'This book is one of the most comprehensive treatments I have ever seen about gestalt play therapy. Dr Blom's interpretation of the theoretical concepts of gestalt therapy and its application to work with children will certainly assist therapists in their understanding of Gestalt Play Therapy. Her research is impressive and her presentation of my model of the therapeutic process is clear with many suggestions for its implementation. *The Handbook of Gestalt Play Therapy* is a vital and important contribution to the literature of psychotherapy with children.'

– Violet Oaklander

Violet Oaklander's book, *Windows to our Children: A Gestalt Therapy Approach to Children and Adolescents*, internationally recognized and translated into 11 other languages, was published in 1978 by Real People Press, and then in 1988 by the Gestalt Journal Press.

The Handbook of Gestalt Play Therapy

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The Handbook of Gestalt Play Therapy

Practical Guidelines for Child Therapists

Rinda Blom

Foreword by Hannie Schoeman

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Dedicated to all the children who have touched my heart
and shared their pain with me

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Foreword

The Handbook of Gestalt Play Therapy: Practical Guidelines for Child Therapists will provide you with the most current research in gestalt play therapy. This book presents an integrated perspective that emphasizes the necessity for knowledge in assessment, treatment planning, loss and trauma and HIV/AIDS. To help the reader to think critically and get the most out of this book the author has incorporated case studies handled the gestalt way.

The author has used her creative talents and skilful emotional intelligence to form a compendium of ideas and to escape the bounds of rigidity. The aim of this book is not only to provide theoretical information but also to bring understanding through the practical handling of particular situations as exemplified in the case studies.

This work provides an extensive source of information on gestalt play therapy. It is a comprehensive work and applicable to therapists working the gestalt way. It serves as a thought-provoking springboard in various topics for both therapists and students.

Dr Hannie Schoeman, Gestalt play therapy trainer

Preface

When I began my career as a social worker in 1992, I had the best of intentions to help my clients to reach their optimum potential. As a social worker at a place of safety, however, I soon realized that therapeutic work with children requires specialized knowledge and skills, as child clients differ from adult clients in many ways. Therapy often failed because I expected children to be able to discuss their unfinished trauma and emotions verbally, which they could not do because they did not understand those feelings themselves.

Those children, way back then, had no appropriate way, nor permission, to express their emotions of anger, fear and loss; they ended up needing to break windows and doors, steal each other's belongings, abscond time after time, wet their beds, and hurt themselves and others through aggressive behaviour. After three years with few positive outcomes, I was introduced to gestalt play therapy during a short course. For the first time I felt that I had some practical tools in hand, to help children therapeutically through directive play techniques. This book was only born, however, after another nine years of studying gestalt play therapy, seeing many children with emotional problems in private practice, learning from my own mistakes and guiding several students through their own studies in play therapy.

The Handbook of Gestalt Play Therapy: Practical Guidelines for Child Therapists aims to guide the reader on a practical journey in putting into practice gestalt play therapy with children. The contents of the book are based on the gestalt play therapy model of Violet Oaklander, internationally recognized founder of gestalt play therapy. I believe that, when practising therapy with children of any culture, therapists need to address their needs holistically. Therefore children's holistic functioning of their senses, body, emotions, intellect and spiritual issues, as well as their process and temperament, should be taken into account. Furthermore, therapists should not focus on children's symptomatic behaviour, but rather on the process of how they interact with the environment to satisfy their needs.

I have learnt that there is no quick fix for children's problems, as each child is unique and has unique circumstances. Adults and parents often have

difficulty understanding this and require immediate results. It is therefore important to explain to them the specific experiences children must have in order to satisfy their needs in a healthier way and to function as integrated human beings once more. Parents sometimes come back after two or three sessions, telling me that something 'magic' has happened with their child. However, sometimes it takes much longer than that before any progress is made.

I want to thank the Lord for giving me the inner strength and for guiding my life in this direction, because I feel fulfilled in what I am doing. I also want to thank my husband Hendrik and two daughters, Marna and Menike, for your patience when I had to spend time with children in need, and for when I spent long hours in front of the computer over the past four years. To my father for helping me with the pictures, my mother for your support with the children, my sister Annelie for your practical advice and support, and all my friends for your interest, I appreciate you. Thank you also to all the students that I have trained over the past years, not only for your belief in what I have taught you, but also for what I have learnt from your research, in doing gestalt play therapy with children. Morné, a special word of thanks to you, for encouraging me to write this book. Sandra, Marinél and Sayeeda, I sincerely appreciate your contributions to this book in Chapters 6 and 7. Thank you for sharing your specialized knowledge and skills.

Lastly, I would like to thank all the children who have touched my heart over the past years. I have learnt so much from you and appreciated each one of you as a special and unique creation of God, who loves you so much.

PART ONE

INTRODUCTION TO GESTALT PLAY THERAPY

In this section, consisting of one chapter, attention is given to the historical background of gestalt therapy, as well as to the theoretical concepts in gestalt play therapy and the application of these when doing gestalt play therapy with children.

Gestalt therapy is a humanist and process-oriented form of therapy. It includes principles from various other theoretical approaches such as psychoanalysis, gestalt psychology and humanist theories. It is also an existential approach with the emphasis on awareness of the present and immediate experience (Magill and Rodriquez 1996; Oaklander 1994a). According to Yontef and Jacobs (2000, p.313), gestalt therapy is: 'a radical ecological theory that maintains there is no meaningful way to consider any living organism apart from interactions with its environment'. Gestalt therapy encompasses the cognitive and emotional totality of each person, each moment and during each event. This theory emphasizes right-hemisphere, non-linear thought and is characterized by the use of metaphors, fantasy, figurative language, body posture and movement, and full expression of emotion by using the entire body in action (Clarkson 1989).

Violet Oaklander is considered the founder of gestalt play therapy. She mentions the following in this respect: 'People often ask me incredulously, "[h]ow can you do gestalt therapy with children?"' (Oaklander 1992, p.64). According to her, the philosophy, theory and practice of gestalt therapy can also be used with slight adaptation in therapy with children (Oaklander 1992, 1994a, 1994b, 1997). This aspect is consequently discussed

throughout this book. After many years in private practice doing gestalt play therapy with children, the author shares this opinion with Oaklander.

DEFINITION OF CONCEPTS

Before discussing the theoretical concepts of the gestalt theory, the three concepts, namely gestalt, gestalt therapy and gestalt play therapy, must be described in detail in order to give the reader a clear idea of what is meant by each one.

Gestalt

The gestalt concept is a German term that has no equivalent in English (Clarkson 1989; Yontef and Jacobs 2000). These authors regard the concept as the shape, the pattern, the whole form, the configuration. It connotes the structural entity which is both different from and much more than the sum of its parts. Papalia (1985) defines the gestalt concept as the meaningful arrangement of the parts of a whole in a way which the individual parts are not, whereas Gouws *et al.* (1987) describe it as a whole that has a certain degree of structure, that is more than the total of the parts and that is transposable, i.e. it is recognizable, even if the component parts are substituted, as long as the relationship between the parts remains.

The gestalt concept can be considered an entity or whole of which the total is more than its component parts, which has a certain degree of structure and which remains recognizable as a whole, as long as the relationship between the parts remains. This aspect is related to holism as one of the theoretical concepts of the gestalt theory, discussed in more detail in Chapter 1.

Gestalt therapy

Gestalt therapy is considered a form of psychotherapy that focuses on that which is immediately present. The aim of gestalt therapy is to help the client to improve the perceptions of his or her experiences in their totality (Gouws *et al.* 1987). It is also considered an existential and phenomenological approach, with the emphasis on awareness in the here and now and immediate experience (Fagan and Shepherd 1970; Hardy 1991; Magill and Rodriquez 1996). In the opinion of Yontef (1993), gestalt therapy is defined by three principles, namely:

1. This therapy is phenomenological; the exclusive aim is awareness and the methodology is that of awareness. In this respect, Korb, Gorrell and van de Riet (1989) mention that the phenomenological basis of gestalt therapy implies that each person constructs

his or her world in a unique manner. People are thus active in organizing their world of experience and in creating meanings about it.

2. It is based on existential dialogue, in other words I–thou contact and withdrawal.
3. The conceptual foundation of gestalt therapy is gestalt, which is holism and the field theory. In respect of the latter, Clarkson (1989) mentions that it implies that it is impossible to look at a person without taking into account the context of his or her environment field. The interdependence between the person and his or her environment thus forms a central concept of the gestalt approach.

Hardy (1991) adds that gestalt therapy emphasizes organismic self-regulation by promoting awareness. According to this theory, describing an emotion does not suffice; it must also be experienced in order to achieve the gestalt objectives. The existential nature of gestalt therapy focuses on the fact that people can choose their behaviour, thereby defining the significance of their life. By focusing on consciousness, the individual can choose and experience his or her own behaviour.

Gestalt therapy can be considered an existential, phenomenological and holistic approach, with the emphasis on awareness in the here and now and the interdependence between people and their environment. This improves organismic self-regulation in that people become aware of choices they can make in respect of their behaviour and they can thus define the significance of their life.

Gestalt play therapy

Play therapy is, according to Gouws *et al.* (1987), defined as a psychotherapeutic technique whereby the therapist attempts to give the child the opportunity to express his or her feelings verbally and non-verbally. It is assumed that the child will play out his or her problems in a symbolic manner, will learn to know and will channel his or her own emotions more effectively, will learn to enter into a relationship of trust with another person and that devious behaviour will consequently be normalized. Oaklander (1992, 1994a, 1994b, 1997) describes gestalt play therapy by mentioning that a number of theoretical principles of gestalt therapy – such as relationship, organismic self-regulation, contact boundary disturbances, awareness, experience and resistance – are directly related and have an effect during therapeutic work with children. She also mentions a therapeutic process when

play therapy is used with children and adolescents according to the gestalt approach. This process is associated with the philosophy, theory and practice of gestalt therapy and starts with the building of a therapeutic relationship as a prerequisite, followed by making contact, confirming the child's sense of self and emotional expression. This stage is followed by self-nurturing and concluded with termination. Various forms of play such as creative, expressive, projective and dramatized play can be used, for instance clay play, fantasies, story-telling, puppet-shows, sand play, music, body movement and sensory contact-making exercises.

Gestalt play therapy can be considered a psychotherapeutic technique that uses the principles and techniques of gestalt therapy during play therapy with the child. By developing a therapeutic relationship and contact, and according to a specific process, children are given the opportunity to confirm their sense of self verbally and non-verbally, to express their thoughts and to nurture themselves. Various forms and techniques of play are used during the different stages.

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Chapter 1

Theoretical Perspective of Gestalt Play Therapy

This chapter presents a theoretical perspective of gestalt play therapy as a therapeutic model for rendering assistance to children. The historical background of gestalt therapy is discussed first, followed by a discussion of the theoretical concepts of gestalt play therapy.

1.1 HISTORICAL BACKGROUND OF GESTALT THERAPY

Fritz Perls, who is considered the father of gestalt therapy, primarily developed the gestalt theoretical approach. After completing his medical studies, he studied psychoanalysis at the Berlin and Viennese Institutes for Psychoanalysis. Perls initially worked in Europe, where he was exposed to the ravaging effect of the First World War. Hitler's Nazism in 1933 caused him to flee to Holland, whereupon he was invited to come to South Africa. During his time in South Africa, he established among others the South African Institute for Psychoanalysis. Perls challenged Freud's psychoanalytical theory for 30 years. Apart from his rejection of some of Freud's theories, personal rejection by Freud contributed to his breaking the final bonds with formal psychoanalysis. Initially many people were sceptical of this theory, but in the course of time it was greeted more positively. At the age of 53 he returned to New York where gestalt therapy was formally born. The theory blossomed in the 1950s and 1960s and reached theoretical and ethical maturity in the 1980s (Aronstam 1989; Clarkson 1989; Clarkson and Mackewn 1994; Fagan and Shepherd 1970; Oaklander 1994a; Phares 1984; Thompson and Rudolph 1996).

According to Yontef and Jacobs (2000), gestalt institutes, literature and journals have proliferated worldwide in recent decades. Furthermore there are gestalt therapists and gestalt play therapists all over the world. Gestalt therapy tends to attract therapists inclined to an experiential approach.

Although literature on gestalt play therapy is still not widely available and Oaklander remains the main author of most of this, there is extensive gestalt literature and a growing number of books that address various aspects of gestalt theory and practice.

1.2 THEORETICAL CONCEPTS OF GESTALT PLAY THERAPY

Theoretical concepts from gestalt theory, which also apply to gestalt play therapy, include the following: holism, homeostasis and organismic self-regulation, means of self-regulation, figure-ground, process of gestalt formation and destruction, contact and contact boundary disturbances, polarities and the structure of the personality. These concepts are discussed with specific reference to the way in which they apply during gestalt play therapy with the child.

1.2.1 Holism

Yontef and Jacobs (2000) believe that most humanistic theories of personality are holistic. This implies that human beings are in themselves self-regulating, that they are growth-oriented and that people and their symptomatic behaviour cannot be understood apart from their environment. The concept of holism can be considered the most important theoretical concept of gestalt therapy.

A fundamental principle of holism is that all elements in the world, such as plants, animals, people and things, survive in a changing process of coordinated activities. Man is but an active element in the complex ecological system of the cosmos. However, Perls in particular was interested in holism with respect to the human organism (Clarkson and Mackewn 1994). Although individuals always function as an entity, they cannot survive without the environment, as they need the environment for satisfying their needs (Aronstam 1989).

According to Perls, people are an entity, both within themselves and in their environment. He thus rejects the dichotomy between the psyche and the soma (body), which forms part of the psychoanalytical theory. The entity is more than the sum total of its various components. Although one can distinguish between the components, these can never be separated (Aronstam 1989). This emphasizes the inseparable entity of the body, emotional and spiritual aspects, language, thought and behaviour. If the child thus experiences a specific emotion such as sadness, it will always be associated with a physiological and psychological component. According to Perls, man has learnt in the present times to separate the psyche from the soma (body) – in

other words, to live as a fragmented person. One of the objectives of gestalt therapy is to redress intrinsic holistic harmony within the individual. This is referred to as integration (Clarkson and Mackewn 1994; Yontef and Jacobs 2000). From a holistic point of view, the therapist holds the opinion that the individual is more than the sum total of his or her behaviour, perceptions and dynamics and that each individual moves towards an entity. The gestalt theory thus rejects the use of logical analysis during therapy (Korb *et al.* 1989).

In view of the holistic approach, Perls considers the activities of the left and right hemispheres of the brain important. Gestalt therapy includes techniques and approaches that integrate synthesis of both the left hemisphere (the more rational and analytical part) and the right hemisphere (the more spontaneous and creative part). The left-hemisphere activities are often overemphasized at the expense of the right-hemisphere activities (Clarkson and Mackewn 1994; Korb *et al.* 1989).

From the point of view of gestalt theory, children can also be considered a holistic entity, which means that the sum total of their physical, emotional and spiritual aspects, language, thought and behaviour is more than its components. These components can be distinguished, but they cannot be separated. The experience of emotion will thus also have an effect on the other components. During therapy the child should be guided to be aware of his or her experience in respect of all the components in order to survive not as a fragmented entity but rather as an integrated entity. During gestalt play therapy with children, the focus will thus be on their physical, emotional and spiritual aspects, as well as language, thought and behaviour, in order to approach them as holistic individuals.

1.2.2 Homeostasis / organismic self-regulation

From the point of view of gestalt theory, all behaviour is regulated by a process called homeostasis or organismic self-regulation. Homeostasis is described as the process during which the organism maintains its balance under different circumstances. According to Yontef and Jacobs (2000, p.305): '[o]rganismic self-regulation requires knowing and owning, i.e., identifying with what one senses, feels emotionally, observes, needs or wants, and believes'. This process of self-regulation is a way in which individuals satisfy their needs. Needs are satisfied both within the individual and from the environment. The environment continuously creates new needs. New needs give rise to discomfort, until people find a way to satisfy them so that they can grow (Aronstam 1989; Clarkson and Mackewn 1994; Korb *et*

al. 1989). There can be physical, emotional, social, spiritual or intellectual needs. Discomfort is experienced until a specific need is satisfied and balance is consequently restored.

The concepts of homeostasis and organismic self-regulation imply that the child continuously experiences needs of a different nature such as physical, emotional, social, spiritual or intellectual needs. This causes discomfort, until action is taken to satisfy this need, upon which homeostasis is restored. The process whereby action takes place in order to satisfy needs is organismic self-regulation.

With respect to the theoretical concepts of homeostasis and organismic self-regulation, the focus is on ways of self-regulation, figure-ground, the process of gestalt formation and destruction, and organismic self-regulation in the child.

1.2.2.1 Ways of self-regulation

There are two ways in which self-regulation can take place, namely external and internal (self)-regulation. Internal regulation is considered an inherent characteristic of the individual. It occurs spontaneously and is specifically aimed at satisfying organismic needs (Aronstam 1989). Korb *et al.* (1989, p.11) consider self-regulation 'a spontaneous integral, natural part of the organism, biologically as well as psychologically'. External regulation normally interferes with the spontaneous process of internal regulation and causes the spontaneous process of gestalt formation to be lost. This leads to fragmentation and the individual no longer functions as a holistic entity.

Internal regulation is a spontaneous and natural process unique to the individual, whereas external regulation is usually enforced upon a person from the outside. This normally impedes gestalt completion and fragmentation occurs. The following example is a practical illustration of this concept.

Children who need love and attention make use of internal regulation when they spontaneously run to their mother and hug her, whereas external regulation, such as when children are afraid that their friends will laugh at them because of cultural prescriptions, can deter them from naturally and spontaneously satisfying this need. The need is therefore not satisfied and this often leads to fragmentation and an incomplete gestalt in the child.

1.2.2.2 Figure-ground

The concept of figure-ground forms a primary part of the theoretical concepts regarding organismic self-regulation. The figure is considered as that which is the most significant at that moment for the child – in other

words, that which draws the child's attention the most, for instance that he or she is hungry. The ground refers to the background of the child's experience at the specific moment, for instance music playing in the background while the child is eating. Once the need is satisfied and the gestalt is completed, the figure disappears; it becomes part of the background and a new figure (need) appears in the foreground. The process of figure-ground interaction is continuous (Aronstam 1989; Clarkson 1989; Clarkson and Mackewn 1994; Thompson and Rudolph 1996; Yontef and Simkin 1989).

Children thus organize their senses, thoughts, cognition and behaviour around a specific need until it is satisfied. Once it is satisfied, the child is in a state of withdrawal, rest or balance until a new need appears and the cycle is repeated. If the child experiences more than one need simultaneously, the healthy organism will pay attention to the most dominant need. Organismic self-regulation does not imply that all needs will be satisfied at all times, as the environment sometimes lacks the necessary resources. However, it does imply that a child will attempt to act in a self-regulatory manner within the resources that are available at a specific time (Aronstam 1989; Clarkson and Mackewn 1994). Thompson and Rudolph (1996) add that psychologically healthy persons are able to maintain their awareness without their attention being detracted by various environmental stimuli. These individuals can thus clearly identify their own needs, as well as the environmental alternatives for satisfying these needs.

The healthy organism can identify the most dominant need on his or her foreground, in order to use resources within him- or herself or the environment to satisfy these. Satisfaction then contributes to homeostasis. However, younger children will only be able to gain awareness of their needs in a limited way, according to their level of development, in order to find resources within themselves and the environment to satisfy these, so that they can achieve homeostasis. The needs, which children may experience at a specific point of time, will relate to their level of development and to environmental influences. Therefore, a teenager will experience different needs, such as a need of freedom and independence, while pre-school children may experience a need to feel secure and to be with their primary caregivers most of the time. It is important that children should be guided towards becoming aware of their needs in a way that correlates with their developmental stage.

Perls, via his concept of self-regulation, does not deny the fact that the individual must often inhibit self-regulation for the sake of his or her own interests or those of others. When a person is very angry, he or she will most of the time be able to resist committing murder. As a result of the holistic

entity between man and the environment, taking into consideration the needs of others is considered an intrinsic aspect of self-regulation (Clarkson and Mackewn 1994).

Children must at times suppress their need on their foreground in favour of another need, for instance to act in a socially acceptable manner. Pre-school children often have difficulty with this aspect, as they are still very egocentric. Egocentrism implies that these children are not able to view the world from someone else's perspective. The egocentric child can therefore not understand that another person may feel different from him or her within the same situation. Egocentric children take everything that happens to them very personally and they often want their needs satisfied immediately. Primary school children should be able to take other people's needs increasingly into account in the light of the decrease in egocentricity characteristics of their level of development. The extent to which children are able to inhibit their own needs for the sake of their interests and those of others is also related to other aspects of development such as their level of moral development, their capacity for emotional management and environmental influences.

1.2.2.3 The process of gestalt formation and destruction

The process of gestalt formation and destruction or organismic self-regulation consists of a cycle of stages. The stages emphasize various focal points and can thus overlap. Authors (Clarkson 1989; Korb *et al.* 1989; Clarkson and Mackewn 1994) hold different views in respect of the number of stages that form part of the process, distinguishing five to eight stages. The content of these stages corresponds with each other to a great extent. For the purposes of this discussion, the information is integrated by dividing the process into a cycle of five stages. A brief discussion of the various stages follows.

STAGE ONE: AWARENESS/SENSATION

The individual experiences a need or is disturbed by an environmental stimulus. The need or sensory stimulus serves as the figure (need). An example of this is when a child experiences pain in his or her chest. He or she becomes aware of the pain, assigns meaning to it and experiences specific emotions such as he or she feels alone and needs to go and play with a friend.

STAGE TWO: MOBILIZATION/CHOICE OF RELEVANT ACTION

The awareness of a need is followed by a mobilization of the self and resources in order to satisfy the need. The healthy person is now ready for action. If the child who is capable of healthy organismic self-regulation experiences an emotion of loneliness, for instance, he or she will now prepare him- or herself to contact a friend in order to satisfy his or her need.

STAGE THREE: FINAL CONTACT/ACTION

During this stage, the individual becomes fully involved in the action he or she has chosen in order to satisfy his or her need, whereas all other aspects continue in his or her background. For a few moments, gestalt completion takes place in the here and now, for example when the child hugs his or her friend and the need for a friend is satisfied.

STAGE FOUR: POST-CONTACT

Once contact has been completed, the child experiences homeostasis. The child for instance no longer feels that he or she is alone and lonely. The figure (need) returns to the background and the gestalt is destroyed.

STAGE FIVE: WITHDRAWAL

During this stage, the person withdraws to a state of rest or equilibrium between gestalt destruction and the formation of a new gestalt. There is no clear figure and the organism is in a state of perfect balance. This stage is short, as a new need can develop spontaneously, upon which the cycle of organismic self-regulation will be repeated. The child could possibly experience a new need, such as hunger, upon which the process starts again from scratch.

Although specific stages can be identified in the process of gestalt formation and destruction or organismic self-regulation, these stages often take place unconsciously and repeatedly in the daily life of children as they attempt to satisfy the various needs on their foreground. If children are not able to identify the need on their foreground, they will not be able to identify relevant ways to satisfy it. This may contribute to fragmentation of the holistic entity of the self. Pre-school children are only able to gain awareness of their needs to a limited extent, as mentioned earlier. Certain needs such as emotional needs are too abstract for these children's cognitive level of development and they often find it difficult to understand. From the author's own practical experience it was, however, found that the concrete way in which the techniques of gestalt play therapy focus on promoting children's

awareness of their needs can contribute to even the younger child gaining awareness of emotional needs, such as a need for a friend due to an emotion of loneliness.

1.2.2.4 The child and organismic self-regulation

When babies are born, they are able to make full use of their senses, emotions, body and intellect in order to satisfy their needs. However, they initially fully depend on adults to satisfy their needs. By crying they hint at their needs, to which adults then react. This healthy uninterrupted development of children's holistic entity serves as a basis for the development of a strong sense of self, which in turn serves as a basis for good contact with the environment. Humphreys (2002, p.138) explains it as follows: 'If their needs are met most of the time, babies begin to get a sense of being in a world that takes care of and is responsive to their needs.' As children grow and develop new skills, they find more satisfactory ways to satisfy their needs. The way in which adults act towards children when they experience a specific need plays an important role in respect of how they will satisfy their needs in the future. If children's need for acceptance is satisfied by the recognition they get when they eat all their food, they will probably eat all their food when they experience this need in the future. If children, for example, repeatedly get the message that the expression of anger is not permissible, they will possibly start suppressing it. The need to express this emotion will, however, persist and can cause the development of psychosomatic symptoms such as stomach-aches or headaches in the child (Oaklander 1992, 1994a, 1994b).

Children often react to the traumas in their life by blaming themselves and by taking responsibility for them. These children may experience a fear that their needs will not be satisfied. Due to a lack of emotional and intellectual maturity, they then use unsuitable ways to satisfy their needs, such as expressing their anger in destructive ways in order to regain equilibrium. During play therapy children must be assisted to become fully aware of their needs, in order to prevent fragmentation of their holistic entity (Oaklander 1992).

The way in which an infant's carers react in respect of his or her needs thus plays an important role regarding the strategies the child learns for satisfying his or her needs when growing older. If children's needs are recognized, they will most probably make use of healthy ways of contact with the environment in order to satisfy them. However, if they receive the message that a need such as the expression of an emotion is wrong, they will probably learn destructive ways to satisfy this need, as the need for homeostasis will

persist. They may perhaps turn the feelings inward, so that their emotions are experienced as physical sensations, for instance headaches, or they may project their feelings towards others, so that emotions are expressed in the form of destructive behaviour, such as uncontrolled outbursts of anger.

According to Thompson and Rudolph (1996), an incomplete gestalt is considered to be incomplete situations in the child's life. Play therapy from the gestalt theory's perspective focuses on the incomplete gestalt in the child's life, by removing the distorted or interrupted parts in the formation of a significant figure-ground experience. Although children can handle a degree of incompleteness, when these interruptions persist and are overpowering, they can have a negative influence on the child's functioning. Gestalt therapy believes that all clients who need therapy, including children, have within themselves the energy and resources needed for satisfactory self-regulation (Clarkson 1989; Korb *et al.* 1989).

Gaining awareness of needs and incompleteness should be a primary step towards healthy organismic self-regulation in the child. Attention should be paid during therapy to suitable ways to satisfy these needs, in order to assist children to finish incomplete gestalts in their life. It is believed that children internally have the necessary energy and resources to satisfy their needs and that the therapist should act only as a facilitator during therapy with children.

1.3 CONTACT

According to Yontef and Jacobs (2000, p.305) contact refers to 'being in touch with what is emerging here and now, moment to moment'. Contact takes place as soon as the organism uses the environment to satisfy its needs. Healthy contact can be regarded as children's ability to make contact with the environment by making use of their senses, awareness of and suitable use of their body, the ability to be able to express emotions in a healthy manner and the use of their intellect in various ways such as the ability to express ideas, thoughts and needs (Oaklander 1999). Contact is an integral part of all experience, therefore no experience can exist without contact.

The child's environmental field is differentiated by boundaries. In gestalt theory, both intrapersonal contact (contact between children and aspects of themselves) and interpersonal contact (contact between children and the environment) are considered important. The contact boundary can be regarded as the point where the child experiences the 'I' in relation to that which is 'not I' – in other words, that which is within (part of) and outside (foreign to) the organism. This contact boundary has two functions, namely

that it connects people with one another, but also maintains a form of separation between people. Although children must always be viewed as being in contact with their environment, there must also be boundaries that distinguish them from their environment. As such, children retain their identity (Aronstam 1989; Clarkson and Mackewn 1994; Korb *et al.* 1989; Oaklander 1994a).

Boundaries must be penetrable in order to ensure exchange between children and their field environment. Through contact-making and appropriate withdrawal, children's needs are met and they grow. When the child's boundary is rigid and not flexible, it impedes change and this is referred to as isolation. If the child's sense of self is poorly defined, there is no clear contact boundary and the self experiences problems with making contact. This is referred to as confluence (Aronstam 1989; Oaklander 1994a; Yontef 1993; Yontef and Jacobs 2000).

Contact-making implies that the environment is used for satisfying needs. The capacity for intra- and interpersonal contact-making is essential for healthy organismic self-regulation in children. In order to retain their own identity, and to be able to have healthy contact with the environment, a penetrable boundary is necessary to distinguish children from their field environment. The most important characteristics of the contact boundary are identification and alienation. Identification is the process whereby children distinguish between that which belongs to them and that which is foreign to them, for instance that which they can identify with a specific family and culture. Within the contact boundary there is usually a feeling of cohesion, whereas that which is outside the contact boundary can be considered foreign. By means of the process of contact-making and withdrawal, children attempt to satisfy their needs. Not one of these two processes is in itself positive or negative. It is important that children have the ability to regulate the relevant flow of contact and withdrawal for completing the gestalt (Aronstam 1989; Korb *et al.* 1989; Oaklander 1997).

Healthy functioning implies that children must be capable of distinguishing which aspects belong to them and which aspects are foreign to them. Children must also be capable of relevant contact and withdrawal with the environment in order to complete the gestalt on their foreground and to effect organismic self-regulation. As already explained, younger children do not have the capability to satisfy needs on their own and still need a lot of help from adults in their life in this regard.

1.3.1 Contact boundary disturbances

A contact boundary disturbance, or neurosis, occurs when children are no longer capable of forming a sound balance between themselves and the world. These children are not capable of suitable awareness and can no longer respond to their real needs. This neurosis impedes gestalt completion. The boundary between the self and the environment thus becomes unclear or gets lost. This disturbs both contact and awareness. Children with contact boundary disturbances are incapable of actualization and try increasingly to involve other people to tell them how they must be (Aronstam 1989; Hardy 1991; Yontef and Simkin 1989). According to Yontef and Jacobs (2000, p.315), a contact boundary disturbance may lead to isolation because 'it is fixed, does not respond to a whole range of needs, and fails to allow close contact to emerge. By the same token, if the need to withdraw is blocked, there is a corresponding boundary confluence'.

Oaklander (1994b, p.144) mentions the following in respect of contact boundary disturbances in the child:

> The child, in his quest for survival, will inhibit, block, repress, and restrict various aspects of the organism: the senses, the body, the emotions, the intellect. These restrictions become contact boundary disturbances and cause interruptions of the natural, healthy process of organismic self-regulation.

As a result of life experiences, children learn often from a very early age to make use of contact boundary disturbances in order to satisfy their needs. Children with contact boundary disturbances are incapable of being aware of their needs and healthy contact with the environment. These children's integrated holistic functioning of the senses, body, emotions and intellect is fragmented by using contact boundary disturbances, which negatively affect the natural process of organismic self-regulation.

From the gestalt theory perspective, most authors identify various contact boundary disturbances, namely introjection, projection, confluence, retroflection and deflection (Aronstam 1989; Clarkson 1989; Clarkson and Mackewn 1994; Oaklander 1994a; Yontef 1993; Yontef and Simkin 1989). In addition, Clarkson (1989) and Clarkson and Mackewn (1994) mention desensitization and egotism as contact boundary disturbances. Contact boundary disturbances are regarded as descriptions of processes and not of character traits. The implication is that contact boundary disturbances refer to the process which children use for satisfying the needs on their figure-foreground – in other words, their process of gestalt completion and

destruction. Subsequently attention is paid to contact boundary disturbances, as well as to the way in which these may manifest in children.

1.3.1.1 Introjection

Introjection occurs when children take in contents from their environment without criticism and awareness. These contents are not assimilated and remain foreign and unprocessed. Children thus sacrifice their own opinion and beliefs and accept the point of view of others, without questioning it. An introject can include an idea, attitude, belief or behaviour (Aronstam 1989; Hardy 1991, p.13; Korb *et al.* 1989; Yontef and Jacobs 2000). According to Yontef and Simkin (1989), this causes the development of a rigid personality. Introjects interfere with children's natural organismic self-regulation and lead to the development of unfinished business. The opposite of introjection is called assimilation. Assimilation is the process of experiencing what is to be taken in, deconstructing it, keeping what is useful, and discarding what is not. Therefore assimilation implies where children process and make that which they receive from the environment part of themselves. It is thus a critical manner of action, where the good is kept and the bad is rejected (Aronstam 1989).

Introjection implies that children take in aspects from the environment without considering the positive and negative aspects, as is the case with assimilation. As a result, introjects never actually become part of children, although they affect their functioning. Assimilation is a healthier form of contact, in that attitudes, beliefs, ideas or behaviour are not merely taken in from the environment without being criticized, but they are critically considered and only positive aspects are kept. Young children take on aspects such as behaviour patterns, rules for action and manners as introjects. By means of these, they learn how to act in certain situations. Children do not have the ability to understand separate experiences and points of view and thus take responsibility for everything that happens in their lives and what others do to them. During gestalt play therapy the focus should be on identifying and examining introjects that interfere with children's optimal functioning, and helping them to identify with or reject these.

Introjects can negatively influence children's self-awareness in that from a young age they get the message that certain emotions are negative and may not be experienced or expressed. Environmental influences such as the way parents discipline their children can also cause introjection. If children, for example, frequently have to hear that they are naughty, stupid or selfish, these messages may become introjects in their life and they may start living

according to these labels. Parental styles can also indirectly cause children to believe that certain emotions such as anger and fear are wrong, as they are deprived of the consent to express these emotions. Furthermore, indirect influences from the environment can also cause introjection. Cultural rules for expressing emotion and gender differences associated therewith can cause introjection, for instance where daughters are expected to suppress anger and boys are expected to suppress sadness. Gestalt play therapy should be used during assistance-rendering to address introjects that negatively influence children's organismic self-regulation. Figure 1.1 gives an illustration of introjection.

Figure 1.1 Illustration of introjection

1.3.1.2 Projection

Projection can be regarded as the tendency to hold the environment responsible for that which happens in the self (Aronstam 1989; Yontef and Simkin 1989). The child attempts to get rid of his or her own fantasized introjects and does not take the responsibility for that which is projected. Projection is used, in particular, if children have learnt that certain personality traits, emotions or behaviour are unacceptable.

By means of projection, children deny their own personal experience. Children often tell lies and deny their emotions, because they have too little ego strength to take responsibility for their actions. They blame others for the unpleasant events in their lives. These emotions are projected, since it is too painful to possess them. It is easier for the child to say 'My dad is always cross with me' than to say 'I am very cross with my dad'. Projection is a way to protect the frail and can cause a loss of the self's own observed abilities (Oaklander 1994b). Projection implies that children do not accept responsibility for their own emotions or behaviour but hold others responsible for these. An example of this could be that a child justifies his or her aggressive behaviour by blaming his or her parents' divorce for this. This child may

project his or her introjects, such as that he or she may not express anger, by mentioning reasons from the environment that justify his or her behaviour.

However, projection can also be used in a constructive way, for example in creative work, where parts of the self are projected in the work (Clarkson 1989). Hardy (1991) adds that during gestalt therapy an attempt is made to help the client to own that which he or she projects onto others, in order to enhance his or her awareness of his or her self-identity and to promote contact with the environment in a self-nurturing manner. Projective techniques during gestalt play therapy can contribute to children owning their own projection. This can positively influence their awareness of needs on their foreground and healthy organismic self-regulation. Projection is illustrated in Figure 1.2.

Figure 1.2 Illustration of projection

1.3.1.3 Confluence

Confluence occurs when there are no boundaries between children and their environment. Children therefore do not know where they are and where other people are. This lack of boundaries keeps children from making positive contact with others (Aronstam 1989; Clarkson 1989). Thompson and Rudolph (1996, p.142) regard this confluence as one where children 'may incorporate too much of themselves into others or incorporate so much of the environment into themselves that they lose touch with where they are'.

Children who make use of confluence do not have a boundary that separates the 'I' from the 'not I' – in other words, the self from the environment. Confluence implies that the children's own identity becomes lost, and that they do not have a sense of self that distinguishes them from the environment (Clarkson and Mackewn 1994; Korb *et al.* 1989). A common example of confluence is where a parent has specific expectations of his or her child which are not at all related to the child's need. The father is, for

instance, not aware of the fact that his child is a separate person, that there is a boundary between him and his child. If children do not meet their parents' expectations, they are often directly or in a subtle manner rejected by their parents.

Oaklander (1994a) is of the opinion that the child who discloses confluence has a poor sense of self. These children usually act as pleasers in that they are prepared to do anything that is expected of them. It is important that children with confluence as contact boundary disturbance must be helped during gestalt play therapy to show resistance. Furthermore, these children should be assisted to develop a strong sense of the self. The author's own practical experience has found that children who are in confluence find it difficult to make choices during play therapy and expect the therapist to choose for them.

Confluence can, however, be used in a positive manner. When there is true and healthy contact between people, there is natural and healthy confluence of energy (Clarkson and Mackewn 1994; Hardy 1991). Confluence may occur between the therapist and the child when there is a positive therapeutic relationship. Refer to Figure 1.3 for an illustration of confluence.

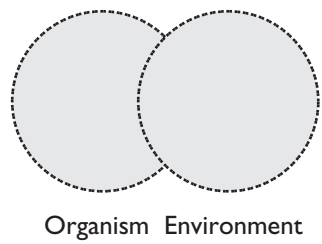

Figure 1.3 Illustration of confluence

1.3.1.4 Retroflection

Perls, Hefferline and Goodman (1977, p.183) define retroflection as follows: 'When a person retroflects behaviour, he does to himself what originally he did or tried to do to other persons or objects'. Yontef and Simkin (1989, p.332) define retroflection as 'the resisting of aspects of the self by the self'. It can be inferred from this that retroflection means that the individual treats him- or herself as he or she would actually treat others.

According to Clarkson and Mackewn (1994), chronic unconscious retroflection is an obstacle for contact and usually occurs when expressing emotions is considered dangerous. Children in particular tend to retroflect when their emotions and thoughts are not considered valuable by their

primary caregivers or when they are punished for expressing natural impulses. Anger in particular is an emotion which is often retroflected, since the child from an early age learns that expressing anger is prohibited (Clarkson 1989). Children often retroflect emotions of grief and anger by means of symptoms such as headaches, stomach-aches, asthma attacks or hyperactivity (Oaklander 1994a). The manifestation of psychosomatic symptoms in the child can be an indication of retroflection. Introjects, such as that the expressing of anger is prohibited or dangerous, can also cause children to retroflect their emotions. The latter may then also negatively influence the child's self-awareness.

Retroflection can sometimes be to the advantage of children, such as when a response in a specific situation is suppressed because it can be disadvantageous to them or contradict social norms. However, the child should be aware of this (Hardy 1991). An example of this would be where children temporarily suppress their anger, when they in fact want to attack someone. Retroflection is illustrated in Figure 1.4.

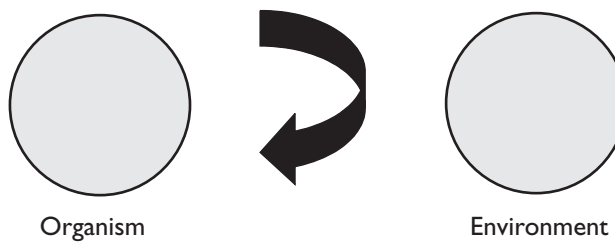

Figure 1.4 Illustration of retroflection

1.3.1.5 Deflection

Deflection refers to avoiding direct contact with other people – in other words, reducing awareness with the environment, for instance avoiding eye contact during a conversation or changing the subject. Children who often make use of deflection do not use their energy effectively in order to receive feedback from themselves, others or the environment. They attempt to avoid the impact of stimuli from the environment – for example, something is said about someone instead of talking directly with the person or there is communication about the past and the future rather than the present (Clarkson 1989; Korb *et al.* 1989; Yontef and Simkin 1989). Deflection can therefore manifest in various ways, although it implies in fact diminished contact and awareness of the environment.

Children use deflection as a handling strategy for painful experiences by outbursts of anger or other forms of reactionary behaviour, or by fantasizing and daydreaming. In the short term, this behaviour offers the child a feeling of the self and energy, but this is of short duration (Oaklander 1994a). Deflection can manifest itself in children in various ways, in order to protect themselves against emotional pain. The most frequent examples that are experienced in practice are when children change the subject by asking 'What else are we going to play today?' or when they break contact by standing up and walking to another part of the playroom while still busy with a certain play activity. Children making use of deflection as contact boundary disturbance are often vulnerable and responsive in respect of their emotions and not able to understand or control them, which then gives rise to unsuitable behaviour. Deflection thus has a negative influence on children's self-awareness. Figure 1.5 illustrates deflection.

Figure 1.5 Illustration of deflection

1.3.1.6 Desensitization

Clarkson and Mackewn (1994, p.77) define desensitization as 'the process by which we numb ourselves to the sensation of our bodies. The existence of pain or discomfort is kept out of awareness'. This contact boundary disturbance can be regarded as the process whereby children exclude themselves from sensory and physical experience related to aspects such as pain and discomfort. Sensory experiences and emotions associated therewith are not appreciated and kept from being a figure on the child's foreground (Clarkson 1989; Clarkson and Mackewn 1994). An example of a form of desensitization is where a child who was exposed to physical abuse for a long period of time does not feel the pain of the beating any more or where a child whose parents fight and shout at each other a lot does not hear the shouting any more, although it takes place in his or her presence.

Children who are abused or who have experienced some form of trauma often desensitize themselves in order to protect themselves from getting hurt. They also function without contact with their bodies. These children need to experience their sensory contact functions in order to gain a stronger sense of self (Oaklander 1994b, 1997). Desensitization implies that children do not have sensory or physical contact with themselves. They are often not capable of emotional contact-making, because they cannot distinguish the physical experience from the emotional.

Desensitization can sometimes be considered positive, such as when severe toothache is experienced or where an athlete ignores the burning sensation of a blister on his or her foot. However, Perls believed that Westerners in particular have learnt to block physical experience to their disadvantage. A person who suffers from insomnia will take medication rather than gain awareness of the experience of restlessness in order to obtain its existential meaning. Although desensitization is sometimes necessary, it can in the long term negatively influence children's awareness of their experience and emotions, and thus also their healthy organismic self-regulation. Desensitization is illustrated in Figure 1.6.

Figure 1.6 Illustration of desensitization

1.3.1.7 Egotism

Egotism refers to diminished spontaneity by purposeful introspection, in order to make certain that there is no threat, danger or risk (Clarkson and Mackewn 1994). Clarkson (1989, p.54) defines egotism as follows: 'Egotism in Gestalt is characterised by the individual stepping outside himself and becoming a spectator or a commentator on himself and his relationship with the environment'. This style of neurotic contact restrains children from taking effective action in order to satisfy their needs. Perls, quoted in Clarkson (1989, pp.54–55), explains egotism as follows: '[T]he neurotic is

aware and has something to say about everything, but the concentrating self feels empty, without need or interest'.

Egotism implies that children have objective, rational awareness of their experience, but not subjective or emotional awareness of their experience. They are thus not in contact with themselves. A certain degree of egotism is normal in respect of any important decision or long-term process. If children are not capable of repressing their spontaneous enthusiasm at times, they can possibly commit themselves to actions for which they will be sorry later. Healthy egotism allows children to take an objective look at themselves and their situation. This applies especially to senior primary school children and older, as younger children do not have the mental capability to look at themselves and their situation objectively.

