. Autism Speaks Inc. (2010:15) states that the effectiveness of the intervention with children diagnosed with AS depends on the skill, experience and style of the therapist.

According to the participants, the therapist's characteristics, understanding, attitude and personality all play a part in the therapeutic relationship and certain aspects become particularly important when building a therapeutic relationship with a child diagnosed with AS. It becomes clear that specific characteristics such as patience, compassion, sympathy and the ability to be non-judgemental, are prerequisite characteristics a therapist should have in order to build a meaningful therapeutic relationship with children diagnosed with AS.

Participant B and E claims that the therapeutic relationship depends on the therapist's attitude and characteristics, and suggests approaching children diagnosed with AS with more sympathy and understanding. Cochran, Nordling and Cochran (2010:49) list empathy, unconditional positive regard and genuineness as some of the most important characteristics of a therapist. Furthermore, non-judgmental, patient approach from the therapist creates a calm and relaxing environment in which healthy boundaries can be established and a solid therapeutic relationship can be built. Schoeman (1996:38) suggests that therapists should be sensitive to the child and that the therapeutic relationship depends on considering the child's attitudes, feelings and thoughts. Schoeman (1996:34) further highlights humility, kindness, warmth, sensitivity, sincerity and honesty as important characteristics for a therapist to have.

According to participants A, B and F, trust is a key factor in building a therapeutic relationship which is built through consistency. Trust naturally encourages participation and progress. Trust can be built through acceptance and a feeling of being understood. Furthermore, therapists should be cautious of rushing children, as they take longer to experience and process information in order to become aware.

The concepts of theory of mind, understanding oneself and others, self-awareness and emotional expression are all difficult concepts for children diagnosed with AS (Attwood, 2008:318-319). Participant A explains that children diagnosed with AS struggle with abstract reasoning, considering how others feel, empathy and understanding different opinions of others. Participant D and F add that stress and anxiety are part of the daily struggles for them and this can cause them to act out when they are struggling emotionally. This could lead to therapists feeling despondent or frustrated when building a therapeutic relationship becomes difficult, or when therapeutic goals are not being reached. The therapist's own goal-directedness can be conflicting with the child diagnosed with AS' process. Participant F

therefore suggests that therapists should not take these children's lack of interest in a relationship personally, but should keep themselves motivated by focusing on the goal of building a therapeutic relationship.

Working in the here and now requires therapists to be aware of their own thoughts, feelings, likes, dislikes and behaviour and should be willing to share these openly in order to develop a therapeutic relationship (Schoeman, 1996:35). Working in the here and now, staying with the child and being comfortable to work in the moment is consequently an important aspect of working with these children, according to the data collected.

4.2.2.3 Subtheme 3: Therapy related aspects that therapists should remain aware of

Table 4.6: Subtheme 3, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Therapy related aspects that therapists should remain aware of</i>	Setting boundaries and remaining consistent during therapy	• <u>To build that relationship with the child you need to set boundaries...it is a good foundation to start a relationship</u> (Participant C) • <u>Follow through...on what you say</u> (Participant B) • They struggle with change...<u>having those boundaries obviously gives them the security to know, okay, this is what is going to happen</u> (Participant C) • Setting those boundaries are important, so that they can know what is to be expected, but it is okay, <u>I am safe enough in my boundaries to deal with something that has just come up</u> (Participant C) • <u>Some children will push the boundaries, because they want to test if they are still going to be there</u> (Participant E)

	Teaching the child diagnosed with AS skills during therapy in order to build a therapeutic relationship	• <u>They don't understand another person's emotions...you have to teach them to understand their emotions...deal with their emotions...understanding other's emotions</u> (Participant C) • <u>Teach them...that we all interact and we all need to understand each other</u> (Participant C)
	Support and education of parents, siblings and other family members	• <u>Parents...need a bit of support and praise, understanding, sympathy or empathy</u> – I think it is very difficult...they can be impatient (Participant B) • <u>Parents are very unsure and very overwhelmed on what to do, so we will go into the homes and try to help them and give them some techniques of how to help work with their children</u> (Participant C) • <u>Giving the parents the skills that they need to be able to work with the child</u> (Participant C) • <u>Try to incorporate the sibling into therapy...the siblings tend to be very isolated</u> (Participant C) • <u>The family on the whole needs to have a support system...support groups</u> (Participant C) • <u>You have to work with the parents as well...explain to them the different roles and the boundaries</u> (Participant E)

	The importance of having fun while building a therapeutic relationship	• <u>I use humour and try to teach them to laugh at themselves</u> (Participant B) • To actually get that child to laugh...<u>to find what that child likes doing...finding what you enjoy doing together</u> (Participant C) • It is important for that child to actually know, “You know what? <u>I can have fun with this adult, I can interact with this adult, I feel safe with this adult.</u>” (Participant C) • <u>And through enjoyment...they learn that it is okay to make mistakes and it is still fun and we can still laugh and we can still...do nice things</u> (Participant E) • <u>If you are having fun and it makes sense to you, then, yes, you will use it, but if you are not having fun, then you might want to use it because you are fearful of something else</u> (Participant E)
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In order for the child diagnosed with AS to understand the difference between the therapeutic relationship and a friendship, clear boundaries need to be implemented and explained (Attwood, 2008:318; Gilberg, 2002:120). All the participants agree that boundaries and consistency are important when working with children diagnosed with AS, especially while building a therapeutic relationship. Attwood (1998:100) suggests that order and consistency alleviates anxiety for children diagnosed with AS and by providing that, the therapeutic