Egotism becomes a contact boundary disturbance when children continuously attempt to control the uncontrollable and surprising aspects in their life by means of continuous objective action, at the expense of emotional contact. The chronic egotist seems to be in control of him- or herself, but never allows him- or herself to experience, give or receive spontaneously (Clarkson 1989; Clarkson and Mackewn 1994).

Egotism is sometimes necessary and in the child's interest in order to make responsible choices. However, the organismic self-regulation and self-awareness of children who want to control all aspects in their life and who are not at all capable of spontaneity are negatively affected by their egotism. In the author's own practical experience, it has been found that children who make use of this contact boundary disturbance find it difficult to play spontaneously, and experience problems with fantasizing. They can for instance not fantasize about an aspect of themselves which is like a monster and which they do not like. They will for example often resist this by saying that monsters do not exist. If the therapist asks them which animal they would like to be if they had a choice, they would immediately say that that could not happen in reality. Figure 1.7 illustrates egotism.

1.4 POLARITIES

According to gestalt theory, the personality consists of polarities and a large part of daily life is devoted to solving conflicts arising from these polarities (Thompson and Rudolph 1996). Yontef (1993, p.148) regards polarities as 'parts that are opposites that complement or explicate each other'. People move between current natural divisions in themselves such as body–spirit, self–external world, emotional–real and conscious–unconscious. According to Korb *et al.* (1989), this classification can cause polarization of emotions,

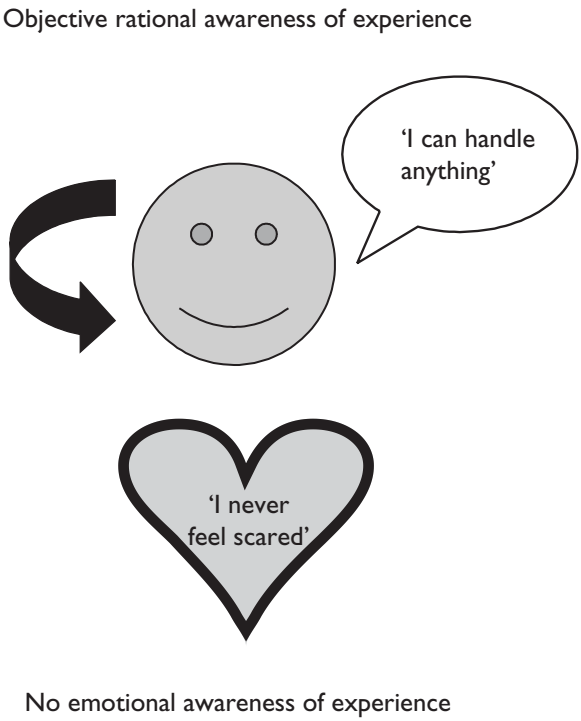

Figure 1.7 Illustration of egotism

such as love–hate, observed traits about the self, such as good child–bad child, or observed traits about others, such as friendship–hostility. Polarization takes place in particular when children identify mainly with one set of opposite traits. These children spend increasingly more energy to maintain the pole with which they have identified. Experiences or traits that do not conform to this construct are denied. Organismic self-regulation leads to the integration of polarities, where differences are accepted and integrated. A lack of integration, however, causes fragmentation (Yontef 1993). From the gestalt theory perspective, both aspects of the polarity are considered valid and both can be relevant in specific situations. For example, both love and hate are valid emotions and both good child and bad child traits can exist within the self-structure of the personality (Korb *et al.* 1989).

Polarities can be considered as opposites that complement or oppose each other. Various forms of polarization can occur, such as polarities in respect of emotions, traits of the self or traits of others. Conflict between polarities can often manifest itself within children and maintaining the antipole with which children identify absorbs a large amount of energy and

can lead to fragmentation of the children's holistic entity. On the other hand, organismic self-regulation causes integration of polarities.

During therapy children must be guided to become aware of their polarities and that both sides of their polarities are part of them. They must also be guided to accept responsibility for this in order to make a more realistic choice concerning their conduct than when they denied these parts of themselves (Aronstam 1989). Clarkson (1989, p.105) mentions the following:

> Instead of avoiding extremes of personality, passion or propensity, Gestaltists seek to discover, accentuate and acknowledge the widest possible differences between people and within one particular person. Phenomenologically, Gestalt seeks not to deny difference but to bring polarisations, if not into reconciliation, then into dialogue.

The aim of gestalt play therapy is to integrate polarities, in order to allow children to function better and to ensure that each part of the polarity finds its place in a well-integrated personality (Thompson and Rudolph 1996). From the gestalt play theoretical approach, the focus should be to guide the children towards awareness of polarities within themselves and their lives, so that they may integrate them by making choices regarding handling them and taking responsibility for them.

Children also function by means of opposites and even emotions are classified into opposites, for example sad and happy, disappointed and satisfied (Schoeman 1996). They feel confused as the result of the polarities within themselves, for instance when they experience love and hate towards the same person, as well as the polarities they observe in adults. Children generally also experience difficulty in accepting those aspects within themselves which they find unacceptable, or which their parents criticize. The latter contributes to fragmentation of the self (Oaklander 1988). Harter (1983, p.151) mentions the following in this respect:

> Repeatedly I have seen young children adopting this kind of all-or-none conceptualization of their own affective life, accepting a very one-sided view of their feelings. That is, they deny alternative emotions and experience great difficulty in accepting the possibility that seemingly contradictory feelings might simultaneously exist.

Polarities can thus cause feelings of confusion in the child, which in turn contribute to a fragmented existence. Children of six years and younger developmentally have difficulty in understanding the simultaneous experience of conflicting emotions, such as love and anger towards the same person. This contributes to a fragmented existence as they will often deny

and suppress the negative emotion, for instance anger towards their divorcing parents. This fragmentation should be addressed during gestalt play therapy, in order to effect integration of these polarities.

The integration of polarities is a prerequisite for a dynamic and healthy life process. Activities such as drawing, clay work and stories can be used during gestalt play therapy to assist the child to integrate polarities in his or her life. The use of these techniques as part of gestalt play therapy is discussed in detail in Chapters 3 to 5.

1.5 STRUCTURE OF THE PERSONALITY

According to Perls, the structure of the personality consists of five layers, indicating how people can fragment their life and in so doing not achieve success (Clarkson and Mackewn 1994; Thompson and Rudolph 1996). From the gestalt perspective, the following layers of the personality are distinguished: the synthetic layer, the phobic layer, the impasse layer, the implosive layer and the explosive layer.

1.5.1 Synthetic/false layer

The synthetic or false layer is the outermost layer of the personality and represents the role people play in their life. Children are caught up in the synthetic layer, trying to be what they are not. They seek roles created by themselves or others. Many unresolved conflicts are found in this layer. Children's behaviour is motivated in this layer mainly by introjects or culturally acceptable behaviour expected of them (Aronstam 1989; Clarkson 1989; Clarkson and Mackewn 1994; Phares 1984; Thompson and Rudolph 1996).

Children act in the synthetic layer according to what they themselves or others expect of them and thus not as their true selves. The self-awareness and emotional behaviour of children who function from the false layer are often influenced directly and indirectly by the environment, such as their parents' handling of emotions and the rules for expressing emotions within the relevant culture.

In the false layer, children act as if they have characteristics expected of them. They internalize these external expectations, which then represent the 'top dog' part of the self. The 'top dog' makes demands and expectations with which children must comply with and functions via 'You should' messages to children. The 'top dog' opposite is the 'underdog' part of the self. The 'underdog' is unsure of itself and reacts by means of promises and submissiveness such as 'I shall try again tomorrow'. This represents the

pleasure-seeking ('I want') aspect of the personality and usually gets the upper hand over the 'top dog'. The 'top dog' mainly uses threats to make the 'underdog' comply with instructions, such as 'If you do not obey your father, something terrible will happen to you'. These parts are thus in continuous conflict with each other (Aronstam 1989; Thompson and Rudolph 1996).

According to Perls, the 'top dog' and 'underdog' are one of the most common bipolarities in people. During assistance-rendering, the individual must become aware of the conflict between these polarities in order to gain insight that these can complement each other and as such function in a more integrated manner (Clarkson and Mackewn 1994; Thompson and Rudolph 1996, p.146). The 'top dog' and 'underdog' are two polarities which continuously cause conflict within children in the false layer. Furthermore, a lack of awareness of this contributes to a fragmented existence, whereas awareness can lead to integration. Younger children's ability to be aware of the conflict between their 'top dog' and 'underdog' is limited due to their developmental stage, since these polarities, such as the concept of ambivalent emotions, are an abstract concept and thus difficult for them to understand. During gestalt play therapy, the therapist should promote children's awareness of the conflict between these polarities in a concrete manner. Children's insight in this respect can be promoted more effectively only at a later age, when they become teenagers and are capable of more abstract thought.

1.5.2 Phobic layer

The synthetic layer is followed by the phobic layer or the layer of roles. As children become aware of their synthetic game, they also become aware of their fears that maintain this game. This awareness is often accompanied by anxiety (Thompson and Rudolph 1996). According to Aronstam (1989, p.636), the most important characteristic of this layer is 'man's resistance to be what he can be'. This can be considered as the layer of game and roles. In the phobic layer, children act according to the role expected of them, for example the helpless victim, the bully or the clown (Clarkson 1989; Clarkson and Mackewn 1994).

Children in the phobic layer can experience anxiety when they become aware of their game within the synthetic layer. Children who for example pretend that they have considerable self-confidence and take on the role of a clown can feel anxious when they become aware thereof and acknowledge that they do not actually believe in themselves. Although they experience anxiety, they will probably resist a change in behaviour and continue to function according to this role.

1.5.3 Impasse layer

The phobic layer is followed by the impasse layer. According to Yontef and Simkin (1989, p.337), an impasse can be considered as 'a situation in which external support is not forthcoming and the person believes he cannot support himself'. Children seek external support in order to solve their problem and they believe that they cannot act in a self-supporting manner (Aronstam 1989). Two polarities of the self are in conflict during the impasse layer, namely the healthy part that wants to complete unfinished business and the other part that wants to avoid the accompanying pain and hardship. Individuals usually try to avoid the impasse layer, as they want to avoid responsibility for their being caught up. By resisting, children deny the anxiety experienced when they become aware of both their freedom and their limitations. This layer is characterized by feelings of confusion, being caught up and anxiety, and contributes to high levels of discomfort (Clarkson 1989; Clarkson and Mackewn 1994).

Children in the impasse layer are aware of the roles they play, but show resistance that prevents them from acting in a self-supporting manner. Although these children start experiencing a need to complete unfinished aspects, they do not feel ready to handle the pain associated therewith. They still depend on external support such as others prescribing to them how to solve the problem.

Resistance during the impasse layer plays an important role in gestalt play therapy. It does not refer to the child's unwillingness to take part in the therapeutic process, but to a loss of contact by the child. Important information is obtained by assessment regarding the types of therapeutic experiences the child requires. The child protects him- or herself by resisting pain (Oaklander 1994b).

According to Oaklander (1988, p.198), the child says through resistance: 'Stop! I must stop right here. This is too much! This is too hard! This is too dangerous.' Some children reveal resistance repeatedly during the therapeutic process. This indicates progress, as the child thus discards old strategies and moves to a new stage of development.

Resistance is children's way of looking at themselves and this must be expected, acknowledged and respected during the therapeutic process. This is also an indication for the therapist that there are significant aspects behind this resistance that should be addressed as soon as the child is ready for these. Children intuitively know when they are strong enough to handle these aspects and this must guide the therapist (Oaklander 1997).

Resistance during the impasse layer represents an essential aspect in the therapeutic process as the child moves to new handling strategies. Children must be ready for moving through the impasse layer, since they experience resistance as painful.

1.5.4 Implosive layer

The impasse layer is followed by the implosive layer or dead layer. During the implosive layer, people start becoming aware of how they confine themselves. However, they have no energy for the behaviour required to free themselves from the impasse and a form of catatonic paralysis occurs. The child may feel paralysed by fear of the unknown and experience paralysis due to these opposing forces (Clarkson 1989; Clarkson and Mackewn 1994).

Children can start experimenting with new behaviour during this layer. They seem to be fully aware of their own behaviour and emotions, although they experience a lack of energy to take the responsibility for this in order to do something about it.

1.5.5 Explosive layer

The implosive layer is followed by the explosive layer. During this layer, children become aware of the emotions they express or suppress (Aronstam 1989). Clarkson and Mackewn (1994, p.80) mention the following in respect of this layer: 'If the individual really faces the existential anxiety of the stuckness and confusion at the impasse and stays with the deadness of the implosive layer, he eventually comes to life in the explosive layer.' If experimenting with new behaviour is applied successfully, the explosive layer is reached where children come into contact with reserve energy which was previously caught up for maintaining the synthetic layer (Thompson and Rudolph 1996). Children who function from the explosive layer can start completing unfinished business and are capable of experiencing and expressing their true emotions. They thus acquire energy in order to complete unfinished business, to experience emotions and to experiment with new behaviour.

With the start of gestalt play therapy, children will normally function from the false layer of the personality, in that their behaviour will be directed mainly from external influences and introjects. As soon as they become aware of these, they will experience anxiety and a lack of security, since they do not know how to act otherwise and how to satisfy their needs in a more effective manner. This anxiety and loss of control lead to the resistance of the

impasse layer, during which children depend on the therapist to make choices on their future behaviour and satisfaction of needs. They will for example say to the therapist: 'I do not have friends and you must solve this problem for me.' When they move to the implosive layer, children are becoming aware of their need to change, although the energy necessary to do this is lacking. When they reach the explosive layer, they begin to take responsibility for their behaviour and emotions and they can start experimenting with new behaviour. The progress of children's awareness of their process, emotions and ways of satisfying needs in order to reach the explosive layer of the personality is thus an important objective of gestalt play therapy. Normally when children reach this layer, therapy can be terminated.

1.6 CONCLUSION

Gestalt therapy is an existential, phenomenological and holistic approach with the emphasis on obtaining awareness in the here and now and the interdependence between people and their environment. The philosophy, theory and practice of gestalt therapy can also be used with slight adjustments in therapeutic work with children. Oaklander can be considered as the founder of gestalt play therapy.

Specific theoretical concepts can be considered typical of gestalt theory. The concept of holism is viewed as the most important theoretical concept. According to this theory, people are holistic entities, which implies that the sum total of their body, emotional and spiritual aspects, language, thought and behaviour is more than its parts. Children continuously experience needs of different natures, which cause discomfort until action is taken to satisfy these needs. This leads to homeostasis. Children have to organize their senses, thoughts, cognition and behaviour around a specific need until it is satisfied.

Healthy organisms are capable of identifying the most dominant need on their foreground, in order to use resources within themselves or the environment to satisfy it. Gestalt formation and destruction take place according to a specific process, namely pre-contact, sensation and awareness, the choice of a suitable action and mobilization, final contact, post-contact and withdrawal, whereupon the entire process repeats itself. The abilities for intra- and interpersonal contact-making are essential for satisfying needs and organismic self-regulation. Contact is established as soon as children use the environment to satisfy their needs.

A contact boundary disturbance occurs when children are no longer capable of forming a sound balance between themselves and the world in order to satisfy the needs on their foreground effectively. There are seven contact boundary disturbances, namely introjection, projection, confluence, retroflection, deflection, desensitization and egotism.

Polarities can be regarded as opposites that complement or oppose each other. There are different forms of polarization, namely polarities in respect of emotions, characteristics of the self and characteristics of others. Conflict often arises between polarities within the individual and leads to a fragmented existence.

During therapy, children should be guided to become aware of polarities within themselves and their life, in order to obtain integration of the self. The structure of the personality consists of five layers, namely the false layer, which represents the roles children play; the phobic layer, where children are aware of their synthetic play and thus experience anxiety; the impasse layer, where children are aware of the roles they play but resist acting in a self-supportive way; the implosive layer, where catatonic paralysis prevents children from being freed from their impasse; and the explosive layer, where new energy is acquired in order to complete unfinished business. Children in this layer experience true emotions and experiment with new behaviour.

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PART TWO

GESTALT PLAY THERAPY IN PRACTICE

In this section attention will be given to the implementation of gestalt play therapy in practice. First the objectives of gestalt play therapy will be outlined, so that child therapists will be able to use these as a guideline during the process. The gestalt play therapy model of Violet Oaklander, the founder of gestalt play therapy, will be used as a basis for the discussion on the gestalt play therapy process, as it was found in practice that this model provides the therapist with a structured guideline of what and how to work with children in need, in order to address their needs holistically. Although this model consists of specific phases that need to be followed, it is not rigid and therapists will find that they often have to move back and forth during the therapeutic process, depending on the child's process at a specific stage.

In order to enhance children's awareness of their process, Oaklander (1994a, 1994b, 1997) proposes a specific therapeutic process in her model for gestalt play therapy. During each stage of the process a variety of experiences is provided for the child.

The different phases and aspects that need to be addressed in each phase are summarized in Appendix 1. Although a therapeutic process is followed during gestalt play therapy, there are some dynamics that may figure during each session. In Appendix 2, an illustration of the horizontal and vertical development of gestalt play therapy is given.

The phases in the gestalt therapeutic process, as well as specific techniques that can be applied in that phase, will be discussed in this section, from Chapters 2 to 5.

Chapter 2

Building a Therapeutic Relationship, Assessment and Treatment Planning

Gestalt therapy is viewed as a process therapy during which attention is paid to the *what* and *how*, rather than the *why*, of behaviour. Awareness, which includes choices and the taking of responsibility and contact, leads to natural change (Yontef and Simkin 1989). The aim of gestalt play therapy with children is to make them aware of their own process. Oaklander (1994a, p.285) defines the child's process 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'. Awareness of their own process in the here and now leads to the discovery that choices with respect to emotional expression and needs satisfaction can be made and that they can explore with new behaviour (Oaklander 1994a, 1994b). Gestalt play therapy thus focuses on enhancing children's awareness of their own process, rather than on analysing why specific behaviour manifests in children. Children's process can be considered as who they are, what emotions they reveal, what they like and do not like, what their needs are, what behaviour they reveal and how they reveal this.

2.1 OBJECTIVES OF GESTALT PLAY THERAPY

One of the central objectives of gestalt play therapy is to enhance children's awareness, in order to promote their ability to live in the here and now. Other objectives are to teach them to be self-supporting by accepting responsibility for themselves, and to facilitate the achievement of personal integration (Thompson and Rudolph 1996). These aspects form the objectives of gestalt play therapy and are addressed simultaneously during the therapeutic process. The objectives are consequently explained in more detail.

2.1.1 Promoting self-supporting behaviour

A therapeutic objective of gestalt therapy is to teach children to accept more responsibility for themselves and to expect less support from the environment, in order to develop into adult persons. Becoming an adult is regarded as the transition from environmental support to self-support (Aronstam 1989). The gestalt play therapist will establish how children support themselves in solving problems and will facilitate problem solving by means of self-regulation and self-support. According to Yontef (1993), self-support includes both self-knowledge and self-acceptance. Assistance-rendering must guide children towards knowing and accepting themselves. They thus learn to accept increasingly more responsibility for their own existence and are capable of more realistic choices for their behaviour. This does not imply, however, that children do not need other persons in their environment, but that they understand the relationship between the self and the environment (Aronstam 1989).

Self-support as an objective of gestalt play therapy implies that children are guided to take more responsibility for themselves and for satisfying their own needs, as well as making relevant choices in respect of satisfying their needs. Although children must learn how to satisfy their own needs, younger children still depend to a great extent on the environment – such as their parents – for satisfying their needs. This objective in respect of pre-school children does not imply that these children should be self-supporting on the same level as an adult person. During gestalt play therapy, however, children should be guided to know, understand and accept themselves and their needs in order to exercise responsible choices in respect of satisfying their needs according to their age. Awareness of needs, self-knowledge and self-acceptance and the ability to exercise choices and to take responsibility for these are also regarded as important skills which children should master regarding their emotional intelligence.

2.1.2 Promoting awareness of their own process

Awareness of their own process (what they do and how they do it) is considered a primary objective of gestalt therapy and gestalt play therapy (Oaklander 1994a, 1999b; Yontef 1993; Yontef and Simkin 1989). This includes: knowing the environment, taking responsibility for choices, self-knowledge, self-acceptance and the ability to make contact – in other words, awareness on cognitive, sensory and affective levels (Yontef 1993; Yontef and Simkin 1989). Perls considers awareness as the capacity to be in touch with your own existence, to notice what is happening around or inside you,

to connect with the environment, other people or yourself; to know what you are feeling or sensing or thinking; how you are reacting at this very moment (Clarkson and Mackewn 1994).

Awareness brings clients into contact with their own needs and emotions and they thus learn to accept responsibility for who they are and what they do (Aronstam 1989). According to Korb *et al.* (1989), taking responsibility for the self means being capable of reacting to expectations, wishes, fantasies and actions in the self and others. It also means the awareness that the self is not responsible for the behaviour, attitudes and emotions of others, although this does not imply a lack of concern for the needs of others or an inability to react to their needs. Responsibility, awareness, freedom and choices are different aspects of the same process, since the extent to which individuals have awareness and responsibility is also an indication of the extent to which they are free to choose their response, including actions, thoughts and attitudes.

As children become more aware of themselves in the therapeutic process – who they are, what they feel, what they like and do not like, what they need, what they do and how they do it – they also become more aware of the fact that they can exercise choices regarding the expression of their emotions, the ways in which they satisfy their needs and the exploration of new behaviour. Awareness can be obtained by a variety of experiences and experiments during the process of gestalt play therapy (Oaklander 1992, 1994a).

Promoting children's awareness as objective of gestalt play therapy implies that children are placed in full contact with themselves on cognitive, sensory and affective levels, but also with other people and their environment, that they know and accept themselves, and that they take responsibility for their choices. The concepts of awareness, responsibility, choices and freedom are interdependent within the gestalt play therapeutic process, as these aspects influence one another. All these aspects should be taken into account during gestalt play therapy with children.

2.1.3 Promoting integration

Gestalt therapy (and gestalt play therapy) is not concerned with symptoms and analysis, but rather with the organism's total existence and integration. Integration and maturity are continuous processes that are directly related to the individual's awareness in the here and now. Integration can be considered as the completion of an unfinished business to form a new entity. If children's functioning is integrated, their needs can be satisfied more easily.

The aim of integration is to assist children to function more systemically and holistically, in order to pay their full attention to the relevant satisfaction of their needs (Thompson and Rudolph 1996). Gestalt therapy seeks to effect integration of body muscles, sensations, fantasies, thoughts and emotions. According to Korb *et al.* (1989), holism implies that the individual has the need and ability to achieve integration.

Integration as an objective of gestalt play therapy requires that children, as a holistic entity, must be helped to integrate their cognition, emotions, body and senses in order to complete unfinished business on their foreground. All of these aspects of the child's holistic entity should be attended to during assistance-rendering. The gestalt play therapy model of Oaklander focuses on all these aspects of the child's holistic self.

2.2 BUILDING A THERAPEUTIC RELATIONSHIP WITH CHILDREN

The focus of the first few sessions during gestalt play therapy is mainly to build a therapeutic relationship. The therapeutic relationship is considered the most fundamental aspect of the therapeutic process and therapy without it is worthless. The first few sessions assess the child's therapeutic needs and are of an evaluating nature. The development of the relationship and the child's ability for contact are prerequisites for further therapy (Oaklander 1988, 1992, 1994a, 1994b, 1997). Aspects that play a role in respect of this stage of the process are consequently discussed.

2.2.1 Development of an I–thou relationship

The process of emotional contact-making with children starts the moment the therapist comes into the child's presence. The child asks him- or herself the following questions during the first contact: 'Am I safe, will I be able to handle this and will I be acceptable?' Building the therapeutic relationship starts with what the child sees and observes in the therapist and depends on the therapist's sensitivity in respect of that which the child experiences at a specific moment (Landreth 1991, pp.156–157). Contact occurs during the therapeutic process between the child and the therapist by means of building an I–thou relationship. The I–thou relationship means a relationship where both the therapist and the client are equals, irrespective of aspects such as their age or education (Aronstam 1989; Clarkson 1989; Oaklander 1994a; Yontef and Simkin 1989).

The I–thou relationship implies that the therapist and the child, irrespective of aspects such as age and status, are considered on an equal level.

This contributes to the child feeling comfortable in the presence of the therapist, despite the fact that the therapist is an adult. Although children often at first experience it as unfamiliar when the therapist meets them on their level as equal persons, they normally find it easier to be themselves when they become used to it.

An important aspect to take note of when building an I–thou relationship with children is multiculturalism. O'Connor and Ammen (1997, p.17–18) mention the following in this regard:

> Play therapists must struggle to become competent with respect to all aspects of human culture and diversity. This is complicated by the present lack of diversity among mental health professionals, which may often mean that client and play therapist will be of different groups, making cultural diversity competence even more important in the conduct of good treatment. Failure to become competent with respect to diversity increases chances that the play therapist will not succeed in helping a client find ways to get his or her needs met only to ignore or override the needs of the cultural group of which he or she is a member. As members of the middle class, play therapists tend to value long-range planning, adherence to schedules, and to have a high tolerance for ambiguity. Whether or not one believes these values to have any inherent importance, it is clear that these cannot come into play until one is at a relatively high level of Maslow's (1970) hierarchy of needs.

Therefore it may be difficult for some play therapists to see the world through the eyes of their clients. In order to establish an I–thou relationship during gestalt play therapy, the therapist will have to strive to become culturally and diversity competent. O'Connor and Ammen (1997) suggest three ways for the play therapist to become culturally and diversity competent. First, to have the ability to recognize diversity in others, the play therapist must have a sound sense of his or her own identity with respect to membership in a wide variety of groups. Second, the play therapist must accept that humans often experience differences as threatening and must try to overcome these perceptions. Lastly, the play therapist must accept the existence of biases, myths and stereotypes. According to O'Connor and Ammen (1997): 'Colour (diversity)-blindness ignores essential elements of individuals and their experience, and it diminishes them in very direct ways'. In order to build an I–thou relationship with the child, the therapist may need to have a solid base of the knowledge about the cultural group to which the child belongs.

The I–thou relationship is considered an essential basis for interaction between the therapist and the child and has an important implication for therapeutic work with children. The therapist must act openly and congruently and the child must be met with respect, without judgement or manipulation. Despite differences in education, experience and age, the therapist is not the child's superior. Although the therapist can have objectives and a plan, he or she should not have any expectations in respect of the session, as each session is an existential experience. The therapist also creates a safe environment where the relationship in itself can be valuable for the child, as it is often an experience that is unique and new to the child (Oaklander 1994a, 1997, 1999b). During therapeutic work with children, the I–thou relationship implies that the child should be treated openly, with respect and congruence, and that the child should at no stage be judged or manipulated. Similarly, no specific expectations regarding the events in the session should be made.

Oaklander (1997) describes the I–thou relationship as follows: 'I will accept her as she is. I will respect her rhythm and will attempt to join her in that rhythm; I will be present and contactful. In this way our relationship flourishes.' The therapist must become the child's playmate and friend and this is regarded as the main objective of the therapeutic relationship (Schoeman 1996). The way in which the therapist presents him- or herself to the child plays an important role in respect of the child's willingness to join other therapy sessions. Children sometimes decide in one session that they trust the therapist. Oaklander (1988) mentions that she will never let a child wait in the waiting room while she is talking with his or her parents in her office. That which the parents want to say about the child must be said in his or her presence. This action is considered the start of a relationship of trust with the child. She also mentions that she does not share her notes written after each session with the child's parents, except for general summaries on the child's progress. These notes are often read to the children.

The development of an I–thou relationship between children and their therapists implies that the therapists become children's playmates by meeting them on their level. The way in which the first meeting with the child is handled will have a direct influence on the development of the therapeutic relationship and the relationship of trust with the child. If children see that the therapist touches on all the aspects that are discussed with their parents in their presence, they will often find it easier to trust the therapist.

Transfer occurs normally in any relationship. However, Oaklander (1997) discourages this. She mentions that children can act towards

therapists as if they are a parent figure. Therapists must, however, remain aware that they are not the child's parent, but unique persons with their own point of view, limitations and conduct. Therapists must also be honest and open and not be afraid of their own emotions and limitations. They must take cognizance of their own restrictions and must accept themselves, including their humaneness and imperfections.

The most significant aspect which therapists bring into therapy is the dimension of themselves. The therapist must also be emotionally mature in order to be able to act with empathy, without becoming emotionally overinvolved with the child. Furthermore, therapists who work with children must be in contact with the child in themselves. Therapists who value their own creativity and ability to play will also be able to allow children to play creatively and spontaneously (Axline 1994, p.58; Landreth 1991; McMahon 1992; Oaklander 1997; van der Merwe 1996; West 1992).

During the therapeutic process, gestalt play therapists must remain aware of their own experiences and restrictions, in order to limit transfer between themselves and the children, and to act as persons in their own right. Therapists must also remain aware of the boundaries that distinguish them from the children in order to prevent emotional overinvolvement. Therapists must, however, also be in contact with their inner child, in order to be able to make effective contact with children.

2.2.2 Awareness in the present (here and now)

In gestalt therapy, direct experience is used as a primary tool and the focus is always on the here and now (Yontef and Jacobs 2000). Gestalt play therapy focuses on promoting children's awareness in the present. The influence of events from the past and expectations for the future are not denied, but growth cannot take place by recreating the past or by predicting the future. The only reality with which the therapist can work is the here and now because the child can only experience the present. The therapist is interested in how unfinished business affects the child client at the present moment (Aronstam 1989; Yontef and Simkin 1989).

During the therapeutic process, therapists play an important role in seeing to it that they focus continuously on promoting children's awareness in the present, even if attention is paid to past emotions and unfinished business.

2.2.3 Responsibility

Responsibility is considered an important component of the gestalt therapy relationship. Gestalt therapy emphasizes that both the client and the therapist are responsible for themselves. Therapists are responsible for the quality and quantity of their presence, for knowledge about themselves and their clients and for maintaining the awareness and contact processes of the clients, as well as for establishing and maintaining a therapeutic atmosphere (Yontef 1993; Yontef and Simkin 1989). Clients, on the other hand, are responsible for the way in which they experience life, as well as the minute-to-minute choices they make to act or not to act in a specific way (Clarkson 1989). Children often do not come to therapy out of their own free will. Therefore one of the first tasks of therapists is to guide children from no responsibility to self-determination. The first session plays an important role in respect of this: the way the therapist makes contact with the child, includes the child in the session and acts during the session can influence the child's sense of responsibility (Oaklander 1992).

From the gestalt perspective, the therapeutic relationship rests on the fact that both the child and the therapist must accept responsibility for their own experiences, choices and behaviour. Deliberate attention should be paid to this when building the therapeutic relationship with children, as they often do not go for therapy out of their own choice. When children's parents take them for therapy, they can experience that others make a choice for them and this can have a negative influence on their taking responsibility for themselves.

2.2.4 Experience and discovery

All techniques and modalities from gestalt theory focus on direct experience and experimentation (Yontef 1993). From the gestalt therapy perspective, direct experience is the only way in which learning can take place. The gestalt therapist avoids counselling and interpretation during therapy and rather focuses on creating an atmosphere within which the client can discover what is important. Clients can then react to the information as it is important to them. The therapist is primarily a catalyst in the process of therapy (Aronstam 1989; Yontef 1993). Oaklander (1994a) adds that any interpretation by the therapist must be verified with the child. The primary aim of the gestalt play therapist is to help children to become aware of their process. The focus is on the experience of the process, what children do and how they do it, who they are, what they feel and what they want. Acceptance of this leads to the realization that they can personally make choices and

experiment with new behaviour. Gestalt play therapy focuses on children's direct experience in the here and now and the therapist does not act as an advisor. The therapist's role is to facilitate the clients' awareness of their process and therefore all interpretations during therapy should be verified with children.

In order to enable the child to experience and discover, the therapist must be capable of listening to the child's total communication, of which body language forms an important part. Therapists must seriously consider the physical symptoms, which are regarded as more accurate communication of children's true emotions than their verbal communication. Without the therapist's sensitive observation, the experimental approach of gestalt theory is not feasible (Yontef 1993). Child therapists should therefore have the ability to observe children's verbal and non-verbal communication during therapy, in order to guide their action as facilitator of children's awareness on the basis of this.

Experience plays a primary role in respect of therapeutic work with children. Because they are provided with various experiences and experiments, they can increasingly become aware of themselves. Experience becomes intense as the various aspects of the self are integrated when children start experiencing themselves in a new way. The use of techniques for experience and experimenting during gestalt play therapy should thus promote children's awareness of their process.

2.2.5 Resistance

Resistance is considered a normal and essential aspect during the gestalt play therapeutic process. This can be regarded as the manifestation of energy and is also an indication of the contact level of the child. It is not regarded as the child's unwillingness to cooperate during the therapeutic process, but rather as a loss of contact in the child (Oaklander 1994b, 1997). Resistance is also considered a healthy response since children who do not show resistance in general have a poor sense of self. The therapist thus expects the child to show a degree of resistance and respects it.

High levels of resistance, however, have a negative impact on satisfactory contact-making between the therapist and the child. As children begin to feel safer during the therapeutic process, they should be ready to move through it. However, if children come into contact with that which they see their way clear doing at that stage and have the energy to support themselves, resistance could manifest again. Resistance can thus occur repeatedly during the therapeutic process (Oaklander 1997, 1999b).

Resistance is a normal part of the therapeutic process and is an indication of a lack of contact in children. Due to specific reasons such as that they do not feel safe or because they do not have a sufficiently strong sense of self, children have to be resistant, by breaking contact with the therapist. Although the repeated incidence of resistance during the therapeutic process should be considered normal, high levels of continuous resistance in the child will normally have a negative influence on contact-making between the therapist and the child.

Resistance can manifest in different ways during the therapeutic process. Some children reveal resistance unconsciously, but they are inhibited in such a way that they first need experience in a number of safer activities. An effective technique for handling resistance is for the therapist to do that which is expected of the child. The therapist thus takes his or her turn, for example, to draw or do a puppet-show. Another way in which resistance may be handled is by reflecting it to the child by saying, for instance: 'I know you will probably not do the drawing, but I would like you to do it in any case. Whatever you do, I do not want you to do your best, because we just do not have the time for it'. The mere fact that the therapist accepts children's resistance can contribute to their taking the risk to try something new (Oaklander 1988).

Some children find difficulty in building a relationship and do not quickly overcome the initial resistance. These children have often experienced severe emotional trauma, especially at an early age. For these children, therapy focuses on building a relationship. The therapist has an important task to find creative, non-threatening ways to make contact with these children. It can also happen that while children are busy with a play therapy activity, their energy level suddenly drops and they break contact with the therapist. This can for instance be observed in their body posture. Stopping the play therapy activity and playing a game in order to restore contact can in this case redress contact with children.

Resistance can manifest in a passive manner in that children ignore the therapist by pretending that they do not hear what is being said, or by beginning to do something else other than that proposed by the therapist. In this case, it is important to develop a sufficiently strong sense of self in children, so that they will be able to communicate verbally that they do not want to do what the therapist is asking them to do. A verbal statement, such as 'I do not want to do it', is considered positive contact-making and should be positively strengthened by the therapist (Oaklander 1988).

There are different ways in which resistance can manifest during the therapeutic process. It must, however, be considered an essential part of the child's growth. The way in which it should be handled depends on when and how it manifests during the therapeutic process. The therapist must be sensitive to the way in which resistance manifests, in order to react to it in an appropriate way. Some children, as a result of trauma, may find difficulty in building relationships. This is regarded as resistance. The therapist will have to spend more time with these children in order to build the therapeutic relationship.

2.2.6 Boundaries and limitations

Positive parenthood implies that parents establish age-related boundaries for their children so that they know their boundaries, can experiment with them and test them. When these boundaries are not available, children tend to feel anxious and their sense of self has no structure. Parents also need to know when it is suitable to broaden the boundaries and in respect of each level of development so that the child is afforded the opportunity to find new areas for exploration. Boundaries and limitations are necessary during the therapeutic process for the same reason (Oaklander 1997). This gives structure to the development of the therapeutic relationship, since growth cannot take place within a chaotic disorganized relationship (Landreth 1991).

According to Landreth (1991) and van der Merwe (1996), setting boundaries has the following advantages during the therapeutic process:

- It brings the therapist and the child in contact with everyday life, anchors the session to reality and emphasizes the here and now.
- It gives structure to the therapeutic relationship.
- It builds children's self-control and makes them aware of their responsibility towards the therapist, the playroom and themselves.
- By means of boundaries the child experiences how it feels to make choices and to take responsibility.
- It provides security and predictability within the therapeutic situation and provides consistency in the playroom.
- It ensures that the child plays safely.

- It helps the therapist to accept the child and thus to maintain a professional, ethical and socially acceptable relationship.
- It ensures emotional safety for the child, since the child without boundaries can move to uncertain and threatening emotional areas, which can lead to emotions of anxiety and guilt.
- It protects the play apparatus and room.

Boundaries provide a structure for the development of the therapeutic relationship, which contributes to the experience of physical and emotional security in the child. This positively promotes the child's sense of self. Boundaries and limitations during the play therapy session can contribute to giving the child the opportunity to make choices and to take responsibility for these. This aspect, together with the fact that boundaries promote self-control, can indirectly contribute to children's skills for emotional control.

2.2.6.1 Types of boundaries

A distinction can be made between different kinds of boundaries, namely time boundaries, boundaries in respect of the use of material, boundaries in respect of aggressive behaviour, boundaries in respect of movement, boundaries in respect of people present and respect, and moral boundaries.

TIME BOUNDARIES

The length of the session is never exceeded, even when the child requests so; in other words, the session starts and ends on time (Axline 1994; McMahon 1992; Oaklander 1997). For young children the play therapy sessions can be at the most 45 minutes, as they can concentrate for only a limited period. Children must be warned when the time is almost over so that they can experience that they have the time to complete the task (Landreth 1991; van der Merwe 1996).

From the author's practical experience, it was found that children often resist stopping play when the time is over, especially when the therapeutic I–thou relationship is established. Children will ignore the therapist when she warns that the time is almost up, or they will try to start playing something else. Sometimes they will also ask the therapist if they may stay longer. In accordance with the above-mentioned authors, it was thus found that during each session the child needs to be warned when the time is almost over.

BOUNDARIES IN RESPECT OF THE USE OF MATERIAL

Boundaries must be set in respect of handling toys, so that children do not damage them. Furthermore, children are normally not allowed to take toys home (Axline 1994, p.123; Landreth 1991; van der Merwe 1996). According to Oaklander (1997), the child should for instance not be allowed to throw paint around in the playroom and she expects the child to help her clean up at the end of the session, except when they are playing in the sand tray. Termination of the activity is thus made explicit to the child. The amount of water that the child may throw in the sand tray should also be restricted. Too much water in the sand tray can result in the next child not being able to use it, as the sand can take weeks to dry out.

From the author's own experience it has been found that some children ask to take toys home. It happens in particular that a child who is especially interested in an item, for instance a little car, expresses the need to borrow it. However, children understand when it is explained to them that other children also come to the playroom and that the toys should rather not be removed from the playroom.

BOUNDARIES IN RESPECT OF AGGRESSIVE BEHAVIOUR

No aggressive behaviour towards the therapist is allowed. Any attack on the therapist must immediately be stopped. The therapeutic relationship is built on mutual respect and physical injuries to the child or therapist must be prevented (Axline 1994; McMahon 1992; van der Merwe 1996).

Practical experience has shown that if a positive I–thou relationship is established, it is associated with mutual respect, and that children seldom find it necessary to display aggressive behaviour towards the therapist if they are given the opportunity to offload aggressive energy in an acceptable manner, such as by means of various play activities.

BOUNDARIES IN RESPECT OF MOVEMENT

Children are normally not allowed to go in and out of the playroom, except under specific circumstances, such as when the child wants to go to the bathroom or drink water. Children must learn that they cannot run away from their responsibilities, and that their commitment to the relationship means that problems are worked through (Landreth 1991; van der Merwe 1996).

From the author's own experience, it has been found that children sometimes repeatedly request to go to the bathroom as a means of breaking contact. Although this form of resistance must be respected, a positive way

to handle this aspect is to request that the child go to the bathroom before the start of the session.

BOUNDARIES IN RESPECT OF PEOPLE PRESENT AND RESPECT

Normally only the child and the therapist are allowed in the session. However, other persons, for example the parents, may be allowed under special circumstances. Contact with the child should not take place on a social basis between sessions, since it can make the therapist's role difficult. The therapist must also guard against substituting the role of the absent parent (van der Merwe 1996).

In practice it was found that the child's parents should initially be allowed in the session if the I–thou relationship has not yet been established and the child's anxiety is so intense that he or she feels too unsafe to go to the playroom alone with the therapist. However, as soon as the relationship of friendship is established and the children start trusting the therapist, they are no longer concerned about whether their parents are present or not.

MORAL BOUNDARIES

Children should not be allowed to undress during the sessions. They may take off a jersey or shoes. Children are normally allowed to swear in the playroom, but not so that people outside the room can hear them, for instance leaning out the window and swearing (van der Merwe 1996).

Practical experience has shown that children in particular like taking off their shoes, but it seldom if ever happens that a child wants to undress completely.

A distinction can be made between the various boundaries as part of the therapeutic process. These boundaries are not aimed at punishing or restricting the child, but rather at contributing to the child's emotional and physical security.

2.2.6.2 Guidelines in respect of setting boundaries

Boundaries should be set when the need for a boundary arises during a session. Children's daily experiences prepare them for some of the boundaries. If all the boundaries are set during the first session, children know what to expect, but this can also draw their attention to negative behaviour about which they would probably not have thought on their own, such as throwing sand at the therapist (Axline 1994; Oaklander 1997). According to van der Merwe (1996), certain boundaries, such as the duration of the session, can be explained to the child during the first session in order to prevent disappointment in the child. The process during which the

boundaries are set must take place carefully so that it does not stop behaviour, but rather so that it is expressed in a more acceptable manner. The boundary must be set in such a way for children that they are given the responsibility to make choices in order to change their behaviour (Landreth 1991).

It is agreed that certain boundaries such as the time boundary should be set at the start of the session, whereas other boundaries such as the use of toys should be set when the need for these boundaries arises. If a list of dos and don'ts is given to the child at the start of the therapeutic process, it might prevent the child from acting spontaneously.

2.2.6.3 Steps for setting boundaries

According to Landreth (1991), the following steps can be taken when setting boundaries:

1. Step 1
   Accept the child's emotions, wishes and needs and reflect the emotion to the child when it occurs.
2. Step 2
   Communicate the boundary specifically, for example: 'I can see that you are cross, but you may not throw the block at me.'
3. Step 3
   Set acceptable alternatives for expressing emotions, for example: 'You may not stand on the doll's house; you can stand on the chair or table.' When the child breaks the boundary, the therapist must still act in an accepting manner. He or she must move patiently two to three times through steps 1 to 3. If the child still breaks the boundary, proceed with step 4.
4. Step 4
   Set the final choice slowly to the child so that he or she realizes he or she has a choice, for example: 'If you choose to shoot me with the gun, then you choose to leave the playroom/no longer play with the gun.' The child must understand that he or she has a choice and that the consequences are related to his or her choice.

When setting boundaries, children should experience that they have a choice and that they must accept responsibility for the consequences of their choice. Setting boundaries in this way contributes to promoting children's self-supportive behaviour, where they start to accept more responsibility for themselves and their own choices.

2.3 ASSESSMENT OF CHILDREN DURING GESTALT PLAY THERAPY

Assessment in gestalt play therapy is done in the here and now. Although certain background information may be important to arrive at a holistic overview of the child's situation, the therapist can work only with the child's situation and functioning in the here and now. According to Oaklander (1988, p.184), she often receives reports, test results, diagnostic reports, court reports and school reports when a child is admitted to her for therapy. She mentions that this information can be interesting reading matter, but that the only aspect with which she can really work is the way in which children present themselves within the therapeutic situation. If one relies on the information provided to the therapist as the basis for the therapeutic process, attention will have to be paid to that which is written rather than to the child. She mentions the following: 'So I must begin with the child from where she is with me, regardless of anything else I hear, read, or even diagnose about her myself.' Korb *et al.* (1989) add that diagnostic evaluation and taking down historical details can form part of record keeping, although this does not usually form part of gestalt therapy. The way in which children present themselves during therapeutic sessions is thus the only aspect that can be assessed. The study of reports on children can contribute to unfounded interpretations.

Children are normally seen in the presence of their parents at the beginning of the first session. A discussion is held on the reasons why the child was brought for therapy. The author makes sure that children understand what their parents are saying and that they are given the opportunity to voice their opinion. Children often say they do not know why they had to come to the play therapist. Sometimes they really do not know and sometimes they are too shy to say, for example, 'I wet my bed' or 'I fight at school all the time'. Parents also sometimes feel uncomfortable about telling their children the reasons for bringing them for therapy. Some parents tell their children that they are just going to play nicely, or that the therapist is going to help them with their schoolwork. It seems that parents are in general themselves uncomfortable about the idea of bringing their children for therapy. One child, aged eight, brought a textbook with him to the play session, as his parents had told him that the therapist was going to help him to read better. The gestalt play therapist must be very honest with children and can say something like: 'In here we play a lot and I am going to help you to talk about your feelings and to start to feel better'. A questionnaire is also

handed out to the parents in the first session. The questionnaire contains questions to determine the parents' issues on raising their child, such as:

- Was the pregnancy planned?
- Were there any complications during the pregnancy or thereafter?
- Were there any problems with your child's early development?
- Are there any factors that negatively influenced the bonding between you and the child?
- How much time do you spend with your child every day?
- Do you and your spouse agree on ways of disciplining your child?
- Which ways of disciplining do you use?
- Describe your child's most unacceptable behaviour.
- Are there any traumatic experiences that your child has experienced?
- Does your child have any chronic medical condition?
- How does your child react when he or she is angry, sad, scared and happy and are you satisfied with this behaviour?
- Has your child experienced any traumatic event such as death, hospitalization, etc.?
- Are there any parental issues that you want to discuss?
- Describe your child's personality traits in a few sentences.
- Has your child received any previous therapy?
- Describe your child's sleeping patterns.
- How is your child's general health?
- Describe your child's eating habits.
- What are the general levels of stress in your family?
- Is there anything else that the play therapist should know?

This questionnaire is handled with the parents in a parent guidance session after the third session with the child. No information about the play sessions is shared with the parents without the permission of the child. The objective

of these parents' sessions is to talk to them about their own issues on rearing their child, as well as to explain to them the gestalt play therapy process and the specific experiences that their child may need within this process. Parents are seen in this way about once a month. Sometimes children are part of the session and sometimes, because of working on the parents' own issues, they are seen without the children.

Table 2.1 presents a guideline, adjusted from the one originally developed by Oaklander (1999a), for assessing children during gestalt play therapy.

Table 2.1 Guideline for assessing children during gestalt play therapy

Main aspect	Subcomponents
Therapeutic relationship	• What is the child's level of trust and is the therapeutic relationship taking shape? • Does the child manifest relevant resistance, or does he or she appear confused?
Contact and contact skills	• Does the child make good contact with the therapist and can he or she maintain contact? • Does the child withdraw relevantly at times? • How does the child use his or her contact skills?
Contact boundary disturbances	• Does the child make use of any of the contact boundary disturbances to satisfy his or her needs? • What is the influence of introjects in the child's life?
Interest	• Does the child show involvement, interest and excitement? • Is his or her voice expressive or 'weak'? • How does the child use his or her breathing? • What is the child's energy level and when does he or she have more and less energy?
Body posture	• How does the child walk, sit and stand; is his or her body impaired or loose and flexible? • How is his or her posture? • Are his or her shoulders rounded?
Humour	• Does the child respond relevantly to humour? • Does the child have a sense of humour?
Resistance	• What is the child's level of resistance? • How does resistance manifest in the child? • Out of which layer of neurosis is the child functioning?

Main aspect	Subcomponents
Emotional expression	• Does the child know what emotions are? • Can the child express basic emotions, such as happiness, sadness, anger and fear? • Can the child identify reasons for his or her emotions? • Is the child's emotional expression relevant? • Is the child able to express emotions? • How does the child handle his or her emotions towards the therapist, his or her family and friends? • How does the child handle his or her emotion of anger? • Does the child have old, unexpressed and unfinished emotions of grief or anger that should be addressed?
Cognitive aspects	• Can the child express his or her feelings and thoughts? • How are the child's language skills? • Can the child follow directions, play a game, make choices, solve problems and organize? • Does the child have ideas and opinions of his or her own? • Does what the child says make sense? • Does the child use age-related abstractions and symbols? • Does the child have a sense of right and wrong?
Creativity	• Is the child capable of taking part openly and freely in creative techniques? • Can the child test new things? • Is the child withdrawn, restricted and defensive?
Sense of self	• Does the child have a degree of self-awareness and introspection? • Can the child own his or her projection from various projective techniques? • Does the child run himself or herself down? • Is the child self-critical, uncertain of him- or herself and seeking acceptance? • Can the child make statements about him- or herself? • Can the child make choices? • Is the child self-assertive or inhibited? • Is the child capable of separating from his or her parents? • Does the child reveal confluent behaviour?

Continued on next page

Table 2.1 *cont.*

Main aspect	Subcomponents
Sense of self	• Does the child fight for power? • Does the child have an age-related sense for mastery?
Social skills	• How is the child's relationship with others in his or her life? • Does the child have friends? • Does the child show signs of independent thoughts and actions? • Does the child have environmental support for his or her needs? • How does the child satisfy his or her needs? • Does the child have age-related egocentricity?
Process	• How does the child present him- or herself to the world (quiet, noisy, aggressive, passive, 'very good', leader, follower, etc.)? • Is the child fast-paced or slow-paced? (see page 75) • Is the child an introvert or extrovert? (see page 75) • What is the child's temperament according to the DISC temperament analysis? (see page 76) • How does the child act towards his or her parents, siblings, friends and teachers? • What behaviour does the child reveal? • In what ways does the child try to satisfy his or her needs and acquire a sense of self? • Do the events in the therapy sessions and events outside correspond?

This guideline assesses children holistically in accordance with the gestalt theory approach by taking the various aspects of their holistic self into account. These aspects, however, show a close connection with the stages of the therapeutic process to which attention should be paid, according to Oaklander's model, in order to enhance children's awareness of their process. This guideline can be used during every gestalt play therapy session to assess the child's process in respect of the various main aspects and subcomponents.

2.3.1 Practical ways of assessing children during gestalt play therapy

There are a lot of practical play techniques that can be utilized during the gestalt play therapy process to assess the aspects mentioned in Table 2.1. When doing assessment, the therapist should keep in mind what the goal of the assessment is. It is important to remember that the goal of assessment in gestalt play therapy is not just to get certain information out of the child. The goal of assessment is based on the three objectives of gestalt play therapy, namely to determine the child's level of awareness of his or her own process, the child's level of self-support, and also unfinished business that contributes to the child's functioning in a fragmented way, and not as an integrated whole. Therefore, when applying certain techniques for the purpose of assessment, the therapist must make sure that the child feels safe enough to become involved in the specific activity. Assessment is an ongoing process and although the first few sessions are more evaluative in nature, it actually forms part of every session. Each therapist can be creative in deciding on ways to assess the different aspects. However, the author has found that there are certain techniques that are particularly helpful in assessing the child during the beginning phases of therapy. These techniques will be described in brief below.

2.3.1.1 Animal cards

Gestalt play therapists can create their own assessment cards with all kinds of animals on them. At the back of each card, a question may be written such as:

- If you could make three wishes about things that should happen, what would they be?
- Tell me about the naughtiest thing you have ever done.
- What things scare you, even though you know there is no reason to be afraid?
- What is the luckiest thing that ever has happened to you?
- If you were allowed to stop going to school, would you? What is the worst thing about school? The best?
- What would you do if everyone in the family forgot your birthday?
- If you were to offer your parents one tip on how they could be better parents, what would you tell them?

- Whose room would you most like to spend the afternoon looking through?
- Who is your best friend?
- When is the last time you really laughed at yourself because you did something silly or stupid?
- If your parents told you your best friend was a bad influence on you and that you were no longer allowed to play together, how would you feel?
- Tell me about the things that make you the angriest.
- Would you rather have no rules at all or live with the rules you have now?
- If you had a lot of money and could use it in any way you want to, what would you do with it?
- What do you think your friends like most about you?
- If you could be invisible for one day, what would you do?
- If you could change one thing about the way you look, what would it be?

The therapist and the child can take turns to pick up a card, read the question and then a token is handed to each if they are able to answer a specific question. The child therefore has the opportunity to decide not to answer a question, but then he or she loses one token. The one with the most tokens is the winner. Children often are so interested in winning the game that they are relaxed about answering the questions.

2.3.1.2 Graphic family portrayal

Graphic family portrayal is a modified form of family portrayal, which was developed by Venter in the 1980s. With this technique, each family member is expected to draw his or her family on a sheet of paper by representing each member of the family with a circle (Venter 1988).

The author has found that this technique can be applied to children as young as five years of age. It is applied in the following way:

- The child is asked to draw each one of his or her family members as an empty circle – just like a head, but without eyes, a nose and a mouth.

- The child is then asked 'To whom does each one of them look most of the time?' (This may be explained to younger children by asking them who is spending the most time with whom.)
- Next, the child is asked what each one of the family members does most of the time. (Children will often say that both their parents work all the time.)
- A feelings card with six feelings – namely happy, sad, angry, tired, jealous and scared – is shown to the children and they are asked to name each one of these. Then they are asked how each of the family members feels most of the time. While answering this, the children are also asked to draw this particular feeling in the empty circle of the specific person. If the child quickly says that everyone in the family is happy, the author will work with polarities, by asking for example: 'Tell me about one time that you can remember that your mother/father, etc., was not happy/angry'.
- As part of this technique, the child may be asked to assign an animal card to each family member and to be that animal, e.g. if the child picks a lion for his or her father, he or she can say something like 'I am a lion and I like to fight and bite everyone. I am always angry and everyone is scared of me'.
- The child may then be asked if there are similarities between his or her father and the lion. Figure 2.1 shows how a child, aged 13, drew her family during graphic family portrayal.

It was evident that the stepfather and mother of the child who drew Figure 2.1 had a poor marriage relationship and the girl had a poor relationship with her stepfather. She felt that her baby brother was rejected, because it was an unplanned pregnancy. Her mother was sad, because of the conflict between her and her stepfather. Her stepfather was furious most of the time, because he was fighting with everybody.

As an alternative, children can also be asked to draw their family doing something together. When the child has finished, he or she can be asked to tell the therapist what is happening in the picture. Questions can be asked to

obtain further information on the family set-up and the ways in which it operates. If the child for example drew the family having a meal together, the therapist may ask: 'I can see that you are sitting next to your father, is it always like that?' 'Do you like sitting next to your father?' 'In this picture you look really cross. Do you feel cross?' Before finishing, the therapist can ask the child if there is anything else to write about this picture (Hobday and Ollier 2002). From the gestalt perspective, it is important to focus on polarities when doing this exercise. If the child reveals only positive views, the therapist may ask if it is always like this and ask the child to think of one time that it was not like this, for example: 'I can see that you are all smiling in this picture. Is everybody in your house always happy? Can you tell me about one time that each one of you felt angry/sad/scared?'

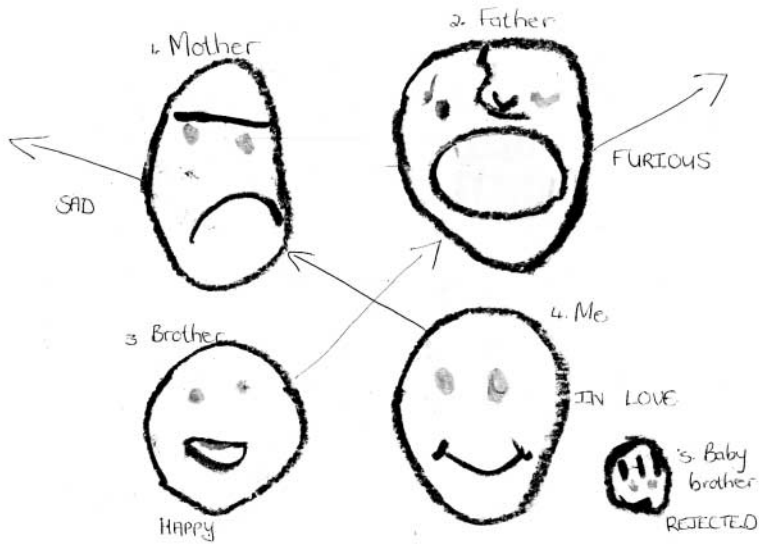

Figure 2.1 Drawing of child's family

2.3.1.3 Rosebush fantasy

Oaklander (1988) and Thompson and Rudolph (1996) describe the rosebush fantasy as follows.

The child is asked to shut his or her eyes and to imagine that he or she is a rosebush. Then the child is given the following suggestions:

- What type of rosebush are you – strong or weak?
- What does your root system look like – deep or shallow? Maybe you do not have one?

- Do you have any flowers on your bush? If so, are they roses?
- How many roses do you have – a lot or a few?
- What colour are your roses?
- How many thorns do you have – a lot or a few?
- What do your leaves look like?
- What does the environment look like?
- Where are you standing – in a garden, in town, in the desert, in the middle of the sea?
- What is around you? Are there other roses or flowers, or are you standing there alone?
- Are there any people or animals around you?
- Do you look like a rosebush?
- Is there something like a fence around you?
- What does it feel like to be a rosebush?
- How do you survive – who looks after you?
- What is the weather like around you?

The child is then asked to draw his or her rosebush and to describe to the therapist in the present tense as if he or she is the rosebush. The therapist writes down the child's descriptions. The descriptions are read out to the child and the child is asked how each one of them can fit into his or her life. Younger children need help to own their projection, therefore the therapist will have to ask 'Can it be' questions, for example: 'Can it be that you also sometimes feel as lonely as this rosebush that is standing all alone here in the desert?' A foster child's rosebush drawing is presented in Figure 2.2.

When explaining his rosebush, the child who drew Figure 2.2 said that although he was standing alone, there were two dogs, as well as a fence around the rosebush. He also had very sharp thorns that could protect him. He then said that all the rosebushes around him had been killed and hurt. Therefore he needed a high fence with sharp points to protect him. The child owned his projection when he said that he often felt that he needed protection against children who wanted to

hurt him and that he felt that his foster parents were protecting him (Blom 2000, p.415). It was clear from this projection that the child has a need to feel protected, possibly because he was in a situation in his family of origin where he was not physically and emotionally protected and his needs were not satisfied.

Figure 2.2 Seven-year-old child's rosebush drawing

2.3.1.4 Fantasy of a safe place

The fantasy of a safe place seems to give children the opportunity to create a space for self-maintenance and self-nurturing by using fantasy (Oaklander 1999a).

The child is asked to relax and to shut his or her eyes, whereupon he or she is taken on the following guided fantasy.

> Imagine you could go to a safe place. This could be a place which you remember from your past, or a place where you live now. It could also be a place which you create for yourself. It could even be on the moon. It could be any place. It could also be a place which you already know and which you want to make better for yourself. Imagine you could go to that place. Look around – what does it look like, what do you see and hear? What do you smell and taste? What do you do in your safe place? When you are ready, I want you to draw your safe place. Nobody has to understand it. It can be in any lines, shapes and colours.

This drawing is then discussed with the child. The child may be asked to draw the polarity, namely an unsafe place, and is then asked to write down a statement about the safe place and unsafe place.

Another technique which focuses on polarities is to hand out to children two pages and to ask them to draw on the one page how their life is right now and on the other page how they would like their life to be. They then get the opportunity to describe each page by being it, for example: 'I am the river, I feel peaceful and quiet and like it when people come and visit me'. Afterwards the children are helped to find out how their projection may fit their life in the here and now. The therapist can, for example, ask: 'Do you also feel that your life is peaceful and quiet like the river?' In Figure 2.3 (on p.78) an illustration of a child's safe-place drawing is given.

2.3.1.5 Family questions

An interesting way to assess the roles of the different family members is discussed by Hobday and Ollier (2002). They suggest that the therapist write down questions about family life, each on a separate piece of card. It is important to make sure that these questions fit the vocabulary and family life of a specific child. Therefore the therapist may adapt some of the questions to fit a specific child. Examples of questions may be as follows.

Who in your family:

- reads the most?
- likes animals the most?
- makes you happy when you feel sad?
- gives you the biggest hugs?
- gets up first in the morning?

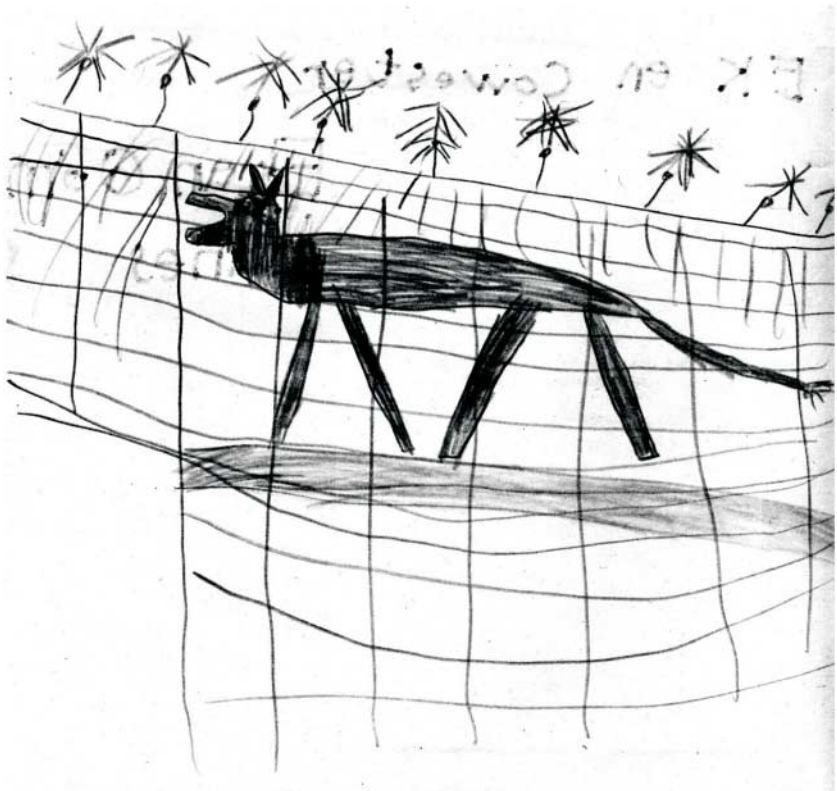

Figure 2.3 'My safe place is on my grandfather's farm'

- watches television the most?
- keeps the neatest bedroom?
- makes you laugh the most?
- scares you the most?
- fights with you?
- takes you to places?
- teaches you how to take care of yourself?
- punishes you?
- makes you feel safe?
- gives you pocket money?
- loves you?

- plays with you?
- helps you with your schoolwork?
- listens to you?

These questions may be thrown in a hat and the therapist and the child can take turns to pick up one and answer it. The therapist can encourage the child also to answer the questions even if it was the therapist's turn. It was however found that this activity is more exciting to children when it is done as a game, where each one of them can earn a token when a question is answered, or even by building in a choice, such as for some questions one can receive two points and for some one point. This includes the aspect of choices, which is constantly an important issue during gestalt play therapy for empowering children and giving them back control in their lives. The one with the most marks or tokens can then for example choose an activity that can be followed for the rest of the session.

2.3.2 Assessing children's process

When assessing children's process, it is important to remember that their process refers to the way they present themselves to the world and satisfy their needs. An aspect to take note of, when assessing children's process, is their unique temperament. The concept temperament is defined by Papalia *et al*. Olds and Feldman (1999, p.237) as: 'a person's characteristic way of approaching and reacting to people and situations'. It can be described as the *how* of behaviour, rather than the *what*. The author makes use of the DISC temperament analysis in helping her determine the child's process. The DISC temperament analysis must however not be used to label children, but as a guideline to have a better understanding of children's inborn characteristics and way of satisfying their needs. A short explanation of this temperament analysis is given below (Boyd 1994):

- Children may be either fast-paced or slow-paced and task-oriented or people-oriented.
- Fast-paced children are always on the go and are extroverts, meaning that they focus their actions on their outside environment.
- Slow-paced children are introverts and tend to be more quiet, shy, reserved, slow and self-contained.

- Task-oriented children focus on doing things; they plan their activities and base their decisions on facts and data, rather than opinions and feelings.
- People-oriented children focus on being with people, are more relaxed, warm, personable and caring.
- Children who are fast-paced and task-oriented fall into the **D** (*directive/determined*) behavioural style.
- Children who are fast-paced and people-oriented fit into the **I** (*interactive/influencing*) category.
- Children who are slow-paced and people-oriented fit in the **S** (*supportive/soft-hearted*) category.
- Slow-paced and task-oriented children can be described as **C** (*corrective/conscientious*).

Each category has certain prominent characteristics, which are summarized in Table 2.2. The play therapist can assess the child's temperament by observing the child's behaviour during several play therapy sessions. Children may display characteristics of more than one group.

Table 2.2 Prominent characteristics of children according to the DISC analysis

Directive children (D)	Interactive children (I)	Supportive children (S)	Corrective children (C)
High self-confidence	People-oriented	Steadfast	Maintain high standards
Courageous	Emotional	Team player	Attentive to key details
Result-oriented	Talkative	Prefer familiarity	Self-disciplined
Demanding	Fun-loving	Helpful	Cautious
Competitive	Optimistic	Committed	Analytical
Change-agent	Spontaneous	Pragmatic	Highly intuitive
Direct	Seek social acceptance	Humble	Perfectionists

Sources: Boyd (1994, pp.51–84) and Rohm (1998, pp.29–32).

According to the children's specific temperament, they may react in a certain way during play therapy, as a way of satisfying their unique needs. Possible needs and ways in which every temperamental group may react during gestalt play therapy are indicated below.

2.3.2.1 Handling of directive (D) children during gestalt play therapy

Directive children are normally also described as strong-willed children and may easily become self-centred. They tend to be aggressive in conflict situations. They are very independent and will easily tell the play therapist that they will be able to do something on their own. Their greatest need is to feel in control of situations.

They will often naturally challenge and rebel against any structure imposed on them. Therefore they will often manifest behaviour (positive or negative) to feel in control again. It is important that the gestalt play therapist take note of this need of D children (Boyd 1994; Voges and Braund 1995).

> A directive child, aged eight, was once brought to the author for therapy, because of her 'stubbornness'. By further investigation, it was clear that the mother also fell into this group, creating an enormous power-struggle between the two of them. After explaining this aspect to the mother and suggesting ways in which she could satisfy her child's need to be in control, the relationship between the mother and child improved substantially and therapy could be terminated.

One way of providing for their need for control is to give a lot of choices to these children, as well as specific goals to work toward. Directive children also need to learn how to slow down and to relax. These children have a need for physical activity and the therapist can therefore use activities such as playing cricket, or doing all kinds of body movements, as part of the phase of building a therapeutic relationship with the child and contact-making. They will also enjoy games with a competitive element, such as a clay-throwing competition, and will often quickly take control and tell the therapist what the rules are and how they must play the game.

2.3.2.2 Handling of interactive (I) children during gestalt play therapy

Interactive children like to dream and fantasize during play therapy. They often do not have problems with talking to the therapist about their

thoughts and feelings, as they love to talk. Interactive children like to have a lot of fun and will therefore enjoy fun activities during play therapy. They have a high need for personal recognition and social acceptance and their biggest fear is social rejection. It is therefore important that the therapist create a favourable, friendly environment during play therapy. The therapist must not be cool, distant or impersonal, because these children will easily conclude that there is something wrong with them (Boyd 1994; Voges and Braund 1995).

These children will often ask the therapist if their drawings or paintings are beautiful. It is important to remember that a response of praise, such as 'Look how beautiful your picture is', is normally not used in gestalt play therapy, as it would give children the message that the beauty of their pictures is an important aspect. The therapist may rather use responses of encouragement, such as: 'I can see that you have enjoyed making this drawing.' Interactive children will talk easily during play therapy and are real extroverts.

2.3.2.3 Handling of supportive (S) children during gestalt play therapy

Supportive children are softhearted. They tend to be quiet and easygoing, but are concerned about pleasing others. They are so accommodating that they will sometimes have difficulty making choices, or they will make choices to please others, for example the therapist (Boyd 1994; Voges and Braund 1995).

It is important that the therapist help these children with choices early during therapy. Initially it can be easier choices, such as: 'Would you like to draw with pastels or crayons?' Supportive children are vulnerable to family instability and do not like conflict. Because they are introverts, they do not easily express their emotions and the play therapist must therefore give special attention to the building of a therapeutic relationship where these children feel safe enough to express their feelings. It is further important that supportive children are encouraged to disagree sometimes with the therapist, in order to strengthen their sense of self and help them to understand that it will not damage their relationship with the therapist. Although it is important for all children, it is extremely important that the therapist make an effort to keep to his or her promises to these children. If something comes up that prevents the therapist from following through, for example when the therapist promised to arrange something for the children and does not do it, they may really struggle with disappointment.

2.3.2.4 Handling of conscientious (C) children during gestalt play therapy

Conscientious children are real introverts and will often tend to be very quiet during play therapy. It is important that the play therapist carefully bring them out of their shells. It sometimes helps to ask these children 'What are you thinking?' rather than asking them 'What are you feeling?' These children are also slow-paced and hate it when someone pushes or rushes them (Boyd 1994). They need a lot of time to complete tasks, because they want to make sure that they do it right. This often creates a problem during play therapy, because the accent is not on doing it right or making it beautiful. Even if the play therapist tells them that they have only ten minutes for a drawing, or that they have to draw it the way they did it when they were three years old, they become frustrated if they cannot do it perfectly.

> A boy, aged eight, once started crying after he said the monster that he was drawing was not right and he wanted to start over for the third time. This was after the author had frequently assured him that it did not matter how it looked, as they were just playing.

Conscientious children must therefore be helped to develop a tolerance for imperfection. The play therapist must allow these children time before a response is required. Because these children are so serious in everything they do, others sometimes tease them about their concerns.

> A boy in this group was once brought for play therapy to the author, because he was having nightmares about whether he would understand his maths when he was in grade 7. At that stage, the boy was in grade 2.

Conscientious children sometimes lose sight of the big picture, because they focus on detail so much. They are also very sensitive and will take everything that happens to them seriously. They can become very negative if they do not

reach their goals, for example if they do not get the marks that they studied for in the exams.

In conclusion it is important to take note of the fact that every child who comes for play therapy has certain inborn ways of being, which form part of his or her process. Some children feel free to be themselves, but most of them do not know their real selves, because of negative messages (introjects) that they have internalized when receiving messages that they are not allowed to be who they are. These children normally make use of contact boundary disturbances to satisfy their needs and function at the beginning of the therapeutic process in the synthetic layer, where they have to play certain roles. The therapist must therefore facilitate a process where children can become aware of these roles and make certain choices about them. It is believed that children can only really be happy when they are allowed to be themselves in the way they were created.

2.4 TREATMENT PLANNING

After assessing children according to the gestalt play therapy assessment guideline, discussed in Table 2.1, it is important to do treatment planning. Aspects that need attention when doing treatment planning are the child's age and specific developmental level, the child's unique temperament and specific issues related to the child's traumas and other life experiences. In order to be able to assess the child's developmental level, the gestalt play therapist must have thorough theoretical knowledge on child development. For example, the first developmental stage, according to Erikson's model, requires children to learn to trust themselves, their primary caregivers and the world around them. If trust predominates against mistrust, they develop hope that they can fulfil their needs and obtain their desires (Papalia *et al.* 1999). Children who have not had the opportunity to form a good emotional bond with their primary caregivers may have difficulty trusting others. This may contribute to relationship problems in their later life. Therefore, one of the treatment objectives will be to work on this issue, starting by building an I–thou relationship with these children.

After determining all the above-mentioned aspects, the gestalt play therapist will formulate specific goals with reference to the building of the I–thou relationship, the child's contact-making and self-support, emotional expression, self-nurturing and focusing on the child's persistent inappropriate process. If a child has, for example, difficulty making contact, one of the objectives will be to focus on the child's contact-making and contact-making skills. The child's resistances and contact boundary disturbances

must also be examined, as this becomes his or her way of satisfying needs and coping with the environment.

From the author's practical experience, it has been found that all children coming for gestalt play therapy and who are manifesting symptomatic behaviour are making use of at least one contact boundary disturbance to satisfy their needs. Children who are desensitized need a lot of sensory experiences such as finger painting, sand touching and other exercises described in Chapter 3. Children who are in confluence need heightened awareness of differences and similarities and strengthening of their sense of self through self-work, described in Chapter 3. Children who retroflect need help to 'act out', by coming into contact with their aggressive energy, doing body work and by helping them with emotional expression with techniques described in Chapters 4 and 5. When children project, they can be helped through gestalt play therapy to 'own' these projections, as described in Chapters 4 and 5. Children with a lot of introjects need help to focus on fragmented polarities and also exposure to self-nurturing work, as described in Chapter 5.

Another important aspect when assessing children is to look at specific issues involved in their life history, for example child abuse, divorce, family violence, abandonment, depression, attention deficit hyperactivity disorder or any loss and trauma that they may have experienced. Each one of these has general issues that may be applicable during gestalt play therapy. Children with HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) may, for example, experience specific losses at a certain stage of their illness. Children exposed to loss and trauma may normally react in a certain way, depending on their circumstances and their developmental phase. These children need to work through specific tasks in order to complete this unfinished business. These aspects are discussed in more detail in Chapters 6 and 7.

Lastly, the gestalt play therapist can also look at the child's specific behaviour and symptoms, in order to determine in which way this child is trying to satisfy his or her needs. This normally gives an indication of the contact boundary disturbances that the child uses.

In conclusion, it is important when assessing children during gestalt play therapy, and when therapists do treatment planning, to do it in a holistic way, taking into consideration all the aspects that may influence their healthy organismic self-regulation, integrated functioning, self-support and awareness of their own process. (See Appendix 3 for a diagrammatic illustration of the

process of assessing and treatment of children out of a holistic perspective during gestalt play therapy.)

2.5 CONCLUSION

Three objectives can be distinguished in respect of gestalt play therapy, namely promotion of children's self-supportive behaviour, promotion of children's awareness of their process and promotion of integration, where children are assisted to integrate their cognitions, emotions, body and senses as a holistic entity in order to complete unfinished business on their foreground. Gestalt therapy is a process therapy during which attention is paid to the *what* and *how* of behaviour, rather than to the *why*. In order to enhance children's awareness of their own process, Oaklander proposes a specific therapeutic process in her model for gestalt play therapy. The first stage of the therapeutic process focuses on building the therapeutic relationship. Important aspects include the establishment of an I–thou relationship, a focus on the here and now, the responsibilities of the child and therapist, a focus on experience and discovery, handling resistance and setting boundaries.

Assessment is done continuously during gestalt play therapy, although there is a greater accent on it during the first few sessions. Children are however assessed holistically in accordance with the gestalt theory approach by taking the various aspects of their holistic self into account. Specific aspects are assessed during gestalt play therapy, namely the therapeutic relationship, contact and contact skills, children's interest, body posture and humour, resistance, emotional expression, cognitive aspects, creativity, sense of self, social skills and the child's process. As part of assessing children's unique process during gestalt play therapy, the therapist should give attention to every child's unique temperament as it contributes to certain inborn characteristics and ways in which children will satisfy their needs. As a result of assessment, treatment planning can be done by focusing on the child's developmental level, unique process and temperament, contact and contact boundary disturbances, level of resistance and issues involved in the life history of the child.

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Chapter 3

Contact-making and Building Self-support in Children

Contact-making is a primary concept from gestalt theory and an important indicator of the child's process. The child's ability to make and maintain good contact is an important aspect that must be addressed during the therapeutic process. Contact-making between the child and the therapist facilitates the I–thou relationship. It is also an important aspect during each session as nothing can take place without it. When children find it difficult to maintain contact with the therapist, the focus of therapy can initially be on helping them to feel comfortable so that they can make and maintain contact.

During the therapeutic process, contact-making also includes the ability to withdraw sometimes relevantly, rather than to remain rigidly within the space in which contact-making occurs. Children who continuously talk, or who cannot play by themselves and always need people to play with, are regarded as children who do not have the ability to withdraw at times. Contact skills can be considered as the *how* of contact. These skills include touch, look and see, listen and hear, taste, smell, talk, sound, body posture, language and movement.

Children with contact boundary disturbances require many experiences in order to improve their contact skills during the therapeutic process. They require specific support within themselves in order to be able to express blocked emotions. There are three components of self-support for healthy contact-making, namely sensory contact-making, bodily contact-making and strengthening the self (Oaklander 1994a, 1994b, 1997).

Positive contact-making between the therapist and the child implies that relevant contact and withdrawal occur during the therapeutic session. There are various contact boundary disturbances by means of which the child can sever contact. When children restrict their senses and body, their ability for self-support and emotional expression will probably be slight.

Contactmaking between the therapist and the child is considered a prerequisite for promoting the child's self-support and emotional expression.

3.1 SENSORY AND BODILY CONTACT-MAKING

The development of sensory and bodily awareness has specific therapeutic value from the gestalt approach, as it contributes to the child functioning again as a holistic entity of thought, emotions and body. Individuals often lose their sensory awareness and sensitivity in respect of their bodies to a great extent as the result of traumatic events in their life (Clarkson 1989). By focusing on children's sensory and bodily contact-making, they can be made more aware of the emotions they experience at a specific moment (Thompson and Rudolph 1996).

A baby has a primitive sensory system and has considerable inherent potential for development. As children grow older, sensory inquisitiveness develops and they want to investigate everything they see. It is important to afford them the opportunity to make sensory contact with their external environment, as they must continuously make choices in their life which must be acceptable in the community (Schoeman 1996b). Artz (1994, p.76) mentions that '[t]hrough sensing, we record the physiological actualities of experience'. Children who experience trauma usually tend to desensitize themselves sensorily in order to protect themselves. Oaklander (1988, p.109) mentions the following: 'Yet somewhere along the line many of us lose full awareness of our senses; they become hazy and blurred and seem to operate automatically and apart from ourselves.' Experiences directed at the child's senses, namely vision, hearing, taste, smell and touch, focus on the child's new awareness in respect of his or her senses (Oaklander 1994b).

Children who experience trauma shut themselves off sensorily in order to protect themselves against experiencing further pain. Sensory awareness fulfils an important function in the child's life, as it should have a direct influence on the child's contact-making with the environment. Children should therefore be afforded the opportunity during the therapeutic process to come into contact with the environment through their senses.

Young children make use of the sensory function of sight to investigate the world and this is one of the most important ways in which children gain knowledge about the world surrounding them. The latter in turn enhances children's awareness of themselves, gives them inner strength, they become comfortable within themselves and acquire self-confidence. With respect to hearing, children learn, as they get older, to hear that which they want to hear, while they ignore that which is unpleasant to hear. Sound, however,

can be regarded as psychological experiences created in the brain, in response to stimulation (Morris 1996). Children who suppress their sense of hearing deprive themselves of intense sensory observation and emotional contact-making. The ability to produce sound affords children another opportunity to feel that they are in control. In order to effect sound, children must be in contact with themselves. The sense of smell is also used to gather information about what happens around the person, and to distinguish between pleasant and unpleasant events from the child's past. In this way, children can come into contact with specific emotions. The sense of touch enables them to socialize by means of touching. Touch by another person also contributes to a specific message to the child. The organ connected with the sense of taste is the tongue. This is a very sensitive organ in the body which helps to verbalize emotions and to make contact with the environment (Oaklander 1988; Schoeman 1996b).

All the sensory functions, namely sight, hearing, taste, smell and touch, play an important role in respect of the child's ability for emotional contact-making. If children shut themselves off sensorily in respect of one or more senses, they will find it difficult to come into contact with their repressed emotions.

Every emotion has a link with the body and children develop body patterns from a young age as their bodies' reaction to emotion (Artz 1994; Oaklander 1988, 1992, 1994b, 1997). Artz (1994, p.74) explains this aspect as follows:

> Our bodies provide us with rich and detailed information about emotions, and while emotion can neither be reduced to nor explained in terms of our neurological and physiological arousal, that arousal serves us well by alerting us to the fact that we are in the midst of an emotional process.

Artz (1994) also mentions that attention to the physical locus point of emotions provides information which can promote understanding of emotional experiences. Children with emotional problems usually also have a problem with their contact functions (Oaklander 1988, 1992, 1994b, 1997). Yontef (1993) adds that clients who report for gestalt therapy are often not sensorily or emotionally in contact with themselves. Oaklander (1997, p.297) explains this aspect by stating that '[c]hildren who are troubled restrict their bodies and become disconnected from them'.

During the contact-making stage of the therapeutic process, the therapist must focus on helping children to bridge this block by breathing in deeply,

knowing their body, feeling proud of their body and experiencing specific energy from their body. Breathing is an important part of body awareness and therefore attention is often paid to that first. Children who experience anxiety and fear often restrict their breathing, thus further restricting contact-making with the self. Various breathing exercises and physical activities should be done with children during this stage (Oaklander 1988, 1997). These activities enhance children's awareness of their physical functioning. They are thus capable of becoming aware of how they use their body to maintain or break contact (Yontef and Simkin 1989). Children's body posture also serves as an expression of their emotion and body awareness serves as a basis for a strong sense of self (Oaklander 1988).

Children who experience trauma exclude themselves not only sensorily, but also physically and often emotionally from this and no longer function as a holistic entity. As there is an important link between the body and emotion, these children then also experience problems in respect of emotional contact-making. Attention to children's breathing and body posture as part of their process is an important prerequisite for emotional contact-making.

Sensory and bodily contact-making can be addressed by means of various play therapy techniques and activities during the therapeutic process (Oaklander 1994a, 1997). An entire session does not necessarily have to be spent on sensory, breathing and bodily activities.

3.1.1 Techniques and activities for sensory and bodily contact-making

Sensory contact-making is a prerequisite for children to come into contact emotionally with themselves. A great variety of techniques and activities can be used during gestalt play therapy in order to improve children's sensory contact-making. Most of the sensory experiences include a combination of the senses and it is difficult to provide the child with a sensory experience that does not include more than one of the senses (Oaklander 1988). In respect of sensory contact-making, the focus is on the child's sight, hearing, taste, smell and touch. Most media required for activities in respect of sensory contact-making can easily be gathered by therapists themselves.

3.1.1.1 Touch

Children's function of touch plays an important role in respect of their sensory contact-making. A variety of activities can be used to promote children's sensory contact-making in respect of their function of touch. These activities are of a non-threatening nature, in that they can be implemented in a playful way with the child, without the child having to share painful

information of an emotional nature with the therapist. These activities can therefore also be utilized to promote the therapeutic I–thou relationship.

According to Blom (2000), Cooke (1996), McMahon (1992), Oaklander (1988, 1994b, 1997), Schoeman (1996b), Senior and Hopkins (1998) and Thompson and Rudolph (1996), the following media, techniques and activities can be used for promoting the child's function of touch:

- Finger painting, sand, water, wet clay and foot painting provide positive experiences for touch. The child and therapist can for instance play with their hands in the sand while talking.
- Objects that feel different, for instance sand, sandpaper, wood, stone and shells, can be touched by the child and the play therapist while talking about how each object feels and of what it reminds the child. The child can also be asked to verbalize descriptions by saying, for instance, 'I do not like this, because it feels…'
- These objects can be placed in a little bag, and the child could be asked to take something that feels smooth, coarse or soft out of the bag.
- Place a number of objects such as a pencil, a little car, etc. in a bag and ask the child to find an object starting with the letter 'p'.
- Do an exercise where, together with the child, all the words that describe a touch sensation, for instance hard, soft, coarse and smooth, are written down.
- Walk barefoot on various surfaces such as newspapers, cushions, sandpaper, metal, stones and water.
- Talk about things that hurt the skin.
- The therapist and child touch their own face, head, arms, legs or other body parts and describe the feeling.
- Teach children to massage themselves.
- Ask children to focus for five minutes on the way in which things feel on their skin, how their weight feels on the chair, how their feet feel in their shoes, and whether some places feel warmer or colder.

3.1.1.2 Sight

The child's function of sight is an important way in which information and knowledge about the world is gathered. This can, in turn, promote children's awareness of themselves. According to Blom (2000), McMahon (1992), Oaklander (1988, 1997), Senior and Hopkins (1998) and Thompson and Rudolph (1996), the following media, techniques and activities can be used to promote the child's function of sight:

- Ask the child to search for an object and then to look at that object for approximately three minutes. The child is then asked to draw his or her emotions and memories by using only lines, colours and shapes.
- Experiment with sensation and touch by means of open and shut eyes.
- Look at objects through glass, water or cellophane.
- Look at objects from various perspectives such as close, far away or upside down.
- Pour water, food colouring, glitter and plastic objects into a plastic bottle. Let the child see how the glitter moves about in the water when the bottle is shaken.
- Look at various objects through cellophane.
- Pour colourful ice blocks in water and let the child see how the colour of the water changes as the ice is melting.
- Make sunglasses from toilet rolls and use cellophane for the lenses through which the child can look at various objects.
- Ask children to look at themselves in the mirror for 30 seconds without talking. Then they are asked to describe what they see and are encouraged to describe more.

3.1.1.3 Hearing

The sensory function of hearing can be used by children to pay attention to that which they want to hear, while they can also use it to shut off sensorily from unpleasant aspects which they do not wish to hear. By promoting children's sensory function of hearing, they should find it easier to come into contact with their emotions. Various activities can be used to promote the child's sensory contact function in respect of hearing. Some of these activities seem to be less threatening in that they are not linked to an emotional

memory or event, whereas others are linked to the gestalt therapeutic phase of emotional expression, for example where music is used to promote the child's emotional awareness and contact-making. The use of the latter activities for promoting the child's function of hearing can thus also contribute to emotional contact-making and expression.