relationship will become stronger. The participants are of opinion that boundaries create a safe and comfortable space where both therapist and child understand, know and accept the rules. Discipline becomes a known and necessary consequence when boundaries are overstepped and this also helps the child feel safe and in control. The child will know what to expect and can behave accordingly. Participant B states that by being consistent and by following a routine, children diagnosed with AS know what to expect, and participant C adds that this helps them feel safe and more willing to cooperate, therefore strengthening the therapeutic relationship. Participant D is further of the opinion that it is important to find a balance between strict boundaries, consistency and routine, as well as introducing new challenges in order for children to be able to learn and adapt when building a therapeutic relationship with children diagnosed with AS. The therapist wants these children to be comfortable, but also stretch their limits and push their boundaries. Wilson and Ryan (2005:207) add that it is crucial to find a balance between allowing children to express themselves freely and communicating openly as well as setting boundaries for their behaviour. Setting boundaries will ensure that children feel safe and experience the therapeutic relationship positively. Finding that balance between helping the child diagnosed with AS feel happy, safe and comfortable, but also push their boundaries to show them that the therapeutic relationship is manageable (Wilson & Ryan, 2005:22).

McNeil, Bahl and Herschell (2006:177) state that the establishment of clear and strict boundaries early during therapy facilitates in the optimal functioning of the therapeutic relationship. The therapeutic relationship serves as a platform for practicing, modelling, teaching and learning of appropriate social skills, acceptable behaviour, emotional awareness, as well as communication and expression. Therefore, the therapeutic relationship cannot function without personal, professional and social boundaries (Blom, 2006:61).

Attwood (2008:150) describes therapy with children diagnosed with AS as including an educational element where the therapist teaches children to understand and express their emotions and thoughts. Therapy begins with an opportunity to learn about emotions and includes expression and appropriate management of these emotions (Attwood, 2008:152; Docter & Naqvi, 2010:75). Participant F is of opinion that therapy can be used to teach children diagnosed with AS social skills through the use of the therapeutic relationship by practicing the necessary interaction. Therefore, developing a therapeutic relationship has an educational element where the therapist serves as a teacher in order to build and strengthen

the therapeutic relationship (Blundon & Schaefer, 2006:374). Docter and Naqvi (2010:101) adds that the therapist can monitor the way they interact during therapy, help children diagnosed with AS become aware of their contribution or lack of contribution to the relationship, as well as provide feedback as to more appropriate ways of interacting. Through the modelling and interacting within the therapeutic relationship, the participants suggest that the child can become more confident and competent in building relationships outside of therapy.

Attwood (2008:98) notes that children diagnosed with AS will only change their behaviour, thought process or way of interacting if the reason is logical. Furthermore, the participants suggest that therapists use simple, to the point means of interacting and building rapport with the child in order to avoid unnecessary relational confusion. It may be helpful to work on an intellectual level, rather than an emotional level in order for children diagnosed with AS to understand the process of therapy and become comfortable in the therapeutic relationship (Attwood, 2008:324).

An important aspect to keep in mind according to participants C and D is that everyone involved with children diagnosed with AS are affected, and the parents and or their caregivers may find these children and their difficulties challenging at times. Attwood (2008:160) states that it is important to work with the parents and family members in order to maximize the success of therapy, which involves education and support. A strong family support system with siblings that understand the diagnosis and interaction helps the child diagnosed with AS cope better. Stokes (2002:2) is of opinion that parent and family training can also be beneficial to the therapeutic growth of children diagnosed with AS and awareness about AS can equip caregivers to implement successful treatment plans at home which contributes to the consistent and holistic approach that is needed. According to the data the therapist should be willing to guide the parents on how to handle the child, pre-empting behaviour, supporting the parents on an emotional level as well as offer empathy and sympathy when necessary. As participant C suggests, training and support groups of parents, siblings and family members can be helpful in building and strengthening the therapeutic relationship. The participants agree that as the change in awareness and understanding of the parents occur, the child may experience a willingness to cooperate and grow as well. Shaw and Magnuson (2006:216) point to the fact that parental support, encouragement and education will benefit the child and strengthen the therapeutic relationship.

Attwood (1998:102) mentions that the therapist should be enjoyable to be around. All the participants agree that the therapeutic relationship and process should be fun and focused on the child's needs, interests, thoughts and ideas. Blundon and Schaefer (2006:347) suggest that therapists should incorporate activities that are fun and interesting to the children to add value to therapy and the therapeutic relationship. Spending time together and giving the child undivided attention is often good enough to strengthen the therapeutic relationship. Participant F adds that the child should value the relationship and enjoy the interaction in order to build a therapeutic relationship. McNeil, Bahl and Herschell (2006:173) state that having fun during therapy improves a child's self-esteem and is helpful in building a therapeutic relationship. Participant B and F mentioned that they use humour in order to build a therapeutic relationship and Schoeman (1996:34) also recommends using humour as a way of building a relationship.

4.2.3 Main theme 3: Teamwork as a requirement to build a therapeutic relationship with a child diagnosed with AS

Mishne (in Van der Merwe, 1996:23-24) is of opinion that therapy with children is multidimensional and that teamwork is required in order to make therapy work. Support systems, such as parents, teacher and other therapists, should be involved during every step of the process, especially the therapeutic relationship. Van der Merwe (1996:25) further states that without the involvement of the support systems, therapy could quite possibly be unsuccessful. The involvement and partnership with the support systems may alleviate feelings of guilt or helplessness of parents, teachers and therapists and encourage everyone involved to follow through on the treatment plan.