Blom (2000), McMahon (1992), Oaklander (1988, 1994a, 1997), Schoeman (1996b), Senior and Hopkins (1998) and Thompson and Rudolph (1996) suggest the following techniques, activities and media to promote the function of hearing:

- Ask children to sit quietly with eyes shut and become aware of all the noises they hear. Ask them to be aware of their emotions when they hear each noise. These emotions are then discussed. The exercise can be done at various places, within or outside a room.
- Talk with the child about different sounds such as that water sounds are soft, hard, pleasant and so forth.
- Help children to identify sounds that are similar. Different objects such as rice, beans and buttons can be placed in a bottle which is then closed. When the children pick up a bottle and shake it, they must try to find the other bottle containing the same sounds.
- Household articles can be banged against each other to promote the child's sensitivity to sound.
- Take the sounds of various musical instruments, such as a toy xylophone, where the therapist plays various notes to give the child the experience that some tones sound similar while others are higher or lower, or drums, where the child is asked to play emotions such as sadness or happiness on the drum, or where the child plays an emotion and the therapist must guess which emotion it is.
- One can listen to a melody on tape or it can be played on the piano. Talk about the sounds heard and ask children to draw their emotions or memories while they listen to the music or to write down how the music makes them feel, what they are thinking of when they hear it and whether they like it.
- Paint while listening to music.

- Ask children to draw shapes, lines and symbols while they listen to music or play music in the background while they paint with their finger or model clay.
- Help children identify sounds by making noises behind their back, such as pouring water into a glass. They must guess where the noise comes from.
- Talk with the child about happy noises, sad noises or scary noises.
- Demonstrate to the child by means of body movements the expression of different emotions and talk about these.

3.1.1.4 Taste

The tongue is linked to the sensory contact function of taste while it also serves to verbalize emotions. If children are asked to say what a specific smell reminds them of, such instruction could build a bridge to their emotional expression. According to Blom (2000), Cooke (1996), McMahon (1992), Oaklander (1988, 1997), Schoeman (1996b), Senior and Hopkins (1998) and Thompson and Rudolph (1996) the following techniques, activities and media can be used to promote the child's function of taste during play therapy:

- Talk with the child about different tastes.
- Talk with the child about the functions of the mouth and tongue.
- Let the children stick out their tongue and then let them look in the mirror. Ask them to feel the texture of the food under their tongue, lips, teeth and mouth and to distinguish between various textures. Let them guess what they tasted.
- Discuss the tastes that the child likes and dislikes.
- Give the child objects with different tastes, such as sour, salty, sweet and bitter.
- Taste different segments of an orange and compare the taste of each.
- Mix a variety of sweets in a bowl. Ask the children to choose one sweet that they liked when they were younger and to describe an event which reminds them of this taste.

3.1.1.5 Smell

By means of the function of smell, children can gather information from their environment which can also contribute to contact-making with pleasant and unpleasant events from their past. According to Blom (2000), Cooke (1996), McMahon (1992), Oaklander (1988, 1994b), Schoeman (1996b) and Senior and Hopkins (1998) the following techniques, activities and media can be used to promote the child's function of smell:

- Discuss the function of the nose, nostrils and breathing and let the children look at their noses in a mirror.
- Experiment with breathing through the nose, mouth and nostrils.
- Discuss different smells that the child likes and dislikes.
- Give the child different smell experiences such as a sweet smell, the smell of a flower or herbs. This can be done by placing objects of different smells in small bottles. The child must then try to identify the smells. The therapist can ask children to say of what the smells remind them.
- Ask children to smell different flowers and to choose the one that smells the best. Ask them to give at least two reasons for their choice.

It seems clear that some activities for promoting children's sensory contact-making are more of a non-threatening nature whereas others can contribute towards strengthening their sense of self and emotional expression, if they are ready to come into contact with their emotions.

3.1.1.6 Techniques and activities for bodily contact-making

Every emotion has a bodily contact point and bodily contact-making is an essential aspect that should receive attention during the gestalt therapeutic process. In respect of bodily contact-making, a distinction is made between techniques for promoting body awareness, breathing techniques and relaxation techniques.

TECHNIQUES AND ACTIVITIES FOR PROMOTING BODY AWARENESS

A variety of techniques and activities can be used for promoting the child's body awareness during gestalt play therapy. Some of these are to a great extent of a non-threatening nature and should contribute to a relaxed atmosphere, such as dramatizing various actions without an emotional link.

However, techniques that focus on the link between the body and specific emotions could also be used as an introduction to the stage of emotional expression. These techniques also address children's self-awareness, namely that they must be made aware of their body's reaction to a specific emotion.

Fontana and Slack (1998), Oaklander (1988, 1997), Senior and Hopkins (1998), Shapiro (1997), Stone-McCown, *et al.* (1998) and Weston and Weston (1996) suggest the following techniques and activities to enhance children's awareness of their body:

- Mimic certain ways of walking such as a person in a hurry, a lazy person, a person walking on warm grass, a person climbing a mountain or a person walking on snow. The child can also exaggerate movements of various parts of the body.
- Perform an action: lay a table, bake a cake, give food to a dog or do housework.
- Let the children imagine that they are in a very large or small cardboard box.
- Experiment with the following: walking like a man in a hurry, a child who is late for school or a giant.
- Let the fingers do different movements, such as cutting paper or wrapping a package.
- Let the child walk like an animal and the therapist must guess which animal he or she is.
- Let the children roll, crawl, turn round and round, walk on their toes, walk trembling and do other movements of the body.
- Let the children exaggerate or minimize a certain movement and then describe to the therapist of what the movement reminds them.
- Let the children look in a mirror while they do certain movements such as pulling a face at themselves, raising their arms, or taking up various positions.
- Stand with the children in front of a mirror while they express various emotions non-verbally. Discuss the way in which facial expressions differ when emotions such as happiness and sadness are depicted.

- Ask the child to move in different ways in order to depict specific emotions and to exaggerate these movements on purpose, for instance happy (clap hands and laugh loudly), sad (pretend to cry), afraid (tremble and bite nails), surprised (jump and throw arms in the air) and cross (stamp feet) (Schomburg and Sharapan 1999).
- Let the children take a card out of a number of cards depicting emotions and let them express the emotion by means of their facial expression and posture while they move in the room. The therapist can also have a turn.
- Tell the child a story – for example, something happened to a child that made him or her cross. Ask the child to move around the room like the child who is cross and do his or her own 'angry dance'.
- Ask the children to take up a specific body position or posture when they have drawn a picture and ask them to express their drawing further.
- Talk to the child about the relationship between the body and emotions, and explain that all emotions are experienced by means of a bodily sensation and are expressed by body posture.
- Draw the children's body on paper. Then give them various magazines and let them make a collage on this drawing, showing where in their body they experience different emotions.
- Use a technique called awareness continuum. A game is played where the therapist and the child take turns to report their inner and outer awareness to each other – for example, 'I am aware of your blue eyes' (outer) and 'I am aware of the fact that your heart is beating' (inner) or 'I see how the light shines through the window' (outer) and 'My mouth feels dry' (inner). The child learns that bodily sensations change continuously.
- Ask the children to do a certain movement of the body, such as to continuously kick with their legs, to make themselves bigger, or to shift their awareness to various parts of the body as named by the therapist – for example, 'Be aware of your left knee, then your middle finger of your right hand, your nose' and so forth.

- Ask the children to allow their awareness to move to different parts of their body by starting at the feet and moving upwards to the rest of the body. The therapist can then guess on which part of the body they are focusing at a specific stage.

TECHNIQUES AND ACTIVITIES WITH RESPECT TO AWARENESS AND USE OF BREATHING

A lot of fun can be experienced during the gestalt play therapeutic process, when promoting children's awareness of their own breathing, as well as the effect it can have on handling emotions and tension. By promoting this awareness, children can use their breathing more relevantly to regulate certain emotions such as fear and anger. Awareness of the way they breathe thus promotes children's self-awareness and skills for handling emotions.

Children's breathing is considered another important aspect regarding their body awareness. Blom (2000), Fontana and Slack (1998), Oaklander (1988, 1997) and Schoeman (1996b) recommend the following techniques and activities with respect to breathing:

- Exercises for breathing, such as comparing shallow breathing to deep breathing.
- Teach the child to experience the effect of deep breathing on various parts of the body.
- Talk with children about that which they experience emotionally when they usually keep their breath, such as that it can be a way to protect the self.
- Experiment with the contrast in respect of what children can do when they keep their breath and when they breathe deeply and fully.
- Teach children to let their entire body progressively relax and to do breathing exercises, as deep breathing leads to a greater availability of oxygen, enabling them to control their body better. Regular rhythmic breathing contributes to relaxation.
- Blow up balloons with the child, and then try to keep the balloon in the air by means of various breathing exercises.
- Hold a cotton wool blowing competition over the table to see whose cotton wool is first on the other side.
- Use meditation. Ask children to shut their eyes and become aware of their breathing. Let them focus on the cool feeling of

their nose when they breathe in and the warm feeling when they breathe out. Try to focus only on the breathing in and out of air, and not on the air which goes into the lungs, like a guard at the entrance of a town who must carefully supervise what comes and goes. Ask the children to count from one when the air is first breathed in and out. They must count to ten, and then start again from one.

RELAXATION TECHNIQUES AND ACTIVITIES

As part of the process of bodily contact-making, children need to learn how to relax, as tension often contributes to psychosomatic symptoms such as stomach-ache and headache, which in turn can contribute to symptomatic behaviour. It can also affect children's posture such as that they walk with rounded shoulders and neck. Tension is often the way in which children protect themselves against physical or mental attacks, the so-called fight-or-flee reaction which develops in the body. Another cause of this can be the suppression of emotion, due to the fact that the child is deprived of the consent to express it. When children learn to relax, they can also express the cause of their tension more easily (Fontana and Slack 1998; Oaklander 1988). Children should learn relaxation skills to be able to apply this in any situation where they are tense. The ability to relax can promote effective emotional management in children in that they acquire skills to express their emotions in a relevant manner, rather than to suppress them.

Blom (2000), Fontana and Slack (1998), Oaklander (1988), Schoeman (1996b), Shapiro (1997) and van der Merwe (1996b) suggest the following techniques and activities to help children to relax:

- Use metaphors. Let the children imagine that they are a snowman which has just been made and that the sun is warm. Tell them then that they are slowly but surely starting to melt, from their head to their toes, until they are just a pool of water on the ground. While the therapists proffer the metaphor to the children, they dramatize what they say by using their body.
- Let the child do bending and stretching exercises.
- Teach the children to let their bodies relax progressively from their feet to their facial muscles and by breathing deeply while music is playing.

- Use music at the start and end of sessions to let the child relax. The child can listen passively to the music or it can be combined with movement.
- Use meditation: children can for instance be asked to shut their eyes and to imagine they are swimming in the sea and that they move up and down like a wave. Then they start feeling that they are melting and disappearing in the sea. They are then one with the sea and are asked to hear the sound of the sea in their head until the noise moves away and the wave comes back.
- Take children on a relaxed, guided fantasy. Ask them to shut their eyes and to imagine that they are going to a comfortable place which they know and which they like, or a place which they can imagine will be pleasant.

The techniques and activities for the promotion of children's body awareness, awareness and use of their breathing and relaxation techniques prepare them for coming into contact with their own emotion, thus the phase of emotional expression, as part of the gestalt play therapy process.

3.2 STRENGTHENING CHILDREN'S SENSE OF SELF

From a gestalt theoretical perspective, children's self is distinguished from the environment by means of the contact boundary, which is the point where they make a distinction between that which is part of themselves and that which is considered to be outside them. Children's sense of self is central to their development. Their self-esteem is the amount of their real self that they dare show to the world. Children with a strong sense of self do not need to make use of contact boundary disturbances in order to have their needs met. They have the ability to focus on the here and now and to accept failure and mistakes as opportunities for learning. They can tolerate criticism and acknowledge their strengths and weaknesses. Children with a strong sense of self also do not measure their importance by grades and accomplishments. They accept their physical appearances, attempt new tasks with courage and also show love and acceptance of other people. These children feel accepted for their uniqueness. If children's early childhood experiences were of a loveless and harsh nature, they often have a poor sense of self and have to protect their real self from further pain. These children often make use of one or more contact boundary disturbances, in order to protect themselves against any further hurt (Humphreys 2002; Wright and Oliver 1995).

Children are not born with a poor sense of self. Their sense of self starts to develop during infancy. Oaklander (1988, p.280) explains it as follows:

> A baby is not born with bad feelings about himself. All babies think they are wonderful. How a child feels about himself after a time, however, is certainly determined to a great extent by the early messages he gets about himself from his parents. In the final analysis though, it is the child himself who translates those messages to himself.

It is not easy to find the specific source of children's poor sense of self, as the messages that they receive from the environment are sometimes vague and subtle. Often parents did not intentionally mean to contribute to their children's poor sense of self (Oaklander 1988; Wright and Oliver 1995). It is experienced that most children who come for therapy have a poor sense of self and also that it is difficult to change these negative messages that have already become part of their being.

Assistance-rendering to children to develop a strong sense of self is considered a primary prerequisite in order to help them to express suppressed emotions. According to Humphreys (2002, p.4): 'Change can only begin with the acceptance of the shadow self as being a necessary evil. This is the first step on the journey back to the real self.' This implies that children must first be helped to accept that they do not like themselves and believe that they are bad or cannot do anything good. Children with emotional problems usually have injured senses of self and develop a dysfunctional way to satisfy their needs, which then forms part of their process. A good sense of self is a prerequisite for good contact with others and the environment. The way in which children use their contact functions is an indicator of the strength of their sense of self. Children with a strong sense of self can act and make contact in a self-supportive way, whereas children who lack a sense of self experience problems with contact-making (Oaklander 1992, 1994a).

Children's sense of self has two dimensions, namely their need to feel lovable and their need to feel capable. Children who are overly timid, reserved, attention seeking, clinging, aggressive and bullying may doubt their lovability. Children who are frightened, resistant to new changes, fearful of failure or easily upset by mistakes may doubt their capability (Humphreys 2002). It is evident that different symptomatic behaviour and contact boundary disturbances can form part of children's strategy to protect their real self from further pain and to try to satisfy their need of acceptance. Children may make use of:

- projection, such as aggressive behaviour towards others, constantly blaming others for their own mistakes, bullying others and acting destructively towards the belongings of others
- deflection, when they act as shy and withdrawn and make poor contact for example by means of regular temper tantrums or by daydreaming
- retroflection, when they continuously complain about headaches and stomach-aches without any physical reason.

Introjects may also contribute to a poor sense of self in children as they often lead to children feeling that they are only conditionally accepted. They may for example act overly conscientiously and feel easily upset when they are corrected, because they experience it to mean that they are bad. These children will also put themselves down. Confluence is often seen in children with a poor sense of self, where they are constantly trying to please other people, find it difficult to make choices on their own and often ask if they are loved.

Children's sense of self can be divided into six main headings, namely (Humphreys 2002):

- physical sense of self (appearance)
- emotional sense of self (whether the child is lovable, interesting)
- intellectual sense of self (whether the child is able to comprehend certain aspects in the world)
- behavioural sense of self (whether the child is skilled, able and independent)
- social sense of self (whether the child has a sense of uniqueness or inferiority)
- creative sense of self (whether the child conforms or resists conformity, whether the child is a people-pleaser or does things in his or her own way).

Some children do not have a poor sense of self with reference to all six aspects. They may perhaps experience that they are lovable, but have a poor intellectual sense of self because they are having trouble doing maths. Or a child may have a poor social sense of self and constantly feels inferior, while having excellent academic performances, as it is a way where he or she may gain acceptance and recognition. Children need to hear that their body is

unique, right and need not be like anyone else's body. Therefore, when working on children's bodily contact-making, the therapist also gives attention to this aspect of the child's sense of self.

A child, aged six, was once asked to describe herself, after making a painting of herself. The child said that she had brown eyes, but was ugly, because blue eyes are more beautiful. She said that her sister had blue eyes and that everyone always complimented her on this. After this she added that she had brown hair, but she would have liked to have blonde hair, like her sister, because it was prettier. It was clear that the child already had a poor physical sense of self, as she had an introject that only blue eyes and blonde hair were beautiful and acceptable.

Humphreys (2002, p.133) explains this as follows:

> There are many ways in which children's physical self-worth can be neglected: remarks about physical size or shape, negative comparisons with others, over fussiness with regard to how they are dressed, overreaction when they mess up their 'perfect little suit' and so on.

Aspects that need to be addressed with respect to strengthening children's sense of self do not necessarily follow each other chronologically. As with the therapeutic process, one can move forward and backward. For example, when attention is paid to sensory contact-making by working with clay, the child's sense of self can simultaneously be strengthened; this, in turn, contributes to spontaneous emotional expression. Strengthening the self includes both sensory and physical experiences (Oaklander 1997). Children's sense of self can thus be strengthened during various stages of the therapeutic process.

3.2.1 Aspects to address when strengthening children's sense of self

Oaklander's (1997) model for strengthening children's sense of self includes that they must be able to define themselves, provided with choices, mastery and control, and opportunities to own their projections. Boundaries and limitations, as well as an atmosphere of playfulness and

humour, and opportunities to fantasize are further important aspects when strengthening children's sense of self.

3.2.1.1 Definition of the self

In order to empower the self, self-knowledge is a prerequisite. Children need to be encouraged to be comfortable with themselves and to accept their uniqueness (Humphreys 2002). They must be given a variety of experiences during the gestalt play therapy process in order to enable them to make self-statements. The child is thus able to express 'this is who I am and this is who I am not'. These aspects are also integrated in the child's awareness. Respecting children's thoughts, opinions, ideas and suggestions is an important aspect in strengthening their sense of self. As children are assisted to define themselves, their sense of self should become stronger, which in turn provides the opportunity for healthy growth (Oaklander 1994b, 1997). During the gestalt play therapeutic process, children should be assisted to become aware of who they are and how they differ from others and their uniqueness should be respected at all times. They should also be afforded the opportunity continuously to make self-statements.

3.2.1.2 Choices

Providing various choices to children gives them the opportunity to build inner strength. Children typically are given so little power in families that they will often try to find power through one or other behavioural strategy, such as bullying other children or throwing temper tantrums. Landreth (1991, p.120) states that 'self-control grows out of interaction between the child's responsibility to make decisions, to choose without adult interference or guidance, and the child's redirection of unacceptable behaviors into controlled acceptable avenues'. When adults choose on behalf of the child, the child is restrained from developing a sense of responsibility.

Children are often anxious to make simple choices, as they are afraid that they will make the wrong choice. As their senses are awakened, they again become aware of their body, they can acknowledge and accept it, and explore emotions of loss. Children learn that they can make choices and can explore the options of choices that are available. They can thus experiment with new behaviour and can acknowledge and handle the fears which they deny and which prevent them from making the choices to improve their life (Oaklander 1988, 1997). Axline (1994, p.89) adds that '[f]rom the beginning session, the therapist lets the child know that she respects his ability to make his own decisions and she abides by that principle'.

The following choices can be presented to the child during the therapeutic process: 'Would you rather sit on the bench or the carpet?' or 'Do you want to colour in with chalks or pastels?' As the therapeutic process progresses, more complex choices can be given to the child such as: 'What size paper do you need?' or 'What would you like to play with today?' When the child refuses to choose, the therapist should insist that the child makes the choice, unless he or she experiences this as too painful (Oaklander 1997, p.29). Providing opportunities for choices to children during the therapeutic process can contribute to strengthening their sense of self and to their experimenting with new methods and behaviour. Initially simpler choices should be given to children until their sense of self has strengthened to such an extent that they can make more complex choices.

3.2.1.3 Mastery and control

All children have a need to feel that they can master problems in their life and they should be afforded the opportunities to do so. Experiences of mastery strengthen children's belief in themselves and contribute to a positive self-concept (Oaklander 1988; Papalia and Olds 1996; Seligman 1996). According to Shapiro (1997), mastery refers to an inner sense of control; the ability to understand the environment and to respond effectively towards the environment. Without a sense of mastery the child's sense of self is vague.

Children in dysfunctional families are often deprived of the opportunity to experience mastery which is essential for healthy development. In some cases, parents do too much for children, thus depriving them of their need to experiment. Other parents act so rigidly that children are never allowed to experiment and discover (Oaklander 1994a, 1997). Parents often through direct communication, as well as through indirect messages, give their children the message that they will only be acceptable if they are for example good, perfect, clever, like a brother or sister, grateful, a good example or beautiful. These messages then become introjects in children's life and have a negative influence on their sense of self, as they feel only conditionally accepted when they fulfil the specific role. Introjects like these may undermine, weaken, distort and even destroy children's good sense of self. Conditional love means that behaviour becomes more important than the child. Unconditional loving not only means acceptance, care, affirmation and the absence of comparisons, but it also implies that behaviour that builds confidence is encouraged, while the behaviour and the person are kept separate (Humphreys 2002).

Parents sometimes do not realize that praising the successful performance of an activity breeds dependence in their children and these children may often experience fears that they are not good enough to please their parents. Therefore it is important that therapists and parents learn to encourage children in their effort to master an activity. The child's effort is important, and not the performance (Humphreys 2002). Experiences of mastery can be given to the child by means of various play therapy techniques and activities.

Children also have a need that others must see and respect them and want to make a difference by what they say and do. They must thus obtain the consent to take responsibility for their life and to be able to exercise choices about it (Schoeman 1996a). Oaklander (1997) adds that as children begin to trust the therapist, they start taking control during the sessions. She views this action of children as positive progress, as most children in therapy have no control and power in their life and most of them must fight for this. The type of control which the child experiences during the therapy sessions is not the same as the control gained during a struggle for power, but it is rather viewed as contact-making by means of interaction between the therapist and the child whereby the child then experiences control.

It is thus apparent that children should experience feelings of mastery throughout the therapeutic process in order to strengthen their sense of self and give them control. When a child starts taking control during therapeutic sessions, it should be considered as contact-making and positive growth and not as a power struggle between the therapist and the child. The opportunity to make choices and to take responsibility for these promotes the child's experience of control and mastery.

3.2.1.4 Possession of projections

Some of the techniques used during gestalt play therapy are of a projective nature. For example, the child's projection in the sand tray or with clay is often a metaphorical representation of his or her life. If children are capable of projection, they make a statement about themselves and their process, thereby enhancing their awareness of themselves and strengthening their boundaries (Oaklander 1997). Projection as a technique of play therapy is discussed in detail in Chapter 4. Children's ability to own projections is an indication of their sense of self. If they are capable of projection, they thereby make a statement about the way in which they satisfy their needs, as part of their process.

3.2.1.5 Boundaries and limitations

According to Oaklander (1997), boundaries and limitations present further opportunity for strengthening the child's sense of self during the play therapy session. This aspect was discussed in detail in Chapter 2.

3.2.1.6 Playfulness, imagination and humour

Gestalt play therapy should include elements of playfulness, imagination and humour in order to follow children's natural development and as such strengthen their sense of self. On many occasions, the author has noted that playfulness and humour can contribute to the building of an I–thou relationship even when children are shy, restricted and withdrawn. When children are severely traumatized, they often find it hard to react to humour and playfulness at first, as they are not in contact with themselves and their senses. These children usually make use of contact boundary disturbances in order to protect themselves from further hurt and pain. From the author's own experience, it has been found however that when these children's contact-making skills are used in an optimal way again, they can start reacting in more playful ways and react towards humour initiated by the therapist.

Young children have a natural feeling for playfulness and imagination and enjoy laughing at that which is funny. They are usually not inhibited or restricted. Imaginative play is also an integral part of the child's development. The element of pleasure is always present in the child's play, as play is the child's natural way of self-expression: the expression of that which is important to the child at that moment (McMahon 1992; Oaklander 1997; Schoeman 1989; West 1992). Children who have experienced trauma, however, often find it difficult to fantasize or laugh. Providing various opportunities for symbolic and joyful play is thus an essential aspect that must be addressed during gestalt play therapy, in order to promote the child's sense of self.

Children's sense of self can thus be strengthened in various ways during the gestalt play therapy process. This aspect is an important prerequisite for emotional contact-making. Strengthening the child's sense of self is not restricted to one stage in the therapeutic process, as all the above-mentioned aspects – such as self-statements, choices, opportunities to experience mastery and control and owning projections – should take place continuously and repeatedly during the gestalt play therapy process.

3.2.2 Techniques and activities for strengthening children's sense of self

Children can be helped to talk about themselves by using fantasy, drawings, clay modelling, puppets, dramatized play, music, metaphors or dreams. These techniques and activities can strengthen children's sense of self and provide them with the opportunity to make self-statements and choices, as well as the opportunity to experience mastery within certain boundaries. Although the projective techniques as discussed in Chapter 4 may contribute to a stronger sense of self when children own their projections, there are certain techniques and activities that can be used, especially in the contact-making and building of self-support phase, in order to help children to acquire enough inner strength to own their projections. These techniques will now be outlined.

3.2.2.1 Semantic clarifications

Semantic clarifications can be used successfully with children during gestalt play therapy in order to guide them to act in an increasingly self-supportive manner. However, on the basis of their level of cognitive development, they should continuously be guided, otherwise this would prove to be a mere abstract repetition of words to them, especially to the younger children. Semantic explanations can be used at any stage of the therapeutic process, and they contribute to strengthening children's sense of self in that they are guided to making self-statements.

Perls, quoted in Aronstam (1989) and Yontef (1993), strongly emphasizes semantic clarifications during the therapeutic process, as these clarifications contribute to clients' accepting more responsibility for themselves and thus making self-statements. During therapy, clients are thus regularly requested to substitute or emphasize certain words. Thompson and Rudolph (1996) give the following examples in respect of using semantic explanations with children between the ages of 5 and 12:

- 'I' language – children are encouraged to use the word 'I' when they use a generalized 'you' such as in 'You know how bad it is when you do not understand a sum and the teacher is cross with you'. The therapist helps children to rather say: 'I know how bad it is when I do not understand the sum and the teacher is cross with me'. By being helped to substitute 'you' with 'I', children take responsibility for their thoughts, emotions and behaviour (Fagan and Shepherd 1970). The use of 'I' language promotes children's self-supportive behaviour, in that they learn to take increasingly more responsibility for themselves.

- Substitution of 'cannot' by 'will not' – as in 'I cannot do mathematics' is substituted by 'I do not want to do mathematics'. This semantic clarification also contributes to children's acceptance of responsibility for their own behaviour and emotions.
- Substitution of *why* with *what* and *how* – instead of asking *why* questions, the following questions are asked: 'How do you feel about what has just happened?' or 'What have you done with your feet while we talked about your behaviour?' As an extension of this, the child can be asked to say: 'At this moment I feel (emotion) and I take (amount) percentage of responsibility for how I feel.' Once they have answered the *what* and *how* questions, the children can be helped to take responsibility for them. Pre-school and junior primary school children will not be capable of indicating what percentage of responsibility they take for their emotions, as this can be an abstract concept to them. It would however be possible to substitute *why* questions with *what* and *how*.
- Substitution of questions with statements – this method helps children to express their emotions and thoughts more directly. Instead of the child asking: 'Do you think I should no longer play with those friends', he or she is encouraged to say: 'I think I should no longer play with those friends' (Fagan and Shepherd 1970; Yontef 1993). This semantic clarification can be used successfully with children in order to assist them to make increasingly more self-statements which should in turn strengthen their sense of self.
- No gossiping – when children talk about someone who is not in the room, they are encouraged to talk in the present time with this person, for instance by placing him or her in the empty chair. An example of this is where the child is taught, instead of saying 'I think my teacher treats me unfairly', to place his or her teacher in the empty chair and tell the teacher 'I think Miss treats me unfairly'. The child is then encouraged to move to the other chair and to answer on behalf of the teacher and this dialogue is continued until all aspects are discussed (Fagan and Shepherd 1970; Yontef 1993). The empty chair technique is discussed in detail in Chapter 4. This principle helps children to

be able to make further self-statements. It is often difficult for children to express their emotions directly to an adult due to introjects that restrain them from doing so. The use of the empty chair in this respect may help children to express their unfinished emotions, as it is a more non-threatening way.

3.2.2.2 Other techniques and activities to strengthen children's sense of self

There now follows a summary of techniques that can be used to strengthen children's sense of self, as described by Blom (2000), Hobday and Ollier (2002), Oaklander (1988, 1997, 1999), Schilling (1996), Schoeman (1996b), Schomburg and Sharapan (1999).

FOCUS ON POLARITIES

During strengthening children's sense of self, various techniques, activities and media can be used to focus on polarities which they experience in themselves. Integration of the polarities can take place during this phase and can contribute to achieving the gestalt objective of integration, as well as strengthening children's sense of self.

- The therapist can make a list, as dictated by children, of the food they like and dislike or of aspects at school they like and dislike.
- Ask children to cut pictures out of magazines that give an indication of the things they like and dislike and then make a collage of the things they like and a collage of the things they do not like.
- Let children make a drawing of all the aspects they like and dislike, aspects that make them happy, sad, angry or afraid, or of all the things they like doing.
- Let children throw a ball at a target while they make statements about themselves each time they throw the ball.
- Let children make figures or abstract symbols that represent them when they feel good and when they feel bad.
- Let children make clay figures of themselves as they see themselves and clay figures of themselves as others see them.
- Let children draw a circle divided into segments. In each segment they write words or draw pictures representing a part of themselves. Dialogue can then be carried on between the various parts in order to clear up and explain conflicts and aspects of each part.

FOCUS ON MASTERY

Let children experience mastery during sessions for instance by building a jigsaw puzzle or a structure with Lego blocks. Some projective techniques, such as using drawings or clay modelling, give children feelings of inner mastery and satisfaction without someone having to praise their creation. The experience of mastery provided by the use of these techniques, activities and media promotes children's sense of self in a positive manner. During the gestalt play therapy process, children should continuously have the opportunity to experience mastery; this aspect is not only restricted to the stage that focuses on strengthening their sense of self in particular.

FOCUS ON SELF-STATEMENTS

- Give children a list of words that describe appearance – fat/thin, straight hair/curly hair, beautiful nose/large ugly nose and so forth – and let them draw a circle around the words that describe them at present. The children can also be given another list of words that describe them such as brown hair/blond hair, things that can be enjoyed such as reading/listening to music, and words that describe activities which they can possibly do well such as sums/computer games. Ask them to draw a red circle around the words that describe them, a blue circle around the things they enjoy and a green circle around the words that describe activities which they can do well.
- Ask children to complete the following statements:
  - My favourite colour is…
  - My favourite smell is…
  - My favourite taste is…
  - My favourite thing to touch is…
  - My favourite sound is…
- Let children look in the mirror and talk with their image.
- Look at new and old photos of the child.
- Draw the outlines of the child on a large piece of paper and focus on certain parts of the body by means of fantasy or discuss each part of the body as it is drawn.
- Ask children to draw a picture of themselves in the middle of a piece of paper and to write 'I am…' with their name on the top.

If they cannot manage to do this, the therapist can do it. Explain that this is an exercise to see what sort of person they are, what they like and dislike and to find out all about them. Ask them all kinds of questions that they can write down around the picture, for example:

  - What is your favourite food?
  - Who is your best friend?
  - What do you like to do after school?
  - What are you good at?

- Use a board game such as the 'Talking, feeling, doing' game where children must express their own ideas, thoughts or opinions. The game is as follows: the child and the therapist move a disc on the board following a number on the dice which is thrown. If the player lands on a white block, he or she takes a talking card; landing on a yellow block results in a feeling card; and landing on a red block means taking a doing card. The therapist uses the child's response to each question for therapeutic interaction. The talking cards in particular encourage the child to give cognitive responses, while the feeling cards focus on affective aspects. The doing cards in turn focus on physical activities. Some cards have questions on them which can elicit a low degree of anxiety such as 'What is your favourite ice cream?' Most cards, however, have questions that can elicit a moderate amount of anxiety such as 'Let's say two people talk about you and they are not aware that you are listening to them – what do you think they are saying?' (Gardner 1983; van der Merwe 1996a). This game was revised in 1998 in order to substitute some questions with questions that are more relevant to children in modern life.

MAKING USE OF FANTASIES

Use fantasy with specific reference to the rosebush fantasy and the fantasy of a safe place. According to Oaklander (1999), these two fantasies can be used successfully for strengthening the child's sense of self. These two fantasies were discussed in Chapter 2 (pp.70–73).

3.3 CONCLUSION

Enhancing children's contact skills and self-support is an important phase of the gestalt play therapeutic process. Specific attention is paid to sensory and bodily contact-making and the strengthening of children's sense of self. With respect to the latter, attention must be paid to: the definition of the self; choices; mastery, authority and control; owning of projections; boundaries and limitations; and playfulness, imagination and humour. Self-support and a strong sense of self is a prerequisite for the next stage of emotional expression.

A great variety of media, such as clay modelling and sand play, and activities can be used to promote the child's sensory contact-making. Activities focus on all the senses, namely touch, sight, hearing, taste and smell. Some of these activities could also be used in combination in order to address more than one sensory contact function simultaneously. For example, playing music while working with finger paint can involve the functions of both touch and hearing.

In respect of techniques and activities for bodily contact-making, a distinction is made between: techniques and activities for promoting body awareness, such as dramatizing certain movements or emotions; techniques and activities for enhancing the children's awareness and effective use of their breathing; and relaxation techniques and activities. Techniques for strengthening children's sense of self include focusing on polarities in themselves, such as aspects that they like and dislike. The experience of mastery by for example building a jigsaw puzzle can also contribute to this, as well as techniques that focus on bringing children into contact with their own body and characteristics, so that they can understand their own uniqueness. Other activities that could be used include board games, namely the 'Talking, feeling, doing' game, or using the rosebush fantasy and the fantasy of a safe place.

Semantic clarifications such as the use of the 'I' language and the substitutions of questions with statements can also strengthen children's sense of self. However, this must be explained in a concrete way to younger children to prevent them from experiencing this as the mere abstract repetition of words. Semantic clarifications contribute to the fact that children start taking more responsibility for themselves, which can in turn promote their self-supportive behaviour positively.

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Chapter 4

Emotional Expression

Emotional expression is another important phase in the gestalt play therapeutic process. Therapists are often in a hurry to come to this phase where children can come into contact with their unexpressed emotions, because they think then they are really making progress. It is however important to remember that children must first be able to use their contact functions effectively and have a strong enough sense of self before the focus of the therapeutic process moves to emotional expression.

In her model, Oaklander (1994a, 1994b, 1997) distinguishes between two main aspects of emotional expression that should be addressed, namely the expression of aggressive energy and the expression of emotion. These two aspects, as well as appropriate techniques that can be used during each, will be outlined in this chapter.

4.1 EXPRESSION OF AGGRESSIVE ENERGY

According to Oaklander (1994b), taking action and satisfying needs requires aggressive energy. She defines aggressive energy as 'marked by driving forceful energy or initiative' (Oaklander 1997, p.304). She also mentions that 'aggressive energy is more than a sense of power within: it involves action' (Oaklander 1994b, p.150). The concept refers to the energy necessary, for instance, to bite into an apple or to express a strong emotion which gives children the self-support to enable them to take action. Children with emotional problems are often confused as the result of this energy. Children who for example experience fears with a poor sense of self show a lack of aggressive energy and thus often use retroflection in order to handle it. Therefore they turn this energy inwards, resulting in psychosomatic symptoms such as headaches or stomach-aches. When children act aggressively and fight for control, they experience a lack of this energy, as they act beyond their boundaries. They make use of deflection as contact boundary disturbance.

During this stage of the therapeutic process, various opportunities must be given to the child for experiencing aggressive energy and for feeling comfortable with it. The self-support thus obtained is a prerequisite for expressing suppressed emotions. However, activities for expressing aggressive energy should take place by means of interaction with the therapist. This is usually first done in a playful manner, without any link to content (Oaklander 1994a, 1994b, 1997). As children with problems often confuse aggressive energy and handle this by means of contact boundary disturbances, they must have various opportunities to express this energy in a playful, non-threatening manner during the gestalt play therapy process. The expression of aggressive energy is a prerequisite for healthy emotional expression. Numerous times during therapy the author has found that after children came into contact with their aggressive energy, they felt much more comfortable with coming into contact with their unexpressed emotions. The activities used during this phase also contribute to the therapeutic I–thou relationship, as the therapist is actively involved in this.

A child, aged seven and diagnosed with attention deficit hyperactivity disorder, made very poor contact with the author up to the sixth session when the whole session was spent on activities for expression of aggressive energy. After this session the child spontaneously told the author that he 'wanted to come to therapy for ever and ever'. His contact-making and contact skills improved and a basis for a positive I–thou relationship was created.

4.1.1 Techniques and activities for the expression of aggressive energy

The expression of aggressive energy is considered as a prerequisite for healthy emotional expression by the child. Fun activities such as clay modelling and puppet playing can be used during this stage whereby children can express their aggressive energy. Some of these activities, such as throwing clay, or hitting pillows with rackets, can also be done with children during the next part of this stage, where they are helped to come into contact with their own unfinished emotions, as possible handling strategies for these emotions. They can thus for instance learn that, when they are cross, instead of hitting someone, they should rather express their anger by for example throwing balls made of clay forcefully against a wall. The author often

suggests after such a 'practising' session that children's parents buy them some clay or other 'tools' to do the same kind of activities at home.

From practical experience, it has been found that an activity where the child hits various round wooden blocks with a mallet into a wooden frame with round holes could be used effectively during this stage.

> A child aged six, who had a lot of aggression because of the birth of a new baby sister, enjoyed this activity so much that she actually asked her parents to buy her one as well and they decided to call it the family's anger machine.

Blom (2000), Oaklander (1988, 1994a, 1994b, 1997) and Schoeman (1996b) suggest the following techniques and activities for expressing aggressive energy:

- Wet newspaper and hold it in front of children so that they can hit it with their fists.
- Let the child hit cushions.
- Let the child run around the block.
- Let the child make a clay model and destroy it.
- Hold a clay-throwing competition to see whether the child or the therapist throws the clay the hardest. The therapist can make loud encouraging noises each time the clay is thrown and encourage the child to do so too.
- Let puppets challenge and eat each other. The therapist can for example pick up a hand puppet and challenge the child with it by saying: 'I think it would be nice to eat you, but don't hit me with your big paws', whereby the child is challenged to chase or hit the therapist's puppet.
- Shoot each other with dart guns.
- Have a fight with 'batacas' (objects that look like cricket bats covered with foam rubber, see Figure 4.1).
- Throw balloons full of water against a wall.

Figure 4.1 Picture of a gestalt play therapist having a 'fight' with a child during the phase of the expression of aggressive energy

According to Oaklander (1997), activities for expressing aggressive energy must meet specific requirements in order to be effective, namely:

- The therapist must take part in these activities, because if the therapist looks on passively, this will not have the same effect as when the therapist is actively involved. This involvement makes the child feel more at ease to come into contact with that inner strength of which he or she was afraid.
- The activities must take place within a safe environment where the child must realize that the therapist is in control and will not allow any injuries to interfere with the experience. Before the start of the activities, the child should be told of specific boundaries in respect of the activity, for instance in a 'bataca' fight the therapist and child may not hit each other in the face.
- The activities must take place in a spirit of fun and playfulness.
- The game must be exaggerated, as the child has previously avoided the experience of this energy. Oaklander (1997, p.305) states: 'she must go beyond the centre point before she can come back to balance'.

The therapist must thus take an active part during the stage of expressing of aggressive energy in order to let the child feel more at ease, although the game must also take place within specific boundaries to protect the child and the therapist. When the activities meet the above requirements, they also contribute to strengthening the children's sense of self, in that both the boundaries, and the spirit of fun and playfulness within which these take place, play an important role in respect of children's sense of self.

4.2 EXPRESSION OF EMOTIONS

During the stage of emotional expression, the therapist will initially focus on aspects such as what emotions are, the kinds of emotions and the body's reaction to various emotions. These aspects are less threatening for children who have suppressed their unfinished emotions for some time and they prepare children for projecting and expressing their own suppressed emotions. Various play therapy techniques can help children to project and own their emotions, to learn handling strategies, and to be able to make choices on how to express emotions.

Children's emotional expression is an important indication of the nature of their process. Some children are not aware of what emotions are. This does not mean that they do not experience emotion. They often just do not know how to verbalize it. In many cases, children tend to suppress negative emotions and will seldom announce on their own during a therapeutic session that they want to talk about an emotionally painful aspect. However, emotional pain and unfinished emotions are often reflected by the child's behaviour and process. Assistance-rendering to children to identify and experience their suppressed emotions is an essential aspect during therapeutic work with children (McMahon 1992; Oaklander 1988, 1997; Schoeman 1996d). The more children are allowed to acknowledge and experience their emotions, and to gain insight into the fact that emotions are a natural part of human nature, the easier they will be able to learn skills to express their emotions in a healthy and socially acceptable manner (Fontana and Slack 1998).

The way in which children express their emotions is related to their process and is often expressed in their behaviour rather than in their verbalization. Children thus tend to suppress negative emotions, whereas they are mostly reflected by their behaviour. Contact boundary disturbances such as introjects contribute to the fact that children tend to suppress emotions, as they are often deprived of the consent to express these emotions openly. Some children have suppressed their emotions for such a long period of time that they must first talk about emotions during the stage of emotional

expression. Aspects such as what emotions are, various intensities of emotions and the body's reaction to different emotions are initially explored during this stage in a cognitive manner. If children succeed in identifying their body's response to specific emotions, they can use it as a guideline to become aware of their emotions.

Children do not necessarily move automatically from conversation on emotions to expression of their own emotions. Various techniques, including drawings, clay work, fantasy, dramatized play, music, movement, stories, sand and metaphors are used during gestalt play therapy to help the child to express suppressed emotions. Children often project aspects of the self and their process, as well as what they need and wish and their unexpressed emotions (Oaklander 1988, 1994b, 1997; Schoeman 1996d). They must be guided to come into contact with the emotions that they experience – in other words, to own them during the phase of emotional expression.

Another aspect that is addressed during this stage is handling strategies which children can use for specific emotions, such as acceptable ways in which they can express their anger. These handling strategies are usually written down and practised in the play therapist's office. Children must thus get consent to talk about their emotions, learn that they can make choices about expressing emotions and acquire skills to handle emotions. It is important during this stage that the therapist asks questions in a soft and gentle manner. Furthermore, therapists must not focus on children's tears when they cry, as they can experience this as a reprimand. If they focus on these tears, children will probably try to stop crying. Therapists should rather continue talking (Oaklander 1988, 1994b, 1997).

In conclusion, during the stage of emotional expression, children must be given support so that they can talk about emotions in general and about the body's reaction to different emotions; they must be afforded the opportunity to experience, project, own and express emotions by means of play therapy techniques and activities, and learn handling strategies for different emotions. In respect of this discussion, a distinction is drawn between two main events, namely techniques and activities for dialogue about emotions in general, and projective techniques that serve as a forum for emotional expression within a gestalt play theoretical perspective.

4.2.1 Techniques and activities for dialogue on emotions in general

Different activities, techniques and media can be used for dialogue with the child about emotions in general. These promote children's emotional vocabulary, and their ability to give reasons for emotions, as well as their ability to

recognize emotions in others non-verbally. As such, attention is paid to children's self-awareness. Techniques and activities that assist the child to become aware of his or her body's reaction to different emotions are discussed in Chapter 3. A discussion follows of the techniques and activities that can be used to promote children's awareness of emotions in general, as indicated by Blom (2000), Hobday and Ollier (2002), Jensen and Freedman (1999), Oaklander (1988, 1997), Schilling (1996), Schoeman (1996d), Shapiro (1997), Stone-McCown *et al.* (1998), van der Merwe (1996a, 1996b) and Weston and Weston (1996).

- Give children various magazines and interesting pictures, a pair of scissors and glue. Ask them to make a collage of themselves experiencing different emotions. A picture of a car involved in an accident can represent an injured emotion. Let them then describe their collage to the therapist.
- Let children make a collage of pictures from magazines of people expressing different emotions and write down the emotion next to each picture. They can later use these pictures in therapy to name their emotion, if they find it difficult to express emotions.
- Give the child an emotional barometer with a happy face at the top and a sad face at the bottom. This can be used to assess his or her state of mind or emotions in respect of a specific event and can be used for further dialogue.
- Make a list of as many emotions as you can think of with the child. Write each emotion on a separate index card. Let the child draw a picture of a facial expression of each emotion. Then play a game where the child draws a card and expresses the emotion non-verbally, whereupon the therapist must guess what emotion it is. Schoeman (1996d) mentions, however, that with younger children the therapist should focus on a maximum of five emotions, as too many emotions can confuse them. A card with five basic emotions (such as happy, sad, cross, proud and afraid) can be shown to the child whereupon he or she can choose the face that represents his or her emotion at a certain time.
- Give the child a piece of paper with a number of circles on it representing faces. Ask the child to draw as many different emotions as possible in the faces. According to van der Merwe

(1996b), this technique can effectively assess a child's emotional vocabulary.

- Make a list of emotions and discuss possible events that can elicit such emotions.
- Read a poem or a story to children and ask them to identify as many emotions as possible from this story. According to Oaklander (1988), storybooks dealing with emotions are especially suitable.
- Make masks from paper plates with different emotions drawn on them and hold a conversation about a time when the child felt that emotion.
- Make a list with the title 'Things that make me cross/happy/sad'. Divide it into two columns, namely situations and people, and what I can do about this.
- Use clay modelling to depict different emotions such as angry, sad and happy. The child is for instance asked to build a symbol with clay, which depicts each of these emotions.
- A feelings game, the 'Feeling word game', is described by Kaduson (1997). The therapist tells the child that they will play a game where the child tries to make a list with the therapist of all the emotions which a child of his or her age can experience. Each emotion is written down on a separate piece of paper. The therapist explains to the child that a story will be told and that the child must place poker chips which depict emotions on the cards when he or she thinks the characters in the story experience the specific emotion. The child can also place the chips representing how he or she would feel under similar circumstances. A variation of this game is that, instead of writing down emotions, the child can draw a facial expression for each emotion, as younger children may find this easier to do. These children will understand a visual depiction of the emotions better than a word describing the emotions.
- McDowell (1997), Meagher (1997) and O'Connor (1983) describe a variety of emotional games, where emotions are linked to colours. According to O'Connor (1983), an activity named 'Colour your life technique' can be played. This game is

designed to give the child a concrete way to understand emotions and is especially effective for the 6- to 12-year-old child. This should thus be suitable for children in the middle childhood years. The objectives of the game are as follows:

- to enhance the child's awareness of different emotions
- to encourage the child to discuss events on an affective level
- to help the child to make a transition from a purely action-oriented way of acting to one that is more verbal
- to assist the therapist to obtain information on the child's previous and present emotional life in a more non-threatening manner than a verbal interview.

The following method is used. The therapist asks the child to link a specific colour to specific emotions by saying, for example: 'Can you tell me which emotion goes with the colour red?' If the child says that he or she does not know, one can continue by asking whether the child can imagine how people feel when they get red in their face. If the child then says that this is when they are cross, the colour red can be linked to angry. In this way colours are linked to emotions such as angry, furious, sad, very sad, jealous, bored, lonely and happy. Children often link the following colours to emotions: red (angry), violet (furious), blue (sad), black (very sad), green (jealous), brown (bored), grey (lonely) and yellow (happy). The child can also be helped to distinguish in a concrete manner between intensities of emotions such as the difference between angry and furious, or sad and very sad, by making use of practical concrete examples. The child is then given a sheet of white paper and he or she must colour in the paper to show different emotions which he or she has experienced in his or her life. One can, for example, say to the child: 'If you were happy for half of your life, half of the paper will be coloured yellow.' The child can colour in the paper by making use of any lines or shapes. Then the child's picture is discussed.

- Meagher (1997) adds the 'Feelings tree' game. According to this game, colours are also linked to emotions. Four fruit balls of each colour are made out of clay to represent different emotions. These fruit emotions are hung on a grey feelings tree and the child gets the opportunity to pick the fruits whereupon the specific emotion is discussed. As a variation of this game, the author tells children a story by making use of puppets and then asks children to pick a clay ball every time that a character in the

story is experiencing a specific emotion. The different characters' emotions are discussed afterwards and children may also be asked if they have ever felt this way.

- The sticks of the game 'Pick-up sticks' can, according to McDowell (1997), be used in a similar way in that emotions are linked to the different colours of the sticks. The game is played as usual, namely that the child and therapist try to remove a stick without moving one of the others. When a stick is removed successfully, the person has the opportunity to tell of a time in his or her life when the specific emotion was experienced.

4.2.2 Projective techniques for emotional expression

Children do not always move automatically from the previous stage of verbalization of emotions to taking possession of their own emotions. In light of this, projective techniques are used from a gestalt play theoretical perspective as a forum for expressing emotions. Creative and projective techniques – such as sand, stories, fantasy and metaphors, puppet-show and puppets, creative stage play and drawings – assist children to project, own and directly express their emotions during the stage of emotional expression (Oaklander 1994b, 1997). Oaklander (1997, p.306) mentions the following in this respect: 'These modalities lend themselves to powerful projections that can evoke strong emotions. Everything the child creates is a projection of something inside of her or, at the very least, something that interests her.'

In this chapter, attention is given to drawings and paintings, sand play, clay play, the processing of dreams and the empty chair technique as projective techniques, Puppets, puppet theatre, stories and metaphors are also considered as projective techniques that can be applied appropriately during this phase. They will however be discussed in Chapter 5. Although these techniques are described in Chapter 5 as techniques for addressing the child's inappropriate process, the reader must take note that they are also powerful tools to use for projection during the phase of emotional expression, discussed here.

Projection is considered a contact boundary disturbance, where the environment is held responsible for that which happens in the self. However, it can also be used positively during therapy in that parts of the self are thus projected and owned (Clarkson 1989; Hardy 1991). Projection has various functions in children's lives. It gives them the space to sort out what is expected of them and it is their attempt to suppress aspects which they cannot face. It also provides children with a way to maintain their

self-respect and to escape when they are not ready to accept criticism and rejection (Schoeman 1996c).

According to Schoeman (1996c), the following objectives are sought by the positive use of projection during gestalt play therapy:

- It facilitates awareness of that which makes children unhappy in the present – in other words, by means of projection they are able to handle their problem in the here and now. This objective is linked to one of the principles of the gestalt play therapy, namely to facilitate the child's awareness in the here and now.
- It facilitates self-growth in that children make self-statements by means of their projection of who they are and who they are not. This aspect is linked to the definition of the self, which is addressed during this stage of strengthening the sense of self.
- It assists children to complete their unfinished business and to work through the traumas in their life. Children's lack of experience causes them to project their unfinished business on someone else and on their own body, and this can lead to physical and other symptoms in the children.

Oaklander (1999) distinguishes the following therapeutic steps in respect of the use of projective techniques during gestalt play therapy with children:

- Children must be willing to do the projective techniques such as drawing, playing with clay, puppets or sand, or story-telling.
- Children share information on their projection with respect to how it felt to do the activity.
- Children enter the metaphor or the image is penetrated in that they become part of the projection such as the picture or puppet and look at the situation from the perspective of the object or part of the whole.
- The story is told in that children identify with certain objects in the projection and dialogue is carried on between objects.
- The projection is taken into possession on two levels, namely:
    - symbolic level – children share information on the situation, but only on the level of the metaphor; fragmentation still occurs

    - reality/personal level – children find a connection between that which happens in the metaphor and that which they experience in their life. Questions asked are: 'Do you also feel like that?' or 'How does this fit in with your life?'

- The therapist must note patterns, themes, polarities and places of resistance throughout.

Children must first own their projection on a symbolic level, before they can move to the personal significance thereof for them. Once children have projected and owned their emotions, learning handling strategies and skills for handling daily emotions, for example anger, must be addressed. They must thus be assisted to experiment with new behaviour (Oaklander 1997; Thompson and Rudolph 1996). A list of activities can serve as handling strategies and the child can practise these with the therapist in the office. The child can for example learn to tear up papers when he or she is cross, scream into a pillow, throw clay or do one or other physical activity (Oaklander 1997, 1999; Schomburg and Sharapan 1999).

From a gestalt play therapeutic perspective, a discussion of the various projective techniques that can be used during this stage follows.

4.2.2.1 Drawing and painting techniques

Various drawing and painting techniques can be used to help children to express their emotions. The mere act of drawing is an expression of the self, which helps children to express their self-identity (Oaklander 1988). According to McMahon (1992), Nickerson (1983) and Thompson and Rudolph (1996), drawing and painting have the following advantages:

- They help children to express their thoughts and emotions in a non-threatening way and thus to acquire new handling strategies which can contribute to positive change in behaviour.
- They facilitate communication with children.
- They encourage creativity, self-expression and spontaneity.
- They contribute to catharsis in that the emotions and ideas of children are projected, explored and understood.
- They provide experiences of mastery.

The use of drawing or painting techniques positively promotes children's self-awareness, as they can come into contact with their emotions and handling strategies for future handling in a non-threatening manner. The

experience of mastery provided by drawing and painting techniques also strengthens children's sense of the self.

USING DRAWING AND PAINTING TECHNIQUES DURING GESTALT PLAY THERAPY

The child must be given a variety of drawing material to choose from, namely chalks, pastels, colour pencils and an ordinary pencil. The scribbling technique is a non-threatening drawing technique that can help children to express an aspect of their inner self. Children are asked to imagine that there is a large sheet of paper in front of them and that they hold a chalk in each hand with which they scribble on the paper until the entire paper is full of scribbles. Then they are asked to draw the scribble on the paper with eyes open or shut. The scribble is examined and the children are asked to look for a picture in the scribble and to colour it in. Children can also be asked to tell a story about their picture (Oaklander 1988).

Instead of drawing, the child can also make use of paints (see Figure 4.2). According to Oaklander (1988), the use of paint has specific therapeutic value and children in their middle childhood years enjoy painting. McMahon (1992), Mills and Crowley (1986) and Oaklander (1988) give other examples of drawing or painting techniques that can be given to the child and that can serve as metaphors:

- Draw or paint an emotion that is being experienced, for example anger, happiness, sadness or fear (Schomburg and Sharapan 1999).
- Draw how an emotion such as fear or being cross will look when it is better.
- Make a free drawing – in other words, the child gets the opportunity to draw anything he or she likes (Nickerson 1983).
- Draw what you do when you are cross, afraid, alone, jealous and so forth and what you would rather do.
- Draw a scary place.
- Draw yourself as you are and would like to be.
- Draw your ideal place.
- Draw happy, sad or cross lines.
- Draw in response to a story, a fantasy or a piece of music.
- Draw polarities of weak or strong, happy or sad, good or bad emotions.

- Draw how you felt yesterday, how you feel today and how you will feel tomorrow.
- Draw a secret.
- Draw a house, a tree and a person on one paper. The therapist then tells the child that the drawing tells him or her something of the child and then proposes hypotheses to the child concerning the drawing, which the child must confirm or refute (Schoeman 1996c; van der Merwe 1996a).
- Draw a picture of how you feel and of what your problem looks like. Draw another picture of what your problem looks like when it is better.
- Draw a picture of when you are not getting attention today and another picture of when it feels better.

Figure 4.2 Picture of a child busy painting a house during gestalt play therapy

Drawing and painting techniques promote children's self-awareness in that they can thereby project their emotions. The therapist can then focus on more relevant handling strategies for these emotions, which could in turn positively influence children's management of their emotions. Drawing and painting techniques can also be used relevantly during the stage of strengthening the child's sense of self, as discussed in Chapter 3. Some of these

drawing and painting assignments, namely those focusing on polarities such as how you are and how you would like to be, can be used effectively during the stage of strengthening the child's sense of self, whereas others which, for instance, focus on drawing an emotion can in turn be used effectively during the stage of emotional expression.

OAKLANDER'S STEPS FOR HANDLING PROJECTIONS BY MEANS OF DRAWINGS

When working therapeutically with the child's drawing, the aim is not to interpret it in order to give an adult or professional opinion, but rather to explore the drawing with the child (McMahon 1992). According to Oaklander (1988), children's drawings can be dealt with in the following ways during gestalt therapy:

- Motivate children to share their experience when they were drawing as well as the way in which they tackled the task.
- Let them share the drawing with the therapist, by describing it in their own way.
- Motivate the children to expand in more detail on various parts of the drawing by describing shapes, colours and objects.
- Ask the children to describe the drawing as if they are the drawing, by using the words, for instance: 'I am the picture – I have red lines all over me.'
- Choose specific aspects in the picture with which children can identify, for example: 'Be the blue square and describe yourself.'
- Ask the children questions to help the process, namely: 'What are you doing?' or 'Who is helping you?'
- Focus the children's attention on sharpening their perception in that a certain part of the drawing is highlighted and overemphasized. Ask, for instance: 'Where are you going now?' or 'What is she going to do next?' If they say that they do not know, the therapist can make a suggestion and ask them if this is right.
- Ask the children to carry on a conversation between parts of the drawing such as between the car and the road.
- Encourage children to pay attention to the colours they used. Ask questions: 'What do bright colours mean to you?'

- Pay attention to children's tone of voice, posture, facial expression, breathing and silences.
- Help the children to own their drawing or parts thereof. Ask questions: 'Have you ever felt this way? Does this fit in with your life?' (Some children cannot own their projection and the therapist must respect this.)
- Pay attention to the unfinished business that comes to the fore from the projection.
- Seek possible omitted parts in the picture and pay attention to these. Stay with children's figure-foreground.

When applying these steps, children are guided to first own their drawing or painting on a symbolic level, whereupon the therapist proceeds to the reality level to try to find similarities with their life. The therapist does not make any interpretations regarding children's projection, but rather verifies possible hypotheses with them. Guiding children to own their projection on the reality level, by assisting them to find out how this is linked to their life, promotes their awareness and integration. In the author's own practical experience, it has been found that Oaklander's steps could be used for any projection of children during gestalt play therapy. In addition, it was found that even when children cannot own their projection on the reality level, the mere opportunity to project their emotions serves as catharsis and may contribute to the completion of unfinished business. Figure 4.3 illustrates an anger drawing where the above-mentioned steps of Oaklander were applied during gestalt play therapy.

4.2.2.2 Sand play

According to Miller and Boe (1990), sand play is considered a form of non-directive projective play, where miniature figures are chosen by the child and placed in wet or dry sand. Weinrib (1983, p.1) defines the concept as follows:

> Sand play is a non-verbal non-rational form of therapy that reaches a profound pre-verbal level of the psyche. In this psychotherapeutic modality, patients create three-dimensional scenes, pictures or abstract designs in a tray of specific size, using sand, water and a large number of miniature realistic figures.

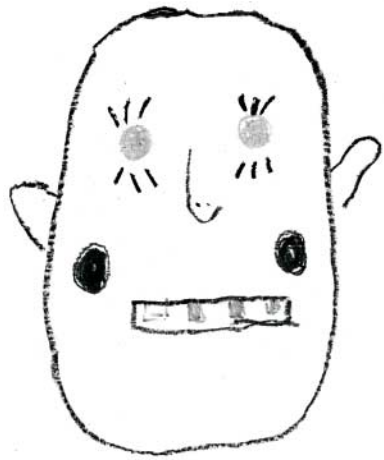

Figure 4.3 Anger drawing of a seven-year-old boy

Sand play can thus be considered a form of non-verbal projective play, where children create landscapes, pictures or abstract concepts in a sand tray of specific size, in which they place miniature figures chosen by them.

THERAPEUTIC VALUE OF SAND PLAY

According to Allan and Berry (1993), Carey (1990, pp.197–198), Miller and Boe (1990), Oaklander (1988, 1997) and West (1992), sand play has unique therapeutic value for the following reasons:

- It provides sensory stimulation of the sense of touch in that it feels good to touch it.
- Boundaries are set to children, namely the size of the sand tray, which helps them to act within their own boundaries.
- Sand play allows children to take total control of the action and thus experience control in that the sand-tray models can stand, move about or be buried in the sand to depict a specific situation.
- It can encourage verbal discussion where the child has poor verbal skills, or encourage non-verbal communication if the child uses defence mechanisms.

- It gives children the opportunity to handle traumas by externalizing fantasies; they thus develop a sense for control over inner impulses.
- It contributes to expressing emotions such as aggression and anxiety with which the child sometimes finds it difficult to come into contact.
- The miniature toys are exhibited and children do not have to create their own material as in drawing activities.
- The projection of symbolic material by means of sand-tray play has therapeutic value as children thus express something within themselves. When children tell a story about their sand picture, they express more of themselves on another level and, when they can own various parts of the sand picture, integration takes place.

Sand play as a projective technique has various advantages that can promote the children's awareness of unfinished business, in that they can project and own their emotions within the safe space of the sand tray. The control this activity gives children, as well as the boundaries it offers, promotes children's sense of the self.

SAND TRAY AND PLAYING APPARATUS

The sand tray consists of a container, for example a plastic container. There are usually two watertight bowls available. One bowl contains dry sand and the other one contains wet sand (Allan and Berry 1993; Oaklander 1988; West 1992). The inside of the sand tray can be painted blue to create the idea of water when the sand is pushed to one side. Children should be given a variety of miniature toys during sand play in order to give them the opportunity to make choices about that which they want to use for their sand scene. In the author's own practical experience, it has been found that children of eight years and younger often tend to try to pack in as many miniature toys as possible in the sand tray. It helps if the therapist at the start tells children to choose for instance ten models to make a sand scene. If children indicate that they still need something, they may be allowed to add another model. Toys can be placed on shelves in containers, for instance baskets, or be arranged on a large table.

According to Allan and Berry (1993) and Oaklander (1988) the categories for selecting toys for the sand tray include:

- people – household, military and mythological, for instance defence force men, 'Batman', Snow White and the seven dwarfs, a monster and a witch
- buildings – for example, houses, schools, churches and castles
- animals – tame, wild and prehistoric animals, birds, snakes and sharks
- means of transport – for instance, cars, trucks, boats, motorcycles, trains, helicopters, an ambulance and war vehicles
- plants – for example, trees, plants and vegetables
- structures – for example, bridges, fences, gates, furniture, blocks, stop signs, flags and Lego blocks
- natural objects – for example, shells, stones, bones and eggs
- symbolic objects – for example, a wishing well or treasure chest.

SAND PLAY AS PROJECTIVE TECHNIQUE

The process of sand play is as follows: the play therapist invites the child to play with sand and to choose the miniature toy he or she wants to play with in the sand. Children are invited to create a picture in the sand tray. They are also told that the sand scene does not have to make sense and that they can create anything they feel like (Allan and Berry 1993; Oaklander 1988, 1999). Children can also be asked to build a picture around a specific theme, such as 'a scene depicting the divorce between your parents' or 'the children teasing you at school'. The therapist can play music to the child and ask the child to build anything the music makes him or her think of.

Younger children usually start to play something like war in the sand tray, while older children work out the scene more purposefully and the items with which they play are chosen with great care. The therapist talks as little as possible while the child creates his or her scene in the sand tray and interrupts the process only when the child is asking for help to find an object. A record can be kept by making a quick sketch of the sand scene or by taking a photo of each scene (Allan and Berry 1993; Oaklander 1988, 1997; West 1992).

From the gestalt play theoretical perspective, sand play can be dealt with in the same way as a drawing. The child is asked to describe the scene, to tell a story about it or to say what happens. Most children look at the finished sand scene and try to find sense in it. This represents an important step in respect of the gestalt objective of integration. The child can be asked to

identify with different objects or to carry on a dialogue between objects. One can sometimes look at the scene as a whole and communicate a general idea about it to the child, for instance: 'You struggle to choose between the figures. Do you also experience problems in your everyday life in deciding about things?'

The therapist can pay attention to the following aspects during the use of sand play as projective technique (Oaklander 1999):

- The child's process
  - What is the child's level of energy?
  - Does he or she often alter his or her decision?
  - Does he or she have everything he or she will need around him or her, although these items are available on the shelves?
  - Does he or she use only a few or many objects?
  - Does he or she spend a lot of time feeling the sand?
  - Does he or she use lots of water?
- General picture of the sand tray
  - Is it organized?
  - Is it organized compulsively?
  - Is it chaotic?
  - Is there any organization whatsoever?
  - Is it an angry scene or a peaceful scene?
- Symbolic level
  - Is it organized?
  - What symbolism appears? (Guard against interpretation.)
- The field
  - What is the general picture of the sand scene?
- Level of significance
  - What meaning does the child attach to different aspects in the sand scene?
  - How does the child describe different aspects?
- Depicting different objects, for instance:

    - ‘Be the lion and tell me about yourself.’
    - The therapist can ask the lion questions such as: ‘Where are you? What would you like to do?’
- Dialogue
    - The child becomes involved in dialogue between two objects: ‘What does the lion say to the tiger?’
- Taking into possession
    - Does any aspect remind the child of something in his or her life, for example: ‘Do you also sometimes feel like hiding away like the tiger?’
- Change of scene by moving objects
    - The child can get consent to wage war for instance in the sand tray or remove or shift a character.
- Getting the existential message
    - ‘What does this scene tell you about yourself and your life?’ (Younger children often find it difficult to think in an abstract way and it is then more meaningful if the therapist makes a statement about this and verifies it with the child.)

These aspects correspond with the way in which the child’s projection should be handled from a gestalt play therapeutic perspective, namely the initial focus on the symbolic level, then on the personal level, as well as with Oaklander’s steps for handling drawings, as already discussed. However, there are specific aspects that distinguish sand play from projective techniques such as drawing or painting: the child is allowed to change the scene. He or she can add and remove certain characters, or execute an action such as waging war in the sand tray. This aspect contributes to children owning their emotions to a greater extent than when they make a drawing. Sand play then serves as an effective aid in completing unfinished business. The sand-tray models can also be moved around, which contributes to experiences of control, which in turn promotes children’s sense of self. It has been experienced on numerous occasions how certain children make use of sand play for a number of consecutive weeks, where they will create and play out the same sand scene over and over, without owning their projections.

A child, aged five, whose father died in a car accident, played out this accident every week, up to where the cars crashed and the injured people were brought to the hospital. After a few weeks he said that the father had died and created a funeral in the sand scene. Although asked, he was never ready to own these projections and would break contact if the therapist asked something such as: 'Do you also feel like this child, because of your father's death?' Then, after about ten weeks, one day he started creating the same sand scene. After putting the cars and people in the sand tray, he looked at the therapist, saying: 'I'm finished with this', then took all the models out and asked to play something else. The mother reported that the child's behaviour of bed-wetting and separation anxiety had stopped, although he never once owned his projection.

4.2.2.3 Clay modelling

Clay as a medium can be used effectively during all stages of the gestalt play therapy process. Clay modelling can be used as a medium for sensory contact-making with respect to the function of touch. It can also be used as projective technique during the emotional expression phase, as it gives children the opportunity to project their emotions on a symbolic level. At the same time, it promotes their experience of mastery, as there are no specific rules for using clay. This in turn promotes children's sense of self. Clay play has advantages for the children's skills regarding self-awareness and emotional control, as they can project and own their emotions, while the clay can also be used to air emotions such as anger. It has been found that even adolescents like to make use of throwing clay as a handling strategy for their frustration.

The advantages of clay play during the gestalt play therapy process can be summarized as follows (Blom 2000; Oaklander 1988; Schoeman 1996d; Webb 1991; West 1992):

- It is flexible and soft and can be used by children of all ages.
- It provides kinaesthetic and sensory stimulation, which in turn promotes the child's emotional expression.
- Aggressive children can use it to air their aggression in various ways, such as to throw or beat the clay.

- It provides children with a sense of mastery, in that they can bend the clay and shape it as they wish. There are no specific rules for using it.
- It affords an opportunity for the therapist to observe the child's process.
- The therapist can see what is happening with the child by observing how he or she works with the clay.
- It serves as a bridge for verbal expression, especially for children who have difficulty talking.
- It affords the child the opportunity for symbolic and three-dimensional depiction.

USING CLAY MODELLING AS PROJECTIVE TECHNIQUE

Clay can be used in many different ways during the phase of emotional expression. Clay tools such as a rubber hammer, cheese cutter and so forth can be supplied to the child with the clay. Oaklander (1988, pp.69–70) suggests the following exercise to provide children with experiences with clay:

> Shut your eyes and become aware of the feeling of clay in your hands. Breathe in deeply twice. Now follow the instructions. Feel the clay as it is now. Is it smooth? Coarse? Hard? Soft? Bumpy? Cold? Warm? Wet? Dry? Pick it up and hold it. Is it light? Heavy?… Now I would like you to put it down and pinch it. Use both hands. Press it slowly…now faster, pinch small and large pieces. Do it for a while…press the clay…now make it smooth. Use your thumbs, fingers, palms, back of your hands. When it is smooth, feel the places you made smooth. Does it bunch together in a ball?… Slap it… When it is flat, bunch it again and slap it again. Try with the other hand… Bunch it up and flatten it…beat it…slap it… Feel the smooth place which you made when you beat it. Bunch it up. Tear it. Tear small pieces and large pieces… Bunch it up. Pick it up and throw it down. Do it again. Do it harder. Make a hard noise with it. Do not be afraid to hit hard. Bunch it up again… Stick it with your fingers. Take a finger and bore a hole in the clay… Bore more holes. Bore one right through to the other side. Feel the sides of the hole you made… Bunch it up and try to make lines and small holes with your fingers and finger nails and feel those things you made… Try your knuckles, the lower part of your hand, the palm – different parts of your hand. See what you can make. You can even try your elbows… Now tear a piece and make a snake. It becomes thinner

> and longer as you roll it. Turn it around your other hand or a finger. Now take a piece and roll it between the palms of your hands and make a small ball… Bunch it up again. Place both your hands in your piece of clay. Now you know it reasonably well.

After doing this exercise, children's experiences are discussed with them. Ask them questions to find out what they liked the most and the least, as well as the reasons for this. Children can also be asked to repeat the action which they liked the most. They can tell the therapist what the action makes them think of. This activity promotes children's sensory contact-making, while addressing their sense of self, in that they must make a self-statement about that which they liked and disliked. This discussion can also contribute to emotional contact-making in that it can bring children into contact with previous similar pleasant or unpleasant experiences.

Another way in which clay can be used is by asking children to shut their eyes and to make something with the clay, while they move only their fingers. It can be a shape or whatever enters the child's mind at that moment. They are given approximately three minutes to complete this exercise.

Younger children prefer to work with their eyes open. Examples of other assignments that can be given to the child when playing with clay (Oaklander 1988):

- Make your family in the shape of objects, symbols or animals.
- Make your ideal family with clay.
- Keep your eyes shut and make a picture of yourself when you were younger.

According to Schoeman (1995), the child's model can be dealt with in the following ways:

- Give the model a name.
- Identify its traits, characteristics and emotions.
- Personify like in your life – in other words, how does this fit in with your life?
- Obtain balance (how will I change, adapt, redress it?).
- Find self-maintenance (nurturing, safe place).

These steps correspond in principle with the steps suggested by Oaklander for handling projections. If these steps are used with younger children, they will need to be put concretely to them in order to relate to their level of

development. For example, the therapist may ask the following questions: 'Tell me about yourself', 'What do you look like?', 'How do you feel today?' and 'What are you doing?' The child will also be helped to personify it by making suggestions to him or her such as 'Do you also sometimes feel lonely?' and then a relevant handling strategy and self-nurturing can be sought, for example: 'What can you do when you feel so lonely?', 'What can you do for yourself everyday/today that is nice?'

Sometimes clay is used as the only medium for projection during a session and sometimes clay is used as part of a session, together with another medium, such as a drawing or sand play, to help children to come into contact with certain emotions, or to express their feelings (see Figure 4.4). A child may for example make a drawing and, while working through that, the therapist may realize that this child has a lot of unexpressed anger towards his or her father. The therapist can then provide the child with some clay and ask him or her to build his or her father. After this the therapist can help the child to talk to his or her father clay figure and to tell him how he makes him or her feel. Children also experience some catharsis if they can destroy the clay model afterwards, although they know that they cannot destroy the person in real life. Therapists can ask children to use clay to build a person that can support them through this difficult time and to talk to that figure as well, telling the figure what they need.

4.2.2.4 Using the processing of dreams during gestalt play therapy

Dreams can be regarded as examples of the child's secondary world, as they often contain aspects that can exist only in fantasies. They can thus be considered a form of fantasy and a form of projection (Schoeman 1996a,1996c). From the gestalt theory perspective, dreams are also considered the most spontaneous expression of the human being. Each part of a dream is considered an unintegrated and unfinished part of the personality. Dreams are not interpreted by the gestalt therapist but children are helped to experience them in the here and now, in order to integrate fragmented parts (Aronstam 1989; Phares 1984; Thompson and Rudolph 1996; Yontef 1993). Children often resist telling their dreams, as those dreams they remember usually make them afraid. However, dreams have various functions in the life of the child. They can express the child's anxiety or worries. They can also serve as symbols of emotions which the child is incapable of expressing, or be an indication of wishes, needs or fantasies which the child experiences (Oaklander 1988).

Figure 4.4 Picture of a child using a wooden hammer to beat clay during a gestalt play therapy session

The processing of dreams can be done during gestalt play therapy with children as young as six years old. Oaklander (1988) deals with this in children by using the following steps:

- Ask the child to tell the dream in the present.
- Ask the child to play out the different parts of the dream. The child must thus talk on behalf of each object in the dream (Yontef 1993).
- Ask the child to suggest another ending to the dream.
- Ask the child what message the dream can have.

Children can be given a notebook in which they can write down their dreams between sessions. During the processing of dreams the therapist can also focus on missing parts, polarities, contact points or aspects that prevent contact, wishes and aspects that are avoided. Fantasies and daydreams can be dealt with in the same manner as dreams (Oaklander 1988).

Children's dreams can express an unfinished business or fragmented aspect in themselves. The suggested steps assist children to project these fragmented aspects in themselves and own them and thereby also express and complete unfinished emotions. This technique also promotes children's

self-awareness. Children often have frightening nightmares after a traumatic experience, for example after their parents die in a car accident.

A child, aged 13, who saw her father shoot himself, repeatedly dreamed of where he sat in his chair, took the revolver and shot himself, where the dream ended, and she was terribly scared. She was asked to draw the dream (see Figure 4.5, p.146) and to tell it in the present. She was then guided to be every part in the dream. When asked to suggest another end for the dream, she said she wanted the dream to end where her father was in heaven and she had a new father, her stepfather.

After suggesting another end for the dream, she wrote the following letter to her father: 'Daddy, I am so sad that you have shot yourself, but I forgive you. I know you are in heaven now. I am also happy again, because I have a new stepfather. I choose to forget how you have shot yourself. I choose not to dream about it any more. I want to remember the nice things that we have done together, like when you bought me a doll.' These steps helped her not only to complete her unfinished emotions concerning her father's suicide, but also to integrate the polarity of loving her father, but also loving her stepfather. The following week she was excited when she told the author that her nightmare had stopped.

Sometimes, children need to project the different fragmented parts in themselves many times before integration takes place and they stop having these nightmares. Most often the processing of dreams during the gestalt play therapy process helps children to express and own unfinished business and to develop new handling strategies for emotions such as fear and anger.

4.2.2.5 Empty chair technique

The empty chair technique was developed by Perls as a means of bringing the client to greater awareness during therapy. It also brings unfinished business to the present and helps to handle polarities within the self. Children can complete an unfinished gestalt in their life if they talk in the empty chair with a person with whom they have the unfinished business, rather than to talk about the person with the therapist (Oaklander 1988).

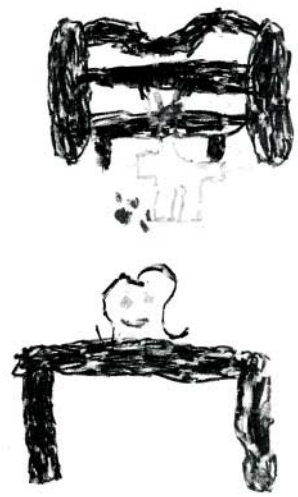

Figure 4.5 Child's drawing of a dream where her father sat on a chair and committed suicide

There are many variations to using the empty chair technique during therapy with the child. It can be used to solve conflict between children or in the child him- or herself. The child can for instance place a person who is not present in the empty chair. Aspects of the self can, however, also be placed in the empty chair. A child could for instance place his or her shy part in the chair and talk with it. By means of this projective technique, integration of polarities can take place. It can also be used to help children to become aware of their behaviour in a specific situation, to solve conflict, to take responsibility for their own behaviour and to find possible solutions to problems. The child can for example tell his or her teacher in the empty chair that the teacher is unfair, whereupon the child switches chairs to react as the teacher – in other words, a projection is played out by the child of what the other person says or does in reaction. The empty chair technique can be used in the same way with younger children, in order to assist them to play out conflict situations in a symbolic manner and to obtain handling strategies for them. Another variation of the technique is that a hypothetical child is placed in the empty chair with problems similar to those of the child. The child can experience it as less threatening to discuss the emotions and behaviour of the child in the empty chair, rather than to explore his or her own emotions or behaviour (Oaklander 1988; Thompson and Rudolph 1996).

According to Schoeman (1996b), the empty chair technique consists of three stages. During the first stage, the conflict is brought to the consciousness. The aim of the first stage is to bring the polarity to the child's consciousness by enabling him or her to take responsibility for both sides. The child must be helped to own his or her projection by for instance talking with his or her parent in the empty chair, but also answering on behalf of the parent. During the second stage the two sides confront each other and the conflict is intensified. There are three aspects, namely intense conflict, dialogue and the solution of the conflict. Once the conflict has been worked through fully, the conflict is solved during the third stage.

The empty chair technique promotes children's self-awareness in respect of emotions in that, by means of dialogue with the empty chair, they can come into contact with unfinished emotions. However, it also helps children to integrate polarities, which promote the gestalt objective of integration as they are forced to reply on behalf of the person in the empty chair. Handling the conflict by means of this technique also positively influences the children's emotional management, as it gives them the opportunity to consider various options for solving problems and handling their emotions.

In the author's own practical experience it has been found that this technique can also be used positively with younger children. In relation to their cognitive development, the person with whom they have to talk can be drawn or modelled with clay and then placed in the empty chair to make the process more concrete. Sometimes children also need help to decide what they want to say to the person in the empty chair. They can be helped by asking them at first to repeat the words after the therapist, for example: 'You make me angry and scare me when you shout at me like this.' The therapist can then encourage the child to say the words several times in order to express his or her unexpressed emotions and to come into contact with them. However, sometimes children are not ready to express their emotions towards someone in the empty chair, or feel too shy to do so in the presence of the therapist. If the therapist then insists that the child must talk to the person in the empty chair, the child's words can become just a mere repetition of words and not an expression of emotions with which he or she is in contact.

4.3 CONCLUSION

During the stage of emotional expression, the focus is first on the expression of aggressive energy, which refers to energy required to take action and to express emotions. The expression of aggressive energy serves as a prerequisite

for healthy emotional expression. The expression of aggressive energy must take place in a spirit of fun and playfulness, but also in an atmosphere of safety. The therapist should be actively involved in this. Beating cushions and holding a clay-throwing competition are examples of activities that can be used.

After coming into contact with aggressive energy, the focus is on a cognitive conversation about emotions, such as what emotions are and the link between emotions and the body's reaction thereto. Different techniques and activities can guide children to talk about emotions, before projective techniques are used to own and express their emotions, and obtain handling strategies for these. Examples include making a collage of people in magazines that experience different emotions, making feelings masks or depicting different emotions by means of clay. Emotions can also be linked to colours in order to convey them more concretely to the child.

Projective techniques can be used as a forum for expressing emotions, as children do not always move automatically from the verbalizing of emotions to the expression thereof. These techniques facilitate children's awareness in the present, promote self-growth because they help children to make self-statements and help children to complete unfinished business in their lives. The following steps can be used in respect of projective techniques: children are helped first to enter the metaphor or projection and own it on a symbolic level before moving to the reality level where they are guided to find a link between their projection and that which they experience in their life. Children are therefore helped during the phase of emotional expression by means of various play therapy techniques to project emotions, to learn handling strategies for these and to make choices for expressing these.

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Chapter 5

Self-nurturing, Addressing the Inappropriate Process and Termination

When children use their contact skills more appropriately, have a stronger sense of self and have had numerous opportunities to express their unfinished emotions through different projective techniques, they become ready for the last part of the therapeutic process, where they have to learn to become nurturing towards themselves, before termination can take place. The last three phases of the gestalt play therapy process, namely self-nurturing, addressing the child's inappropriate process and termination, are discussed in this chapter. The focus is further on activities and techniques that can be applied during each of these phases.

5.1 SELF-NURTURING

Children blame themselves for the trauma in their life, despite the amount of support they receive from their therapist or parents. Although the trauma that they are exposed to is not their fault, it often seems to become an introject in their life. Children younger than eight years are egocentric and therefore they do not have the skills to understand that they are not responsible for the bad things that happen to them. The emotions they experience when blaming themselves can contribute to fragmentation of the self.

During therapy, children often experience polarity: one part of themselves is self-supportive whereas the other part is still experiencing anxiety. It is important that children are helped to use the supportive part in themselves in order to handle the detrimental part. Self-nurturing means that children learn to accept those parts of themselves which they hate in order to achieve integration – in other words, to accept and nurture themselves (Oaklander 1994b, 1997). They must learn to nurture themselves in order to maintain their control. They must be able to forgive themselves and be aware of the polarities in their life, both the bad and the good. They must accept the

self-nurturing parts of themselves in order to experience integration of the self (Schoeman 1996b). Self-nurturing helps children to integrate polarities within themselves, to accept and nurture that part in themselves which they blame for the trauma, and to forgive themselves. Another aspect that must be addressed during this stage is that children must acquire skills to treat themselves well, as they often think that it is selfish to be good to themselves. They thus expect others to treat them well and feel disappointed when this is not the case.

The first part of the self-nurturing process is as follows: children must come into contact with those aspects of themselves which they hate, in order to understand the function thereof. These are often introjects from their earlier childhood years. In practice, it is often found that children received a message that they are for example naughty or selfish, which they then carry as an introject with them.

> A boy, aged eight, who was bullying and fighting all the time, as well as opposing his parents' authority, told the author during self-nurturing work that he was naughty because he had accidentally broken a window when he was five years old. His parents told him that he was very naughty and also gave him a hiding. He told the therapist that since then a naughty monster was inside him, telling him to be naughty and to hit his brother. The child was helped to own this monster, in order to get control over it and to learn how to nurture himself.

Children often identify themselves in totality with that negative part, which then leads to fragmentation. When children achieve insight into the fact that this represents only a part of themselves, they acquire new control. This aspect is then enlarged and taken into possession by means of various play therapy techniques and often represents children's younger selves. This is followed by helping children to find a nurturing part in themselves in order to nurture the part they hate (Oaklander 1994b, 1997).

Children must be taught during the self-nurturing phase that it is not wrong to be good to themselves. They must also be helped to own and experience the aspects within themselves that they do not accept and thereafter to find other aspects within themselves that can nurture this polarity.

5.1.1 Techniques for self-nurturing

The process of self-nurturing consists of three stages during which different projective techniques can be used. The first stage, where children must come into contact with their introjects or the part of themselves which they find unacceptable, can be reached by means of projective techniques such as drawing, clay modelling and metaphors (Oaklander 1994b, 1999). Practical experience, however, has indicated that a projective technique (the monster technique) described by Schoeman (1996c), is most suited for this. The technique works as follows.

Ask the child to identify a monster in his or her life. Pictures of a monster can also be shown to the child so that he or she forms an idea of how a monster can look. Younger children can be requested to draw the monster or to model it out of clay so that they can project it more concretely according to their level of development. A discussion focuses on the following:

- For how long has the monster existed?
- Do other people know about the monster?
- Is there anything about the monster that makes you afraid?
- Would you like to have the monster in your life?
- Can you give the monster a name?
- How old were you when the monster came into your life?
- Ask the child to place the monster in the empty chair and to talk with it.

Children can be asked to model their younger self out of clay, namely a clay model of themselves at the age when the monster came into their life. The therapist can then move to the second stage of self-nurturing, where children are helped to nurture the part they find unacceptable. It can be explained to them that they must imagine that they can move back in a time machine to that specific age. They must be assisted to nurture their younger self, as the introject according to which they started blaming themselves for the trauma in their life. In order to assist younger children with this, the therapist can initially talk with their younger self and nurture them by means of a puppet that represents a good fairy. Children can then be encouraged to repeat the words after the therapist and can be asked how it feels to say those words for themselves.

When they accomplish nurturing their younger self, the third stage can begin where they are given homework – they must find an object such as a

teddy bear or a pillow at home which can represent their younger self and with which they can repeat each evening the self-nurturing process as discussed above. Another aspect that can be addressed is that a list of nice things, which children can do for themselves, is made with them. Children are then encouraged to do one of these activities each day and to tell the therapist about it (Oaklander 1994a, 1994b, 1999). Children can also be helped to become self-nurturing by making a self-nurturing collage, with pictures of nice things they can do for themselves every day.

The stage of self-nurturing, described by Oaklander (1994a, 1994b), is a method she follows on the basis of intuition and it cannot necessarily be accounted for theoretically from a specific model. In the author's own practical experience it has however been found that this aspect forms an essential part of the therapeutic process, despite the child's age. Even children as young as five years old can also be helped in a concrete manner to nurture themselves during this stage. Children who succeed during this stage in freeing themselves from blaming themselves for events in their lives will also find it easier to nurture others in their life and to forgive themselves and others.

A child aged seven was brought for gestalt play therapy because of aggressive behaviour towards himself and others. He was placed in foster care at the age of 21 months. During the gestalt play therapy process, he projected a lot of aggression, but was seldom ready to own his projections. Because of poor health, he was hospitalized a lot and most of his projections centred on the doctors and medication. When reaching the self-nurturing process, he was asked to think of a monster in his life and to draw it. Figure 5.1 depicts his monster.

The questions when doing this monster work were handled with him and he said that the monster came into his life when he was still a baby. He could not say what happened, but spontaneously took some clay to build the monster, whereafter it was destroyed, while he shouted how he hated it. He was then asked to build himself with clay when he was still a baby. He built a baby, but quickly told the therapist that this was not his younger self, it was a 'Tarzan' baby. (Tarzan was on his foreground, because of watching a video about it the previous evening.) The author realized that 'Tarzan' baby was also not raised by his parents and therefore asked the child if Tarzan baby thought he had done something wrong and therefore he could not stay with his

parents. He confirmed it. He was then asked whether he also had parents other than the ones with whom he was staying. He confirmed it and said their names. This was the first time during the therapeutic process that he said anything about his foster care. The author then built his younger self with clay and asked him whether he felt he had done something wrong and that he was not good enough to stay with his biological parents. He confirmed it and, because of owning this introject, integration could take place and he could be helped to nurture his younger self (Blom 2000).