4.2.3.1 Subtheme 1: The involvement of parents, siblings and other family members

Table 4.7: Subtheme 1, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>The involvement of parents, siblings and other family members</i>	Cooperation, involvement and consideration of parents, siblings and other family members	• <u>Take parents into consideration</u> – should they be part of the first few sessions? (Participant A) • <u>Build that relationship with the parents so they can trust you...if you have a good relationship with the parents, you will have a good relationship with the child</u> (Participant C) • <u>(Parental) involvement is essential to the child's development and prognosis</u> (Participant F) • The <u>teacher or the parent might tell you that the child really loves horses</u> for example, and <u>that is your key...you can lose a lot of information (about the child) if you do not talk to everyone involved</u> (Participant F)

Simon (2012:262) suggests that the therapists, the child and family members participate as partners in therapy as everyone forms part of the child's world and is influenced by it. Woldt and Toman (2005:167) agree that parents, siblings and family members all form part of the child's field and play a part in the therapeutic success. Simon (2012:263) therefore further states that all significant family members, carers and siblings (as defined by the parents) should be invited to the first session to collaborate on goals and therapy outcomes and this idea is especially supported by participant A. Hull (2011:29) as well as Woldt and Toman (2005:167) are of opinion that parental involvement is of utmost importance as parents are a valuable source of information in gaining a detailed picture of

the child diagnosed with AS. Furthermore, according to Autism Speaks Inc (2012:16), parental involvement in therapy develops the child's interests and self-esteem. Therefore, parental involvement and responsibility in the therapeutic process helps the therapist and child to successfully apply the relationship building skills during therapy (Shaw & Magnuson, 2006:218). Kaduson (2006:103) state that parental involvement improves the functioning of a therapeutic relationship.

Attwood, Randall and Parker, as well as Wing (in Simon, 2012:260) agree that empowerment of parents through behaviour management and cooperation between parents and professionals are important aspects in conjunction with or before any form of treatment. Stokes (2002:18) consider a team approach, with the parents being crucial members, essential in addressing the needs of children diagnosed with AS, as well as contributing to the therapeutic relationship. All the participants agree that parental involvement, participation, trust, cooperation and support in the therapeutic process is necessary in order to build a therapeutic relationship and for therapy to be successful. As participant E suggests, a trusting parent leads to a trusting child. Blom (2004:145) highlights that the parents' trust in the therapist is essential in building a therapeutic relationship and in working as a team in order to effectively help children. Wilson and Ryan (2005:181) are of opinion that parental involvement in the therapeutic process can also ease the parent's anxiety about the process and what to expect, which in turn can positively impact on the child's experience.

4.2.3.2 Subtheme 2: Other professionals and teachers

Table 4.8: Subtheme 2, categories and verbatim quotes

SUBTHEME	CATEGORY	VERBATIM QUOTES
<i>Other professionals and teachers</i>	Consultation with other professionals and teachers	• <u>Speak to other therapists who have been in the same situation or worked with the diagnosis before</u> and see what worked for them, what didn't work (Participant A)

		• If you are finding that it is difficult to work with the child, <u>go and see another professional in the team</u>...an Occupational Therapist...who understands...sensory integration that <u>can help you to...understand...what the child needs to be able to, to concentrate and work in a session</u> (Participant E) • <u>I think it is just important for you to know that you can go approach other people to understand the child better</u> (Participant E)
	Collaboration with other professionals and teachers	• <u>There is not one therapy that makes the whole thing work</u>...no one recipe...and you need everyone to add to that recipe...<u>you need to look at the school, the therapists...very multi-disciplinary type of team and you need to work as a team</u> (Participant C) • <u>You need to work as a team...one specific goal and that is to build a relationship with that child, to help that child grow to their best potential...so you can't do it alone</u> (Participant C)

Wilson and Ryan (2005:232) consider teamwork of everyone involved in a child's life necessary in order for the child to feel comfortable and free to interact and form a therapeutic relationship. Participant E is of the opinion that therapists need to work within a team that

follows the same philosophy in order to optimally benefit the child and build a strong therapeutic relationship. Lombard (2004) is of opinion that a multi-dimensional therapy approach works best for children diagnosed with AS due to the many and complicated problems they face. Therefore, numerous interventions will be used in order to address these difficulties, often simultaneously as well.

Collaboration of other professionals in the therapeutic process can increase the success of the therapeutic relationship and in turn, increase the success of the specific intervention (Attwood, 2008:320). The participants were also of opinion that it is helpful to be able to consult with other professionals that work with the child in order to get tips and feedback with regards to the child's personality and sensory profile. This could prove to be extremely helpful when a therapist feels frustrated by the lack of progress in the therapeutic relationship. Other professionals may reveal certain aspects of the child that the therapist can use in therapy in order to gain trust and mutual interest.

It is helpful to involve everyone in the therapeutic process as one therapist cannot facilitate change on his or her own (Walter & Petr, 2009:11). Furthermore, the participants advise to be able to brainstorm as a team in order to add value to the therapeutic relationship. Looking at every possible therapy and intervention available is necessary to facilitate change, as there is not one single recipe or therapy that works for all the difficulties these children face. Other professionals and teachers can give a detailed picture and share new ideas which can assist the therapist to build a therapeutic relationship.