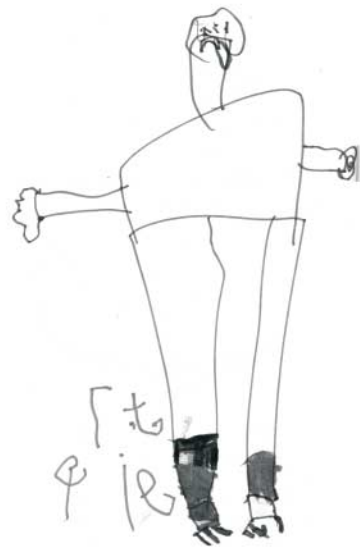

Figure 5.1 Monster drawing ('Tarzan')

Another child, aged eight, who was brought to therapy because of his poor sense of self, started drawing his monster. After a while, he said that the monster was not good enough and that he wanted to start over. He was assured that the monster did not have to be perfect and that it did not matter how it looked. He still insisted on starting over. He drew a new monster and after a while he started crying, complaining that this monster was not OK.

The therapist then asked whether they could call the monster: 'I am not good enough' and he said yes. Working through the steps of the self-nurturing process, it was clear that he was feeling that he was not good enough. Again it was the first time during the two-and-a-half months of therapy that he was ready to own that introject, in order to find a stronger part in himself to nurture it (Blom 2000). Figure 5.2 illustrates this monster drawing.

Figure 5.2 Monster drawing ('I am not good enough')

It is important to take note of the fact that children must have a certain amount of inner strength before they are ready to move to this self-nurturing process. Therapists sometimes move too quickly to this. What happens then is that children are not ready to become aware of and own these introjects in their life. Often it has been experienced how children reveal 'new' facts during this stage, although they have gone through the stage of emotional expression and had numerous opportunities to project their emotions. When they are ready to nurture themselves, they experience it as a great relief and can move on to the explosive layer of neurosis.

5.2 ADDRESSING THE PERSISTENT INAPPROPRIATE PROCESS

Children's symptomatic behaviour, which is often the reason for their reporting for therapy, normally no longer manifests when working through the various aspects of the therapeutic process. In the light of the fact that gestalt therapy is a process-oriented therapy rather than a contents-based therapy, the focus is not on children's symptomatic behaviour during the therapeutic process. The primary focus is helping children to become aware of their process and not changing their behaviour by means of problem solving, rewards and other types of interventions.

However, there are a few cases where children's inappropriate way of satisfying their needs occurs, although they have gone through the experiences of contact-making, strengthening the self, emotional expression and self-nurturing. The focus of the play therapist during this stage is to help these children to experience themselves to the full within their process. Activities and experiments are then aimed at enhancing their awareness of their behaviour, such as letting children focus on their shame and withdrawal behaviour by means of play therapy techniques, as well as handling strategies for this in their daily life (Oaklander 1994b, 1997).

Children must thus learn that they can make choices in respect of how they handle situations in their life, but also that they must accept responsibility for the choices they make. The therapist must also assist children to experiment with new behaviour, rather than to maintain old behaviour. They thus have the opportunity within the play therapy set-up to start experimenting with new behaviour (Oaklander 1988; Thompson and Rudolph 1996).

Focusing on children's inappropriate process (by directly focusing on symptomatic behaviour) takes place only if they have moved through all other stages of the therapeutic process and this behaviour is still manifested. In accordance with the gestalt philosophy, the emphasis is then on enhancing children's awareness of their own process, so that they can take responsibility for this and start experimenting with new behaviour. The aspects that are addressed during the stage of emotional expression often also address children's symptomatic behaviour, as they learn more relevant ways to express suppressed emotions. This stage often forms an entity with the stage of emotional expression.

5.2.1 Techniques for addressing children's inappropriate process

As already stated, this stage is seldom necessary, as children's inappropriate behaviour often disappears when they learn healthier ways of satisfying

their needs. The author has, however, found that techniques that work well during this part of the therapeutic process are story-telling by making use of metaphors, puppets and puppet theatre. These techniques will be outlined here. However, it must be stressed that these can be used during all the other phases of the gestalt play therapeutic process.

5.2.1.1 Stories

Oaklander (1988), Smith (1982), Stutterheim and Kroon (1991) and van der Merwe (1996a) consider children's stories as a bibliotherapeutic technique that can be used in various ways with the child during therapy. It can be an existing story, a story created by the therapist, a story created by both the child and the therapist, a story told by means of puppets, clay figures made to depict the characters in the story or letters written on behalf of one or more characters in the story. According to Shapiro (1997), the technique of story-telling is especially effective for children between the ages of three and five years. This discussion focuses only on the use of stories created by the therapist or child and not on existing stories, as existing stories with a specific topic are not always available during therapy, whereas the therapist can write a story for the child on any topic.

ADVANTAGES OF USING STORIES

The use of stories has various advantages during gestalt play therapy, as it links effectively to the children's living world. This projective technique can be used effectively to improve children's awareness. By identifying with the story, children can be made more aware of their emotions. Effective handling strategies for emotions in the self and others can be included in the handling strategy in the story. If children can identify with this, it will promote their emotional competence in this respect.

According to Pardeck and Pardeck (1987), Shapiro (1997, pp.90–91), Smith (1982), Thompson and Rudolph (1996) and van der Merwe (1996a), using stories has the following advantages during therapy with children:

- Stories link spontaneously with the living world of children and with their emotions.
- They give the opportunity for emotional offloading and give children a symbolic world within which they can own and evaluate situations, circumstances, wishes, thoughts and emotions. They create indirect channels whereby children can project that which is threatening for them.

- Children can identify with models in children's stories whereby they can learn positive behaviour. This gives the opportunity for alternative handling strategies in that they can see how others handle emotions.
- They give children new insight into possible solutions for their problems.
- They can prevent the aggravation of a problematic aspect in children's lives, for example uncontrolled aggressive behaviour.
- They can initiate discussion on a subject.
- They reduce the experience of isolation in that children realize that others have similar problems.
- They help children to own emotions for which they were not otherwise ready.

STAGES IN USING STORIES

Different stages are identified when using stories (Shapiro 1997; Smith 1982; van der Merwe 1996a):

- Generalization – children realize that other people experience the same situations as they do and this can contribute to their feeling less lonely and less overwhelmed by their situation.
- Identification – the process whereby children identify and associate with the characters. This can lead to projection and modelling. By means of projection, children are like one of the characters, usually the main character in the story, while they compare themselves through modelling with a character in the story.
- Projection – children unconsciously displace certain unfinished and unacceptable contents of their inner world to the characters in the story. This projection serves as a defence mechanism and enables them to transfer their own unfinished experiences onto the character. Projection will occur when children experience the similarities between their world and that of the character and when they can make an emotional link between their experience and that of the character.
- Modelling – a process whereby children perceive a model and learn and copy the specific behaviour of the model. The effective

functioning of the model and regular successful practice and repetition of learnt behaviour could promote modelling which has specific value for them.

- Catharsis – the processes of projection and modelling give children the opportunity for catharsis whereby they can offload their emotions, wishes, desires and so forth via the story's characters. By means of projection thereof onto the characters in the story, children are given the opportunity to examine and experience their own emotions at a safe distance.
- Self-insight – implies that children can develop conscious knowledge that there are similarities between their living world and that of the models. This insight figures especially if children admit the similarities by saying, for example: 'My father is also dead like the bear's father in the story'. When children have come to self-insight, they are also more prepared to own and analyse their own emotions, thoughts, wishes and needs.

The stages when using stories with children focus on giving children the opportunity to project their emotions, in that they have the opportunity to identify with the main character's emotions in the story, while insight into their own situation and that of others can be promoted simultaneously. They also gain the opportunity to offload their emotions. Another important aspect is the fact that, by means of the modelling of the characters in the story, children learn handling strategies for the future handling of their own emotions.

REQUIREMENTS WHICH STORIES MUST MEET

Stories must also meet specific requirements in order to promote the processes of identification, projection, modelling, catharsis and self-insight in the child. Smith (1982) indicates the following requirements:

- It must link to the living world of children, as well as to their stage of life, although the living world of children and of the character need not be identical.
- It must link to the emotions children experience: when a child is sad about a parent's death, the character in the story must also experience this emotion.
- There must be a distinct main character with whom children can identify.

- There must be other characters in action in situations that correspond with the children's situation, for example a dog that is scared of the large dogs that tease him or her.
- It must present a model of a healthy processing process to children by means of the characters in the story. The characters must thus be able to offload their emotions, seek causes of behaviour, obtain intellectual and emotional insight, recognize their own potential and abilities, use healthy handling strategies and have definite life objectives.
- The story must have a model that makes use of healthy and effective handling strategies. On the basis of the action of the main and other characters, children must be given an example of the ways in which situations can be handled.
- The character that models the handling strategy must function in a healthy way on various levels, psychologically and socially.
- The story must end with a reassuring conclusion. The main character must be optimistic although it should never offer children false reassurance.

The stages when using stories, as well as the requirements that stories must meet, are aimed at promoting children's projection of emotions – in other words, at promoting their self-awareness. In order to obtain this projection, it is important that the story links in such a way to children's living world so that they can identify with it. The fact that children by means of the story can realize that others experience similar problems gives them further consent to experience the emotions, especially where they are restrained from this by means of introjects. The requirements with respect to the handling strategies, which must be modelled by the characters, contribute to children's obtaining more effective strategies for handling their own emotions. Deficient empathic skills are also addressed in this way in that the characters can model effective skills in this respect to children.

MUTUAL STORY-TELLING TECHNIQUE

Another way in which story-telling can be used during therapy is the 'mutual story-telling technique' initially designed by Gardner (1983). The child tells the therapist a story, whereupon the therapist then tells the child his or her own story, using the same characters as in the child's story, but a better solution for the problem is presented. As the child's story is a projection, it

should reflect an aspect of the child's life situation. In order to motivate children to tell a story, the therapist can tell them that they must imagine that they are the guests of honour of a television programme, where original stories are told. The therapist is the presenter of the programme and puts children at ease by asking them a few general questions. Children then tell their story as well as the lesson to be learnt from the story (Oaklander 1988; Smith 1982; Thompson and Rudolph 1996; van der Merwe 1996a). According to Oaklander (1988), the use of a video camera or the making of a cassette of the story can contribute to the effectiveness of the technique. When this technique is used, it is important to have information on children's life situation in order to understand the main theme in their story. According to Smith (1982), it is important that the story, which the therapist creates on the basis of the child, must have the same characters in the same situation as that of the child, in order to promote the child's identification with it. However, handling strategies, the processing process, the general functioning of the characters and the end must differ. The use of the mutual story-telling technique offers children the opportunity to project unfinished aspects of their foreground on the story. As the therapist repeats the story, children obtain more effective handling strategies for their situation or emotions.

Stories can be used effectively to promote the child's empathic understanding. According to Schilling (1996), a story can be read to the child, whereupon specific questions can be asked in respect of the main character's emotions and handling strategies in the story. The technique can for example be applied in the following way:

> I will tell you a story. I would like you to think of solutions for the problem which the character experiences in the story. Once we have discussed the story, I will ask you to write another ending to the story by drawing a picture.
>
> This is the story: James is going to school today for the first time. He has never been to school before and starts running around in the class making noises. When the teacher asks him to sit quietly, he does not understand what the teacher means and he continues to make strange noises. The other children start laughing and making noises. The teacher then punishes the children and mentions that they must remain in the class for five minutes during break to discuss their behaviour. During the discussion the teacher explains that James does not understand their language and has never learnt how to act in the class. She asks the children to help him to adjust.

Questions that may be asked of the child:

- How do you think James felt being a new boy in the class?
- How do you think James felt not being able to understand what someone said?
- What can you do to help James?

Using stories in this way gives children the opportunity to place themselves in the shoes of one or more of the characters in the story – in other words, to promote their empathic understanding of others and to focus on skills for handling emotions in others.

USING STORIES IN COMBINATION WITH PUPPETS

As mentioned, stories can be used during gestalt play therapy to children in combination with other techniques and media such as puppets. In a research study with children in their middle childhood years, Venter (1998) found that stories enhance the child's emotional awareness, while the puppet serves as a projection medium on which the child can project his or her level of emotional awareness. Puppets convey the story to the child in a more concrete manner, which positively links to younger children's level of cognitive development.

5.2.1.2 Puppets and puppet-shows

Symbolic play such as play using puppets is considered a natural activity for the child aged between 6 and 12 years old, as it links to the child's fantasy life at that age. It can also be used with great success with pre-school children. The use of puppets and a puppet-show as projective techniques during gestalt play therapy has a number of advantages for children. One of the most important advantages is that it helps children to feel more at ease, as they can communicate in a more non-threatening manner by means of the puppets. In the author's own experience, it has been found that shy and introvert children often forget that they are actually talking. This promotes their awareness, as they first project their emotions onto the puppet and then take it into possession. Children also experience that they are in control when they are presenting a puppet-show. This contributes to strengthening their sense of self. Handling strategies for emotions that are modelled by means of puppet play and a puppet-show promote children's skills in respect of managing emotions in themselves and others, when they identify with this.

The advantages of this form of play can be summarized as follows (Axline 1994; Irwin 1983, 1991, 1993; Oaklander 1988; van der Merwe 1996b, p.133; Webb 1991):

- Children learn strategies for handling emotions and often use fantasy or fantasy-oriented activities such as a puppet-show to express their emotions.
- Puppets can be considered one of the most valuable aids to obtaining a multidimensional picture of the personality and process of children by means of their play.
- The fact that the puppet can be manipulated so easily, together with the rich symbolic value of the story, which is acted out spontaneously, leads many therapists to use puppets during therapy with children, groups and families.
- Puppets and a puppet-show also help children to feel at ease, as they take the focus away from children and serve as a protective screen, behind which children can temporarily escape. The latter gives children the opportunity to play out forbidden actions, while the puppet must take responsibility for this. The therapist gains the opportunity to penetrate the children's world in a non-threatening manner.
- Shy and introvert children focus on the puppet rather than on their own action.
- As the puppet encourages emotional offloading, it provides a variety of socially acceptable ways to offload tension-related emotions. Shy children can thus express themselves better by means of the puppet and have the opportunity to build up their self-esteem to a point where they can be more objective with respect to their problems.

A wide range and choice of puppets within specific categories must be available in order to obtain information on the child's ideas and emotions (Irwin 1983, 1991, 1993; Oaklander 1988; West 1992). Therapists must have puppets representing polarities such as the good and the bad. They must have sufficient puppets in order to offer children a choice during gestalt play therapy. It is, however, not always possible to have puppets in all these categories. Most of the time, children are able to adapt by making use of another puppet, which more or less fits the theme, or by playing it as a puppet they need.

The following categories of puppets can be used during therapy with the child:

- puppets that depict various emotions, for instance aggression, happiness and anxiety
- a variety of family puppets such as a man, a woman, a boy and a girl, a grandfather and grandmother
- puppets for fantasy, for example a witch, a good fairy and a sorcerer
- royal puppets, for example a king, a queen, a prince and a princess
- puppets depicting a specific profession such as a nurse, doctor, policeman and teacher
- animal puppets distinguishing between domestic and wild animals, for example dog, bird, monkey, dragon, crocodile and tiger; aggressive animals: shark, wolf and crocodile; soft animals: a dog or a rabbit
- a group of neutral puppets such as an owl and a tortoise.

Finger puppets are the simplest of all the puppet families and can easily be made. They attract children's attention immediately and they are usually excited to play with them (Irwin 1993). They can be used to help children to sort out complex relationships and can also take the form of animals, if they need more distance from their own situation (van der Merwe 1995). Finger puppets can be made, for example, using rubber balls. An opening is cut in the little ball for the forefinger. The ball serves as the finger puppet's head. Figures can also be cut out of foam and stuck to the head. The thumb and middle finger serve as the finger puppet's arms and the ring finger and little finger as the legs. A wide variety of finger puppets can be created in this way (Irwin 1993). According to van der Merwe (1995), small photos of family members can also be used as finger puppets when a more realistic puppet-show is needed. The photos can be stuck to a small triangle of cardboard and the triangle's lowest points can be stuck to fit around the finger.

Finger puppets can be used in the same way as hand puppets during gestalt play therapy. An advantage of using them is that where at the most two hand puppets can be used simultaneously, the skilful therapist can use more than two finger puppets at a time. This can for instance be used where a conversation between members of a family is portrayed.

USING PUPPETS DURING GESTALT PLAY THERAPY

Puppets can be used during directive activities or spontaneously in the course of therapy as well as during a puppet-show. The therapist must take part with the child when using puppets. The therapist learns much from children by means of the puppets they choose. Puppets can be used in different ways and in different stages of the therapeutic process during gestalt play therapy. They can be used during the building of the therapeutic relationship, where the puppet is used as an aid to get to know the child. They can also be used to focus on polarities in respect of the child's self, such as by requesting that the child choose a puppet that depicts the opposite of that which he or she is experiencing at that moment. This activity strengthens children's sense of self. Puppets can, however, also be used during the stage of emotional expression and handling of the persistent inappropriate process, as a medium for projection of children's emotions and to obtain effective handling strategies for this.

Oaklander (1988) gives the following examples as ways in which puppets can be used during the therapeutic session:

- Ask children to choose one puppet out of all the puppets and to be the puppet's voice. Let the puppet introduce itself and ask him or her to tell something of him or herself. Questions that can also be asked are 'How old are you?' or 'Do you have any friends?' The therapist can then at some stage ask children whether there are any aspects concerning the puppet that are similar in their life and whether they also sometimes feel that way.
- Ask children to choose one or two puppets that remind them of someone they know. The therapist can then ask the puppet some questions.
- The therapist and the child can each choose a puppet and communicate non-verbally for a while. They then start communicating with each other.
- Ask the puppet what he or she likes and does not like, in respect of the child that picked him or her up, or ask the puppet to say something to the therapist.
- A fantasy story can develop when both the child and the therapist have a puppet, where the therapist asks the child to dictate what the puppet must say in order to give the child the opportunity to develop the story.

Other suggestions for activities with puppets (Oaklander 1999) are to tell the child to choose a puppet that

- represents how you feel now
- depicts the opposite of what you feel now
- reminds you of a part of yourself you do not like
- depicts how you would like to be
- represents every member of your family. Introduce them to the therapist. What do you want to say to each one?
- is angry.

Alternatively, tell the child a story with puppets in for which a solution is needed and ask the child to provide a solution.

USING A PUPPET-SHOW IN GESTALT PLAY THERAPY

Children enjoy presenting a puppet-show where they have the opportunity to tell their story using puppets. The therapist can also present the puppet-show and then for example ask the child what the topic of the puppet-show must be. A topic based on a specific problematic situation in a child's life can also be chosen.

According to Irwin (1991, 1993), a puppet-show can also be used to assess various aspects during therapy with children. Irwin identifies three stages when using a puppet-show, namely the warming-up stage, the puppet-show, and the discussion after the puppet-show.

1. Warming up
   During this stage, children can be asked to tell why they think they had to come to the therapist. The therapist can also for instance tell the child that he or she is interested in the stories children make up and explain that he or she will be asked to think of a story with puppets. The basket with the puppets can then be emptied onto the floor and the child be invited to choose specific puppets, go behind the cupboard or table and introduce the characters chosen for the puppet-show. Some children need the support of the therapist to start and it may be necessary to lengthen their initial warming up by conducting a friendly dialogue with the puppets (Irwin 1983, 1991, 1993).

2. Puppet-show
   During this stage, the child introduces his or her puppets and starts to depict the story. Most children enjoy it when the therapist acts

as the audience and do not find it difficult to start. If the child is very inhibited and experiences problems, the therapist can help the child in the following ways.

During the warming up, the therapist can ask the child open-ended questions, for instance: 'Oh, policeman, tell me what it is like being a policeman in this place.' If the child still finds it difficult, the therapist can focus on the essential elements of a story, for instance: the characters ('I wonder who is in the story?'), the set-up ('I wonder where the story is taking place?'), and the subject ('I wonder what will happen first?'). This helps the child to think about who, what, where, when and why he or she will play out the story (Irwin 1991, 1993).

If the child insists that the therapist must also take part, the therapist must emphasize that it is the child's story and whisper that the child must say how the story must run. The therapist must, however, take part if all the other means to support the child to present a puppet-show on his or her own have been tried (Irwin 1993). Oaklander (1988) supports this point of view and mentions that she does not make suggestions for the puppet-show unless the child finds it difficult to start or gets stuck in the middle. Another expansion of this stage is the mutual story-telling technique where, once the puppet-show is over, the therapist uses the same characters and offers a better solution for the conflict by means of another puppet-show.

3. Interview with the puppets and the child
When the child has presented the puppet-show, the therapist can conduct an interview with the puppets to lengthen the story line. The therapist obtains additional information about the child's thoughts and emotions. Questions about who did what and the reasons for this can be asked of the puppets (Irwin 1983, 1991, 1993).

The child can then be invited to come out from behind the puppet box and talk directly with the therapist about the story. The therapist has the opportunity to observe the child's defence mechanisms and handling styles and can also observe whether the child can distinguish between the story and the reality of real life. One can also focus on recurrent topics and questions can be asked on the characters in the story. Information can thus be obtained in respect of characters with which the child identifies and characters which the child rejects. Characters which the child sometimes likes and sometimes dislikes represent a polarity within the child him- or

herself (Irwin 1991, 1993). The latter is linked to a theoretical concept of gestalt theory, namely that the self can include specific polarities. The aim of therapy using puppets is to help children to become aware of these polarities in their life, in order to function in a more integrated manner.

Other questions that can be asked of the child during this stage are which parts of the story he or she enjoyed the most and the least, or who in the story he or she would like to be or not be at all. The child can also be asked to give a title for the story as well as whether the story reminds him or her of something which he or she previously saw or heard. However, questions must be asked with sensitivity as children often play out their life story by means of a puppet-show (Irwin 1983, 1991, 1993). Assessment of the story material and specifically the way in which the child handles the emotions can provide information about the children's contact boundary disturbances. As the puppet-show is non-threatening to children, they do not have to make use of contact boundary disturbances to handle their emotions and suppressed emotions can come to their foreground. As the story unfolds, the therapist can observe how the child attempts to handle conflict which develops and the emotions flowing from it.

Puppet-shows in combination with story-telling can be used during gestalt play therapy with children. During the puppet-show, children are given the opportunity to project their emotions onto the characters in the story. By talking with the puppets and children after the puppet-show, they have another opportunity to own their projection and to move to the reality level of how this corresponds with their life. A puppet-show can thus be used effectively in combination with story-telling to promote the children's awareness of their process and unfinished business. By talking after the puppet-show and by presenting a puppet-show for the child, the therapist can model more relevant handling strategies for the child's emotions and problems. This can positively promote children's skills in respect of managing emotions in themselves and others.

5.2.1.3 Fantasies and metaphors

From the gestalt theory perspective, metaphors and fantasies are considered metaphoric expressions of the content of self-experience and can be used during therapy to bring to the foreground unfinished business of which children are unaware (Korb *et al.* 1989). Fantasy forms part of children's

inner world and normal development. Consequently they project aspects within themselves on objects that help them to make sense of the world beyond themselves. The word fantasy is derived from the Latin 'phantasticus' which is in turn derived from the Greek word meaning 'to make something visible'. The concept fantasy thus implies that an intellectual picture is made visible for the child. Various intellectual pictures form part of this concept, namely metaphors, symbolic and creative play and products of the child's own imagination (Mills and Crowley 1986; Oaklander 1988; Schoeman 1996a). Fantasy can be used as part of the projective techniques discussed in Chapter 4, such as drawing techniques, sand play and clay modelling, as well as stories or puppets discussed earlier. This discussion focuses, however, on the functions and guidelines for using fantasy as metaphor.

A metaphor is defined as a metaphorical, figurative expression based on a comparison and similarity – in other words a picture is put in the place of the actual representation. It is also considered a technique that can be used to convey a message to the child in a more effective way. This is an attempt to change children's perspectives of their situation (Spies 1993). According to Schoeman (1996a) and Spies (1993), the metaphor has the following functions:

- It is a description or hypothesis for that which happens in the world of children and serves as a bearer of information in that the effective metaphor contributes for instance to a change in children's perception of their living world or to giving possible solutions to problems. By using the metaphor, children can evaluate their emotions and take decisions as to how to handle the situation without using extra energy for denial. It gives them a learning experience without experiencing their real trauma and can provide relief for children. In this way they can acquire more effective handling strategies for emotions.
- By using the metaphor, children can experience having control over their life and the right to make specific choices. By means of the metaphor and by observing the way in which the characters handle their problems, children can acquire handling strategies and start to direct their behaviour accordingly. The metaphor gives children hope that their situation can improve because without this hope they will probably not be motivated to change their situation. This aspect positively promotes children's sense of self, as the experience of control and the

opportunity to make choices contribute to strengthening children's sense of self.

- The metaphor is an attempt by the therapist to understand the living world of the child, in that the therapist gives the child a description of the significance he or she attaches to a specific situation. This is a bridge that conveys the child's fears and emotions more concretely to him or her. The child finds it easier to discuss this concrete situation.
- By means of the metaphor, children receive the message that their situation is not universal. This limits their experience of isolation and they can acknowledge and experience their needs. Children who are able to acknowledge and accept their needs are capable of healthy organismic self-regulation and completing unfinished business on their figure-foreground.
- During assistance-rendering, metaphors can stimulate the child's power of imagination (in other words the child's ability to fantasize) and to change perceptions. This aspect makes the use of metaphors during assistance-rendering to children very suitable, as they are experts at fantasizing and enjoying it. Another advantage of fantasy play for the child is that it gives the child the opportunity to solve problems, to think creatively and to concretize, as well as the opportunity to handle fears in a non-threatening manner. It gives children a safe haven within which they can change their world and stimulate new behaviour. Fantasy also promotes children's empathic understanding in that they become aware of the emotions, attitudes and opinions of others. It helps them to understand that there are alternatives for each situation. According to Oaklander (1988), fantasy play gives the therapist the opportunity to observe the children's process, as their fantasy process will probably be similar to their life process.
- Metaphors can teach the child moral values, in particular in stories where good defeats evil. Mastery, control and perseverance are prominent aspects in fantasy stories. Children usually identify with positive behaviour of characters and would rather identify with specific moral values within a metaphor than when these values are merely conveyed verbally to them.

> Metaphors can thus contribute to a leading awareness of values in the child, which can in turn be used to guide the child's choices in respect of the management and control of emotions.

The metaphor performs various functions during gestalt play therapy with children. These functions can be regarded as relating to the objectives of gestalt play therapy, of improving their awareness and promoting their self-support and integration.

GUIDELINES FOR CHOOSING METAPHORS

According to Mills and Crowley (1986) and Schoeman (1996a), metaphors should meet the following guidelines, although each metaphor will not necessarily meet all the guidelines:

- They must create a main topic of conflict in relation to the main character, such as the conflict created in the fairy tale of the ugly duckling with the birth of the duckling.
- The unconscious processes in the form of helpers and heroes (which refer to the main character's abilities) and obstacles or bandits (which refer to the main character's fears and negative thoughts) must be personified. For instance, the ugly duckling's mother observed how well it used its legs while the rest of the ducks rejected him.
- They must provide a metaphorical crisis within the context of an unavoidable solution whereby the main character can solve his or her problem: the ugly duckling survives, when dogs and hunters kill all the other ducks.
- They must provide a parallel learning situation within which the main character succeeds, such as when the ugly duckling finds a cottage where he can stay with an old woman, a hen and a cat and where he can learn to make choices. This learning situation can start at the onset of the metaphorical crisis.
- They must lead to the development of a new sense of identification in the main character, as the result of his or her victory, such as when the ugly duckling as the result of his new identification changes into a beautiful swan.
- They must reach a climax where the main character's special value is acknowledged, such as where the children clap hands when the old swans bow before the new swan.

- The main character must be prominent and must be in contact with the primary world.
- The metaphor must be written in such a way that the child can experience it as realistic.
- The child must be able to identify with the metaphor and it must contain elements of spontaneous learning.
- The metaphor must be presented as simply as possible in order to meet children within their living world.
- The child's individuality must be respected when the metaphor is chosen or written. The therapist must take into account the child's specific way of functioning, his or her level of activity and attention span, his or her ability to adapt and the intensity of the child's reactions.
- The secondary world created by the fantasy must contain order and structure. The child must thus find this secondary world convincing and credible.
- The value of the fantasy can be enhanced if it contains elements of humour. Humour contributes to objectivity and within this atmosphere children find it easier to laugh at themselves.

These guidelines seem to correspond to a great extent with the requirements a story for the child must meet, as discussed earlier. van der Merwe (1996a) confirms this aspect and mentions that the story must serve as a metaphor so that the child can identify with it. Spies (1993) mentions that the metaphor creates a climate within which the client can tell his or her story. If the metaphor meets these requirements, it gives children the opportunity to identify with it, to project their emotions, to own it and to obtain alternative handling strategies for their problem.

USING FANTASY AND METAPHORS DURING GESTALT PLAY THERAPY

As mentioned, metaphors can be used as part of a story to the child, in drawing or painting, puppets and a puppet-show, clay modelling and sand play. By means of their projection, children create a metaphor for their situation, or the therapist gives children a metaphor for their situation by telling a story.

According to Mills and Crowley (1986), everyday situations can also provide raw material from which a unique therapeutic metaphor can be created. Children can for example be asked to give their problem a name and

thus present their own metaphor for this. For example, Spies (1993) mentions the sexually molested child who referred to the little packet which she had to wear and which was full of stones, which she wanted to destroy or throw away. Another example indicated by Mills and Crowley (1986) is the metaphor of a dog with only three legs who could succeed in adapting and functioning efficiently, although it was difficult. This metaphor was used to show two sisters, aged five and eight, whose father left them, that they are capable of adapting and experiencing joy although their father was no longer with them. The said authors also mention living metaphors which refer to homework given to the child. For example, a metaphor of a garden, where various plants must be cared for, can be given to a child who bites her nails. She can be told to plant ten small plants and to care for them. She can even go to the nursery to find out what she needs for these plants to grow well.

Shapiro (1997) gives an example where fantasy is combined with a metaphor. An eight-year-old boy who suffers from leukaemia, and who refuses to go for blood tests because of the pain, is taken on a fantasy where he must imagine that he goes outside, that there is snow and that he takes some snow and places it on the part where the needle must be put in. He is then taken on a fantasy where he can feel his arm become numb and that he must pinch himself there where the snow touched. Once the child indicates that it is slightly sore, the therapist assures him that he can use the same fantasy with a little practice when blood will be taken again.

Oaklander (1988) and Shapiro (1997) describe various fantasies. The child can for example be taken on a fantasy in a wood or on a fantasy where he or she is a ship in a storm. Oaklander (1988) often uses drawing techniques in combination with a fantasy, such as that the child must make a drawing of an aspect from the fantasy. Compare this with the fantasy of a safe place and the rosebush fantasy discussed in Chapter 2. On the basis of the above, it can be inferred that the therapist, taking into account all the requirements which the metaphor must meet, can be creative to create a metaphor for children that adapts to their unique life situation, age and developmental stage.

5.3 TERMINATION

Termination forms an important stage in the gestalt play therapy process and is not merely the ending of therapy. Therapy can to some extent be considered as the figure on the child's foreground and the completion of this gestalt gives the child the go-ahead to move to a new place. As children's needs are satisfied, they gain new control and mastery, make new discoveries

and experience a stage of homeostasis. With children, there is no talk of termination, as they have limited abilities developmentally to handle certain situations therapeutically. Therapy terminates at a specific stage, although they may receive therapy at other stages of their life, namely when they must work through other unfinished business as the result of their cognitive and emotional development (Oaklander 1994b).

Children reach a plateau in therapy, and this is a good time to terminate therapy. Due to therapy, they must assimilate changes within themselves, in their own time, and according to their natural maturing and growth. Changes in behaviour, more interest in other activities than in therapy, and what happened during therapy must be used as a norm in evaluating or termination. Repeated resistance on the part of the child is an indication that termination must take place some time, as the child is not prepared to deal further with his or her unfinished business. Other aspects that indicate that children are ready for termination are the following: children can openly verbalize their needs, accept responsibility for their emotions and behaviour, have inner control, and accept themselves better (see Landreth 1991; Oaklander 1988, 1994b, 1997). Parents and teachers also often give the therapist an indication of how the child is functioning in the outside world and what positive changes in behaviour the child is manifesting. Children should be adequately prepared for termination of therapy so that they do not experience it as rejection. They often find it difficult to accept termination and cannot determine when it is necessary. They will sometimes ignore the therapist when he or she reminds the child that only a few sessions are left.

A special session must be devoted to the end of the therapy, although the child must be prepared for some time prior to termination of therapy. During the last session, the child can for example get the opportunity to play with his or her favourite game or medium, or look at previous drawings and photos. The child's emotions regarding termination must also be dealt with (Oaklander 1988, 1992, 1994b, 1997).

Children often experience polarities with reference to termination, as one part of them feels happier and the other part feels sad to terminate. It is important to give them permission to feel this way and to accept and integrate these polarities. Termination is an important stage in the therapeutic process that needs special attention. Early preparation for this is important in order to prevent children from experiencing this as rejection. Children must be given adequate opportunity to express their emotions regarding termination. In the course of time, children may find it necessary to report for therapy again in order to handle new unfinished business for

which they are ready. Therapists and parents must not see this as meaning that the previous therapy has failed.

Oaklander (1988, 1994a, 1994b) suggests the following activities for use during the last session:

- Talk about what was done or discussed during the previous sessions and look at drawings and photos of sand scenes.
- Make goodbye cards for each other.
- Let children choose their favourite game, medium or activity and let them play with it.
- Draw and discuss mixed emotions surrounding termination with the child (West 1992).

Another activity that can be used is to assist the child to create a 'secret friend' during the last session. For example, the child can be asked to bring a small stone to the session. Different materials such as glue, wool, cotton balls and paint can be provided to the child and he or she can be asked to create this secret friend. Thereafter the child can give his or her 'secret friend' a name and can be told that although he or she will not see the therapist any more, the child can still tell the 'secret friend' anything he or she would like to.

The activities during the last session should be aimed at summarizing what was done during all the sessions and at helping children to own and express their emotions on termination. Children can experience termination to a greater extent as the completion of an unfinished gestalt if they get the opportunity to do their favourite activity, owning their emotions on termination and saying goodbye in a concrete manner by making a goodbye card.

> One child, aged eight, made himself a secret friend, called Jan. His mother reported that when they got home, he made a bed and a desk for his secret friend, so that his friend could sleep next to him and be with him all the time. He also took his secret friend to school every day.

5.4 CONCLUSION

Following the stage of emotional expression, the focus is on the child acquiring self-nurturing skills. During therapy children are taught to use the supportive part in themselves to nurture the parts they hate. They also learn

skills to treat themselves well. Projective techniques can be used during the stage of self-nurturing to help children to own their negative introjects. The monster technique, where children represent an aspect in themselves or in their life which they found unacceptable, is best suited for this. Children are then helped to nurture their younger self by modelling a clay figure of themselves. A puppet such as the good fairy can be used to show them how they can nurture their younger self. This explains the concept more concretely to children. Homework, where they can continue with the self-nurturing at home by using something like a teddy bear, which they imagine represents their younger self, can be given to them.

If children still manifest inappropriate behaviour upon termination of the said stages, their awareness of their process must be enhanced in order to help them to exercise choices regarding their behaviour and taking responsibility for it. Making use of appropriate stories, story-telling through puppets and puppet-shows, and using metaphors are effective techniques to use in this stage. Termination forms the last stage of the therapeutic process. Therapy terminates when children have reached a plateau in therapy or manifest such resistance that progress cannot be made. However, it is sometimes necessary that, upon reaching the next stage of development, children must again report for therapy in order to handle unfinished business for which they are then developmentally ready. A special session must be set aside for the final termination. Activities can be used to help children to project their emotions on termination, by drawing it, for example, and making goodbye cards for each other.

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PART THREE

GESTALT PLAY THERAPY WITH GRIEVING, TRAUMATIZED AND HIV/AIDS CHILDREN

Children worldwide are more and more exposed to traumatic situations daily, such as divorce, family violence, physical and sexual abuse and chronic diseases such as cancer and HIV/AIDS. These situations cause grieving reactions in children that can manifest in different kinds of behaviour, for example temper tantrums, depression, poor school performance, psychosomatic complaints and interpersonal conflict. Grieving children and children with HIV/AIDS often fear rejection, abandonment, loss and isolation or not having their basic needs met. This may lead to symptomatic behaviour as a way in which they try to satisfy their needs. Children, unlike adults, do not necessarily have the verbal skills to express their feelings, as they sometimes do not understand these feelings. They will often tell adults that they just feel bad, or that they do not want to go to school, because they have a headache.

By grieving, children are enabled to adapt to the loss they are experiencing, as well as to their new circumstances. Gestalt play therapy with grieving and traumatized children provides these children with the opportunity to enhance their contact functions, as traumatized children often desensitize their senses to protect themselves from further pain. They further get the opportunity to project their unfinished emotions, for example loss, anger

and fear, and to own them on a reality level. These children also need to learn handling strategies for their emotions, as they often did not have any control over what happened to them. They therefore have to learn to manage their emotions in the situations they are in. Grieving and traumatized children, such as children with HIV/AIDS, often blame themselves for the trauma they experience. Children with HIV/AIDS, who are hospitalized often, may for example think they are ill because they have done something wrong and are punished for it. They therefore have to be helped to nurture themselves and to stop blaming themselves.

Grieving and traumatized children may have a lot of needs, such as the need to be aware of their feelings, the need to build trust, the need for power and control in their life, the need for family support and the need to express their feelings, such as fear, anxiety and anger. During gestalt play therapy they can become aware of these needs, and find healthy ways to satisfy it. By its holistic approach, gestalt play therapy therefore aims to focus on how the grieving and traumatized child's holistic functioning of the senses, body, intellect, spiritual aspects and emotions are fragmented and to help the child to function as an integrated whole again.

In this section, attention is given to:

- gestalt play therapy with grieving and traumatized children in Chapter 6
- gestalt play therapy with HIV/AIDS children in middle childhood in Chapter 7.

Chapter 6

Gestalt Play Therapy with Grieving and Traumatized Children

Sandra Ferreira and Marinél C. Read

In their daily lives, children can be exposed to a variety of occurrences that can influence their healthy growth and development. Although children have a natural ability to recover, the possibility exists that the lives of these children could be radically influenced. Especially because children use a great deal of energy just *to grow*, they need all of their strength for the growth-developmental tasks of the relevant life-cycle phase in which they find themselves. Built into some of the occurrences is the potential for loss and trauma with which the child and his or her family are confronted. The normal reactions to loss and trauma are grieving and post-traumatic stress reactions.

The extent and intensity of the impact of this loss and trauma can be overwhelming for the child and therapist alike. However, although loss and trauma may be injurious to the child, gestalt play therapy creates a vehicle for children to express and verbalize their experiences and feelings, helping them to get into contact with themselves and their environment – aspects that are often destroyed in situations of loss and trauma. Some of the following case studies are familiar portrayals of what the play therapist has to deal with every day.

Richard's father often comes home drunk and hits Richard's mother. Recently, he has threatened to shoot her. During playtime at the nursery school the five-year-old Richard crawls in under his little table and refuses to go and play outside.

Fifteen-year-old Christian's parents are divorced. Christian and his nine-year-old sister, Lee-Ann, first lived with their mother, as directed by the court decision. The mother began abusing alcohol and drugs and sometimes did not even come home at night, leaving the children alone at home. Their father did not visit them or come and fetch them for holidays, as the court had decreed. At present he is untraceable, after having absconded from work. Both children are currently in foster care. Christian is doing extremely well at school and is popular among his friends and his teachers. Lee-Ann has recently started wetting her bed.

A year ago, when Michael was six years old, he was a passenger in the car that his father was driving. During a motor accident, his father was killed. His mother and grandparents stop him when he wants to talk about his father and tell him to forget about what happened, because it was not his fault, even though he thinks it was. He complains of stomach-ache and nightmares.

In the childhood years, the individual is already exposed to the possibility of loss and trauma situations that could include any of the following, among others:

- divorce of parents
- death of a parent, sibling or grandparent
- death of a beloved pet
- diagnosis of a disability, a medical problem, developmental handicap, leukaemia or HIV/AIDS in the child
- injury and disfigurement as a result of an accident
- sexual molestation or rape
- moving house
- beginning school
- loss of personal property, such as in the case of robbery or fire
- family violence
- physical abuse.

It is clear from the above examples that children could be confronted by situations that can vary from less serious to extremely serious. What must be kept in mind is that children experience the same feelings as adults, but do not have the language skill to verbalize them, nor the cognitive ability to understand, identify or express their feelings. Children will express their feelings through play, drawing and non-verbal behaviour, while feelings will be felt physically (for instance, feelings of sadness will manifest as physical pain, such as stomach-ache or headache). Children will have a shorter attention span, may struggle to learn new things, and may even be accident prone.

Reactions shown by the child are often intense and can be accompanied by intense outbursts. This kind of behaviour is the child's way of working through the occurrence. Where the child has been exposed to loss and trauma situations, it can be expected that this will be stressful and that adults often make this worse by expecting the child to behave in a particular manner.

This chapter will give an overview of age-related experiences and reactions of the grieving and traumatized child and also include play therapy techniques that the social worker can utilize in order to address the child's situation. Apart from practical uses of the different play therapy techniques, two examples of assessment aids are also included in the discussion.

6.1 DEFINITIONS OF CONCEPTS

Distinctions can be made between the concepts of loss, trauma and stress, and related concepts to describe the seriousness of the occurrence in the child's life. It is, however, not always easy to distinguish between these concepts. This is probably because in practice a specific occurrence can include elements of loss, trauma and stress. At present it is generally accepted that a trauma situation can also include elements of loss and vice versa (Hyer and Brandsma 1999). One should nevertheless avoid simply accepting that a loss situation automatically means that the child will experience post-traumatic stress.

In the field of traumatology and loss there are a variety of descriptions used to explore, describe and explain the phenomena of stress, trauma and loss, depending on the theoretical framework. An attempt towards defining these concepts is provided below.

6.1.1 Stress

Stress can be described as the inability to handle the physical and/or emotional demands of a specific situation (Lewis 1999). Children could thus

experience stress regarding the scope and degree of difficulty of the work for an examination or being part of a restructured family.

6.1.2 Trauma

Briefly, trauma can be seen as an emotional condition of discomfort and stress that arises from memories of a personal experience of an occurrence that has destroyed the individual's sense of invulnerability towards pain (Figley 1985), and includes the following:

- an actual or threatening possibility of death or a serious injury
- threatening of the physical integrity of the individual
- being an eyewitness to an occurrence of death, injury or the threatening of the physical integrity of another person
- taking note of the unexpected or violent death, serious injury, or threat of death or injury experienced by a family member or other interested party
- reaction to the occurrence includes intense fear, helplessness and dread; the child evinces disorganized behaviour (Briere 1997).

The traumatic occurrence, furthermore, has an impact on the physical behaviour and emotional functioning of the person. Immediate or at least speedy intervention prevents dysfunctional adjustment and post-traumatic stress disorder. The typical reactions that follow as a result of a trauma can be presented in the following categories of symptoms (Keppel-Benson and Ollendick 1993):

- avoidance of stimuli of related occurrences
- intensified reactions and attention problems
- reliving of the trauma occurrence.