4.3 CONCLUSION

From the above-mentioned discussion of the main themes, sub-themes and categories, it became evident that building a therapeutic relationship with a child diagnosed with AS requires many multi-faceted components. Preparation in the form of research and being knowledgeable on the AS diagnosis, as well as obtaining thorough background information on the specific child is essential. Furthermore, awareness about all the aspects of the child and self-awareness as a therapist also proved crucial. Certain therapy considerations were highlighted, such as the importance of boundaries and consistency, the teaching aspect, as well as the importance of having fun. Lastly, teamwork was highlighted and discussed by focusing on parental and family involvement, as well as collaboration with other professionals and teachers.

Chapter 5: Conclusions and recommendations

5.1 INTRODUCTION

In this chapter, the conclusions derived from the findings of this study are described. The goal is to determine whether the aims set for this study were adequately met and whether the research question was answered. The presentation of the summary of the findings, as well as recommendations based on the research findings will follow.

5.2 AIM

In order to make recommendations to therapists working with children diagnosed with AS, the aim of this study was to qualitatively explore and describe the components required to build a therapeutic relationship with children diagnosed with AS by exploring the opinions of therapists working with these children.

The sample was purposefully selected from a population of therapists working with children diagnosed with AS in the Nelson Mandela Metropolitan. The sample consisted of therapists working with these children at schools for children with learning difficulties, Autism and AS or therapists who form part of the referral teams of these schools. Semi-structured interviews were digitally video recorded after consent was gained from the participants. Transcriptions were done, analysed and themes and subthemes were identified.

Chapter 2 of this study focused on existing literature in order for the researcher to identify relevant information, build a logical framework for the research, become knowledgeable on the topic and convey the importance of the proposed research study. The findings of the study were presented by discussing the main themes and subthemes in Chapter 4. Conclusions and recommendations will be provided in this chapter for professionals such as Occupational therapist, Speech therapists, Counselling Psychologists and Clinical Psychologists, working with children diagnosed with AS. The researcher thus maintains that the aim of this study was met.

5.3 EVALUATING THE ANSWERING OF THE RESEARCH QUESTION

The following research question was formulated for this study:

What are the components required to build a therapeutic relationship with a child with AS?

The researcher is of the opinion that the research question was adequately answered. The data gathered from the participants during the semi structured interviews was analysed and divided into three main themes. The themes revealed a detailed description of participants' opinions on the components required to build a therapeutic relationship with these children.

The three main themes that were identified were as follows:

- Preparation as a requirement to build a therapeutic relationship with a child diagnosed with AS
- The therapist's awareness as a requirement to build a therapeutic relationship with a child diagnosed with AS
- Teamwork as a requirement to build a therapeutic relationship with a child diagnosed with AS

The main themes were further divided into subthemes which were elaborated upon and substantiated by research literature in Chapter 4. The researcher is of the opinion that the findings generated in this study answered the research question adequately and provided insight into the opinions of therapists with regards to components required to build a therapeutic relationship with children diagnosed with AS.

5.4 CONCLUSIONS OF THE STUDY

The focus of this study was on exploring and describing the components required to build a therapeutic relationship with children diagnosed with AS, by qualitatively exploring the opinions of therapists working with such children in different professional settings. The researcher applied Gestalt theory and literature, such as Field theory, holism, awareness, contact and dialogue (Blom, 2006:19; Joyce & Sills, 2006:27; Parlett, 2005:43; Yontef & Jacobs, 2011:343) in order to elaborate on the main themes and subthemes and create a better understanding of the components identified by the participants. The participants were from different therapeutic backgrounds, thus each participant's opinion related to different theoretical backgrounds. The researcher is of opinion that the components identified are

valuable contributions to all therapeutic backgrounds and can be generalised. The data will be summarised according to each main theme:

Main theme 1: Preparation as a requirement to build a therapeutic relationship with a child diagnosed with AS

It appears to be thoroughly prepared is an important and necessary component required to build a therapeutic relationship with children diagnosed with AS. The data gathered reveals that preparation involves the therapist doing research on AS and remaining knowledgeable on the topic. Becoming familiar with the latest research and continuing to educate themselves on AS as new information arises is important in order to understand that aspect of the child, what the diagnosis entails and what areas the child might struggle with. The diagnosis of AS can reveal important aspects to consider when building a therapeutic relationship with these children, such as sensory considerations and co-morbid disorders which can all impact on the process of developing a therapeutic relationship. Remaining knowledgeable about such aspects can make a difference to the therapist and help to simplify the process and avoid frustration.

Another aspect of preparation involves obtaining background information and a thorough history on the child through consulting with parents, teachers, other therapists and siblings. The participants were of the opinion that the more knowledge on the background information and history the therapist can gather on the child, the better equipped they can be to form a therapeutic relationship. Background information and history can reveal what the child struggles with, strengths and weaknesses, co-morbid disorders, sensory difficulties, obsessions, likes and dislikes, communication styles, behaviours, significant relationships and information that can guide the therapist to make a connection with the child. Studying scholastic, developmental and psychological assessments done by other professionals, such as Occupational Therapists, Counselling Psychologists and Clinical Psychologists could also be helpful in gaining important knowledge with regards to the children and their personality traits.