Some of the most important symptoms in these categories that may be experienced by the child include nightmares, repetitive play in which the child is stuck reliving the trauma and is unable to establish psychological distance from the traumatic event, clinging to parents and fear of strangers, outbursts of anger, irritation, weepiness, nervousness, regression to a previous stage of development, withdrawal, amnesia, psychosomatic complaints, bed-wetting, changes of eating and sleeping patterns, extraordinary fear of the dark, fear of separation or of being alone, sleeping difficulties and difficulty

concentrating. It must however be emphasized that these symptoms are the 'normal' reactions to 'abnormal' situations.

If the above-mentioned symptoms continue for longer than one month, the individual may be diagnosed by a clinical psychologist or a psychiatrist as having post-traumatic stress disorder. In the case of trauma the focus is especially on the personal perception of loss of control that arises from the occurrence and suppositions about life that are questioned. This is why it is so important that intervention should take place as speedily as possible so that children can be assisted in identifying, verbalizing and expressing their feelings in the manner which most suits their age. This process usually takes place by means of play therapy, among other things, with a trained play therapist.

A distinction can be made between a one-off traumatic occurrence such as a motor accident or a hijacking situation to which the child was exposed, and a longer-term situation (multiple traumas) like physical or sexual abuse that has taken place over a period of time in the child's life. In both cases the child will present with post-traumatic stress reactions, while the child could experience serious longer-term psychosocial problems with regard to the multiple traumas (Cook 1996; Lewis 1999).

The emotional experience of the child is influenced by a variety of determinants, among which are different types of occurrence (for instance divorce, the death of a parent or significant other, foster care, hospitalization of the child or of the primary caregiver, etc.), the family and social network, the characteristics of the child (age, gender, assigning of meaning and concept of loss), religious convictions and cultural customs, to name but a few. These convictions and cultural customs can eventually make it 'easier' or 'more difficult' for the child to move through the healing process. Therapists should therefore also work from a holistic point of view in the assessment and treatment of the child, and to take these determinants into account.

6.1.3 Loss

Loss can briefly be described as a condition of losing someone or something that is to the disadvantage of the child because the person or thing lost has played an important role in the healthy functioning and existence of the child. Built into the loss situation is the element of separation which leads to the child's experiencing of separation anxiety. The term 'grief' refers to the emotional process that follows loss, while 'mourning' refers to the process of adjustment to the loss, also referred to as 'being in mourning'. For the

purposes of this chapter, the terms 'mourning' and 'grief reactions' will be used interchangeably so as to include both concepts.

The immediate reaction of children to loss and the challenges that follow include, according to Jewett (1992), the following: fear about personal survival, separation anxiety, impaired ability to form emotional ties, sorrow, anger, feelings of guilt, shame, depression and despair, self-image problems, ongoing pessimism and feelings of futility. These are normal feelings resulting from a loss situation.

Ward and Associates (1993) and Worden (1996) agree with this, emphasizing at the same time the following typical grief reactions:

- disbelief, shock, dulling, searching, wishing to reunite
- longing memories, dreams and games have undertones of grief (emotions), psychosomatic reactions
- reduced interest in things that previously took up a great deal of attention and time (depression), sorrow, feelings of dullness while actions are automatically carried out
- sleep disorders, difficulty in concentrating, anger and irritation
- problems with academic performance, concentration problems and dropping of scholastic performance
- self-destructive behaviour, thoughts of suicide and other behaviour that threaten the emotional and physical safety of the child.

Neglecting to address the above-mentioned feelings can have serious implications for the child as an adult. Increasing evidence exists that there is a connection between loss during childhood years and depression, problems in forming intimate relationships, alcoholism, anxiety and proclivity towards thoughts of suicide during the adolescent and adult years of the individual (Jewett 1992; McGoldrick and Walsh 1991). It thus seems clear that in both the short and the long term there may be possible spiritual health implications and that preventative intervention is necessary.

When the child is exposed to a situation (for example, where the child is an eyewitness to the murder of his parent/s) where the elements of both trauma and loss exist, this can be referred to as traumatic loss (Nader 1997). Traumatic loss includes elements of separation (crying, searching) and post-traumatic stress (physical threat). In such cases, where the child exhibits both loss and trauma reactions, it is important that the trauma reactions be

addressed first, because the emotional and often also the physical safety of the child may be at stake. This does not however mean that the loss reactions should take second place. The focus is just more sharply aimed at the trauma reactions.

6.2 GRIEF AND POST-TRAUMATIC STRESS REACTIONS OF THE CHILD IN RELATION TO AGE PHASES

When a loss takes place the child moves through the same series of emotions as the adult does. The difference lies in the expression of feelings, however, and this is especially related to the age and developmental level of the child.

6.2.1 Birth to two years

Children in this age group react as a result of the separation that has taken place rather than to the occurrence itself, for instance in the case of the divorce or death of a parent (Lendrum and Syme 1992). The emotional condition and reaction of the other parent will in a large measure determine the reaction of the child falling in this age group (Pennells and Smith 1995; Ward *et al.* 1993). However, because of their cognitive development children don't understand the implications of the loss situation and they react simply to the separation or absence of the significant other person or primary caregiver in their life and the reaction of the present other parent or primary caregiver.

6.2.2 Age two to five years

At this age children have already developed an ability to think and they have a measure of self-control. This means that they have a certain amount of independence and this gives them a little more self-confidence. Loss experienced at this stage by children undermines their self-confidence and they all of a sudden experience their world as uncertain and unsafe. Feelings of anxiety, fears and worries about safety of self and others may be expressed after a traumatic event by the child (Gurwitch *et al.* 2002) and may result in clingy behaviour to the primary caregiver.

According to Pennells and Smith (1995), children attempt to make sense of occurrences by repeatedly asking questions; they also become easily confused as a result of the explanations. They may even feel that their thoughts, wishes and actions have caused the specific loss situation (Ward *et al.* 1993).

As a result of their level of reasoning children also think that if they are good or if they undertake a specific action this will change the situation, for

instance that the parent will come back. This is why it is also said that the child does not understand the irreversibility of death.

6.2.3 Age five to nine years

At this age the children have already begun school and are supposed to have basic skills with regard to social integration which allow them to form part of a greater social network than just the family. The incorporation into a greater social network also, however, makes them sensitive to other persons and to the comments of their peer group. Children learn the following very quickly when they are exposed to a loss situation (Lendrum and Syme 1992; Pennells and Smith 1995):

- They learn whom they can trust with their thoughts and feelings.
- They notice very carefully the reactions of adults to the loss situation and may even deny their own feelings in order to shield the feelings of adults.

Fears and fantasies lead to the personification of an occurrence such as death as a monster or a ghost. Many questions are still asked at this age, with reference to the causes and the consequences of not only their own actions but also the actions of others. In the case of death, questions like 'How will mummy breathe and who will give her food?' may also be asked.

6.2.4 Age nine to twelve years

During this phase of concrete thoughts the child begins to develop a greater cognitive ability to understand, for instance, the finality of death. The child still thinks, however, in terms of the one or the other, such as good people and bad people, for instance. This is known as polarity. It is still difficult for children at this stage to deal with contradictions, euphemisms and figurative speech, for example, and they would have difficulty in dealing with such statements as 'your sister has gone to Jesus' (Pennells and Smith 1995; Ward *et al.* 1993). This situation leads to anxiety and uncertainty and, according to Gurwitch *et al.* (2002), behaviour changes result from this as traumatized children may show signs of irritability with family members, friends and events, and even anger outbursts.

A measure of 'adulthood' begins phasing in at this stage, in that the child realizes cognitively that the situation is irreversible, as in the case of death.

6.2.5 Adolescence

Adolescents have the ability to mourn in the same way that adults do, in that they are capable of crying, of experiencing feelings of sorrow, anger and depression, and of expressing these. Pennells and Smith (1995) and Gurwitch *et al.* (2002) underscore, however, the possibility that adolescents may harbour thoughts of suicide:

- They have strong emotions, because of their emotional development, which may lead to their questioning their identity or the meaning of their lives. At the same time they may show discomfort with feelings, particularly revenge, but also those of vulnerability.
- They may become involved in the occult, and questions about or searching for the meaning of the afterlife are sometimes the order of the day. An increased risk for substance abuse, including drinking, can become a reality for the adolescent.
- Socially speaking, there may be an increase in pressure to take on an adult role, especially in the case of a divorce or the death of a parent. Comments by the surviving parent, family or friends such as 'Now you are the man of the house' or 'You must look after mummy well' could deprive adolescents of their freedom to grieve.

The expectations and actions of the peer group of adolescents play an important role in their experience of the loss situation. There may be peer group members who do not know how to act towards the grieving adolescent. This could lead to adolescents feeling isolated and alone without the support and understanding of their friends.

Irrespective of the age of the child, in families where relationships are characterized by open communication and shared feelings, children will receive the necessary support that will allow them to express their sorrow, so that they can deal with the situation of loss or trauma.

6.3 OBJECTIVES FOR ASSISTANCE TO THE CHILD

In the literature different models and theories exist that explore, describe and explain the phenomena of loss and trauma. Worden (1996) refers to the process of grieving as a series of tasks that must be carried out by the grieving person in order to move through the healing process. Although his model was designed in terms of the death of a parent as a loss situation, some

of the premises in this model can also be relevant to other loss situations with which the child may be confronted. Separation that has been caused by loss causes an intrapsychic process through which children must work in order to construct a new reality – a reality that often differs dramatically from the one that they knew before the loss or trauma occurrence. The usefulness of the task model lies in the fact that the tasks through which the child must work can be formulated as objectives for assistance to the child.

- Acceptance of the reality of the loss or new context: initial reactions of shock and disbelief are replaced in time by the recognition of the reality of what has taken place. This requires that children should be able to understand abstracts such as the finality and irreversibility of the situation – an understanding that they are only capable of during the development phase of operational thinking. According to Worden (1996) the awareness of an individual's relationship to the physical and social world is gained through reality testing, and a young child who is not yet capable of this finds it difficult to understand the reality of the loss. In order to help children with this, explanations suited to their age may be used. Explanations must be made in a way that they can understand. It may also be necessary to repeat the explanations patiently. If this does not help them, they may prefer to make up their own stories in order to promote their own understanding.
- The experience of the pain of the loss or the working through of emotional aspects of the loss. A variety of feelings may be present as normal reactions to loss. Generally, feelings of grief include feelings of sorrow and discomfort – in other words, painful feelings. For the child, feelings present mostly on the somatic and the behaviour levels. According to Worden (1996) children especially must be assisted to approach this task gradually, so that their ability to deal with it is not overwhelmed.
- Feelings that are experienced are the same as those of adults. Children evince feelings of sorrow, anger, guilt, anxiety and other feelings associated with loss. From a systemic perspective, one must keep in mind that the reactions of adults and other determinants as highlighted above have an influence on the child's own ways of dealing with things. By helping children to

work through their feelings they are offered an opportunity to experience feelings of mastery. The expression of feelings can take place through projective techniques such as drawing and sand play.

- Adjustment to a changed environment: The rearrangement, restructuring and redefinition with which children need to be assisted with reference to their own place and role and the absent person or object is the third task in the healing process. Adjustment is a process and for children it means that as they get older they should be assisted in each phase of life. The meaning of the loss and the reality of how the loss touches the life of children must therefore be re-evaluated in each stage of development.
- Re-investment in life: the relationship that existed with the person or object must be redefined and emotionally placed and integrated into the life of the child. Briefly, children must be helped to get on with their life, and to deal with the loss and its implications. This may even mean that children might have to learn certain skills, such as learning to study on their own. The process of adjustment is complex and a variety of factors influence it. The influential factors must be continuously assessed and taken into account during the assistance of the child.

6.4 GENERAL GUIDELINES FOR ASSISTANCE TO CHILDREN AND THEIR FAMILIES

For parents, adults and professional helpers a number of general guidelines are valid when one works with the grieving or traumatized child. These are not presented in any particular order of importance.

- Show genuine concern and caring by allowing the child to express emotions.
- Reinforce ideas of safety and security by ensuring the child that he or she will be taken care of.
- Answer the questions that children ask, even though they may sound strange. Ask them what led to their asking of that particular question.

- Encourage adolescents by telling them that they must be patient with themselves and that they must not be hard on themselves regarding what they are supposed to do.
- Verbalize own sorrow and pain because of what the child is going through.
- Retain the routine as far as possible, since this is what gives them a measure of security.
- Involve the school and other interested systems in the community in order to extend the support network for children and their family.
- Keep up to date on the existing legislation and policies that have been passed for the protection of children and their family.
- Be available for the child. A hug or a friendly smile is often all the child needs at a particular moment.
- Be honest with regard to answers provided. Keep explanations to the level of the child's development. Use simple direct terms to describe what happened, rather than terms designed to soften the information.
- Determine the child's perception of the occurrence and rectify this if necessary.
- Build in as much ritual as possible to help children to take their leave and to rejoin normal life. The planting of a tree, keeping of a diary and the compiling of a book of memories can help the child to move on with life.
- Do not become upset over regression or difficult behaviour on the part of the child. These are the normal reactions to abnormal circumstances. If however this continues for too long (for example, if the behaviour goes on for longer than a month or if it intensifies) then professional help must be sought immediately.
- Allow children to express their feelings and create opportunities for discussing how feelings can be handled.
- Protect the child from explicit pictures with regard to specific loss or trauma occurrences that might be shown on television.
- Because grieving is 'hard work', the child needs an opportunity to rest physically and emotionally. Create opportunities for this.

- A soft toy, a new article of clothing or a little gift can create a feeling of being special and leads to a feeling of security.
- Give the opportunity for small nutritious meals for those who have lost their appetite.
- Leave a nightlight burning for those children who suddenly develop a fear of the dark.
- Parents can pray with their children for the strength and grace to move through the process.
- Helping the child through post-traumatic stress and bereavement reactions implies knowledge about the phenomenon of loss and trauma, and a patient and caring attitude towards the child. For the parent or primary caregiver the first step may well be taking the child for therapy, but at the same time remember that parents or primary caregivers may be in need of therapy themselves.

Children will be able to resolve loss and trauma situations appropriately when they have enjoyed or still enjoy a secure relationship with a trusted parent or other adult, when children receive prompt accurate information about what has happened and are allowed to ask questions, which adults answer as honestly as possible, and are allowed to express their feelings and participate in mourning rituals.

6.5 THE USE OF GESTALT PLAY THERAPY TO ADDRESS LOSS AND TRAUMA IN CHILDREN

The ability of children to understand these situations of loss and trauma differs during different life phases and this must be kept in mind during therapy (Jewett 1992). It is difficult for younger children to verbalize or to express their feelings meaningfully. As a result of the attitude of society towards children, it is difficult for children to be heard. Loss and trauma however affect the child in totality.

- Physical effects
  The effect on the child's body is described as a hollow feeling in the stomach and tightness in the chest and throat. Children might be very sensitive to noise, closed off, short of breath and out of breath. Weakness in muscles and a lack of energy are observed and the child may complain of a dry mouth (Worden 1996).

Psychosomatic symptoms can be an indication of deeper-lying causes in the psyche, for example ongoing headaches that have no physical causes. According to the principles of the gestalt approach these symptoms can be attributed to a contact boundary disturbance, namely retroflection, because children literally focus the pain that they would like to administer to others against themselves.

- Cognitive effects
  There are several thought patterns at a time of experience of loss, for instance initial disbelief, confusion, reliving, imagination and even hallucinations (Worden 1996).

  Children thus experience changing thought patterns during the different phases of the grieving process that could discompose and derail them. These thought patterns could manifest physically in fixations, for example when the child continues to hope that his or her parents will become reconciled, in spite of the fact that both parents have already married other partners since the divorce. In terms of the gestalt approach these thoughts would be described as egotism, because the child wants to control all aspects of his or her life and tries to restrict spontaneity.

- Behavioural effects
  Sleep disturbances, eating disorders, memory loss, social withdrawal, dreams, avoidance of memories, searching behaviour and calling out behaviour occur. Sighing, restless overactivity, weepiness, the wearing of mementoes and the keeping of precious objects are some of the behaviours that may be observed (Worden 1996). Emotional problems in children manifest mostly in the form of behaviour changes (Blom 2000b). The above-mentioned behaviour is an indication of the trauma through which the child goes. In the gestalt approach this behaviour will be explained as deflection, because a contact boundary disturbance takes place that restricts the satisfaction of needs and causes imbalance.

  Often normal loss reactions display the same symptoms as depression. In both cases sleep disturbances, eating disorders and intense sorrow are found. With the experience of loss there is usually not a loss of self-worth present, as there is in the case of depression (Worden 1996).

Parents are generally willing to assist their children during experiences of loss and trauma. However, conflict often exists between parents' own needs and their ability to distinguish their children's needs. A therapist could play a meaningful role in this regard. With guidance and preparation, both parents and children can be assisted in loss situations. Therapeutic services with a view to the expression of feelings and the working through of the loss and trauma are indispensable for children, but are often not available to them through lack of knowledge, prejudice or financial considerations.

6.5.1 Objectives of gestalt therapy

The objectives of the gestalt approach may be described as awareness, integration and self-support. These objectives were discussed in Chapter 2 and are only briefly discussed here. The play therapist must keep them in mind throughout the play therapy process.

During the play therapy process the most important aim is to make contact. Making contact implies therefore that the environment is used for the satisfaction of needs. If children are fully 'present' and 'in touch' with their present functioning in the various facets of their life, their needs are satisfied. Awareness is reached when children are in contact with themselves and with the environment.

Integration as an objective of gestalt therapy is aimed at clients' ability to function as a whole. It implies that certain parts of themselves, their experience and feelings, will not be ignored. The result is that the restricting of their functioning will be recognized and accepted. Children thus learn to accept themselves in totality, in all their facets.

Self-support is therefore also aspired to through gestalt therapy, through the children being accompanied in accepting responsibility for themselves. Available inherent potential is used by the discovery of inherent strengths. During the use of gestalt play therapy the focus is on the process of the child, although a therapeutic process is also used to address experiences of loss and trauma.

6.5.2 Therapeutic process

The therapeutic process is one of the most important aids to use during play therapy. Through play, the therapist offers the opportunity to children to make contact, to be able to integrate fragmented parts in themselves through emotional expression and to begin to support themselves.

Emotional expression is the focus of any therapeutic process. The child is offered the opportunity to recognize, to own and to express emotions so that unfinished business can be accomplished. Sometimes because of cultural customs and upbringing, children are discouraged from experiencing or expressing emotions, and this leads to loss of cognition. This process is probably the most important of all in accompanying the child successfully and in facilitating change.

6.5.3 Play therapy techniques that can be used to address loss and trauma

A variety of play activities can be used during the gestalt play therapy to provide the child with experiences to address aspects of the self and to promote healthy functioning (Geldard and Geldard 1997; Oaklander 1992, 1994; van der Merwe 1996b). van der Merwe (1994) divides play therapy techniques into five groups, namely relaxation play, assessment play, biblio-play, dramatized play and creative play. The therapist specifically uses these play techniques in therapeutic work with young children in divorce situations. Each play technique is described, as it can be used to address experiences of trauma and loss in children.

6.5.3.1 Relaxation play and sensory contact-making

Relaxation play is used to build up a therapeutic relationship with the child client and to create an atmosphere advantageous to therapeutic inputs. These play activities focus on fun, in relation to the level of development of the child (van der Merwe 1994). Children can learn to relax through the process of physical contact-making. Different techniques and activities can be used during play therapy to help the child to relax, as explained by Oaklander (1988), Schoeman (1996b) and van der Merwe (1996e) and are related to free play according to Geldard and Geldard (1997). Allowing the child to do stretching exercises, for instance, teaches him or her to relax various parts of the body progressively, from the feet to the scalp. Make use of music and breathing, or blowing activities, or take children on a relaxed accompanied fantasy to a place that they are familiar with.

During the first phase of the gestalt therapy process, the play activities and techniques are used to give the child the opportunity to learn to know the playroom and the therapeutic situation. These activities promote the relationship between the child and the play therapist, but also offer opportunities for the child to feel at ease, to relax, to become aware of his or her own need and to be ready for the therapeutic process, during which feelings will

be addressed. Relaxation play does the preparatory work for the therapeutic process to follow.

6.5.3.2 Assessment play

Assessment play is necessary to observe the child's cognitive, perceptual, emotional and cultural background, behaviour and motivation (van der Merwe 1994). van der Merwe (1996a) describes assessment playfully and is of the opinion that these aspects should be assessed before change can be observed. It is important to remember that the goal of assessment in gestalt play therapy is not to get certain information. The goal of assessment is based on the three objectives of gestalt play therapy, namely awareness, self-support and integration. Although various aids, games and even therapeutic toys are available, and professional people draw up reports and make diagnoses about the children, Oaklander (1988, p.184) indicates that: 'I begin with the child from where she is…regardless of anything else I hear, read or even diagnose about her myself.'

In the practice of therapy the emphasis is often laid upon assessment with the purpose to diagnose, drawing up reports and suggesting guidelines for treatment. Clients' own experience of their problem situation can easily be ignored through the eagerness of the professionals to assess, evaluate and to form an opinion. Although assessment is done during the gestalt play therapy process, it should not be the focus of the therapy process. When people are in therapy, they should not be treated as objects and observed for the purpose of forming an opinion. It is extremely important that the client (and also the child client) is treated as a person in his or her own right. The therapist will literally have to stand still with children and then start moving at their tempo, while they share their experience as they experience it and not as the therapist observes it.

Examples of activities for assessment are described in Chapter 2 as the use of animal cards, graphic family portrayal, rosebush fantasy and the fantasy of a safe place, family questions and temperament analysis. The therapist can also compile assessment aids based on literature studies, as assessment is necessary to direct the therapeutic process. Read (2002) suggests assessing the loss experiences of children in divorce situations by asking the child to name things they felt they lost when their parents divorced. Appendix 4 gives a list of possible things from which a child may be asked to choose.

6.5.3.3 Biblio-play

Biblio-play includes the use of books, the written word and audio-visual aids. The incomplete sentence test may be used, as well as cards, letters, poems, books and diaries. Therapists should know and use children's literature; they should be able to apply stories creatively and use unexpected situations in a therapeutic way (van der Merwe 1994).

Any form of written or audio-visual material that can be used may be regarded as biblio-play (van der Merwe 1996c). Blom (2000a, 2000b) and Geldard and Geldard (1997) recommend the use of stories and expand upon the advantages of stories, and the requirements that stories should fulfil. Biblio-therapy offers unlimited opportunities that can be used in gestalt play therapy and can be used creatively by both the therapist and the child. It is nonetheless necessary that the therapist continuously exploits new material as it becomes available on the market, or even develops material especially for particular clients. Creativity is a requirement for seeing the possibilities of existing stories, the written word, videos, computer games and so on, or to develop one's own aids that can be used applicably for different children. Stories offer children the opportunity to convey in a child-friendly way a message that will answer their questions and that will reassure them with regard to what they are experiencing.

The incomplete sentence test can be used, for instance, as a method of giving children the opportunity to express their experience. This method can be used to determine the themes on the child's foreground and what unfinished business should be addressed during therapy (Read 2002). See an example of an incomplete sentence test in Figure 6.1.

Biblio-therapy offers the opportunity for the therapist to enter and to explore the child's world.

6.5.3.4 Dramatized play

In the change-oriented phase the child should have the opportunity to play out threatening situations in a safe environment. Dramatized play requires both creativity and a skilled therapist. The focus should be on unconscious fears and feelings. Role-play can be used, as well as hand puppets, paper dolls or masks (van der Merwe 1994). Playing with dolls offers the child the opportunity to make contact with various parts of him- or herself, according to Oaklander (1988). By playing with dolls the child is enabled to bring reality into the here and now, to relive traumatic experiences and to gain control over them (van der Merwe 1996d). Feelings are projected onto the dolls, new roles and skills are learnt, problems are solved and the child can

Name Date

Complete the sentence with the first thought that comes into your mind

1. I like
2. The happiest moment
3. Before I got to sleep at night I think
4. I would really like to
5. I feel
6. My friends know
7. Other children tease me
8. People who don't understand me
9. I get annoyed
10. My mother
11. My greatest fear
12. My father
13. I never could
14. When I was younger
15. I will never forget
16. I get angry
17. My greatest worry is
18. I sometimes wonder
19. I feel sad
20. If I could change things
21. It worries me
22. I prefer
23. What I need is
24. People who don't like me
25. I have no time for
26. I wish
27. I am sorry
28. I hate
29. I am very
30. I wish I could tell my mum
31. I sometimes imagine
32. It is my fault
33. I wish I could tell my dad
34. I can't understand
35. I long for
36. If my mum and dad
37. I feel alone
38. In school
39. I feel ashamed
40. Divorce

Figure 6.1 Example of incomplete sentence test

make decisions (Geldard and Geldard 1997). Chapter 5 provides a full exposition of the use of various types of dolls in dramatic play.

For children it is less painful to project situations that cause pain onto dolls. A playroom should preferably have a variety of dolls, for instance hand puppets with different characteristics, finger puppets, paper dolls and masks could be offered to the child to choose from. From practical experience it has been proven that this is a play technique that children use to verbalize occurrences that are too difficult for them to narrate to someone else. The opportunity is also offered to them to play changes into the situation, as they prefer, and through this the child gains control over the situation.

> A child and the therapist play with hand puppets and the following story is initiated by the child. L is a duck played by the child and the therapist is a bear that mostly asks questions. The duck tells the story of a family who live in a house in Bloemfontein. A husband, wife and three children live in the house. The father and mother of the family work during the day. The older children are at school and the youngest child stays at home alone. A stranger comes to the house and takes L, the youngest child, with him to a fun place. The family members search for her. She is told not to go out on her own again. L had enjoyed the dancing, but it was very bad for her when her mother beat her. L's mother and father argued with each other because she had gone out. Her mother took her things and left the family. Father and sister were very angry with L. She was not allowed to respond. From that day on L was alone. (Read 2002, p.75)

This story, born in the heart of a child, indicates the nature of circumstances, the experience of loss and also the emotions that can be dealt with by the therapeutic process.

6.5.3.5 Creative play

Creative play includes aspects of art therapy, such as drawing, painting and playing with clay. These techniques are used to depict projections that the child experiences in a non-threatening way (Thompson and Rudolph 1996; van der Merwe 1994). Oaklander (1988) describes the advantages of drawing and painting techniques and indicates that painting and drawing tasks can be given to the child that can serve as a metaphor, for instance to draw an emotion such as anger, being afraid or sadness. Geldard and Geldard (1997) suggest that lines, shapes or colours could represent family members. McMahon (1992) and Oaklander (1988) agree that the therapist should not

use the drawing for interpretation, but that the creation should be explored together with the child.

Playing with clay is an ideal medium for the discharging of aggression (Geldard and Geldard 1997; Oaklander 1988): because children can beat, chop and manipulate the clay to their heart's content, the opportunity is offered for the child to get rid of their inner frustrations during this kind of play.

Creative work offers the opportunity for projective techniques to be used (Blom 2000a, 2000b). Drawing, painting and clay objects are used to expose the actual experiences of the child during play therapy, as well as in the discussion of the creation with the child.

Projective techniques that can be used with the child who experiences loss and trauma are discussed in Chapter 4. Examples of projective techniques that may be used include the following:

- monster technique (Blom 2000a; Schoeman 1996a)
- empty chair technique (Blom 2000a; Thompson and Rudolph 1996)
- sand play (Blom 2000a; Geldard and Geldard 1997)
- clay modelling.

Creative work can be used meaningfully in play therapy, especially to give children the opportunity to express their feelings, of which they may not even be aware. The above-mentioned projective techniques are applied in practice with amazing results. Children are led through their own creation to insight into their actual experience of a situation, such as the divorce of their parents, for instance. By means of using projective techniques children are led to complete unfinished business and the balance in their lives can be restored in order that their overall functioning is improved.

By using the creative work of the child, the opportunity is afforded to own the projection, and to own the emotions that arise from the projection as observed during therapy sessions. Actually children give themselves a message because authentic emotions are named, experienced and owned, while different objects that have been chosen by the children are used. The polarity that causes conflicts comes to the foreground and can be dealt with so that the child's unfinished business in this regard can be completed.

The following is an example of a conversation during sand play with a child:

> A sand scene is built with various objects, people and animals. The tiger wants to catch and eat people. He prefers not to do it, but is obliged to for the sake of survival. Sometimes, therefore, the tiger takes on the role of the protector. The turtle usually lives in the water, but is on the sand at the moment. Turtle prefers having friends to swim with him. He feels lonely without friends. The whale swims in deep water and enjoys it, because the whales swim in a group. The whale reveals concern about the dolphin and offers to save him when he gets into trouble. The octopus reminds the participant of a family holiday where they were all together as a family. During that holiday an octopus got stuck onto his sandal. Although his father and mother tried to get the sandal back, they were unsuccessful. His father went deep into the sea during the holiday. The child was afraid that his father would drown. On the beach, though, there were lifesavers to look after the people. These men saved people and the child would also very much like to save people. He saved his brother when he wanted to run across the street in front of a car. The men in the scene were standing with their weapons ready, to ward off the conflict. Conflict between his parents before the divorce is on the foreground of the child. The gestalt could be complete by the owning of the projection. His father knocked his mother against the table. The child tried to stop them fighting and hurting each other. Feelings that he felt at the time of his parents' conflict are owned. (Read 2002, p.79)

Creative work and projective techniques can be used productively to manage the unfinished business of the child and to provide the opportunity for emotional expression.

6.6 CONCLUSION

With the use of gestalt play therapy children are placed in a position where they can verbalize the different feelings that have been experienced, after they have been made aware of the feelings, discussed feelings and are given the opportunity to express their feelings. Even young children can convey their feelings with the assistance of gestalt play therapy, which leads them into contact with their own experiences in the present. Through the use of different play techniques in the gestalt therapeutic process, loss and trauma can be addressed.

Experiences of loss and trauma can be productively addressed through gestalt play therapy. Practical experience has shown that the symptoms of children with experience of loss disappear after the therapeutic process has

been completed. Children thus obtain the opportunity to complete unfinished business. A gestalt is therefore completed and moved to the background. Children come into contact with themselves and no longer use energy to repress emotions. Integration of the fragmented parts within themselves takes place so that they can function as a whole. Children are also capable of supporting themselves through addressing the discomfort in themselves as they have developed a stronger sense of self during the therapeutic process.

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Chapter 7

Gestalt Play Therapy with HIV/AIDS Children in Middle Childhood Years

Rinda Blom and Sayeeda Dhansay

The human immunodeficiency virus (HIV) causes acquired immune deficiency syndrome (AIDS). Being HIV infected has an impact on the medical, psychological, social, spiritual, educational and economic life of the infected adult or child. There are approximately 16.3 million children in South Africa, of whom the majority live in poverty. Many live on the streets, exposed to violence, abuse and prostitution. South Africa has the largest number of persons with HIV infections in the world, barring India which has a far larger population (Whiteside and Sunter 2000).

Women and children are not only physically abused but also raped and sexually abused which makes them more vulnerable to HIV/AIDS infection. According to Keke (2002), 15,650 child rapes were reported for the period January 2001 to September 2001 to the South African Police Services and many other cases go unreported.

Young parents are dying of AIDS due to lack of treatment, leaving behind children who may be HIV infected and who may also suffer due to poverty. These children may suffer loss, grief, depression, abuse, abandonment, isolation, loneliness, rejection, fear from the stigma that HIV/AIDS still has, in addition to physical discomfort, pain and hospitalization. The fact that HIV/AIDS still carries a major element of stigma and secrecy compounds the problem in terms of the utilization of resources, as well as fears of rejection. Caring for an HIV-infected child can be both expensive and challenging.

Much of the emphasis has rightfully been placed on meeting the needs of the HIV-infected child in terms of treatment, care and support. However, the emotional impact of the illness on the HIV/AIDS child needs to be addressed as well. Children in the middle childhood develop cognitively, emotionally, socially, morally and sexually. They need to be seen as a totality

in communication with their world (Kruger 1991). Because of fear of HIV/AIDS, influence of friends, mass media, the perception of AIDS as a punishment for sin, prejudices and the social world of children in the middle childhood years, they can become very conscious of HIV/AIDS. They therefore may have unanswered questions, myths and prejudices, leading to suppressed emotions and symptomatic behaviour, that need to be addressed during therapy.

This chapter will focus on the value of gestalt play therapy with HIV/AIDS children in the middle childhood years and how gestalt play therapy can be implemented with these children in practice. The emotional and psychological effects of HIV/AIDS on children in the middle childhood years as well as theoretical concepts and techniques of the gestalt play therapy process will be discussed. A case study with an HIV/AIDS child, utilizing gestalt play therapy theoretical concepts, process and techniques, will then be described.

7.1 MIDDLE CHILDHOOD DEVELOPMENT AND THE HIV/AIDS CHILD

The middle childhood years stretch from about 6–7 years to 12 years with development occurring on the physical, social, cultural, cognitive and emotional levels. Moral and sexual development is also influenced at this level.

7.1.1 Physical development

Physical development of children in the middle childhood years takes place in proportion to body rather than in height or mass. The child cannot sit still for long periods of time and exercise is vital. Bone and ligament growth are still incomplete. Questions of sexual development may arise and should be handled truthfully (Kruger 1991). HIV/AIDS can be suspected in children by looking at the following criteria (van Dyk 2001):

- weight loss, abnormally slow growth and a failure to thrive
- prolonged fever that has lasted for longer than one month
- chronic diarrhoea for more than one month
- a chronic cough that has lasted longer than one month
- generalized lymph node enlargements
- recurrent common infections such as ear and throat infections
- the mother of the child is HIV positive.

In developing countries, children with HIV/AIDS have the same illnesses as children without, such as measles, diarrhoea and respiratory infections. However, the illness may be more severe, frequent and persistent. Although the rapid progress of HIV infection in some children means that these children will die within the first two years of life, the children who can be classed as slow progressors often survive to older childhood years and even into the early teenage years (Smart 2000; van Dyk 2001).

The effect of HIV/AIDS on children's physical development, when they suffer from persistent coughs, skin lesions, diarrhoea, ear and throat infections and weight loss, can be enormous. If children are persistently tired, they may be unable to participate in physical activities such as running and jumping which are usually encouraged during this period. This can influence their social interaction, emotional well-being and peer support. Neatness may be a problem as well as visual and auditory demands.

HIV/AIDS children are dependent on healthy nutrition, personal hygiene and exercise, which parents and caretakers need to provide. Should HIV/AIDS children perceive their body as negative, their self-image may be influenced negatively, as body image has an influence on children's sense of self. HIV/AIDS can thus contribute to absenteeism from school and isolation from friends.

7.1.2 Social development

Family support, community structures, school and friendship networks are important sources of opportunity for children in the middle childhood years. Furthermore, social obstacles such as poverty, anxiety over safety, prejudice and culture influence growth in middle childhood. The importance of the peer group in the child's social development and preparation for functioning in the adult world is stressed by Louw (1990).

Poverty, a lack of resources and poor treatment may influence HIV/AIDS children's developmental progress. A sense of dysphasia, preoccupation with illness, poor body image and hopelessness may occur. Risk-taking behaviour, conduct and hyperactive disorder may manifest themselves. Repeated hospitalization and isolation from peers may also have an adverse effect on their social, cognitive and communicative development (Brown and Lourie 2000). Extreme stress in the family may even lead to child abuse, neglect or abandonment (Berger, McBreen and Rifkin 1996). Often a lack of attention is given to the above aspects concerning HIV/AIDS children within schools and institutions and therefore these children suffer more stress, such as abandonment, living on the streets, being in the care of an elderly family member, rejection or isolation, grief and loss.

7.1.3 Cultural development

Male and female roles are defined by the child's culture and responsibilities at home. The HIV/AIDS child may be unable to participate in household tasks which promote growth and self-development (van Dyk 2001). Culture plays an important part in determining how people of different backgrounds view and cope with HIV/AIDS and this also shapes the HIV/AIDS child's behaviour and reaction to illness (Brown and Lourie 2000). Some parents and caretakers may in fact deny their child's illness and attribute it to other factors, such as jealousy by someone else. If the sickness is denied because of cultural beliefs, children will not get the support necessary to deal with emotional experiences during different phases of the illness. This may lead to symptomatic behaviour, such as bed-wetting, nightmares and aggressive outbursts, because their feelings are suppressed.

7.1.4 Cognitive development

Healthy children in the middle childhood phase normally become enthusiastic learners, since perception, memory, integration and differentiation are more prominent. The environment, cognitive limitations or perceptual deficits may result in fear, anxiety and withdrawal. Thus the HIV/AIDS child who is being pushed into social and educational situations beyond his or her ability may react with hostility or withdrawal. It is accepted that interaction between the child and the environment is critical and if the world is perceived to be cruel and threatening, it restricts the psychological development of children (Berger *et al.* 1996, p.146).

The psycho-educational implications for the HIV/AIDS child – such as school absenteeism, adjustment to medical regimes, stigma and isolation – may also result in developmental decline, language problems or neuropsychological deficits (Wordrich and Swerdlik 1999). Therefore ongoing schooling, for example in the hospital, in order to maintain educational needs is essential.

7.1.5 Emotional development

The emotional development of children in the middle childhood years is characterized by emotional flexibility and differentiation, while their expression of emotions like anger or aggression is closely related to their psychosocial development. The child in this phase learns to express emotion, control it, suppress it or hide it. Fear seems to be the emotion most relevant to HIV/AIDS children. During this phase, they may already express fear of the supernatural, monsters, darkness, lightning, physical injury and death as

well as respond to media reports or awareness programmes on HIV/AIDS (van Dyk 2001). Therefore a HIV/AIDS diagnosis and infections may have major implications on the child's emotional development. Besides the acute emotional and physical suffering, the disease may be compounded by the fact that most of these children come from lower socio-economic groups in which poverty and drug abuse may be high. Violence, crime, unemployment and overcrowding may further exacerbate the problem.

There are other additional issues relating to HIV/AIDS children, namely infectivity, delayed onset of symptoms, public panic, fear of stigmatization and rejection. The issues of guilt and attribution of blame are important considerations (Stuber 1990). Frequent hospitalization and painful medical procedures may cause further mental anguish, fear, depression or grief. Stress due to poor body image, feelings of hopelessness and preoccupation with illness may be prevalent. Little is known at this stage about mood disorders or suicidal attempts (Brown and Lourie 2000). The issue of secrecy may lead to children being abandoned in hospital since the disease places stress on the family system and resultant lack of support. The authors' own experience has shown that mothers often do not inform other family members of their children's illness. Thus family support may falter when it is most needed.

Adults, adolescents and children deserve to know the truth about their illnesses and treatment, with developmentally appropriate explanations, otherwise they invent their own explanations which may result in self-blame and interfere with support, therapy or nurturing. Children at the age of six do not really care about terms such as 'HIV' or 'AIDS'. They need to know the following, namely that it is a serious illness, that doctors may not be able to cure it as yet, that treatment is necessary and that they will be kept informed about the progress of the illness. This will assist the therapist in handling children's fear, anger, frustration and other unfinished emotions (Stuber 1990).

According to research studies, children with HIV/AIDS may experience anxiety, depression and manifest hyperactivity or conduct disorders. Paediatric HIV patients also experience more subjective distress than their uninfected peers as a result of deterioration in developmental skills. They may experience poor body image, hopelessness and a preoccupation with their illness. Little is still known about mood disorders and suicide of HIV/AIDS children (Brown and Lourie 2000). In practice, these phenomena and emotions have been observed when a 13-year-old HIV-infected girl appeared depressed due to lesions on her face. It is thus clear that children with

HIV/AIDS have to cope with multiple emotions – among others, emotional pain associated with social stigma, disclosure, anxiety about medical procedures, hospitalization, loss, grief, loss of healthy physical appearance and body image. Thus withdrawal, loneliness, anger, confusion, depression, fear and guilt may be unfinished emotions in these children and they have to be supported during therapy to express these emotions and to acquire handling strategies for them.

7.2 GESTALT PLAY THERAPY WITH HIV/AIDS CHILDREN IN MIDDLE CHILDHOOD

The most important area of concern of gestalt theory is that which the adult or child is feeling or experiencing at this moment (Thompson and Rudolph 1996). However, Oaklander (1994a) describes gestalt therapy as a humanistic process-oriented therapy that is concerned with the healthy functioning of the total organism, which is its senses, body, emotions and intellect. The above author also concedes that these principles can relate directly to children. Thus HIV/AIDS children may benefit from this approach in that the disease can impact on their total functioning in terms of body, senses, emotion and intellect and the emotions they experience at a specific point in time. Different theoretical concepts of gestalt play therapy, as well as how they may be applicable when working with HIV/AIDS children in the middle childhood years, will be discussed below.

7.2.1 Organismic self-regulation

Organismic self-regulation is the process whereby the organism tries to satisfy needs, thus gaining homeostasis. Children normally react to trauma and loss in fairly common developmental ways. They fear rejection, abandonment or not having their needs met. Children also take responsibility for what happens to them due to a lack of emotional and intellectual maturity, and reluctantly they will do anything to have their needs met. Children who have their needs met achieve homeostasis, while others who cannot satisfy their needs in this way may manifest with symptomatic behaviour (Oaklander 1994a). Children are constantly faced with physical, emotional or intellectual needs and discomfort will be experienced until they find some way in order to satisfy a need and achieve equilibrium (Oaklander 1994b).

The HIV/AIDS child may have many needs, for example:

- the need to understand how they obtained the infection
- the need to deal with pain or hospitalization

- the fear of death or loss of parent or caregiver
- the need for proper nutrition or care
- the anger they feel at being ill.

The healthy development of the HIV/AIDS children's organism – that is, their senses, body, emotions and intellect – can be interrupted and their sense of self diminished if they cannot make contact with the environment in order to satisfy their needs. This may result in poor relationship building and contact-making with their environment, as well as the therapist.

7.2.2 Contact boundary disturbances

Contact involves the ability to be fully present in a particular situation with all the aspects of the organism – senses, body, emotions and intellect. In an effort to satisfy their needs, children often inhibit, block, repress or restrict various aspects of the organism. These restrictions may cause contact boundary disturbances and therefore block the process of healthy organismic self-regulation. Should the HIV-infected child have a poor sense of self, it will influence how he or she relates to others or the environment. These children are in confluence, because there are no clear boundaries between them and the environment. HIV/AIDS children may try to avoid contact in order to protect themselves from stigma and prejudice. They may project their feelings onto others by blaming others for bad things because they are scared to take responsibility for these fearful feelings (Oaklander 1997).

Some HIV/AIDS children may retroflect, which means that they will pull their energy inwards, doing to themselves what they would want to do unto others (Oaklander 1994a). They may experience psychosomatic illnesses such as headaches or stomach-aches, suffer nightmares, injure themselves or wet their beds. It could also mean that they may become obsessed with symptoms of HIV/AIDS infection. Other children may deflect and deny the grief or anger they feel at having the HIV infection by being aggressive towards others or throwing temper tantrums. HIV/AIDS children may also dream or fantasize as a way of avoiding contact with their emotional pain. According to Oaklander (1997), these behaviours are called contact boundary disturbances or resistances in gestalt therapy literature as they affect healthy contact with the self and environment. Furthermore, HIV/AIDS children who restrict and inhibit aspects of the organism, especially emotions, diminish their sense of self. Thus it may be terrifying for the HIV/AIDS child to imagine that he or she may be abandoned, isolated and rejected and lack food and shelter.