Theme 2: The therapist's awareness as a requirement to build a therapeutic relationship with a child diagnosed with AS

In order to build a therapeutic relationship with a child diagnosed with AS, the therapist and child should both be able to make contact on a physical, social and emotional level. Contact occurs when the therapist and child are both fully aware of themselves, their environment as well as the way in which to make contact, or engage. Engaging requires dialogue, which in turn facilitates awareness and contact. During the study, it became clear that there were certain aspects that therapists should remain aware of in order to make contact and to build a meaningful and functional therapeutic relationship.

The child related aspects to take into consideration were:

- Co-morbid disorders
- Sensory considerations
- The therapy room and the therapeutic environment
- Obsessions, routines, coping with change and dependability on therapist
- Social behaviour pertaining to the contact-making skills of the child
- Communications and relational aspects pertaining to the therapeutic relationship and the contact-makings and dialogue skills of the child
- The child's personality

The first aspect that therapists should remain aware of are that children diagnosed with AS often suffer with co-morbid disorders such as Depression, Anxiety, Obsessive Compulsive Disorder and ADHD. These conditions might all impact on the way in which therapists approach a child in order to build a therapeutic relationship. A child diagnosed with AS and ADHD, for example, will require the therapist to keep the sessions short and include physical activities and movement in order to make a lasting connection. Sensory integration dysfunction, or difficulty relating to the environment on a sensory level, might cause these children to shy away from certain activities or often refuse to participate in certain activities. For example, using music might cause damage to the therapeutic relationship if the child has an auditory sensitivity. These aspects are important for the therapist to be aware of and might also be a reason for disruptive behaviour or rudeness.

Therapists should also consider the environment that they bring the child into during therapy and a slow pace that creates a non-threatening environment is recommended. A relaxed atmosphere with minimal pressure is best in order to help the child feel comfortable with the environment. It is also recommended that visual aids and support strategies can be implemented to help the child understand and forewarn the child if there will be any changes to the therapeutic environment, for example when a different room will be used.

Children diagnosed with AS are inflexible, struggle to cope with change and adjust to boundaries. These children often become fixated on a particular subject or topic and their obsessions can slow down the building of a therapeutic relationship. The data revealed that therapists should remain sensitive to the fact that these children struggle to cope with change, but find a balance between accommodating the children in their special rituals and challenging them to overcome these behaviours and habits. Using their special interests can be helpful in building a therapeutic relationship with children diagnosed with AS and these interests can be used to guide the children to form other meaningful relationships and friendships.

Children diagnosed with AS have a tendency to become dependent on the therapist and often only want to see that particular therapist. It is difficult for these children to generalize what they have learnt during therapy and can become too comfortable in the relationship with the therapist. Therefore, it is important for the therapist to find a balance between bonding and forming a therapeutic relationship, as well as facilitating these children to generalize and use the skills learnt to form other significant relationships.

The therapist should meet children diagnosed with AS on a social and communication level that is comfortable for them. It could be necessary to indulge the children in their interests and try to truly understand their special hobbies or habits. This could open up a great opportunity for dialogue and foster trust. The therapist should also be direct and avoid using symbolism, sarcasm and idioms as this will only confuse these children. Therapists should remain aware of the social and communication difficulties children diagnosed with AS face with regards to family and peer interaction. In order to make a connection, the therapist must be sympathetic and understanding to their ways of communicating and not expect these children to socialize and communicate as their peers would.

Furthermore, it is important for the therapist to get to know each specific child, be aware of that child's emotional needs, build a therapeutic relationship and make a connection according to that. The therapists should remain aware of the feelings of fear and low self-worth that children diagnosed with AS suffer from, in order to be sensitive to their self-esteem and feelings of insecurity when building a therapeutic relationship. Therapists should realize that there is a difference between children diagnosed with AS and typically developing children of the same age. The therapeutic relationship may suffer and it may cause more stress for the child if therapists are not sensitive to this fact. In order for the therapeutic relationship to truly be helpful, the therapist should be understanding and accepting of the child and all aspects surrounding the child.

Therapist related aspects that therapists themselves should remain aware of are the characteristics of the therapist that are helpful in forming a therapeutic relationship with a child diagnosed with AS. Characteristics such as empathy, patience, determination, non-judgement, supportive, willingness to understand, sensitivity, humility, kindness, warmth, sincerity and honesty are prerequisites of building a functioning therapeutic relationship with these children. The therapist's own attitude, body language and expression play a part in how these children perceive the therapeutic relationship and can influence the way in which these children make contact. Consistency builds trust and children diagnosed will be less reluctant to build a therapeutic relationship with the therapist when they feel accepted and understood. Therapist should also be careful of becoming despondent or de-motivated when these children show a lack of interest, but should rather persist and remember that building a therapeutic relationship with children diagnosed with AS may take longer and require more patience.

The therapy related aspects that need to be considered while building a therapeutic relationship with children diagnosed with AS are:

- Setting boundaries and remaining consistent during therapy
- Teaching children diagnosed with AS skills during therapy in order to build a therapeutic relationship
- Support and education of parents, siblings and other family members
- The importance of having fun while building a therapeutic relationship

Boundaries and consistency are of the utmost importance with these children as it creates a safe environment in which they can become comfortable enough to learn, trust and become open to a therapeutic relationship. The therapist should try to find a balance between helping the child diagnosed with AS to feel happy, safe and comfortable as well as push their limits and boundaries to show them that a therapeutic relationship is manageable. The study also showed that it is important that children diagnosed with AS understand the difference between a therapeutic relationship and a friendship and this can be achieved by setting strict boundaries and through consistency. Boundaries and consistency also alleviates anxiety for children diagnosed with AS as they will know what to expect.