7.2.3 The here and now

The here and now starts with current awareness, since prior events may be the object of present awareness. The focus of gestalt play therapy is on the present. Although the influence of happenings in the past or predictions of the future cannot be denied, the only reality the child can work with, in order to achieve growth, is the present. Events in the past have probably not been assimilated and become part of the personality. This unfinished business may prevent children from meeting their needs in healthy ways (Aronstam 1989).

What HIV/AIDS children are experiencing in the here and now – their anger, fear, or grief but also their physical pain and discomfort – should be taken into consideration during gestalt play therapy. From experience with a terminally ill HIV/AIDS child who was experiencing pain, it was best just to sit with her and acknowledge her feelings in the here and now.

7.2.4 Resistance

In gestalt play therapy, resistance is not seen as an unwillingness to participate, but rather as a lack of contact on the part of the child. Resistance is thus considered as faulty contact with the environment, meaning that there is a lack of contact in terms of the senses, body, intellect and emotions; children will thus resort to behavioural manifestations, seen as resistances, which in fact is their way of sidestepping the real issues in their lives (Oaklander 1994a). Children normally manifest with resistance, because they do not have enough inner strength to deal with their pain.

These resistances imply the closing down of aspects of the organism, be it senses, body, emotions or intellect. Should the HIV/AIDS children sense that they are being rejected or stigmatized at school, they may resist by denying their illness or being angry at home, because of their poor sense of self. It will be important for the therapist to respect the child's resistance, because the child needs to be resistant, until he or she has a strong enough sense of self to deal with pain and unfinished emotions.

7.2.5 Holism

From the gestalt perspective, people are a unit comprising not only themselves, but also interaction with the environment. Human beings need their physical and social environment in order to survive (Aronstam 1989). During gestalt play therapy, children must be seen as holistic entities and their bodies, emotions, spiritual aspects, language and bodily experiences cannot be separate. Thus when children have physical pain, they may also

have an emotional experience, for example being scared, and this may interfere with their cognitive abilities, such as their concentration at school. Thus when doing gestalt play therapy with HIV/AIDS children, the therapist must take their mental aspects, physical well-being, social environment, community, culture, traditions, family and school, all of which play a part, into consideration.

7.2.6 Unfinished business

Children may have unfulfilled needs, unexpressed feelings or uncompleted situations that require attention (Thompson and Rudolph 1996). These are unfulfilled needs or unfinished business from the past, which impact on the child's present functioning. The HIV/AIDS child may for example be angry with a parent who has 'given' him or her this illness, or may experience unexpressed grief because the parent is already deceased.

7.2.7 Polarities

Polarities are seen as the conflicts and opposites which occur in life (Thompson and Rudolph 1996). For example, the HIV/AIDS child may feel anger at having an incurable illness, but also at doctors for having no cure. They may believe in God but also feel God is punishing them. Feelings of hate/love, depression/excitement and the fact that the body may feel ill but the mind may be happy may be typical of the polarities the HIV/AIDS child experiences. Therefore, a split may arise in these children's organisms, as a result of what they want to do – or what others feel they should do. For the HIV/AIDS child, it may be a matter of wanting to show anger towards the parents, but also having love and respect for their parents. Children will often repress their anger towards their parents, because of a belief that this is not allowed. This then results in fragmentation of their holistic self, as there is a part of their feelings that is denied. It is important that the gestalt play therapist help these children during therapy to become aware of these fragmented polarities and find ways to integrate them as part of their holistic self.

7.2.8 The layers of neurosis

Layers of neurosis, as postulated by Perls (1971) in Thompson and Rudolph (1996), are important in the gestalt play therapy work. Five layers are identified, namely:

- The synthetic/false layer, where children are trapped in their false existences. The HIV/AIDS child in this layer may deny he or she is feeling sick and may pretend that nothing is wrong. Introjects, such as that HIV/AIDS may not be discussed and admitted to anyone, can give children the message that they are not allowed to feel sick, or that they are feeling this way because of something they have done wrong.
- The phobic layer, where children become aware of their false behaviour and this creates stress and tension for them. HIV/AIDS children may feel the physical pain, which is getting worse, but do not know how to tell someone. When they tell the therapist that they are not feeling well, they may feel scared, because they are not living according to their introjects any more. They may thus be scared of what the therapist will do on seeing beyond their false existence.
- The impasse layer, where children are looking for external support in order to solve their problems. If the therapist does not solve their problems, for example healing them from the bad feelings and illness, they may get stuck, for example become withdrawn or depressed, and refuse help or they may refuse to come to therapy any longer.
- The implosive layer, where children become aware of how they have restricted themselves and find new strategies to solve their problems, although they are still experiencing a lack of energy in addressing their needs in a healthy way. The HIV/AIDS child may start to feel good about therapy and decide that he or she can talk to the therapist about his or her real feelings, although he or she may still experience a lack of energy to do so.
- The explosive layer, where children realize that they have the capacity to use their energy to own their emotions and to experiment with new behaviour. They thus realize new ways of adapting to the environment. HIV/AIDS children that reach this layer during gestalt play therapy can use their energy to meet their needs in a healthy way, own their unfinished emotions and experiment with new behaviour.

The idea of gestalt play therapy is to help the children grow, mature, take charge of their lives and become responsible for themselves through

awareness and living in the here and now (Thompson and Rudolph 1996). Therefore HIV/AIDS children will need to be taken through the gestalt play therapy process in order to reach the above goal.

7.2.9 Awareness and experience

The prime goal of gestalt play therapy is helping children to become aware of their process, which is what they do, how they do it and how they satisfy their needs. Heightened awareness is created when children are able to identify who they are, what they feel, what they like and dislike, their choices and how their needs are met. This happens through the techniques and activities therapists use during gestalt play therapy. Experiencing in the here and now is the key to awareness when working with children (Oaklander 1992, 1994a). Awareness during gestalt play therapy must comply with three requirements (Aronstam 1989):

- it must be governed by the dominant need
- there must be awareness of the situation and how the child fits in
- awareness is sensorial in the here and now and happens in reality.

HIV/AIDS children who have shut themselves off from the environment due to lengthy hospitalization would benefit from practical experiments during gestalt play therapy, to gain awareness, sensations and feelings that will strengthen their sense of self and self-determination. It is thus clear that all the theoretical concepts of gestalt play therapy may be suitably applied in dealing with the emotions of the HIV/AIDS child during therapy.

7.3 THE GESTALT PLAY THERAPY PROCESS AND HIV/AIDS CHILDREN IN MIDDLE CHILDHOOD

The process of gestalt play therapy fits in with the philosophy, theory and practice of gestalt therapy. It begins with the relationship, contact functions and building of self-support, in order to express emotions, become self-nurturing, deal with inappropriate behaviour and then terminate therapy (Oaklander 1997). For HIV/AIDS children, who may have deep-seated blocked emotions as a result of their terminal or chronic illness, it could be beneficial to apply the process of gestalt play therapy as discussed by the above author, in order to build a trusting relationship. This would assist them in gaining self-support so that they can express blocked emotions and learn new handling strategies for it. This process will be discussed below.

7.3.1 Building of a therapeutic I–thou relationship

The I–thou relationship involves the meeting of two people who are equal, meaning that the therapist, regardless of age, education or economic status, is no better than his or her client. It is important that the therapist in his/her dealing with the HIV/AIDS child respects and honours the child and is aware of his or her own limits and boundaries, as well as prejudices (Oaklander 1994b). HIV/AIDS children may be immobile, have lesions on their face, or suffer from diarrhoea, but it remains the responsibility of the therapist to meet, respect, accept and be genuine towards the HIV/AIDS child.

Nothing happens without the thread of a relationship during therapy (Oaklander 1997). For the HIV/AIDS child, who may be withdrawn or feel different, building a trusting relationship with the therapist would be imperative. In fact, in some instances, for example where the child may have been abandoned in an institution, the relationship itself could be curative. Respect, honour, genuineness and responsibility on the part of the therapist, as described by Oaklander (1994a) as the I–thou relationship, could be essential for the growth of a HIV/AIDS child. According to Reid (1991), the following play materials are suggested for relationship building: a sand tray, a medical kit, dolls, adhesive tape, tissues, plasters, string and insects. Music, clay, puzzles and drawing all assist in building a therapeutic I–thou relationship.

7.3.2 Contact-making

After a therapeutic I–thou relationship has been established, the therapist has to assess whether the child is able to make and sustain good contact. This involves the ability to be fully present in all aspects of the organism, meaning the body, senses, emotions and intellect. When children's senses and their body become restricted, as with children who are frightened, grieving or angry, emotional expression and a strong sense of self will largely be absent (Oaklander 1997). The process of contact-making is a continuous one, since this is a prerequisite for in-depth therapy and emotional expression of children.

In the authors' own experience, it has been observed that children who have been physically abused just stare into space. These children do not even react when a doctor approaches them, as other children would. Their bodies have become totally restricted in terms of their environment. HIV/AIDS children often have pain or discomfort, which influences their ability to make good contact. It is important to work with their contact skills during

this phase, such as focusing on their touching, seeing, hearing, tasting and smelling, as well as breathing and body activities. For HIV/AIDS children, bodywork is important, in terms of their illness and how it is affecting them. Breathing activities, dancing, ball playing, balloon blowing, finger painting, clay work, listening to music and eating an orange to enhance their sensory contact-making can be done during this phase. For a more complete description of activities that can be done during this phase, refer to Chapter 3.

7.3.3 Self-support

Self-support – which means helping children establish inner strength through expression of self, namely what they look like, their likes, dislikes, choices and mastery activities – is the next important phase of the gestalt play therapy process. The healthy uninterrupted development of children's organism – that is, senses, body, emotion and intellect – is the underlying basis of their sense of self. A strong sense of self helps children to make good contact with their environment, in order to satisfy their needs. Children need this support within themselves, in order to express their emotions (Oaklander 1994b).

Fantasy techniques, music and puppetry could help HIV/AIDS children to gain inner strength. Drawing on all the polarities in HIV/AIDS childrens lives is important, for example love/hate of a parent for abandoning them. Children can for instance be asked to use clay to build a part of themselves that they like and a part that they do not like. Other techniques that can be used are outlined in Chapter 3.

During this stage, children must be supported to make self-statements, for example to tell the therapist about things in themselves or their life that they like and dislike. It is essential for HIV/AIDS children to gain self-support before moving on to the phase of emotional expression. Gaining self-support by expressing aggressive energy or by mastery and having choices can assist these children in gaining and regaining a stronger sense of self. Aggressive energy is the energy children need to express a strong emotion. It should thus not be confused with aggressive hostile behaviour. This energy gives children the self-support in order to take further action or express buried emotions (Oaklander 1997).

7.3.4 Emotional expression

Assisting children to unlock their buried emotions and learning healthy ways of expressing them is the main accent of this phase. In order to unlock buried emotions and teach children ways to express emotions, Oaklander

(1997) uses drawings, collages, clay, fantasy, imagery, drama, music, movement, story-telling, metaphors and games. These techniques give children the opportunity for powerful projections that can evoke strong emotions.

The above applies as well to HIV/AIDS children, who need to understand what feelings (anger, fear, grief) they may be suppressing, learn to own those feelings and express blocked feelings such as anger in a safe manner. Blom (2000) states that it is also therefore important to provide time to teach the child ways and means of expressing aggressive energy. Cushion fights, clay throwing, wet newspaper boxing, shooting with dart guns at a token and tearing up newspapers are possible activities that can be used to help HIV/AIDS children come into contact with their aggressive energy. The therapist may experience these activities as exhausting, because they require the active involvement of the therapist.

During this phase, therapists can talk to children about feelings, make lists of feelings or draw all kinds of feeling faces to help them to become familiar with emotions on a cognitive level. Children do not just move from talking about feelings to expressing them and therefore a variety of activities are used during gestalt play therapy to assist them to project and own their emotions. Projective techniques that can be used are outlined in Chapters 4 and 5 and include the following:

- Drawings – according to Oaklander (1988) the very act of drawing without interference from the therapist helps children establish a self-identity and allows for emotional expression. Asking children to draw themselves or their family, or to draw happy, sad, scared or angry feelings, can lead to the projection of their unexpressed emotions. The therapist can then assist them to elaborate and describe their picture, to be each item in the drawing and to have a dialogue between different parts. Children may also be asked to think how their drawings can fit into their lives.
- Clay play – the use of clay can help children to relax; it promotes tactile experiences and brings children closer to their experiences. They can build body parts or their family. Music can also be played to them and they can then be asked to build anything that comes into their awareness while listening to the music. The authors have found that children like to play with clay, because they can mould it the way they want. This contributes to their experience of mastery and control.

- Empty chair technique – this play therapy technique helps children to come into contact with their feelings by fantasizing they are putting someone or something in an empty chair and then expressing their feelings towards him, her or it. This technique can assist children to close their unfinished gestalt (Oaklander 1988). HIV/AIDS children can for example be assisted to imagine their sickness is put in the empty chair and then to express their feelings towards it.
- Rosebush technique – this fantasy technique assists children to become aware of their feelings in the here and now. They are asked to imagine themselves as a rosebush and to consider the type of rosebush, root system, number of roses and thorns, the environment, other plants surrounding it and its future (Thompson and Rudolph 1996). Afterwards, children are requested to draw their fantasy and a discussion is held on how this projection can fit into their lives.

After projecting and owning their emotions, HIV/AIDS children must be assisted to acquire new handling strategies for their emotions. Regarding the handling of feelings, Oaklander (1997) states that children should be taught how to express for example feelings of anger, without creating further trouble for themselves. In order to be able to do so, they must have a need to get rid of the negative energy that is created by their emotions. HIV/AIDS children can learn to hit a designated pillow, to scream into a pillow, or to hit a 'bopbag', in order to manage their angry feelings. These children often experience a lot of fear and anxiety because of their sickness and must be helped to acquire handling strategies for this as well.

7.3.5 Self-nurturing

Many children take in faulty messages about themselves at a time when they do not have the maturity and cognitive ability to know what applies or does not apply to them. These negative introjects cause them to inhibit aspects of the self and this interferes with their healthy emotional development (Oaklander 1997). During the self-nurturing phase, children must learn to accept those hateful parts and to work towards self-integration and self-worth. They must thus learn to become more accepting, caring and nurturing towards themselves (Oaklander 1992).

HIV/AIDS children may have taken in faulty messages regarding the mode of transmission of their illness. They may believe that they have done

something wrong and that the sickness is the punishment for it. Children can be helped to become more nurturing towards themselves by using projective techniques such as the empty chair technique, clay or even a nurturing bear to talk to, in order to help them to become more accepting of those hateful parts (Blom 2000). Other techniques that can be used are outlined in Chapter 5. HIV/AIDS children can also benefit from these exercises. Even when they are in hospital, they can have a teddy bear or other soft toy, which they can talk to, imagining it is their hurt younger self and nurturing it. They can be taught to do something nice for themselves every day.

7.3.6 Dealing with persistent inappropriate behaviour

The aim of gestalt play therapy is to help children to become more aware of themselves and their process. Therefore the focus is on the *what* and *how* of their process and not on their symptomatic behaviour. Children's symptomatic behaviour, which they display generally, normally disappears as they begin to develop a deep sense of self and find healthier ways of satisfying their needs (Oaklander 1994a). Thus, after expressing unexpressed emotions, HIV/AIDS children may be more spontaneous and feel less isolated from other children. However, feelings of aggression may persist at times and, as suggested by Blom (2000), it would be important to highlight awareness of this behaviour during this phase and to give choices that allow children to take responsibility for their behaviour.

HIV/AIDS children should develop a sense of self, which may have been diminished due to stigma and feelings of loss or grief, before they are assisted in dealing with the ways in which they try to satisfy their needs. Although this phase is often not necessary after children have expressed their emotions and have learnt new handling strategies for them, the therapist can make use of an appropriate story and puppet-shows to increase their awareness of their process during this phase. It is however important that they are able to identify with the story, to project their own emotions and to learn about healthier ways in which they can express their emotions and satisfy their needs.

7.3.7 Termination

Special attention needs to be given to termination: activities like the drawing of emotions, making of goodbye cards and paging through previous activities done are helpful (Blom 2000). For HIV/AIDS children, proper termination is essential so that they may not see this as another form of loss or rejection. Unfortunately therapy often has to stop due to financial constraints and

transport problems. For HIV/AIDS children, termination may result because of death, pain and deterioration in illness. Thus working through grief, loss and fears of death are important considerations in anticipation of what may happen, for instance death or pain or loss of a loved one.

7.3.8 Working with other significant people

Identifying HIV/AIDS children in distress and implementing early interventions will enhance their coping with the situation. In summarizing intervention strategies, Brown and Lourie (2000) have identified the following as being of importance:

- Support of members of extended family – taking into consideration limitations on the part of the family, as well as losses they may have had.
- The need of the HIV/AIDS child to express fears and fantasies. Reactions of grief may occur as well as anger – possible unresolved unrestricted anger towards an infected parent which may inhibit communication and thus also limit emotional support.
- A programme to deal with issues surrounding death and dying.
- An intervention model dealing with support for the child and family in coping with chronic and terminal illness.
- Multidisciplinary services are important, namely the paediatrician, social worker, psychologist, psychiatrist, a medical ethicist, a psycho-educationalist as well as occupational, physical and language therapists.
- Focusing on HIV as a chronic disorder and lessons from other chronic diseases will help. However, the authors concede that the prevalence rates of psychiatric disorders in HIV/AIDS children are still unknown.

According to Lesar and Maldonado (1997) in their study on the impact of children with HIV/AIDS infection on the family system, it is clear that the factor most highly related to stress in families of HIV/AIDS children is the psychological burden of additional care demands and providing training in this regard. Therefore parent-guidance counselling with caretakers of HIV/AIDS children would be beneficial.

7.4 OTHER GESTALT TECHNIQUES THAT CAN BE APPLIED

The function of the gestalt therapist is to facilitate the client's awareness in the here and now (Thompson and Rudolph 1996). Blom (2000) mentions that techniques and activities should suit each phase of the gestalt process but similar activities may also be applied to suit each child's unique process. The following techniques are important in gestalt therapy and may be used with HIV/AIDS-infected children (Thompson and Rudolph 1996):

- No gossiping
  Use the empty chair technique and allow the child to speak to the empty chair as if that person were present. The child's awareness of the problem is increased as well as the fact that he or she obtains another viewpoint. This may be a useful technique for HIV/AIDS-infected children whose parents may be deceased, when they feel angry at having the illness.
- Changing questions into statements
  This may help children to be more authentic and direct. Helping children to say, for example, 'I am HIV infected' may assist in them taking responsibility for their thoughts and feelings.
- Taking responsibility
  Allow children to write down how they are feeling right now concerning an issue such as: 'This is how I feel about my sickness and I take responsibility for it.' This can assist HIV/AIDS children to express their unfinished emotions.
- Incomplete sentences
  This exercise helps children to become aware of how they help or hurt themselves, for example:
  - I help myself when…
  - I hurt myself when…

Many HIV/AIDS children may be withdrawn, shy or fear rejection and writing down their feelings will assist them in expressing blocked emotions. Furthermore, van der Merwe (1996) mentions the following activities:

- Music, either merely listening to it or with movement.
  Well-known songs may be adapted to convey messages. The HIV/AIDS child may have tense feelings which music may relax.

- Muscle relaxation training: the feeling children experience when they can distinguish between tense and relaxed muscles may create comfort for them. Breathing exercises also help with muscle relaxation. If the child became HIV infected as a result of rape or sexual abuse, this technique may help him or her to accept his or her body more easily.
- Puzzles develop a relationship of trust and create a relaxed atmosphere.
- Pets and animals: these pave the way to build a relationship with the therapist as well as give the child unconditional love and teach responsibility. The above is aimed at decreasing tension and preparing the child for therapy.

It is important that the techniques of play used with the HIV/AIDS child are suitable in terms of building the relationship, self-support, expressing emotions as well as developing self-nurturing.

7.5 CASE STUDY OF GESTALT PLAY THERAPY WITH AN HIV/AIDS INFECTED CHILD IN MIDDLE CHILDHOOD

X, an 11-year old girl, became HIV infected as a result of mother-to-child transmission. Her mother died of AIDS when she was seven years old and X was diagnosed with HIV/AIDS at the age of eight years, since she developed seizures. X is staying with her maternal uncle and aunt. The whereabouts of X's biological father is unknown. X's uncle and aunt cannot visit her regularly when she is hospitalized, because of their working conditions. She has been hospitalized several times at different hospitals and at the time of the therapy she was in hospital again due to pulmonary tuberculosis. She experienced medical procedures such as medical examinations, drawing of blood and receiving of oxygen. X attended the hospital school where she was in grade 5. She was referred for therapy by the nursing staff for a disturbed sleeping pattern. She never asked questions as to the reasons for her lengthy hospitalization. The nursing staff were uncertain as to how she coped with her HIV diagnosis, of which she had been informed.

The goal of therapy was to assist X to become aware of her unfinished emotions, in order to function in a more integrated way and to become more self-supportive, by utilizing the gestalt play therapy process and play techniques.

7.5.1 Relationship building

Since the relationship is the foundation of the therapeutic process it was essential to nurture this and build on it throughout the process with X. Ball games, painting, colour exploring, play-dough, sand play, music and differently coloured gemstones were used in this phase. Activities in this phase needed to be non-threatening, as it would assist in building a therapeutic I–thou relationship.

Heightened awareness of X's body was developed by activities such as breathing, playing, movement and touching. The building of trust with the therapist, as well as contact, was easily established. X enjoyed playing with different dolls in the sand. She created a sand scene of her aunt, uncle and herself and told the therapist that her mother had died. She however did not want to explore more on this. The feeling of power, of being in control of the ball, was also evident during a ball play activity. Humour and a sense of enjoyment, excitement and energy were present, although not much verbal communication took place.

The use of colour-in, painting and hearing seashells assisted in sensory contact-making, which X needed for emotional expression. Choices given in choosing the play-dough herself also contributed to strengthening her sense of self and she displayed sadness at her aunt not visiting her. Music assisted in relaxation. Issues of possible confluence, deflection, projection or introjections as contact boundary disturbances needed to be assessed further. Since X was not communicating much on a verbal level, play therapy was suitable, as she could express herself without using words.

7.5.2 Contact-making and building self-support

X's contact-making skills needed attention and she needed to gain a strong sense of self which would lead to good contact with the environment.

Activities that were used during this phase included music, drum beating, puzzles, clay play, drawing, tasting of sweets (sour and sweet) and using hand lotion to enhance tactile contact-making. Attention was given to X's contact-making skills during this phase by focusing on sight, touch, hearing and smell as well as taste. For X this was beneficial, since HIV/AIDS children may have restricted themselves in this manner. She was encouraged

with the help of the therapist to listen to different sounds and happily made her own tune using different traditional instruments. She seemed to feel in control. In addition, heavy breathing during the drum beating activity was useful and also assisted her in expressing anger and frustration. While busy with the puzzles, X started to express herself verbally by making comments on the animals in the puzzles.

With the clay she created different members of her extended family. She could relate to whom she liked and disliked in her family and the reasons for that. She could also relate to her favourite people in the hospital, as well as outside. She used animals to portray her likes and dislikes and hated the snake the most. These self-directed statements of X's likes and dislikes and mastery activity served to give her the inner strength to start expressing herself in terms of her family. This was also done in conjunction with the use of polarities, when focusing on things she liked and did not like. After this activity, X displayed resistance by breaking contact and asked if she could build a puzzle. Resistance may have surfaced when she broke contact and also when she refused to respond to the dance music, but it could also be because she was tired by that time.

7.5.3 Emotional expression

The way in which X handled emotions and how she expressed these, as well as the techniques used, may be important considerations for gestalt play therapy with HIV/AIDS-infected children.

Activities that were used during this phase included drawing, playing with hospital toys, building puzzles, the monster technique, painting, drum playing and story-telling through puppets.

Initially the primary focus was to assess X's knowledge of emotions and assist her in communicating them. She said that the doctor doll reminded her that she was in hospital. Her drawing herself in a hospital and identifying her feelings of loneliness and sadness continued this. She identified her name, diagnosis of tuberculosis and her symptoms, which made her feel ill. She compared her present situation in hospital with being at home, where she had family and close friends. She expressed feelings of sadness at being in hospital, as well as the desire to go home. In Figure 7.1, X's drawing of herself lying in hospital is illustrated.

The therapist requested that X drew a monster that she had in her life. She drew a picture of a black monster and wrote HIV next to it. Figure 7.2 illustrates the painting of the HIV-monster.

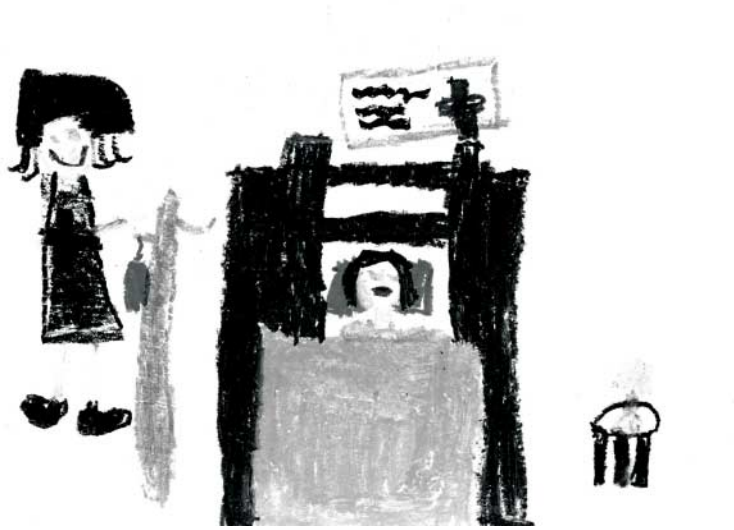

Figure 7.1 X's drawing of herself lying in hospital

Figure 7.2 Painting of HIV-monster

This was continued with a discussion of her emotions about having HIV/AIDS. She expressed a fear of death. A discussion followed as to how she had become HIV infected and X displayed sadness at her illness, which she got from her mother. A discussion of her knowledge of her HIV diagnosis proceeded, as well as her fear of death. This was explained via the fact that children die, due to different reasons, but that it is never a fault of their own. She seemed somewhat relieved. Aspects of guilt were also clarified, since X felt that she was bad because she was HIV infected. X was encouraged to say something to the monster drawing. She said that, as a result of the HIV, she was now sick and had to attend hospital and take a lot of tablets. Anger was expressed towards the monster and she gained control by hitting a drum and telling the monster that this was her body and that she was bigger and stronger than the monster.

X proceeded to play with the doll's house and said she wished her mother was still alive. She was given the opportunity to talk to her mother in the empty chair and put a pretty doll in the chair, whereafter she expressed her love for her mother. She could also come into contact with her sadness about losing her mother at a young age. Relaxation exercises were done by teaching X how to imagine that she was doing something that made her feel good.

In assessing what happened during this phase, it became clear that X had gained self-support and begun verbalizing her emotions and expressing them by using projection. The medical kit aroused her interest and she began projecting her feelings. She could express her anger with the traditional drums, as well as by doing monster work. The taking of responsibility for feelings was evidenced here as well. As X began gaining insight, she realized that she had become HIV infected, because of her mother's illness, but that it is not her fault. This had resulted in her being hospitalized. She also felt lonely, since her family was not able to visit her. The fact that she could express her sadness and longing to her mother in the empty chair further assisted in emotional expression.In this manner, X was starting to handle her inner process and reality. Since middle childhood is characterized by greater emotional maturity, X was able to express her anger and fear.

7.5.4 Emotional expression and self-nurturing

It was essential for X to have enough opportunities to project and own her unexpressed emotions and to make contact with negative introjects in herself. She also had to learn to nurture herself.

During this phase, the empty chair technique, the rosebush fantasy, a drawing and cutting pictures out of a magazine were done.

A drawing activity was done first. X drew a house with different levels and a staircase with her aunt standing on the top level. She agreed to speak to her aunt utilizing the empty chair technique. She questioned her aunt as to the reasons for not visiting her. The fact that she verbalized her thoughts gave her a feeling of power, but also the opportunity to vent her anger. Ways in which she could deal with anger were discussed. She preferred a soft toy to a pillow fight and seemed happy to cuddle it. The rosebush fantasy was done. X drew a rosebush in colours of pink, green and blue. She said that she was a small bush with no thorns standing in a yard. She was not alone, although she was scared that she would be left alone.

Magazines were given to X and she was asked to cut out pictures of things that made her happy. She cut out pictures resembling happy smiling faces, her sister, food, ice cream and her favourite necklace.

Since X may have received negative introjects about herself, especially in the light of her illness and the fact that she may blame herself for it, she might be mistrustful and have guilt feelings. These could have influenced her sense of self. In order to assist X to become a nurturing being, the above activities were utilized. Already the dominant theme for X had become the longing for her family, which she portrayed using the empty chair technique. This theme took up a lot of X's energy. The fact that she could speak directly to her aunt and clarify opposing ideas or views helped her to close that gestalt. By means of projection, X was able to become aware of her feelings of loneliness and isolation, but also discover ways of dealing with it. This she needed to utilize in other parts of her life as well. The magazine pictures chosen seemed to provide a sense of nurturing, which X could also utilize to nurture herself when she felt feelings of insecurity and fear.

7.5.5 Emotional expression, self-nurturing and dealing with the process

How X handles herself, how she behaves or satisfies needs and how she gains awareness were all part of her process.

During this phase, building puzzles, puppets playing and a celebration worksheet were used. After each puzzle was completed, some aspects of the picture were highlighted to X concerning sensory feelings, as well as emotions. For example, one picture resembled a family. She said that her aunt was not visiting her. This caused her great distress, but she used her soft toy to cuddle her when she felt like this. Another puzzle was related to a monster, since it had a hidden spider. A discussion of her fears, death, illness and HIV/AIDS followed. X could relate to her anger, but could suggest

some handling strategies for her anger, such as to tear up papers or to pound a pillow.

The session continued with a celebration worksheet, which directed attention to what was good in X's life. She wrote down what she was proud of, someone who cared about her, something she enjoyed, something she did well, something that made her laugh and that made her felt good. After this, puppets were selected by X of animals/people who were important in her life. She selected the lady puppet representing her aunt, the doctor, the nurse, as well as her cousin and some friends and identified the role of each in her life. Other activities to assist with painful feelings were discussed, such as smelling play-dough, feeling it and pounding it, as well as breathing and relaxation exercises. Preparation for termination was done.

It was clear during this phase that X was developing a sense of self and becoming more spontaneous. She developed heightened awareness of her emotions, for example her longing for her aunt, her fear of death and her HIV illness. This was achieved through drawing or polarities since she began to realize that not all in her life was negative, but that there were also positive aspects. X was taking a position of responsibility by being more verbal through self-directed statements. By allowing X to experience her process fully she was able to find alternative ways of dealing with anger and fear, like tearing up newspaper or pounding on pillows.

7.5.6 Termination

Proper termination with X was an important part of the therapy process, since she needed to know that this was not rejection on the part of the therapist.

During this session, a memory box was made, bodywork and breathing exercises were done, a celebration certificate was completed and all the activities were discussed by paging through the file. X was also given the choice of doing one favourite activity. She chose to build another puzzle. Breathing and relaxation exercises were done again, since this was a basis for a strong sense of self and further emotional expression.

In assessing the above phase, it was essential for X to experience proper termination in order to avoid feelings of loss or rejection. She enjoyed most of the activities. The gaining of mastery, homeostasis and self-support were evident. The making of the celebration certificate seemed to indicate a real sense of achievement and growth. The making of choices and drawing on polarities was easier towards the termination session. X was able to easily indicate different emotions and express herself and did not seem to experience

termination as a loss or rejection. X was also doing well in school as well as in hospital. X's body language portrayed more energy and vibrancy towards termination. There was less dependency on the therapist, more verbalization and she was able to see both the good and bad in a situation.

7.6 GUIDELINES WHEN DOING GESTALT PLAY THERAPY WITH HIV/AIDS CHILDREN

- It is important that HIV/AIDS children be helped to maintain and sustain good contact in terms of their senses, body, emotions and intellect. Activities in this regard are important, since HIV/AIDS children may have inhibited fears, anger, grief, loss and withdrawal and they may restrict themselves, thus emotional expression and a strong sense of self may be absent. Focus must also be on acceptance of the body, since their body image may be a major issue. Pain and discomfort may have restricted contact-making. Drawing of the body, breathing, dancing, and describing body parts can be utilized.
- HIV/AIDS children need to develop a strong sense of self, which is a prerequisite for emotional expression. It is important for them to develop an awareness of themselves by learning to define themselves, by experiencing power and control, making choices, experiencing mastery, owning projections, setting boundaries and limits, being playful, as well as being in contact with their aggressive energy.
- The HIV/AIDS child needs to learn to unlock buried emotions like fear, withdrawal, poor self-image, body issues, guilt and loneliness, by using expressive and projective techniques such as drawing, painting, fantasy and imagery, puppetry, movement, clay play and story-telling. Therefore, addressing unfinished business and fragmentation is essential for them. These children should be allowed to understand what feelings are, how they block them, learn to own the feelings and learn to express them in a constructive manner.
- Since HIV/AIDS children may have little family support and suffer poverty or isolation, it is vital that these children be taught to be more accepting, caring and nurturing towards themselves. HIV/AIDS children may have received negative introjects concerning themselves, when they did not have the maturity nor

cognitive ability to distinguish whether it was relevant or not, thereby causing these children to inhibit aspects of the self. Teaching children to accept these hateful parts like the virus in the blood, hospitalization and fearful medical procedures will assist them in working towards self-integration and self-worth.

- In order to gain approval, HIV/AIDS children who fear rejection, stigma or abandonment may manifest behaviour that could keep them from engaging in healthy contact with other children, teachers, parents or significant others. They may project, deflect, retroflect or become confluent. These contact boundary disturbances may be seen as resistances, which should be anticipated, accepted and respected in therapy, since this may be the child's way of discovering new ways of being and acting in this world.
- It is important for HIV/AIDS children to develop an awareness and experience who they are, what they feel, their needs, wants and how they do things. These experiences and experiments will assist them in dropping unproductive behaviour and feeling a sense of calmness and awareness through the therapy process. Sometimes heightened awareness alone leads to a new sense of self and self-support.
- HIV/AIDS children may suffer a lot of confusion as a result of the fact that they may love their caregiver but also feel anger at being left alone, or the fact that they fear medical procedures although they may make them feel better later. These confusing feelings may cause further alienation, isolation or fragmentation. Learning to integrate and reconcile these opposing parts, be they positive or negative, will assist them in finding more healthy ways of being.
- A lack of significant people in the life of the HIV/AIDS child for family support, lack of treatment and proper nutrition can produce high levels of stress. Therefore, parent guidance and training as well as multidisciplinary services become essential for the comprehensive treatment of HIV/AIDS children.
- The effect of middle childhood development in terms of physical, cognitive, social and emotional growth needs to be taken into account when doing gestalt play therapy with HIV/AIDS children.

7.7 CONCLUSION

The theoretical concepts, therapeutic process of gestalt play therapy, and different play techniques can be utilized during therapy with HIV/AIDS children. The aim of gestalt play therapy is to help children to become aware of what they are experiencing in the here and now, by using certain techniques in order to become more integrated and self-supportive.

HIV/AIDS children in the middle childhood may experience stress with regard to their normal development and may have many unfinished and unexpressed emotions, due to their sickness and the treatment thereof. The implication of HIV/AIDS children's physical, social, cognitive, moral and emotional development should be taken into account during gestalt play therapy, as these can determine how they deal with different feelings, such as grief, loss, anger and fear.

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PART FOUR

APPENDICES

Appendix 1

Summary of Aspects that Should Be Addressed During Each Stage of the Gestalt Play Therapeutic Process

Stage in the therapeutic process	Aspects that should be addressed
Building the therapeutic relationship, assessment and treatment planning	• establish the I–thou relationship • focus on the here and now • responsibility of therapist and child • techniques and activities that focus on experience and discovery • manifestation and handling of resistance • setting boundaries and limitations • assessing children according to holistic gestalt assessment criteria • doing treatment planning with reference to objectives of gestalt play therapy
Contact-making and promoting self-support	• sensory contact-making • bodily contact-making • strengthening the self by: ◦ defining the self ◦ choices ◦ mastery, authority and control ◦ owning projections ◦ boundaries and limitations ◦ playfulness, imagination and humour

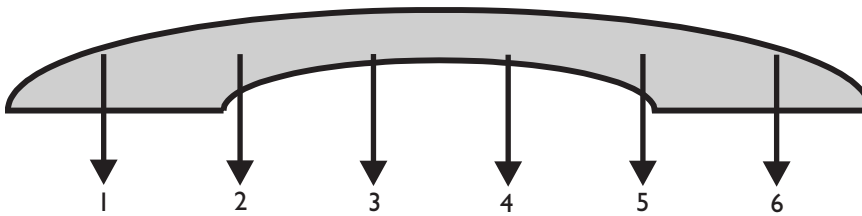
Continued on next page

Stage in the therapeutic process	Aspects that should be addressed
Emotional expression	• expression of aggressive energy • expression of emotions by: ◦ cognitive conversation on emotions ◦ conversation on body's reaction to different emotions ◦ projecting and owning emotions ◦ learning handling strategies and skills to handle emotions
Self-nurturing	• contact-making with unacceptable part in the self • gain skills to use nurtured parts in order to integrate and nurture unacceptable parts • gain skills to be good to the self
Handling persistent inappropriate process	• promote awareness of own process and behaviour • acquire skills to make choices and to take responsibility • learn handling strategies for problems
Termination	• thorough evaluation to determine suitable time and thorough preparation for this

Appendix 2

Horizontal and vertical development of gestalt play therapy

The gestalt play therapy process



KEY

1. Building the therapeutic relationship, assessment and treatment planning
2. Contact-making and strengthening the sense of self
3. Emotional expression
4. Self-nurturing
5. Addressing the persistent inappropriate process
6. Termination

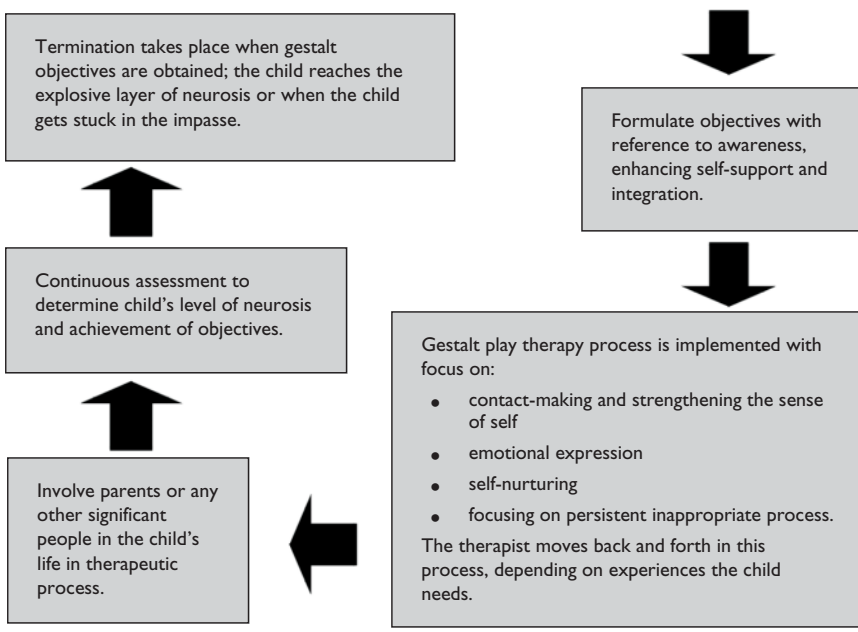
Development during a session

Establishment of I–thou contact
Experiences in the here and now
Imaginary experiences, e.g. 'Imagine a safe place in your life.'
Sensory experience, e.g. 'What do you see, hear, touch, smell and taste?'
Metaphoric narrative articulation, e.g. 'I have some very gentle fish in me.'
Sense-making, e.g. 'It reminds me of the time before my parents got divorced.' Focus on polarities, e.g. 'Do you always think of that?'
Focus on handling strategies, e.g. 'What can you do if you feel so sad?' Empower the child, e.g. 'I know that you will be able to keep up to your decision, because you are very determined.'
Give homework, e.g. 'I want you to do two nice things for yourself every day this week.' Ground the child, e.g. 'What are you going to have for dinner tonight?'

Appendix 3

Assessment and Treatment Planning of Children from a Gestalt Theoretical Perspective

Assessment during each session focuses on:	**Are there specific experiences or circumstances that must be taken into account such as:**	**Child's developmental phase and level must be taken into account when doing assessment and treatment planning:**
• therapeutic I–thou relationship • contact and contact-making skills • contact boundary disturbances • emotional expression • cognitive aspects • sense of self • body awareness • resistance • humour • creativity • social skills • process and child's unique temperament	• loss an trauma, e.g. death, divorce, a new baby brother, sister, HIV/AIDS • attention deficit hyperactivity disorder • mood disorder • separation anxiety • statutory intervention • adoption • Tourette's syndrome • abuse • family dysfunction • child exposed to violence	Does the way the child behaves to satisfy his or her needs correlate with his or her: • cognitive development • affective development • social development • moral development



Appendix 4

Checklist for Things that the Child Lost when the Divorce Happened

- ☐ House
- ☐ Pet
- ☐ Well-known school
- ☐ Stable life
- ☐ Transport
- ☐ Money
- ☐ Income of one parent
- ☐ Friends
- ☐ Dreams of the future
- ☐ Peace of mind
- ☐ One parent away from family
- ☐ Contact with one parent
- ☐ Less opportunity to talk with…
- ☐ Grandfather/grandmother
- ☐ Parent that you live with is different
- ☐ Contact with other family
- ☐ I am torn in two
- ☐ Lost love
- ☐ Physical contact
- ☐ Lost happy life
- ☐ People look at me differently
- ☐ Garden
- ☐ Can't talk with confidant any more
- ☐ People who supported me
- ☐ Wonder who I am and where I belong – identity
- ☐ Being carefree
- ☐ I think less of myself
- ☐ Brother/sister
- ☐ Divorce is my fault – innocence
- ☐ My own reaction makes me lose more
- ☐ People think I am worthless
- ☐ Have lost confidence in others
- ☐ One family – family unity
- ☐ Lost everything that is good
- ☐ Happiness
- ☐ I have lost…

About the Author

Dr Rinda Blom has a master's degree in social work with specialization in play therapy. She also completed a doctorate in play therapy, titled *A Gestalt Play Therapy Aid Programme in Social Work Aimed at Junior Primary School Children's Emotional Intelligence*. She received intensive gestalt play therapy training in the USA, presented by Dr Violet Oaklander. Dr Blom has presented many courses on gestalt play therapy, emotional intelligence and parental guidance all over South Africa. Currently she holds a position as part-time senior lecturer in social work at the University of the Free State, after lecturing at the university on a full-time basis for a period of five years. She is director of a company, the Foundation for the Development of Emotional Intelligence in Children, which trades under the name Wisechild. This company was established in 2002, in order to provide children of all ages and cultures in South Africa with the opportunity to enhance their emotional intelligence by means of age-appropriate programmes. Dr Blom has more than ten years' experience of therapeutic work with children with emotional problems.

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Subject Index

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