The therapists should remain aware of the fact that there will always be an aspect of teaching involved during therapy with children diagnosed with AS. These children struggle with relational aspects of therapy and the therapist will be required to coach them through it on some level. Through the therapist practicing interaction and monitoring the way these children interact during therapy, they can help children diagnosed with AS become aware of their contribution, relational habits and communication patterns. Therefore, it becomes easier to provide feedback to these children on more appropriate ways of interacting and communicating and building a therapeutic relationship. In turn, these children can become more confident and competent in building relationships outside of therapy.

Supporting the parents, siblings and other family members on an emotional level can create a strong alliance which will also strengthen the therapeutic relationship with the child. Educating them on how the child interacts and make contact with the world, how to go about dealing with difficult behaviour, as well as exchanging tips on how to be involved in the child's world and process, can assist in building a therapeutic relationship for similar reasons. Follow-through on ways of building a relationship, incorporating the rules and boundaries at home as well as in therapy, contributes to the consistency, familiarity and trust of the therapeutic relationship, which adds to the value and teaches children that the work they do during therapy is relevant.

The therapist should also remember that relationships form by having fun together, which is another important aspect to remain aware of. Laughing and sharing common interests can be really helpful during this process. The therapist should be enjoyable to be around and use humour to make a connection with children diagnosed with AS. By making therapy fun and

interesting and using these children's special interests to make a connection will help keep these children's attention and strengthen the therapeutic relationship. Having fun together also improves children's self-esteem which in turn is helpful in building a therapeutic relationship.

Main theme 3: Teamwork required to build a therapeutic relationship with a child diagnosed with AS

Building a therapeutic relationship with a child diagnosed with AS can be assisted by involving parents, siblings and other family members of these children. Involvement is valuable in the establishment and maintenance of the therapeutic relationship as trust and cohesion develops more readily between the child and therapist if there is cooperation, trust and consideration between the therapist and parents, siblings and other family members. Participation of parents, siblings and other family members in therapy and the therapeutic relationship may especially be of value if the child is anxious or shy. Their involvement might ease the child's feelings and help develop trust. Parents, siblings and other family members can be a valuable source of information to the therapist. Information such as the child's interests, like and dislikes can assist the therapist in building a therapeutic relationship.

Consultation and collaboration with other professionals and teachers the child frequently sees or has seen in the past, can prove valuable to the building of a therapeutic relationship as they might have insights, thoughts or knowledge about the child that you did not previously have. The information shared, such as personality traits, likes and dislikes can be used to establish trust and create common interest with the child. In order to facilitate true change, a multi-disciplinary approach should be taken. The therapist might also find it helpful to consult and collaborate with others professionals and teachers in order to feel that they are doing the correct thing and sharing ideas can help alleviate frustration and despondence for the therapist.

5.5 RECOMMENDATIONS

The following recommendations are made to therapists and other professionals working with children diagnosed with AS with regards to building a therapeutic relationship:

- Therapists and other professionals working with children diagnosed with AS should prepare themselves for building a therapeutic relationship with these children by educating themselves on the latest research on AS and being knowledgeable on AS through reading and attending workshops on the topic.
- It is recommended that therapists obtain information on the child through consulting with parents, teachers, other therapists and siblings. This can be achieved by doing a thorough intake interview with the parents and gaining as much information as possible from teachers and other therapists working with the child. It can also be helpful to consult with siblings in order to gain a better understanding of the child diagnosed with AS.
- Obtaining information by doing psychological assessments, scholastic assessments and by studying assessments done by other professionals is also recommended to be of value.
- Therapists should remain aware of certain aspects pertaining to the child when building a therapeutic relationship with a child diagnosed with AS, such as co-morbid disorders, sensory issues, therapy room and the therapeutic environment in order to make accommodations during therapy.
- Therapists should consider children diagnosed with AS's obsessions, strictness to routines and inability to cope with change as well as remain aware that these children can easily become dependent on the therapist.
- Other considerations that therapists should remain aware of include an understanding of the social behaviour, communication patterns and relational aspects pertaining to the contact-making and dialogue skills of the child
- It remains important for the therapist to consider the child's personality, likes, dislikes, interests and unique process, as all children are different.
- It is recommended that therapists themselves should remain aware of the fact that their personality and certain characteristics such as empathy, patience, non-judgement and willingness to understand can be helpful in building a successful and meaningful relationship with a child diagnosed with AS. Therapists should strive to personify these aspects when working with children diagnosed with AS.

- Setting boundaries and remaining consistent during therapy is important when building a therapeutic relationship with children diagnosed with AS.
- Teaching the child diagnosed with AS skills during therapy in order to build a therapeutic relationship, as well as supporting and educating the parents, siblings and other family members is recommended in order to build and strengthen the therapeutic relationship.
- Therapists and other professionals working with children diagnosed with AS should remember the importance of having fun while building a therapeutic relationship, as this builds trust and is the cornerstone of any relationship.
- Cooperation, involvement and consideration of parents, siblings and other family members remains important and therapists and other professionals should try to make this a priority, especially during the first stages of therapy with a child diagnosed with AS.
- It is recommended that therapists consult and collaborate with other professionals and teachers on how to build a therapeutic relationship, what the child is like and what to expect before building a therapeutic relationship with such a child.

5.6 FURTHER RESEARCH

In terms of future research, the following recommendations are made:

- Future research studies could include exploring components required to build a therapeutic relationship from the perspective of children or adults diagnosed with AS, to give people diagnosed with AS a voice with regards to this matter.
- Teachers involved with children diagnosed with AS could be approached and the study can be replicated to include their perspective with regards to building relationships with children diagnosed with AS.
- The components required to build a relationship with children diagnosed with AS could be explored by interviewing parents of such children to determine what has worked or failed for them in this regard.
- Further research can be done in the field of Occupational Therapy with regards to sensory, movement, perceptual and vestibular stimulation and relaxation techniques in order to determine how that may impact on a therapeutic relationship.

- Research in the field of Speech and Language therapy may include an element of communication patterns, relational style and language use to explore the components required to build a therapeutic relationship with children diagnosed with AS.

5.7 LIMITATIONS OF THE STUDY

The following limitations were recognized during this study:

- The literature on the topic of AS involving therapeutic relationship building was limited.
- The availability of participants were minimal as very few therapists work with children diagnosed with AS.
- The topic of AS has not been extensively researched and continues to change. The availability of literature and concrete evidence was limited.

5.8 FINAL REMARK

Building a therapeutic relationship with children diagnosed with AS involves more than with typically developing children. This relationship involves educating, supporting and collaborating with everyone involved in the child's life on a holistic level, combining traditional methods of relationship building with knowledge on AS and the specific child. The therapeutic relationship takes longer to establish and has a greater influence on therapeutic success. The therapeutic relationship also entails more than just the therapist and child diagnosed with AS and influences broader aspects of the child's life.

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Appendices

Appendix A

Interview Schedule (Flick, 2009:166; Laforest, 2009: 7-10; Terre Blance, Durrheim & Painter, 2006:298; David & Sutton, 2004:87).

Introduction of interviewer

Background information of interviewee

- Name
- Occupation
- Years of experience
- Therapeutic discipline

Just to clarify, I would like to remind you that:

We will investigate the components required to build a therapeutic relationship with a child diagnosed with Asperger Syndrome.

During the interview I would like to discuss the following topics:

- Asperger Syndrome
- Your role as therapist working with children diagnosed with Asperger Syndrome
- The components required to build a therapeutic relationship
- Defining components:
 - Important aspects
 - Considerations
 - Guidelines
 - Skills
 - Modifications

Please feel free to ask any questions.

Main questions

1. Please tell me about your work with children diagnosed with Asperger's Syndrome?
 - a. The reasons you see children diagnosed with AS for/ reasons children diagnosed with AS are referred to you
2. What can you tell me about your therapeutic relationship with children diagnosed with AS?
 - a. In your opinion, what is important in a therapeutic relationship with a child diagnosed with AS?

- b. What value, in your opinion, does the therapeutic relationship add to your therapy with a child diagnosed with AS?
3. In your opinion, what are some of the components required to build a therapeutic relationship with a child diagnosed with AS?
 - a. Components that help
 - b. Components that hinder
4. Tell me about what you find challenging when building a therapeutic relationship with children diagnosed with AS.

Clarifying questions

- Can you expand on this?
- Can you tell me anything else?
- Can you give me examples?

Conclusion

- Is there anything that you would like to add?
- Summarizing main themes and thanking interviewee
- I will be contacting you with the conclusions and recommendations of the study

Appendix B



NORTH-WEST UNIVERSITY[®]
YUNIBESITHI YA BOKONE-BOPHIRIMA
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1 May 2012

Consent to participation of study

1. Title

The components required to build a therapeutic relationship with children diagnosed with Asperger Syndrome.

Before you agree to participate, please ensure that you have read and understood this explanation of the study. It describes the procedure, benefits, possible risks and discomfort pertaining to the study. It is important to understand that there can be no guarantee as to the results of the study.

2. Aim of the study

I am a Master's degree student and the aim of this study is to assess what therapists feel are the components required to build a therapeutic relationship with children with Asperger Syndrome. This study will provide the participants with the opportunity to express their thoughts and feelings surrounding the topic, as well as conveying what type of support they need in order to enhance the therapeutic relationship with children with Asperger Syndrome.

3. Procedures and time frame for study

Upon agreement of participation, you will be asked to explore and describe what you think the components required to build a therapeutic relationship with children diagnosed with Asperger Syndrome are, by means of some questions that I will be asking. The interview should not exceed 60 minutes. The interview will be recorded on digital video camera to

ensure accuracy of the information during analysis of data. The interview place and time will be scheduled according to your needs and convenience.

4. Possible risks and discomfort

The researcher does not foresee any risks or discomfort with regards to participation in the study. The interviews will be scheduled according to your preferences.

5. Possible benefits to participants and/or community

The aim of the study is to explore the components required to build a therapeutic relationship with a child diagnosed with Asperger Syndrome. New opportunities for knowledge and further studies in this area may arise through sharing your thoughts and feelings on the matter. Possible support groups, guidelines and new ideas could be formed.

6. Incentives

Please be aware that there will be no financial incentive to participate in this study.

7. Confidentiality

I undertake that I will treat any information disclosed by whatever means as being strictly private and confidential, and that I will take all reasonable measures to maintain its status as such. No information will be used for something other than this research study. In the publishing of results, recommendations and conclusions of the research, your identity will remain anonymous. The digital video recordings will only be viewed by the researcher and, if necessary, by the supervisor and external examiner, with your additional consent. The digital video recordings will be stored on a password protected external hard drive and the researcher alone will have access.

8. Participation and withdrawal

You can decide whether to participate in this study. In the case of agreement of participation, you are allowed to withdraw at any time, without any obligations or explanations.

9. Competence of researcher

I, the researcher, am qualified, competent and adequately skilled to complete this research procedure. I have worked under the guidance and leadership of a study leader. I have enough knowledge about the research process, Asperger Syndrome and components of building a therapeutic relationship. I will aim to act professional, sensitive and respectful at all times during your participation.

10. Identification of participants

Researcher: Edré Gerber, Master's degree student, Centre for Child, Youth and Family studies, NWU (Potchefstroom campus).

Contact number: 072 291 1220

11. Rights of participants

As stated previously, withdrawal at any time is acceptable. Participation in research study does not exclude you from any legal rights. If you have questions about your rights as participant in research study, please contact:

Me. Issie Jacobs

Study leader for research study

Centre for Child, Youth and Family studies, NWU (Potchefstroom campus)

Tel: 021-864 3593

12. Declaration of participant

The above mentioned information has been explained to me by Edré Gerber in English, I understood and did not need a translator. I had the opportunity to ask questions that were answered to my satisfaction.

I hereby agree willingly to participate in this research study. I give permission to digitally video record the interviews and that data gathered may be used for this research study. I understand what the study is about and why it is being done.

Name of participant

Signature of participant

Date

13. Declaration of researcher

I declare that the information in this document was extensively explained to the participant. He/she was urged and adequate time was given to ask questions. The conversation was in English and no translator was used.

Signature of researcher

Date

Appendix C

Ethics

According to Terre Blanche, Durrheim and Painter (2006:61) “Research ethics should be a fundamental concern of all social science researchers in planning, designing, implementing, and reporting research with human participants.”

1. Harm to participants

The researcher has an ethical obligation to ensure that no physical or emotional harm comes to the participants and will change the nature of the research in order to prevent harm, if necessary (Babbie, 2010:66; Flick, 2009:41; Strydom, 2011:115; Terre Blanche, *et al.* 2006:67). The participants must be informed of any potential harm. Sensitive and personal information will not be included, unless it is crucial to the research. Due to the nature of the research, the researcher believes that there will be minimal risk of emotional harm and no risk of physical harm, but the research will be conducted in a respectful manner.

2. Informed consent

Flick (2009:41), Strydom (2011:117) and Terre Blanche, *et al.* (2006:71) emphasises the importance and necessity of informing the participants of every aspect of the study, including the goal, procedures and credibility of the researcher. The information must be accurate and complete and allow participants to fully comprehend what the study is about (Flick, 2009:41). Participation is voluntary and the participants have the right to withdraw at any time (Strydom, 2011:116). The participants have to be legally and psychologically competent to give consent (Terre Blanche, *et al.*, 2006:71). The researcher believes that all the therapists that will be involved will be legally and psychologically competent to give consent. The researcher will also ensure that the information given will be clear and in a language understood by the participants. It is important to allow adequate time for participants to ask questions and they must be informed of time, activities and disclosure of personal information. The researcher will ensure that the participants understand all the aspects of the study by explaining the goals and procedures and allowing time for questions. Babbie (2010:72) states that written consent must be obtained (see Appendix B) and all possible risks should be discussed. Written consent will be obtained to do digital video recordings of the interviews. An offer to provide

participants with a summary of the research findings will be made, as suggested by Neuman (2011:136).

3. Deception of participants

Thomas and Hodges (2010:84) highlight the importance of honesty and truthfulness during research. No information must be withheld or represented incorrectly as to deceive participants to comply (Flick, 2009:37; Strydom, 2011:119). The researcher will inform participants about every aspect of the study as the research objective is to make recommendations to the therapists after the study has been completed.

4. Anonymity and confidentiality

Babbie (2010:565) states that anonymity implies that neither the researcher nor the readers of the research results can determine the identity of the participants. Confidentiality ensures the privacy of the participants is respected as cited in Strydom (2011:119). The privacy of participants will be protected in every possible way (Strydom, 2011:120). The data will be stored in a safe place where only the researcher has access as suggested by Flick (2009:42). The participants will be interviewed and thus, complete anonymity will not be possible. The participants' privacy and confidentiality will be maintained and respected by withholding the names of the participants in the collected data and research report.

5. Actions and competence of researcher

Researcher must be adequately skilled and competent to do the research (Strydom, 2011: 114). Thomas and Hodges (2010: 84) state that the researcher must be fair, objective and unbiased in the case of personal relationships and interests as to avoid conflict of interest. The researcher's personal values and interest will not influence the research methods or findings (Thomas & Hodges, 2010:85). The researcher is a registered counsellor and enrolled in the Master's in Play therapy programme at North West University. The researcher is working under supervision and has received training in the master's programme to enable her to conduct the research competently.

6. Release of findings

The research findings will be released in the form of a written article (Strydom, 2011:126) that will be compiled as accurately and objectively as possible. Plagiarism, as cited in Babbie (2010:524) and Thomas and Hodges (2010:86), will be avoided by giving recognition to all sources used during the research process. The researcher will admit to errors and limitations of the study (Strydom, 2011:126) and remain objective and sensitive when findings are released.